DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2008

Centers for Medicare & Medicaid Services

Justification of Estimates for the Appropriations Committees

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

Message from the Acting Administrator

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) performance budget for fiscal year (FY) 2008. CMS is the largest purchaser of health care in the United States, serving 92 million Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) beneficiaries. We also oversee survey and certification of health care facilities. We take both of these roles very seriously, as our oversight responsibilities impact millions of people and have grown dramatically over the last few years.

In FY 2006, CMS successfully launched the new prescription drug benefit, the largest expansion of the Medicare program since its inception. As a result, over 38 million beneficiaries now have some form of affordable drug coverage, thus helping them live better, healthier lives. FY 2008 will be a year of transformation for CMS. We will make sweeping operational changes to improve program efficiency and the quality of services through contracting reform and the implementation of competitive bidding for durable medical equipment on a national scale. We are advancing our public health focus by implementing price transparency in health care, value-based purchasing initiatives, and personal health records for Medicare beneficiaries. Through the President's Affordable Choices initiative, we will work with States to make basic, affordable private health insurance available to every American.

While we are focused on priority areas such as these, CMS' resource needs are principally driven by workloads that grow annually. We formulated our FY 2008 request based on funding these workloads, finding efficiencies to offset increasing costs, and implementing the President's Management Agenda (PMA). Consistent with our increasing responsibilities and with the Secretary's goals for our programs, our FY 2008 Program Management request reflects a 2.9 percent increase above the FY 2007 current rate, including the funds provided by the Tax Relief and Health Care Act of 2006. We have included a user fee proposal for your consideration and have also highlighted initiatives that will generate significant savings.

CMS strives to achieve a transformed and modernized health care system for America. With a new Strategic Action Plan implemented in 2006, we will strengthen our workforce to manage and implement our programs, make sure those who provide health care services receive accurate and predictable payments, work toward a high-value health care system, make our consumers confident by giving them more information, and continue to develop collaborative partnerships. CMS remains committed to budget and performance integration in compliance with the PMA. This FY 2008 performance budget request combines our FY 2008 annual performance goals and FY 2006 annual performance report. This budget request also demonstrates the agency's progress on improving program effectiveness based on the recommendations contained in 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 2008 budget request.

Leslie V. Norwalk, Esq.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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**** Reports to COO**

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Herb Kuhn *

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Performance Budget Overview

AGENCY MISSION

The Centers for Medicare & Medicaid Services (CMS) is an Agency within the Department of Health and Human Services (HHS). The creation of CMS 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. 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 being the addition of a prescription drug benefit which was effective January 2006. In 2006, the Deficit Reduction Act was also passed which restrains spending for 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 establishes physician payments and quality improvement initiatives and expands Medicare Integrity Program efforts. CMS has become the largest purchaser of health care in the United States, serving about 92 million Medicare and Medicaid beneficiaries, including those covered under SCHIP.

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 strengthen our workforce to manage and implement our programs, 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, make our consumers confident by giving them more information, and continue to develop collaborative partnerships.

DISCUSSION OF STRATEGIC GOALS

Consistent with the principles of the Government Performance and Results Act (GPRA), CMS has focused on identifying a set of meaningful, outcome-oriented performance goals that speak to fundamental program purposes and to the Agency's role as a steward of taxpayer dollars. CMS' FY 2008 performance budget reinforces CMS, HHS and Administration priorities including the HHS Strategic Plan and CMS strategic goals. For a link of the HHS and CMS strategic goals, please see the chart on the following page.

CMS' strategic goals and objectives are developed in conjunction with the HHS Strategic Plan, and outline specific goals for achieving our mission. CMS' strategic goals, the HHS strategic plan, the enactment of GPRA, the HHS management plan, the President's Management Agenda, the Secretary's 500-Day Plan and other HHS and government-wide programs have all emphasized the themes of accountability, stewardship and a renewed focus on the beneficiary.

There is a strengthened Agency commitment to beneficiaries as the ultimate focus of all CMS activities, expenditures, and policies. We will communicate, collaborate, and cooperate with key customers, both public and private, to help us achieve the desired outcomes stated in this performance budget.

HHS Strategic Plan - CMS Strategic Action Plan Link

	CMS Strategic Action Plan Objectives				
	Skilled, Committed and Highly-Motivated Workforce	Accurate and Predictable Payments	High Value Health Care	Confident, Informed Consumers	Collaborative Partnerships
HHS Strategic Goals					
1: Reduce the major threats to the health and well-being of Americans	X		X	X	X
2: Enhance the ability of the Nation's health care system to effectively respond to bioterrorism and other public health challenges	X	X			X
3: Increase the percentage of the Nation's children and adults who have access to health care services, and expand consumer choices	X	X	X	X	X
4: Enhance the capacity and productivity of the Nation's health science research enterprise			X		X
5: Improve the quality of health care services	X	X	X	X	X
6: Improve the economic and social well-being of individuals, families, and communities, especially those most in need	X		X	X	X
7: Improve the stability and healthy development of our Nation's children and youth.	X	X	X	X	X
8: Achieve excellence in management practices	X	X		X	X

OVERVIEW OF CMS PERFORMANCE

CMS' total number of FY 2008 performance goals is 36. We carried over the majority of the goals in the FY 2007 plan, with new targets appropriate for FY 2008 focusing on meaningful outcomes. In addition, 8 new Medicaid-related performance goals have been added as a result of the Program Assessment Rating Tool (PART) evaluation of the Medicaid program this summer. During previous PART evaluations for the State Children's Health Insurance Program and the Medicare Integrity Program, significant program activity performance goals were added which further strengthened the

representation of those programs in our budget. Additional information about these PART programs, along with the PART assessment of the Medicare program, may be found on www.ExpectMore.gov and in the relevant program discussions.

Consistent with GPRA principles, CMS has focused on identifying a set of meaningful, outcome-oriented performance goals that speak to fundamental program purposes and to the Agency's role as a steward of taxpayer dollars. There are charts in the Performance Detail section of this submission linking our performance goals to both the CMS and HHS strategic goals. This information is also illustrated in each goal write-up along with a link of the activity to the Secretary's 500-Day Plan.

The 2001 President's Management Agenda (PMA) gave CMS an opportunity to develop initiatives to vigorously move the Agency forward with a focus on five primary objectives: integrating budget and performance; enhancing strategic management of human capital; increasing competitive sourcing; improving financial performance; and expanding electronic government. In addition, CMS spearheads the PMA program initiative Broadening Health Insurance Coverage through State Initiatives and actively manages the Eliminating Improper Payments Initiative. As in previous years, many of our performance goals are consistent with these objectives. Annual performance goals support the PMA objective of integrating budget and performance. To further link budget with performance and consistent with OMB direction, we have developed "full cost" estimates for our FY 2008 performance goals.

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

FY 2006 Reporting

Summary of FY 2006 Successes

Overall, CMS experienced positive results in FY 2006. Of the 45 FY 2006 measures (31 goals) reported on, we have 6 targets for which we do not have complete data. We have met or exceeded expectations for 37 of the 39 targets for which we have complete data. For example:

- Improve Satisfaction of Medicare Beneficiaries with the Health Care Services they Receive
- Improve Medicare's Administration of the Beneficiary Appeals Process
- Implement the New Medicare Prescription Drug Benefit
- Assure the Purchase of Quality, Value and Performance in State Survey and Certification Activities
- Implement Medicare Contracting Reform

- Develop and Implement an Enterprise Architecture
- Assess the Relationship between CMS Research Investments and Program Improvements
- Implement Regional Preferred Provider Organizations (PPO)
- Improve CMS' Information Systems Security
- Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Hemoglobin A1c and Cholesterol (LDL) Testing
- Protect the Health of Medicare Beneficiaries by Increasing the Percentage of Dialysis Patients with Fistulas as Their Vascular Access for Hemodialysis
- Reduce the Medicare Fee-For-Service Error Rate
- Improve the Effectiveness of the Administration of Medicare Secondary Payer (MSP) Provisions by Increasing the Number of Voluntary Data Sharing Agreements with Insurers or Employers
- Improve the Provider Enrollment Process
- Improve Health Care Quality Across Medicaid and SCHIP
- Decrease the Prevalence of Restraints and Pressure Ulcers in Nursing Homes

Summary of FY 2006 Performance Challenges
Although we are not reporting success in meeting the following 2 goals in their entirety, we have made significant progress:
Decrease the Medicare Provider Compliance Error Rates – Under the current methodology, this goal was not met for FY 2006. Due to systems limitations, CMS did not collect covered charge data from fiscal intermediaries (FIs) during this reporting period. CMS was therefore unable to produce this rate for FIs during the November 2006 reporting period.

Increase the Use of Electronic Commerce/Standards in Medicare - Due to competing priorities, we were not able to reach our FY 2006 Electronic Funds Transfer (EFT) target; however, we were able to make some progress. The FY 2007 target for EFT is to obtain 100 percent enrollment of all new providers.

Final Results for Pending FY 2005 Performance Goals
Results are now available for the following previously unreported FY 2005 goals:

Met
- Assure the Purchase of Quality, Value and Performance in State Survey and Certification Activities
- Decrease the Prevalence of Restraints in Nursing Homes
- Decrease the Prevalence of Pressure Ulcers in Nursing Homes
- Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries
- Improve Beneficiary Understanding of Basic Features of the Medicare Program
- Protect the Health of Medicare Beneficiaries by Optimizing the Timing of Administration of Antibiotics to Reduce the Frequency of Surgical Site Infection

Not Met

- Increase the Percentage of Medicare Beneficiaries Age 65 Years and Older Who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal
- Increase the Percentage of Medicare Beneficiaries Age 65 Years and Older Who Receive a Mammogram

Partially Met

- (1 target met, 3 not met) Improve Satisfaction of Medicare Beneficiaries with the Health Care Services they Receive
- (1 target met, 2 not met) Improve the Provider Enrollment Process

OVERVIEW OF CMS BUDGET REQUEST

Size and Scope of CMS Responsibilities

CMS is the largest purchaser of health care in the world. Our programs provide health care coverage to about 92 million beneficiaries, almost one in three Americans. Medicare and Medicaid combined pay about one-third of the Nation's health expenditures.

CMS is committed to administering its programs as efficiently as possible. Non-benefit costs, most of which are administrative costs, are minute when compared to Medicare benefits and the Federal share of Medicaid and State Children's Health Insurance Program (SCHIP) benefits. In FY 2008, these benefit costs are expected to total almost $657 billion. Non-benefit costs, which include 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 $17.8 billion**,** or 2.7 percent of total benefits under current law. Program Management costs are one-half of one percent of Medicare benefits while Medicaid State and local administrative costs are about 4.9 percent of Medicaid benefits under current law.

Challenges in FY 2008

CMS faces several challenges in FY 2008. We must stabilize systems and operations designed and built for the new programs enacted by the Medicare Modernization Act (MMA) and finish implementing MMA provisions. Two of these provisions, contracting reform and competitive bidding for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), involve substantial implementation costs in FY 2008 but are also expected to generate significant savings. CMS continues to look for ways to be more efficient and effective while continuing to implement these major initiatives.

Framework for FY 2008 Budget Request

CMS' Program Management needs are driven largely by the ongoing work we must complete which includes processing almost 1.3 billion Medicare fee-for-service claims, handling millions of inquiries and appeals, and conducting health care facility inspections and complaint investigations. In formulating our FY 2008 request, we focused first on these workloads and then on priority areas specific to the Administration and the Secretary, including the President's Management Agenda.

Secretarial and Administrative Priorities

In addition to processing claims-related workloads and implementing legislation, CMS supports the following priorities as part of our overall strategic approach. These priorities align directly with four of Secretary Leavitt's principles in his 500-Day Plan: Transforming the Health Care System; Modernizing Medicare and Medicaid; Securing the Homeland; and Protecting Life, Family, and Human Dignity. Collectively, they improve the health and well-being of our beneficiaries.

- Value-Driven Health Care: CMS is leading the industry in the shift to a quality-oriented, patient-centered payment system by developing and implementing a value-based purchasing system in five clinical settings: physician offices, hospitals, home health agencies, nursing homes, and end-stage renal disease (ESRD) facilities. We are also actively working with several State health departments to implement a quality-based purchasing program for Medicaid and the State Children's Health Insurance Program (SCHIP). As a result, the Department has initiated the Better Quality Information for Medicare Beneficiaries project which combines public and private quality and price information to measure and report on the performance of the health care system in a meaningful and transparent way for consumers and purchasers of health care. The Tax Relief and Health Care Act of 2006 included $60 million for physician payments and quality improvement initiatives. These value-driven health care efforts have been reinforced by a Presidential Executive Order issued on August 22, 2006.

- Health Information Technology: CMS is modernizing its IT architecture and systems in support of Health Information Technology. We have implemented a national rollout of the MyMedicare.gov web portal which provides Medicare beneficiaries with access to personalized information regarding their Medicare benefits and services. We launched an online enrollment center and completed several million online enrollments to the prescription drug program. We completed two pilots which tested the use of Medicare claims history data to populate Personal Health Records and five pilot sites which tested e-prescribing standards. Currently, about 4,500 practices are participating in the Doctor's Office Quality-Information Technology (DOQ-IT) initiative. In addition, we published a regulation to clarify when hospitals may donate electronic health technology to physicians and other providers.

- Modernizing Medicaid: CMS is making strides to ensure that Medicaid program dollars are used appropriately, that consumers can make more informed choices, and that States can tailor their benefits to meet the needs of their beneficiaries. In 2006, CMS approved four State Plan Amendments to allow States to restructure Medicaid benefits under Deficit Reduction Act of 2005 authority. CMS also launched the comprehensive Medicaid Integrity Program and established the Medicaid Integrity Group to combat fraud and abuse. Greater use of community-based long-term care services and increased flexibility afforded by the Deficit Reduction Act of 2005 will lead to further efficiencies and slower growth for this vital program.

- Modernizing Medicare: CMS successfully launched a new prescription drug benefit, the first major expansion of the Medicare program in its 40-year history. In 2006, over 38 million Medicare beneficiaries had access to prescription drug coverage, either through Part D or another source. The average Part D premium for basic benefits is 42 percent lower than the independent HHS actuaries had projected when originally scoring this cost, and beneficiary satisfaction rates are 75 percent or higher. We have also enhanced the Internet tools that help beneficiaries get the most of their Medicare benefits. In addition, CMS plans to modernize administrative aspects of Medicare by implementing nationwide competitive bidding and contracting reform. We have already awarded five contracts allowing CMS to select Medicare administrative contractors through full and open competition; we expect to award a total of 23 contracts.

- Prevention: As part of the My Health, My Medicare initiative, CMS is helping seniors improve their health by providing them with the information, resources, and support they need to make lifestyle changes and get important preventive services. Medicare has added a variety of new preventive benefits to help seniors take better care of themselves. These include the *Welcome to Medicare* exam, which provides education and counseling about important preventive services including screening tests and shots, and referrals for other services for all new Medicare enrollees within their first six months of starting their Medicare Part B coverage. Other preventive benefits include cardiovascular screening blood tests, diabetes screening, counseling to quit smoking, and glaucoma screening for Hispanic Americans age 65 and over.

- Emergency Response and Preparedness: CMS played a key role in the emergency health care response to the disasters created by Hurricanes Katrina and Rita. CMS assumed responsibility for managing the reimbursement aspect of the National Disaster Medical System, contracting for and disbursing payment to hospitals that served evacuees from Katrina. We increased flexibility for providers and beneficiaries by approving numerous waivers and a pharmacy relief model, allowing more providers to give care and receive payment, and for displaced beneficiaries to receive care in their new locations. In addition, CMS has assumed the lead in rebuilding the Gulf Coast health care infrastructure. CMS has established a New Orleans satellite office to coordinate with the Louisiana Healthcare Redesign Collaborative to reestablish access to health care in the region.

The following pages of this summary describe the Program Management portion of the CMS budget request in detail.

FY 2008 Program Management Overview

CMS' FY 2008 current law appropriation request is $3,274.0 million, an increase of $125.6 million above the FY 2007 President's budget and $93.0 million above the FY 2007 current rate. The table below presents CMS' budget request for each of the line items under Program Management. In FY 2008, funding for projects included in the Revitalization Plan has been included in the Medicare Operations line. MMA funds are

included with the line item account which they support. A non-add breakout of MMA funding is provided for informational purposes.

	FY 2006 Enacted 1/	FY 2007 Pres. Bud.	FY 2007 Current Rate 2/	FY 2008 Pres. Bud.
	($ in Millions)			
Program Management				
Medicare Operations	$2,200.8	$2,145.2	$2,210.6	$2,303.6
Federal Administration	641.4	655.4	648.0	643.2
Survey & Certification	258.1	283.5	258.1	293.5
Research	69.4	41.5	41.5	33.7
Revitalization Plan	24.0	22.8	22.8	0.0
Appropriation	**$3,193.8**	**$3,148.4**	**$3,181.0**	**3,274.0**
MMA, non-add	**$669.3**	**$585.6**	**$562.1**	**$687.2**

1/ FY 2006 includes $74 million provided by the Deficit Reduction Act of 2005 (P.L. 109-171) and $40 million from the Secretary's Section 202 transfer.
2/ FY 2007 Current Rate includes $105 million provided by the Tax Relief and Health Care Act of 2006 (P.L. 109-432)

- **MMA**

CMS's request includes $687.2 million for on-going MMA activities including running the prescription drug benefit and Medicare Advantage programs, educating beneficiaries, supporting fee-for-service improvements, maintaining the systems developed for the new MMA programs, continuing to implement contracting reform, and expanding DME competitive bidding nationwide. MMA funds are included in three of the Program Management line item activities—Medicare Operations, Federal Administration, and Research—discussed below. CMS will continue to track its MMA spending.

- **Medicare Operations**

The Medicare Operations account provides funding for a variety of activities, including the on-going work—processing claims, answering inquiries, handling appeals—performed by the Medicare contractors; operational support for these workloads, primarily information technology costs; and activities that implement legislation, including the MMA, the Health Insurance Portability and Accountability Act (HIPAA) of 1996, and the Benefits Improvement and Protection Act (BIPA) of 2000. The FY 2008 request for Medicare Operations is $2,303.6 million, an increase of $93.0 million above the FY 2007 current rate including the Tax Relief and Health Care Act of 2006.

This funding level will cover the Medicare contractors' on-going workloads, including an anticipated increase in claims, and the information technology (IT) that supports claims processing. It will allow CMS to administer the prescription drug and Medicare Advantage programs, including the outreach and education efforts that support these programs. It will also allow CMS to complete the first round of contracting reform begun in FY 2007, initiate the second round of transitions and terminations to the new Medicare

Administrative Contractors (MACs), and implement the systems strategies (enterprise data center and standard front end) that are needed for a successful MAC environment. We will continue to implement HIGLAS at selected contractors, and will develop new modules including the administrative accounting module and HIGLAS for Parts C and D. As mentioned above, CMS will also implement nationwide competitive bidding for DMEPOS.

Beginning in FY 2008, CMS will no longer maintain a separate line item account for its IT capital investment fund, the Revitalization Plan. Instead, we will incorporate $10 million for strategic IT investments into the Medicare Operations account. Since FY 2004, CMS has successfully modernized its computing platform, developed the ability to support health plan and provider services over the Internet, begun to redesign antiquated claims processing systems, and started work on an Integrated Data Repository that will support interoperability and Administrative priorities such as value-based purchasing. As a result of these and other investments, CMS is better positioned to meet future challenges in the Medicare program.

- **Federal Administration**

The majority of the Federal Administration budget pays the salaries and payroll benefits for CMS' Federal employees while the remainder covers essential administrative costs such as information technology, rent, contracts, travel, and training. The FY 2008 request is $643.2 million, a decrease of $4.9 million below the FY 2007 current rate including the Tax Relief and Health Care Act of 2006. Of this amount, CMS is requesting $517.2 million to cover payroll for 4,344 direct FTEs, the same FTE level as the FY 2007 current rate. This amount supports a 3.0 percent pay increase in calendar year 2008. The request continues the Administration's support of the "Healthy Start, Grow Smart" program for new Medicaid mothers.

- **Survey and Certification**

The Survey and Certification (S&C) budget provides funding to the States for surveys, complaint visits, and associated costs. It also covers related support contracts managed internally by CMS. The FY 2008 CMS request is $293.5 million. While this is an increase of $35.4 million over the FY 2007 Current Rate, it is only a $10.0 million, or 3.5 percent, increase over the FY 2007 President's Budget. The budget request will ensure that survey frequencies meet Administration policy goals. CMS is again proposing a user fee for revisit surveys that would allow CMS to collect an estimated $35 million. Collections will offset our current law Program Management appropriation on a dollar-for-dollar basis.

- **Research, Demonstration, and Evaluation**

The FY 2008 request for the Research, Demonstration, and Evaluation budget is $33.7 million, a decrease of $7.8 million from both the FY 2007 President's Budget and the FY 2007 current rate. This amount funds ongoing projects, such as the Medicare

Current Beneficiary Survey and MMA-related research, and includes $10.0 million for Real Choice System Change grants.

CONCLUSION

CMS' FY 2008 current law Program Management appropriation request is $3,274.0 million, an increase of $93.0 million or 2.9 percent above the FY 2007 current rate including funding provided by the Tax Relief and Health Care Act of 2006. This budget will allow CMS to cover its basic operational needs, run the new programs implemented under the MMA, continue to implement an accelerated model of contracting reform, expand competitive bidding for DMEPOS, improve financial management processes, continue its beneficiary education efforts, make investments in IT, survey health care facilities at the mandated frequencies, and conduct basic levels of research. The justifications in the following section highlight our program administration plans for FY 2008.

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Funding Summary

FY 2008 Total Obligations (Current Law)	**$674,383,888,000**
Federal Benefits: 1/	**$656,598,957,000**
Medicare	$457,688,000,000
Medicaid 2/	$193,870,957,000
State Children's Health Insurance Program	$5,040,000,000
Federal Operating Costs:	**$17,784,931,000**
State Agents:	**$11,137,940,000**
Medicaid Agencies	$10,014,716,000
State Grants and Demonstrations	$786,700,000
Survey and Certification Agencies	$293,524,000
Clinical Laboratory Surveyors	$43,000,000
Private Sector Agents:	**$4,071,104,000**
Intermediaries and Carriers	$2,303,615,000
Health Care Fraud and Abuse Control	$1,324,000,000
Quality Improvement Organizations	$307,700,000
Research Contractors and Grantees	$33,700,000
Coordination of Benefits User Fees	$32,289,000
MA/PDP User Fees 3/	$69,800,000
Federal Agencies:	**$2,575,887,000**
Social Security Administration	$1,680,000,000
Centers for Medicare & Medicaid Services 4/	**$645,387,000**
Other (Treasury, OIG, etc.)	$250,500,000
CMS Full-Time Equivalent (FTE) Staff 5/	***4,581***

1/ Corresponding benefit outlays total $657.0 billion.

2/ The Medicaid benefits shown above include funds for the Vaccines for Children program.

3/ Previously shown as Medicare+Choice User Fees.

4/ Includes $643.2 million in the Federal Administration portion of CMS' Program Management appropriation, plus user fees from the sale of data.

5/ Includes 153 FTEs funded from the State Grants and Demonstrations and HCFAC accounts.

Department of Health and Human Services
The Centers for Medicare & Medicaid Services
FY 2008 All-Purpose Table (Discretionary)
(dollars in thousands)

Activity	FY 2006 Enacted 1/	FY 2007 President's Budget	FY 2007 Current Rate	FY 2008 President's Budget
Medicare Operations	$2,172,987	$2,145,208	$2,120,588	$2,303,615
Deficit Reduction Act (P.L. 109-171)	$53,600	$0	$0	$0
Section 202 Transfer	$40,000	$0	$0	$0
Tax Relief and Healthcare Act (P.L. 109-432)	$0	$0	$90,000	$0
Rescission (P.L. 109-148)	($21,245)	$0	$0	$0
Rescission (P.L. 109-149)	($44,500)	$0	$0	$0
Net Medicare Operations BA	**$2,200,842**	**$2,145,208**	**$2,210,588**	**$2,303,615**
Federal Administration	$655,000	$655,377	$633,065	$643,187
Deficit Reduction Act (P.L. 109-171)	$8,400	$0	$0	$0
Comparability Adjustment (JFA/TAPS) 2/	($26)	($26)	($26)	$0
Tax Relief and Healthcare Act (P.L. 109-432)	$0	$0	$15,000	$0
Rescission (P.L. 109-148)	($6,435)	$0	$0	$0
Rescission (P.L. 109-149)	($15,500)	$0	$0	$0
Net Federal Administration BA	**$641,439**	**$655,351**	**$648,039**	**$643,187**
State Survey & Certification	$260,735	$283,524	$258,128	$293,524
Rescission (P.L. 109-148)	($2,607)	$0	$0	$0
Net State Survey & Certification BA	**$258,128**	**$283,524**	**$258,128**	**$293,524**
Research	$58,000	$41,528	$41,528	$33,700
Deficit Reduction Act (P.L. 109-171)	$12,000	$0	$0	$0
Rescission (P.L. 109-148)	($580)	$0	$0	$0
Real Choice Systems Change Grants (Non-Add)	*$24,750*	*$0*	*$0*	*$10,000*
Net Research BA	**$69,420**	**$41,528**	**$41,528**	**$33,700**
CMS Revitalization Plan	$24,205	$22,765	$22,757	$0
Rescission (P.L. 109-148)	($242)	$0	$0	$0
Net CMS Revitalization Plan BA	**$23,963**	**$22,765**	**$22,757**	**$0**
Emergency/Supplemental Funds	**$0**	**$0**	**$0**	**$0**
Appropriation/BA C.L. (Discretionary)	**$3,119,792**	**$3,148,376**	**$3,076,040**	**$3,274,026**
Appropriation/BA C.L. (Mandatory)	**$74,000**	**$0**	**$105,000**	**$0**
Appropriation/BA C.L.	**$3,193,792**	**$3,148,376**	**$3,181,040**	**$3,274,026**
Est. Offsetting Collections from Non-Federal Sources: **Offsetting Collections, C.L.**	**$100,909**	**$144,388**	**$144,388**	**$147,289**
Subtotal, New BA, C.L.	**$3,294,701**	**$3,292,764**	**$3,325,428**	**$3,421,315**
P.L. User Fee Offset 3/	$0	($35,000)	$0	($35,000)
Appropriation P.L.	**$3,193,792**	**$3,113,376**	**$3,181,040**	**$3,239,026**
Proposed Law Offsetting Collections (Non-Add) 3/	*$0*	*$35,000*	*$0*	*$35,000*
Offsetting Collections, P.L.	$100,909	$179,388	$144,388	$182,289
Subtotal, New BA, P.L.	**$3,294,701**	**$3,292,764**	**$3,325,428**	**$3,421,315**
No-Year Carryforward (C.L., FY 98-06) 4/	$13,140	$0	$22,956	$0
Emergency/Supplemental Funds	**$0**	**$0**	**$0**	**$0**
Program Level, Current Law	**$3,307,841**	**$3,292,764**	**$3,348,384**	**$3,421,315**
Program Level, Proposed Law	**$3,307,841**	**$3,292,764**	**$3,348,384**	**$3,421,315**
HCFAC Discretionary	**$0**	**$118,404**	**$0**	**$183,000**
CMS FTEs:				
Direct (Federal Administration)	4,554	4,531	4,344	4,344
Reimbursable (CLIA)	72	72	75	84
Subtotal, Prog. Mgt. FTEs, C. L. 5/	**4,626**	**4,603**	**4,419**	**4,428**
Medicaid Oversight (HCFAC/State Grants)	90	200	119	153
Total, CMS FTEs, Current Law 5/	**4,716**	**4,803**	**4,538**	**4,581**

1/ The FY 2006 column reflects the enacted (net) appropriation after all rescissions, transfers and reprogrammings. The FY 2006 column also includes funding provided by P.L. 109-171, the Deficit Reduction Act of 2005.

2/ Reflects the comparable transfer of $26,000 to DHHS GDM for various joint funding agreements and TAPS.

3/ Reflects CMS' proposal to charge user fees to facilities requiring a follow up survey to verify corrective action ($35.0 million).

4/ Reflects remaining no-year and multi-year funding attributable to CMS' managed care redesign, HIGLAS and IT revitalization activities.

5/ The FY 2006 column reflects actual FTE consumption.

Program Management
Appropriation Language

Primary Exhibit:

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act (SSA), titles XIII and XXVII of the Public Health Service Act, and the Clinical Laboratory Improvement Amendments of 1988, not to exceed $3,274,026,000, to be transferred from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, as authorized by section 201(g) of the SSA; together with all funds collected in accordance with section 353 of the Public Health Service Act and section 1857(e)(2) of the SSA, 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 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 $49,869,000, to remain available until September 30, 2009, is for contract costs for the Healthcare Integrated General Ledger Accounting System: Provided further, That the Centers for Medicare & Medicaid Services will take all reasonable actions necessary to ensure that before December 15, 2008 no fewer than 15 Medicare Administrative Contractors will commence the duties of Medicare claims-processing activities and related responsibilities: Provided further, That $253,775,000, to remain available until September 30, 2009, 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 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.

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 2008 shall be reduced by the amount credited to this account under this paragraph.

Comparison of Proposed FY 2008 Appropriation Language to Most Recently Enacted Full-Year Appropriation (FY 2006)

Supplementary Exhibit:

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act ***(SSA)****, titles XIII and XXVII of the Public Health Service Act, and the Clinical Laboratory Improvement Amendments of 1988, not to exceed* ***$3,274,026,000,*** *to be transferred from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, as authorized by section 201(g) of the SSA; together with all funds collected in accordance with section 353 of the Public Health Service Act and section 1857(e)(2) of the SSA,* ***funds retained by the Secretary pursuant to section 302 of the Tax Relief and Health Care Act of 2006***[1]*; and such sums as may be collected from authorized user fees and the sale of data, which shall 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 $24,205,000, to remain available until September 30, 2007, is for contract costs for the Centers for Medicare and Medicaid Services Systems Revitalization Plan:*~~[2] *Provided further, That* ***$49,869,000,*** *to remain available until September 30,* ***2009****, is for contract costs for the Healthcare Integrated General Ledger Accounting System:* ***Provided further, That the Centers for Medicare & Medicaid Services will take all reasonable actions necessary to ensure that before December 15, 2008 no fewer than 15 Medicare Administrative Contractors will commence the duties of Medicare claims-***

[1] Section 302 of the Tax Relief and Health Care Act authorizes the Secretary to retain a portion of the amounts recovered under the recovery audit program.
[2] The FY 2008 policy request eliminates CMS' Revitalization Plan.

processing activities and related responsibilities: Provided further, That $253,775,000, to remain available until September 30, 2009, is for CMS Medicare contracting reform activities:[3] *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 to the extent Medicare claims volume is projected by the Centers for Medicare and Medicaid Services (CMS) to exceed 200,000,000 Part A claims and/or 1,022,100,000 Part B claims, an additional $32,500,000 shall be available for obligation for every 50,000,000 increase in Medicare claims volume (including a pro rata amount for any increment less than 50,000,000) from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds:*~~[4] *Provided further, That the Secretary of Health and Human Services is directed to collect fees in fiscal year* ***2008*** *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.*

In addition, the Secretary may, contingent upon enactment of authorizing legislation, charge a fee for conducting revisit surveys on health care facilities cited for

[3] Our FY 2008 request sets aside $253.8 million in two-year funding for Medicare contracting reform activities.
[4] CMS' FY 2008 policy request excludes the claims contingency provided in the FY 2006 appropriation.

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 2008 shall be reduced by the amount credited to this account under this paragraph.[1]

[1] The FY 2006 Program Management appropriation did not include the proposed Survey & Certification revisit fees first requested in the FY 2007 President's Budget.

Language Analysis

Language Provision	Explanation
For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act (SSA), titles XIII and XXVII of the Public Health Service Act, and the Clinical Laboratory Improvement Amendments of 1988, not to exceed $3,274,026,000, to be transferred from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, as authorized by section 201(g) of the SSA;	Provides a one-year 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 SSA, 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 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.

Language Analysis

Language Provision	Explanation
Provided further, That $49,869,000, to remain available until September 30, 2009, is for contract costs for the Healthcare Integrated General Ledger Accounting System:	Authorizes $49,869,000 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 the Centers for Medicare & Medicaid Services will take all reasonable actions necessary to ensure that before December 15, 2008 no fewer than 15 Medicare Administrative Contractors will commence the duties of Medicare claims-processing activities and related responsibilities: Provided further, That $253,775,000, to remain available until September 30, 2009, is for CMS Medicare contracting reform activities:	Authorizes $253,775,000 of this appropriation to be available for obligation over a period of two fiscal years for contracting reform activities. Authorizes CMS to award contracts to Medicare Administrative Contractors for the purpose of commencing the duties of Medicare claims processing.
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 2008.

Language Analysis

Language Provision	Explanation
Provided further, That the Secretary of Health and Human Services is directed to collect fees in fiscal year 2008 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 fees from Medicare Advantage organizations for costs related to enrollment, dissemination of information, and certain counseling and assistance programs.
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 2008 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.

PROGRAM MANAGEMENT APPROPRIATION SUMMARY

Current Law

Activity	FY 2006 Enacted 1/	FY 2007 President's Budget	FY 2007 Current Rate	FY 2008 President's Budget
Medicare Operations				
Appropriation	$2,172,987,000	$2,145,208,000	$2,120,588,000	$2,303,615,000
Deficit Reduction Act (P.L. 109-171)	$53,600,000	---	---	---
Tax Relief and Health Care Act (P.L. 109-432)	---	---	$90,000,000	---
Section 202 Transfer	$40,000,000	---	---	---
Enacted Rescission (P.L. 109-148)	($21,245,000)	---	---	---
Enacted Rescission (P.L. 109-149)	($44,500,000)	---	---	---
Subtotal,	$2,200,842,000	$2,145,208,000	$2,210,588,000	$2,303,615,000
Federal Administration				
Appropriation	$655,000,000	$655,377,000	$633,065,000	$643,187,000
Deficit Reduction Act (P.L. 109-171)	$8,400,000	---	---	---
Tax Relief and Health Care Act (P.L. 109-432)	---	---	$15,000,000	---
Comparability Adjustment (JFA/TAPS) 2/	($26,000)	($26,000)	($26,000)	---
Enacted Rescission (P.L. 109-148)	($6,435,000)	---	---	---
Enacted Rescission (P.L. 109-149)	($15,500,000)	---	---	---
Subtotal,	$641,439,000	$655,351,000	$648,039,000	$643,187,000
State Survey & Certification				
Appropriation	$260,735,000	$283,524,000	$258,128,000	$293,524,000
Enacted Rescission (P.L. 109-148)	($2,607,000)	---	---	---
Subtotal,	$258,128,000	$283,524,000	$258,128,000	$293,524,000
Research, Demonstration, & Evaluation				
Appropriation	$58,000,000	$41,528,000	$41,528,000	$33,700,000
Deficit Reduction Act (P.L. 109-171)	$12,000,000	---	---	---
Enacted Rescission (P.L. 109-148)	($580,000)	---	---	---
Subtotal,	$69,420,000	$41,528,000	$41,528,000	$33,700,000
Revitalization Plan				
Appropriation	$24,205,000	$22,765,000	$22,757,000	---
Enacted Rescission (P.L. 109-148)	($242,000)	---	---	---
Subtotal,	$23,963,000	$22,765,000	$22,757,000	---
Appropriation/BA, Prog. Mgt.	**$3,193,792,000**	**$3,148,376,000**	**$3,181,040,000**	**$3,274,026,000**

1/ The FY 2006 column reflects the enacted (net) appropriation after all rescissions, transfers and reprogrammings.

2/ Reflects the comparable transfer of $26,000 to DHHS GDM for various joint funding agreements and TAPS.

Program Management Proposed Law Summary

The CMS request includes a proposed user fee totaling $35.0 million in FY 2008. If enacted, collections associated with this user fee will offset our current law Program Management appropriation on a dollar-for-dollar basis. 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 2008 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.

The legislation will be self-implementing and will also include a mechanism to allow CMS to annually adjust the user fee rates for the impact of inflation and workload variation. The user fee will initially be based on a national average per facility type, adjusted to account for both facility size and the 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.

PROGRAM MANAGEMENT APPROPRIATION SUMMARY

Proposed Law

Activity	FY 2006 Enacted 1/	FY 2007 President's Budget	FY 2007 Current Rate	FY 2008 President's Budget
Medicare Operations	$2,200,842,000	$2,145,208,000	$2,210,588,000	$2,303,615,000
Approp. Offset, Prop. Law	---	---	---	---
Approp., Net Prop. Law	$2,200,842,000	$2,145,208,000	$2,210,588,000	$2,303,615,000
User Fees, Prop. Law	---	---	---	---
Subtotal, Approp.+ P.L. User Fees	$2,200,842,000	$2,145,208,000	$2,210,588,000	$2,303,615,000
Federal Administration 2/	$641,439,000	$655,351,000	$648,039,000	$643,187,000
Approp. Offset, Prop. Law	---	---	---	---
Approp., Net Prop. Law	$641,439,000	$655,351,000	$648,039,000	$643,187,000
User Fees, Proposed Law	---	---	---	---
Subtotal, Approp.+ P.L. User Fees	$641,439,000	$655,351,000	$648,039,000	$643,187,000
State Survey & Certification	$258,128,000	$283,524,000	$258,128,000	$293,524,000
Approp. Offset, Prop. Law 3/	---	($35,000,000)	---	($35,000,000)
Approp., Net Prop. Law	$258,128,000	$248,524,000	$258,128,000	$258,524,000
User Fees, Prop. Law 3/	---	$35,000,000	---	$35,000,000
Subtotal, Approp.+ P.L. User Fees	$258,128,000	$283,524,000	$258,128,000	$293,524,000
Research, Demonstration & Evaluation	$69,420,000	$41,528,000	$41,528,000	$33,700,000
Approp. Offset, Prop. Law	---	---	---	---
Approp., Net Prop. Law	$69,420,000	$41,528,000	$41,528,000	$33,700,000
User Fees, Proposed Law	---	---	---	---
Subtotal, Approp.+ P.L. User Fees	$69,420,000	$41,528,000	$41,528,000	$33,700,000
Revitalization Plan	$23,963,000	$22,765,000	$22,757,000	---
Approp. Offset, Prop. Law	---	---	---	---
Approp., Net Prop. Law	$23,963,000	$22,765,000	$22,757,000	---
User Fees, Proposed Law	---	---	---	---
Subtotal, Approp.+ P.L. User Fees	$23,963,000	$22,765,000	$22,757,000	---
Subt. Approp., Net Prop. Law	**$3,193,792,000**	**$3,113,376,000**	**$3,181,040,000**	**$3,239,026,000**
Subt. User Fees, Prop. Law	---	**$35,000,000**	**$0**	**$35,000,000**
Total Approp. + P.L. User Fees	**$3,193,792,000**	**$3,148,376,000**	**$3,181,040,000**	**$3,274,026,000**

1/ The FY 2006 column reflects the enacted (net) appropriation after all rescissions, transfers and reprogrammings.

2/ Includes a comparable transfer of $26,000 to DHHS GDM for various joint funding agreements and TAPS.

3/ If enacted, the user fees collected in fiscal years 2007 and 2008 will offset our Program Management appropriation on a dollar-for-dollar basis, so that our program level remains unchanged.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
PROGRAM MANAGEMENT
Amounts Available for Obligation
CURRENT LAW

	2006 Actual	2007 Current Rate	2008 President's Budget
Discretionary Appropriation	$3,170,927,000	$3,076,066,000	$3,274,026,000
Mandatory Appropriation	74,000,000	105,000,000	---
Section 202 Transfer	40,000,000	---	---
Enacted Rescission	-91,109,000	---	---
Subtotal, Net Appropriation/B.A., Prog. Mgt.	**$3,193,818,000**	**$3,181,066,000**	**$3,274,026,000**
Comparable Transfer From CMS (JFA/TAPS)	-26,000	-26,000	---
Subtotal, Adjusted Approp./B.A., Prog. Mgt.	**$3,193,792,000**	**$3,181,040,000**	**$3,274,026,000**
Offsetting Collections			
Sale of Data User Fees	4,507,000	2,153,000	2,200,000
Coordination of Benefits User Fees	18,890,000	30,335,000	32,289,000
CLIA User Fees	45,446,000	43,000,000	43,000,000
MA/PDP User Fees	55,796,000	68,900,000	69,800,000
Reimbursables	26,379,000	---	---
Subtotal, Offsetting Collections	**$151,018,000**	**$144,388,000**	**$147,289,000**
Program Level, C.L., Prog. Mgt.	**$3,344,810,000**	**$3,325,428,000**	**$3,421,315,000**
Unobligated Balance, Start of Year 1/	102,403,000	115,800,000	115,800,000
Change in Prior Year Offsetting Collections	8,811,000	---	---
Unobligated Balance Lapsing	-9,092,000	---	---
Prior Year Recoveries	2,564,000	---	---
Unobligated Balance, End of Year	-115,800,000	-115,800,000	-115,800,000
Total Obligations, C.L., Prog. Mgt. 1/	**$3,333,696,000**	**$3,325,428,000**	**$3,421,315,000**

1/ In FY 2007, CMS has available for obligation the remaining $23.0 million of no-year and multi-year authority included in CMS' prior years appropriations for managed care redesign, HIGLAS and Revitalization Plan activities. The total obligations for fiscal years 2007 and 2008 reflect obligations from new budget authority, only.

MEDICARE MODERNIZATION ACT (C.L.) 2/

Subtotal, Net Appropriation/B.A., MMA	---	---	---
Unobligated Balance, Start of Year	212,000	---	---
Change in Prior Year Offsetting Collections	---	---	---
Transfer to OIG	---	---	---
Prior Year Recoveries	9,466,000	---	---
Unobligated Balance Lapsing	-694,000	---	---
Unobligated Balance, End of Year	---	---	---
Total Obligations, Current Law, MMA	**$8,984,000**	---	---
Total Obligations, C.L., Prog. Mgt. + MMA	**$3,342,680,000**	**$3,325,428,000**	**$3,421,315,000**

2/ Beginning in FY 2006, funding for ongoing MMA activities will be included within the traditional Program Management appropriation. P.L. 109-77 extended the period of availability for remaining MMA start up funding through FY 2006.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
PROGRAM MANAGEMENT
Summary of Changes

FY 2007 Current Rate 1/	**$3,181,040,000**
FY 2008 President's Budget	**$3,274,026,000**
Net Change	**$92,986,000**

	2007 Curr. Rate Base		Change from Base	
Increases:	**(FTE)**	**Budget Authority**	**(FTE)**	**Budget Authority**
A. Built-in				
1. One quarter of FY 2007 Pay Raise				$3,234,000
2. Three quarters impact of FY 2008 Pay Raise				$11,023,000
3. 2 Extra Days of Pay				$3,768,000
Subtotal, Built-in Increases				**$18,025,000**
B. Program				
1. Medicare Operations		$2,210,588,000		$258,203,000
2. Federal Administration 1/	4,344	$648,039,000	0	$2,788,000
3. State Survey & Certification		$258,128,000		$35,773,000
4. Research, Demo. & Eval.		$41,528,000		$10,400,000
5. Revitalization Plan		$22,757,000		$0
Subtotal, Program Increases				**$307,164,000**
Total Increases				**$325,189,000**
Decreases:				
B. Program				
1. Medicare Operations		$2,210,588,000		($165,176,000)
2. Federal Administration	4,344	$648,039,000	0	($25,665,000)
3. State Survey & Certification		$258,128,000		($377,000)
4. Research, Demo. & Eval.		$41,528,000		($18,228,000)
5. Revitalization Plan		$22,757,000		($22,757,000)
Subtotal, Program Decreases				**($232,203,000)**
Total Decreases				**($232,203,000)**
Net Change, Appropriation, Current Law				**$92,986,000**
Offsetting Collections:				
CLIA User Fee	75	$43,000,000	9	$0
Sale of Data User Fee		$2,153,000		$47,000
Coordination of Benefits User Fee		$30,335,000		$1,954,000
MA/PDP User Fees		$68,900,000		$900,000
Subtotal, Offsetting Collections				**$2,901,000**
Net Change, Total Program Level, Current Law				**$95,887,000**

1/ Reflects the comparable transfer of $26,000 to DHHS GDM for various Joint Funding Agreements and TAPS.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
PROGRAM MANAGEMENT
Budget Authority by Activity
(dollars in thousands)

Activity	2006 Actual 1/		2007 Current Rate		2008 President's Budget	
	FTE	Amount	FTE	Amount	FTE	Amount
1. Medicare Operations	---	$2,172,987	---	$2,120,588	---	$2,303,615
Deficit Reduction Act		$53,600		---		---
Section 202 Transfer		$40,000		---		---
Tax Relief and Health Care Act		---		90,000		---
Enacted Rescission		-65,745		---		---
Subtotal, Medicare Operations	---	$2,200,842	---	$2,210,588	---	2,303,615
(Obligations)		(2,199,528)		(2,210,588)		(2,303,615)
2. Federal Administration	4,554	655,000	4,344	633,065	4,344	643,187
Deficit Reduction Act		8,400		---		---
Tax Relief and Health Care Act		---		15,000		---
Enacted Rescissions		-21,935		---		---
Comparability Adjustment (JFA/TAPS)		-26		-26		---
Subtotal, Federal Administration	4,554	641,439	4,344	648,039	4,344	643,187
(Obligations)		(638,711)		(648,039)		(643,187)
3. State Survey & Certification	---	260,735	---	258,128	---	293,524
Enacted Rescission		-2,607		---		---
Subtotal, State Survey & Cert.	---	258,128	---	258,128	---	293,524
(Obligations)		(257,730)		(258,128)		(293,524)
4. Research, Demonstration & Evaluation	---	58,000	---	41,528	---	33,700
Deficit Reduction Act		12,000		---		---
Enacted Rescission		-580		---		---
Subtotal, Research	---	69,420	---	41,528	---	33,700
(Obligations)		(62,396)		(41,528)		(33,700)
5. Revitalization Plan	---	24,205	---	22,757	---	---
Enacted Rescission		-242		---		---
Subtotal, Revitalization Plan	---	23,963	---	22,757	---	---
(Obligations)		(22,892)		(22,757)		---
Total Appropriation/Budget Authority	**4,554**	**$3,193,792**	**4,344**	**$3,181,040**	**4,344**	**$3,274,026**
Subtotal, Obligations 2/		**($3,181,257)**		**($3,181,040)**		**($3,274,026)**
Offsetting Collections: Current Law						
Program Management User Fees	72	124,639	75	144,388	84	147,289
(Obligations)		(127,246)		(144,388)		(147,289)
Other Reimbursables	---	26,379	---	---	---	---
(Obligations)		(25,193)		---		---
Program Level, Current Law	**4,626**	**$3,344,810**	**4,419**	**$3,325,428**	**4,428**	**$3,421,315**
Total Obligations 2/		**($3,333,696)**		**($3,325,428)**		**($3,421,315)**
Medicare Modernization Act						
Medicare Modernization Act		---		---		---
(Obligations)		(8,984)		---		---
Appropriation/BA, C.L., Prog. Mgt. + MMA	**4,554**	**$3,193,792**	**4,344**	**$3,181,040**	**4,344**	**$3,274,026**
Subtotal Obligations, C.L., Prog. Mgt. + MMA		**($3,190,241)**		**($3,181,040)**		**($3,274,026)**
Program Level, C.L., Prog. Mgt. + MMA	**4,626**	**$3,344,810**	**4,419**	**$3,325,428**	**4,428**	**$3,421,315**
Total Obligations, C.L., Prog. Mgt. + MMA		**($3,342,680)**		**($3,325,428)**		**($3,421,315)**

1/ The FY 2006 actual column reflects final (net) comparable appropriation after all rescissions, transfers and reprogrammings. The FY 2006 column also reflects actual FTE consumption. Budget authority for MMA start-up is shown separately.

2/ Fiscal Years 2007 and 2008 reflect obligations from new budget authority, only. In FY 2007, CMS has available to obligate $23.0 million in remaining no-year and multi-year budget authority from prior appropriations.

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

Budget Authority by Object - 2 Year

	2007 Current Rate	2008 President's Budget	Increase or Decrease
Total number of full-time permanent positions 1/	4,344	4,344	---
Average ES salary	$155,217	$159,733	$4,516
Average GS grade	13.4	13.4	---
Average GS salary	$88,883	$90,417	$1,534
Average salary of ungraded positions	$81,611	$83,986	$2,375
Personnel Compensation:			
Full-time Permanent	$370,771,000	$390,612,000	$19,841,000
Other than Full-time Permanent	13,328,000	13,734,000	406,000
Other Personnel Compensation	8,123,000	6,397,000	(1,726,000)
Military Personnel	6,741,000	6,998,000	257,000
Personnel Benefits	95,963,000	96,207,000	244,000
Military Personnel Benefits	3,131,000	3,250,000	119,000
Subtotal, Pay Costs, Current Law	**$498,057,000**	**$517,198,000**	**$19,141,000**

1/ Excludes reimbursable FTEs in FY 2007 and FY 2008. Also excludes FTEs attributable to Medicaid financial management and program integrity activities (HCFAC/State Grants and Demonstrations).

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

Budget Authority by Object (Continued)

	2007 Current Rate	2008 President's Budget	Increase or Decrease
Travel	$9,069,000	$8,939,000	($130,000)
Transportation of Things	---	---	---
Rent:			
Rental Payments to GSA	27,283,000	28,174,000	891,000
Communications, Utilities, and Miscellaneous Charges	2,297,000	2,297,000	---
Printing and Reproduction	2,790,000	2,699,000	---
Advisory and Assistance Services	---	---	---
Other Services	137,212,000	89,792,000	(47,420,000)
Purchases of Goods and Services from Government Accounts	3,388,000	3,388,000	---
R&D Contracts	41,528,000	23,700,000	(17,828,000)
Medical Care	2,448,716,000	2,577,139,000	128,423,000
Subtotal, Contractual Services, Current Law	**2,630,844,000**	**2,694,019,000**	**63,175,000**
Supplies and Materials	800,000	800,000	---
Equipment	100,000	100,000	---
Land and Structures	9,800,000	9,800,000	---
Grants, Subsidies, and Contributions	---	10,000,000	10,000,000
Total Non-Pay Costs, C.L., Prog. Mgt.	**$2,682,983,000**	**$2,756,828,000**	**$73,845,000**
Total Budget Authority, C.L., Prog. Mgt.	**$3,181,040,000**	**$3,274,026,000**	**$92,986,000**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
PROGRAM MANAGEMENT
Salaries and Expenses

Activity	2007 Current Rate	2008 President's Budget	Increase or Decrease
Personnel Compensation:			
Full-time permanent (11.1)	$370,771,000	$390,612,000	$19,841,000
Other than Full-Time Permanent (11.3)	13,328,000	13,734,000	406,000
Other Personnel Compensation (11.5/11.8)	8,123,000	6,397,000	(1,726,000)
Military Personnel (11.7)	6,741,000	6,998,000	257,000
Total Pers. Compensation (11.9)	**$ 398,963,000**	**$ 417,741,000**	**$ 18,778,000**
Civilian Personnel Benefits (12.1)	95,963,000	96,207,000	244,000
Military Personnel Benefits (12.2)	3,131,000	3,250,000	119,000
Subtotal Pay Costs	**$ 498,057,000**	**$ 517,198,000**	**$ 19,141,000**
Travel (21.0)	9,069,000	8,939,000	(130,000)
Transportation of Things (22.0)	---	---	---
Communications, Utilities, and Miscellaneous Charges (23.3)	2,297,000	2,297,000	---
Printing and Reproduction (24.0)	2,790,000	2,699,000	---
Other Contractual Services:			
Advisory and Assistance Services (25.1)	---	---	---
Other Services (25.2)	137,212,000	89,792,000	(47,420,000)
Purchases of Goods and Services from Government Accounts (25.3)	3,388,000	3,388,000	---
R&D Contracts (25.5)	41,528,000	23,700,000	(17,828,000)
Medical Care (25.6)	2,448,716,000	2,577,139,000	128,423,000
Subtotal Other Contractual Svcs.	**$ 2,630,844,000**	**$ 2,694,019,000**	**$ 63,175,000**
Supplies and Materials (26.0)	800,000	800,000	---
Subtotal Non-Pay Costs	**$ 2,645,800,000**	**$ 2,708,754,000**	**$ 62,954,000**
Total Salaries and Expenses 1/	**$ 3,143,857,000**	**$ 3,225,952,000**	**$ 82,095,000**

1/ The FY 2007 column includes $105.0 million in mandatory funding provided by the Tax Relief and Health Care Act.

FY 2008 President's Budget
Centers for Medicare & Medicaid Services
Program Management
Authorizing Legislation

	2007 Amount Authorized	2007 Curr. Rate	2008 Amount Authorized	2008 Pres. Bgt.
Program Management:				
1. Research:				
a) Social Security Act, Title XI,				
- Section 1110	Indefinite	Indefinite	Indefinite	Indefinite
- Section 1115 1/	$2,200,000	$2,200,000	$2,200,000	$2,200,000
b) P.L. 92-603, Section 222	Indefinite	Indefinite	Indefinite	Indefinite
2. Medicare Operations: Social Security Act, Sections 1816 & 1842	Indefinite	Indefinite	Indefinite	Indefinite
3. State Certification: Social Security Act, Title XVIII, Section 1864	Indefinite	Indefinite	Indefinite	Indefinite
4. Administrative Costs: Reorganization Act of 1953	Indefinite	Indefinite	Indefinite	Indefinite
5. CLIA 1988: Section 353, Public Health Service Act	Indefinite	Indefinite	Indefinite	Indefinite
6. MA/PDP: Balanced Budget Act of 1997, Section 1857 (e)(2)	---	---	---	---
7. MA/PDP: Balanced Budget Refinement Act of 1999	---	---	---	---
8. MA/PDP: Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173, MMA)	2/	2/	2/	2/
9. CMS Revitalization Plan: Reorganization Act of 1953	Indefinite	Indefinite	Indefinite	Indefinite
10. Coordination of Benefits: Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173, MMA)	Indefinite	Indefinite	Indefinite	Indefinite
Total appropriation	---	---	---	---
Total appropriation against definite authority	---	---	---	---

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.

FY 2008 President's Budget
Centers for Medicare & Medicaid Services
Program Management

Appropriations History Table (Non-Comparable)

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
1999	--	--	--	--	
Trust Fund Transfer	1,678,000,000	1,942,500,000	1,685,550,000	1,946,500,000	
Supplemental Appropriation				174,200,000	1/
2000	--	--	--	--	
Trust Fund Transfer	2,016,126,000	1,752,050,000	1,991,321,000	1,994,548,000	
Rescission				-1,214,000	
Transfer				2,992,000	2/
2001	--	--	--	--	
Trust Fund Transfer	2,086,302,000	1,866,302,000	2,018,500,000	2,246,326,000	
Rescission				-4,164,000	3/
Transfer				-564,000	
2002	--	--	--	--	
Trust Fund Transfer	2,351,158,000	2,361,158,000	2,464,658,000	2,440,798,000	
Rescission				-8,027,000	3/
2003	--	--	--	--	
Trust Fund Transfer	2,538,330,000	2,550,488,000	2,559,664,000	2,581,672,000	
Rescission				-16,781,000	3/
2004	--	--	--	--	
Trust Fund Transfer	2,733,507,000	2,600,025,000	2,707,603,000	2,664,994,000	4/
Rescission	--	--	--	-28,148,000	4/
Trust Fund Transfer	--	--	--	1,000,000,000	5/
2005	--	--	--	--	
Trust Fund Transfer	2,746,127,000	2,578,753,000	2,756,644,000	2,696,402,000	
Rescission	--	--	--	-23,555,000	6/
2006	--	--	--	--	
Trust Fund Transfer	3,177,478,000	3,180,284,000	3,181,418,000	3,206,927,000	7/
Direct Appropriation	--	--	--	38,000,000	7/
Transfer				40,000,000	8/
Rescission	--	--	--	-91,109,000	
2007	--	--	--	--	
Trust Fund Transfer	3,148,402,000	3,153,547,000	3,149,250,000	3,181,066,000	9/
Rescission	--	--	--	--	
2008	--	--	--	--	
Trust Fund Transfer	3,274,026,000	--	--	--	
Rescission	--	--	--	--	

1/ CMS received $174.2 million in general funds under the government-wide FY 1999 emergency supplemental for Y2K.

2/ Net DHHS transfer for ICFs/MR, less CMS' allocation for Government-wide CIO/CFO councils

3/ CMS' allocation of the Labor/HHS/Education rescission from administrative expenses.

4/ Reflects the anticipated final conference mark at the time the FY 2005 President's budget was prepared. The rescinded amount reflects CMS' allocation of the Labor/HHS/Education reductior from administrative expenses. This amount also includes the effects of a 0.59 percent across-the-boarc Government-wide rescission.

5/ Reflects funding for the Medicare Prescription Drug, Improvement, and Modernization Act of 200 (P.L. 108-173).

6/ The rescinded amount reflects CMS' allocation of the Labor/HHS/Education reduction fron administrative expenses. This amount also includes the effects of a 0.80-percent across-the-boarc Government-wide rescission.

7/ The FY 2006 trust fund transfer includes $36.0 million in additional authority from the Deficit Reductio Act of 2005 (DRA). This legislation also includes a direct appropriation totaling $38.0 million. All fundin provided in the DRA is considered mandatory authority, as opposed to discretionary.

8/ Reflects $40.0 million transferred to CMS pursuant to DHHS' Section 202 transfer authority.

9/ Reflects House and Senate committee action, only. The appropriation reflects the FY 2007 current rate, plus $105,000,000 provided by the Tax Relief and Health Care Act of 2006.

Department of Health and Human Services
The Centers for Medicare & Medicaid Services
FY 2008 Discretionary Budget Summary
(dollars in thousands)

Activity	FY 2006 Enacted 1/	FY 2007 President's Budget	FY 2007 Current Rate	FY 2008 President's Budget
Medicare Operations	$2,172,987	$2,145,208	$2,120,588	$2,303,615
Deficit Reduction Act (P.L. 109-171)	$53,600	$0	$0	$0
Section 202 Transfer	$40,000	$0	$0	$0
Tax Relief and Health Care Act (P.L. 109-432)	$0	$0	$90,000	$0
Rescission (P.L. 109-148)	($21,245)	$0	$0	$0
Rescission (P.L. 109-149)	($44,500)	$0	$0	$0
Medicare Operations BA, Net	**$2,200,842**	**$2,145,208**	**$2,210,588**	**$2,303,615**
Federal Administration	$655,000	$655,377	$633,065	$643,187
Deficit Reduction Act (P.L. 109-171)	$8,400	$0	$0	$0
Tax Relief and Health Care Act (P.L. 109-432)	$0	$0	$15,000	$0
Comparability Adjustment (JFA/TAPS) 2/	($26)	($26)	($26)	$0
Rescission (P.L. 109-148)	($6,435)	$0	$0	$0
Rescission (P.L. 109-149)	($15,500)	$0	$0	$0
Federal Administration BA, Net	**$641,439**	**$655,351**	**$648,039**	**$643,187**
State Survey & Certification	$260,735	$283,524	$258,128	$293,524
Rescission (P.L. 109-148)	($2,607)	$0	$0	$0
State Survey & Certification BA, Net	**$258,128**	**$283,524**	**$258,128**	**$293,524**
Research	$58,000	$41,528	$41,528	$33,700
Deficit Reduction Act (P.L. 109-171)	$12,000	$0	$0	$0
Rescission (P.L. 109-148)	($580)	$0	$0	$0
Research BA, Net	**$69,420**	**$41,528**	**$41,528**	**$33,700**
CMS Revitalization Plan	$24,205	$22,765	$22,757	$0
Rescission (P.L. 109-148)	($242)	$0	$0	$0
CMS Revitalization Plan BA, Net	**$23,963**	**$22,765**	**$22,757**	**$0**
Est. Offsetting Collections from Non-Federal Sources (Current Law):				
CLIA User Fees	$43,000	$43,000	$43,000	$43,000
MA/PDP User Fees	$55,800	$68,900	$68,900	$69,800
Coordination of Benefits User Fees	$0	$30,335	$30,335	$32,289
Sale of Data User Fees	$2,109	$2,153	$2,153	$2,200
Offsetting Collections BA, Net	**$100,909**	**$144,388**	**$144,388**	**$147,289**
Total, Program Level, Current Law	**$3,294,701**	**$3,292,764**	**$3,325,428**	**$3,421,315**
Less: Offsetting Collections, Current Law	$100,909	$144,388	$144,388	$147,289
Total, Appropriation, Current Law	**$3,193,792**	**$3,148,376**	**$3,181,040**	**$3,274,026**
Total, Discretionary Appropriation, Current Law	$3,119,792	$3,148,376	$3,076,040	$3,274,026
HCFAC Discretionary	$0	$118,404	$0	$183,000
CMS FTEs:				
Direct (Federal Administration)	4,554	4,531	4,344	4,344
Reimbursable (CLIA)	72	72	75	84
Subtotal, Disc. FTEs, Curr. Law 3/	**4,626**	**4,603**	**4,419**	**4,428**
Medicaid Oversight (HCFAC/State Grants)	90	200	119	153
Total, CMS FTEs, Current Law 3/	**4,716**	**4,803**	**4,538**	**4,581**

1/ The FY 2006 column reflects the enacted (net) appropriation after all rescissions, transfers and reprogrammings.

2/ Reflects the comparable transfer of $26,000 to DHHS GDM for various joint funding agreements and TAPS.

3/ The FY 2006 staffing level reflects actual FTE consumption.

SIGNIFICANT ITEMS AND REPORTS TO CONGRESS
FOR INCLUSION IN THE
FY 2008 CONGRESSIONAL JUSTIFICATION
HOUSE REPORT# 109-515

Expand Quality of Life Demonstration Project - The Committee commends CMS for expanding the Quality of Life Demonstration (QoL) project to include oral chemotherapy regimens in its data collection on this project. The QoL as implemented by CMS in 2005 was an excellent first step in gathering data on the impact of chemotherapy as it started to measure important outcomes for cancer patients specifically related to infused chemotherapy. The Committee is pleased with CMS' decision to broaden the demonstration in 2006 to collect data on all types of cancer management. The inclusion of oral chemotherapy regimens will provide a more comprehensive understanding of the quality of life issues impacting all cancer patients. The demonstration project is intended to provide a better understanding from cancer patients receiving chemotherapy on such important issues as their pain control management, minimization of nausea and vomiting, and the reduction of fatigue. The action taken by CMS to expand the demonstration project will provide important data on all anti-cancer regimens and their impact on patients' quality of life. (Page. 145)

Action taken or to be taken
The oncology demonstration ended for services furnished on or before December 31, 2006. CMS contracted in October 2006 with a research firm to perform an evaluation of the 2006 oncology demonstration. The evaluation will use a combination of qualitative and quantitative methods, including site visits, a survey of eligible physicians, and analyses of claims data.

CMS is currently working to implement a new Physician Quality Reporting Initiative (PQRI) for 2007. Specifically, the President signed the Tax Relief and Health Care Act of 2006, mandating establishment of a physician quality reporting system and authorizing a payment incentive. The payment incentive will be based on quality measures reported for care delivered to Medicare beneficiaries July 1 through December 31, 2007.

To support this initiative, CMS is developing a quality reporting program for physician and practitioner services delivered in the second half of 2007. The statute establishes a preliminary list of measures and a process to identify additional measures for physician quality reporting. The measures referenced in the statute are those named in the list posted by CMS on December 5, 2006, under the title "2007 Physician Voluntary Reporting Program (PVRP) Quality Measures". According to the statute, additional measures that could apply to oncologists and other specialties may be added via an appropriate consensus process this year.

Pending finalization of quality measures directly applicable to cancer care, the G codes used in previously conducted oncology demonstrations remain available in the event oncology practices wish to voluntarily submit these codes for their own purposes.

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 requests that CMS review a recently released report by HRSA on the healthcare workforce, a portion of which focuses on the critical care workforce shortage, and that CMS also review other relevant research and consult with the relevant critical care societies in order to develop recommendations for addressing the critical care workforce shortage issue, including the possible use of the pulmonary/critical care specialty as a model for developing and testing policy approaches to address workforce shortage issues. (Page 145)

Action taken or to be taken
CMS will review and summarize the relevant HRSA report and other existing literature on critical care workforce shortages. CMS will use any recommendations that are determined to be appropriate.

Heart Disease, Stroke and Cardiovascular Disease in Women – The Committee is aware that heart disease, stroke and other cardiovascular disease are the leading cause of death among women and is concerned that women are less likely than men to receive treatments for cardiovascular disease, perhaps due to lack of awareness and the presence of different symptoms in women than in men. The Committee also recognizes that certain diagnostic tests for cardiovascular disease may be less accurate in women than men. Therefore, the Committee urges the Center for Beneficiary Choices of CMS to develop and distribute to female Medicare beneficiaries, physicians, and other appropriate health care professionals educational materials relating to the prevention, diagnosis, and treatment of heart disease, stroke, and other cardiovascular disease in women. (Page 145 and 146)

Action taken or to be taken
CMS is committed to providing information to all people with Medicare regarding their Medicare benefits, including preventive services. Below are the existing publications that include information about the preventive services covered under Medicare Part B, including information about cardiovascular screening:

- Medicare & You 2007 handbook
- Your Medicare Benefits
- Your Guide to Medicare's Preventive Services

CMS also continues to raise awareness about preventive services (such as cardiovascular screenings) by encouraging beneficiaries to take advantage of their preventive benefits in our public presentations and other media materials. In addition, we work closely with partners on these topics to continue to provide education to those with Medicare. Our advertising campaigns included a Hispanic Public Service Announcement (PSA) in April 2005 which highlighted the new preventive benefits, including cardiovascular screenings. CMS will investigate the possibility of conducting similar PSAs relating to the prevention, diagnosis, and treatment of heart disease, stroke, and other cardiovascular disease in women.

In addition to these publications and media outlets, CMS will further explore venues for addressing prevention, diagnosis, and treatment of heart disease, stroke, and other cardiovascular disease in women. CMS will look into creating a tip sheet to provide to partners (such as health care provider organization and coalitions, caregiver organizations, pharmacy organizations, etc) and a publication written specifically for female beneficiaries that focuses on prevention, diagnosis, and the treatment of heart disease, stroke, and other cardiovascular disease in women. As with all CMS publications, any developed materials are available at www.medicare.gov (for people with Medicare) or www.cms.hhs.gov (for partners and other health care professionals) on the web.

CMS will also explore designing a web banner to be made available to partner web sites, especially physicians and providers that would provide links to the National Heart, Lung, and Blood Institute's Heart Truth website and the CMS Prevention overview page on the cms.hhs.gov website. On these sites, educational materials for cardiovascular disease could be viewed and printed. In addition, CMS is exploring the idea of modifying the prevention page on the cms.hhs.gov website to put red dress icons next to the Cardiovascular Screening and Smoking Cessation benefits, denoting their relevance to women's heart health.

CMS will also explore the possibility of including information relating to the prevention, diagnosis, and treatment of heart disease, stroke, and other cardiovascular disease in women in future training sessions.

Pharmaceutical Benefits Counseling – The Committee recognizes that CMS has initiated some commendable community-based activities for an MMA education and outreach campaign directed towards dual eligible persons, but the Committee is also aware that there is considerable evidence that low-income dual eligible persons with mental disabilities continue to need direct help with Part D enrollment. Therefore, within the amounts appropriated, the Committee encourages that five percent of the funds be directed for one-on-one pharmaceutical benefits counseling to be provided through community-based organizations and safety net community mental health centers. (Page 146)

Action taken or to be taken

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

- CMS will require that SHIPs submit FY 2007 program budgets that demonstrate that at least 5% of Federal SHIP funding will be directed toward one-on-one pharmaceutical benefits counseling to low-income dual eligible persons with mental disabilities.

- CMS will mandate that all State SHIP directors attend training in June 2007 that will be based on a pilot project recently completed by the Office of the Medicare Ombudsman with SHIPs in North Carolina and Texas to enhance SHIPs' reach and service to

beneficiaries with mental health disabilities through partnerships with an expanded network of community organizations serving people with mental health disabilities.

- During 2007, CMS will include the provision of one-on-one pharmaceutical benefits counseling provided to low-income dual-eligible persons with mental disabilities as part of a more comprehensive report on the increased number of dual eligible individuals currently served by SHIPs.

- As part of the 2007 grant report process, CMS will require 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.

- CMS will encourage SHIPs to partner with community mental health centers to assist the centers in providing Medicare and Medicaid counseling for their clients.

Services for End Stage Renal Disease Patients – The Committee is concerned that patients suffering from end stage renal disease (ESRD) are offered the proper modality for the best medical outcome and the highest quality of life. The Committee is particularly concerned about factors that may be influencing the choice of modality and the availability of services to ESRD patients. Given that Medicare provides coverage for 90 percent of the prevalent dialysis population and 69 percent of those with a transplant, the Committee urges CMS, in conjunction with other health agencies, to review these patterns and requests CMS to provide the Committee with recommendations to ensure public health policies, in the form of reimbursement rates, public health service, research or other activities related to ESRD, give priority to positive medical outcomes and quality of life for ESRD patients. (Page 146)

Action taken or to be taken

Under the current ESRD payment system, Medicare pays the case-mix adjusted composite rate to ESRD facilities for dialysis services. The same rate is paid for both in-facility and home dialysis patients regardless of treatment modality.

Congress has concluded that a bundled payment system that includes drugs, clinical laboratory tests, and other items that are currently being separately billed by facilities could overcome many of the composite payment system's limitations. Therefore, CMS is currently preparing a Report to Congress that will detail the elements and features for the design and implementation of a bundled prospective payment system for services furnished by end stage renal disease facilities. The Report to Congress will be released in the summer of 2007.

In addition, CMS intends to include in any demonstration of a bundled payment system for ESRD services under MMA §623(e) value-based purchasing features to create incentives to encourage and reward providers for care that achieves positive outcomes for patients and for improving performance. The impact of financial incentives on choice of modality, including both peritoneal dialysis and home hemodialysis as well as transplantation, was identified by the Advisory Board for that demonstration. We expect to address the impact of bundled

payment and value-based purchasing incentives on choice of modality in the evaluation of that demonstration after it commences.

CMS has taken a closer examination of the differences that currently exist for hemodialysis and peritoneal dialysis populations and has set up the infrastructure by which coverage of peritoneal dialysis before hemodialysis may be requested by the ESRD community, stakeholders, and advocacy groups. In addition, CMS has proposed a hospital Conditions of Participation ruling that specifies the requirements for approval for transplant centers to perform organ transplants. CMS anticipates the final ruling to be published in the beginning of CY 2007.

SIGNIFICANT ITEMS AND REPORTS TO CONGRESS
FOR INCLUSION IN THE
FY 2008 CONGRESSIONAL JUSTIFICATION
SENATE REPORT# 109-287

Study of the Impact of the Proposed Policy Change on the Availability of Services for Students with Disabilities and Other Health Care Needs – The President's budget proposes to restrict the ability of schools to claim reimbursement for administrative and transportation services for Medicaid enrolled children with disabilities who receive early intervention, special education and related services through the Individuals with Disabilities Education Act. The Committee is very concerned that this proposal will reduce the availability of and access to needed health and developmental services for students with disabilities and other low-income children with special needs. For these children, school is their primary site for healthcare delivery. The Committee directs the Centers for Medicare and Medicaid Services to submit a report to the Appropriations Committee no later than March 1, 2007, examining the impact of the proposed policy change on the availability of services for students with disabilities and other health care needs, participation rates of States and school districts in school-based Medicaid claiming and the general impact on the health of children with special needs in rural and urban areas. The Committee expects CMS to take no additional action on the proposal until the Committee has received and reviewed the report. The Secretary should be prepared to testify on this issue at a fiscal year 2008 appropriations hearing. (Page 184)

Action taken or to be taken
CMS appreciates the Committee's concerns regarding the proposed policy change on the availability of services for students with disabilities and other health care needs. These changes do not affect the treatment of expenditures for direct medical services that are included in the approved State Medicaid plan and provided in schools. Nor does it affect transportation of school-aged children from school to receive IDEA direct medical service from a non-school based Medicaid provider. School-based administrative activities and transportation are performed primarily to serve the needs of the educational program rather than administration of the State Medicaid plan. CMS will review the request, and the Secretary will be prepared to testify at the FY 2008 Appropriations hearing.

Real Choice Systems Change Grants - The Committee has included $10,000,000 for Real Choice Systems Change Grants for Community Living to States to fund initiatives that establish enduring and systemic improvements in long-term services and supports. (Page 186)

Action taken or to be taken
Since 2001, CMS has awarded almost 300 Real Choice System Change (RCSC) grants totaling over $260 million across all 50 States, the District of Columbia and two U.S. Territories. While the number of RCSC grants per State and the amount per grant varies significantly, 70% of States/territories have more than 5 RCSC grants and 94% have 3 or more RCSC grants. The RCSC grants have spurred significant advances in addressing long-

term care needs and enabled States to develop improvements to provide community-based supports for individuals with disabilities. These changes are designed to enable individuals of all ages to live in the most integrated community setting, to have meaningful choices about their living arrangements, and to exercise more control over the services they receive.

Through the investment in the RCSC program to date by Congress and the Administration, States have made tremendous strides in building the infrastructure necessary to effectuate enduring improvements in community-integrated services and long-term support systems. With these grants, many States have reorganized their State administrative structures (i.e., planning, budget management, operations, quality monitoring, and consumer protection) to facilitate 'rebalancing'. The experimentation that occurred under the RCSC grants to date has laid the groundwork for certain changes provided under the Deficit Reduction Act, including the Money Follows the Person Rebalancing Demonstration, the Family to Family Health Information and Educational Resource Centers, and a State plan option for self-directed care.

Population Density in Hawaii -The Committee requests the Centers for Medicare and Medicaid Services consider waivers for rural and/or isolated area demonstration projects when calculating such requirements as population density in Hawaii. (Page 186)

Action taken or to be taken
When CMS identified eligible States for the Rural Community Hospital demonstration, Hawaii was not considered an eligible State because of the legislative language in Section 410A of the MMA that states that the demonstration should be held in low density States. However, for future demonstrations in low density rural areas, CMS will work within the requirements of the authorizing legislation to consider the participation of hospitals in Hawaii.

Reimbursement for Services at Federally Qualified Health Centers - The Committee urges the Centers for Medicare and Medicaid Services to avail reimbursement for services delivered in federally qualified health centers to Native Hawaiians in the same manner as it does for American Indians and Alaskan Natives. (Page 186)

Action taken or to be taken
Currently, CMS provides reimbursement under the Medicare federally qualified health center (FQHC) program in the same manner for all Medicare beneficiaries receiving services in FQHCs, including American Indians, Alaskan Natives, Native Hawaiians, and all other Medicare beneficiaries. Native Hawaiians eligible for Medicare may receive Medicare FQHC services at any Medicare FQHC, and may do so in the same manner as any other Medicare beneficiary. Medicare payment is made on the basis of an all-inclusive rate per visit for the package of Medicare-covered FQHC services.

With respect to the determination of health center entities eligible to participate in Medicare as FQHCs, P.L. 94-437 expanded Medicare FQHC qualification requirements to include an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under

Title V of the Indian Health Care Improvement Act. Expansion of current Medicare FQHC statutory requirements to include outpatient health programs or facilities operated by Native Hawaiians in the same manner that it currently does for American Indians and Alaskan Natives would require a similar statutory change. New statutory language for Native Hawaiian-operated programs or facilities would need to include statutory references for Native Hawaiians similar to the references to the Indian Self-Determination and Indian Health Care Improvement Acts, or some other mechanism of identification of Native Hawaiian–operated programs or facilities.

Rural Healthcare – The Committee is aware that senior citizens constitute a larger proportion of the United States rural resident population and in such rural areas, the availability of primary health care professionals and specialized services for seniors are more austere. The Committee recommends that the Centers for Medicare and Medicaid Services consider funding projects with a focus on rural healthcare, specifically those serving the elderly and minority populations such as Native Hawaiians, Native Alaskans, and Native Americans. (Page 186 – 187)

Action taken or to be taken

CMS is actively working to implement demonstration projects that include rural areas. The MMA section 410A Rural Community Hospital Demonstration is operating at a series of small community hospitals in sparsely populated States. This demonstration will test whether higher payments based on costs in the initial base year of implementation will improve the financial condition of the participating hospitals and improve the services provided by the hospitals to their communities. The MMA section 434 Frontier Extended Stay Clinic Demonstration Project is currently under development, and will provide for Medicare funding for clinics in frontier areas, such as communities in remote areas of Alaska. The Cancer Prevention Demonstration provides for prevention services to several minority groups, including Native Americans in Utah and Montana and Pacific Islanders in Hawaii, most of who live in rural areas. In May 2006, CMS also awarded a two year grant to the Hawaii Health Systems Corporation to reduce disparities and improve access to culturally appropriate care for Native Hawaiians and underserved populations by establishing collaborative rural training programs for physicians, nurses and allied health professionals.

Quality of Life Demonstration - The Committee commends CMS for expanding the Quality of Life Demonstration project to include oral chemotherapy regimens in its data collection on this project. The inclusion of oral chemotherapy regimes will provide a more comprehensive understanding of the quality of life issues impacting all cancer patients. The demonstration project is intended to provide a better understanding from cancer patients receiving chemotherapy on such important issues as their pain control management, minimization of nausea and vomiting, and reduction for fatigue. CMS' action to expand the demonstrations project will provide important data on all anti-cancer regimens and its impact on patients' quality of life. (Page 187)

Action taken or to be taken
The oncology demonstration ended for services furnished on or before December 31, 2006. CMS contracted in October 2006 with a research firm to perform an evaluation of the 2006 oncology demonstration. The evaluation will use a combination of qualitative and quantitative methods, including site visits, a survey of eligible physicians, and analyses of claims data.

CMS is currently working to implement a new Physician Quality Reporting Initiative (PQRI) for 2007. Specifically, the President signed the Tax Relief and Health Care Act of 2006, mandating establishment of a physician quality reporting system and authorizing a payment incentive. The payment incentive will be based on quality measures reported for care delivered to Medicare beneficiaries July 1 through December 31, 2007.

To support this initiative, CMS is developing a quality reporting program for physician and practitioner services delivered in the second half of 2007. The statute establishes a preliminary list of measures and a process to identify additional measures for physician quality reporting. The measures referenced in the statute are those named in the list posted by CMS on December 5, 2006, under the title "2007 Physician Voluntary Reporting Program (PVRP) Quality Measures". According to the statute, additional measures that could apply to oncologists and other specialties may be added via an appropriate consensus process this year.

Pending finalization of quality measures directly applicable to cancer care, the G codes used in previously conducted oncology demonstrations remain available in the event oncology practices wish to voluntarily submit these codes for their own purposes.

State Health Insurance Counseling Program - The Committee recommends that not less than $30,000,000 be made available for the State Health Insurance Counseling Program. SHIPs provide one-on-one counseling to beneficiaries on complex Medicare-related topics, including Medicare entitlement and enrollment, health plan options, prescription drug benefits, Medigap and long-term care insurance, and Medicaid. (Page 188)

Action taken or to be taken
CMS has made tremendous progress in building an extensive partnership network that will help establish a more permanent grassroots Medicare program. The State Health Insurance Assistance Programs (SHIPs) are a valuable partner to CMS. In FY 2006, over $30,000,000 was allocated to the SHIPs and SHIP support.

One-on-One Counseling for Dual Eligible Beneficiaries with Mental Impairments - The Committee recognizes that CMS has initiated some commendable community-based activities for an education and outreach program directed towards dual-eligible persons with mental impairments, and encourages that additional efforts be directed to one-on-one pharmaceutical benefits counseling through community-based organizations and safety net community mental health centers to help with part D enrollment. (Page 188)

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

- CMS will require that SHIPs submit FY 2007 program budgets that demonstrate that at least 5% of Federal SHIP funding will be directed toward one-on-one pharmaceutical benefits counseling to low-income dual eligible persons with mental disabilities.

- CMS will mandate that all State SHIP directors attend training in June 2007 that will be based on a pilot project recently completed by the Office of the Medicare Ombudsman with SHIPs in North Carolina and Texas to enhance SHIPs' reach and service to beneficiaries with mental health disabilities through partnerships with an expanded network of community organizations serving people with mental health disabilities.

- During 2007, CMS will include the provision of one-on-one pharmaceutical benefits counseling provided to low-income dual-eligible persons with mental disabilities as part of a more comprehensive report on the increased number of dual eligible individuals currently served by SHIPs.

- As part of the 2007 grant report process, CMS will require 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.

- CMS will encourage SHIPs to partner with community mental health centers to assist the centers in providing Medicare and Medicaid counseling for their clients.

Healthy Start, Grow Smart Program - The Committee recommends continuing the Healthy Start, Grow Smart program, which disseminates informational brochures to new Medicaid-eligible mothers. These brochures are distributed at the time of birth, then monthly over the first year of each 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. In addition to these educational suggestions, Healthy Start pamphlets include vital health and safety information for new parents. (Page 188)

Action taken or to be taken
CMS has distributed more than 42 million "Healthy Start, Grow Smart" brochures to low-income parents and caregivers since the program began in FY 2003. The series is available in four languages: English, Spanish, Chinese and Vietnamese.

Beginning in FY2007, CMS enhanced the program by distributing a 3-issue series containing similar information for children in the second year of life. CMS is developing 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. The prenatal issue will be distributed beginning in FY 2008.

Demonstration project at the MindBody Institute – The Committee is very pleased with the demonstration project at participating sites licensed by the Program for Reversing Heart Disease and encourages its continuation. The Committee further urges CMS to continue with the demonstration project being conducted at the Mind Body Institute of Boston, Massachusetts. (Page 188-189)

Action taken or to be taken
On June 21, 2006, CMS implemented a National Coverage Decision (NCD) on Cardiac Rehabilitation Services. This NCD indicated that life-style modification programs, specifically naming the program offered by the Mind/Body Medical Institute as an example, would fall under the purview of the NCD, and could now be covered under Medicare as cardiac rehabilitation services.

Under the current demonstration, the treatment for services will end in February 2007. CMS is currently exploring potential plans for other programs involving the Mind/Body Medical Institute.

Rural Healthcare - The Committee recognizes that rural residents account for 25 percent of the general population in the United States with a disproportionate number of them being seniors. Additionally, 67 percent of the country's primary care health professional shortage areas are located in rural areas and access to specialized care is limited for seniors. The Committee urges CMS to consider funding projects with a focus on rural healthcare, specifically those serving minority populations such as Native Hawaiians, Native Alaskans, and Native Americans. (Page 189)

Action taken or to be taken
CMS is actively working to implement demonstration projects that include rural areas. The MMA section 410A Rural Community Hospital Demonstration is operating at a series of small community hospitals in sparsely populated States. This demonstration will test whether higher payments based on costs in the initial base year of implementation will improve the financial condition of the participating hospitals and improve the services provided by the hospitals to their communities. The MMA section 434 Frontier Extended Stay Clinic Demonstration Project is currently under development, and will provide for Medicare funding for clinics in frontier areas, such as communities in remote areas of Alaska. The Cancer Prevention Demonstration provides for prevention services to several minority groups, including Native Americans in Utah and Montana and Pacific Islanders in Hawaii, most of who live in rural areas. In May 2006, CMS also awarded a two year grant to the Hawaii Health Systems Corporation to reduce disparities and improve access to culturally appropriate care for Native Hawaiians and underserved populations by establishing collaborative rural training programs for physicians, nurses and allied health professionals.

Sole Community Hospitals - The Committee recognizes that the Centers for Medicare and Medicaid Services has denied requests by community hospitals to be designated as Sole Community Hospitals on the basis that they are within 25 miles of the nearest like hospital. CMS has measured these distances by determining the absolute shortest distance between these hospitals even if the routes may be obscure, unknown, and unused by emergency vehicles. As such, the Committee recommends that when making SCH eligibility determinations, CMS calculate the distance between hospitals using improved roads which (1) are maintained by a local, State or Federal Government entity for use by the general public and (2) represent the most expeditious and accessible routes between hospitals as designated by State Departments of Transportation in accordance with the Manual on Uniform Traffic Control Devices for Streets and Highways [MUTCD] as published by the Federal Highway Administration. (Page 189)

Action taken or to be taken
Currently, in the regulations at 42 CFR 412.92(c)(1), the word "miles" is defined as "…shortest distance in miles measured over improved roads. An improved road for this purpose is any road that is maintained by a local, State, or Federal Government entity and is available for use by the general public. An improved road includes the paved surface up to the front entrance of the hospital."

We are concerned that the criteria suggested by the Committee, using "expeditious and accessible routes" according to instructions provided in the "Manual on Uniform Traffic Control Devices for Streets and Highways," would require more subjective decisions making it difficult to equitably apply the criteria to all short-term acute care hospitals that may apply for sole community hospital designation.

Critical Care Workforce Shortage - The Committee expects CMS to review a pending report prepared by HRSA on the healthcare workforce as well as other relevant research, in order to develop recommendations addressing the critical care workforce shortage issue, including the possible use of the pulmonary/critical care specialty as a model for developing and testing policy approaches to address workforce shortage issues. (Page 189)

Action taken or to be taken
CMS will review and summarize the relevant HRSA report and other existing literature on critical care workforce shortages. CMS will use any recommendations that are determined to be appropriate.

Services for End Stage Renal Disease Patients - The Committee is concerned that patients suffering from end-stage renal disease [ESRD] are offered the proper modality for the best medical outcome and the highest quality of life. The U.S. Renal Data System [USRDS] reports that hemodialysis is dominant across the country, while the use of peritoneal dialysis is growing, but in a minority of regions. In addition, USDRS reports that prevalent rates of transplantation have grown more in some areas of the country than others. The Committee is particularly concerned about factors which may be influencing the choice of modality and the availability of services to ESRD patients. Given that Medicare provides coverage for

90 percent of the prevalent dialysis population and 69 percent of those with a transplant, the Committee urges CMS, in conjunction with other health agencies, to review these patterns and requests CMS to provide the Committee with recommendations to ensure public health policies, in the form of reimbursement rates, public health services, research or other activities related to ESRD, give priority to positive medical outcomes and quality of life for ESRD patients. (Page 189-190)

Action taken or to be taken
Under the current ESRD payment system, Medicare pays the case-mix adjusted composite rate to ESRD facilities for dialysis services. The same rate is paid for both in-facility and home dialysis patients regardless of treatment modality.

Congress has concluded that a bundled payment system that includes drugs, clinical laboratory tests, and other items that are currently being separately billed by facilities could overcome many of the composite payment system's limitations. Therefore, CMS is currently preparing a Report to Congress that will detail the elements and features for the design and implementation of a bundled prospective payment system for services furnished by end stage renal disease facilities. The Report to Congress will be released in the summer of 2007.

In addition, CMS intends to include in any demonstration of a bundled payment system for ESRD services under MMA §623(e) value-based purchasing features to create incentives to encourage and reward providers for care that achieves positive outcomes for patients and for improving performance. The impact of financial incentives on choice of modality, including both peritoneal dialysis and home hemodialysis as well as transplantation, was identified by the Advisory Board for that demonstration. We expect to address the impact of bundled payment and value-based purchasing incentives on choice of modality in the evaluation of that demonstration after it commences.

CMS has taken a closer examination of the differences that currently exist for hemodialysis and peritoneal dialysis populations and has set up the infrastructure by which coverage of peritoneal dialysis before hemodialysis may be requested by the ESRD community, stakeholders, and advocacy groups. In addition, CMS has proposed a hospital Conditions of Participation ruling that specifies the requirements for approval for transplant centers to perform organ transplants. CMS anticipates the final ruling to be published in the beginning of CY 2007.

Medicare Reimbursement for Advanced Interactive Balancing Mobility Systems - The Committee urges CMS to consider a new Medicare benefit category for advanced interactive balancing mobility systems and to issue a National Coverage Determination to provide for Medicare reimbursement for such interactive balancing mobility systems. This type of technology allows individuals with disabilities to achieve extensive function and mobility in order to live independently. (Page 190)

Action taken or to be taken

CMS received a request to develop a National Coverage Determination (NCD) providing for coverage of the INDEPENDENCE iBOT 4000 Mobility System (iBOT) under the durable medical equipment (DME) benefit and under the generic term "Interactive Balancing Mobility Systems." The iBOT is a new mobility device developed by Independence Technology, a Johnson & Johnson Company. CMS opened an NCD to evaluate coverage of the iBOT in response to the formal NCD request. CMS also opened a formal review of the benefit category determination for the iBOT as part of the NCD process since at the time the NCD request was made, CMS had not yet made a benefit category determination for the device.

We posted our final decision on the Medicare coverage Web site July 28, 2006. The final decision is located at http://www.cms.hhs.gov/mcd/ncpc_view_document.asp?id=5. We received many public comments during the course of our evaluation, including some that expressed concerns similar to the Committee's. We considered all comments received during the public comment period before publishing the final NCD.

The iBOT is a battery-powered mobility device that relies on a computerized system of sensors, gyroscopes, and electric motors to allow indoor and outdoor use on stairs as well as on level and uneven surfaces. The mobility system incorporates a number of different functions, including: a) Standard Function that provides mobility on smooth surfaces and inclines at home, work, and in other environments; b) 4-Wheel Function that provides movement across obstacles, uneven terrain, curbs, grass, gravel, and other soft surfaces; c) Balance Function that provides mobility in a seated position at an elevated height; d) Stair Function that allows for ascent and descent of stairs, with or without assistance; and e) Remote Function that assists in the transportation of the product while unoccupied. In Standard Function, the iBOT functions like a traditional power wheelchair.

CMS found that the evidence is sufficient to determine that the Standard Function of the iBOT meets the definition of DME and is reasonable and necessary for beneficiaries who have a personal mobility deficit sufficient to impair their participation in mobility-related activities of daily living such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. Determination of the presence of a mobility deficit will use an algorithmic process, as outlined in the National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE).

CMS found that the evidence is insufficient to conclude that the 4-Wheel, Balance, Stair, and Remote Functions of the iBOT meet the definition of DME under Section 1861(n) of the Social Security Act or that these functions offer clinically significant benefits in mobility-related activities of daily living.

Utilization of Nurse Practitioners as Primary Care Providers by Medicaid Managed Care Organizations - The Committee understands that only 40 percent of Medicaid Managed Care Organizations [MCO] allow nurse practitioners to act as primary care providers. The Committee encourages CMS to closely monitor those MCOs that do not

utilize these providers and actively enforce existing regulations which prohibit discrimination against a particular class of healthcare provider. (Page 190)

Action taken or to be taken
States, not Managed Care Organizations (MCOs) or the Federal Government determines the permissible role and scope of practice of nurse practitioners and other physician extenders. CMS will monitor States with Medicaid managed care programs to see the extent to which MCOs permit nurse practitioners to act as primary care providers. CMS will also verify that States are advising enrollees of their right to access these providers out of network, where they are not part of an MCO's panel of providers.

Home Health Agencies and Hospices Accepting Orders from Nurse Practitioners - The Committee is aware that legislation authorizing direct Medicare reimbursement to nurse practitioners providing reimbursable Medicare Services, was passed by Congress and signed into law, effective January 1, 1998. Since that time, 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 refer patients to home health or hospice care. The apparent reason is that an expanded interpretation of the word `physician' is needed in part A, section 1814, of the Medicare law in order for home health agencies and hospice centers to accept these referrals. The Committee is very aware that nurse practitioners have demonstrated the ability to provide safe and responsible care to the patients they serve. They have expert knowledge that allows them to provide high level assessments of patients needs and recognize when additional care, such as home health and hospice care is needed or not needed by their patients. The Committee urges CMS to reinterpret the statute that will authorize home health agencies and hospices to accept orders from nurse practitioners. (Page 190)

Action taken or to be taken
Current law does not prohibit nurse practitioners (NPs) from referring patients to a hospice or home health agency. There is also nothing prohibiting NPs from writing orders under the hospice benefit, provided that State law permits NPs to treat and write orders for patients. However, NPs are prohibited from certifying a beneficiary's terminal illness under the hospice benefit and are prohibited from writing orders under the home health benefit.

In recognition of the role of the NP as a health care professional, section 408 of the MMA amended sections 1861(dd)(3)(B) and 1814(a)(7) of the Social Security Act to add NPs to the definition of an attending physician, allowing beneficiaries who have elected the hospice benefit to maintain an NP as his or her attending physician or to elect an NP to serve as the attending physician, if allowed by State law. However, the statute did not amend section 1814(a)(7) of the Social Security Act, which specifies that the certification of the terminal illness "…shall be based on the clinical judgment of the hospice physician and the individual's attending physician…" This section goes on to specifically state that the definition of attending physician for purposes of certifying terminal illness does not include a nurse practitioner.

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Social Security Act mandate that a physician establishes, certifies, and recertifies the home health plan of care. A physician is

defined in section 1861(r) of the Social Security Act and such definition does not include NP (which is defined in the statute at section 1861(aa)(5)(A)).

Section 1861(m) of the Social Security Act defines the home health services for individuals who are under the care of a physician under a plan of care established and periodically reviewed by a physician. While section 1861(r) is not referenced, we believe that it is implicit by virtue of the use of the term "physician." This is further illustrated in regulations under section 1895(c) which require a unique identifier of the physician "who prescribed the services or made the certification…" In fact, all regulations specifically reference a physician for certifying the homebound status as well as the plan of care.

Focus on Barriers Facing Asian and Pacific Islander Seniors - The Committee is aware of the barriers faced by Asian and Pacific Islander seniors accessing programs such as those contained in the Medicare Prescription Drug, Improvement, and Modernization Act and other similar health and social services programs. The Committee urges additional focus upon this population, utilizing the expertise of organizations such as the National Asian Pacific Center on Aging. (Page 190)

Action taken or to be taken

Since early 2005, CMS has conducted an outreach campaign directed at the Asian-American/Pacific Islander (AAPI) Medicare population to increase access to Medicare covered services. As a result of the campaign efforts, the AAPI elderly population have received education on Medicare's programs as well as one-on-one assistance with enrollment into Medicare's prescription drug program, information to help them decide on whether changing plans in 2007 would be beneficial, applied for extra help through the limited income subsidy, and taken advantage of Medicare-covered preventive services.

The beneficiary outreach campaign's foundation has been the formation of partnerships with AAPI national and grassroots organizations throughout the country, other Federal agencies such as the Administration on Aging (AoA), Social Security Administration (SSA), Office of Minority Health (OMH), Department of Labor (DOL), State Government, and others. CMS and other partners plan and carry out collaborative outreach events such as health fairs, presentations at senior centers, enrollment events, Mobile Office Tours, and other activities.

To meet the language needs of AAPI beneficiaries during events, CMS and its partners make presentations and provide one-on-one assistance in AAPI languages, or arrange for translators. In addition, CMS distributes translated materials at events, provides them to partners for distribution, and makes them available on the Internet. During the initial enrollment period, CMS worked with the Social Security Administration to translate 14 publications on the new Medicare prescription drug coverage into Korean, Chinese, Vietnamese, and Tagalog. The translated publications are available electronically on CMS' internet site and have been distributed widely. We are in the process of translating additional publications on enrollment, preventive services, and Medicare in general into the same languages. Also, AAPI beneficiaries with limited English proficiency can call 1-800-MEDICARE and receive answers to questions, enrollment assistance, etc. from customer service staff. AT&T provides translator assistance.

CMS and its partners also generate earned media as another means of reaching the AAPI population (e.g., cable TV and radio interviews, interviews with journalists, inviting the media to attend events). During the prescription drug open enrollment period from November 15 – December 31, 2006, we also reached the AAPI population through paid media by placing translated ads in Chinese, Korean, Vietnamese, and Filipino daily and weekly print publications in top markets. The campaign along with our partners' involvement have resulted in CMS having a greater reach to AAPI Medicare beneficiaries and their caregivers and ultimately in AAPI beneficiaries having greater access to programs such as Medicare-covered prescription drugs and preventive services. For example, 70 percent of the AAPI population enrolled in the prescription drug program during the first enrollment period as a result of an extensive partnering outreach effort.

One of our most successful partnerships has been with the National Pacific Center on Aging (NAPCA). The Administration on Aging (AoA) awarded a contract to NAPCA (10/1/04 – 9/30/05) to reach out to low-income AAPI seniors, increase their awareness and participation in the Medicare-approved drug discount card program and address linguistic and cultural barriers. NAPCA provided outreach to over 5 million non-English speaking Asians and provided personal assistance to approximately 10,000 beneficiaries. In a subcontract to the National Association of Area Agencies on Aging, which was awarded during Medicare's first enrollment period (11/05-6/06), NAPCA conducted outreach activities throughout the country and ran a Multilanguage Helpline center offering assistance to Chinese, Korean, Vietnamese, and English-speaking elders. Through these activities, NAPCA educated almost 20,000 elders through 68 events and provided enrollment assistance to almost 37,000 non-English-speaking beneficiaries. NAPCA continues to provide assistance through its Helpline by leveraging other resources and AoA contracts. CMS partners with many other organizations, including national organizations such as the Japanese American Citizens League, the Organization of Chinese Americans, and Boat People SOS and grassroots organizations such as the Greater Boston Chinese Golden Age Center, Korean American Senior Center in Illinois, Cambodian Association of Greater Philadelphia, Asian & Pacific American Resource Network in Seattle, Vietnamese American Civic Association in Massachusetts, and many others.

Power Mobility Devices - The Committee is concerned about ongoing fraud and abuse in the power mobility device/power wheel chair program. CMS has not moved quickly enough to adopt accreditation and quality standards for suppliers. The Committee believes that these standards will help eliminate fraud and abuse by limiting the ability of fraudulent suppliers to get provider numbers. The Committee instructs CMS to issue accreditation and quality standards at the earliest possible date. (Page 190)

Action taken or to be taken

CMS has developed supplier accreditation and quality standards. In addition, CMS announced in November Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) accreditation organizations for purposes of accrediting DMEPOS suppliers. These accreditation bodies are expected to prioritize those suppliers that are competitively bidding in 2007 allowing them to be accredited in early 2007. This same time line is

expected to be repeated for the 2008 competitive bidding cycle. CMS will soon provide instructions by which all DMEPOS suppliers need to be accredited in order to obtain and maintain their supplier enrollment number.

Demonstration Project on Medication Therapy Management Program Models for Low-income Medicare Part D Enrollees with HIV/AIDS - The Committee encourages CMS to conduct a demonstration project to identify effective Medication Therapy Management Program [MTMP] models for low-income Medicare part D enrollees living with HIV/AIDS. The demonstration project should emphasize evidence-based prescribing, prospective medication management, technological innovation and outcome reporting. The Committee also encourages CMS to work with the States to establish this demonstration project for HIV/AIDS patients. (Page 190-191)

Action taken or to be taken
The final rule for the Medicare prescription drug benefit made clear that MTMP is one component of the Part D program that we may wish to explore further in the future, and demonstration authority may be an appropriate vehicle. 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 medication therapy management programs (MTMPs) under Part D. CMS is intending to conduct a best practices assessment of MTMPs, and we will consider whether to develop such a demonstration in the future.

Integrated Rural Training Track Program - The Committee is concerned that the agency has not yet issued regulations to implement the Integrated Rural Training Track program as authorized in section 407 (c)(1)(iv) of the Balanced Budget Refinement Act of 1999, Public Law 106-113, for graduate physician training in rural areas. Without implementation of the IRTT, programs to train family physicians to practice in rural and frontier communities will continue to be unable to meet the requirements for GME programs developed for urban and suburban areas. The Committee urges the agency to develop such regulations and directs the agency to report back to the Committee on Appropriations on its progress by April 1, 2007. (Page 191)

Action taken or to be taken
The IRTT provision provides that the Secretary shall adjust a hospital's cap on its full time equivalent (FTE) residents if the hospital is not located in a rural area and establishes separately accredited approved medical residency training programs in a rural area or has an accredited training program with an integrated rural track. In promulgating regulations implementing this provision, the Centers for Medicare & Medicaid Services (CMS) was thus required to adjust the cap for programs that are uniquely accredited as "rural programs." In implementing this provision of the BBRA, we allowed urban hospitals to count a number of residents above their FTE caps for purposes of Medicare graduate medical education (GME) payments when they establish rural training tracks or integrated rural tracks. However, based on information from the Accreditation Council for Graduate Medical Education, there were no programs accredited with "integrated rural tracks." Therefore, in implementing this

provision CMS established one policy for rural GME programs, whether they were rural track programs or "integrated rural tracks."

The regulations state that for cost reporting periods beginning on or after October 1, 2003, if an urban hospital rotates residents to a separately accredited rural track program at a rural hospital(s) or rural non-hospital site(s) (subject to the non-hospital site regulations under section 413.78(e)) for more than one-half of the duration of the program, the urban hospital may include those residents in its FTE count, not to exceed its rural track FTE limitation. Medicare regulations are designed to strongly encourage the establishment of programs in which residents spend a significant portion (the majority) of their time training in rural settings. Given the statutory hospital-specific caps on the number of residents hospitals may count for purposes of determining Medicare payments to teaching hospitals, CMS believes that it is not appropriate to permit broad exceptions from those resident caps for urban hospitals that provide less substantial periods of training for residents at rural sites.

Augment IT Activities with QIO Resources - The Committee urges CMS to augment information technology activities utilizing resources available under the Quality Improvement Organization program. (Page 191)

Action taken or to be taken

CMS is supporting information technology activities through the Quality Improvement Organization (QIO) program. This work is being undertaken in the Physician Office Task of the QIO Program's 8th Scope of Work (August 2005 to August 2008). To date, this project has recruited more than 4,500 physician practice sites nationally (over 1,100 treating underserved patient populations) with the goal of implementing Electronic Healthcare Records (EHRs) and using them to improve the care of patients. To date, approximately 600 implementations have begun, making this the largest informatics project of this type in the nation. In addition, the QIO program has also initiated a care management program that will assist providers in improving the care of patients with chronic diseases. The purpose of this study is to develop care process redesign tools/content for care management in an out-patient small physician office setting, using all elements of health information technology (HIT), and personnel resources, in order to maximally engage patients in their care.

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

Medicare Operations

Authorizing Legislation
Social Security Act, Title XVIII, Sections 1816 and 1842, 42 U.S.C. 1395 and the Deficit Reduction Omnibus Reconciliation Act of 2005.

Medicare Operations Summary Table
Dollars in Thousands

	FY 2006 Actual	FY 2007 President's Budget	FY 2007 CR Level	FY 2008 President's Budget	FY 2008 Pres. Bud. +/- CR Level
Appropriation/B.A.	$2,172,987	$2,145,208	$2,120,588	$2,303,615	$183,027
Rescissions (P.L. 109-148) (P.L. 109-149)	 ($21,245) ($44,500)	 ---	 ---	 ---	 ---
Deficit Reduction Act (P.L. 109-171)	$53,600	---	---		---
Tax Relief and Health Care Act (P.L. 109-432)	---	---	$90,000	---	($90,000)
Section 202 Transfer	$40,000	---	---	---	---
Adjustments for Comparability	---	---	---	---	---
Comparable (Net) Appropriations/B.A	$2,200,842	$2,145,208	$2,210,588	$2,303,615	$93,027

Statement of the Budget Request

CMS' FY 2008 budget request for Medicare Operations is $2,303.6 million, an increase of $93.0 million above the FY 2007 current rate (CR) level. Medicare Operations funding covers the Medicare contractors' and the new Medicare Administrative Contractors' (MACs) ongoing operational costs such as processing fee-for-service claims, responding to inquiries, and handling appeals. The remainder funds information technology and activities required by legislation.

Program Description

From Medicare's inception, the Federal government has used private insurance companies to process claims and perform related administrative services for the program's beneficiaries and health care providers. Today, CMS relies on a network of contractors to process more than 1.2 billion

Nearly 37 million, or 82 percent, of today's Medicare beneficiaries receive benefits through the fee-for-service portion of the program.

Medicare claims each year from more than 1 million health care providers. In addition to processing claims, the contractors enroll health care providers in the Medicare program and educate them on Medicare billing requirements, handle claims appeals, and answer beneficiary and provider inquiries. At present, the contractors include 23 fiscal intermediaries (FIs) and 17 carriers that process FFS claims. FIs process claims for Medicare Parts A and B for facilities and carriers process claims for Medicare Part B, in particular for physician, laboratory and other services. In addition, four fiscal intermediaries serve as regional home health intermediaries (RHHIs) and four carriers serve as durable medical equipment regional carriers (DMERCs). To date, four DME MAC contracts have been awarded. Three have successfully completed their implementation/transition activities and are fully operational; the fourth is currently in the implementation/transition phase. The first A/B MAC began claims processing operations on September 30, 2006.

Contractors process claims for specific jurisdictions. Because of the way Medicare contracts have evolved over 40 years, these jurisdictions can encompass a single county, a single State, a block of States, or several States in different areas of the country. Some contractors serve only one State, and others serve several, sometimes non-contiguous States, resulting in a patchwork of responsibility and service. In addition, some contractors are both FIs and carriers, but do not serve the same geographic areas in both lines of business.

Although health care delivery in the United States has evolved with four decades of advances in medicine and technology, the contracting portion of Medicare's FFS administrative structure has not. The reforms mandated by Congress in the Medicare Modernization Act of 2003 grew out of the gradual realization that Medicare's ability to deliver more efficient and effective services to beneficiaries and health care providers and meet future programmatic challenges is hampered by a number of restrictions and weaknesses in the current administrative system. Section 911 of the MMA contains several important changes to Medicare's administrative structure that will make contracting dynamic, competitive, and performance-based and ensure the program is more responsive to the needs of its beneficiaries and health care providers. CMS' plans for reforming the contracting environment are outlined in detail later in this section.

In the current environment, CMS continues to focus on oversight of Medicare contractor operations and activities. We continuously develop, refine, and improve the methodologies for populating review teams, refine and update the Contractor Performance Evaluation (CPE) review protocols, and identify improved methodologies for drawing CPE review samples. Contractor oversight will be further improved by the centralization of evaluation results to an "Evaluation Results Data Repository" maintained by CMS.

Contracting reform is expected to increase competition among Medicare contractors and result in service improvements for Medicare providers and beneficiaries and the Medicare program. In this new environment, CMS will no longer conduct the traditional CPE review. However, as we transition from Title XVIII contractors to MACs, we will simultaneously conduct CPE reviews and review of MAC operations and adherence to contract terms and conditions. The MAC evaluation efforts will be focused and we will use various methods of

contractor oversight reviews including: quality audit reviews; data validation reviews; ad-hoc reviews; performance monitoring.

Medicare Operations by Major Activity
(Dollars in Millions)

While approximately half of the Medicare Operations request covers the operations of the Medicare contractors described above, it also includes funding for many other important activities, most of which are required by legislation, particularly the MMA. The chart below summarizes our FY 2008 needs for Medicare Operations. (Some numbers may not add due to rounding.)

Activity	FY 2006 Actual	FY 2007 President's Budget	FY 2007 Current Rate	FY 2008 President's Budget
Ongoing Operations & Support Costs	$1,201.2	$1,084.2	$1,109.8	$1,133.8
Ongoing IT Activities	$203.1	$273.2	$273.2	$301.4
Contracting Reform	$13.2	$146.8	$122.2	$253.8
Other Legislative Mandates (HIPAA, BIPA, NMEP, Other MMA, HIGLAS Development, DRA, Tax Relief & Health Care Act)	$773.3	$630.8	$695.2	$606.7
Departmental IT	$10.0	$10.2	$10.2	$8.0
Total	**$2,200.8**	**$2,145.2**	**$2,210.6**	**$2,303.6**

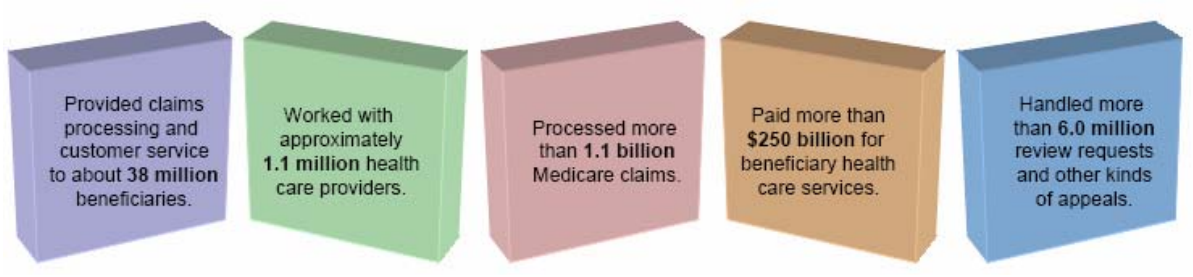
Rationale for the Budget Request

Ongoing Operations & Support Costs: $1,133.8 million

Ongoing Operations: $1,112.7 million

As explained in the program description, approximately half of the Medicare Operations budget supports the negotiated workloads that CMS' claims administration contractors (i.e., FIs, carriers, and MACs) are required to process.

In FY 2005, the Medicare contractors:



The requested funding will allow the Medicare contractors to process their workloads accurately, in a timely manner, and in accordance with CMS' standard program requirements. The table below displays each of the major activities included in this category and the funding levels associated with each:

(dollars in millions)	FY 2007 President's Budget	FY 2007 CR Level	FY 2008 President's Budget	FY 2008 Pres. Bud. +/- CR Level
Bills/Claims Payment	$717.4	$730.2	$747.8	+$17.6
Provider Reimbursement	48.4	48.4	42.7	-5.7
Participating Physician/Supplier Program (PARDOC)	5.0	5.0	4.6	-0.4
Appeals	81.5	94.3	96.4	+2.1
Inquiries	205.5	205.5	206.9	+1.4
Provider Communications	8.0	8.0	14.2	+6.2
Total, Ongoing Operations	**$1,065.8**	**$1,091.4**	**$1,112.7**	**+$21.2**

Bills/Claims Payments: $747.8 million

This category reflects the Medicare contractors' costs of processing and paying Part A bills and Part B claims including electronic data processing, contractor personnel, postage, and printing. It also includes the cost of enrolling providers in the Medicare program. The FY 2008 estimate reflects an increase of $17.6 million above the FY 2007 current rate. This includes $7.0 million in savings from contracting reform.

Medicare contractors process more than 1.2 billion fee for service claims each year.

The table below displays the claims volumes and unit costs from FY 2004 to FY 2008:

	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Estimate	FY 2008 Request
Volume (in millions)					
Part A	179.2	185.6	185.9	185.4	194.5
Part B	949.7	979.9	991.5	1,019.9	1,070.0
Total	1,128.9	1,165.5	1,177.4	1,205.3	1,264.5
Unit Cost (in dollars)					
Part A	$0.93	$0.96	$0.96	$0.96	$0.91
Part B	$0.63	$0.64	$0.64	$0.54	$0.53

Provider Reimbursement: $42.7 million

As part of claims processing activities, the FIs also perform provider reimbursement services, which include establishing and adjusting interim rates to ensure proper payment to providers, maintaining provider-specific permanent files, reporting and collecting provider overpayments, and identifying non-Medicare secondary payer delinquent debt which is eligible for referral to the Department of Treasury for cross-servicing and offset, consistent with the Debt Collection Improvement Act of 1996. This category also includes receiving and reviewing attestations related to provider-based determinations. The estimate for FY 2008 is $5.7 million dollars less than the FY 2007 current rate.

Participating Physician/Supplier Program: $4.6 million

This program strives to reduce the impact of rising medical costs on beneficiaries by increasing the number of physicians and suppliers who participate in the Medicare program and by enforcing the charge limit. This request covers the costs of conducting the annual enrollment process plus some monitoring of limiting charge compliance and limited distribution of information to participating physicians. The estimate for FY 2008 is approximately $400,000 less than the FY 2007 current rate.

Medicare Contractor Appeals: $96.4 million

The Medicare appeals process is statutorily mandated and it affords beneficiaries, providers, and suppliers an opportunity to dispute initial determinations made by Medicare contractors. While the Medicare Program has experienced a decrease in Medicare contractor appeals costs in the last several years, CMS anticipates an increase in FY 2008 due to mandated appeals requirements in the Benefits Improvement and Protection Act (BIPA). In FY 2006, CMS completed implementation of the BIPA appeals requirements. Several BIPA provisions will have an impact on the FY 2008 budget:

- The second-level appeals workload was transferred from the Medicare contractors to the qualified independent contractors (QICs). FY 2007 will be the first year that all QICs are fully operational for the entire year. QIC implementation increased the support services (e.g., report, prepare, and forward case files, and effectuate QIC decisions) provided by the Medicare contractors.

- The timeframe for the Medicare contractors to prepare case files for the QIC level is aggressive due to the statutorily mandated short amount of time QICs have to decide appeals.

- The minimum amount in controversy required to file a second level appeal was changed from $100 to zero. This is increasing the number of appeal requests received.

In addition, the increase in the funding needed to perform appeals activities is related to the number of appeals received that are directly impacted by changes in Medicare policy, (e.g., changes in Medicare contractor medical review strategies or other Medicare Integrity Program directives).

CMS estimates that fiscal intermediaries, carriers, and Medicare administrative contractors will process approximately 5.6 million appeals in FY 2008, with a total request of $96.4 million, $2.1 million more than the FY 2007 current rate.

Beneficiary and Provider Inquiries: $206.9 million

In FY 2008, FFS contractors will process 5.6 million appeals and answer approximately 76 million telephone inquiries from beneficiaries & providers.

The Medicare contractors serve as a direct link to the beneficiary community regarding Medicare program information and services. The majority of the beneficiary inquiry funding supports the daily workload of responding to telephone and written inquiries, as well as conducting educational/outreach efforts. The balance of the funding is used to conduct complaint screening activities; to run the telephone equipment; and to keep pace with technological advances and associated software such as the Next Generation Desktop. Overall, beneficiary communication efforts are designed to continue improving services to CMS' primary customer, the beneficiary. CMS estimates that the

contractors will respond to more than 7.0 million telephone calls and close to 800,000 written inquiries from beneficiaries.

The Medicare contractors also serve as the direct link to the Medicare providers who submit over 1.2 billion claims annually. They are responsible for responding to telephone, written, and, on occasion, walk-in inquiries from Medicare providers. CMS relies on its contractors to keep providers abreast of Medicare program information and to answer questions about the program in general or about specific claims. Based on recent trends, CMS estimates over 68 million inquiries from providers.

In total, the FY 2008 estimate for beneficiary and provider inquiries is $206.9 million, $1.4 million more than the FY 2007 current rate.

Provider Outreach and Education (formerly Provider Communications): $14.2 million

CMS' FIs and carriers are also instrumental in providing Medicare-participating providers and suppliers with timely, relevant, and understandable information in order to better serve Medicare beneficiaries. CMS strives to create a culture that is open, accessible, and responsive to our partners, making it easier for them to understand our programs and navigate our organization. Provider communication activities directly support this mission.

A strong, effective FI and carrier provider communication program also helps reduce claims processing errors and the additional work (e.g., inquiries, appeals, overpayment collections) that flows from these errors. FIs and carriers conduct numerous communication activities, tailored to meet the needs of providers and suppliers in their areas. Activities include expanded education as required by the Medicare Modernization Act, education tailored to small providers, education tailored to reduce the error rate, periodic provider teleconferences, plus updating and expanding the information on the internet websites and maintaining electronic mailing lists. In addition to these activities, other provider communications focused on assisting providers to avoid and detect waste, fraud, and abuse are funded through the Medicare Integrity Program (MIP). The FY 2008 estimate is $6.2 million above the FY 2007 current rate because it reflects outreach activities previously included in the MMA section.

Medicare Fee-for-Service Operations Support: $21.2 million

CMS pays for several other activities that directly support the operation of the Medicare fee-for-service program. The FY 2008 estimate includes:

Provider Toll-Free Lines: $8.5 million

CMS will continue to maintain toll-free lines for responding to the over 68 million provider calls. Toll free lines allow providers to receive quick, accurate answers to questions about billing and claims processing and other Medicare-related issues from our Medicare contractors. This line funds the cost of technical support and management of over 100 toll-free lines and pays the telecommunications costs associated with these lines. It does not

include the cost for the Medicare contractors' provider customer service representatives, which is shown in the inquiries section. This effort also reduces payment errors, eases the financial burden on providers, and supports physicians as they care for Medicare beneficiaries.

National Provider Education, Outreach, and Training: $6.0 million

Medicare national fee-for-service provider education & training is the global source for providing consistent and timely Medicare program information to providers nationally. This activity includes development and dissemination of provider educational products including MLN (Medicare Learning Network) Matters articles, provider training calls, brochures, billing guides, web-based training, and fact sheets. Medicare's national products serve as an authoritative source of fee-for-service information for providers and are extensively used by FIs and carriers in their outreach and training activities. All activities supported by this line are available to all providers across the country, and are complemented by local outreach and training by Medicare contractors. The web site that houses much of this information and educational material is CMS' Medicare Learning Network web page at http://www.cms.hhs.gov/MLNGenInfo/. This request is the same as the FY 2007 current rate level.

Other Operational Costs: $6.7 million
This category includes funds for the Medicare physician fee schedule updates, printing Medicare forms, Medigap cost settlements, and leasing space for document storage.

Ongoing Information Technology: $301.4 million

While FI and carrier ongoing operations costs are the largest part of the Medicare Operations budget, information technology costs represent the second largest part. There are tremendous information technology costs necessary to operate the Medicare program. Below are descriptions of these costs. In addition, the MMA requirements made it essential for CMS to make many changes to existing systems and to build new systems. These costs are described in the MMA section later in this chapter.

Systems Operations and Maintenance: $209.7 million

Of this total, $96.3 million covers information technology costs necessary to process claims. This includes operating and maintaining the Medicare fee-for-service claims processing systems, the common working file (CWF), and the managed care systems. The CWF is a major component of the Medicare claims processing function. All claims are sent to the CWF host to validate and authorize claims payment. This funding also supports the risk adjustment system (RAS). This RAS uses demographic and diagnostic data to produce risk adjustment factors to support Medicare managed care payments. In addition, $113.4 million of this category covers the maintenance costs at the Medicare contractor sites that have transitioned to HIGLAS, as described in the HIGLAS section later in this section. Lastly, this estimate includes enhancements to the continuing modernization efforts under the virtual call center strategy, a multi-year effort to increase the overall efficiency and

effectiveness of call center service delivery. The request is $12.5 milllion above the FY 2007 current rate, mainly for HIGLAS.

Enterprise Activities: $81.7 million

This request provides funding for CMS' critical systems infrastructure that supports ongoing operations. More than half of this category funds the consolidated information technology infrastructure contract (CITIC). This data center contract provides the day-to-day operations and maintenance of CMS' enterprise-wide infrastructure which includes management of the mainframe, network, voice and data communications, as well as backing up CMS' mission critical applications and managing CMS' hardware and software. The remainder of this category funds 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. This request reflects an increase of $5.7 million above the FY 2007 current rate, mainly for the CITIC.

IT Modernization: $10.0 million

Beginning in FY 2008, the Medicare Operation account will support several IT modernization activities that were formerly funded out of the Revitalization Plan line item. This request includes $10 million to continue work already begun including: modernizing Medicare claims processing application systems, developing personal health records, implementing an Integrated Data Repository, expanding enterprise architecture, and supporting web-based applications.

Departmental Information Technology: $8.0 million

Enterprise Information Technology Fund: $6.6 million

The CMS will contribute $6.6 million of its FY 2008 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, $1.7 million is allocated to support the President's Management Agenda Expanding E-Government initiatives for FY 2008. This amount supports the PMA E-Government initiatives as follows:

PMA e-Gov Initiative	FY 2007 Allocation	FY 2008 Allocation
Business Gateway	$126,989	$82,676
E-Authentication	$0	$21,739
E-Rulemaking	$221,027	$190,005
E-Travel	$0	$16,768
Grants.Gov	$17,490	$18,014
Integrated Acquisition	$253,150	$260,877
Geospatial LOB	$0	$0
Federal Health Architecture LoB	$1,038,700	$1,053,339
Human Resources LoB	$9,848	$9,848
Grants Management LoB	$923	$1,822
Financial Management LoB	$15,838	$27,151
Budget Formulation & Execution LoB	$14,255	$16,155
IT Infrastructure LoB	$15,205	$15,205
TOTAL	$1,713,423	$1,713,599

Prospective benefits from these initiatives are:

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.

E-Authentication: Provides standards-based authentication architecture to support Federal E-Government applications and initiatives. It provides a uniform process for establishing electronic identity and eliminates the need for redundant solutions for the verification of identity and electronic signatures. E-Authentication's federated architecture also enables citizens and businesses to use credentials issued by commercial entities, such as financial institutions, to conduct transactions with the government, eliminating the need for HHS to issue credentials for its systems.

E-Rulemaking: Provides citizens and organizations a single point of access to Federal rulemaking information. HHS posts all rulemaking notices on Regulations.gov. HHS and E-Rulemaking are in the requirements and planning process for migrating HHS docket-management process to the E-Rulemaking system.

E-Travel: Provides a standard set of travel management services government-wide. These services leverage administrative, financial and information technology best practices. By the end of FY 2006, all but one HHS OPDIV has consolidated services to GovTrip and legacy systems retired. By May 2008, all HHS travel will be conducted through this single system and the last remaining legacy functions will be retired.

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 2006, HHS received over 56,000 electronic applications from the grants community via Grants.gov.

Integrated Acquisition Environment: Eliminates the need for agencies to build and maintain their own agency-specific databases, and enables all agencies to record vendor and contract information and to post procurement opportunities. Allows HHS vendor performance data to be shared across the Federal government.

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-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.

Lines of Business–IT Infrastructure: A recent effort, this initiative provides the potential to leverage spending on commodity IT infrastructure to gain savings; to promote and use common, interoperable architectures that enable data sharing and data standardization; secure data interchanges; and, to grow a Federal workforce with interchangeable skills and tool sets.

Performance Goal	Results	Context
Develop and Implement an Enterprise Architecture (EA) For FY 2008, continue maturing the Enterprise Architecture (EA). .	The FY 2006 target was met. In FY 2006, CMS migrated its EA modeling activities and all attendant data to the Department's EA repository.	CMS, as required by the Clinger-Cohen Act of 1996, is developing an integrated, enterprise-wide architecture that is aligned with the CMS' strategic business objectives. The EA will document the relationships between CMS' business and management processes and the technology that supports those processes. Its purpose is to ensure that IT requirements are aligned with the business processes that support CMS' mission and that a logically consistent set of policies and standards are developed to guide the engineering of CMS' IT systems.

Unified Financial Management System: $1.4 million

The Unified Financial Management System (UFMS) is being implemented to replace five legacy accounting systems currently used across the Operating Divisions (Agencies). The UFMS will integrate the Department's financial management structure and provide HHS leaders with a more timely and coordinated view of critical financial management information. The system will also facilitate shared services among the Agencies and thereby, help management reduce substantially the cost of providing accounting service throughout HHS. Similarly, UFMS, by generating timely, reliable and consistent financial information, will enable the component agencies and program administrators to make more timely and informed decisions regarding their operations. UFMS has been in production for the CDC and FDA for over a year, with new functionality releases of Grants and IVR in October 2005 and eTravel in April 2006. The PSC implementation was moved to production on October 16, 2006.

Accounting Operations. The PSC has the responsibility for ongoing Operations and Maintenance (O & M) activities for UFMS. The scope of O & M services includes post deployment support and ongoing business and technical operations services. Post-deployment services include supplemental functional support, training, change management and technical help-desk services. On-going business operation services involve core functional support, training and communications, and help desk services. On-going technical services include the operations and maintenance of the UFMS production and development environments, on-going development support, and backup and disaster recovery services. In accordance with Federal and HHS policy, the UFMS application is under an approval to operate through February 16, 2007 by the designated Certifying Authority and Designated Approving Authority (DAA). The UFMS application will be approved for operation for 1 year after this date. After October 2007, when all OPDIVs will be operational on UFMS, then a 3-year certification will be completed. This approval to operate assures that the necessary security controls have been properly reviewed and tested as required by the Federal Information Security Management Act (FISMA). CMS requests $762,225 to support these efforts in FY 2008.

Automating Administrative Activities. With the implementation of a modern accounting system, HHS has efforts underway to consolidate and implement automated administrative systems that share information electronically with UFMS. These systems will improve the business process flow within the Department, improve Funds Control and provide a state of the art integrated Financial Management System encompassing Finance, Budget, Acquisition, Travel and Property. As the UFMS project is nearing completion, the integration of administrative systems is the next step in making these processes more efficient and effective. CMS requests $657,019 to support these efforts in FY 2008.

Legislative Mandates: $860.5 million

The Medicare Modernization Act of 2003: $619.8 million

The MMA of 2003 brought the most dramatic and innovative changes to the Medicare program since it began in 1965, including prescription drug coverage to all people with Medicare, expanded health plan options, improved health care access for rural Americans, and preventive care services, such as flu shots and mammograms.

The MMA brings the most dramatic and innovative changes to Medicare since 1965.

The MMA provides on-going benefits and entails on-going responsibilities. We must administer the new MMA programs just as we administer the traditional fee-for-service program. This requires funding for a variety of activities described below. Two of these activities, contracting reform and competitive bidding for durable medical equipment (DME), require significant funds for implementation but are also expected to provide significant trust fund savings. For example, CMS' actuaries estimate that DME competitive bidding will produce the following savings stream beginning in FY 2008 ($ in millions):

2008 ..... $80
2009 .....$620
2010 ..... $950
2011 .....$1,100

Excluding funds for contracting reform and competitive bidding, our FY 2008 MMA request actually represents a 12-percent decrease from the FY 2007 current rate.

- **Drug Benefit and Medicare Advantage Programs**: **$140.7 million**

  Information Technology: CMS requires $113.9 million in FY 2008 to maintain several IT systems critical to operating the drug benefit program and supporting the new Medicare Advantage (MA) plans. Maintaining and enhancing the new MMA-related systems, while getting our health care system to efficiency and interoperability faster, is vital to the continued success of these new benefits. Some of these projects include: an employer subsidy payment system; risk assessment activities to enable risk-adjusted payments to MA plans; and enrollment and payment systems for MA, prescription drug plan (PDP), and MA/PDP plans for new drug-related claims.

  Oversight and Management: ($26.8 million) CMS will have to provide management support for the new drug benefit and health plans. This includes such diverse activities as: reviewing bids; providing an appeals process for the new drug benefit; administering the low income subsidy; and conducting actuarial reviews. These activities require contractor support. The inset on the following page shows how we are measuring our performance in implementing these new programs.

As noted in the performance goal below, implementation of the Medicare prescription drug benefit is a CMS priority.

Performance Goal	Results	Context
Implement the New Medicare Prescription Drug Benefit a. Percentage of people with Medicare that know that people with Medicare will be offered/are offered prescription drug coverage starting in 2006 b. Percentage of beneficiaries that know that out-of-pocket costs will vary by the Medicare prescription drug plan c. Percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same list of prescription drugs The FY 2008 operational targets for these measures are 63%, 65%, and 46%, respectively.	Having met the FY 2006 targets, and based on our progress to date, we were able to increase the targets for FY 2007 and beyond.	The MMA, as signed by the President on December 8, 2003, provides Medicare beneficiaries access to prescription drug coverage and the buying power to reduce the prices they pay for drugs. As of June 11, 2006, 38.2 million people with Medicare are now receiving comprehensive prescription drug coverage from Part D or another source.

- **National *Medicare and You* Education Program (NMEP): $124.6 million**

  This is part of a larger request for funding for the NMEP that is discussed more fully later in this chapter. The NMEP covers a broad range of education and outreach activities including: printing and distributing the *Medicare & You* handbook and other publications; services provided by the State Health Insurance Assistance Programs (SHIPs) and other community-based organizations; inquiries handled by the 1-800-MEDICARE call-centers; web-based internet services including interactive comparison tools, searchable databases, and on-line publications; and consumer research.

  The MMA has impacted each of these activities, requiring the additional funds requested here. We believe that our request will help ensure that our new competitive approach to Medicare is effective, especially given all the challenges--both new and ongoing--that we face in FY 2008.

- **Contracting Reform: $253.8 million**

  Contracting reform represents a fundamentally new approach to working with the Medicare contractors that provide Medicare claims processing services. Instead of

managing 40 cost-based contracts, CMS will manage 15 truly competitive, performance-based contracts for new entities known as Medicare administrative contractors or MACs. These 15 MAC contracts will integrate Part A and Part B claims processing workloads (that is, these contractors will handle both hospital and physician payments). In addition, CMS plans to have four contractors administer payments to home health and hospice providers, and four contractors administer payments to durable medical equipment suppliers. Successful implementation will result in substantial Medicare trust fund savings from more accurate and effective payments. We also expect substantial administrative savings in the Nation's health care system from reducing the providers' costs of processing Medicare claims accurately.

CMS will reduce its number of contracts from 40 to 15.

CMS awarded four durable medical equipment Medicare administrative contracts (DME MACs) in FY 2006. Two of the four DME MACs have completed their implementation/transition activities in Jurisdictions A and B respectively and became fully operational on July 1, 2006. On May 4, 2006, CMS received notification from the Government Accountability Office (GAO) of its decisions concerning two DME MAC bid protests. The GAO denied one of the protests filed by an unsuccessful bidder and authorized the winning contractor to resume work as of May 8, 2006. That third DME MAC began claims processing operations effective September 30, 2006 in Jurisdiction D. The GAO sustained the unsuccessful bidder's protest of the other award made by CMS in Jurisdiction C and recommended corrective steps. In response to GAO's recommendations, CMS reopened discussions with the offerors within the competitive range in the procurement. CMS requested that the competitive range offerors submit final proposal revisions which were evaluated. CMS made an award which was then protested to the GAO by the unsuccessful bidder/offeror. On January 16, 2007 CMS received notification that GAO denied the protest. CMS has authorized the successful bidder/offeror to resume implementation/transition activity in Jurisdiction C.

On July 31, 2006, CMS also awarded the first of 15 contracts for the combined handling in six States of both Part A and Part B Medicare claims in Jurisdiction 3 (J3). The J3 A/B MAC began full claims processing operations on September 30, 2006. We estimate that we will need $151.5 million in FY 2008 for termination and transition activities associated with the contract changes. Of this total, $61.5 million is needed to complete the transitions associated with the seven MACs in the first cycle. This first cycle was only partially funded in the FY 2007 President's budget. The balance of $90.0 million will be used to begin transferring the legacy contractors' claims processing activities to the new MAC's in the second cycle. Additional funds will be required in FY 2009 to complete the second and final cycle.

The following table reflects the current schedule for the MACs.

DME MAC Regions A & B	Awarded on January 2006. Completed implementation cutover on July 1, 2006. These contractors are fully operational.
DME MAC	Awarded on January 2006, protest resolved May 2006. Began claims

Region D	processing operations on September 30, 2006.
DME MAC Region C	Awarded on January 2006, protest resolved January 2007. Transition is currently underway.
A/B MAC J3	Awarded July 2006 with majority of transition completed by December 2006. Began claims processing operations on September 30, 2006. Final cutover and fully operational status currently scheduled for March 2007.

Cycle One A/B MAC RFP 1	RFP released in September 2006 with a scheduled award date of July 2007. There are three jurisdictions to be awarded under this RFP. Full transition of an individual jurisdiction is not expected to take longer than 12 months following award.
Cycle One A/B MAC RFP 2	RFP released in December 2006 with a scheduled award date of September 2007. There are four jurisdictions to be awarded under this RFP. Full transition of an individual jurisdiction is not expected to take longer than 12 months following award.
Cycle Two A/B, HH MAC RFP 1, RFP 2 and RFP 3	There will be seven A/B MAC (RFP 1 & 2) jurisdictions and four HH MAC (RFP 3) awards to be made during this procurement cycle. Much like Cycle One, these awards and RFPs will be staggered. It has not yet been determined which jurisdictions will be affiliated with RFP 1 and RFP 2. RFP releases are scheduled for September and December of 2007 with anticipated award dates of July and September 2008. Full transition of an individual jurisdiction is not expected to take longer than 12 months following award.

CMS expects to reduce the number of enterprise data centers from 14 to 3 and the number of front end claims processing systems from 43 to 1.

In addition to the $151.5 million in transition and termination funding discussed above, CMS is also requesting $88.7 million for its enterprise data center (EDC), standard front end (SFE) strategies, and other Medicare Contracting Reform information technology. Three performance-based contracts for provision of secure, reliable, redundant, and scalable data centers and world-class application hosting services were awarded in March, 2006. Strategically, CMS plans to transition all FFS data center workloads ahead of the MAC transition schedules. Transitions began in June 2006 and are scheduled to be completed by December 2008. The EDC strategy will provide CMS with better performance in several areas including:

- Interoperability – This initiative will produce one standardized infrastructure and network platform;
- Security – By contracting directly with fewer data centers, CMS will be better able to assure data security;
- E-services – CMS' goal is to have a powerful internet platform for provider transactions and other e-services; and
- Flexibility and Scalability – CMS will be able to determine if and when to expand.

The SFE strategy is linked with the overall Application Modernization initiative. This initiative will provide the reengineered systems for the EDC operating environment. These systems will support the MACs in providing Medicare claims processing services. The SFE will provide CMS with a new front-end transaction editing and eCommerce service for Medicare claims processing. Currently there are 43 separate front end systems developed, owned and operated by contractors. SFE will simplify the process by:

- Reducing the number of discrete systems used in editing transaction submissions;
- Standardizing the editing of claims for providers;
- Helping CMS to implement Medicare program changes with less coordination and testing effort;
- Supporting the e-Government initiative by expanding electronic claims filing and status inquiry options; and
- Streamlining the contracting environment for management and control of front end claims edit processing.

Finally, CMS requests $13.6 million for several activities which support contracting reform implementation, including a provider satisfaction survey required by the MMA. In total, CMS' FY 2008 budget includes $253.8 million for contracting reform.

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

We believe that contracting reform will produce significant program savings to contribute toward deficit reduction. CMS' planned implementation approach will produce additional savings earlier than anticipated in the legislation. Savings would accrue from: reducing the overall number of Medicare contractors, from about 40 to 15; 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 and front-end processing systems. Our performance goal on contracting reform illustrates our commitment to this effort.

Performance Goal	Results	Context
Implement Contracting Reform by awarding 100% and transitioning 54.1% of Fee-for-Service contracts to the Medicare Administrative Contractors (MACs) in FY 2008.	CMS met its FY 2006 target by awarding 8.8% of FFS workload to MACs by September 2006.	This goal reflects the new Medicare Modernization Act, for CMS to transition 100% of the Medicare FFS claims workload to the new MACs.

CMS is concurrently implementing several major modernization initiatives including: the Medicare administrative contractors (MACs), Application Modernization, enterprise data center (EDC), beneficiary call centers (BCC), program safeguard contractors (PSC), and HIGLAS. In order to manage these activities, CMS has convened a project integration team to align assumptions, schedules, interdependencies, and resource competition among these projects. CMS is completing an integrated project schedule for these major initiatives. As CMS monitors its near-term schedules, it continues to work to integrate schedules for the first and second cycles of MAC procurements and

transitions. CMS will closely monitor these schedules for changes and impacts on different projects.

- **Regulatory Reform: $1.4 million**

  Section 923 of the MMA created the position of the Medicare beneficiary ombudsman. CMS has established this position which is responsible for screening complaints, grievances, and requests for information and referring calls to appropriate Federal, State, and local agencies for resolution. Funding covers expenses for the ombudsman's office and some additional beneficiary outreach. This category no longer includes provider education and outreach funds. These have been combined with the provider communication funding.

- **Fee-For-Service Improvements: $53.9 million**

  The MMA mandated numerous improvements in the delivery of health care under Medicare's original fee-for-service program. This category funds the implementation of a competitive bidding for Part B drugs and competitive acquisition of durable medical equipment (DME). As discussed earlier in this section, DME competitive bidding is expected to result in significant trust fund savings. In addition, this category pays for processing emergency medical claims for undocumented aliens under section 1011 and updating the average sales price fee schedule. This section reflects an increase of $44.8 million above the FY 2007 current rate due to the funding required for DME competitive bidding.

- **Enterprise IT, Systems Maintenance and Other IT: $45.4 million**

  This category primarily funds various IT enterprise-wide systems activities including data center computing capacity and accompanying security and network infrastructure enhancements needed to meet MMA Part D and Medicare Advantage data processing workloads. It also provides support for CMS' systems and database capacity needs and funds the expansion of the 1-800-MEDICARE data warehouse reporting for trend analysis and operational improvements. This request is $23.8 million below the FY 2007 President's budget.

National *Medicare and You* Education Program (NMEP): $305.6 million

(including Program Management ($124.6 million for MMA-related activities and $97.3 million for non-MMA activities); $69.8 million in user fees; and an estimated $14.0 million for QIO activities.)

The National *Medicare and You* Education Program (NMEP) educates Medicare beneficiaries about their benefits and helps them make informed health care decisions. NMEP includes five activities: 1) beneficiary materials; 2) 1-800-MEDICARE; 3) Internet; 4) community-based outreach; and 5) program support services. The NMEP FY 2008 program level request of $305.6 million represents a decrease of $31.0 million, or 9.2 percent, below the FY 2007 current rate level. Now that the first enrollment period for

the drug benefit has ended, CMS' education efforts will focus on ensuring that all beneficiaries take full advantage of Medicare's important preventive benefits.

CMS' education and outreach responsibilities will not diminish substantially in FY 2008. In fact, we will need to educate beneficiaries about new preventive benefits, including care management and care coordination services for chronic illnesses, in addition to maintaining our steady progress in implementing the prescription drug benefit. CMS and its partners recently have succeeded in promoting Medicare's prevention-oriented services, but there is more work to be done. For example, in FY 2008, CMS will help beneficiaries make better and more informed decisions about managing their chronic diseases. In order to accomplish this, CMS will use the same grassroots networks and personalized support systems that effectively supported the drug benefit enrollment to close the prevention gap in Medicare.

The following information provides details about the five major line items included in the NMEP.

Beneficiary Materials: $47.1 million

The majority of funding in this category will be used to print and distribute the *Medicare & You* handbook. This activity, approximately 15 percent of the total NMEP program level budget, represents an increase of $3.6 million above the FY 2007 current rate level. This increased funding level is based on the population growth rate of Medicare beneficiaries, anticipated increases in paper costs, enhancements to the book to reflect changes to the program, and any additional postal rate increases. In FY 2008, CMS expects to distribute the *Medicare & You* handbook to more than 45 million Medicare beneficiaries and stakeholders. We anticipate distributing approximately 1 million more handbooks than in FY 2007. Beginning in FY 2005, Medicare prescription drug plan information was added to the handbooks, increasing the number of pages dramatically.

Continuing in FY 2008, the *Medicare & You* handbook will have drug plan comparison information for beneficiaries and information about new preventive benefits. In addition to the handbook, CMS will also fund printing and postage for the enhanced initial enrollment packages.

1-800-MEDICARE: $180.4 million

The 1-800-MEDICARE toll-free line provides beneficiaries with 24 hour a day, seven day a week access to customer service representatives (CSR) in English and Spanish. In FY 2008, the funding for this service comprises more than 59 percent of the total NMEP program level budget. This level represents a decrease of $15.6 million below the FY 2007 current rate level. Even though CMS anticipates receiving about the same number of calls in FY 2008 as compared to FY 2007, enhancements to call center operations will improve efficiency and enable the call centers to handle calls more economically.

Call center costs include telecommunications network management, interactive voice response (IVR), personnel and training costs of call center operators, and fulfillment of requests for printed information. In FY 2007, CMS anticipates plan changes and expects to receive many calls as beneficiaries interpret these changes.

Media events impact the number of calls and questions received by 1-800-MEDICARE. We anticipate that several events will take place in FY 2008 during the annual enrollment period which occurs each year from November 15 through December 31. There will most likely be fewer, less extensive local events because of the increased beneficiary awareness of the program.

	FY 2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Estimate	FY 2008 Estimate
Number of Calls	5.6 million	16.5 Million	21.8 million	42.2 million	22.0 million	22.0 million

Internet: $20.1 million

The Internet budget comprises over 6 percent of the total NMEP program level request and includes both the www.medicare.gov and www.cms.hhs.gov websites. The www.cms.hhs.gov serves as a resource with a large breadth and depth of content and applications for providers, partners and healthcare professionals. The www.medicare.gov website is a beneficiary-centered web site with a variety of real-time, interactive, decision-making tools that enable Medicare beneficiaries to receive information on their benefits, plans, and medical options. This website includes four separate quality tools, ten other complex applications, and MyMedicare.gov. MyMedicare.gov is a portal for beneficiaries to use 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 Personal Plan Finder, the Medicare Prescription Drug Plan Finder, Hospital Compare, Dialysis Facility Compare, and the Medicare Eligibility tool are included under this initiative. In FY 2008, part of the request will be used for ongoing maintenance costs to renew software, licenses, and database support. This funding will also be used for several tools that require complex data updates (e.g. Medicare Prescription Drug Plan Finder) that are necessary to ensure accurate and consistent information is provided to U.S. citizens, Medicare beneficiaries, and health care professionals for decision-making purposes on a daily basis. The websites serve as a less costly communication channel that reaches a large number of beneficiaries and professionals.

In FY 2008, CMS estimates approximately 310 million page views to www.medicare.gov, which is approximately a 40% increase in traffic from the page views anticipated in FY 2007. In FY 2006, CMS experienced an anomaly in high traffic since it was the first year of the Medicare prescription drug benefit program. CMS expects this increase in page views on www.medicare.gov as the Medicare beneficiary population increases, beneficiaries and their caregivers become more internet savvy, and as we continue to implement more self-service features for beneficiaries to use in order to maximize their health and quality of care decisions. This funding level reflects an increase of $1.4 million above the FY 2007 current rate.

	FY 2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Actual	FY 2007 Estimate	FY 2008 Estimate
Number of medicare.gov Page Views	43.3 million	100.1 million	143.0 million	403 million	220 million	310 million

Community-Based Outreach: $37.6 million

CMS administers and conducts many outreach programs, including the State Health Insurance and Assistance Program (SHIP) grants, collaborative grassroots coalitions, and national, local and multi-media training that provide assistance to people with Medicare in their communities. In FY 2008, over 12 percent of the NMEP program level budget will be used to fund community-based outreach. Although this funding level represents a $6.0 million decrease from the FY 2007 current rate level, the decrease will not affect the funding used for SHIPs.

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, Medicaid, the prescription drug benefit, and new preventive benefits. In FY 2008, CMS plans to spend no less than the FY 2007 amount for SHIPs. This funding will provide infrastructure, training, and outreach support to an expanded force of over 13,000 counselors in over 1,300 community-based organizations in all 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands. The SHIPs serve as the primary providers of locally based information and assistance to over five million Medicare beneficiaries. SHIPs experienced significant volunteer and professional staff turnover during the Medicare prescription drug education campaign and will continue to use funds to enhance the quality of locally accessible services through program and staff development and support. Additionally, funds will be used to support a SHIP resource center contractor that provides program development and technical assistance to the SHIP network, a performance measurement contractor that provides data collection and analysis support to CMS and the SHIP network, and to fund the SHIPtalk.org web site that serves as a clearinghouse of information to SHIPs as well as an interactive forum and data collection portal.

CMS has made tremendous progress in building 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. In FY 2008, CMS plans to hold these coalitions firmly together as we focus on promoting high quality care and raising the level of awareness about chronic diseases to help to close the prevention gap for beneficiaries.

Program Support Services: $20.5 million

This activity includes the multimedia ad 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. These 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. In FY 2008, approximately 7 percent of the NMEP budget will be spent on program support. This funding level, a decrease of $14.3 million below the FY 2007 current rate level, reflects a reduction in CMS' ad campaign. In FY 2008, the national multimedia and grassroots education campaign will continue to support HHS priorities and CMS strategic objectives by promoting the CMS information tools and resources that optimize beneficiary independence and responsible decision-making, allowing all people with Medicare to get the most out of their Medicare benefits.

The campaign will continue to feature grassroots outreach including the mobile office tour, earned media and paid advertising in senior-efficient markets. We will also leverage a diverse variety of national, regional and community partners to target specific, hard-to-reach populations with personalized strategies, including beneficiaries in rural areas and minority communities.

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 improvement 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. In FY 2008, CMS will consumer test the *Medicare & You* handbook in addition to other program materials. CMS will also conduct tracking surveys to assess the overall effectiveness of our education activities. Strategic research that develops the message and strategic platforms for CMS initiatives will be done. CMS plans to conduct activities to assess the overall effectiveness of our education activities. Strategic research that develops the message and strategic platforms for CMS initiatives will be done on a very limited basis.

National *Medicare & You* Education Program Budget Summary

(dollars in millions)

	FY 2006 Estimated Actuals	FY 2007 President's Budget	FY 2007 Current Rate	FY 2008 Request
Beneficiary Materials	$46.3 M ($16.1M PM) ($30.2M UF)	$43.5 M ($29.5M PM) ($14.0M UF)	$43.5 M ($29.5M PM) ($14.0M UF)	$47.1 M ($33.1M PM) ($14.0M UF)
1-800-MEDICARE	$359.7 M* ($332.2M PM) ($27.4M UF)	$184.7 M ($129.8M PM) ($54.9M UF)	$196.0 M ($141.1PM) ($54.9M UF)	$180.4 M ($124.6M PM) ($55.8M UF)
Internet	$23.5 M ($21.2M PM) ($2.3M QIO)	$18.7 M ($15.9M PM) ($2.8M QIO)	$18.7 M ($15.9M PM) ($2.8M QIO)	$20.1 M ($17.1M PM) ($3.0M QIO**)
Community-based Outreach	$33.9 M ($33.9M PM)	$43.6 M ($43.6M PM)	$43.6 M ($43.6M PM)	$37.6 M ($37.6M PM)
Program Support Services	$26.1 M* ($17.2M PM) ($9.0M QIO)	$25.3 M ($25.3M PM) ($0 QIO)	$34.8 M ($25.3M PM) ($9.5M QIO**)	$20.5 M ($9.5M PM) ($11.0M QIO**)
Total	**$489.4 M*** **($420.6M PM)** **($57.6M UF)** **($11.2M QIO)***	**$315.8 M** **($244.1M PM)** **($68.9M UF)** **($2.8M QIO)**	**$336.6M** **($255.4M PM)** **($68.9M UF)** **($12.3M QIO)**	**$305.6 M*** **($221.9M PM)** **($69.8M UF)** **($14.0M QIO**)**

*Totals may not add due to rounding.

** QIO funding numbers in FY 2008 are estimates; they have not been finalized and are subject to change.

PM – Program Management
UF – User Fee
QIO – Quality Improvement Organizations

Other Legislatively-Mandated Activities

Healthcare Integrated General Ledger and Accounting System (HIGLAS): $49.9 million in Development Costs; $113.4 million in Operations & Maintenance Costs

HIGLAS provides the capability for CMS and DHHS to achieve compliance with the Federal Financial Management Improvement Act (FFMIA). Transitioning Medicare contractors to the HIGLAS system enables the Agency 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 achieving the goals tracked by the GAO.

CMS has achieved a number of milestones in the development of HIGLAS and continues to make progress according to schedule. Initial implementations during FY 2005 brought the pilot sites live on two separate lines of CMS business: Part A (fiscal intermediaries) and Part B (carriers). Additional transitions demonstrated that the financial capabilities were beneficial to both CMS and the claims processing contractors.

By the end of FY 2006, CMS had deployed HIGLAS at seven of the largest Medicare fee-for-service contractors. Since going "live" at the first pilot contractor on May 4, 2005, HIGLAS has processed more than 196.5 million claims and processed 9.3 million payments worth $106.2 billion (statistics through January 2, 2007). The FY 2007 President's budget request supports the transition of four additional Medicare contractors to HIGLAS.

The FY 2008 estimate includes $113.4 million for operations and application maintenance (O&M) costs. This funds production operations at the 11 contractors which will be running HIGLAS by the end of FY 2007, plus the transitions of six additional contractors to HIGLAS in FY 2008. The O&M costs included in the systems operations and maintenance funding mentioned earlier in the Medicare Operations section are:

- payment to the entity that performs data processing and hosts the HIGLAS application including hardware and software maintenance;
- payment for the disaster recovery hot site and continuity of operations support;
- development and implementation of quarterly software releases to update HIGLAS for changes in two Medicare claims processing and payment rules systems;
- shared system maintainer costs related to changes they make to enable HIGLAS interfaces;
- HIGLAS production help desk; and
- HIGLAS system integration technical and analytical services.

The FY 2008 budget includes $49.9 million in development costs. In FY 2008, CMS will continue as planned with development of the administrative accounting modules in HIGLAS, including the continued analysis and development activities in the area of increased administrative accounting functionality to accommodate Medicare Part C and Part D payments/interfaces. These efforts are critical to support the Agency's clean opinion on the CFO audit; support the "One HHS" goal to improve financial management; support the ability of the Department to realize its UFMS goals and objectives; support the "green" status of the Department's OMB Scorecard in the area of "Improve Financial Performance"; and support the ability to meet OMB mandated FFMIA and FMFIA compliance requirements for CMS and HHS.

HIGLAS implementation will yield significant improvements and benefits to the Nation's Medicare program. These improvements and benefits will strengthen the Federal government's fiscal management and program operations/management of the Medicare fee-for-service program. For example, a significant feature of HIGLAS is the ability to offset or "net" receivables that are owed by affiliates of providers. Because of current contractor shared system limitations, automated netting for accounts receivables has not been available for affiliated providers until the implementation of HIGLAS. In cases where one of the affiliated or chain facilities has terminated from the program or had a change of ownership, Medicare Part A contractors usually employ a manual workaround to accomplish the affiliated netting since the terminated provider is not submitting any claims. This workaround usually requires extensive resources to phone and prepare written correspondence.

Since the implementation of HIGLAS in FY 2005, the Medicare contractors that have been operating the HIGLAS system collected $69.7 million in benefits as a result of affiliated netting functionality, through April 11, 2006. This collection amount would not have been realized without HIGLAS implementation. Moreover, the implementation of HIGLAS has resulted in an overall increase of 17.7 percent in the Medicare collection rate for the six contractors that were operating the HIGLAS system through April 11, 2006. This increased collection rate represents a significant savings to the Medicare trust funds upon full implementation of HIGLAS at all Medicare contractors. CMS expects this favorable collection trend to continue as more Medicare contractors are transitioned onto the HIGLAS system. Apart from the additional collections, the more efficient, automated method of collections made available through HIGLAS positively impacts contractor and CMS resources needed to support tracking, reporting and management of outstanding receivables.

Qualified Independent Contractor (QIC) Appeals (BIPA Sections 521 and 522): $54.7 million

CMS requests $54.7 million, $2.8 million less than the FY 2007 current rate to maintain the BIPA 521 and 522 reforms, as mandated by the Benefits Improvement and Protection Act (BIPA) and amended by the Medicare Modernization Act (MMA). CMS has found that actual costs for QIC operations are lower than originally estimated. Of the amount requested,

In FY 2008, 5 Qualified Independent Contractors (QICs) will process reconsiderations and forward requests for an ALJ hearing to the Department.

$50.0 million will cover the QICs workload. Two QICs became operational in FY 2005 and are currently processing reconsiderations for FI appeals. In FY 2006, two additional QICs became operational (for 75 percent of the year) and are processing reconsiderations for carrier appeals. CMS is restructuring the carrier QIC jurisdictions in FY 2007 to allow each QIC to specialize in certain claim types and further reduce the risk of processing delays. The restructuring will increase the number of QICs performing carrier appeals from two to three. In FY 2008, QICs will process more than 514,000 reconsiderations and forward almost 108,000 requests for an administrative law judge (ALJ) hearing to the Department. The QICs will continue to play a vital role in ensuring that the HHS ALJs meet appeals processing timeframes by sending well-organized case files in a timely manner.

Another important part of the BIPA reforms was the creation of the Medicare Appeals System (MAS). The MAS enhances workflow tracking and reporting capabilities and supports the processing of all (Parts A, B, C, and D) second level appeals. The FY 2008 request includes a total of $4.4 million for the MAS which will provide case management and reporting capability to HHS users, CMS users, and appeals contractors.

Lastly, Section 522 of the BIPA allows certain beneficiaries in need of an item or service to appeal national coverage determinations (NCDs). The FY 2008 request includes $0.3 million to prepare NCDs for appeal, work with the aggrieved parties and the Departmental Appeals Board (DAB) in the NCD appeals process, and defend NCDs at hearings.

HIPAA Administrative Simplification: $24.8 million

CMS' FY 2008 request includes $24.8 million, $0.7 million more than the FY 2007 current rate, to fund HIPAA-enacted administrative simplification provisions. These provisions are intended to reduce health care costs and administrative burdens by standardizing the electronic transmission of certain transactions.

NPPES: HIPAA requires the assignment of a unique national provider identifier (NPI) to all covered health providers and plans that transmit electronically. There are approximately 2.3 million covered health care providers that must obtain their NPIs prior to the compliance date of May 23, 2007. CMS developed the National Plan and Provider Enumeration System (NPPES) to process all of the identifier requests. CMS' FY 2008 request includes $9.2 million for NPPES costs which include: maintaining the system; enumerating any additional providers that apply, but are not required by law to have an identifier; and making any changes to the data in the NPPES records.

The remainder of the FY 2008 request will be used for:

- HIPAA pilot testing of the transaction and code sets;
- Administrative Simplification Enforcement Tool (ASET) and database;
- Operating and maintaining the HIPAA 270/271 data center which will provide Medicare beneficiary eligibility information to providers, clearinghouses, and billing services via the Internet; and

- Electronic Data Interchange (EDI) for implementing shared systems changes and testing carrier and fiscal intermediary systems.

Financial Statement Audits: $8.3 million

This request includes funds for audit activities including the annual audit required by the Chief Financial Officers (CFO) Act of 1990. As shown in the performance goal inset below, maintaining an unqualified opinion is a CMS priority. 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.

Performance Goal	Results	Context
Maintain an unqualified opinion on CMS' FY 2008 financial statements.	CMS has met this performance goal since 1999.	CMS financial statements are a material element of both the DHHS financial statements and the government-wide financial statements required by the CFO Act of 1990 and the Government Management and Reform Act (GMRA). Our long-term plan is to implement an integrated general ledger accounting system.

Managed Care Appeals Reviews: $5.6 million

The Balanced Budget Act requires that an independent contractor review first level Medicare managed care appeals. The FY 2008 request includes funding for the managed care reconsideration contractor to review expected appeals. This is an increase of $200,000 above the FY 2007 current rate.

Appropriations History:

The table below displays Medicare Operations funding levels for the past 5 years.

Medicare Operations
Appropriations History

Fiscal Year	Appropriation
2003	$1,666,680,000
2004	$1,701,038,000
2005	$1,730,920,000
*2006	$2,200,842,000
**2007 CR Level	$2,210,588,000

* Includes funding provided under the Deficit Reduction Act and the Secretary's Section 202 Transfer Authority.

** Includes funding provided by the Tax Relief and Health Care Act of 2006.

Summary

CMS' FY 2008 budget request for Medicare Operations is $2,303.6 million, an increase of $93.0 million above the FY 2007 current rate. This budget request will enable CMS' Medicare contractors to complete their required workloads. In FY 2008, CMS will continue to implement activities required by the MMA, including contracting reform and DME competitive bidding, both of which will generate significant savings for the Medicare trust funds.

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Federal Administration

Authorizing Legislation
Reorganization Act of 1953.

Federal Administration Summary Table
Dollars in Thousands

	FY 2006 Actual	FY 2007 President's Budget	FY 2007 CR Level	FY 2008 President's Budget	FY 2008 Pres. Bud. +/- CR Level
Appropriation/B.A.	$655,000	$655,377	$633,065	$643,187	+$10,122
Rescissions					
(P.L. 109-148)	-6,435	---	---	---	---
(P.L. 109-149)	-15,500	---	---	---	---
Deficit Reduction Act (P.L. 109-171)	8,400	---	---	---	---
Tax Relief and Health Care Act (P.L. 109-432)	---	---	15,000	---	-15,000
Section 202 Transfer	---	---	---	---	---
Adjustments for Comparability	-26	-26	-26	---	+26
Comparable (Net) Appropriations/B.A	$641,439	$655,351	$648,039	$643,187	-$4,852
FTEs [1/]	4,554	4,531	4,344	4,344	---

[1/] The FY 2006 column reflects actual FTE consumption.

Statement of the Budget Request

CMS FY 2008 budget request for Federal Administration totals $643.2 million, a decrease of $4.9 million below the FY 2007 current rate, including the Tax Relief and Health Care Act.

Program Description

In FY 2008, CMS employees working in Baltimore, Maryland; Washington, DC; and ten regional offices nationwide will perform many essential activities, including: implementing the Medicare Modernization Act; providing funds to Medicare contractors; developing operating systems used to oversee our 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.

Rationale for the Budget Request

The FY 2008 Federal Administration account includes the cost-of-living and other adjustments to payroll and benefits. The FY 2008 President's Budget level supports 4,344 FTEs within the Federal Administrative line, excluding 84 FTEs funded through the CLIA program. Other activities are funded at or near the FY 2007 level and consist of training, supplies, HHS human resources, which is part of the "One HHS" initiative, contracts, printing, postage; and travel.

Implementation of Legislation and Other Initiatives

CMS has requested funding in the Federal Administration account to support the MMA, the BBA, the Nursing Home Oversight Improvement Program, the New Freedom Initiative, Medicaid, SCHIP and the Tax Relief and Health Care Act of 2006. Specific activities are described in more detail below:

Medicare Modernization Act of 2003
MMA funds cover several categories of Federal administrative expenses, including: 461 FTEs hired to implement MMA priorities, travel, IT-related expenses and the rental of space for staff working on MMA activities.

Balanced Budget Act of 1997
Funding will support CMS' continuing efforts to adhere to BBA provisions. This includes funds for FTEs, overtime, contracts, printing, travel, and training necessary for ongoing BBA activities.

Nursing Home Oversight Improvement Program
This funding will primarily support *35 FTEs* required to oversee State activities, to provide additional assistance to State inspectors in nursing homes, and to respond to provider and consumer inquiries. CMS' request provides funds required for on-site visits to ensure State surveyors are in compliance with the Federal survey process and contractual agreements.

New Freedom Initiative
This funding will be used to promote full access to community life through the implementation of the new flexibilities under the Deficit Reduction Act including the Money Follows the Person Demonstration Grants, Alternative to PRTF Demonstration Grants, State plan options for self-directed care and home and community based services. In addition, we will continue of existing programs such as Real Choice Systems Change Grant Program, Ticket to Work and Work Incentives Act (TWWIIA), Demonstration to Improve the Direct Service Community Workforce, Independence Plus Initiative and CMS Action Plan for Quality.

State Children's Health Insurance Program
SCHIP will receive financial support for personnel needed to review and approve State plans and amendments, monitor and evaluate the program to ensure compliance with Title XXI, receive and analyze SCHIP quarterly and annual financial reports, compile statistical information, and develop program guidance.

Federal Administration Summary
Dollars in millions

Object of Expense	**FY 2007 Current Rate**	**FY 2008 President's Budget**	**Increase or Decrease**
Fixed Expenses			
Personnel Compensation & Benefits	$498.1	$517.2	+ $19.1
Rent, Communications & Utilities	27.3	28.2	+0.9
Single-Site Building Loan	9.8	9.8	---
Service and Supply Fund	12.8	13.6	+0.8
Human Resources (DHHS)	8.2	8.2	---
Administrative Services	3.1	3.1	---
Information Technology	22.9	21.7	-1.2
Subtotal, Fixed Expenses	**$582.1**	**$601.7**	**+ $19.6**
Variable Expenses			
Inter-Agency Agreements	$3.4	$3.4	---
Supplies and Equipment	0.9	0.9	---
Contracts and Intra-Agency Agreeents	44.6	21.6	-23.0
Training	2.9	1.7	-1.2
Travel	9.1	8.9	-0.2
Printing and Postage	5.1	5.0	-0.1
Subtotal, Variable Expenses	**$66.0**	**$41.5**	**-$24.5**
Total, Federal Administration*	**$648.0**	**$643.2**	**- $4.9**

* Numbers may not add due to rounding.

Fixed Expenses

Personnel Compensation and Benefits: $517.2 million

Personnel Comp. and Benefits percent of Federal Admin. costs: FY 2004 = 76% and FY 2008 = 80%.

The FY 2008 CMS request includes $517.2 million to fund the personnel compensation and benefits costs associated with 4,344 direct FTEs funded in the Federal Administration account. Program Management FTEs and their associated payroll costs are also included in the CLIA line item. Our payroll request reflects the application of a 3.0 percent pay raise in calendar year 2008**.** In FY 2008, we project that 2,941 direct FTEs will staff the central office and 1,403 direct FTEs will staff the regional offices.

Rent, Communications, and Utilities: $28.2 million

This request includes $28.2 million to fund facility-operating costs for our single-site facility in Baltimore, Maryland, 10 regional offices, and our Washington, DC, offices. Rent costs for our 10 regional and Washington, DC offices consist mainly of space rental, utilities, grounds maintenance, security, snow removal, cleaning, trash removal, and painting.

Single-Site Building Loan: $9.8 million

Our FY 2008 land and structure request 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: $13.6 million

These funds primarily support CMS' financial management service system and the personnel and payroll systems. This request also provides funds for the DHHS financial management service system. Other activities supported include the regional mail support, EEO complaint investigations, and other services related to the administrative support of our daily operations.

The HHS Consolidated Acquisition System (HCAS) initiative is a Department-wide contract management system that will integrate with the Unified Financial Management System (UFMS). The applications within the HCAS are Compusearch PRISM and a portion of the Oracle Compusearch Interface (OCI). PRISM is a federalized contract management system that helps streamline the procurement process. The implementation of PRISM includes the functionality of contract writing, simplified acquisitions, electronic approvals and routing, pre-award tracking, contract monitoring, post award tracking, contract closeout and reporting. Major functions include transfer of iProcurement requisition of commitment accounting and funds verification to PRISM and transmission of the award obligation from PRISM to Oracle Financials.

Benefits:
The following benefit will be realized by the Department and the individual OPDIVs/STAFFDIVS once the HCAS system is fully implemented:

- Commitment Accounting
- Integration to Other HHS Administrative Systems

- Decreased Operational Costs
- Increased Efficiency and Productivity
- Improved Decision-Making Unified Systems
    - Data Integrity
    - Reporting
    - Performance Measurement
    - Financial Accountability
- Standardization
    - Business Processes
    - Information Technology
- Consistent Customer Service Levels
- Refocus Personnel Efforts on Value-Added Tasks
- Knowledge Sharing
- System-Enabled Work
    - HHS Acquisition Personnel-Contracting
    - Customers in Requirement Preparation-Requisitioning
- Meets Organizational Drivers and Goals (President's Management Agenda, One-HHS, OMB Line of Business)

The HCAS team is working closely with the UFMS PMO and HHS PMO to ensure a smooth roll out of both PRISM and iProcurement. An integrated team, including personnel from UFMS, Acquisition and Assets has formed to ensure maximum utilization of in-house expertise. CMS requests $669,807 to support these efforts in FY 2008

Human Resources (DHHS): $8.2 million
These funds support Departmental human resource activities, which is part of the "one HHS" initiative. The goal of this initiative is to reduce and consolidate personnel activities that were previously performed independently by each agency.

Administrative Services: $3.1 million
These funds support the physical security of the single-site facility in Baltimore, Maryland, i.e., guard contracts, and the remaining administrative services activities that support the daily operation of CMS' headquarters and regional offices. These activities include: HHS building maintenance and repairs, legal advertisements, medical/health services, job orders, machine repairs, mailroom services, and the Baltimore/DC shuttle.

Information Technology: $21.7 million
This request funds a broad range of IT activities that support CMS' IT infrastructure and daily CMS operations. This includes voice and data telecommunication costs, web-hosting services, satellite services, CMS' share of the HHS enterprise e-mail system, and ongoing systems security activities. This line item also funds a number of enterprise administrative systems that support grants and contract administration, financial management, data management, and document management services. This line item 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 processed by all 50

States, the District of Columbia, and the five territories (Puerto Rico, Virgin Islands, American Samoa, Northern Mariana Islands, and Guam.)

Variable Expenses

Inter-Agency Agreements: $3.4 million
The CMS request includes $3.4 million for inter-agency agreements (IAs). The request includes funds for our largest IA with the Department of Treasury for agency-wide photocopier support for supplies, training, and preventive maintenance. The other large IA is with the Department of Labor to handle the agency's share of annual benefits and payments for worker's compensation. CMS has several smaller IAs, e.g., with the Office of Personnel Management (OPM) for employee services.

Supplies and Equipment: $0.9 million
This request provides funds for general office supplies and materials for both our central and regional offices. CMS has also included funds for furniture, office equipment, and replacement items within this amount.

Contracts and Intra-Agency Agreements: $21.6 million
Ongoing activities accomplished at least partially through contracts and intra-agency agreements include, but are not limited to:

Administrative Contracts

CMS will fund over 100 small administrative contracts and intra-agency agreements. CMS obtains a variety of operational services through contractual arrangements. Examples include: miscellaneous EEO services, conference support, beneficiary and provider outreach, financial and legal services, MMA activities, implementation of the *Olmstead* Supreme Court decision, and implementation of the Temporary Assistance for Needy Families (TANF).

Healthy Start, Grow Smart

The Healthy Start, Grow Smart program prints and disseminates a series of 17 brochures in English, Spanish, Chinese and Vietnamese, to Medicaid-eligible pregnant women and mothers of Medicaid-enrolled babies. The prenatal brochure will be distributed at the time a pregnant woman is determined to be eligible for Medicaid (beginning FY 08). The remaining 16 brochures are distributed at the time of birth, monthly for the first year of the child's life, and at ages 15-, 18-, and 24-months. Each publication focuses on activities that stimulate infant and child development and build the skills these children need to be successful in school. In addition to these educational suggestions, each Healthy Start, Grow Smart pamphlet includes vital health and safety information for new parents.

These funds will be used primarily for printing costs and postage. This initiative will be fully funded by the Federal Government, but will be operated solely by the States.

Training: $1.7 million
CMS will continue with our 5-year plan to hire the right people at the right time for the right position to address the inevitable personnel losses due to projected retirements and new workloads associated with the implementation of legislative mandates, i.e. MMA. The two components that comprise this program are recruitment (use of direct hire authority) and comprehensive training with special emphasis on leadership and management development. CMS remains committed to look for new ways to leverage technology and eliminate redundancies in our 'mission support' functions, positions, and organizational structures.

Travel: $8.9 million
The FY 2008 budget estimate for travel totals $8.9 million to fund a number of programmatic travel requirements, including survey and certification activities, contractor oversight activities, and activities related to legislation, such as the MMA, the HIPAA, the BBA, and the BBRA. Effective implementation requires that CMS periodically conduct on-site visits to ensure, among other things, compliance with the terms and conditions of both contracts and cooperative agreements.

Printing and Postage: $5.0 million
This request provides funding for the printing of brochures that assist beneficiaries in selecting health care plans; Medicare lock-in notices, which inform beneficiaries of their initial enrollment in managed care programs; MMA material; various Medicare and Medicaid SCHIP program guides; *Federal Register* and *Congressional Record* materials; and other printed forms and manuals. Postage expenses to fund the mailing of the above-mentioned material and other correspondence are also included.

Human Capital and Workforce Planning at CMS

In FY 2008, CMS will continue to support the implementation of the President's Management Agenda through a comprehensive Talent Management Initiative (TMI) which systematically addresses strategic recruitment, retention, and employee development for all employees, with an emphasis on key positions. We are working to integrate data from Agency human capital systems and a succession planning analysis to develop cogent recommendations and strategies that we are sharing with Center, Office and Group Directors and Regional Administrators. We will ensure that efforts are targeted to key areas of need, and will measure our progress in these areas.

Strategic Recruitment

Data reveal that CMS should expect to hire approximately 200 to 300 new employees in FY 2007. In addition to following all appropriate hiring practices and procedures, CMS has also established formal relationships with universities, industry associations and beneficiary and consumer organizations to attract high quality, diverse talent in the health care arena. Since attracting diverse talent is a key objective of the Administrator, we are in the process of aligning with associations that represent minority groups such as the Hispanic Association of America, the National Alliance for Hispanic Health, and Blacks in

Government. In addition, CMS has established a presence on websites including: HireDiversity.com and Hispanic Business.com.

CMS is working to develop a marketing package to promote a consistent corporate image that attracts and retains high performing and diverse employees. To achieve its strategic recruitment goals, CMS and the BHRC fully utilize all appropriate hiring authorities and incentives such as: direct hire authority, salary above the minimum and recruitment bonuses.

Employee Development

The SPI process helped CMS better understand where gaps exist in specific competency areas. As a result, the COO has approved a business plan to significantly increase the amount of money for training and development in FY 2007. CMS has developed a focused menu of development opportunities which include: specific courses, coaching, mentoring, stretch assignments and industry exchanges. We are working with HHS University to populate the Learning Management System with the goal of providing CMS employees one-stop shopping for training and development needs.

CMS has also implemented an evaluation methodology that continuously measures the quality and effectiveness of all training and development programs to ensure that an optimum return on investment is achieved.

Performance Management

The Performance Management function in the Agency will focus on ensuring that both organizational and individual performance is monitored and measured relative to the Agency's Strategic Action Plan. By the end of March 2007, Center and Office Directors must complete a succession plan for their specific component. This will help to institutionalize the succession planning philosophy.

CMS will also use competitive sourcing and other organizational development methods to measure and monitor the effectiveness and efficiency of the Agency. Competitive sourcing studies focus on analyzing what entity can provide quality service at the best value to customers. In addition, it aims to promote efficiency, in terms of both cost and procedure, Agency-wide. OMB Circular No. A-76 and the Federal Activities Inventory Reform (FAIR) Act of 1998 require each Federal Agency to compile an inventory, by June 30 of each year, which classifies activities as commercial or inherently governmental. CMS' inventory identified 3,779 inherently governmental positions, and 978 commercial positions. This inventory was prepared after a comprehensive review of all activities performed by CMS employees, with a focus on long-term strategic goals and workforce planning initiatives.

CMS has successfully completed 35 competitive sourcing studies since FY 2003, involving a total of 619 FTEs. In FY 2006, CMS developed five Most Efficient Organizations (MEOs) saving the agency approximately $5 million. For the first time since FY 2003, one of the eight competitive sourcing studies conducted in FY 2005 resulted in a decision to outsource the function. During FY 2007, CMS will conduct seven competitive sourcing

studies involving 115 FTEs. CMS developed a 5-year competitive sourcing plan, which will subject all of CMS' commercial FTEs to competitive sourcing reviews by the end of FY 2008. In addition, CMS has developed and implemented a post-competition accountability process to monitor the performance and cost of each competitive sourcing function reviewed since FY 2003.

APPROPRIATIONS HISTORY:

The table below displays Federal Administration funding and FTE levels for the past 5 years.

Federal Administration
Appropriations History
(Excludes Comparability Adjustments)

Fiscal Year	Appropriation	FTE Target
2003	$571,756,000	4,561
2004	$577,146,000	4,426
2005	$581,493,000	4,592
*2006	$641,465,000	4,554
**2007 CR Level	$648,065,000	4,344

*FY 2006 includes $8.4 million in Deficit Reduction Act funding.
**FY 2007 includes $15.0 million in Tax Relief and Health Care Act funding.

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Medicare Survey and Certification Program

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

Medicare Survey and Certification Header Table
Dollars in Thousands

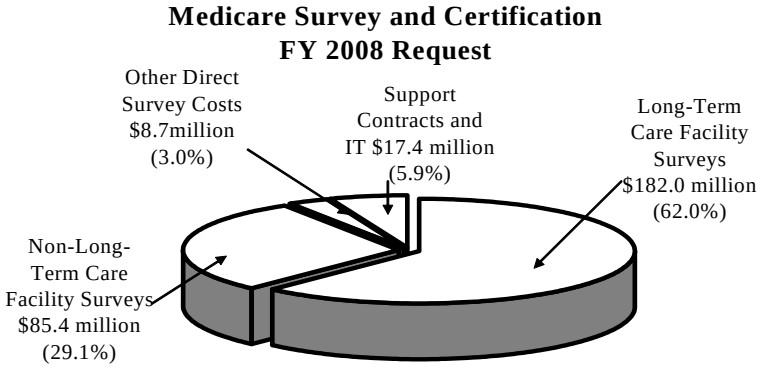
	FY 2006 Actual	FY 2007 President's Budget	FY 2007 CR Level	FY 2008 President's Budget	FY 2008 Pres. Bud. +/- CR Level
Appropriation/B.A.	$260,735	$283,524	$258,128	$293,524	$35,396
Recissions: P.L 109-148	-$2,607	---	---	---	---
Subtotal, Current Law BA	**$258,128**	**$283,524**	**$258,128**	**$293,524**	**$35,396**
Proposed Law:					
User Fee	---	$35,000	---	$35,000	$35,000
Appropriation	---	- $35,000	---	-$35,000	- $35,000
Total, Proposed BA	**$258,128**	**$283,524**	**$258,128**	**$293,524**	**$35,396**

Statement of the Budget Request

CMS' FY 2008 budget request for Medicare Survey and Certification is $293.5 million. The request includes a proposed user fee totaling $35.0 million in FY 2008 (originally proposed in the FY 2007 President's Budget). If enacted, collections associated with this 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 Proposed Law Summary section of this book). About 95 percent of the Survey and Certification request will go directly 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. The costs to administer Medicaid Survey and Certification activities are shown in the Other Accounts tab of this justification.

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 IT. The proportion devoted to the direct surveys conducted by States has increased as

CMS has worked to increase State performance. The proportion devoted to all other functions has remained relatively consistent, considering growth in the automation of the survey process.



Program Description

In FY 2006, about 84.1 percent of nursing home facilities were cited for health deficiencies.

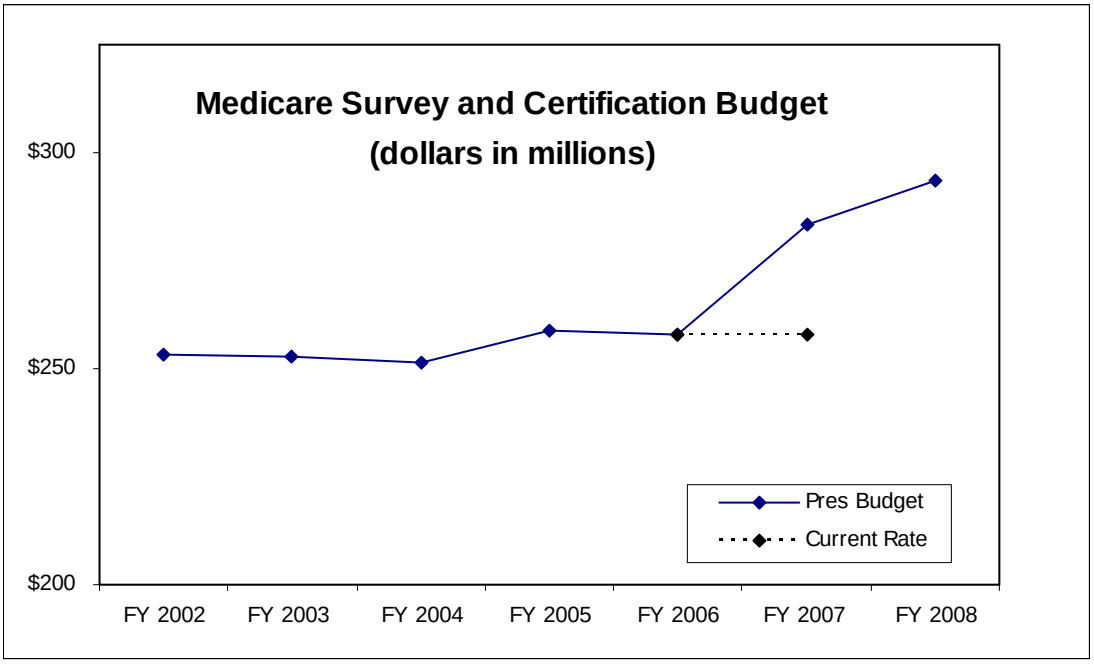
In order to secure quality care for the elderly, one of the Nation's most vulnerable populations, CMS requires that all facilities seeking participation in Medicare and Medicaid undergo an inspection when they initially enter the program and on a regular basis thereafter. To conduct these inspection surveys, CMS contracts with state survey agencies in each of the 50 States, the District of Columbia, Puerto Rico, and two territories. Utilizing 6,500 surveyors across the country, State survey agencies inspect providers and determine their compliance with specific Federal health, safety, and quality standards.

CMS continues to strengthen its work with States to evaluate the performance of State survey agencies and to ensure that surveys and complaint investigations are performed in accordance with CMS and statutory requirements. In 2002, CMS implemented the State Performance Standards System (SPSS) a formal, national system of performance review, which includes 18 separate measures to focus on key performance expectations. Examples include measurements of the adequacy of documentation and promptness of reporting survey results, as well as conformance with expected survey frequencies. Performance by States has improved each year. For example, the percentage of nursing homes surveyed at least every 15 months has increased from about 93.6 percent in 1999 to 99.8 percent in 2006. Federal monitoring of State survey teams occurs through both on-site evaluations of State survey teams conducting certification surveys, as well as through comparative surveys, which review the same facility within 60 days of a State survey. In addition, CMS has enhanced its capacity to analyze and track data through both the ASPEN (Automated Survey Processing Environment) Complaint Tracking System and the Aspen Enforcement Module.

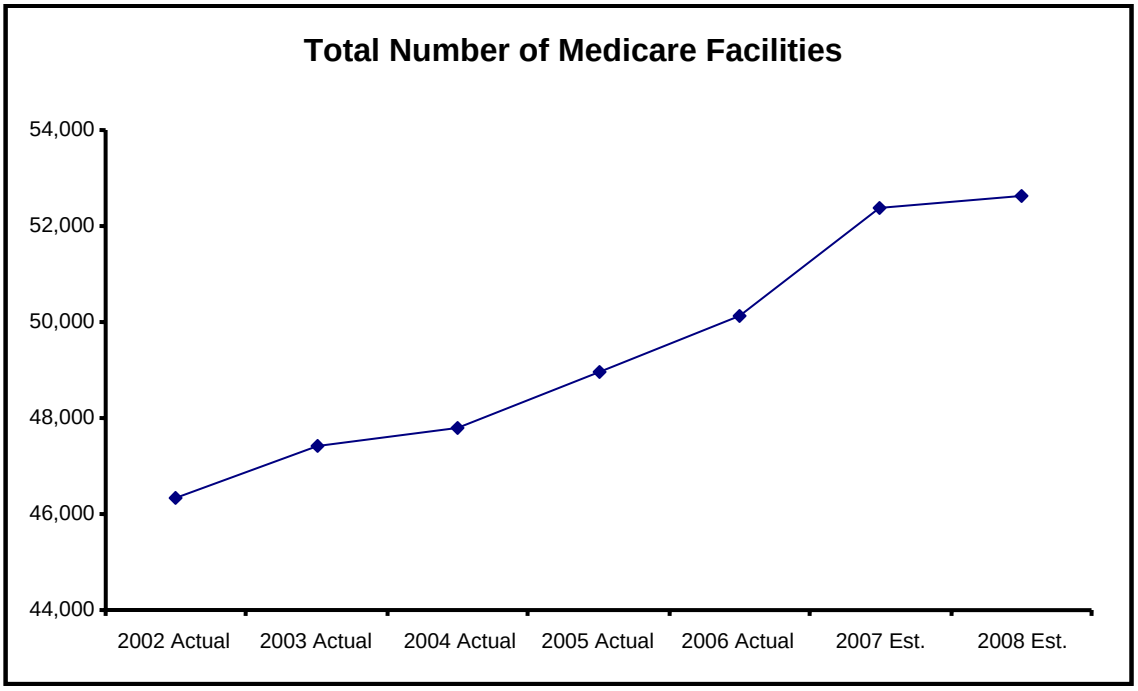
Rationale for the Budget Request

Ensuring that CMS sustains necessary levels of facility survey and certification is a priority of the Secretary. 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. Congressional leadership remains committed to ensuring that beneficiaries receive high quality care. Maintaining survey and certification frequencies at or above the levels mandated by policy and statute is critical to protecting the health and well-being of beneficiaries and ensuring that Federal dollars support only quality care.

The FY 2008 CMS request of $293.5 million is an increase of $35 million over the FY 2007 current rate. The FY 2008 CMS request is a $10 million, or 3.5% increase over the FY 2007 President's Budget. The budget request will ensure that survey frequencies meet statutory and Administration policy goals. The FY 2008 budget will direct additional resources toward oversight of facilities that do not have statutorily mandated frequencies, such as hospitals, ambulatory surgical centers, dialysis facilities, and transplant centers. FY 2008 funding for non-statutory surveys will increase by 3.8 percent over the FY 2007 President's budget level. The resources in the FY 2008 budget will allow a significantly increased number of surveys for these facilities compared to recent years.



Between FY 2002 and FY 2008, the number of Medicare-certified facilities increased by 16 percent from 45,390 facilities in FY 2002 to an estimated 52,632 facilities in FY 2008. In addition, certain additional responsibilities have been added to CMS' survey agenda, such as surveys of all transplant centers.



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 is too low to sustain this progress. A growing number of facilities, growth in complaint visits, and demands to survey other facility types, particularly nursing homes, limit the attention and resources that state agencies can spend on the survey of non-statutorily mandated facility surveys. The FY 2008 survey and certification funding level will ensure adequate oversight of federally funded health care.

DIRECT SURVEY COSTS - $276.1 million

Direct survey costs represent the funding provided directly to the States to perform surveys and complaint visits and to support associated program costs. Funding for nursing home oversight improvement activities is included in direct survey costs, as these activities have become a standard part of nursing home survey procedures (see NHOIP table). 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. The FY08 President's Budget request for direct survey costs is $34.7 million over the FY2007 current rate.

Direct Survey Costs
(dollars in millions)

Provider Type	FY 2007 President's Budget	FY 2007 Current Rate	FY 2008 President's Budget
Skilled Nursing Facility (SNF)	$11.4	$10.8	$11.0
SNF/NF (dually-certified)	$164.1	$153.9	$171.0
Home Health Agencies	$25.9	$25.2	$29.5
Accredited Hospitals	$17.6	$17.6	$17.2
Non-Accredited Hospitals	$11.4	$9.5	$11.3
ESRD Facilities	$12.0	$9.2	$12.9
Hospices	$4.7	$2.4	$5.2
Outpatient Physical Therapy	$1.9	$0.7	$1.6
Outpatient Rehabilitation	$0.5	$0.3	$0.5
Portable X-Rays	$0.2	$0.1	$0.2
Rural Health Clinics	$1.9	$0.8	$1.9
Ambulatory Surgical Centers	$3.9	$1.8	$4.4
Transplant Centers	$0.0	$0.0	$0.7
Other Direct Survey Costs	$9.7	$9.1	$8.6
Total, Direct Surveys*	**$265.1**	**$241.4**	**$276.1**

* Total may not add due to rounding

CMS' FY 2008 funding request provides for inspections of long-term care facilities, home health agencies, and accredited hospitals at the level required by statute. All long-term care facilities must be surveyed at least every 15 months (12 months on average). Home health agencies must be surveyed at least every three years (33 months on average) and accredited hospitals must be surveyed at a rate of at least 2 percent per year. This funding level also allows CMS to maintain survey frequencies at policy level for the remaining facility types. The following chart includes updated frequency rates for fiscal years 2006 and 2007.

Recertification Level Comparison

	FY 2006 Appropriation	FY 2007 Presidents Budget	FY 2007 Current Rate	FY 2008 Estimate
Long-Term Care Facilities	Every Year	Every Year	Every Year	Every Year
Home Health Agencies	Every 3 Years	Every 3 Years	Every 3 Years	Every 3 Years
Accredited Hospitals	1% Per Year	2 % Per Year	2% Per Year	2.5% Per Year
Non-Accredited Hospitals	Every 5 Years	Every 4.5 Years	Every 7 Years	Every 4.5 Years
Organ Transplant Facilities	N/A	N/A	N/A	Every 3 Years
ESRD Facilities	Every 3.4 Years	Every 3.5 Years	Every 5 Years	Every 3.5 Years
Hospices	Every 9 Years	Every 6 Years	Every 39 Years	Every 6 Years
Outpatient Physical Therapy	Every 9 Years	Every 6 Years	Every 39 Years	Every 6 Years
Outpatient Rehabilitation	Every 9 Years	Every 6 Years	Every 39 Years	Every 6 Years
Portable X-Rays	Every 9 Years	Every 6 Years	Every 39 Years	Every 6 Years
Rural Health Clinics	Every 9 Years	Every 6 Years	Every 39 Years	Every 6 Years
Ambulatory Surgery Centers	Every 9 Years	Every 6 Years	Every 39 Years	Every 6 Years

CMS expects to complete a total of nearly 25,000 inspections in FY 2008 (see Surveys and Complaint Visits table below). In addition, CMS estimates almost 45,000 visits in response to complaints. In FY 2005, about 84.1 percent of nursing home facilities were cited for health deficiencies. The average number of health deficiencies per survey was approximately 7. This data demonstrates the importance of strategies aimed at regular comprehensive inspection of health care facilities.

Surveys and Complaint Visits
FY 2007 President's Budget vs. FY 2008 Estimate

	FY 2007 President's Budget				FY 2007 Current Rate				FY 2008 Estimate			
Type of Facility	Total Recert	Total Initial	Total Compl	Total Surveys	Total Recert	Total Initial	Total Compl	Total Surveys	Total Recert	Total Initial	Total Compl	Total Surveys
Skilled Nursing Facility (SNF)	1,018	56	809	1,883	966	56	809	1,831	898	62	681	1,641
SNF/NF (dually-certified)	14,217	318	36,984	51,519	13,497	318	36,984	50,799	14,140	269	37,924	52,333
Home Health Agencies	2,474	442	1,328	4,244	2,538	442	1,328	4,308	2,772	596	1,210	4,578
Accredited Hospitals	97	126	4,052	4,275	90	126	4,052	4,268	113	63	4,350	4,526
Non-Accredited Hospitals	418	276	490	1,184	269	276	490	1,035	373	328	476	1,177
ESRD Facilities	1,331	226	502	2,059	931	226	502	1,659	1,386	206	575	2,167
Hospices	493	117	366	976	76	117	366	559	491	200	385	1,076
Outpatient Physical Therapy	554	198	13	765	85	198	13	296	498	175	6	679
Outpatient Rehabilitation	125	102	7	234	19	102	7	128	110	84	7	201
Portable X-Rays	108	30	4	142	17	30	4	51	104	30	3	137
Rural Health Clinics	597	285	22	904	92	285	22	399	619	294	18	931
Ambulatory Surgery Centers	656	306	52	1,014	111	306	52	469	774	317	61	1,152
Total	**22,088**	**2,482**	**44,629**	**69,199**	**18,691**	**2,482**	**44,629**	**65,802**	**22,278**	**2,624**	**45,696**	**70,598**

The FY 2008 direct survey cost estimate also includes $8.6 million for several continuing activities:

- Minimum Data Set (MDS) State program costs, including system maintenance and ongoing collection and housing of data used in the development and testing of program improvement projects ($5.1 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 ($3.5 million); and

We reflect our commitment to protecting our beneficiaries and improving quality of care with several performance goals that focus on survey and certification activities. Among these is a nursing home quality performance goal to decrease the prevalence of physical restraints, an accepted quality of care indicator. These activities are supported by both the Medicare and Medicaid programs (see Medicaid State Survey & Certification).

Performance Goal	Results	Context
Decrease the Prevalence of Restraints in Nursing Homes to 6.1% by FY 2008.	CMS met its FY 2006 target of 6.4 percent by reaching a rate of 6.1 percent.	The core of the nursing home survey process is a four to five day onsite visit that verifies whether a nursing home is meeting Federal health and safety requirements. The standard survey takes a "snapshot" of beneficiary care. State Survey and Certification Agencies focus on quality of care furnished to residents. In addition, the Quality Improvement Organizations (QIOs), which are dedicated to working directly with individual providers to improve the quality of care delivered, play an important role in helping nursing homes reduce the use of physical restraints in their facilities. Our performance goals to improve the rates of physical restraints and pressure ulcers in nursing homes represent the Agency's commitment to protect its beneficiaries.

SUPPORT CONTRACTS AND IT - $17.4 million

Support contracts, managed internally by CMS, constitute approximately $14.4 million of the FY 2008 request. Critical Survey and Certification support contracts include, but are not limited to the following: psychiatric hospital Federal monitoring and oversight; life safety code comparative surveys; surveyor training; the Surveyor Minimum Qualifications Test (SMQT), as well as other efforts to ensure national program oversight and consistency.

The Medicare Survey and Certification budget includes approximately $3.0 million in IT funding for activities such as maintenance and enhancement of the OSCAR system, Quality Indicator Survey (QIS), and Federal Observation and Support Survey (FOSS) redesign.

SUMMARY OF THE NURSING HOME OVERSIGHT IMPROVEMENT PROGRAM

Total funding dedicated to the Nursing Home Oversight Improvement Program (NHOIP) in CMS' FY 2008 budget is $90.2 million, a $1.5 million increase over the FY 2007 current rate. CMS has made significant strides in the areas targeted by this program, and is committed to continuing to work with residents and their families, advocacy groups, providers, States, and Congress to ensure that residents receive the quality care and protection they deserve. This budget reflects CMS' continued commitment. As discussed below, there are several funding sources for this program.

Funding Source, NHOIP	**FY 2008 Estimate (in millions)**
Discretionary:	
Medicare Survey and Certification	$30.2
Federal Administration	$5.4
Subtotal, Discretionary	$35.6
Mandatory:	
Medicaid Survey and Certification	$54.6
Quality Improvement Organization Support Contracts	TBD
Subtotal, Mandatory	$54.6
Total, CMS	**$90.2**

DISCRETIONARY

Medicare Survey and Certification - $30.2 million

The Nursing Home Oversight Improvement Program (NHOIP) has made significant progress in enhancing and improving the survey process. The FY 2008 Survey and Certification budget includes $26.1 million for NHOIP direct survey costs and $4.1 million for NHOIP support contracts. CMS will continue current NHOIP activities to ensure that Medicare beneficiaries in nursing homes receive quality care in a safe environment. These include the following activities

- Investigating, processing, and reporting complaints which allege actual harm within 10 days ($10.1 million);
- Imposing immediate sanctions for nursing homes found to have care deficiencies that involve actual patient harm on any survey ($6.3 million);
- Developing a systematic, more comprehensive survey process to more effectively detect critical quality of care problems ($7.3 million);
- Staggering inspection times to include a set amount begun on weekends and evenings ($0.6 million);

- Focusing surveys on two repeat offenders with serious violations per State ($1.2 million); and

- Increasing quality of care through nurse aide registry fixes and related functions ($0.6 million).

Additional activities, funded through NHOIP support contracts, include implementing an improved survey process (QIS), understanding survey variations across States, expert testimony, Medicare and Medicaid minimum data set, and public reporting of nursing home staffing information.

Federal Administration - $5.4 million

Federal Administration funding for the NHOIP includes $4.2 million for federal oversight. These funds maintain 35 FTEs to continue the following activities:

- Process sanction notices and respond to litigation and appeals;

- Provide additional training and other assistance to inspectors in States, ensure that proper Federal protocols are being followed, and enhance national uniformity of oversight in the protection of residents;

- Monitor and update information about abuse prevention efforts in nursing homes, and respond to provider and consumer inquiries;

- Develop State sanction options that may be imposed, including termination of Federal nursing home survey funding for those States that fail to comply with Federal survey protocols or fail to improve inadequate survey systems; and

- Ensure that State surveyors enforce existing policy to sanction nursing homes with serious violations, and that sanctions cannot be lifted until after an onsite visit has verified compliance.

The Federal Administration account also includes $1.2 million in funding for travel, contracts, supplies, printing, and equipment associated with the NHOIP.

MANDATORY

Medicaid State Survey Costs - $54.6 million

State Medicaid programs will share in the direct survey costs and complaint visit costs associated with the NHOIP for dually-certified nursing facilities and Medicaid-only nursing homes.

Quality Improvement Organization (QIO) Support Contracts - TBD

QIO support contract funding is done on a three year basis. The current contracts will expire in FY2007 and the new contracts are currently under formulation. The past 3-year contract required QIOs to focus on statewide improvement in pressure ulcers, physical restraints, pain management, and depression. QIOs worked closely with a subset of nursing homes in each State to help these nursing homes set individual targets for quality improvement, implement and document processes related to clinical care, and assist these nursing homes in developing a more resident-focused care model

APPROPRIATIONS HISTORY:

The table below shows the Medicare Survey and Certification funding levels for the past 5 years.

Medicare Survey and Certification Program
Appropriations History

Fiscal Year	Appropriation
2003	$252,743,000
2004	$251,252,000
2005	$258,735,000
2006	$258,128,000
2007 CR Level	$258,128,000

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Research, Demonstration and Evaluation

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

Research, Demonstration and Evaluation
(Dollars in Thousands)

	FY 2006 Actual	FY 2007 President's Budget	FY 2007 CR Level	FY 2008 President's Budget	FY 2008 Pres. Bud. +/- CR Level
Appropriation/B.A.	$58,000	$41,528	$41,528	$33,700	-$7,828
Rescissions: (P.L. 109-148)	-580	---	---	---	---
Deficit Reduction Act (P.L. 109-171)	12,000	---	---	---	---
Comparable (Net) Appropriations/B.A	$69,420	$41,528	$41,528	$33,700	-$7,828

Statement of the Budget Request

The FY 2008 budget request for CMS' Research, Demonstration and Evaluation (RD&E) activity is $33.7 million, a decrease of $7.8 million from the FY 2007 current rate. The request includes $14.4 million to fund the Medicare Current Beneficiary Survey and $10.0 million to fund the Real Choice Systems Change grants. The remainder, $9.3 million, funds ongoing research activities.

Program Description

The RD&E program supports CMS' key role as a beneficiary-centered purchaser of high-quality health care at a reasonable cost. This role requires CMS to develop, implement and evaluate a variety of innovative, new research and demonstration projects, as well as expanded efforts to evaluate the effectiveness of CMS' current health care programs.

Our RD&E activities illustrate a vision of the future of our programs. The activities we conduct strive to balance short-term agency needs with long-term program perspectives through the production, analysis, and dissemination of high-quality information sensitive to the needs of our beneficiaries and customers. Our varied RD&E activities establish broad perspectives that will support informed decision-making processes and will enable policy makers to prepare more strategically the future of the programs that we administer.

Rationale for the Budget Request

The Research Coordination Council (RCC) identifies opportunities for increased collaboration with other HHS agencies. The efforts of the RCC help avoid overlap areas of focus across agencies and fill potential gaps in research efforts. CMS actively participates in the Department's RCC to ensure that the Agency's FY 2008 planned activities align with the Secretary's and President's priority areas and the Department's Strategic Plan.

FY 2008 RD&E Funding by DHHS Strategic Plan Goal
(Dollars in thousands)

Strategic Plan Goal	FY 2008 Estimate
4. Enhance the Capacity and Productivity of the Nation's Health Science Research Enterprise	$18,400
5. Improve the Quality of Health Care Services	$15,300
TOTAL RD&E Budget	**$33,700**

CMS Planned FY 2008 Research, Demonstration and Evaluation (RD&E) Activities

Overview

Our beneficiaries vary and no one health care plan fits all. Throughout the RD&E activities, CMS strives to shape a modern health care system that will meet these varied needs. Our RD&E efforts intend to provide information needed for modernization of our programs, including Medicare reform efforts in both managed care and fee-for-service. RD&E activities support monitoring and evaluating activities to track how well Medicare meets the needs of specific groups of beneficiaries, including vulnerable populations. We examine specific policy issues within CMS' programs. For example, as Medicare pursues new managed care options, beneficiary satisfaction, quality of care, and cost-effectiveness of these new approaches must be assessed.

CMS directs roughly 600 individual research, demonstration and evaluation projects.

Strategic Goal 4 - Enhancing the Capacity and Productivity of the Nation's Health Science Research Enterprise

The **Medicare Current Beneficiary Survey** (**MCBS**) is a continuous, multipurpose survey that represents our Medicare population. The survey's design aids CMS' efforts to monitor and evaluate the Medicare program. The survey's focus is on health care use, cost and source of payment.

Funding will continue to support the production of the **Medicaid Analytic eXtract** data development **(MAX)**, a Medicaid research database. All States are required to submit data to CMS via the MAX database. The MAX database is a unique source of prescription drug information on Medicaid recipients including dual eligible beneficiaries and is the source for many intramural, extramural and externally funded research studies; research studies in demand by the Congress, the Department, and the CMS.

CMS plans to maintain the **Chronic Conditions Warehouse** mandated under section 723 of the MMA designed to support studies to improve the quality of care and reduce the costs for chronically ill patients.

CMS' research budget supports the **Research Data Assistance Center**. This activity supports broader Federal government policies or initiatives, improves the infrastructure of the U.S. health services research system, and develops or enhances the capabilities of the overall health services research system.

Strategic Plan Goal 5 - Improve the Quality of Health Care Services

The FY 2008 budget proposes to fund the **Real Choice Systems Change grants**. The 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.

Investments of CMS' RD&E resources are needed in FY 2008 to carry out the mandates of the Medicare Modernization Act (MMA) including:

MMA Demonstration Activities:

- Implementation and evaluation of a demonstration of a **fully case-mix adjusted payment system for end-stage renal disease** (ESRD) service, involving up to 500 providers of dialysis services. (MMA section 623 (e))
- Implementation and evaluation of the **rural hospice** demonstration. (MMA sec 409)
- Implementation and evaluation of the **rural community hospital** demonstration. (MMA section 410(a))
- Implementation of a **competitive bidding demonstration project for clinical laboratories**. (MMA section 302(b))
- Implementation and evaluation of the **Medicare health care quality** demonstration to examine factors that encourage the delivery of improved patient care quality by increasing efficiency. (MMA section 646)
- Implementation and evaluation of a demonstration testing the provision of **medical adult day-care services** as a part of an episode of Medicare home health care benefits. (MMA section 703)
- Implementation and evaluation of a 3-year value-based purchasing pilot with physicians in four sites to promote adoption and use of health care reporting. The **Medicare care management performance** project supports HHS/CMS priorities to develop physician medical practice quality reporting and to promote use of technology to develop a comprehensive electronic medical record for physician offices. (MMA section 649)
- Evaluation of a demonstration that allows **frontier extended stay clinics** to be treated as providers. (MMA section 434)

MMA Program Evaluations and Research Studies Including:

- A study of geographic variation in drug expenditures and development of recommendations for adjustment of payments made under the program beyond the existing **risk adjustment**. (MMA section 1860D-15(c)(1))
- Monitoring and evaluation of regional **Medicare Advantage** plans. (MMA section 221 and section 222)
- Evaluation of the impact of the **Medicare prescription drug benefit program** on Medicare beneficiaries and other stakeholders. (MMA section 101)

Prospective Payment Systems

Inpatient and long-term care hospital, home health, inpatient psychiatric, inpatient diagnosis-related groups, and outpatient ESRD prospective payment systems need evaluation as they proceed through successive stages of implementation. Research continues to develop PPS for outpatient care for our ESRD patients. Individual PPS systems will be refined and monitored including inpatient and long-term care hospital, home health, inpatient psychiatric and inpatient diagnosis-related groups.

In FY 2008, we will continue to implement and evaluate the **physician group practice** demonstration, which would provide bonus payments for health care groups that achieve specified performance standards. In addition, CMS will consider demonstrations designed to improve the quality of care furnished to Medicare beneficiaries in other settings by awarding incentive payments that achieve certain quality of care thresholds in the **nursing home** and **home health** value-based purchasing demonstrations.

Evaluation of the **vision rehabilitation** demonstration will assess the impact of the new benefit on program expenditures and beneficiary outcome supporting HHS' priority to increase the independence and quality of life of persons with disabilities.

While fully funded, the section 5007 DRA **gainsharing** demonstration will be continuing in 2008. The demonstration will test and evaluate gainsharing incentive arrangements between hospitals and physicians as a means to improve the quality and efficiency of inpatient care for Medicare beneficiaries and operational and financial performance of hospitals in six projects, with each project consisting of one hospital.

In addition, we will continue the implementation and evaluation of the **physician-hospital collaboration** demonstration (MMA sec 646) that seeks to test the power of gainsharing alone as a means of aligning incentives between hospitals and physicians and across hospitals and physicians within a geographic area to make significant improvement in quality around a standardized selection of care processes and quality metrics. This demonstration will be operated in several consortia, with up to 72 hospitals included in the demonstration.

Another DRA project that will continue in FY 2008 is the **post-acute care** demonstration program mandated under section 5008. The post-acute care project requires the development of a post-acute care payment reform demonstration program for purposes of understanding costs and outcomes across different post-acute care sites.

Evaluation of the **BIPA cancer prevention** demonstration aims to identify promising models of cancer prevention, detection, and care for minority populations. CMS will evaluate the impact of the demonstration program and report to Congress on the findings.

CMS will continue to implement and evaluate the **ESRD disease management** demonstration. The design of the ESRD disease management demonstration assesses the effectiveness of disease management programs in a capitated environment for serious chronic medical conditions.

Finally, CMS' research budget supports activities to increase the efficiency of our research and demonstration program and meet the crosscutting research needs of CMS and the wider health research community. These efforts include the CMS grant programs for **Historically Black Colleges and Universities** (HBCUs) and **Hispanic researchers**.

APPROPRIATIONS HISTORY

The table below displays research funding for the past 5 years.

Research, Demonstration and Evaluation
Appropriations History

Fiscal Year	Appropriation
2003	$73,712,000
2004	$77,791,000
2005	$77,494,000
2006*	$69,420,000
2007 CR Level	$41,528,000

*FY 2006 includes Deficit Reduction Act funding.

Medicaid

Appropriation Language

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, *$141,628,056,000* to remain available until expended.

For making, after May 31, *2008*, payments to States under title XIX of the Social Security Act for the last quarter of fiscal year *2008* 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 *2009*, *$67,292,669,000* 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, $141,628,056,000 to remain available until expended.	This section provides a one-year appropriation for Medicaid. This appropriation is in addition to the advance appropriation of $65.3 billion provided for the first quarter of FY 2008 under an anticipated FY 2007 Continuing 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, 2008, payments to States under title XIX of the Social Security Act for the last quarter of fiscal year 2008 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 2008 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 2009, $67,292,669,000 to remain available until expended.	This section provides an advanced appropriation for the first quarter of fiscal year 2009 to ensure continuity of funding for the Medicaid program in the event a regular appropriation for fiscal year 2009 is not enacted by October 1, 2008. It makes clear that the language provides budget authority to the Vaccines for Children program during the first quarter of a fiscal year.
Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.	This section makes clear that funds are available with respect to State plans or plan amendments only for expenditures on or after the beginning of the quarter in which a plan or amendment is submitted to the Department of Health and Human Services for approval.

Medicaid

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

Medicaid Appropriation Summary Table
Dollars in Thousands

	FY 2006 Actual	FY 2007 President's Budget	FY 2007 CR Level	FY 2008 Estimate	Estimate +/- CR Level
Medical Assistance Payments (gross)	$182,548,229	$188,439,000	$179,404,000	$191,109,000	$11,705,000
Obligations Incurred by Providers But Not Yet Reported (IBNR)	6,829,757	2,016,090	3,000,000	3,000,000	0
Vaccines for Children	1,974,295	2,006,445	2,905,330	2,761,957	-143,373
State and Local Administration, Survey and Certification, and Fraud Control Units	10,490,155	9,367,700	9,881,583	10,014,716	133,133
Obligations (gross)	201,842,436	201,829,235	195,190,913	206,885,673	11,694,760
Unobligated Balance, Start of Year	-377,325	-605,162	-26,586,131	0	-26,586,131
Unobligated Balance, End of Year	26,586,131	0	0	0	0
Recoveries of Prior Year Obligations	-12,313,409	0	0	0	0
Appropriation Budget Authority (gross)	**215,737,834**	**201,224,073**	**168,604,782**	**206,885,673**	**38,280,891**
Offsetting Collections	-266,125	-368,000	-350,000	0	-350,000
Total Budget Authority (net)	**$215,471,709**	**$200,856,073**	**$168,254,782**	**$206,885,673**	**38,630,891**
Advanced Appropriation	-58,517,290	-62,783,825	-62,783,825	-65,257,617	-2,473,792
Annual Appropriation	**$156,954,419**	**$138,072,248**	**$105,470,957**	**$141,628,056**	**$36,157,099**

Statement of the Budget Request

CMS' FY 2008 budget request for the Grants to States for Medicaid Appropriation is $206.9 billion, an increase of $38.6 billion above the FY 2007 CR level.

Under current law, the estimated gross Medicaid budget authority requirement for FY 2008 is $206.9 billion in requested appropriated monies. These Medicaid obligations are composed of $191.1 billion in Medicaid medical assistance benefits, $3.0 billion for benefit obligations incurred but not yet reported, $10.0 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.

Program Description

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. 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 2005, 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 the State Medicaid program. 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 or resource 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.

Medicaid payments are made directly by States to health care provider**s** or health plan**s** 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 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. With the passage of the Omnibus Budget Reconciliation Act of 1981 and the Balanced Budget Act of 1997, there has been a vast increase in the number of Medicaid recipients enrolled in a managed care organization. As of June 30, 2005 nearly 63 percent of all Medicaid beneficiaries (more than 28.5 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, test new benefits, financing mechanisms, or significantly restructure State Medicaid programs.

The Balanced Budget Act of 1997 increased State flexibility to allow States 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 (SPA). 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 33 statewide comprehensive health care reform demonstrations in 28 States (Arizona, Arkansas, California, Colorado, Delaware, Florida, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, Utah, Vermont, Washington, and Wisconsin) and the District of Columbia. CMS has also approved two sub-State health reform demonstrations (California and Kentucky) and 19 demonstrations specifically related to family planning (Alabama, Arkansas, California, Florida, Iowa, Illinois, Louisiana, Michigan, Minnesota, Mississippi, New Mexico, North Carolina, Oregon, Oklahoma, 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.

A. Health Insurance Flexibility and Accountability (HIFA) Demonstrations

In August 2001, President Bush announced a new section 1115 initiative entitled the HIFA demonstration initiative. HIFA enables States to use Medicaid and SCHIP funds in concert with private insurance options to expand coverage to low-income uninsured individuals, with a focus on those with incomes at or below 200 percent of the Federal poverty level (FPL). The primary features of the HIFA initiatives are as follows:

1. Gives States the programmatic flexibility to increase health insurance coverage through support of private health coverage.

2. Increases accountability in the State and Federal partnership by ensuring that Medicaid and SCHIP (Title XXI) funds are effectively being used to increase health insurance coverage.

There are a total of 15 Section 1115 HIFA demonstrations approved as follows, by funding source:

- Four HIFA demonstrations (Arkansas, Illinois, Oregon, Utah) that are funded with both title XIX and title XXI funds.

- Nine HIFA demonstrations (Arizona, California, Colorado, Idaho, Michigan, New Jersey, Nevada, New Mexico, Virginia) solely funded with title XXI funds.

- Two HIFA demonstrations (Maine, Oklahoma) solely funded with title XIX funds.

In addition there are four (Minnesota, New Jersey, Rhode Island, and Wisconsin) pre-HIFA 1115 demonstrations approved with title XXI funds.

B. Independence Plus Demonstrations

The Independence Plus initiative helps States enable elders and persons with disabilities to maximize choice and control of services in their own homes and communities. This initiative, developed by DHHS in response to the President's New Freedom Initiative, is based on experiences and lessons learned from states that have pioneered the philosophy of consumer self-direction in the home and community-based services section 1915(c) waivers and the "cash and counseling" section 1115 demonstrations. Elders or individuals with disabilities, direct the design and delivery of the personal assistance services and supports they want and need so that they avoid unnecessary institutionalization, experience higher levels of satisfaction and use community services and supports more effectively.

To be designated as an Independence Plus program, States are currently required to include in the design of their self-directed programs, the following: 1) person-centered and directed planning; 2) authority to hire, manage, supervise and fire workers; 3) authority to manage an individual budget; 4) an appropriate and fair method to determine the participant-centered budget; 5) appropriate services, supports and safeguards, including financial management services and access to a separate advocacy function; and, 6) a quality assurance and quality improvement system that incorporates discovery, remediation and continuous improvement. Additionally, participants must live in their own private residence or with their families, or in a living arrangement where services are furnished to fewer than four persons unrelated to the proprietor.

There are currently 15 approved Independence Plus programs in 13 States: (Arkansas, New Hampshire, South Carolina, Florida, California, Maryland, New Jersey, Connecticut, Vermont, Rhode Island, Montana, and 2 programs in North Carolina and North Dakota). The Arkansas, Florida, California, New Jersey, and Vermont programs are approved under section 1115 demonstration authority.

The remaining programs are approved as section 1915(c) waivers or section 1915(b)/(c) concurrent waivers.

When the initiative was unveiled, CMS released two Independence Plus templates (section 1115 and section 1915(c)) that allowed States to choose different self-directed design features to satisfy their unique programs. In the spring of 2005, the section 1915(c) Independence Plus template was incorporated into a new section 1915(c) waiver application with instructions. One streamlined application enables the expansion of self-directed options through incremental growth in existing waivers; consistent participant protections across all waiver programs; minimal administrative burden to States; an easier amendment process so States may change waivers by modules rather than through a new document; and improved quality by clearly communicating CMS expectations for quality. In November 2006, States were able to submit 1915(c) applications to CMS via the internet in a web-based application. CMS continues to see a growth in self-direction throughout the country, both in programs expanding existing self-direction opportunities and programs newly offering self-direction.

The section 1115 program mirrors the policies of the Independence Plus program contained in the section 1915(c) waiver application and instructions. As of January 21, 2006, Arkansas, Florida, California and New Jersey have Independence Plus section 1115 programs and Vermont has an approved long-term care reform program with Independence Plus embedded within it. Also, Oregon's section 1115 self-direction program, which has operated since 2001, has recently requested the Independence Plus designation in its amendment and extension request. Approval of that program is expected shortly.

With the enactment of the Deficit Reduction Act (DRA) of 2005, new opportunities exist for States to pursue self-directed care effective January 1, 2007 without the need for demonstration or waiver authority. We anticipate that more States will want to pursue self-direction under one of the DRA options including the self-directed Personal Assistance Services State plan option (section 6087), the home and community-based services State plan option (section 6086) or the "Benchmarks" State plan option (section 6044) in addition to the section 1915(c) waiver and section 1115 demonstration authorities.

C. Benefit Flexibility under the Deficit Reduction Act 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. In 2006, CMS approved four State plan amendments for alternative benefit coverage: Idaho, Kansas, Kentucky and West Virginia.

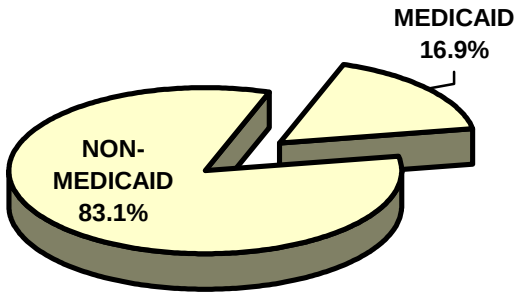
Rationale for the Budget Request

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 2006. The projections incorporate the economic and demographic assumptions promulgated by the Office of Management and Budget for use with the FY 2008 President's budget.

Under current law, the estimated Federal share of Medicaid outlays is estimated to be $203.9 billion in FY 2008. This represents an increase of 6.3 percent over the estimated net outlay level of $191.8 billion for FY 2007. Medicaid person-years of enrollment, which represent full-year equivalent Medicaid enrollment, are projected to increase approximately 1.9 percent during this time period.

According to our projections of Medicaid enrollment in FY 2008, as shown in the pie chart, 16.9 percent, or 50.0 million, of the estimated 295 million U.S. residents will be enrolled in Medicaid for the equivalent of a full year during FY 2008. In FY 2008 Medicaid will provide coverage to more than one out of every five children in the Nation.

FY 2008 ESTIMATED MEDICAID FULL-YEAR ENROLLEES COMPARED TO THE U.S. POPULATION

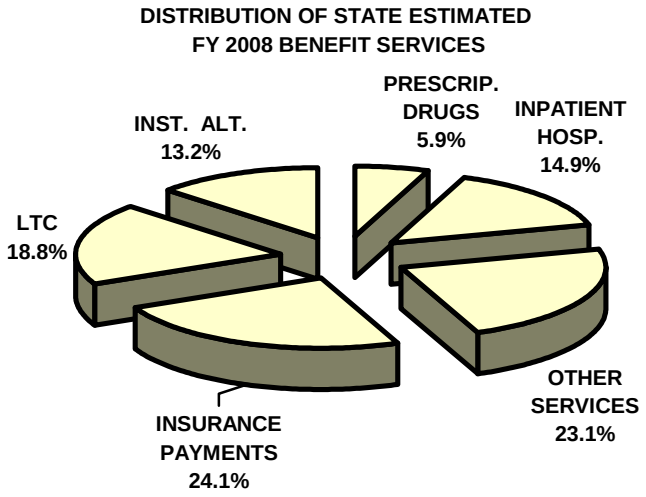


CMS projects that in FY 2008 non-disabled adults under age 65 and children will represent 72 percent of the Medicaid population, but account for approximately 32 percent of the Medicaid benefit outlays, excluding disproportionate share hospital (DSH) payments. In contrast, the elderly and disabled populations are estimated to make up about 28 percent of the Medicaid population, yet account for approximately 68 percent of the non-DSH benefit outlays. Medicaid is the largest payer for long-term care for all Americans.

Distribution of Medicaid Benefit Services and Growth

As displayed in the table on the following page, medical assistance payments are projected to increase $12.9 billion, or 7.2 percent, from $180.0 billion in FY 2007 to $192.9 billion in FY 2008.

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 $47.1 billion in funding for FY 2008, representing 24.1 percent of the State benefit estimates for FY 2008. The second largest FY 2008 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 2008 estimates totaling $36.8 billion or about 18.8 percent of Medicaid benefits. The next largest category of Medicaid services for FY 2008 are inpatient hospital services ($29.1 billion), followed by institutional alternative services such as home health, personal care, home and community-based care ($25.7 billion), and prescription drugs ($11.4 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 nearly 77 percent of the State estimated cost of the Medicaid program for FY 2008.



According to the State estimates, the fastest growing service category is the health insurance payments category. States expect this payment 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 $4.4 billion, or 10.3 percent, between FY 2007 and FY 2008. The State estimate increases in this service category account for more than 53 percent of the total FY 2008 benefit growth. Rising enrollments and shifts in how services are paid, e.g., from fee-for-service to capitated plans, explain this growth. All other categories of service display estimated annual growth of 7.7 percent or less.

Estimated Benefit Service Growth, FY 2007 to FY 2008

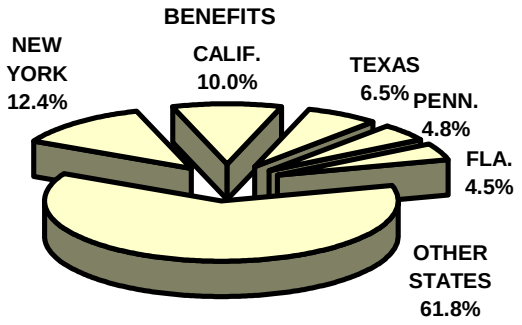
November 2006 State-Submitted Estimates and Actuarial Adjustments
(dollars in thousands)

Major Service Category	Est. FY 2007	Est. FY 2008	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)	$42,695,150	$47,094,285	$4,399,135	10.3%	53.3%
Institutional Alternatives (Personal care, home health, and home and community-based care)	$24,376,312	$25,740,296	$1,363,984	5.6%	16.5%
Long-Term Care (Nursing facilities, intermediate care facilities for the mentally retarded)	$35,512,390	$36,777,269	$1,264,879	3.6%	15.3%
Prescribed Drugs (Prescribed drugs and drug rebate offsets)	$10,618,846	$11,438,771	$819,925	7.7%	9.9%
Physician/Practitioner/Dental	$9,282,324	$9,735,427	$453,103	4.9%	5.5%
Inpatient Hospital (Regular payments –inpatient hospital and mental health facilities)	$28,635,809	$29,067,492	$431,683	1.5%	5.2%
Other Acute Care (Clinics, lab & x-ray, Federally-qualified health clinics and early periodic screening, and diagnostic treatment (EPSDT)	$7,719,310	$8,022,929	$303,619	3.9%	3.7%
Outpatient Hospital	$7,119,875	$7,346,736	$226,861	3.2%	2.7%
Other (Targeted case management, hospice, all other services, and collections)	$10,500,569	$10,148,684	-$351,885	-3.4%	-4.3%
Disproportionate Share Hospital Payments (Adjustment payments – inpatient hospital and mental health facilities)	$10,412,183	$9,758,247	-$653,936	-6.3%	-7.9%
TOTAL STATE ESTIMATES (Excludes Medicare Part B Transfer)	$186,872,768	$195,130,136	$8,257,368	4.4%	100.0%
Adjustments	-$6,872,768	-$2,230,136	NA	NA	NA
TOTAL	$180,00,000	$192,900,000	$12,900,000	7.2%	NA

Distribution of FY 2008 Medicaid Monies by State

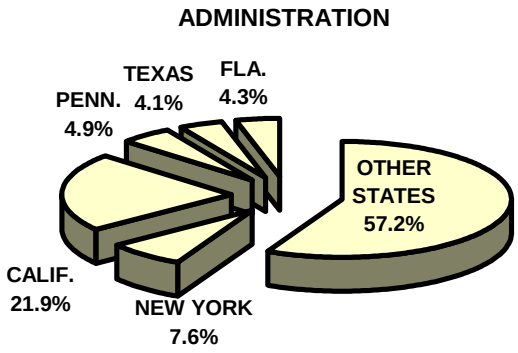
STATE DISTRIBUTION OF MEDICAID BENEFITS

According to the State-submitted estimates, $195.1 billion will be required to fund their Medicaid benefit programs during FY 2008. As displayed, five States account for $74.5 billion, or over 38.2 percent, of the State-submitted estimates for benefits for FY 2008. The next five States in ranking of estimated benefits are, Ohio (4.3 percent), North Carolina (3.9 percent), Illinois (3.0 percent), Massachusetts (2.9 percent), and Arizona (2.6 percent). These five States account for 16.7 percent of total State-submitted benefit estimates. In total, these 10 States account for nearly 55 percent of benefits in FY 2008.



STATE DISTRIBUTION OF MEDICAID STATE AND LOCAL ADMINISTRATION

The State-submitted estimates for FY 2008 State and local administration costs total $9.6 billion. This represents about 4.7 percent of the total State-submitted estimates for Medicaid costs for FY 2008. As displayed, five States account for $4.0 billion, or 42.8 percent of expenditures for State and local administration. The next five States in ranking of estimated expenditures are Illinois (3.9 percent), Washington (3.1 percent), New Jersey (3.1 percent), Tennessee (3.0 percent), and North Carolina (3.0 percent). These five States account for over 16.1 percent of total State and local administration expenditures. In total, these 10 States are expected to account for nearly 59.0 percent of expenditures for State and local administration.



A. Estimates for Medical Assistance Payments (MAP)

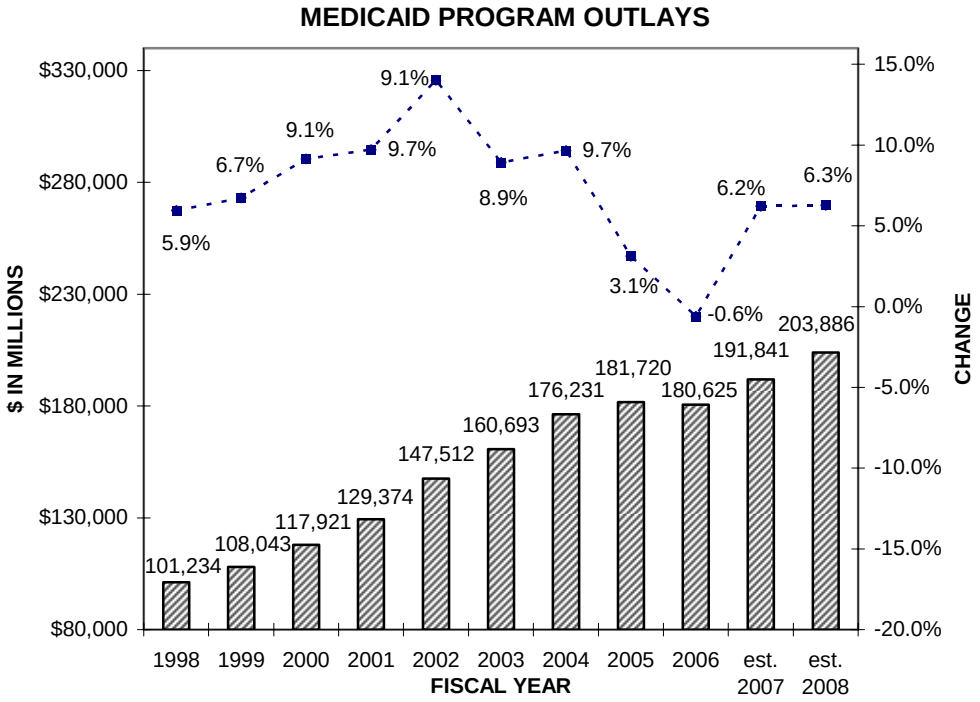
In order to arrive at an accurate estimate of Medicaid expenditures, adjustments have been made to the November 2006 State estimates. These adjustments reflect actuarial estimates, recent legislative impacts, Medicaid financial disallowances, and CMS financial management reviews.

1. Actuarial Adjustments to the State Estimates for Medical Assistance Benefits

The November 2006 State estimates for medical assistance payments (MAP) of $195.1 billion in FY 2008 are the first State-submitted estimates for FY 2008. 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 2008. Using the first three quarters of FY 2006 State-reported expenditures as a base, expenditures for FY 2007 and FY 2008 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 2006 State-submitted estimates. Based on this analysis, the CMS' Office of the Actuary decreased the States' medical assistance payment estimates for FY 2008 by $2.2 billion to $192.9 billion.



In the mid 1990s, the factors impacting the historical growth in Medicaid program costs began to moderate as a result of an improving economy, legislative restrictions on tax and donation programs and DSH payments, and welfare reform, resulting in slower program outlay growth, averaging 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; however, spending growth is expected to increase again in 2007 and 2008.

2. Adjustments to the State Estimates for Legislation

Tax Relief and Health Care Act of 2006 (Public Law 109-432)

The following is a summary of the major Medicaid provisions included in the Tax Relief and Health Care Act of 2006:

Extension of Transitional Medical Assistance (TMA)

Extended the Transitional Medical Assistance program through June 30, 2007.

Change in Threshold for Indirect Hold Harmless Provision of Broad-Based Health Care Taxes.

Phased-down the allowable provider tax rate from 6 percent to 5.5 percent, effective the second quarter of FY 2008 through the end of FY 2011.

DSH Allotments for Fiscal Years 2007 for Tennessee and Hawaii.

Established disproportionate share hospital (DSH) programs for Tennessee and Hawaii for FY 2007.

3. Adjustments to the State Estimates for Administrative Reform

Payment Reform
(Estimated FY 2008 savings are $530 million)

The Administration proposes to further improve the integrity of the Medicaid matching rate system by proposing steps to curb financing arrangements that have been used by a number of States to avoid the legally determined State matching funds requirements. Through various mechanisms, Federal funds are returned from providers back to the State and "recycled" to draw additional Federal dollars. The budget proposes to build on past CMS efforts to curb questionable financing practices by (1) clarifying that only units of government are able to participate in the financing of the non-Federal share of Medicaid expenditures; (2) establishing minimum requirements for documenting cost when using a certified public expenditure as part of the non-Federal share; (3) limiting providers operated by units of government to reimbursement that does not exceed the cost of providing covered services to eligible Medicaid recipients, and (4) establishing a new regulatory provision explicitly requiring that providers receive and retain the total computable amount of their Medicaid payments; and, (5) making all corresponding and conforming changes to SCHIP.

Services Reform
(Estimated FY 2008 savings are $230 million)

Rehabilitation services are optional Medicaid services typically offered to individuals with special needs or disabilities to help improve their health and quality of life. Medicaid rehabilitation services are prone to inappropriate claiming and cost-shifting from other programs because they are not well defined in regulation. The Administration plans to address this concern by issuing a regulation that clearly defines allowable services that may be claimed as rehabilitation services.

School-Based Administration Reform
(Estimated FY 2008 medical assistance payment savings are $167 million and State and local administration savings are $448 million)

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. The Administration plans administrative actions to phase out Medicaid reimbursement for certain school-based IDEA-related transportation and school administrative claiming. These Medicaid benefit savings are attributable to transportation cost savings. The Medicaid State and local administration cost savings are displayed in the State and local administration budget estimate portion of the justification. Appropriate medical services and transportation to and from these services under IDEA would continue to be reimbursed as under current law.

Graduate Medical Education (GME) Reform
(Estimated FY 2008 savings are $140 million)

Under current law, Medicare provides billions of dollars in support of graduate medical education (GME) nationwide. Many States also use Medicaid to pay for physician training programs, even though current law does not explicitly authorize such payments. The Administration plan to clarify that Medicaid will no longer be available as a source of funding for GME. Paying for GME is outside of Medicaid's primary purpose, which is to provide medical care to low-income individuals.

Managed Care Reform

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.

Clarifying Regulations

The Administration plans to take administrative action to codify and clarify existing policies related to the Disproportionate Share Hospital (DSH) program, provider taxes and the pharmacy cost avoidance standard. Specifically, the DSH regulation will clarify existing policy related to allowable uses of DSH funds. A provider tax regulation will revise existing rules to more explicitly state the policies and procedures CMS uses when evaluating States' provider taxes. The pharmacy regulation will clarify that States will no longer have the option of "pay and chase," or paying the claim and pursuing payment from a third party.

4. Other Adjustments to the State Estimates for Medical Assistance Payments

Medicaid Financial Management Reviews
(Estimated FY 2008 savings are $704 million)

Financial management (FM) reviews conducted by regional office staff are expected to produce additional savings of $656 million in FY 2007 and $704 million in FY 2008. 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.

B. Estimates for Entitlement Benefits Due and Payable (incurred but not reported, or IBNR)

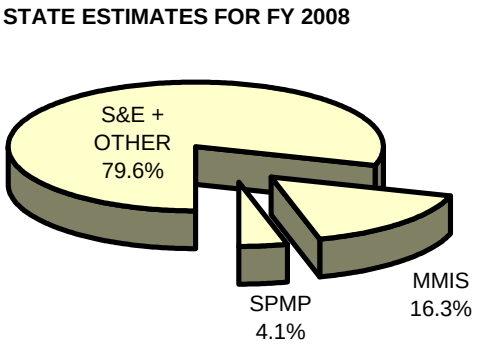
The FY 2008 estimate of $3.0 billion represents the increase in the liability for Medicaid medical services incurred but not paid from October 1, 2007 to September 30, 2008. The Medicaid liability is developed from estimates received from the States. The Medicaid estimate represents the net of unreported 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.

C. Estimates for the Vaccines for Children (VFC) Program

The current FY 2008 estimate for the Vaccines for Children (VFC) program is $2.8 billion. This represents a decrease of $0.1 billion from the current FY 2007 estimate of $2.9 billion. Actual FY 2006 VFC program obligations were $2.0 billion.

D. Estimates for State and Local Administration (ADM)

In November 2006, the States estimated the Federal share of State and local administration to be $9.5 billion for FY 2007 and $9.6 billion for FY 2008. The FY 2008 estimate is composed of $1.6 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 (SPMP); and $7.6 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.



CMS adjusted the FY 2008 State-submitted estimates of $9.6 billion to reflect a growth rate more consistent with recent expenditure history (+$447.0 million), costs associated with the Payment Error Rate Measurement (PERM) fee-for-service and managed care activities (+$5.2 million), and (-$448.0 million) for the following anticipated school-based administration reform:

Under current law, Medicaid is the primary payer for some medical services that are included in a child's Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP) as described in the Individuals with Disabilities Education Improvement Act of 2004 (IDEA). Evidence has shown that Medicaid claiming for IDEA-related services in a school setting are prone to abuse and overpayments, especially in the areas of administrative claiming and transportation. The Administration plans administrative actions to phase out Medicaid reimbursement for certain school-based IDEA-related transportation and school administrative claiming. These activities extend beyond covered medical services and are prone to abusive claiming. Appropriate medical services

and transportation to and from those services under IDEA would continue to be reimbursed as under current law.

After these adjustments, the State and local administration for FY 2008 is estimated to be $9.6 billion, or 1.3 percent higher than the adjusted FY 2007 estimate of $9.4 billion.

E. 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 2008 is to ensure that Medicaid beneficiaries are receiving quality care in a safe environment. The current FY 2008 estimate for Medicaid State survey and certification is $262.0 million. This represents an increase of $5.1 million above the current FY 2007 estimate of $256.9 million. This increased funding level includes monies to support increasing workload requirements, costs associated with survey and certification activities, and direct State survey costs associated with nursing home quality.

F. State Medicaid Fraud Control Units

The Medicaid Fraud Control Units mission is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect. In FY 2008, State Medicaid fraud control unit operations are estimated to require $183.5 million. This represents an increase of $8.7 million over the estimated FY 2007 funding level of $174.8 million.

Performance Analysis

Medicaid received an Adequate score in the FY 2006 cycle. The PART summary will be available at www.ExpectMore.gov in the near future. CMS is developing new goals and will develop an improvement plan as a result of the PART assessment. In response to the PART evaluation, CMS is using portions of its budget request to fund initiatives that support efforts to increase program performance.

CMS has now implemented the following national Medicaid and SCHIP payment error rate program:

Performance Goal	Results	Context
FY 2008 target is to report national Medicaid and SCHIP error rates in the FY 2009 Performance and Accountability Report (PAR) based on: **a. Medicaid:** 17 Medicaid States measured in FY 2008, and **b. SCHIP:** 17 SCHIP States measured in FY 2008.	FY 2006 data available Nov-07.	CMS sponsored a pilot program to estimate payment accuracy in the Medicaid program from FY 2002 - FY 2004 and in SCHIP from FY 2003 - FY 2004. In FY 2006, CMS implemented the PERM program in 17 States to produce a national Medicaid fee-for-service error rate. This Medicaid fee-for-service error rate will be reported in the FY 2007 Performance and Accountability Report (PAR).

Providing quality health care for Medicaid and SCHIP beneficiaries is a high priority at CMS as demonstrated by the following performance goal:

Performance Goal	Results	Context
Increase the number of States that demonstrate improvement related to access and quality health care through the Medicaid Quality Improvement Program. For 2008, 15% (8 States) will participate in the Medicaid Quality Improvement Program (MQIP).	This goal uses the CMS Quality Roadmap, released July 2005, with the vision for the "right care for every person every time." FY 2007 data will be available February 2008.	The Roadmap outlined a plan of action to implement, in close partnership with States, a strategy to improve the quality of care of Medicaid beneficiaries. Results will be used as building blocks for the development of national level quality framework.

G. Impact of Proposed Legislation

1. Streamline Administrative Match Rates

Generally, Medicaid administrative activities are reimbursed at a 50 percent Federal medical assistance percentage (FMAP), however, there are exceptions where reimbursement is at a rate higher than 50 percent. The FY 2008 President's Budget proposes to create consistency and eliminate bias in reimbursement among Medicaid administrative activities by aligning the matching rate at 50 percent.

Five-year budget impact: Savings: $5.3 billion

2. 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 impact: Savings: $1.8 billion

3. Require State Reporting and Link Performance to Reimbursement

The FY 2008 President's Budget would require States to monitor and report on several performance measures aimed at improving Medicaid quality of care, program integrity, and efficiency. Reporting on these measures would begin in FY 2008 with a three-year phase-in for each of these measures. States that do not meet targeted thresholds for each performance measure beginning 2011 would receive either an FMAP or Medicaid grant award reduction, depending on the performance measure. The reduction would last until the State meets the designated thresholds for specific performance measures. Performance measures currently being considered include increasing estate recovery collection rates, and reducing the prevalence of daily physical restraints in nursing homes.

Five-year budget impact: Savings: $0.3 billion

4. Reimburse Targeted Case Management at 50 percent

The FY 2008 President's Budget proposes to reimburse all case management activities, at a 50 percent FMAP. Case management activities are inherently the same, whether they are reimbursed as an administrative activity or as a medical assistance service. These 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 for States 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 impact: Savings: $1.2 billion

5. Rationalize Pharmacy Reimbursement

The Federal government limits payments to State Medicaid agencies for the aggregate costs of prescription drugs when a generic substitute is available. The Deficit Reduction Act of 2005 (DRA) reduced overpayments by establishing a new Federal upper limit (FUL) for multiple source drugs (defined as a drug marketed or sold by two or more manufacturers or labelers) that is equal to 250% of the lowest average manufacturer's price (AMP). On December 22, 2006, CMS published a proposed rule to implement the DRA changes pertaining to prescription drugs under Medicaid program. As required by DRA, this proposed rule includes a proposed definition of AMP. The definition of AMP will have an impact on the FUL levels and the rebate payments drug manufacturers are required to make to the States and Federal government.

The FY 2008 President's Budget proposes to build on the DRA changes to the FUL for multiple source drugs. The Budget proposes to limit reimbursement for multiple source drugs to 150% of the AMP. This will continue efforts to further reduce Medicaid overpayments for prescription drugs in line with pharmacy acquisition costs.

Five-year budget impact: Savings: $1.2 billion

6. Allow Optional Managed Formulary

The FY 2008 President's Budget proposes to allow States to use private sector management techniques to leverage greater discounts through improved negotiations with drug manufacturers. This proposal would permit States to establish a "managed formulary", which is essentially a list of prescription drug products that are covered under the program. Products not on the list are not covered.

Five-year budget impact: Savings: $0.9 billion

7. Require Tamper Resistant Prescription Pads

Medicaid prescription drug fraud and abuse can take place as a result of illicitly obtained and illegally used prescription pads. Thirteen states have utilized tamper-resistant pads, realizing fairly significant savings and decreases in drug diversion. The FY 2008 President' Budget proposes to require all states where providers use hand-written prescription pads to utilize "tamper-resistant" pads.

Five-year budget impact: Savings: $0.2 billion

8. Replace Best Price With Budget Neutral Rebate

As required by the Medicaid Drug Rebate Program, drug manufacturers must enter into a rebate agreement with CMS in order to have their products covered by the Medicaid program. Current law requires all manufacturers of single source drugs and innovator multiple source drugs (commonly referred to as brand name drugs) to pay the State a base rebate equal to the greater of 15.1% of the average manufacturer's price (AMP) or the difference between the AMP and the "best price" extended to any private buyer. OBRA 90 defines "best price" as the lowest price available to any wholesaler, retailer, provider, HMO, nonprofit, or governmental entity with certain exceptions. The FY 2008 President's Budget proposes to modify the way the Medicaid drug rebate is calculated by eliminating best price and revising the rebate percentage. The rebate percentage would be calculated in a budget neutral manner to offset the cost. This proposal would administratively simplify the drug rebate calculations and allow private purchasers to negotiate lower drug prices. Because this proposal is budget neutral, the States will not be disadvantaged by lower prices that large volume private purchasers may get.

Five-year budget impact: None

9. Expand Asset Verification Demonstration

The Social Security Administration (SSA) has achieved impressive results from its pilot asset verification system for Supplemental Security Income benefits. SSA worked with a contractor to develop a new automated, secure, web-based asset verification request and response process. The process permits an automated paperless transmission of all asset verification requests from an SSA field office to the respective financial institution and back to the SSA field office.

The FY 2008 President's Budget proposes that CMS partner with SSA on a demonstration project, applying the SSA system to CMS programs whose eligibility criteria include limitations on financial resources. CMS will work with States to establish Medicaid demonstrations in the same locations as SSA.

Five-year budget impact: Savings: $0.6 billion

10. 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, such as those found in section 1902(a)(25)(E) and (F) of the Social Security Act.

Five-year budget impact: Savings: $0.1 billion

A. Payment for prenatal and preventive pediatric care

The FY 2008 President's Budget proposes to change the statute to require providers to bill third parties and wait at least 90 days before billing Medicaid. This would allow states to cost avoid claims for prenatal and preventive pediatric care for a limited time while assuring protection for providers and beneficiaries.

B. Payment in Cases Involving Medical Child Support

The statute requires Medicaid agencies to pay claims and seek reimbursement from the liable third party after 30 days in situations where health insurance is derived from a non-custodial parent's obligation to provide coverage. The FY 2008 President's Budget proposes to require providers to bill third parties and wait at least

90 days before billing Medicaid. This would allow states to cost avoid claims where the third party is derived through a non-custodial parent's obligation to provide coverage for a limited time while assuring protection for providers and beneficiaries.

C. Authority to 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 2008 President's Budget proposes to explicitly permit States to use liens against liability settlements to recover matching 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 first from any and all recover from a liable party regardless of whether the recipient has been fully compensated.

11. Publish Medicaid Actuarial Report

The FY 2008 President's Budget proposes to require CMS to publish an annual report assessing the financial status of the Medicaid program. This new requirement would enhance the capability of CMS to collect new or better data on the Medicaid program and impose reporting requirements similar to other large programs, e.g. Medicare Trustees Report, SSI Program Report.

Five-year budget impact: None

12. 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, statewideness, and comparability, that prevent a State from mandating Medicaid beneficiaries obtain their care from a single provider or health plan. These waivers are also known as Freedom of Choice waivers and are currently approved for two year

periods. The FY 2008 President's Budget proposes to ease administrative burdens by extending the 1915(b) waiver renewal period from two to three years.

Five-year budget impact: None

13. Define Home Equity Definition at $500,000

Section 6014 of the DRA 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 2008 President's Budget proposes to maintain the substantial home equity limit at $500,000 and not allow States the option to substitute an amount between $500,000 and $750,000.

Five-year budget impact: Savings: $0.4 billion

14. 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 2008 President's Budget proposes to extend the TMA provision from July 1, 2007 through September 30, 2008.

Five-year budget impact: Cost: $0.7 billion

15. Extend Qualified Individuals

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 receive 100 percent Federal funding for the QI program. The Secretary is required to estimate the number of eligibles in each State to determine the amount allotted to each State for coverage of the QIs, which sets the limit on the total amount of Federal funds available for payment of Part B premiums for QIs each fiscal year. The FY 2008

Budget proposes to continue for one year, through September 30, 2008, the requirement to pay current coverage of the full Part B premium for QIs. Under this proposal, States pay the Part B premium costs of $425 million, which are offset by a reimbursement from Medicare Part B.

Five-year budget impact: Cost: $0.4 billion

16. Modify HIPAA

Medicaid/SCHIP eligibility as qualifying event for employer-sponsored insurance

Individuals become eligible for Medicaid or SCHIP at any time during the year, but states may have to wait many months until an employer's open season to use premium assistance to help the individual buy into the employer's health insurance. The FY 2008 President's Budget proposes to make eligibility for Medicaid and SCHIP a trigger for private health insurance enrollment outside the plan's open season.

Five-year budget impact: None

17. SCHIP Reauthorization Impact on Medicaid

The FY 2008 President's Budget proposes to reauthorize SCHIP for 5 years, consistent with submission of a five-year Budget to the Congress, 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. Toward this end, the Budget provides approximately $5 billion over 5 years in additional allotment funds. The Budget assumes that with the additional funding States would cover fewer children under Medicaid resulting in Medicaid savings.

Five-year budget impact:	SCHIP:	+$5.9 billion
	Medicaid:	-$1.8 billion
	Net impact:	+$4.2 billion *

* Estimates do not add due to rounding.

18. Refugee Exemption Extension

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 2008 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.

Five-year budget impact: Cost: $0.1 billion

MEDICAID PROGRAM

Authorizing Legislation

	2007 Amount Authorized	2007 President's Budget	2008 Amount Authorized	2008 Budget Request
Grants to States for Medicaid (Social Security Act, title XIX, Section 1901)	Indefinite	$165,349,452,000	Indefinite	$204,123,716,000
Vaccines for Childrens Program (Social Security Act, title XIX, Section 1928)		$2,905,330,000		$2,761,957,000
Total appropriations		$168,254,782,000		$206,885,673,000

MEDICAID PROGRAM

Appropriations History Table

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
1998	99,519,422,000	99,519,422,000	99,591,422,000	99,591,422,000	
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				

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 have not yet provided an FY 2007 allowance amount. The appropriation level reflects an FY 2007 anticipated continuing resolution appropriation.

MEDICAID PROGRAM

Budget Authority by Object

	2007 Estimate	2008 Estimate	Increase or Decrease
CMS - GRANTS TO STATES			
Grants to States, Subsidies, and Contributions	$165,349,452,000	$204,123,716,000	$38,774,264,000
CDC - VACCINES FOR CHILDREN			
Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance	$2,905,330,000	$2,761,957,000	($143,373,000)
Total budget authority	$168,254,782,000	$206,885,673,000	$38,630,891,000

STATE TABLES

Estimates of Grant Awards

(dollars in thousands)

	FY 2006 Obligations	FY 2007 Estimate	FY 2008 Estimate
Alabama	2,811,355	2,806,831	2,819,149
Alaska	733,492	872,800	897,687
American Samoa	6,120	8,496	8,496
Arizona	4,436,368	4,662,315	5,114,866
Arkansas	2,304,017	2,444,471	2,661,730
California	21,931,980	20,818,937	21,560,850
Colorado	1,532,446	1,603,055	1,675,586
Connecticut	2,227,657	2,224,734	2,285,441
Delaware	515,728	545,539	592,470
District of Columbia	1,062,487	1,199,039	1,279,839
Florida	8,733,890	8,715,628	9,121,444
Georgia	4,744,732	4,541,194	4,955,788
Guam	9,390	13,130	13,690
Hawaii	728,625	643,587	657,414
Idaho	777,351	820,475	891,629
Illinois	5,993,277	5,775,493	6,168,570
Indiana	3,696,015	3,888,848	4,069,372
Iowa	1,754,671	1,717,644	1,829,478
Kansas	1,320,586	1,354,092	1,395,370
Kentucky	3,343,139	3,306,988	3,461,452
Louisiana	3,631,368	3,692,810	3,999,621
Maine	1,506,300	1,157,172	1,194,973
Maryland	2,929,314	2,952,992	3,116,243
Massachusetts	5,150,675	5,911,206	5,927,750
Michigan	5,206,747	5,336,206	5,162,765
Minnesota	3,079,537	3,168,233	3,577,872
Mississippi	2,810,880	2,696,873	2,970,793
Missouri	4,208,911	4,442,233	4,712,989
Montana	569,840	546,316	563,911
Nebraska	1,050,601	957,874	1,008,403
Nevada	719,691	671,157	671,000
New Hampshire	626,147	650,051	694,608
New Jersey	5,047,720	4,952,112	5,130,144
New Mexico	1,929,108	1,997,852	2103655

Estimates of Grant Awards (cont.)
(dollars in thousands)

	FY 2006 Obligations	FY 2007 Estimate	FY 2008 Estimate
New York	24,223,095	25,020,102	24,961,924
North Carolina	6,206,828	6,528,916	7,831,399
North Dakota	354,268	366,542	386,256
Northern Mariana Islands	3,467	4,662	4,662
Ohio	7,945,914	8,543,294	8,687,791
Oklahoma	2,199,646	2,662,883	2,732,840
Oregon	2,079,179	2,158,554	2,316,595
Pennsylvania	9,287,096	9,469,818	9,928,379
Puerto Rico	241,017	286,222	286,222
Rhode Island	1,004,539	974,072	1,056,158
South Carolina	2,986,972	2,898,600	2,853,534
South Dakota	430,904	431,162	430,179
Tennessee	4,825,494	4,594,265	4,629,530
Texas	11,431,765	12,634,509	13,023,608
Utah	1,167,263	1,119,241	1,192,293
Vermont	575,123	591,582	625,536
Virginia	2,529,202	2,726,856	2,943,719
Virgin Islands	9,702	13,295	13,815
Washington	3,240,127	3,197,092	3,281,008
West Virginia	1,658,639	1,779,241	1,899,449
Wisconsin	2,880,647	2,985,034	3,040,913
Wyoming	256,828	265,055	274,265
Subtotal /Grants/Unadj. St. Ests	**$192,667,880**	**$196,347,380**	**$204,695,123**
Survey & Certification	186,478	256,900	262,000
Fraud Control Units	161,600	174,800	184,540
Vaccines For Children	1,974,295	2,905,330	2,761,957
Adjustments	(243,699)	(7,843,497)	(4,017,947)
Total Net Obligations	**$194,746,554**	**$191,840,913**	**$203,885,673**
Medicare Part B Transfer	264,230	350,000	0
VFC Offsetting Collection	1,895	0	0
Incurred But Not Reported	6,829,757	3,000,000	3,000,000
Total Gross Obligations	**$201,842,436**	**$195,190,913**	**$206,885,673**

MEDICAID PROGRAM

Summary of Changes

(dollars in thousands)

2007 Budget Authority	$168,254,782
2008 Estimated Appropriated Budget Authority	$206,885,673
Net Change	**$38,630,891**

Explanation of Changes

	2007 Current Base Budget Authority	FY 2008 Change From Base Budget Authority
Program Increases:		
1. Medical Assistance Payments	$180,000,000	$12,900,000
2. State Administration	9,474,612	90,375
3. Fraud Control Units	174,800	8,740
4. State Certification	256,900	5,100
5. Offsetting Collections From Medicare Part B	-350,000	350,000
6. State and Local Administration Financial Adj.	-29,612	476,625
7. Unobligated Balance Start of Year	-26,586,131	26,586,131
8. Payment Error Rate Measurement	4,883	293
Total program increases	$162,945,452	$40,417,264
Program Decreases:		
1. Tax Relief and Health Care Act of 2006	180,000	-200,000
2. Administrative Actions Affecting State and Local Administrati	0	-448,000
3. Vaccines for Children Program	2,905,330	-143,373
4. Financial Management Reviews	-656,000	-48,000
5. Obligations Incurred But Not Reported	3,000,000	0
6. Administrative Actions Affecting Medical Assistance Payments	-120,000	-947,000
Total program decreases	5,309,330	-1,786,373
TOTAL	**$168,254,782**	**$38,630,891**

MEDICAID PROGRAM

Medicaid Requirements

(dollars in thousands)

	2007 Estimate	2008 Estimate
November 2006 State Estimates (MAP & ADM)	$196,347,380	$204,695,123
State Certification	256,900	262,000
Fraud Control Units	174,800	183,540
Total, unadjusted estimates	**$196,779,080**	**$205,140,663**
Adjustments		
Financial Management Reviews	-656,000	-704,000
Financial Adjustments for Administrative Costs	-29,612	447,013
Obligations Incurred But Not Reported	3,000,000	3,000,000
Tax Relief and Health Care Act of 2006	180,000	-20,000
Administrative Actions Affecting State and Local Administration	0	-448,000
Payment Error Rate Measurement (PERM)	4,883	5,176
Actuarial Adjustments for State Estimates	-6,872,768	-2,230,136
Administrative Actions Affecting Medical Assistance Payments	-120,000	-1,067,000
Subtotal, Adjustments	-$4,493,497	-$1,016,947
Vaccines For Children Program	$2,905,330	$2,761,957
Current law requirement	**$195,190,913**	**$206,885,673**
Unobligated Balances,		
Start of Year	-26,586,131	0
End of Year	0	0
Gross Budget Authority	**$168,604,782**	**$206,885,673**
Indefinite Authority		
Offsetting Collections	-350,000	0
Appropriation/ net budget authority	**$168,254,782**	**$206,885,673**

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

Amounts Available for Obligation
(dollars in thousands)

	2006 Actual	2007 Estimate	2008\ Estimate
Appropriation: Annual	$215,471,709	$168,254,782	$206,885,673
Appropriation: Indefinite.....	0	0	0
Unobligated balance, start of year	377,324	26,586,131	0
Unobligated balance, end of year	(26,586,131)	0	0
Recoveries of Prior Year Obligations	12,313,409	0	0
Offsetting Collections	266,125	350,000	0
Total Gross Obligations	$201,842,436	$195,190,913	$206,885,673
Medicare Part B Transfer	0	(350,000)	
Obligations Incurred but not Reported	0	(3,000,000)	(3,000,000)
Total Net Obligations	$201,842,436	$191,840,913	$203,885,673

MEDICAID

(State Submitted Estimates with Actuary Adjustments)

MEDICAL ASSISTANCE PAYMENTS BY TYPE OF SERVICE CATEGORY

(dollars in thousands)

	FY 2007		FY 2008	
	Amount	**%**	**Amount**	**%**
Ins. Pmts - MCOs	30,466,219	16.30%	$33,484,746	17.16%
Nursing Facility	27,992,189	14.98%	28,957,471	14.84%
Inpatient Hosp - Reg Pmnts	25,536,519	13.67%	25,790,893	13.22%
Home/Community Based Care	16,540,885	8.85%	17,511,923	8.97%
Prescribed Drugs	15,290,650	8.18%	16,389,298	8.40%
Inpatient DSH Adj Payment	8,640,379	4.62%	7,769,584	3.98%
All Other	7,772,611	4.16%	7,590,346	3.89%
Outpatient Hospital	7,119,875	3.81%	7,346,736	3.77%
Physician	5,963,834	3.19%	6,195,996	3.18%
Personal Care	5,450,702	2.92%	5,708,393	2.93%
Ins Pmts - Pt B Prms	4,715,848	2.52%	5,171,897	2.65%
Clinic	4,646,441	2.49%	4,805,204	2.46%
ICF/MR Public	4,603,193	2.46%	4,783,863	2.45%
Ins Pmts - Prepaid Health Plans	4,080,663	2.18%	4,493,077	2.30%
Mental Health Facilities	3,099,290	1.66%	3,276,599	1.68%
ICF/MR Private	2,917,008	1.56%	3,035,935	1.56%
Home Health	2,096,871	1.12%	2,206,312	1.13%
Dental	2,008,922	1.08%	2,152,941	1.10%
Mental Health Facilities - DSH	1,771,804	0.95%	1,988,663	1.02%
Targeted Case Management	1,734,246	0.93%	1,807,857	0.93%
Ins Pmts - Pt A Prms	1,516,559	0.81%	1,617,607	0.83%
Other Practitioners	1,309,568	0.70%	1,386,490	0.71%
Federal Qualified Health Ctr	1,128,183	0.60%	1,186,809	0.61%
Hospice	1,075,392	0.58%	1,180,615	0.61%
Ins. Pmts - Medicaid Other	895,409	0.48%	1,078,198	0.55%
Lab & Radiological	850,536	0.46%	900,340	0.46%
EPSDT Screening Services	700,063	0.37%	705,443	0.36%
Emergency Srvs Undoc Aliens *	576,085	0.31%	636,522	0.33%
Ins Pmts - Group Health Plan	336,116	0.18%	532,477	0.27%
Medicare Coins & Deduct	472,602	0.25%	500,165	0.26%
Rural Health Clinics	394,087	0.21%	425,133	0.22%
Functionally Disabled Elderly	287,854	0.15%	313,668	0.16%
Prog. of All-Inclusive Care Elderly **	183,455	0.10%	214,253	0.11%
Primary Care Case Mgt Svs	199,307	0.11%	203,530	0.10%
Sterilizations	91,949	0.05%	89,686	0.05%
Medicaid Coins & Deduct - Group Hlth	12,427	0.01%	12,588	0.01%
Abortions	43	0.00%	44	0.00%
Collections/Adjustments	(933,212)	-0.50%	(1,370,639)	-0.70%
Drug Rebate Offset	(4,671,804)	-2.50%	(4,950,527)	-2.54%
Total State Submitted Estimates	**$186,872,768**	**100.00%**	**$195,130,136**	**100.00%**
Part B - Qualified Individuals	$350,000		$0	
Actuary Adjustments	(7,222,768)		(2,230,136)	
Total	**$180,000,000**		**$192,900,000**	

* Estimates from reporting prior allotment states

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

MEDICAID PROGRAM
Proposed Law

	FY 2007	FY 2008
Streamline Administrative Match Rates		-$945,000,000
Implement Cost Allocation		-$280,000,000
Require State Reporting and Link Performance to Reimbursement		$0
Reimburse Targeted Case Management at 50 Percent		-$200,000,000
Rationalize Pharmacy Reimbursemen		-$160,000,000
Allow Optional Managed Formulary		-$160,000,000
Require Tamper Resistant Prescription Pads		-$35,000,000
Replace Best Price With Budget Neutral Rebate		$0
Expand Asset Verification Demonstration		-$65,000,000
Enhance Third Party Liability		-$10,000,000
Publish Medicaid Actuarial Report		$0
Extend Section 1915(b) Waiver Period		$0
Define Home Equity Definition at $500,000		-$70,000,000
Extend Transitional Medical Assistance	$35,000,000	$460,000,000
Modify HIPAA		$0
SCHIP Reauthorization Impact on Medicaid *		-$510,000,000
Extend Refugee Exemption		$33,000,000
SUBTOTAL	$35,000,000	-$1,942,000,000
Extend Qualified Individuals	$0	$425,000,000
TOTAL		-$1,517,000,000

* Net SCHIP reauthorization costs (SCHIP and Medicaid) are $.7 billion in FY 2008

MEDICAID PROGRAM
Vaccines for Children Program (CDC)
Obligations
(dollars in thousands)

	FY 2006 Actual	FY 2007 Estimate	FY 2008 Request	Change +/-
Intramural Research and Program Assistance	$8,828	$10,640	$10,219	-$421
Extramural Programs: Grants/Cooperative Agreements and Research Contracts	$1,940,134	$2,862,776	$2,712,355	-$150,421
Subtotal Direct	$1,948,962	$2,873,416	$2,722,574	-$150,842
Centralized Utilities, Rent, and Program Support Services	$25,333	$31,914	$39,383	$7,469
Total	$1,974,295	$2,905,330	$2,761,957	-$143,373

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 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, *$188,628,000,000*.

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.

Amounts Available for Obligation
(dollars in thousands)

	FY 2006 Enacted	FY 2007 President's Budget	FY 2007 CR Level	FY 2008 Estimate
Appropriation: Annual	$177,742,200	$197,135,795	$176,298,480	$188,628,000
Appropriation: Advance for Part D Benefits	5,216,900	---	---	---
*Appropriation: Indefinite Annual for Supplemental Medical Insurance	6,240,054	---	---	---
Lapse in Program Management	-33,203			
Lapse in General Revenue Part D: Federal Administration	-502,598	---	---	---
Lapse in General Revenue Part D: Benefits	-25,652,764	---	---	---
Lapse in General Revenue Part D: State Eligibility Determinations	-99,100	---	---	---
Total Obligations	**$162,911,489**	**$197,135,795**	**$176,298,480**	**$188,628,000**

*Amounts made available as "such sums" equal actual obligations, not full indefinite authority.

Summary of Changes

2007 CR Level	$176,298,480,000
2008 Estimate	$188,628,000,000
Net Change	+ $12,329,520,000

Changes:	FY 2007 CR Level	FY 2008 Change from Base
Federal Payment for Supplementary Medical Insurance	$137,623,000,000	+ $3,081,000,000
Hospital Insurance for the Uninsured	239,000,000	+ 30,000,000
Hospital Insurance for Uninsured Federal Annuitants	229,000,000	+ 8,000,000
Program Management Administrative Expenses	175,000,000	+ 17,000,000
General Revenue for Part D (Drug) Benefit	37,329,000,000	+ 8,970,000,000
General Revenue for Part D Federal Administration	703,480,000	+ 40,520,000
Part D: State Low-Income Determination	0	0
Reimbursement for HCFAC	0	+ 183,000,000
Net Change	$176,298,480,000	+ $12,329,520,000

Budget Authority by Activity
(dollars in thousands)

	FY 2006 Enacted	FY 2007 President's Budget	FY 2007 CR Level	FY 2008 Estimate
Supplementary Medical Insurance	$128,015,000	$139,351,000	$137,623,000	$140,704,000
Indefinite Authority for Supplementary Medical Insurance under "such sums"	7,500,000	0	0	0
Hospital Insurance for Uninsured	202,000	239,000	239,000	269,000
Hospital Insurance for Uninsured Federal Annuitants	206,000	229,000	229,000	237,000
Program Management Administrative Expenses	164,000	153,000	175,000	192,000
General Revenue for Part D Benefit	53,596,000	56,574,000	37,329,000	46,299,000
General Revenue for Part D Federal Administration	677,000	453,391	703,480	744,000
Part D: State Low-Income Determination	99,100	18,000	0	0
Reimbursement for HCFAC	0	118,404	0	183,000
Total Budget Authority	**$190,459,100**	**$197,135,795**	**$176,298,480**	**$188,628,000**

Budget Authority by Object
(dollars in thousands)

	FY 2006 Actual	FY 2007 CR Level	FY 2008 Estimate
*Grants, subsidies and contributions: Non-Drug	$128,015,000	$137,623,000	$140,704,000
Indefinite Authority for Supplementary Medical Insurance under "such sums"	7,500,000	0	0
Grants, subsidies and contributions: Drug	53,596,000	37,329,000	46,299,000
Insurance claims and indemnities	408,000	468,000	506,000
Administrative costs-General Fund Share	940,100	878,480	936,000
Total Budget Authority	**$190,459,100**	**$176,298,480**	**$188,628,000**

General Statement

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. These payments make the trust funds whole for certain costs initially borne by the trust funds which are properly charged to general funds, and 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 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. Similarly, the appropriation makes the trust funds whole for costs related to 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 that portion of the administrative costs of the Centers for Medicare & Medicaid Services, initially borne by the Hospital Insurance Trust Fund, which is properly chargeable to general funds, e.g., Federal administrative costs for the Medicaid program.

Beginning in FY 2007, this appropriation reimburses the HI Trust Fund for the cost of program integrity activities in the Part D Drug Benefit program and the Medicaid program under the HCFAC program.

This appropriation also includes the 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.

As a result of enactment of P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, new activities are funded by payments from the general fund to the new Medicare Prescription Drug Account. Most of these activities started in FY 2006.

Federal Contribution for SMI

The estimate of $140.7 billion for the FY 2008 Federal Contribution for SMI is a net increase of $3.1 billion over the FY 2007 appropriation request. The cost of the Federal match continues to rise from year to year because of beneficiary and program growth.

Hospital Insurance for the Uninsured

The FY 2008 estimate of $269 million for Hospital Insurance for the Uninsured is $30 million higher than the FY 2007 appropriation request of $239 million. Most of the amount is due to adjustments for prior years (including interest accrued) and not for FY 2008.

Hospital Insurance for the Uninsured Federal Annuitants

The FY 2008 estimate of $237 million for Hospital Insurance for Uninsured Federal Annuitants is $8 million higher than the FY 2007 appropriation request of $229 million. The estimate reflects an increase in payment amount from FY2007 to FY2008, for about the same population.

General Revenue for Part D (Benefits)

The FY 2008 estimate of $46.3 billion for General Revenue for Part D (Benefits) is $9 billion higher than the FY 2007 appropriation request of $37.3 billion. This estimate reflects increases in drug plan enrollments and benefit costs.

General Revenue for Part D Federal Administration

The FY 2008 estimate of $744 million for General Revenue for Part D Federal Administration is $41 million higher than the FY 2007 appropriation request of $703 million. This estimate reflects increases in drug plan benefit administration costs. The program is still starting up, and the level is a higher allocation because of higher Medicare Contractor costs such as 1-800 Medicare, computer systems demands, as well as the notable demand on CMS staff.

Program Management Administrative Expenses

The FY 2008 estimate of $192 million to reimburse the HI Trust Fund for Program Management administrative expenses is $17 million more than the FY 2007 appropriation request of $175 million.

Reimbursement for HCFAC

The FY 2008 estimate of $183 million reimburses the HI Trust Fund for HCFAC activities appropriately paid for by the general fund through a discretionary annual appropriation. Beginning in FY 2008, the HI Trust Fund, through the HCFAC account, will initially make available resources for new program integrity work, predominately for the Part D Drug benefits program and the Medicaid program.

Permanent Budget Authority by Activity

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. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provide funds for transitional assistance to low income beneficiaries under the Transitional Prescription Drug Card program until FY 2006.

Permanent Budget Authority
(dollars in thousands)

	FY 2006 Actual	FY 2007 President's Budget	FY 2007 CR Level	FY 2008 Estimate
Tax on OASDI Benefits	$10,319,000	$11,352,000	$10,810,000	$12,245,000
SECA Tax Credits	55	--	--	--
HCFAC, FBI	114,000	114,000	118,218	120,582
HCFAC, Criminal Fines	143,760	30,000	200,000	200,000
HCFAC, Civil Monetary Penalties	10,976	13,000	22,000	22,000
General Revenue for Transitional Drug Assistance Account	339,000	--	--	--
Transitional Assistance Outlays for Benefits (non-add)	[228,594]	--	--	--

Health Care Fraud and Abuse Control

Appropriations Language

In addition to amounts otherwise available for program integrity and program management, $183,000,000, 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, of which $137,840,000, is for the Medicare Integrity Program at the Centers for Medicare & Medicaid Services to conduct oversight of activities authorized in Titles I and II of Public Law108-173, with oversight activities including those activities listed in 18 U.S.C 1893(b); of which $17,530,000 is for the Department of Health and Human Services Office of Inspector General; of which $10,100,000 is for the Medicaid program integrity activities; and of which $17,530,000 is for the Department of Justice: Provided, That the report required by 18 U.S.C. 1817(k)(5) for FY 2008 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.

Language Analysis

Language Provision	**Explanation**
In addition to amounts otherwise available for program integrity and program management, $183,000,000 to be transferred from the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act, of which $137,840,000, is for the Medicare Integrity Program at the Centers for Medicare & Medicaid Services to conduct oversight of activities authorized in Titles I and II of Public Law108-173, with oversight activities including those activities listed in 18 U.S.C 1893(b); of which $17,530,000 is for Department of Health and Human Services Office of Inspector General; of which $10,100,000 is for the Payment Error Rate Measurement project; of which $8,765,000 is for the Federal Bureau of Investigation; and of which $8,765,000 is for the Department of Justice.	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 18 U.S.C. 1817(k)(5) for FY 2007 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

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

Health Care Fraud and Abuse Control Summary Table
Dollars in Thousands

Mandatory	FY 2006 Actual	FY 2007 President's Budget	FY 2007 CR Level	FY 2008 Estimate	Estimate +/- CR Level
Medicare Integrity Program (MIP)	$820,000	$720,000	$720,000	$720,000	$0
Medi-Medi	$12,000	$24,000	$24,000	$36,000	$12,000
FBI	$114,000	$114,000	$118,218	$120,582	$2,364
DoJ	$49,415	$49,415	$51,243	$52,268	$1,025
OIG	$160,000	$160,000	$165,920	$169,238	$3,318
Wedge	$31,143	$31,143	$32,296	$32,943	$647
Subtotal	$1,186,558	$1,098,558	$1,111,677	$1,131,031	$19,354
Discretionary					
Medicare Integrity Program (MIP)		$85,634		$137,840	$137,840
CMS PERM		$10,098		$10,100	$10,100
DoJ		$11,336		$8,765	$8,765
FBI		$0		$8,765	$8,765
OIG		$11,336		$17,530	$17,530
Subtotal		$118,404		$183,000	$183,000
Total, B.A.	$1,186,558	$1,216,962	$1,111,677	$1,314,031	$202,354

Statement of the Budget

For FY 2008, CMS is requesting a funding level of $1,314.0 million to carry out the Health Care Fraud and Abuse Control (HCFAC) program. Section 1128C of the Social Security Act established the Health Care Fraud and Abuse Control (HCFAC) program. Section 1817 of the Social Security Act established HCFAC in the Federal Hospital Insurance (HI) Trust Fund and specified the levels of funding for the activities in this account. Funds are permanently appropriated and are made available through the apportionment process. Section 1893 of the Social Security Act established the Medicare Integrity Program (MIP). The HCFAC account funds MIP and other health care fraud and abuse control activities. Funds are to be used for prosecutions of health care matters, investigations, audits, inspections, evaluations, as well as for educating consumers and providers.

In addition to MIP, funding is available for HCFAC work carried out by the Federal Bureau of Investigation (FBI). Funding levels for MIP and the FBI are specified in the statute. Funding also is available for the HHS Office of Inspector General (OIG), the Department of Justice (DOJ) and other HHS agencies. Funding other than that spelled out in statute for OIG is known as "wedge" money, a term from the original negotiations about the bill. The activities and amounts for each agency funded with wedge money are, by statute, negotiated between the Attorney General and the Secretary of HHS.

Program Description

Under the HCFAC program, reducing fraud, waste, and abuse continues to be a top priority for CMS in FY 2008. 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 of incorrect payment, 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.

Medicaid and SCHIP Financial Management

CMS expects funding in FY 2008 for Medicaid and SCHIP financial management, for projects such as:

- Enhancement of the current financial management review of State Medicaid/SCHIP programs;
- Continuation of the Payment Error Rate Measurement project; and
- Strengthening financial management staffing.

Wedge Funding for Medicare and Crosscutting Projects

In addition to MIP and drug benefit program funding, 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 using HCFAC funding in FY 2007 and FY 2008.

Rationale for the Budget

Medicare Integrity Program Activities

The MIP activity in the HCFAC account provides funds for medical review, benefit integrity, provider and Health Maintenance Organization (HMO) audits, Medicare secondary payer activities, and provider education and training.

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 support 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 finally 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.

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

MIP: Program Safeguard Contractors Background

In 1996 Congress enacted the Medicare Integrity Program (MIP) to give the CMS the authority to contract with organizations other than, but not excluding, Medicare fiscal intermediaries (FIs) which handle Part A claims and carriers, which handle Part B claims, to perform certain program safeguard functions.

CMS awarded contracts to twelve Program Safeguard Contractors (PSCs) to perform certain program safeguard functions. (Benefit integrity work and to a lesser extent, medical review, local provider education and cost report audit.) Work originally was allocated between the PSCs and the carriers and FIs. The PSCs were accountable for reducing fraud and abuse in the Medicare program. The Medicare carriers and FIs were responsible for reducing the Medicare fee-for-service claims payment error rate.

CMS gradually transitioned the program safeguard work from the Medicare carriers and FI's to the PSC's. Currently there are 17 PSC task orders addressing the benefit integrity workload formerly performed by fiscal intermediaries and carriers. Four of the benefit integrity task orders also include medical review to determine if services are reasonable and necessary.

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 A/B Medicare Administrative Contractors (MACs) through shifting workload and competition. There are 15 MAC jurisdictions. Every A/B MAC will have a corresponding PSC task order; and PSCs can have more than one task order.

A/B PSCs will not be performing straight medical review work with the exception of the single PSC that performs cost report audit work and associated postpayment medical reviews. Benefit Integrity work will remain with the PSCs. All benefit integrity and medical review work from the durable medical equipment regional carriers (DMERCs) moved to the PSCs and was subsequently aligned with the new DME MACs.

In FY 2004 the PSC model was utilized to provide oversight for the prescription drug card program under MMA. A similar approach is being used for the drug benefit program. We have contracted with the PSCs (the MEDICs) to provide oversight to the Part D program. The MEDIC is the same model as the PSCs.

MIP: Part D Drug Benefit Program Integrity

CMS is developing a comprehensive plan for a Part D oversight program building off the approach that has worked so successfully in MIP for Part A and Part B. This program will ensure that Part D contractors and other program stakeholders meet all applicable statutory, regulatory and program requirements. CMS will build into the drug benefit program strong safeguards in areas of particular vulnerability, such as:

- eligibility;
- bidding process;
- beneficiary, plan, and retail pharmacy fraud;
- incentives to reduce cost/cost sharing;
- formulary development (kickbacks);
- misuse of Part D beneficiary lists;
- and many others.

To implement this plan [*the comprehensive plan described in the preceding paragraph*] — and to enhance our efforts related to Medicare Advantage—the Administration is requesting $137.8 million to supplement the $720 million provided in the HIPAA legislation for MIP activities related to efforts with the fee-for-service fiscal intermediaries and carriers. As proposed, these funds would be appropriated as part of a discretionary cap adjustment. Unfortunately, the MMA legislation did not provide program integrity funding for the prescription drug benefit. To initiate fraud and abuse efforts in the first year of the new Part D benefit, the Deficit Reduction Act provided $100 million for MIP, as well as a dedicated stream of funding for the Medicare-Medicaid ("Medi-Medi") data match project—$36 million in FY 2008. Because to date no funds have been provided in FY 2007 for Part D program integrity, the need for this funding is pressing in order to limit the obvious risk of fraud and abuse becoming imbedded in the new program.

Four MEDIC contracts were awarded in FY 2006. Initially a MEDIC was established to perform enrollment, eligibility and marketing surveillance. This MEDIC also investigated Part D fraud complaints and made appropriate referrals to law enforcement as necessary. Three regional MEDICs were subsequently established to deal with the issues related to potential fraud, waste or abuse in the Part D program on an ongoing basis.

A major systems initiative is also a component of the Part D effort. A national data contractor is being established to support all of Program Integrity's staff, contractors and Law Enforcement partners in drilling and obtaining data. CMS will consolidate Medicare and Medicaid data across the various program integrity contractors such as the MEDICs, PSCs, MACs and CMS staff and streamline data operations and access.

MIP: Program Integrity Table

	(dollars in thousands)			
	Part A	**Part B**	**Part D**	**Total**
Audit	$208,325	$0		$208,325
MSP	83,880	60,915		144,795
Medical Review	75,440	94,610		170,050
Provider Outreach & Education	20,840	35,860		56,700
Benefit Integrity	62,580	62,380		124,960
Drug Benefit Activities			15,170	15,170
Medi-Medi	14,400	21,600	0	$36,000
Total, FY 2008	**$465,465**	**$275,365**	**$15,170**	**$756,000**

The MIP Program Integrity table (above) is our best estimate of how FY 2008 funds will be spent based on FY 2007 spending levels.

MIP: Performance Analysis

The primary performance measure of the fiscal intermediaries and carriers is their ability to reduce the fee-for-service claims payment error rate. This is being measured by the Comprehensive Error Rate Testing (CERT) contractor through a sampling of claims and an independent review. Contractors will be expected to decrease their rate to the overall national goal. Maintaining current funding levels and/or retaining the MIP workload would be dependent upon making such progress.

The contractor performance evaluation (CPE) process whereby teams of CMS staff evaluate compliance with CMS policy and directives is also utilized by a number of the programs under MIP. In addition, SAS-70 reviews, conducted by independent auditors, have been utilized to a smaller degree.

The PSC's overall objective is to reduce fraud and abuse in the Medicare program. Their performance is measured primarily by the timeliness of complaint investigation; the degree quality cases are developed for referral to OIG and their responsiveness to our law enforcement partners. In addition, their attention to cost control and relationships with CMS, law enforcement, and other Medicare contractors is examined.

The PSC evaluation process has been evolving. The CPE process similar to that employed for the fiscal intermediaries and carriers has been utilized along with a balanced scorecard approach. More recently there has been limited experimentation with the SAS-70 approach.

OMB evaluated the Medicare Integrity Program during the FY 2004 budget process, and it received an Effective score. The PART summary can be viewed at www.ExpectMore.gov. We are taking the following actions to improve the performance of the program: continue developing and implementing safeguards to protect the Medicare Advantage program and the Medicare Prescription Drug Benefit against fraud, waste and abuse; and, 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.

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 the detail of error rates through increased sampling size and rolling month error rates.

Error Rate Reduction

CMS has set a performance goal of reducing the Medicare fee-for-service claims payment error rate to 4.2 percent by the end of FY 2008. This goal supports the PMA and Secretary's strategic goal to promote the fiscal integrity of CMS programs. CMS has implemented a corrective action plan designed to minimize the vulnerabilities associated with the complexities of the Medicare payment systems and the large number of contractors, providers and insurers involved in the Medicare fee-for-service program.

In order to monitor and report the accuracy of Medicare fee-for-service payments, CMS established the Comprehensive Error Rate Testing (CERT) program. CERT uses randomly selected claims and medical records and reviews them for compliance with Medicare coverage, coding, and billing rules. Identified problems are addressed through specific corrective action plans. Contractors are expected to decrease their rate to the overall national goal.

Performance Goal	Results	Context
Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service (FFS) Program to 4.2% by 2008	In FY 2006, CMS exceeded its target of 5.1% with an error rate of 4.4%. Therefore, CMS adjusted its error rate targets downward for future years	Paying claims right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars. The purpose of this goal is to continue to reduce the percentage of improper payments made under the Medicare fee-for-service program.

MIP: 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 FBI.

Deficit Reduction Act

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 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. Lastly, the DRA provided $100 million for CMS for fiscal year 2006 for MIP.

Tax Relief Bill

The tax relief bill authorized a consumer price index increase for all mandatory funding except MIP.

Clinical Laboratory Improvement Amendments of 1988

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

CLIA Summary Table
Dollars in Thousands

	FY 2006 Actual	FY 2007 President's Budget	FY 2007 CR Level	FY 2008 Estimate	Estimate +/- CR Level
Appropriation/B.A.	$45,446	$43,000	$43,000	$43,000	---
FTEs	72	72	75	84	12

Statement of the Budget

$43,000,000 will fund the Clinical Laboratory Improvement Amendments in FY 2008.

Program Description

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 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 20,276 laboratories during the FY 2007-2008 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, 194,500 laboratories are registered with the CLIA program. Approximately 153,000 or 78.7 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 106,415, or 54.7 percent, of the laboratories registered under the CLIA program. Approximately 86,837 or 81.6 percent, of the POLs perform testing classified as waived or as provider-performed microscopy. We project this population will grow at a rate of 3.5 percent for the FY 2007-2008 survey cycle.

Rationale for the Budget

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 2007-2008 cycle include surveys of 20,276 non-accredited laboratories, State validation surveys of 802 accredited laboratories, and approximately 1,419 follow-up surveys and complaint investigations.

The CLIA program has evolved beyond the original projections of the scope and complexity of the program. 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 only submit applications to 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.

Performance Analysis

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) strengthen quality performance requirements under the Public Health Service Act and extend these requirements to all laboratories that test human specimens for health purposes. The following inset highlights our performance goal.

Performance Goal	Results	Context
Improve cytology laboratory testing through targets to (1) enroll and test 90%applicable cytotechnologists and pathologists subject to proficiency testing (PT), and (2) design and implement an effective database for tracking compliance for cytology PT requirements.	This is a new performance goal for FY 2007, using 2005 and 2006 data to set baselines for 2008 targets.	Cytology proficiency testing data will be collected in 2005 and 2006 to develop future targets to improve the percent enrollment and performance rate over time of cytotechnologists and pathologists

Medicare Benefits

The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the Nation's largest health insurance program, which covers about 45 million Americans. Medicare provides health insurance to people age 65 and over, those who have permanent kidney failure, and certain people with disabilities. For four decades, this program has helped pay medical bills for millions of older and disabled Americans, providing them with comprehensive health benefits they can count on.

CMS has successfully implemented many provisions of the Medicare Modernization Act of 2003 (MMA), including the new Medicare drug benefit and the Medicare Advantage program. Additionally, CMS is beginning to implement provisions of the Tax Relief and Health Care Act of 2006, which was signed into law on December 20, 2006. This legislation included a number of Medicare changes relating to quality, physician and provider payments, beneficiary protections and program integrity.

Medicare Performance Analysis:

The integration of CMS' Annual Performance Plan with the budget submission is illustrated below. CMS has selected representative performance measures to ensure that beneficiaries receive the high-quality care they need and depend on. In addition to the performance goals shown in other sections of this document, several are directly related to Medicare benefits and beneficiary services. For example:

Performance Goal	Results	Context
Improve Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive Baselines and FY 2008 targets related to Medicare Modernization Act (MMA) measures will be set in FY 2007.	Final FY 2005 data for the first 5-year measurement period of the Medicare Advantage portion of this goal are shown below. Due to competing priorities and in light of future changes to the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS), we were unable to determine FY 2005 Fee-for-Service performance; however, FY 2004 results were: MA Access to care: 90% (Goal not met) MA Access to specialist: 93% (Goal met) FFS Access to care: 92.0% FFS Access to specialist: 86.9% (FFS goals not met due to unavailability of FY 2005 data)	A fundamental CMS goal is to assure satisfaction in the Medicare-related experiences of our beneficiaries. Beneficiary survey responses to getting medical care when needed and being able to see a specialist were used to assess satisfaction in the first 5-year measurement period for this goal. While we did not meet our target for MA access to care, we maintained our already high level of performance. Passage of the MMA required modifications to the Medicare CAHPS. These modifications were reflected in the field-tested version implemented in four States in the summer and fall of 2006, and implemented nationally in 2007.

Performance Goal	Results	Context
Increase annual influenza (flu) and lifetime pneumococcal vaccinations for Medicare beneficiaries 65 years and older. <u>FY 2008</u> Flu – 74% (nursing home) Pneumococcal – 71%	According to the most recent data (FY 2005), at 65.2%, we did not meet our national flu target of 72.5%, and fell slightly short at 68.4% of our pneumococcal target of 69%.	Based on recent challenges concerning influenza vaccine supply and distribution, we are focusing on nursing homes where we may have greater impact. We issued a final rule requiring nursing homes to provide residents with the opportunity to be immunized against influenza and pneumococcal disease as a condition of participation in the Medicare and Medicaid programs. Our influenza targets for FY 2006 – FY 2008 (74%) reflect this change.

Medicare received a "Moderately Effective" score as a result of the PART evaluation. The PART summary can be viewed at *www.ExpectMore.gov*. CMS will continue to improve performance through the following actions: 1) increased focus on sound program and financial management, including prevention of fraud, waste and abuse; 2) timely implementation of recent legislation; and 3) strengthening the linkage between Medicare payment and provider performance.

State Children's Health Insurance Program

Authorizing Legislation
The Balanced Budget Act of 1997 (BBA), the Balanced Budget Refinement Act of 1999 (BBRA), the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), Public Law 108-74, the Deficit Reduction Act of 2005, and the National Institutes of Health Reform Act of 2006--Public Law 109-482.

State Children's Health Insurance Program Summary Table
Dollars in Thousands

	FY 2006 Actual	FY 2007 President's Budget	FY 2007 CR Level	FY 2008 Estimate	Estimate +/- CR Level
Budget Authority	$4,050,000	$5,000,000	$5,000,000	$5,000,000	0
BBRA—Additional Funding for Territories	32,400	40,000	40,000	40,000	0
Deficit Reduction Act (P.L. of 109-171)— available through Sept 30, 2006 & not available for Redistribution	283,000	0	0	0	0
Total Budget Authority	4,365,400	5,040,000	5,040,000	5,040,000	0
Redistribution from:					
FY 2003 Available through FY 2006	173,372				
*FY 2004 Available through FY 2007 to shortfall States per P.L. 109-482		146,880	146,880		
*FY 2005 Available after March 31, 2007			TBD**		
FY 2006 and following				TBD***	
Total Budgetary Resources	$4,538,772	$5,186,880	$5,186,880	$5,040,000***	

* 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.

** To be determined after the expenditures are finalized as of March 31, 2007 against the FY 2005 allotment as stated in P.L. 109-482.

*** FY 2008 is assumed in current law baseline. See proposed law section for reauthorization proposal and impact.

Statement of the Budget

From FY 1998 through FY 2007, the Balanced Budget Act of 1997 (BBA) authorized and appropriated funding for the State Children's Health Insurance Program (SCHIP) allotments to States, territories, commonwealths, and the District of Columbia. Also, the Balanced Budget Refinement Act of 1999 (BBRA) authorized and appropriated additional funding for SCHIP allotments to commonwealths and territories. The total funds that were available for CMS to grant to States, commonwealths, and territories for the State Children's Health Insurance Program in FY 2007 were $5,040,000,000. This amount is currently assumed in the SCHIP baseline for FY 2008 and beyond.

The recently enacted 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 qualifying shortfall States in FY 2007 instead of FY 2008. More information about this legislation is discussed in the Recent Legislation section below.

Program Description

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program (SCHIP) under title XXI of the Social Security Act. This program is the largest single expansion of health insurance coverage for children in more than 30 years and has improved the access to health care and quality of life for millions of vulnerable children under 19 years of age. Under title XXI, States have been given the option to expand Medicaid (title XIX) coverage, set up a separate SCHIP program, or have a combination of both a Medicaid expansion and a separate SCHIP program.

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 the flexibility of SCHIP to make innovative changes. As of January 2007, a total of 275 amendments to SCHIP plans were approved.

As of Federal Fiscal Year 2006, CMS has approved Title XXI HIFA 1115 Demonstrations in 13 States (Arkansas, Arizona, California, Colorado, Idaho, Illinois, Michigan, Nevada, New Jersey, New Mexico, Oregon, Utah and Virginia). CMS has also approved four Title XXI non-HIFA 1115 demonstrations, (Minnesota, New Jersey, Rhode Island, and Wisconsin). Many of these waivers allowed States to enroll low-income parents and other adult-caregivers of children. These States continue to be committed to the goals of the SCHIP program, including quality, access and retention.

In August 2001, the Administration announced the HIFA demonstration initiative. The primary goal of the HIFA demonstration initiative is to encourage new comprehensive State approaches that will increase the number of individuals with health insurance coverage within current-level Medicaid and SCHIP resources. The Administration places a particular emphasis on broad Statewide approaches that maximize private health insurance coverage

options and target Medicaid and SCHIP resources to populations with income below 200 percent of the FPL.

Rationale for the Budget

The State Children's Health Insurance Program (SCHIP) is a Federal-State matching capped-grant program providing health insurance to targeted low-income children in families with income above Medicaid eligibility levels. Congress authorized and appropriated $40 billion for FY1998-FY2007, with each State receiving access to a portion of the annual amount.

The FY 2008 President's Budget proposes to reauthorize SCHIP for five years, consistent with submission of a five-year Budget to the Congress, 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. Toward this end, the Budget provides approximately $5 billion over five years in additional allotment funds.

Performance Analysis

The State Children's Health Insurance Program received an Adequate score in the FY 2005 cycle. The PART summary can be viewed at www.ExpectMore.gov. As a result of the PART findings, CMS developed an SCHIP action plan to address certain concerns. 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.

In response to the PART evaluation, CMS is using portions of its budget request to fund initiatives that support efforts to increase program performance. The budget includes funds that will measure quality improvements on core performance measures, reduce the number of uninsured children and reduce SCHIP improper payments.

The performance goal is summarized below.

Performance Goal	Results	Context
Decrease the Number of Uninsured Children by Working with States to Enroll Children in SCHIP and Medicaid Future enrollment will depend on States' economic situations, changes to State plans, and budgetary issues. For FY 2008, the target is to maintain enrollment at FY 2005 levels.	FY 2005: Goal met. Enrollment in Medicaid and SCHIP increased by 3.1% over FY 2004 enrollment.	The purpose of SCHIP as stated in Title XXI of the Social Security Act is "to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children." Consistent with this purpose, and to affirm our commitment to decreasing the number of uninsured children, CMS established this goal to increase the number of children enrolled in SCHIP and Medicaid. While this goal focuses on enrolling children in Medicaid and SCHIP rather than on measuring uninsurance rates, there is overwhelming evidence that the rate of uninsurance in children has reduced since the inception of SCHIP. Although estimates of insurance coverage for children vary, a recent CDC survey found that the percentage of uninsured children dropped from 13.9% in 1997 to 8.9% in 2005.

Recent Legislation

The National Institutes of Health Reform Act of 2006 (P.L. 109-482) amended SCHIP current law. Section 201 of the NIH Reform Act requires the Secretary to redistribute unexpended FY 2004 and FY 2005 SCHIP allotments to States experiencing funding shortfalls in FY 2007. This funding is to be redistributed on a monthly basis, in the order by which States realize monthly funding shortfalls. Unexpended FY 2004 SCHIP allotments will be utilized for the first half of FY 2007 and unexpended FY 2005 SCHIP allotments will be utilized for the second half of FY 2007; redistributions will be pro rata reduced if the monthly shortfalls exceed available funding.

Unexpended FY 2005 allotments are obtained from States with unexpended FY 2005 funds as of March 31, 2007 in excess of 200 percent of the State's total projected SCHIP expenditures for FY 2007. Funds available for redistribution by each State are limited to the lesser of 50 percent of a State's unexpended FY 2005 allotment or $20 million.

The redistributed funding is restricted to coverage for populations eligible for SCHIP under the State plan on October 1, 2006. Regular Federal matching for coverage of populations other than children or pregnant women (instead of enhanced Federal matching normally available) will apply using redistributed funding.

This Act also extends the authority for qualifying States to use certain SCHIP funds for Medicaid expenditures currently in FY 2005 to now include FY 2006 and FY 2007.

Lastly, Section 201 also required the Secretary, by April 30, 2007, to submit a report to the House Energy and Commerce Committee and Senate Finance Committee on the extent to which this redistribution process has reduced shortfalls and the effect of the redistribution on the donor States.

Proposed Legislation

SCHIP legislative proposals are described below.

A. Reauthorize the State Children's Health Insurance Program (SCHIP)

The State Children's Health Insurance Program (SCHIP) is a Federal-State matching capped-grant program providing health insurance to targeted low-income children in families with income above Medicaid eligibility levels. Congress authorized and appropriated $40 billion for FY1998 through FY2007, with each State receiving access to a portion of the annual amount.

The FY 2008 President's Budget proposes to reauthorize SCHIP for five years, consistent with submission of a five-year Budget to the Congress, 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. Toward this end, the Budget provides approximately $5 billion over five years in additional allotment funds. The Budget assumes that with the additional funding States would cover fewer children under Medicaid resulting in Medicaid savings.

Five-year budget impact:	SCHIP Cost:	+$ 5.9 billion
	Medicaid Interaction:	-$1.8 billion
	Net Impact*:	+$4.2 billion

*Estimates do not add due to rounding.

B. SCHIP Certificates of Creditable Coverage

This proposal would require SCHIP programs to issue certificates of creditable coverage. Even though Medicare and Medicaid are exempt from other HIPAA requirements, they are required by statute to issue these certificates, which verify the period of time an individual was covered by a specific health insurance policy. When SCHIP was enacted, the HIPAA statute was not amended to require the program to issue certificates of creditable coverage. Therefore, some SCHIP beneficiaries have to provide other evidence of coverage causing a burden for SCHIP beneficiaries that does not exist either for Medicare or Medicaid beneficiaries. This proposal would provide greater continuity in coverage for Medicaid/SCHIP beneficiaries.

Five-year budget impact: None

C. Medicaid/SCHIP Eligibility as Qualifying Event for Employer-Sponsored Insurance

Individuals become eligible for Medicaid or SCHIP at any time during the year, but States may have to wait many months until an employer's open season to use premium assistance to help the individual buy into the employer's health insurance. The FY 2008 President's Budget proposes to make eligibility for Medicaid and SCHIP a trigger for private health insurance enrollment outside the plan's open season.

Five-year budget impact: None

State Grants and Demonstrations

Authorizing Legislation - The Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170), Title II and the Trade Act of 2002 (P.L. 107-210), Title II are the authorizing legislation for the Ticket to Work and High-Risk Pools Programs. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L.108-173) authorized the creation of the following programs: Background Checks pilot program, Federal Reimbursement for Undocumented Aliens, Infrastructure Hospital loan program, and State Pharmaceutical Assistance Program. Funds are included to carry out the provisions of Katrina/Rita Hurricane Support under the authority of P.L. 109-62. Many new program activities enacted by the Deficit Reduction Act of 2005 (P.L. 109-171) are identified later in this chapter.

State Grants and Demonstrations Summary Table
(dollars in thousands)

	FY 2006 Actual	FY 2007 President's Budget	FY 2008 Estimate	Increase or Decrease
Ticket to Work				
Section 203 – Medicaid Infrastructure Grants	$41,320	$42,849	$44,006	$1,157
Section 204 - Demonstration to Maintain Independence & Employment	$41,000	$0	$0	$0
Subtotal – Ticket to Work Appropriation/BA	**$82,320**	**$42,849**	**$44,006**	**$1,157**
MMA and Miscellaneous programs				
Background Checks – Direct Patient Access	$0	$0	$0	$0
Federal Reimbursement – Undocumented Aliens	$250,000	$250,000	$250,000	$0
State Pharmaceutical Assistance Program	$62,500	$0	$0	$0
Health Care Infrastructure Improvement Program	$0	$0	$0	$0
Katrina/Rita Hurricane Support – FEMA/HHS IA	*Note 1* $70,000	$0	$0	$0
Subtotal – MMA and Miscellaneous Programs	**$312,500**	**$250,000**	**$250,000**	**$0**

[table continued on next page]

State Grants and Demonstrations Summary Table (cont)
(dollars in thousands)

	FY 2006 Actual	FY 2007 President's Budget	FY 2008 Estimate	Increase or Decrease
DRA programs				
Qualified High-Risk Pools				
Seed Grants	$15,000	$0	$0	$0
Operations	$75,000	$0	$0	$0
Site Development Grants-Rural PACE	$7,500	$0	$0	$0
PACE outliers	$10,000	*Note 2* $10,000	$0	-$10,000
Survey of Retail Prices	$5,000	$5,000	$5,000	$0
Partnerships for Long-Term-Care	$3,200	$3,200	$3,200	$0
Alternate Non-Emergency Network Providers	$50,000	$0	$0	$0
Psychiatric Residential Treatment Demonstration	$0	$21,000	$37,000	$16,000
Money follows the Person Demonstration	$0	$248,800	$297,700	$48,900
MFP Evaluations & Technical Support	$0	$1,200	$2,300	$1,100
Medicaid Transformation Grants	$0	$75,000	$75,000	$0
Katrina Relief	$2,000,000	$0	$0	$0
Medicaid Integrity Program	$5,000	$50,000	$50,000	$0
Subtotal – DRA programs	**$2,170,700**	**$414,200**	**$470,200**	**$56,000**
Appropriation/B.A.	**$2,565,520**	**$707,049**	**$764,206**	**$57,157**
Obligations	**$2,514,913**	**$821,418**	**$786,700**	**-$34,718**

1. The $70 million in funds received from FEMA for the Katrina/Rita Support IA is a reimbursable, and is not reflected in the Total.
2. Funding for the PACE outlier payments under the DRA has been re-appropriated in Section 205 of the Tax Relief and Health Care Act of 2006 (P.L. 109-432).

TICKET TO WORK GRANT PROGRAMS

Statement of the Budget Request

In FY 2008, the projected[1] budget authority provided by statute for the Medicaid Infrastructure Grant Program is $44,006,000. Section 203 of this Act authorizes and appropriates this funding for 100 percent Federally-funded Medicaid infrastructure grants to States. Budget authority for the Demonstrations to Maintain Independence and Employment, Section 204 of this Act terminated in FY 2006.

Program Description

Title II of the Ticket to Work and Work Incentives Improvement Act of 1999 (P.L. 106-170) established two grant programs starting in FY 2001. The Medicaid Infrastructure Grant Program (section 203) of the Act is an 11-year program with appropriations of $150,000,000 over the first 5 years. Beginning in FY 2006, the funding level is tied to the Consumer Price Index for all Urban Consumers (CPI-U). The program provides 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,
- Statewide strategic planning to improve the systems serving individuals with disabilities seeking employment and foster coordinated work incentives, and
- Training and outreach programs for State Medicaid workers.

A major goal of the program is to support the establishment of Medicaid services for workers with disabilities (Medicaid buy-in).

The other program activity under section 204 provides funding for States to establish a Demonstration to Maintain Independence and Employment, providing Medicaid benefits and services to impaired workers who, without medical assistance, would potentially end up on disability. This program provides for an appropriation of $42 million for each of the fiscal years from 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.

[1] The new budget authority for the Section 203 (Medicaid Infrastructure grants) in FY 2008 is determined by calculating the amount appropriated for the preceding fiscal year increased by the percentage increase (if any) in the Consumer Price Index for all Urban Consumers (United States City average) for the preceding fiscal year.

Through FY 2007, a total of 50 entities (49 States and the District of Columbia) have been approved for funding from the Infrastructure Grant Program (Section 203). 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 , Arkansas, will continue 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. Of the $42.8 million (FY 2007) that has been appropriated for the upcoming grant year, $34.7 million was granted to the States. States continue to enroll fewer participants in Medicaid buy-in programs than Congress originally anticipated. Higher levels of funding are legislatively related to the yearly amount of Medicaid buy-in service costs expended by a State. States may be hesitant to enroll individuals in the optional buy-in category because of budget shortfalls. The remaining funding rolls over into the FY 2008 funding appropriation.

With this infrastructure funding, the recipients plan to make systemic changes that will 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 June of 2005, supplemental grant awards were made to 27 States that had Medicaid buy-in programs and Medicaid Infrastructure grants in the total amount of $3.2 million. The purpose of these awards was to provide outreach to Medicaid buy-in participants on the Medicare Part D Prescription Drug Program, since over three-fourths of the buy-in participants are dually eligible.

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 funding for Demonstrations to Maintain Independence and Employment since the program's inception. States implementing demonstration grant programs will provide Medicaid-equivalent services to targeted populations of working individuals with disabilities. The demonstration projects will be used to evaluate the impact of providing Medicaid benefits to a working person with a potentially severe disability. The State demonstration projects cover individuals with all types of disabilities including HIV/AIDS, and various mental illnesses. In FY 2006, a total of almost $73 million was obligated for the section 204 program.

Rationale for the Budget Request

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

Performance Analysis

Effective with the FY 2006 President's Budget, the Ticket to Work program has established an annual performance goal, wherein CMS will prepare an annual report for the preceding calendar year on the status of the grantees in terms of the States' outcomes in providing employment supports for people with disabilities. The performance goal is summarized in the following inset.

Performance Goal	Results	Context
Accountability through Reporting in the Medicaid Infrastructure Grant Program Using this as a management tool by providing feedback to the grantees, CMS will prepare an annual report beginning with FY 2006 on the status of the grantees in terms of the States' outcomes in providing employment supports for people with disabilities.	The first of these annual reports was prepared and shared with participating States, summarizing their progress through December 31, 2005, the fifth year of this eleven year grant program.	The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) provides CMS the responsibility for making grants to States "to support the design, establishment, and operation of State infrastructures that provide items and services to support working individuals with disabilities" (Section 203 of TWWIIA). CMS provides an annual report describing the goals established by individual grantees, their accomplishments, and the problems or issues that have arisen. This report will allow fellow grantees and interested stakeholders to judge the relative success of each grant. It will also provide examples of best practices and because of a heavy reliance on outcome measures will provide a kind of competition among the States and the ability, over several years, for a State to judge whether it is improving and making progress to the long-term program outcomes.

QUALIFIED HIGH-RISK POOLS

Statement of the Budget Request

Section 6202 of the Deficit Reduction Act of 2005 (P.L. 109-171) and the State High Risk Pool Extension Act of 2006 (P. L. 109-172) extended funding for seed and operational grants for State high risk pools. For FY 2006, the DRA authorized and appropriated $75 million for grants to help fund existing qualified State high risk pools and $15 million for seed grants to assist States to create and initially fund qualified high risk pools. The Extension Act authorizes an additional $75 million for each of fiscal years 2007 through 2010. No funds are currently appropriated beyond FY 2006.

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, unaffordable, or undesirable. 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.

Thirty-four States currently operate high risk pools. These programs target individuals who cannot otherwise obtain or afford health insurance in the private market primarily due to pre-existing health conditions and are at risk for being uninsured. 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.

CMS awarded $75 million in operation grant funds among 31 States at the end of FY 2006. In addition five States were awarded seed grants totaling $2,450,000. Since the original seed grant funding of $15 million is available for obligation until September 30, 2007, CMS plans to initiate another solicitation during the second quarter of FY 2007.

Rationale for the Budget Request

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

PILOT PROGRAM FOR NATIONAL AND STATE BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES OR PROVIDERS

Statement of the Budget Request

Funds are included to carry out the provisions of the Background Checks program authorized by the Medicare Modernization Act (MMA), section 307. The statute appropriated $25 million to the Secretary to carry out the pilot program for the period of fiscal years 2004 through 2007. CMS is the agency within the Department of Health and Human Services that has lead responsibility to administer this pilot program.

Program Description

Section 307 of the MMA directs the Secretary, in consultation with the Attorney General, to establish a pilot program to identify efficient, effective, and economical procedures for long-term care facilities or providers to conduct background checks on prospective direct patient access employees. This timely legislative mandate complements the existing HHS Nursing Home Quality Initiative (NHQI) launched on November 12, 2002. The Background Checks pilot augments the NHQI phase aimed at strengthening CMS' regulatory and enforcement activities.

Seven States (Alaska, Idaho, Illinois, Michigan, Nevada, New Mexico and Wisconsin) are receiving grants to participate in the Background Check Pilot. These States have received funding to participate in the pilot in the form of grant awards. The pilot program is evaluating procedures used by States to conduct State and national background checks for prospective direct access employees in long-term care settings, and may help to determine the impact of such background checks on abuse and neglect in nursing homes and other long-term care facilities. During FY 2005 - 2006, CMS issued grant awards totaling $20,291,607 to the seven pilot States for the three-year pilot period. To assist the pilot States with implementation, and facilitate peer networking opportunities, CMS secured the services of a national contractor. Approximately $3.0 million has been issued to the technical assistance contractor, to work with the States throughout the pilot period. In addition, as required by section 307 (d)(2) of the MMA, which earmarks up to 4 percent of the funds to be used for the evaluation, CMS has contracted with a national research entity for $1.0 million, to conduct an independent and neutral evaluation of the pilot. The evaluator submitted a draft interim report to CMS in January 2007, and the final draft evaluation is due December 2007.

Rationale for the Budget Request

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

FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS

Statement of the Budget Request

Funds are included to carry out the provisions of this program authorized by the Medicare Modernization Act (P.L. 108-173) MMA, section 1011. This section appropriates $250 million per year for FY 2005 through FY 2008. Two-thirds of these funds ($167 million) will be 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) will be allotted to the six States with the largest number of undocumented alien apprehensions.

Program Description

Section 1011 of the MMA makes funding available to pay eligible providers for furnishing emergency health services to undocumented and certain other aliens. This legislation provides $250 million per year for FY 2005 through FY 2008. Funds appropriated shall remain available until expended.

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 (EMTALA)[2] 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.

Rationale for the Budget Request

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

[2] The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals participating in Medicare to medically screen all persons seeking emergency care and provide the treatment necessary to stabilize those having an emergency condition, regardless of an individual's method of payment or insurance status.

STATE PHARMACEUTICAL ASSISTANCE PROGRAM

Statement of the Budget Request

An annual appropriation of $62.5 million for both FY 2005 and FY 2006 ($125 million in total) is provided by statute to carry out this program. There is no budget authority for this program activity past FY 2006.

Program Description

Established under the Medicare Modernization Act (P.L. 108-173), section 1860D-23(d), this program provides financial assistance to State Pharmaceutical Assistance Programs (SPAP) to educate Part D eligible individuals enrolled in the SPAPs about prescription drug coverage available through Part D of the Medicare Prescription Drug benefit. These funds may also be used by States to provide technical assistance, telephone support, and counseling for SPAP enrollees; to facilitate the selection of and enrollment into Part D plans; and for other activities designed to promote the effective coordination of enrollment, coverage, and payment between SPAPs and the Part D plans.

This new activity created by the MMA was for a period of two years. The entire FY 2005 and FY 2006 appropriations of $62.5 million for each fiscal year have been awarded and are being systematically disbursed to the eligible State SPAPs.

Rationale for the Budget Request

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

HEALTH CARE INFRASTRUCTURE IMPROVEMENT PROGRAM

Statement of the Budget Request

Funds are included to carry out the provisions of this program authorized by the Medicare Modernization Act (P.L. 108-173) MMA, section 1016. The initial legislation authorized $200 million to establish a loan program to improve hospital infrastructure including capital improvement of a qualifying hospital. Subsequently, P.L. 109-13 decreased funding by $58 million.

Program Description

Established under section 1016 of the MMA these funds are used to establish a loan program that provides loans to qualifying hospitals for payment of the capital costs of projects designed to improve the health care infrastructure of a qualifying hospital, including construction, renovation, or other capital improvements. In order to receive assistance, the statute dictates that the qualifying hospital must be engaged in cancer research; and be designated by the National Cancer Institute (NCI) as a cancer center or designated by the State legislature as the official cancer institute of the State prior to December 8, 2003.

The Secretary is authorized to forgive such loans if the hospital establishes an outreach program for cancer prevention, early diagnosis and treatment for a substantial majority of the residents of the State, a similar outreach program for multiple Indian tribes, and either unique research resources or an affiliation with an entity that has unique research resources.

The MMA created the loan program for FY 2004 through FY 2008. CMS established the implementation plan for the loan program under section 1016 in two rules which were both published in the *Federal Register* on September 30, 2005. First, the interim final rule with comment period developed a loan application process and established the selection criteria to be used to select participants from among the qualifying hospitals that submitted applications. Secondly, the proposed rule put forward the loan forgiveness criteria for qualifying hospitals who receive loans under the program. The public comment period for both rules ended on November 29, 2005. CMS received a total of only five comments on both rules. The deadline for qualifying hospitals to submit loan application to CMS was December 29, 2005.

CMS approved and granted two loans in the amounts of $100 million and $40 million. These loans were disbursed in May of 2006.

Rationale for the Budget Request

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

KATRINA/RITA HURRICANE SUPPORT

Statement of the Budget Request

A supplemental budget appropriation approved by Congress on September 8, 2005, provides disaster relief funds to the Department of Homeland Security (DHS). Congress appropriated supplemental disaster relief funds to DHS, including up to $100 million available for transfer to and merging with the "Emergency Preparedness and Response, Public Health Programs" budget for the National Disaster Medical System (NDMS) to support medical care as authorized under 42 U.S.C. 300hh-11. P. L. 109-62, 119 Stat. 1990 at 1991.

Through an interagency agreement (IA) with the Federal Emergency Management Agency (FEMA), CMS will administer reimbursements in the amount of $70 million from FEMA's Natural Disaster Medical Systems Budget. The original IA was extended on September 26, 2006 and shall remain in effect through September 30, 2007.

Program Description

In response to the public health emergencies caused by Hurricane Katrina, the DHS sought emergency supplemental funding to support medical care for hurricane victims.
The purpose of the IA is to provide funding for:

- Reimbursement of health care providers participating in the NDMS, for services provided to eligible individuals who received definitive medical care as victims of Hurricanes Katrina and Rita; and
- Definitive uncompensated medical care payments to States with approved waivers for uncompensated care pools to reimburse providers that incur uncompensated care costs for medically necessary services and supplies provided to Hurricane Katrina and Rita evacuees without other insurance coverage.

This is a new activity for CMS originating through an IA with DHS representing a bona fide need of the requesting agency and in the best interests of Government in accordance with Federal Acquisition Regulations. CMS will establish and administer mechanisms for reimbursing NDMS hospitals (and licensed practitioners providing medical services to NDMS inpatients within such facilities) for definitive medical care and for making definitive uncompensated medical care payments to States with approved waivers for uncompensated care pools to reimburse providers that incur uncompensated care costs for medically necessary services and supplies for Hurricane Katrina and Rita evacuees who do not have other coverage for such services and supplies through insurance.

Rationale for the Budget Request

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

KATRINA RELIEF

Statement of the Budget Request

The DRA authorized and appropriated for FY 2006 $2 billion to provide payments to eligible States for the health care needs of individuals affected by Hurricane Katrina. Funds are available until expended.

Program Description

Payments under Section 6201 of the DRA shall be made for the following purposes:

1) The non-Federal share of Medicaid and SCHIP expenditures for evacuees and in-State individuals receiving temporary eligibility under a Hurricane Katrina section 1115 waiver. These payments end no later than June 30, 2006, in accordance with the section 1115 waiver.

2) Total uncompensated care costs under a Hurricane Katrina section 1115 waiver for evacuees and in-state individuals who do not have any other source of health coverage, as well as total costs of uncompensated care for services not covered by the state Medicaid plan for evacuees and in-state individuals receiving temporary eligibility under a waiver. These payments end January 31, 2006, in accordance with the section 1115 waiver. Payment may not be made for items or services funded by another public or private hurricane relief effort.

3) Reasonable administrative costs, as determined by the Secretary, relating to health care provided under a Hurricane Katrina section 1115 waiver.

4) For affected counties and parishes (defined as those counties and parishes for which a disaster declaration is made with respect to Hurricane Katrina), the non-Federal share of regular Medicaid and SCHIP costs for regular Medicaid and SCHIP eligibles.

5) For other purposes approved by the Secretary at his discretion to restore health care in impacted communities.

Congress authorized this program in FY 2006. Budget authority is available until expended. CMS obligated $1.86 billion of the $2 billion in FY 2006 after a careful evaluation of the State estimates that were submitted. During 2006 about $960 million was expended to the States. CMS plans to award the remaining funds in FY 2007 after actual expenditures are reconciled.

Rationale for the Budget Request

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

MEDICAID INTEGRITY PROGRAM

Statement of the Budget Request

This program is authorized under section 6034 of the DRA and was implemented in FY 2006 with an initial funding of $5 million. The DRA authorized and appropriated permanent authority for the Medicaid Integrity Program (MIP) beginning in FY 2006.

Program Description

The Secretary must promote Medicaid integrity by entering into contracts with eligible entities to carry out certain specified activities including reviews, audits, identification of overpayments and education. Authority of $5 million in 2006 would increase to $50 million in 2007 and 2008. Beginning in FY 2009 budget authority would increase to $75 million annually each year thereafter.

Rationale for the Budget Request

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

MEDICAID TRANSFORMATION GRANTS

Statement of the Budget Request

This program is authorized by Section 6081 of the DRA which adds a new subsection, 1903 (z) to the Social Security Act. This section provides new grant funds to States for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under Medicaid. Congress authorized and appropriated $75 million for grants for FY 2007 and $75 million for FY 2008.

Program Description

Grants of $75 million per year will be made available to States in FY 2007 and FY 2008 for the adoption of innovative methods to improve the effectiveness and efficiency in providing Medicaid. Grant money may be awarded for a variety of approaches, including reducing patient error rates, improving rates of estate collection, reducing waste, fraud and abuse including improper payment rates as measured by the annual payment error rate measurement (PERM) project rates, implementation of medication risk management programs, reducing expenditures for covered outpatient drugs with high utilization and substituting generic drugs, and 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 1) design programs that target providers that treat significant numbers of Medicaid beneficiaries and also; 2) earmark 25 percent of funds for States with population increases of 5 percent or greater based on December 2005 U.S. Census data.

Note: These are the States that were determined to be those with 5% population growth

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

Section 6081(a)(4)(B) stipulates that Census Bureau data is to be used to calculate that as of July 1, 2004 the population was more than 105 percent of the population of the respective State 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 to receive payments for transformation grants.

CMS developed the State Medicaid Director (SMD) Letter/Grant Solicitation including grant criteria and released this to the States on July 25, 2006. Applications were due to CMS by October 2, 2006 at which time they were reviewed and evaluated. Awards are expected to be made during the second quarter of FY 2007.

Rationale for the Budget Request

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

SITE DEVELOPMENT GRANTS FOR RURAL PACE PROGRAMS/FUNDING FOR PACE OUTLIERS

Statement of the Budget Request

Section 5302 of the DRA appropriated $7.5 million for Federal fiscal year 2006 for rural Programs of-all-Inclusive Care for the Elderly (PACE) site development grants. During FY 2006, grants of up to $750,000 will be awarded up to 15 individual providers, with all appropriated funds available for expenditure until FY 2008. In addition to the original intent and purpose of the use of grant dollars, all grant money will also be used for designated expenses established in the DRA as expenses related to establishing or delivering PACE program services in a rural area.

Moreover, the law also establishes cost outlier protection funding for rural PACE pilot sites and appropriated $10 million in FY 2006. 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 would 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. The Tax Relief and Health Care Act of 2006 (P.L. 109-432) made these funds available for obligation through FY 2010.

Program Description

The purpose of the rural PACE provider grant program is to promote the development of programs in rural service areas. This program will also provide technical assistance outreach and education to State agencies and provider organizations interested in serving rural areas.

Section 5302 of the DRA provides for the awarding of up to 15 grants to qualified PACE providers that have been approved to serve in rural areas. The grants, not to exceed $750,000 per site, are to be used for a variety of purposes to start-up PACE sites in rural areas. The law requires that we obligate all the funds ($7.5 million) in FY 2006 to be expended through FY 2008. CMS awarded the grants to expand the PACE program in rural areas on September 28, 2006. CMS selected 15 awardees ($500,000 each) in 13 States that will maintain communication with CMS and provide quarterly reports of their progress to establish the program in their area.

The law also specifies the establishment of a technical assistance program to provide outreach and education to State agencies and provider organizations interested in setting up PACE programs in rural areas, and technical assistance to support rural PACE pilot sites.

The law also establishes cost outlier protection funding for rural PACE pilot sites. The outlier fund provides additional monies to rural PACE pilot sites which incur more than $50,000 in recognized costs in a 12-month period for PACE program eligible individuals residing in the rural areas. Funds in the amount of $10 million are available through fiscal year 2010 for obligation.

Rationale for the Budget Request

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

SURVEY OF RETAIL PRICES -

Statement of the Budget Request

Section 6001(e) of the Deficit Reduction Act (DRA) of 2005 requires the Secretary to contract with a vendor to conduct a survey of retail prices for covered outpatient prescription drugs. Five million dollars has been appropriated for each of fiscal years 2006 through 2010 to carry out the requirement. CMS will provide the overall leadership for the survey.

Program Description

The Secretary may contract for services of a vendor to determine retail survey prices (RSP) for covered outpatient drugs. The vendor must update the Secretary each time a therapeutically equivalent drug becomes available and the Secretary must have 7 days to determine if the drug is eligible for inclusion on the federal upper limit[3] (FUL) list. In addition, the provision requires the Secretary to provide information on RSP to States on at least a monthly basis.

CMS has taken the following actions to accomplish the requirement of this legislation: 1) published a proposed rule on December 22, 2006 to implement the provisions of this section, and 2) awarded a contract to IMS Health to conduct the retail price survey.

Rationale for the Budget Request

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

[3] Federal reimbursements to States for State spending for certain outpatient prescription drugs are subject to ceilings called Federal upper limits (FULs). The FUL applies, in the aggregate, to payments for multiple source drugs – those that have at least three therapeutically equivalent drug versions.

EXPANSION OF STATE LONG-TERM CARE PARTNERSHIP

Statement of the Budget Request

The Partnership for the Long-Term Care (LTC) enacted under section 6021 of the DRA, combines private LTC insurance and Medicaid to help individuals prepare financially for the possibility of needing nursing home or home care. The program allows 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. Currently there are only 4 States that allow private LTC policies with Medicaid eligibility status. The DRA expands the Partnership for Long-Term Care by giving States the authority to implement LTC partnerships. The DRA authorized and appropriated $3.2 million for FY 2006 through FY 2010 for reporting on the Partnership for LTC and for the establishment of a National Clearinghouse for LTC information.

Program Description

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.

Three million dollars is appropriated for each of fiscal years 2006 through 2010 to carry out the provisions of this section.

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). The roles of each organization would be identified as a first step. This approach continues the management structure that has been in place for Phases I and II of the Long-Term Care Awareness Campaign Demonstration Project. The two major components of this clearinghouse are:

- **Website to enhance consumer access to long term care information** – Under this component, we would expand the consumer website (www.aoa.gov/ownyourfuture) currently hosted and maintained by the Administration on Aging for the Long-Term Care Awareness Campaign. The funding needed for this activity would be approximately $110,000 for each of fiscal years 2006 through 2010.

- **Consumer education campaign to increase awareness of the need to plan for long-term care** –Campaign Model - Under this component, we would build upon the core model developed in Phases I and II of the Long-Term Care Awareness Campaign Demonstration Project, and lessons learned from their evaluations. The funding needed for this activity would be approximately $2.89 million for each of fiscal years 2006 through 2010. The core model for the Campaign is a letter from the Governor of participation states to all households with a household's member between the ages of 50 and 70. The letter encourages consumers to order the Long-Term Care Planning Kit, which provides objective information on a broad range of potential long-term care planning actions.

The National Clearinghouse for Long-Term Care Information website (located at www.longtermcare.gov) was launched in the fall of 2006. Six States were selected from 16 applications to participate in the 2006 – 2007 "Own Your Future" Awareness Campaign: Georgia, Michigan, Nebraska, South Dakota, Tennessee and Texas.

Rationale for the Budget Request

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

ALTERNATE NON-EMERGENCY NETWORK PROVIDERS

Statement of the Budget Request

Deficit Reduction Act of 2005, P.L. 109-171, enacted section 6043, Alternate Non-Emergency Network Providers. This provision adds a new subsection 1916A(e) to the Social Security Act (the 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 $50 million in Federal grant funds over 4 years for States to use for the establishment of alternate non-emergency service providers, or networks of such providers.

Program Description

Funds from this program may be used for the establishment of alternate non-emergency service providers, or networks of such providers to provide non-emergency care. States may not use funds as the State's share of the Medicaid program costs or as supplemental Disproportionate Share Hospital (DSH) payments. Grant applicants are limited to the 51 State Medicaid Agencies and the Medicaid Agencies in the Federal Territories

Under this legislation, a total of $50,000,000 over 4 years (FY 2006-2009) has been made available for the establishment of alternate non-emergency service providers or networks of such providers to provide non-emergency care. CMS will have two separate competitive grant solicitations. The first was for FY 2006 and FY 2007, and the second will be for FY 2008 and FY 2009.

Rationale for the Budget Request

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

Statement of the Budget Request

Over the last decade, psychiatric residential treatment facilities (PRTFs) have become the primary provider for youth with serious emotional disturbances requiring an institutional level of care. However, since they are not recognized as hospitals, nursing facilities or intermediate care facilities for 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 the youth in their homes and with their families.

Section 6063 of the DRA of 2005 addresses this issue by providing up to $218 million to up to 10 States to develop demonstration programs that provide home and community-based services to youth as alternatives to PRTFs. CMS anticipates awarding each successful applicant between $21.7 and $50 million. The PRTF Demonstration is authorized for up to 5 years. Payments may not be made to States after fiscal year 2011. CMS will review and approve each State's implementation plan prior to allowing States to access funds for Federal reimbursement of services under this grant. This five-year demonstration authorized by Section 6063 of the DRA provides community-based alternatives to psychiatric residential treatment facilities for individuals under the age of 21. The Secretary is authorized during the period from FY 2007 through FY 2011 to conduct demonstration projects in up to 10 States. This proposal would appropriate $218 million for the project period, and, of that amount, $1 million is made available for required interim and final evaluations and reports. Total expenditures for State demonstration projects would not be allowed to exceed $21 million in FY 2007 and funds not expended in FY 2007 will be continue to be available in subsequent fiscal years.

Program Description

Any single State Medicaid Agency, State Mental Heath Agency, or instrumentality of the State may apply for this Demonstration Grant. Only one application can be submitted for a given State. The level of care for Medicaid eligible individuals for this demonstration at a minimum 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". States shall ensure that each participant under the demonstration meets this level of care criterion to participate in the demonstration. 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. As a part of the application process, States shall submit a copy of the level of care assessment used to assess eligibility for participation in this demonstration.

In December 2007, CMS issued demonstration grants to 10 States totaling $21 million. CMS is also in the process of acquiring an evaluation contractor and expects to award a contract by April of 2007.

Rationale for the Budget Request

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

MONEY FOLLOWS THE PERSON (MFP) REBALANCING DEMONSTRATION

Statement of the Budget Request

Section 6071 of the DRA authorized and appropriated a total of $ 1.75 billion under for the Money Follows the Person (MFP) Demonstrations over the period January 1, 2007 through FY 2011. States that participate in the MFP demonstration will be awarded an enhanced Federal medical assistance percentage (FMAP) 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 a number of percentage points that is equal to 50 percent of their State share. The provision would appropriate $250 million for the portion of FY 2007 that begins on January 1, 2007, and ends 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 through FY 2011. Also, of the $1.75 billion total, up to $1.1 million from each year's appropriation in FY 2008 through FY 2011 can be used to carry out a required report to Congress.

Program Description

For more than a decade, States have been asking for the tools to modernize their Medicaid programs. With the enactment of the DRA, States now have new options to rebalance their long-term support programs to allow their Medicaid programs to be more sustainable while helping individuals achieve independence. The MFP demonstration supports State efforts to "rebalance" their long-term support systems by offering $1.75 billion over 5 years in competitive grants to States.

Specifically, the 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 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.

In early January 2007, CMS awarded grants to 17 States totaling over $23 million for FY 2007. Awarded States may be eligible for up to $900 million over 5 years. CMS is considering a second round of grants for FY 2007 and is currently acquiring both evaluation and quality assurance contracts.

Rationale for the Budget Request

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

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

Given the uncertainty of final FY 2007 appropriation levels at the time CMS developed the performance targets for the FY 2008 Congressional Justification, the FY 2007 targets were not modified to reflect differences between the President's Budget and the Continuing Resolution funding levels. Enacted funding may require modifications of the FY 2007 performance targets.

Summary of Measures and Results Table
Centers for Medicare & Medicaid Services

FY	Total Measures In Plan	Results Reported		Targets			
		Number	%	Met	Not Met		% Met
					Total	Improved	
2002	59	59	100%	45	14	9	76%
2003	63	63	100%	50	13	7	79%
2004	56	56	100%	46	10	6	82%
2005	49	49	100%	39	10	6	80%
2006	45	39	87%	37	2	n/a	95%
2007	41	n/a	n/a	n/a	n/a	n/a	n/a
2008	46	n/a	n/a	n/a	n/a	n/a	n/a

Medicare

Long Term Goal: Improve Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive			
Measure	**FY**	**Target**	**Result**
MMA Measures **Baseline:** Developmental (*outcome*)	*2008*	TBD	Sep-07
	2007	Collect data, set baselines/targets	Sep-07
	2006	Develop survey	Goal met
Access to care/specialists Medicare Advantage (MA) – Access to care. Collect and share data toward FY 2005 target. (*outcome*) **Baseline:** 90.5% (CY 2000)	*2005*	93%	90% (Goal not met
	2004	Monitor annual data toward 5-yr target	Goal met
	2003	"	Goal met
	2002	"	Goal met
MA – Access to specialist. Collect and share data toward FY 2005 target. (*outcome*) **Baseline:** 83.7% (CY 2000)	*2005*	86%	93% Goal met
	2004	Monitor annual data toward 5-yr target	Goal met
	2003	"	Goal met
	2002	"	Goal met
Medicare Fee-for-Service (MFFS) - Access to care. Collect and share data toward FY 2005 target. (*outcome*) **Baseline:** 92.8% (CY 2000)	*2005*	95%	FY 2004: 92.0% Goal not met*
	2004	Monitor annual data toward 5-yr target	Goal met
	2003	"	Goal met
	2002	"	Goal met
FFS - Access to specialist. Collect and share data toward FY 2005 target. (*outcome*) **Baseline:** 82.8% (CY 2000)	*2005*	85%	FY 2004: 86.9% Goal not met*
	2004	Monitor annual data toward 5-yr target	Goal met
	2003	"	Goal met
	2002	"	Goal met
Data Source: The Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a set of annual surveys of beneficiaries enrolled in all Medicare managed care plans and in the original Medicare fee-for-service plan. *The Medicare FFS Survey was not fielded for 2005.			
Data Validation: The Medicare CAHPS are administered according to the standardized protocols as delineated in the CAHPS 2.0 Survey and Reporting Kit developed by the Agency for Healthcare Research and Quality (AHRQ). This protocol includes two mailings of the survey instruments to randomized samples of Medicare beneficiaries in health plans and geographic areas, with telephone follow-up of non-respondents with valid telephone numbers. CAHPS data are carefully edited and cleaned prior to the creation of composite measures using techniques employed comparably in all surveys. Both non-respondent sample weights and managed care-FFS comparability weights are employed to adjust collected data for differential probabilities of sample selection, under-coverage, and item response.			
Cross Reference: This performance goal supports HHS Strategic Goals 3 and 5, and is linked to the Secretary's 500-Day Plan.			

*Not met due to unavailability of FY 2005 data.

Discussion: In response to the need to standardize the measurement of and monitor beneficiaries' experience and satisfaction with the care they receive through Medicare, CMS developed a series of data collection activities under the CAHPS. CMS fielded these surveys annually to representative samples of beneficiaries enrolled in each

Medicare managed care (later called Medicare Advantage, MA) plan as well as to those enrolled in the original Medicare fee-for-service plan (MFFS).

Passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required modifications in the Medicare CAHPS Surveys to include measurement of experience and satisfaction with the care and services provided through the new Medicare Prescription Drug Plans (PDP) as well as the MA and MFFS health plans. Through FY 2005, measures related to access to care and specialist physicians were collected for beneficiaries in MA plans. Results for the FY 2005 MA measures show that we exceeded our target for access to specialists and while we did not meet our target for access to care, we maintained our already high level of performance. Similar measures were collected for enrollees in the Original MFFS through FY 2004, but due to competing priorities and in light of the future changes to the Medicare CAHPS, the Medicare FFS survey was not fielded in FY 2005. We, therefore, were unable to determine FY 2005 FFS performance; however, we have posted FY 2004 results. These results indicate our performance for FFS access to care was much the same as the already high baseline, and show we surpassed our FFS access to specialist target. As a result of the MMA, the focus of this goal now shifts to MMA-related measures.

Planning for the new Medicare CAHPS Surveys began in FY 2005 and continued through FY 2006. In FY 2006, the goal for the Medicare CAHPS program was to develop the survey instruments and sample designs for implementing the revised MA, MFFS, and PDP surveys in January 2007. CMS continued to work with the CAHPS Consortium through the Agency for Healthcare Research and Quality, and developed a field test version of the 2006 Medicare CAHPS survey that was implemented in four States in the summer and fall of 2006. The field test results will be used to finalize the survey instruments that will then be implemented nationally in early 2007 and will ask about enrollees' experience with the Medicare health and prescription drug plans they had in 2006. These revised CAHPS measures will be reported to the beneficiaries and the general public in summer of 2007. In FY 2007, the goals will be to begin data collection and develop baseline measures of beneficiary experiences in the new plans in 2006 as well as to set target levels for these measures for FY 2008 and beyond.

Medicare

Long Term Goal: Improve Medicare's Administration of the Beneficiary Appeals Process			
Measure	**FY**	**Target**	**Result**
Improve Medicare's Administration of the Beneficiary Appeals Process **Baseline:** Developmental. Baseline data collection for Medicare + Choice (now called Medicare Advantage) Organizations (M+CO) appeals will begin in FY 2002 and continue through FY 2003.	*2008*	**Medicare Prescription Drug Program:** Enhance Medicare Appeals System (MAS) functionality and support major maintenance releases. **Medicare Advantage:** Enhance MAS functionality and support major maintenance releases. **FFS:** Enhance MAS functionality and support major maintenance releases.	Oct-08
	2007	**Medicare Advantage**: Enhance MAS functionality and support major maintenance releases **FFS**: Enhance MAS functionality and support major maintenance releases	Feb-07
	2006	**Medicare Advantage:** Fully integrate IRE data reporting into the MAS functionality **FFS**: Develop the third increment of the MAS	Goal met Goal met
	2005	**Medicare Advantage:** Begin integrating IRE data reporting into the MAS functionality. **FFS**: Develop the second increment of the MAS	Goal met Goal met
	2004	**Medicare Advantage:** Begin collection of IRE data. **FFS**: Develop the first increment of the MAS	Goal met Goal met
	2003	Developmental. **Medicare Advantage:** Enhance data collection at the Independent Review Entity (IRE) level. **FFS:** Developmental	 Goal met Goal met
	2002	Developmental. **Medicare Advantage:** Issue OPL with reporting instructions. **FFS:** Evaluate CMS' FFS appeal data needs and capabilities.	 Goal not met Goal met
	2001	Publish Operational Policy Letter (OPL) Begin collecting baseline data for Medicare Advantage.	Goal met Goal not met
	2000	Implement system for collection of Medicare Advantage appeal data.	Goal not met
Data Source: The Medicare Advantage Organization provides the IRE with appeals data to enable the IRE to report and maintain aggregate data in its system. The IRE ultimately will report data into the MAS. Aggregate FFS data are entered into the Contractor Reporting of Operational Workload Data (CROWD) system by FIs and carriers.			
Data Validation: CMS utilizes the Contractor Performance Evaluation (CPE) process to evaluate the performance of FIs and carriers.			
Cross Reference: This performance goal supports goal 5 of the HHS Strategic Plan and is linked to the Secretary's 500-Day Plan.			

Discussion: The appeals process is a critical safeguard available to all Medicare beneficiaries, allowing them to challenge denials of payment or service. Under fee-for-service (FFS) Medicare, beneficiaries and providers have the right to appeal a denial of payment by a Medicare fiscal intermediary (FI) or carrier. This appeal usually comes after the service has been provided. The appeals process takes on added significance under the Medicare Advantage (MA) program because these appeals may also involve

pre-service denials of care, thus opening the possibility of restricted access to Medicare services.

In FY 2002, a contractor performed a Business Case Analysis (BCA) of the benefits of a combined MA and FFS system. As a result, both FFS and MA information technology were combined into the Medicare Appeals System (MAS). The MAS interfaces with databases such as the Medicare Beneficiary Database, the Health Plan Management System, and the Medicare Managed Care System. The MAS is a workflow tracking and reporting system designed to support the end to end level two and level three appeals process. In the MAS, the Qualified Independent Contractors (QICs) for FFS, the Independent Review Entity (IRE) for MA, the Part D QIC, and the level three Office of Medicare Hearings and Appeals (OMHA) process and adjudicate Medicare appeals in one system.

Combined Medicare Advantage/FFS Data Collection

The first increment of the MAS has been completed. The first increment supports the FFS Part A and Part B QICs. The QICs did not begin to process appeals in the MAS until their implementation date of May 2005.

The second increment of the MAS was released into production in May of 2005. The second release of the MAS included enhanced workflow tracking and reporting capabilities for the FFS QICs, the MA IRE, and OMHA. Despite the completion of the second increment of the MAS, a decision was made to delay the use of the MAS by the IRE until January 1, 2006.

The third increment of the MAS was released into production in December of 2005 and the new Part B FFS QICs, IRE, and Part D QIC users began using the system on January 1, 2006. The third increment supports the Part D prescription drug appeals process performed by the Part D QIC and enhanced the functionality for the FFS QICs and OMHA.

CMS met the FY 2006 goal with the integration of IRE data reporting into the MAS functionality and the release of the third increment of the MAS. The incremental releases of the MAS are complete and the system is now on an operations and maintenance schedule. Therefore, CMS is revising its approach to GPRA targets for FY 2007 and FY 2008 GPRA goals. The FY 2007 and FY 2008 GPRA goals will be to enhance the MAS and support major MAS releases.

CMS is still on track to meet the FY 2007 goal and FY 2008 goals. The first major release for FY 2007 went into production on October 21, 2006. The latest release for FY 2007 (release 4.3) went into production on December 16, 2006. One additional release is scheduled for FY 2007 (August 2007). The release schedule for the FY 2008 goals is still pending.

Medicare

Long Term Goal: Implement the New Medicare Prescription Drug Benefit			
Measure	**FY**	**Target**	**Result**
Implement the New Medicare Prescription Drug Benefit **Baseline:** FY 2005 a. Percentage of people with Medicare that know that people with Medicare will be offered/are offered prescription drug coverage starting in 2006 – 47% b. Percentage of beneficiaries that know that out-of-pocket costs will vary by the Medicare prescription drug plan – 50% c. Percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same list of prescription drugs – 27%	*2008*	1. a. 63% b. 65% c. 46% 2. Publish the 2007 report card of Part D plan sponsor performance.	1. Feb-09 2. Nov-07
	2007	1. a. 62% b. 64% c. 45% 2. Publish Part D sponsor performance metrics on the Medicare Prescription Drug Plan Finder (MPDPF) tool.	1. Feb-08 2. Goal met
	2006	1. a. 49.4% b. 52.5% c. 28.4% 2. Implement a Part D Claims Data system, oversight system, and contractor management system.	1. Goal met a. 67% b. 69% c. 50% 2. Goal met
	2005	1. Develop and publish the Final Rule in the Federal Register with requirements for the new benefit. 2. Develop baselines and future targets to measure Medicare's informational activities, including beneficiary awareness of different features of the new benefit.	1. Goal met 2. Goal met
Baseline: Prior to enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, most people with Medicare did not have access to prescription drug coverage through the Medicare program.	*2004*	Develop and publish a Notice of Proposed Rulemaking in the Federal Register with requirements for the new benefit.	Goal met
Data Source: The data source is the National Medicare Education Program (NMEP) Assessment Survey, which is a nationally representative telephone survey. Starting in FY 2007, the data source will change to tracking surveys with nationally-representative samples of beneficiaries.			
Data Validation: The questions on this survey have been extensively tested with Medicare beneficiaries and the survey has been tested for reliability and validity. The NMEP Assessment Survey is subject to verification typical of survey work, including data range checks and internal consistency checks, which are done electronically at the time the responses are entered in the Computer Assisted Personal Interview (CAPI) device.			
Cross Reference: This performance goal supports goal 3 of the HHS Strategic Plan and is linked to the Secretary's 500-Day Plan.			

Discussion: The initial enrollment period for the new Medicare prescription drug benefit began on November 15, 2005 and ended on May 15, 2006. On January 1, 2006, enrolled Medicare beneficiaries could begin to fill prescriptions using the new benefit. As of June 11, 2006, 38.2 million people with Medicare are now receiving comprehensive prescription drug coverage either through Part D or another source. Current Part D enrollment data can be found on CMS' website at: www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp.

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 Medicare Prescription Drug Plan Finder (MPDPF) tool. The MPDPF offers beneficiaries useful information regarding the following performance metrics:

- Telephone Customer Service
- Complaints
- Appeals
- Information Sharing with Pharmacists
- Drug Pricing

To track beneficiary awareness and knowledge of the Medicare prescription drug program, we are going to monitor 3 measures as part of this performance goal.

- Percentage of people with Medicare that know that people with Medicare will be offered/are offered prescription drug coverage starting in 2006. Baseline percentage -- 47 percent

- Percentage of beneficiaries that know that the out-of-pocket costs will vary by the Medicare prescription drug plan. Baseline percentage -- 50 percent

- Percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same list of prescription drugs. Baseline percentage – 27 percent

Baseline data from the NMEP was collected in September 2005. Having already met our FY 2006 targets, and based on our progress to date, we amended our FY 2007 targets and beyond. Starting in FY 2007, data for this goal will be collected from tracking surveys with nationally-representative samples of beneficiaries.

Medicare

Long Term Goal: Decrease the Prevalence of Restraints in Nursing Homes			
Annual Measure	**FY**	**Target**	**Result**
Decrease the Prevalence of Restraints in Nursing Homes (*output*)	*2008*	6.1%	Feb-09
	2007	6.2%	Feb-08
	2006	6.4%	6.1% Goal met
Baseline: FY 2002: 9.3%	*2005*	6.6%	6.6% Goal met
***Measure based on MDS-QM**	*2004*	7.2%	7.3% Goal not met
Decrease the Prevalence of Restraints in Nursing Homes	*2004*	New data source	New data source
Baseline: FY 1996: 17.2% Shaded area indicates goal based on previous data.	*2003*	10%	7.8% Goal met
(See above for new data source) ***Measure based on OSCAR**	*2002*	10%	9.6% Goal met

Data Source: CMS reports physical restraints rates using the Quality Measures derived from the Minimum Data Set (MDS-QM). Nursing homes submit this information to the State MDS database, which is linked to the national MDS database. The physical restraints quality measure used is adapted from one developed by the Center for Health Systems Research and Analysis at the University of Wisconsin, Madison. We report the prevalence of physical restraints that are used continuously for at least one week, excluding side rails, in the last three months of the fiscal year. If the year is not complete, we report the most recent data available. Restraints counted on admission assessments are excluded.

Data Validation: The MDS is the source of the data used to calculate this measure. The MDS is considered to be part of the medical record. The nursing home must maintain the MDS and submit it electronically to CMS for every resident of the certified part of the nursing home. However, MDS data are self-reported by the nursing home.

MDS data quality assurance currently consists of onsite and offsite reviews by surveyors and by CMS contractors to ensure that MDS assessments are reported in a timely and complete manner. In addition, CMS is developing protocols to validate the accuracy of individual MDS items and will continue to provide training to providers on accurate completion of the MDS.

Cross Reference: This performance goal supports goals 3 and 5 of the HHS Strategic Plan and is linked to the Secretary's 500-Day Plan.

Discussion: "Physical restraints" are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. According to the law, restraints may only be imposed to treat the resident's medical symptoms, to ensure safety, and only upon the written order of a physician (except in emergency situations). Restraints should never be used for staff convenience or to punish the resident.

In establishing quality of care performance goals, CMS focused on measures that have been recognized as clinically significant and/or closely tied to care given to beneficiaries. Individuals in nursing homes are a particularly vulnerable population and, consequently, CMS places considerable importance on nursing home quality measures. A significant portion of both Medicare and Medicaid benefit dollars pay for care in nursing homes.

The reduction in the use of physical restraints has been one of CMS' major quality initiatives. The prevalence of physical restraints is an accepted indicator of quality of care and may be considered a quality of life measure for nursing home residents. The use of physical restraints can cause incontinence, pressure sores, loss of mobility, and other morbidities. Many providers and consumers still mistakenly hold, however, that restraints are necessary to prevent residents from injuring themselves.

Restraints prevalence measures for FY 2002 and 2003 were calculated using the Minimum Data Set Quality Indicators (MDS-QI). CMS started reporting the prevalence of restraints in nursing homes using the MDS-QM scores for the FY 2004 performance goal. The purpose of this change is to use a set of measurements that are more consistent with those used in CMS' public reporting initiative.

The prevalence of physical restraints in nursing homes has decreased steadily since FY 1996. Although the prevalence of physical restraints is continuing to decline, it is doing so at a slower rate. This reflects the fact that many nursing homes have achieved low restraint rates. Those that have not will require particularly energetic interventions to reduce the use of physical restraints. The targets for FY 2007 and FY 2008 have been set at rates of 6.2 and 6.1 percent, respectively. CMS met its FY 2006 target of 6.4 percent by reaching a rate of 6.1 percent.

One of the main ways in which CMS has promoted the reduced use of physical restraints is through the annual survey process. State and CMS surveyors who conduct inspections cite nursing homes for the inappropriate use of physical restraints. CMS is providing its Regional Offices (ROs) with a toolkit of resources that can be used to improve SAs performance of the survey process. Among these resources, CMS has scheduled regular sessions with RO staff in order to assist them with accurate interpretation of their States' data reports. Each RO has set its own physical restraints prevalence target and is actively working towards reducing the prevalence of physical restraints in nursing homes. CMS is also working to resolve MDS data accuracy issues and to coordinate QIO quality improvement efforts with State survey agency enforcement actions.

In addition, the Quality Improvement Organizations (QIOs), which are dedicated to working directly with individual providers to improve the quality of care delivered, play an important role in helping nursing homes reduce the use of physical restraints. The QIOs are strengthening their commitment to working with nursing homes that are facing challenges in reducing the rate of physical restraint use. We expect to see a continued reduction in the national mean rate of restraint use due to the QIO efforts.

Medicare

Long Term Goal: Decrease the Prevalence of Pressure Ulcers in Nursing Homes			
Annual Measure	**FY**	**Target**	**Result**
Decrease the Prevalence of Pressure Ulcers in Nursing Homes (*outcome*) **Baseline:** FY 2002: 8.6% ***Measure based on MDS-QM** Decrease the Prevalence of Pressure Ulcers in Nursing Homes Baseline: FY 2000: 9.8% Shaded area indicates goal based on previous data. (See above for new data source) ***Measure based on MDS-QI**	*2008*	8.5%	Feb-09
	2007	8.6%	Feb-08
	2006	8.8%	8.2% Goal met
	2005	8.8%	8.5% Goal met
	2004	8.9%	8.7% Goal met
	2004	New data source	New data source
	2003	9.5%	10.5% Goal not met
	2002	9.5%	9.8% Goal not met
Data Source: Prior to FY 2004, CMS reported the prevalence of pressure ulcers with Minimum Data Set (MDS) - Quality Indicator (QI) scores. In FY 2004, a change was made to using the quality measures (QMs) derived from the Minimum Data Set (MDS) to measure the prevalence of pressure ulcers in long term care facilities. Nursing homes submit this information to the State MDS database, which is linked to the national MDS database. The measure being used for the pressure ulcer goal is adapted from one developed by the Center for Health Systems Research and Analysis at the University of Wisconsin, Madison. For this goal, we report the prevalence of pressure ulcers measured in the last three months of the fiscal year. If the year is not complete, we report the most recent data available. The numerator consists of all residents with a pressure ulcer, stages 1-4, on the most recent assessment and the denominator is all residents. Pressure ulcers counted on admission assessments are excluded.			
Data Validation: The MDS is the source of the data used to calculate this measure. The MDS is considered to be part of the medical record. The nursing home must maintain the MDS and submit it electronically to CMS for every resident of the certified part of the nursing home. However, MDS data are self-reported by the nursing home. MDS data quality assurance currently consists of onsite and offsite reviews by surveyors and by CMS contractors to ensure that MDS assessments are reported in a timely and complete manner. In addition, CMS has renewed contract effort to develop protocols to validate the accuracy of individual MDS items and will continue to provide training to providers on accurate completion of the MDS.			
Cross Reference: This performance goal supports goals 3 and 5 of the HHS Strategic Plan, Healthy People 2010 – Initiative 1, and is linked to the Secretary's 500-Day Plan.			

Discussion: "Pressure ulcer" refers to any lesion caused by unrelieved pressure resulting in damage to underlying tissues. The development of pressure ulcers is an undesirable outcome that can be prevented in most nursing home residents, except in those whose clinical condition impedes the prevention of pressure ulcer development. CMS is committed to decreasing the prevalence of this condition in nursing homes.

Scores for FY 2002 and 2003 are calculated using the Minimum Data Set Quality Indicator (MDS-QI) scores. CMS began reporting the prevalence of pressure ulcers in nursing homes using MDS-QM scores starting in the FY 2004 performance goal. The purpose of this change was to use a set of measurements that are more consistent with those used in CMS' public reporting initiative.

CMS met its FY 2006 target of 8.6 percent by reaching a prevalence rate of 8.2 percent. The recent downward turn in pressure ulcer prevalence represents a marked change from historical upward trends. While we are encouraged by this recent downturn, we are not yet certain that it reflects a lasting trend. Therefore, the targets for FY 2007 and FY 2008 reflect modest decreases of 8.6 and 8.5 percent.

Reduction of facility-acquired pressure sores remains a high priority for the agency. A recent 12-month project, called the Collaborative Focus Facilities (CFF) showed the effectiveness of collaboration between State Survey Agencies (SAs) and Quality Improvement Organizations (QIOs). QIOs and SAs in 18 States worked with 42 nursing homes to achieve statistically significant improvements.

- High risk pressure ulcers decreased by 19 percent [v. 2 percent increase (worsening) nationwide during this same time period].
- Low risk pressure ulcers decreased by 20.7 percent among the CFF nursing homes [v. 13 percent increase (worsening) nationwide].
- Nursing homes referred by State survey agencies that participated in this pilot reduced their use of physical restraints by 27 percent compared to a 7 percent nationwide reduction in the use of physical restraints.
- Total number of deficiencies did not change dramatically, but deficiencies cited as level G (potential for serious harm) or worse, decreased by 24 percent.

The involved nursing homes had been repeatedly cited for serious deficiencies and had not improved in the past. The CFF project indicates that collaboration of both SAs and QIOs in low performing homes improves the quality of care.

CMS is working to improve the care in nursing homes – especially those that report a high prevalence of pressure ulcers – by providing its Regional Offices (ROs) with a toolkit of resources that can be used to improve SAs performance of the survey process. Among these resources, CMS has scheduled regular sessions with RO staff in order to assist them with accurate interpretation of their States' data reports. Each RO has set its own pressure ulcer prevalence target and is actively working towards reducing the prevalence of pressure ulcers in nursing homes. CMS is also working to resolve MDS data accuracy issues and to coordinate QIO quality improvement efforts with State survey agency enforcement actions.

CMS continues to work with States to set pressure ulcer prevalence goals for the coming fiscal year and to provide States with clinical and analytical support to achieve those goals. CMS has completed the preliminary phase of a pressure ulcer prevention pilot with seven volunteer State survey agencies to test refinements to survey protocols. CMS anticipates this effort will produce a more refined pressure ulcer survey process that will encourage nursing homes to reduce their pressure ulcer prevalence.

Medicare

Long Term Goal: Percentage of States that Survey All Nursing Homes at Least Every 15 Months*			
Measure	**FY**	**Target**	**Result**
Increase the percentage of States that survey all nursing homes at least every 15 months. (output) **Baseline:** Developmental	*2008*	80%	Jan-09
Data Source: Certification and Survey Provider Enhanced Reporting System (CASPER), which contains survey data on all Medicare/Medicaid-certified homes. This data is inputted by the State Survey Agencies into the Automated Survey Processing Environment (ASPEN).			
Data Validation: Under the State Performance Standards system, CMS reviews annually whether the State Survey Agencies are entering this data in a timely manner.			
Cross Reference: This performance goal supports goals (5) and (8) of the HHS Strategic Plan, the President's Management Agenda and links to the Secretary's 500 day plan.			

*Goal was developed during the Medicaid PART process.

Discussion: Sections 1819(g)(2)(A)(iii) and 1919(g)(2)(A)(iii) of the Social Security Act require that each skilled nursing facility and nursing facility be subject to a standard survey not later than 15 months after the date of the previous standard survey. These standard surveys are conducted by the State Survey Agencies, which are bound by a formal agreement with the Secretary of the Department of Health and Human Services to carry out survey and certification responsibilities.

This goal measures CMS and its survey partners' success in meeting core statutory obligations for carrying out surveys with routine frequency. Because Federal statute requires that every nursing home be surveyed at least every 15 months, CMS has made achieving this frequency a primary program goal in order to assure quality care to residents of our nation's nursing homes. If the State agency has not completed all the required surveys, it is assessed a penalty.

Medicare

Long Term Goal: Percentage of States That Survey All Home Health Agencies at Least Every 36 Months*			
Measure	**FY**	**Target**	**Result**
Increase the percentage of States that survey all home health agencies at least every 36 months. *(outcome)* **Baseline:** Developmental	*2008*	70%	Jan-09
Data Source: Information on State performance is obtained from the CMS/CMSO National Performance Standards Report.			
Data Validation: Under the State Performance Standards system, CMS reviews annually whether the State Survey Agencies are entering this data in a timely manner.			
Cross Reference: This performance goal supports goals (5) and (8) of the HHS Strategic Plan, the President's Management Agenda and links to the Secretary's 500 day plan.			

*Goal was developed during the Medicaid PART process.

Discussion: The primary mission of CMS' survey and certification program is to ensure that the nation's elderly and people with disabilities receive high quality care and adequate protections. CMS has a responsibility to purchase high value survey services, verify that the survey services are performed as contracted and assess the quality of the survey services performed.

The Social Security Act at Section 1891(c)(2)(A) requires that home health agencies be surveyed every 36 months at a minimum. At the end of each fiscal year, CMS determines whether each State survey agency has conducted the required home health agency surveys. If the State agency has not completed all the required surveys, it is assessed a penalty.

Medicare

Long Term Goal: Percentage of States for Which CMS Makes a Non-delivery Deduction from the States' Subsequent Year Survey and Certification Funds for Those States that Fail to Complete all Statutorily-Required Surveys*			
Measure	**FY**	**Target**	**Result**
Increase the number of States who incur a non-delivery deduction as a percentage of those States who fail to conduct surveys. *(outcome)* **Baseline:** Developmental	*2008*	70%	Feb-09
Data Source: Information on State performance reviews are obtained from the CMS/CMSO National Performance Standards Report. Workload data is obtained from state reported OSCAR 670 data and State Survey and Certification Workload Reports (Form-HCFA-434). The budget, expenditures, and baseline data are obtained from the State Survey Agency Budget/Expenditure Report (Form HCFA-435) and from actual appropriated funding levels.			
Data Validation: OSCAR 670 data are validated annually as part of annual on-site surveys. Form HCFA-434 and Form-435 data are validated by CMS reviews. State Agency performance reviews are conducted by CMS each fiscal year.			
Cross Reference: This performance goal supports goals (5) and (8) of the HHS Strategic Plan, the President's Management Agenda and links to the Secretary's 500 day plan.			

*Goal was developed during the Medicaid PART process.

Discussion: The primary mission of CMS' survey and certification program is to ensure that the nation's elderly and people with disabilities receive high quality care and adequate protections. CMS has a responsibility to purchase high value survey services, verify that the survey services are performed as contracted, and assess the quality of the survey services performed.

To accomplish this goal, CMS has required State agencies to first prioritize all statutorily mandated surveys. If States do not accomplish these surveys within the set timelines they are assessed a non-delivery deduction on the following fiscal year's allocation. This non-delivery deduction is based on the national average cost to complete each survey. A deduction equal to 75 percent of the estimated cost of the uncompleted nursing home or home health surveys is taken from the State Survey Agency's subsequent year's funding. The deduction cannot exceed 2 percent of the State's current survey and certification budget. The purpose of this deduction is to highlight to the States the CMS goal of completing all statutorily mandated workloads.

Medicare

Long Term Goal: Improve Beneficiary Telephone Customer Service			
Measure	**FY**	**Target**	**Result**
Improve Beneficiary Telephone Customer Service	*2008*	(1) Quality Standards: Maintain Quality Standards from the previous fiscal year (2) Implement Virtual Contact Center Strategy (VCS) initiatives for handling beneficiary inquiries.	Oct-08
	2007	(1) Quality Standards: Maintain Quality Standards from the previous fiscal year (2) Implement VCS initiatives for handling beneficiary inquiries.	Oct-07
	2006	(1) Quality Standards: Maintain Quality Standards from the previous fiscal year (2) Continue implementation of VCS initiatives for handling beneficiary inquiries.	Goal Met
	2005	(1) Quality Standards: Maintain Quality Standards from the previous fiscal year (2) Implement VCS initiatives for handling beneficiary inquiries.	Goal Met
	2004	(1) Quality Standards: --Minimum of 90 percent pass rate for Adherence to Privacy Act --Minimum of 90 percent meets expectations for Customer Skills Assessment --Minimum of 90 percent meets expectations for Knowledge Skills Assessment (KSA) (2) Continue national expansion of 1-800-MEDICARE.	Goal met
Baseline: National quality targets defined. Currently no standardization of telephone call centers; 1 pilot underway.	*2003*	(1) Quality Standards: --Minimum of 85 percent pass rate for Adherence to Privacy Act --Minimum of 90 percent meets expectations for Customer Skills Assessment --Minimum of 85 percent meets expectations for KSA (2) Begin national expansion of 1-800-MEDICARE.	Goal met
	2002	New targets in FY 2003	
Data Source: As reviewers/auditors monitor a sample of calls for each customer service representative, they record the assessment of performance on standardized Quality Call Monitoring scorecards. Criteria for rating all aspects of call handling are also standardized. Accuracy and overall quality of the calls handled in contact centers are reported monthly to CMS' Customer Service Assessment and Management System using scorecard totals.			
Data Validation: Data reported by Medicare contractors are routinely reviewed by CMS Regional Offices as part of the contractor performance evaluation process. In addition, contractor reporting is reviewed on a regular basis by CMS for compliance with established standards. CMS plans to validate the data on accuracy of response by having an independent third party sample a minimum of calls.			
Cross Reference: This performance goal supports goal 3 of the HHS Strategic Plan and is linked to the Secretary's 500-Day Plan.			

Discussion: Medicare carriers and 1-800-MEDICARE currently handle nearly 47 million telephone beneficiary inquiries annually. Beneficiary telephone customer service is a central part of CMS' customer service function, and we developed and implemented a long-term and comprehensive strategy to deliver efficient, informative and customer-focused telephone service for our beneficiaries.

We achieved our goal of the nationwide implementation of a single 800 number for beneficiary inquiries. The single 800 number improves responsiveness to our beneficiaries and also enhances contractor efficiency. We continue to measure the quality standards built over the last few years while we introduce improvements in telephone customer service via the 1-800-MEDICARE line nationwide. 1-800-MEDICARE is a single entry point for beneficiaries. Many of the CSRs have access to the systems housing beneficiary information. The 1-800-MEDICARE CSRs and some of the fee-for-service CSRs are equipped with scripts to enable them to handle any question, regardless of which contact center is answering the inquiry.

We have also developed and implemented a standard desktop for customer service representatives at the contractor contact centers. This Next Generation Desktop has been deployed at 1-800-MEDICARE, and all carrier and fiscal intermediary call centers. The desktop tool is designed to increase the consistency and accuracy of all responses to beneficiary inquiries and thus will ultimately increase the customers' satisfaction with the telephone interaction.

We are preparing to transition beneficiary call center operations to one Beneficiary Contact Center (BCC) starting in FY 2007. The BCC will be the vehicle for CMS to provide beneficiaries with a centralized operation center to handle telephone and written inquiries. All of the tools such as the desktop application, and the single 800 number will be utilized at the BCC to provide continuous call center quality improvement.

We met our FY 2006 goal by continuing the implementation of VCS initiatives for handling beneficiary inquiries and by reaching:

- 93 percent pass rate for Adherence to Privacy Act
- 97 percent meets expectations for Customer Skills Assessment
- 94 percent meets expectations for Knowledge Skills Assessment.

Medicare

Long Term Goal: Sustain Medicare Payment Timeliness Consistent with Statutory Floor and Ceiling Requirements			
Efficiency Measure	**FY**	**Target**	**Result**
Sustain Medicare Payment Timeliness Consistent with Statutory Floor and Ceiling Requirements **Baseline:** In the baseline year FY 1998, intermediaries and carriers, respectively, met statutory requirements that 95 percent of clean, electronically submitted non-Periodic Interim Payment electronic bills and 95 percent of clean, electronically submitted claims are processed between 14-30 days of receipt	*2008*	Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims.	Nov-08
	2007	Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims.	Nov-07
	2006	Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims.	Goal met
	2005	Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims.	Goal met
	2004	Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims.	Goal met
	2003	Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims.	Goal met
	2002	Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims.	Goal met
	2001	Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims.	Goal met
	2000	Maintain payment timeliness at the statutory requirement of 95 percent for electronic bills/claims in a millennium compliant environment.	Goal met
Data Source: The primary data source is the Contractor Reporting of Operational and Workload Data (CROWD) system. CROWD contains contractor-specific bills/claims processing timeliness rates. Success in achieving the desired target will be measured at the national level.			
Data Validation: CMS routinely utilizes Contractor Performance Evaluation (CPE) for determining whether intermediaries and carriers are meeting claims processing timeliness requirements. Through CPE, CMS measures and evaluates Medicare contractor performance to determine compliance with specific responsibilities defined in the contract with CMS, and also responsibilities outlined in Medicare law, regulations, and instructions.			
Cross Reference: This performance goal supports the President's Management Agenda as well as goal 3 of the HHS Strategic Plan and is linked to the Secretary's 500-Day Plan.			

Discussion: The Social Security Act, sections 1816 (c)(2) and 1842 (c)(2) establishes the mandatory timeliness requirements for Medicare claims payment to providers of services. As a result, Medicare intermediaries and carriers are required to pay 95 percent of clean electronic media bills/claims between 14 to 30 days from the date of receipt. This requirement does not include Periodic Interim Payment bills. Medicare contractors have traditionally satisfied CMS' bill/claim processing timeliness requirements. The national performance for payment of electronic bills/claims during fiscal year 2006 was 99.8 percent for intermediaries and 99.5 percent for carriers.

Medicare

Long Term Goal: Increase the Use of Electronic Commerce/Standards in Medicare			
Measure	**FY**	**Target**	**Result**
Increase the Use of Electronic Commerce/ Standards in Medicare	*2008*	(a) Electronic Media Claim (EMC) rates: intermediaries – 99%; carriers – 92%. (b) Electronic Remittance Advice (ERA) rates: intermediaries – 55%; carriers – 37%. (c) Electronic claims status volume: intermediary and carrier volumes will be maintained at the FY 2007 level. (d) Eligibility Query: targets will be set based on FY 2007 actual data	Oct-08
	2007	(a) EMC rates: intermediaries – 99%; carriers – 92%. (b) ERA rates: intermediaries – 55%; carriers – 37%. (c) Electronic claims status volume will increase by 5% from the FY 2006 level. (d) Eligibility Query: number of internet users will increase to 1,000 (e) (f) Obtain 100% Electronic Funds Transfer (EFT) for all new providers; and convert remaining physicians, suppliers, and providers not currently utilizing EFT to electronic payment.	Oct-07
	2006	(a) EMC rates: intermediaries - 97% and carriers - 85%. (b) Initial targets for ERA (based on FY 2005 data): intermediaries - 50% and carriers - 35%. Reduce the baseline FY 2005 paper remittance advice volume by 25% for both intermediaries and carriers. (c) Initial target for electronic claims status responses based FY 2005 data is an increase by 10% from FY 2005 level for both intermediaries and carriers. (d) Complete collection of eligibility query baseline data following internet implementation of eligibility query and response transaction. (e) CMS is adopting mandatory EFT for all physicians, suppliers and providers, which will constrain payment via paper checks. Reduce paper check remits by 40% and FI paper check remits by 10%.	Goal partially met (A-D met; E not met)
	2005	(a) EMC rates: intermediaries – 97% and carriers – 80%. (b) Complete analysis of baseline data for electronic claims status, ERA, and EFT, and establish preliminary goals for FY 2006. (c) Begin collection of eligibility query baseline data following completion of eligibility query and response transaction.	Goal met
	2004	(a) EMC rates: intermediaries – 97% and carriers – 80%. (b) Complete baseline data for fiscal intermediaries for electronic claims status, electronic eligibility queries, ERA, EFT, and COB transactions; for carriers for electronic eligibility queries, and for durable medical equipment regional carriers for retail drug claims.	Goal partially met (See FY 2005 Target)
	2003	(a) EMC rates: intermediaries - 97% and carriers – 80%. (b) Complete baseline data for carriers for electronic claims status, electronic eligibility queries, ERA, EFT, and COB transactions. (c) Complete implementation and testing of the HIPAA electronic transaction standards for: claims status and response, eligibility inquiry and response, prior authorization, and retail drugs claims, payments and inquiries. (d) Begin implementation of the HIPAA transaction standard for attachments.	Goal partially met (See FY 2004 Target)
	2002	(a) EMC rates: intermediaries – 97% and carriers 80%. (b) Complete implementation and testing, at Medicare contractor sites of the HIPAA Electronic Data Interchange (EDI) standards for the following Medicare transactions: electronic claims and coordination of benefits (COB), and the ERA. Begin implementation activities for the eligibility inquiries and response, and claims status inquiry and response transactions.	Goal met

Baseline: In the baseline year FY 1999, intermediaries and carriers, respectively, reached Electronic Media Claim (EMC) rates of 97.1% and 80.9%.	*2001*	(a) EMC rates: intermediaries – 97% and carriers – 80%. (b) In the third quarter of FY 2001 begin to establish baseline data for electronic claims status, electronic eligibility inquiries, and ERA and EFT transactions. (c) Begin implementation and testing, at Medicare contractor sites, the HIPAA EDI standards for the following Medicare transactions: electronic claims and coordination of benefits, ERA, eligibility inquiries and response, and claims status inquiry and response.	Goal partially met
	2000	EMC rates: intermediaries – 97% and carriers – 80% through FY 2000.	Goal met
Data Source: The data source for tracking EMC and other data is CMS' Contractor Reporting of Operational and Workload Data (CROWD) system. Medicare contractors started to separately report to CMS on status of HIPAA standards implementation and testing in FY 2002. In FY 2003, collection of baseline data for carriers began through the CROWD system for EDI transactions in addition to claims. Collection of similar data for intermediaries began in FY 2004. In FY 2006, CMS has started collecting additional data for transactions covered by HIPAA that are processed by means other than EDI (e.g. telephone) to assess the overall impact of EDI on program costs to conduct these functions. This will enable more precise goal setting and assessment of the actual impact of increased EDI use on cost.			
Data Validation: CMS routinely utilizes the Contractor Performance Evaluation (CPE) for evaluating the accuracy of contractor data reporting, including CROWD, and investigates outliers reported in any given month. Review and analysis of monthly statistics helps identify where corrective action is needed, and assess when educational articles might be helpful. The CPE measures and evaluates contractor performance to determine if contractors meet specific responsibilities defined in the contract between CMS and the contractor, and also responsibilities outlined in Medicare law, regulations, and instructions.			
Cross Reference: This performance goal supports the President's Management Agenda, goals 3 and 5 of the HHS Strategic Plan, and is linked to the Secretary's 500-Day Plan.			

Discussion: The objective of this performance goal is to maintain, and, in the long-run, increase the percentage of transactions accomplished electronically, rather than using paper format, telephone, or through another manual process. Increasing standardization and increasing the percentage of transactions performed electronically will increase the efficiency of the Medicare contractors and save Medicare administrative dollars.

Health Insurance Portability and Accountability Act (HIPAA) requires that the Secretary of HHS adopt, at a minimum, standardized electronic formats and data contents for claims, Coordination of Benefits (COB), Electronic Remittance Advice (ERA), claims status inquiry/response, eligibility inquiry/response, prior authorization, retail drugs processing, and attachments for use by the entire U.S. health care industry including health plans, and providers who conduct electronic transactions. The Secretary is encouraged to adopt further standards as warranted, and is also required to periodically adopt updates to or replacements for the previously published standards. As a result, the HIPAA transaction standards implementation and maintenance will be an ongoing project for Medicare.

CMS is continuing the process of reducing paper and increasing usage of electronic transactions. Actions like monitoring Administrative Simplification Compliance Act (ASCA) enforcement and implementation of measures to stop sending duplicate

remittance advice in paper format to providers and suppliers contribute to increases in electronic transactions. CMS developed and introduced software in FY 2006 that enables providers to view and print an electronic remittance advice. This software is free to providers and eliminates the need to receive paper remittance advice. In FY 2007, CMS plans to continue to explore other options like developing tools to allow use of the internet to increase usage of electronic transactions. CMS is already testing provider internet based eligibility inquiries.

Ongoing investigations are now performed to identify current and potential problems, and corrective actions are taken promptly. As a result of our increased scrutiny, the contractors have intensified their efforts to encourage providers and suppliers to increase use of EDI transactions. Also, CMS is adopting mandatory electronic funds transfer for all physicians, suppliers and providers, which will constrain payment via paper checks.

Due to competing priorities, we were not able to reach our FY 2006 Electronic Funds Transfer (EFT) target; however, we were able to make some progress. The FY 2007 target for EFT is to obtain 100 percent enrollment of all new providers. This will be accomplished via the revised enrollment application process for all new providers, which require a completed CMS-588 Authorization Agreement for EFT. We also plan on identifying and enrolling the remaining physicians, suppliers, and providers not currently receiving Medicare payment via EFT and convert them to electronic payment via the Provider Enrollment revalidation initiative.

Medicare

Long Term Goal: Maintain CMS' Improved Rating on Financial Statements			
Measure	**FY**	**Target**	**Result**
Maintain an unqualified opinion on CMS' FY 2007 financial statements. (*outcome*) **Baseline:** In FY 1998, one item totaling $3.6 billion was questioned by auditors resulting in a qualified opinion.	*2008*	Unqualified Opinion	Nov-08
	2007	Unqualified Opinion	Nov-07
	2006	Unqualified Opinion	Goal met
	2005	Unqualified Opinion	Goal met
	2004	Unqualified Opinion	Goal met
	2003	Unqualified Opinion	Goal met
	2002	Unqualified Opinion	Goal met
Data Source: The annual audit opinion for CMS' financial statements is issued by a CPA firm with oversight by the OIG.			
Data Validation: The CMS works closely with the OIG and CPA firm during the audit and has the opportunity to review, discuss, and/or clarify the findings, conclusions, and recommendations presented. The Government Accountability Office has the responsibility for the opinion on the consolidated government-wide financial statements, which includes oversight for the audit of HHS, of which CMS' outlays are a vast majority.			
Cross Reference: This performance goal supports the President's Management Agenda, goal 8 of the HHS Strategic Plan, and is linked to the Secretary's 500-Day Plan.			

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

Since FY 1998, we have made significant improvements in our financial statements. On the FY 1998 statements, we obtained a qualified opinion because the auditors found deficiencies in several aspects of the Medicare contractors' accounts receivable: (1) inadequate supporting documents to validate accounts receivable balances and (2) inability to reconcile subsidiary financial records to the accounting reports submitted to CMS.

CMS met its FY 2006 goal of maintaining an unqualified opinion. During FY 2006, CMS continued to improve its financial management performance in many areas. Specifically, CMS was successful in addressing the FY 2005 material weakness on the managed care benefits payment cycle which is now reported as a reportable condition. CMS also effectively transitioned two additional contractors to its Healthcare Integrated General Ledger System (HIGLAS) in FY 2006, bringing the total to seven contractors that have successfully transitioned. Since May 2005, CMS has processes approximately 113 million claims and about $73 billion in payments through HIGLAS which is now the system of record for these sites.

During FY 2006, CMS also implemented the new requirements mandated by the revised OMB Circular A-123, *Management's Responsibility for Internal Control.* In addition, we provided a statement of reasonable assurance regarding the Agency's internal controls over financial reporting.

Medicare

Long Term Goal: Implement Medicare Contracting Reform			
Measure	**FY**	**Target**	**Result**
Implement Contracting Reform **Baseline:** All Medicare claims processing work is currently conducted by 22 Medicare Fiscal Intermediaries and 17 Carriers [None (0%) of Medicare FFS claims workload has been transitioned to MACs].	*2008*	Award 100% and transition 54.1% of the Fee-for-Service (FFS) workload to Medicare Administrative Contractors (MACs).	Sep-08
	2007	Award 54.1% and transition 8.8% of the FFS workload to MACs.	Sep-07
	2006	Award 8.8% of FFS workload to MACs by September 2006.	Goal Met
	2005	Report to Congress	Goal met
Data Source: Data on fee-for-service claims contractor workload is available through CMS' current reporting systems. CMS will present progress reports on MCR to the Department of Health & Human Services, the Office of Management & Budget, and Congress on a regular basis. CMS' contract office will notify the public of MAC contract opportunities and awards in accordance with FAR.			
Data Validation: CMS staff will review all reports with cited data to ensure that the reports are accurate, complete and understandable.			
Cross Reference: This performance goal supports the President's Management Agenda as well as goals 5 and 8 in the HHS Strategic Plan, and is linked to the Secretary's 500-Day Plan.			

Discussion: Since the inception of Medicare, the Centers for Medicare & Medicaid Services (CMS) has contracted out vital program operational functions (i.e., claims processing, provider and beneficiary services, appeals, etc.) to a set of contractors known as Medicare Fiscal Intermediaries (FIs) and Carriers. In FY 2005, these contractors processed approximately 1.2 billion claims and performed their other responsibilities within a total contractor budget of approximately $1.2 billion.

Most of the FI and Carrier contracts were initiated on a non-competitive basis, and CMS renews most of these contracts each year based on satisfactory performance. An exception may occur when a contractor decides to leave the program. For example, CMS teamed with the Blue Cross Blue Shield (BCBS) Association to compete BCBS of Rhode Island's workload when that company chose to end its FI and carrier contracts in FY 2003.

On December 8, 2003, the President signed the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Section 911 of the Act establishes Medicare FFS Contracting Reform (MCR) that will be implemented over the next several years. Under this provision, CMS is to replace the current Medicare FI and Carrier contracts, using competitive procedures, with new MAC contracts by October 2011. The new MAC contracts may be renewed annually based on performance for a period of 5 years, but they must be re-competed every 5 years. The Federal Acquisition Regulations (FAR) will apply to the new MAC contracts except to the extent that any provisions in them are inconsistent with a specific Medicare requirement, and the new MAC contracts may provide for performance incentives.

In accordance with the new legislation, CMS plans to transition 100 percent of the Medicare FFS claims workload to the new MACs. CMS developed an implementation

plan for MCR, which it delivered to Congress in February of 2005. Furthermore, CMS developed an acquisition plan, a procurement strategy, and a MAC statement of work for MCR implementation.

In FY 2004, CMS concluded its FFS Incentive Pilot with three of its current contractors that tested concepts for possible incorporation into the new MAC contracts. Also, in keeping with the MMA requirement, CMS consulted with providers, beneficiary organizations, and others on the development of performance requirements and standards for the MACs. CMS evaluated all industry feedback and used the feedback, as applicable, when drafting the final procurement documents. CMS also conducted various forms of market research to prepare for the anticipated award of FFS workload under the new MAC authority in FY 2006.

On January 6, 2006, CMS awarded four contracts for durable medical equipment (DME) claims. CMS successfully implemented three of the contracts and is currently implementing the remaining contract which was delayed due to multiple protests by bidders.

On July 31, 2006, CMS awarded the A/B MAC contract for Jurisdiction 3 (Arizona, Montana, North Dakota, South Dakota, Utah and Wyoming). The A/B MAC began implementation activities to take over the claims payment work now performed by fiscal intermediaries and carriers in the 6 state jurisdiction. CMS announced on September 29, 2006, a request for proposal (RFP) for three additional primary A/B MAC contracts. The RFP covers Jurisdiction 4 (Colorado, New Mexico, Oklahoma, and Texas), Jurisdiction 5 (Iowa, Kansas, Missouri, and Nebraska), and Jurisdiction 12 (Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania). In December of 2006, CMS will compete 4 additional MAC contracts for Part A and B claims through one RFP.

CMS anticipates the award of three MAC contracts through the first RFP in July 2007, and the award of four MAC contracts in September 2007 with the second RFP. The seven remaining MAC contracts will be awarded by September 2008.

Medicare

Long Term Goal: Develop and Implement an Enterprise Architecture			
Annual Measure	**FY**	**Target**	**Result**
Develop and Implement an Enterprise Architecture (*outcome*) **Baseline:** The CMS use of Information Technology (IT) could not adequately support the future business needs of the Agency. We determined that the development of an improved Information Technology Architecture (ITA) was needed.	*2008*	Continue maturing the Enterprise Architecture (EA).	Oct-08
	2007	Continue maturing the Enterprise Architecture (EA).	Oct-07
	2006	Continue maturing the Enterprise Architecture (EA).	Goal met
	2005	Continue maturing the Enterprise Architecture (EA).	Goal met
	2004	Continue maturing the Enterprise Architecture (EA).	Goal met
	2003	Continue maturing the Enterprise Architecture (EA).	Goal met
	2002	• Continue policy and procedure development • Complete the development of System Design Reference Models and integration into SDLC activities • Monitor ITA (Enterprise Architecture) conformance for major system development.	Goal met
Data Source: Approved standards and preferred IT products are documented in the CMS Target Technical Architecture document, (http://www.cms.hhs.gov/SystemLifecycleFramework/Downloads/TargetArchitecture.pdf) All IT policies and subordinate documents are published in the Framework (http://www.cms.hhs.gov/SystemLifecycleFramework), a comprehensive library of all information relating the acquisition and creation of IT systems. A mechanism for measuring architecture maturity will be the depth and breadth of data in the Enterprise Architecture Repository (http://www.cms.hhs.gov/EnterpriseArchitecture/02_FEAF.asp)			
Data Validation: Compliance with the CMS EA standards and practices is monitored through checkpoints in the Framework that document when and where in the procurement and system development lifecycle EA reviews must take place.			
Cross Reference: The performance goal supports the President's Management Agenda and HHS Strategic Goal 5 and is linked to the Secretary's 500-Day Plan.			

Discussion

CMS, as required by the Clinger-Cohen Act of 1996, has progressed significantly in developing an integrated, enterprise-wide architecture that is aligned with CMS' strategic business objectives. EA is ensuring that IT requirements are aligned with the business processes that support CMS' mission and that a logically consistent set of policies and standards is developed to guide the engineering of CMS' IT systems. CMS' Chief

Information Officer (CIO) has overall responsibility for the EA, and the Chief Enterprise Architect oversees its development and implementation.

CMS has made substantial progress in putting into place a current EA as well as various aspects of a target EA. A mature enterprise architecture will aid decision-making related to strategic IT resource investments and supports maximum effectiveness in technology deployments across the enterprise. Successfully done, this positions CMS to meet the challenges that arise from the implementation of complex large projects.

We met our FY 2006 target to continue maturing the CMS enterprise architecture. The CMS' EA Metis model now clearly and accurately maps to the HHS, Federal Health Architecture, and Federal Enterprise Architectural structures. CMS successfully loaded and mapped all Exhibit 300 documents in the Investment layer. As CMS continues to develop future business process models for IT investments, the Metis business layer continues to grow as business process models are continually uploaded to Metis.

CMS has instituted a new intake process for evaluating new and modified investments. It precedes and links into the CMS IT Investment Management/ CPIC process. Its main purpose is to introduce an upfront business architecture review.

To meet our FY 2007 target, CMS is developing a CMS IT Strategic Plan that will outline comprehensive, and enterprise-wide information technology strategies aimed at achieving CMS business goals and objectives.

Medicare

Long Term Goal: Strengthen and Maintain Diversity at all Levels of CMS			
Measure	**FY**	**Target**	**Result**
Increase representation of EEO groups in areas where agency participation is less than the National and/or Federal baseline **Baseline**: Comparing the CMS Workforce with the 2000 National Civilian Labor Force (NCLF).	*2008*	Increase	Nov-08
	2007	Increase	Nov-07
	2006	"	Progress made
	2005	"	Progress made
	2004	"	Progress made
	2003	"	Progress made
	2002	N/A	Progress made

Data Source:

- Civilian Labor Force data derived from the Department of Labor, Bureau of Labor Statistics' Annual Current Population Survey and 2000 official decennial census figures[1]
- The 2000 official decennial census figures
- OPM's Central Personnel Data File (updated every pay period)
- HHS' Workforce Inventory Profile System (WIPS) (updated every pay period)
- The CMS Workforce Profiles (prepared using WIPS)

Data Validation:

- 2000 Civilian Labor Force data - Validated and verified by the Census Bureau
- Civilian Labor Force data derived from the Department of Labor, Bureau of Labor Statistics' Annual Current Population Survey and 2000 official decennial census figures - Validated and verified by OPM. These are the standard government-wide statistics.
- Central Personnel Data File - Validated and verified by OPM.
- HHS' Workforce Inventory Profile System (WIPS) - Validated and verified by HHS.
- The CMS Workforce Profiles – Validated and verified by CMS.

Cross Reference: This performance goal supports HHS Strategic Goal 8 and the President's Management Agenda, and is linked to the Secretary's 500-Day Plan and CMS' Strategic Plan.

Discussion: Workforce diversity has evolved from sound public policy to a strategic business imperative. Focusing on diversity and looking for more ways to be a truly inclusive organization, one that makes full use of the contributions of all employees, is a good business practice that yields greater productivity and competitive advantage. Diversity management programs are recognized as being a critical link in achieving the Agency's specific mission, relative to employees, customers, suppliers, and other stakeholders. This is the business case for valuing diversity.

CMS' effectiveness in managing its large and important programs depends on the capabilities of its staff. CMS places high emphasis on attracting and developing skilled, dedicated professionals. The Agency is committed to maintaining an effective affirmative employment program that is consistent with the requirements set forth in the U.S. Equal Employment Opportunity Commission's (EEOC) Management Directive (MD) 715 for all areas within the agency's purview that provides full employment opportunities for all employees and applicants for employment. The Agency continues to monitor and assess its equal employment opportunity program against the EEOC standards.

[1] EEOC Office of Federal Sector Programs requires agencies to use current, official Census Bureau Civilian Labor Force data to analyze the Federal workforce.

Equal employment opportunity is a core value at CMS. The Agency's equal employment opportunity program aims to successfully integrate access, inclusion and equality of opportunity into the Agency's mission and align equal employment opportunity principles with its strategic plans and objectives. The Agency's newly initiated Strategic Action Plan clearly articulates a strong commitment to maintaining a skilled, highly-motivated and diverse workforce.

All Federal agencies strive to reach the thresholds established by the National Civilian Labor Force (NCLF). By doing so, we ensure the diversity we seek, since the NCLF is comprised of persons age 16 and over, excluding those in the Armed Forces, who are employed or seeking employment. Federal agencies are required by regulation to monitor the representation of all EEO groups each year and to report Agency activities and accomplishments to the Equal Employment Opportunity Commission (EEOC) and the Office of Personnel Management (OPM). CMS understands its ongoing obligation to eliminate barriers that impede free and open competition in the workplace and prevent individuals of any racial or national origin group or either sex from realizing their full potential. As part of this ongoing obligation, CMS conducts a self-assessment on at least an annual basis to monitor progress and identify areas where barriers operate to exclude certain groups.

The CMS Administrator and other senior management officials continue to demonstrate a firm commitment to equality of opportunity for all employees and applicants for employment by activity implementing the essential elements published by the EEOC. The MD-715 identifies six essential elements for a "model agency" and mandates that CMS models its programs accordingly. The six essential elements are

- A demonstrated commitment from agency leadership
- Integration of EEO into the Agency's strategic mission
- Management and program accountability
- Proactive prevention of unlawful discrimination
- Efficiency
- Responsiveness and legal compliance

Strategies that will bring improvement include: communicating the Agency leadership's strong commitment to diversity, workforce planning, conducting effective outreach and recruitment, utilizing hiring flexibilities, maintaining a supportive work environment, providing development and training opportunities (upward mobility programs), monitoring activities and making adjustments as needed, establishing accountability, rewarding success, and continuously educating and communicating the value of diversity.

CMS has made some progress in achieving its diversity goals by increasing representation in certain EEO groups. Non-white EEO groups accounted for 34.61 percent of the CMS permanent workforce in FY 2006. This represents an increase from FY 2005 and exceeds the overall representation as reflected in the NCLF of 27.2 percent (based on 2000 Census statistics). Women comprised 66.44 percent of the total CMS permanent workforce in FY 2006, compared to a NCLF representation of 46.8 percent. Additionally, the FY 2006 participation rates of African American females,

all American Indians, Asian American females, and White females in the CMS permanent workforce meet or exceed their 2000 NCLF cohort participation rates.

Hispanics, African American male, Asian male and White male representation at CMS is below the NCLF. The agency is launching an aggressive strategy to eliminate any potential barriers and increase participation rates. CMS has been successful, however, in increasing the participation rate of individuals with targeted disabilities. From FY 2005 to FY 2006, CMS increased the number of such-identified employees from 88 to 96 thereby increasing its participation rate from 1.9 percent to 2.1 percent. This more than doubles the Department of Health and Human Services participation rate and nearly equals the Federal Benchmark.

Medicare

Long Term Goal: Implement Regional PPOs			
Measure	**FY**	**Target**	**Result**
Implement Regional PPOs **Baseline:** Prior to the mandate of the new Medicare Prescription Drug and Modernization Act (MMA) of 2003, regional Preferred Provider Organizations (PPOs) did not exist. CMS must implement a Regional PPO program.	*2008*	Through the addition of regional PPOs, the span of coordinated care options will increase so they extend to 87% of Medicare beneficiaries.	Jan-08
	2007	Through the addition of regional PPOs, the span of coordinated care options will increase so they extend to 87% of Medicare beneficiaries.	Goal met
	2006	Through the addition of regional PPOs, the span of coordinated care options will increase so they extend to 70% of Medicare beneficiaries.	Goal met
Data Source: CMS will monitor and maintain the contract service area and the beneficiary enrollment by service area. These data points will validate the penetration of regional PPOs by service area and the number of beneficiaries enrolled in each plan. This information will also validate the expansion of coordinated care plans and the percentage of enrollees affected by the expansion. To capture these data points, CMS will extract data from the Medicare Beneficiary Database (MDB) and the Medicare Advantage Rx (MARx) database.			
Data Validation: The Health Plan Management System (HPMS) also contains a system of record for plan service areas. CMS validates the plan service areas against the official contract service areas and the Medicare Advantage organizations themselves also validate these service areas.			
Cross Reference: This performance goal supports goal 3 of the HHS Strategic Plan and is linked to the Secretary's 500-Day Plan.			

Discussion: Prior to 2006, Medicare Advantage (MA) plans, (formerly M+C plans), operated with minimal or no enrollment in most rural areas. The Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 expanded the definition of coordinated care plans to include Regional Preferred Provider Organizations (PPOs). RPPOs were created to facilitate access to the advantages of coordinated care, to all beneficiaries, especially beneficiaries in rural areas. RPPOs, like other PPOs (1) contract with a network of providers that have agreed with the organization offering the plan, to a contractually specified reimbursement for covered benefits; and (2) reimburse for all covered benefits, provided any place in their service area, regardless of whether such benefits are provided within such a network. The feature distinguishing RPPOs from other PPOs is that they must have (3) a service area that spans one or more entire MA regions. The geographic demarcations of the 26 RPPO regions was established by the Secretary on December 6, 2004.

CMS implemented the Regional PPO program through coordinated efforts within the agency to ensure timely processing of applications; appropriateness of payments; early availability of outreach and marketing materials to notify beneficiaries of this new option; availability of scripts and information by the 1-800-MEDICARE line to answer beneficiary questions; and existence of appropriate enrollment mechanisms to ensure that beneficiaries are able to enroll in the program.

CMS met its FY 2006 goal of having Regional Plan options available to 70 percent of the Medicare beneficiary population. In fact, for FY 2006, Regional PPOs are available as

an option to 87 percent of Medicare beneficiaries. CMS will also meet its FY 2007 goal, as no Medicare Advantage Organizations have withdrawn from the program.

CMS will continue to monitor the penetration of Regional PPO plans. The ultimate success of Regional PPOs will depend on the health plans' continued determination that the Regional approach is feasible. In CY 2007, CMS can utilize the stabilization fund, created under the MMA, to incentivize Regional PPOs to remain in areas with below-national-average MA market penetration or enter MA regions with no RPPO participation.

Medicare

Long Term Goal: Assure the Purchase of Quality, Value and Performance in State Survey and Certification Activities ***(Discontinued after FY 2007)***			
Annual Measure	**FY**	**Target**	**Result**
Develop and implement a measure to allocate State survey and certification funding in a manner that links value to quality performance. (*outcome*)	*2008*	Goal retired.	
	2007	Continue ongoing effort in State Survey and Certification budget allocation methods by; **1. <u>Allocations</u>**: Allocate at least 75% of any survey & certification resource increase primarily according to the workload-sensitive Budget Allocation Tool (BAT). **<u>2. Non-Delivery Deductions</u>**: For states that fail to accomplish 100% of the statutorily-required surveys, deduct at least 75% of the average estimated cost of the non-delivered surveys from the agency's next-year budget allocation	Feb-08
Implement Budget Allocation Method	*2006*	Implement a State Survey and Certification budget allocation method	Feb-07
	2005	Continue to develop a State Survey and Certification budget allocation method	Goal Met
Baseline: Developmental	*2004*	Develop a State Survey and Certification budget allocation method that allocates available resources for State agencies in a manner that promotes high levels of State performance and value-based purchasing of survey activities on the part of CMS.	Goal met
Data Source: Information on State performance reviews are obtained from the CMS/CMSO National Performance Standards Report. Workload data is obtained from State-reported OSCAR 670 data and State Survey and Certification Workload Reports (Form HCFA-434). The budget, expenditures, and baseline data are obtained from the State Survey Agency Budget/Expenditure Report (Form HCFA-435) and from actual appropriated funding levels.			
Data Validation: OSCAR 670 data are validated annually as part of annual onsite surveys. Form HCFA-434 and Form HCFA-435 data are validated by CMS reviews. State Agency performance reviews are conducted by CMS each fiscal year.			
Cross Reference: This performance goal supports goals 5 and 8 of the HHS Strategic Plan, the President's Management Agenda and links to the Secretary's 500-Day Plan.			

Discussion: The primary mission of CMS' survey and certification program is to ensure that the nation's elderly and people with disabilities receive high quality care and adequate protections. CMS has a responsibility to purchase high value survey services, verify that the survey services are performed as contracted, and assess the quality of the survey services performed.

To accomplish the above objectives, CMS has begun to move from a price-based budget development and execution model to a value-based model. In 2001 through 2004, increases to the State survey and certification budget were allocated using price-based boundaries: States only received a budget increase if their average hours per survey were within 115 percent of the national average. Moreover, CMS has designed and implemented a system of State performance indicators for survey and certification activities. Seven (7) performance measures were implemented in FY 2001 on a test basis, were fully deployed in 2002, and further refined in 2003, 2004, and 2005.

The performance measures include analysis for long-term care and non-long-term care State survey activities specific to: Timeliness of States in conducting federal surveys, including complaint investigations; Federal Monitoring Survey oversight activities; Adherence to immediate jeopardy and actual harm enforcement processes; Monitoring of federal spending for expenditures and charges; Timeliness of data processing and entry into the CMS national database (OSCAR/ASPEN); and Documentation of deficiency citations.

The performance standards include: (1) Surveys are planned, scheduled and conducted timely; (2) Survey findings are supportable; (3) Certifications are fully documented, and consistent with applicable law, regulations and general instructions; (4) When certifying noncompliance, adverse action procedures set forth in regulations and general instructions are adhered to (Excludes Clinical Laboratory Improvement Amendments (CLIA)); (5) The conduct and reporting of complaint investigations, both long-term care and hospital complaints, including hospital Emergency Medical Treatment And Labor Act (EMTALA) complaints, are timely and accurate, and comply with general instructions for complaint handling and with the State's own policies and procedures; (6) Accurate and timely data is entered into online survey and certification data systems.

CMS is committed to increased focus on the assurance of purchasing quality, value, and performance in State survey and certification activities. The foundation of this commitment and focus is based on the recent development and broadening of the standards to include other provider types outside of long-term care, and implementation by CMS of the seven State performance measures, as well as the successful CMS efforts (since FY 2001) in meeting Performance Goal: Improve the Management of the Survey and Certification Budget Development and Execution Process and developing Performance Goal: Assure the Purchase of Quality, Value and Performance in State Survey and Certification Activities.

Actual performance data for 2002, 2003, and 2004 activities have been collected and analyzed. We are using such available performance data to develop and implement a measure that moves toward the linking of value and performance to bolster the importance of the quality of surveys; the overall State performance in completing the required number and frequency of surveys; and the effective performance of State survey agencies in taking remedial action on complaints and deficiencies. The measure is incorporated in the allocations process for survey and certification in FY 2004 and FY 2005.

CMS met its FY 2004 and FY 2005 targets to develop a State Survey and Certification budget allocation method for State agencies. State agencies have been provided the results of the FY 2005 State Performance Standards and CMS is continuing to monitor and evaluate the impact of the enhanced FY 2006 State Performance Standards. Furthermore, CMS continues working with States on the development of enhancements to the FY 2007 State Performance Standards.

Medicare

Long Term Goal: Improve CMS' Information Systems Security ***(Discontinued after FY 2006)***			
Measure	**FY**	**Target**	**Result**
Improve CMS' Information Systems Security Baseline: The 1997 OIG electronic data processing (EDP) audit for CMS' Central Office showed one material weakness and 31 reportable conditions, and four material weaknesses and 102 reportable conditions for Medicare contractor systems. In Central Office, there was a material weakness in the control of access to production data. In the contractor area, there was one material weakness in physical access and three in the control of local modifications or overrides to shared system applications and edits programs. Reportable conditions were found in all seven categories of evaluation.	*2007*	Goal discontinued.	N/A
	2006	Accredit Medicare Systems	Goal met
	2005	Eliminate all CFO EDP audit findings attributable to inadequate management oversight by September 30, 2005	Goal met
	2004	1) Achieve zero material weaknesses 2) Accredit security plans	1) Goal not met 2) Goal met
	2003	1) Eliminate all material weaknesses 2) Implement access control management system	1) Goal not met 2) Goal met
	2002	1) Eliminate all material weaknesses 2) Evaluate Medicare contractors' security profile and apply baseline to CMS' business partners Implement intrusion detection and response procedure	1) Goal not met 2) Goal met
Data Source: CMS will retain documents to support its progress on the Performance Goal. OIG audit findings, CMS' review findings, and associated corrective actions will be the primary data sources for the CFO EDP audit portion of this goal.			
Data Validation: Audit and review findings are reviewed by information security personnel and verified by systems owners.			
Cross Reference: This performance goal supports HHS Strategic Goal 2 and is linked to the Secretary's 500-Day Plan.			

The CMS is fully committed to fulfilling its stewardship responsibilities for the information contained in its data systems and transported across its networks.

In FY 2005, CMS adopted a multi-tier strategy to address the material weakness. The short term strategy for FY 2005 is to correct all vulnerabilities attributable to inadequate management oversight from whatever source before the next scheduled audit. We requested, received and reviewed corrective action plans (CAPs) from the Medicare contractors and Central Office staff. Many of the CAPs were found to be lacking, so a series of face-to-face meetings and teleconferences were held. These meetings conveyed to the contractors the specific actions they needed to take to close the findings. In addition, we met our FY 2006 goal of addressing root causes by stressing the need to deal with underlying issues in all of the meetings.

Elimination of the material weakness is challenged by the decentralized nature of Medicare operations and the complexity of fee-for-service processing. The CMS Modernization program represents the long-term solution to simplify the Medicare system and establish more robust security.

Long Term Goal: Assess the Relationship between CMS Research Investments and Program Improvements ***(Discontinued after FY 2006)***			
Measure	**FY**	**Target**	**Result**
Assess the Relationship between CMS Research Investments and Program Improvements	*2007*	Goal discontinued	N/A
	2006	Conduct internal assessment	Goal met
	2005	Conduct internal and external assessments	Goal met
	2004	Conduct internal assessment	Goal met
	2003	Conduct internal assessment	Goal met
	2002	Repeat internal and external assessments	Goal met
	2001	Repeat internal assessment; conduct initial external review	Goal met
	2000	Conduct Internal and external assessments	Goal met
	1999	Develop goal for 2000	Goal met
Data Source: CMS developed an assessment report for evaluating its research efforts. Data sources used for this report include the CMS R&D Plan, legislation that mandates CMS research activities, and other documents produced under CMS research, demonstration, and evaluation projects.			
Data Validation: The application of research effectiveness criteria combines internal self-assessment and review by external experts. All CMS components responsible for research and demonstration projects are involved in the self-assessment process. The external experts are drawn from highly credible researchers familiar with both CMS programs and the national scope of health care research.			
Cross Reference: This performance goal supports the President's Management Agenda, and is linked to the Secretary's 500-Day Plan.			

Discussion: The purpose of CMS' research program is to provide CMS and the health care policy community with objective analyses and information to foster improvement in CMS programs and to guide the Agency in its future direction. The CMS research and development (R&D) functions are to develop, test and implement new health care financing policies and to monitor and evaluate the impact of CMS' programs on its beneficiaries, providers, States, and other customers and partners. In addition, CMS' research program produces a body of knowledge that is used by Congress, the Executive Branch, and the States to improve the efficiency, quality, and effectiveness of the Medicare, Medicaid, and State Children's Health Insurance programs.

A regular systematic review and assessment of CMS' research program is important to ensure that CMS' beneficiaries obtain maximum benefits from R&D spending. CMS' performance on this goal is measured using a formal annual internal assessment that is reviewed and evaluated by external experts. The internal assessment is dovetailed with the development of the 2-year research plan and budget, which involves consultation with all CMS components regarding their research needs. In turn, each CMS component with projects in the research budget will be responsible for performing the internal assessment of their projects.

We successfully completed and exceeded our goal for the FY 2006 internal assessment on schedule through development of a written internal assessment report. The standard

internal assessment was conducted as part of the annual research budget planning process, together with a review of the year's accomplishments. A detailed report was prepared even though a written assessment is only required once every three years as part of the external assessment. In addition, a comprehensive review was conducted of the data needs of research activities of the next several years, with a focus on the need for Part D prescription drug data.

Medicare

Long Term Goal: Improve Effectiveness of Dissemination of Medicare Information to Beneficiaries ***(Discontinued after FY 2005)***			
Measure	**FY**	**Target**	**Result**
Percentage of beneficiaries who reported Medicare information they received answered their questions **Baseline:** 67% (CY 1999)	*2006**	Goal discontinued	N/A
	2005	Maintain target	88% (Goal met)
	2004	77%	74% (Goal not met)
	2003	Monitor annual data	Goal met
	2002	"	Goal met
Percentage of beneficiaries who reported knowing that most people covered by Medicare could select from among different health plan options within Medicare. **Baseline:** 47% (CY 1999)	*2006**	Goal discontinued	N/A
	2005	Maintain target	*See FY 2004 results (Goal met)
	2004	57%	85% (Goal met)
	2003	Monitor annual data	Goal met
	2002	"	Goal met
Data Source: The primary source of data on beneficiary understanding of Medicare will be the Medicare Current Beneficiary Survey (MCBS). The MCBS is an on-going personal-interview survey of a rotating panel of 16,000 Medicare beneficiaries. The sample is nationally representative of the Medicare population. Sampled beneficiaries are interviewed every 4 months to acquire continuous data on services, costs, payments, and insurance coverage.			
Data Validation: The MCBS is subject to verification typical of survey work, including data range checks and internal consistency checks, which are done electronically at the time the responses are entered in the Computer Assisted Personal Interview (CAPI) device.			
Cross Reference: This performance goal supports HHS Strategic Goals 3 and 5 and the President's Management Agenda and is linked to the Secretary's 500-Day Plan.			

*Due to overwhelming success in this measure in 2004, and the need to focus survey resources to more meaningful areas, it was decided not to field this question in the 2005 survey. Instead, the MCBS focused on evolving Part D measures. Given the magnitude of success in 2004, it is safe to assume that 2005 was equally successful. See the performance goal "Implement the New Medicare Prescription Drug Benefit" for related measures.

Discussion: Until the passage of the Medicare Modernization Act (MMA), the Balanced Budget Act (BBA) of 1997 mandated the greatest changes to Medicare since its inception. One of these changes was the expansion of health insurance options under Medicare Advantage. In order to help beneficiaries make informed health care decisions, CMS employs a variety of strategies through many CMS beneficiary-centered programs to maximize information channels and to ensure that targeted audiences, are reached with the "right information at the right time."

Long Term Goal: Improve Beneficiary Understanding of Basic Features of the Medicare Program ***(Discontinued after FY 2005)***			
Measure	**FY**	**Target**	**Result**
Increase number of questions correctly answered by beneficiaries to measure understanding of different components of Medicare. (*outcome*) **Baseline:** 2.75 out of 6 questions (CY 2000)	*2006**	Goal discontinued	N/A
	2005	Maintain target	3.73 (Goal met)
	2004	3.50 in CY 2004	3.11 (Goal not met)
	2003	Monitor annual data	Goal met
	2002	Set baselines/targets	Goal met
Increase percentage of beneficiaries aware of 1-800 MEDICARE number. (*outcome*) **Baseline:** 53.0% (CY 2000)	*2006**	Goal discontinued	N/A
	2005	Maintain target	67.3% (Goal met)
	2004	65% in CY 2004	62.0% (Goal not met)
	2003	Monitor annual data	Goal met
	2002	Set baselines/targets	Goal met
Data Source: MCBS is used. Please see the previous performance detail table for an explanation.			
Data Validation: Please see the previous performance detail table for an explanation.			
Cross Reference: This performance goal supports HHS Strategic Goals 3 and 5, the President's Management Agenda, and is linked to the Secretary's 500-Day Plan.			

*See the performance goal "Implement the New Medicare Prescription Drug Benefit" for related measures.

Discussion: The purpose of this performance goal is not to turn every beneficiary into an expert on Medicare; consumer research has shown that beneficiaries generally seek information about the program only as specific needs arise. Our objectives in this goal are:

- to improve awareness of the core features of Medicare that beneficiaries need to know to use the program effectively, and
- to improve beneficiary awareness of CMS sources from which additional information can be obtained if needed.

Quality Improvement Organizations

Long Term Goal: Protect the Health of Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those Who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal			
Efficiency Measure	**FY**	**Target**	**Result**
Nursing Home Subpopulation Influenza vaccination	*2008*	74%*	Dec-09
	2007	74%	Dec-08
	2006	74%	Dec-07
	2005	N/A	73.7%
	2004	N/A	73.0%
Baseline: 68.8% (FY 2002)	*2003*	N/A	72.1%
Influenza vaccination	*2006*	See above for new focus	
	2005	72.5%	65.2%
	2004	72.5%	72.8%
	2003	72.5%	70.4%
Baseline: 59% (FY 1994)	*2002*	72%	69%
Pneumococcal vaccination	*2008*	71%	Dec-09
	2007	69%	Dec-08
	2006	69%	Dec-07
	2005	69%	68.4%
	2004	69%	67.4%
	2003	67%	66.4%
Baseline: 24.6% (FY 1994)	*2002*	66%	64.6%
Data Source: The Medicare Current Beneficiary Survey (MCBS), an ongoing survey of a representative national sample of the Medicare population, including beneficiaries who reside in long-term care facilities.			
Data Validation: The MCBS uses Computer Assisted Personal Interview (CAPI) technology to perform data edits, e.g., range and integrity checks, and logical checks during the interview. After the interview, consistency of responses is further examined and interviewer comments are reviewed.			
Cross Reference: This performance goal supports HHS Strategic Goals 1 and 3 and Healthy People 2010 – Initiative 14, and is linked to the Secretary's 500-Day Plan.			

* FY 2008 target may include a new data source for nursing homes pending utility of MDS data.

Discussion: An average of 36,000 Americans die from influenza or its complications each year. The National Center for Health Statistics preliminarily reports influenza and pneumonia to be the primary causes of death for more than 54,000 older adults in 2004. For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend lifetime vaccination against pneumococcal disease and annual vaccination against influenza. Through collaboration among the Centers for Medicare & Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC) and the National Foundation for Infectious Diseases/National Coalition for Adult Immunization (NCAI), efforts are ongoing to improve adult immunization rates in the Medicare population.

In recent years, there have been influenza vaccine shortages and distribution delays, which have impacted the delivery of immunizations. Traditionally, pneumococcal immunizations are given by health care providers along with the influenza immunization, so it is possible that disruptions of influenza vaccine supply also impact pneumococcal vaccination rates. Also, studies in the May 1, 2003 edition of the *New England Journal*

of Medicine and the July 1, 2003 edition of the *Journal of Infectious Diseases* question the effectiveness of the pneumococcal vaccine. Finally, an October 2005 article in the *Lancet* reviewed studies of efficacy and effectiveness of influenza immunization and found only modest evidence of effectiveness in preventing influenza-like illness in community residents. Such reports may dissuade some health care professionals from offering pneumococcal vaccine for their older patients. The 2005-06 influenza season experienced localized shortages of vaccine and marked the fifth time in the past six influenza immunization seasons that there were problems with the influenza vaccine supply. Such problems have led to changes in focus and in reimbursement methodology.

As of January 2005, all newly enrolled Medicare beneficiaries are covered for an initial physical examination that includes new preventive health screenings and emphasizes currently available preventive health services such as influenza and pneumococcal immunizations. Medicare has educated beneficiaries and providers about this new "Welcome to Medicare" benefit and, as such, promoted the existing Medicare immunization benefits. We anticipate that preventive services promotion will result in an increase in Medicare-covered services, including immunizations, and will be reflected in our FY 2005 target performance. In addition, since January 2005, physicians have been paid for injections and immunizations administered to people with Medicare, even when administered during a visit which includes other Medicare-covered services. Finally, CMS has recently made available a newly developed Web-based platform called mymedicare.gov, which will allow Medicare beneficiaries to better manage their health care benefits and health care costs. We anticipate that this effort will serve to remind beneficiaries to receive their immunizations.

Based on recent challenges concerning influenza vaccine supply and distribution, a decision was made to change the focus of this performance goal from the general Medicare population to nursing home residents beginning in FY 2006 because of the possibility of achieving a greater impact in the long-term care setting. CMS issued a final rule October 7, 2005, requiring nursing homes to provide residents with the opportunity to be immunized against influenza and pneumococcal disease as a condition of participation in the Medicare and Medicaid programs. In October 2006, CMS issued guidance to survey and certification agencies to include assessment of immunization practices as part of the survey process for nursing homes. Also in October 2006, CMS reported facility-specific rates of providing influenza and pneumococcal immunization to residents on its Nursing Home Compare Web site. Influenza immunization targets are revised to reflect this new focus.

Beginning September 1, 2006, influenza and pneumococcal vaccination assessments will be included as part of the Minimum Data Set (MDS) for nursing homes. As such, information pertaining to resident assessment for the two immunizations will be part of a national database (MDS) that includes patient assessment data for nearly all nursing home residents. As MDS immunization data for nursing homes become available, CMS will review the merits of MDS data as a primary data source for this target. Currently, through the Medicare Current Beneficiary Survey (MCBS), annual estimates of immunization coverage among facility-dwelling persons with Medicare are available.

CMS will use MCBS data for the nursing home influenza target until the utility of the MDS measure for this group can be determined. Until such data are available, we are continuing the FY 2007 nursing home immunization target for FY 2008. We are setting a new 2008 pneumococcal immunization target in hopes that a strong national focus on preventive services by CMS and the additional focus on long term care immunizations will improve rates.

Significant challenges to CMS' attainment of performance goals for influenza and pneumococcal immunization of people with Medicare continue. We expect that the new 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 help to overcome the challenges and will result in dramatically increased immunization rates. CMS will continue to explore additional opportunities to improve adult influenza and pneumococcal immunization rates.

Quality Improvement Organizations

Long Term Goal: Improve Early Detection of Breast Cancer Among Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Women Who Receive a Mammogram

Efficiency Measure	FY	Target	Result
Increase biennial mammography rates	*2008*	52.5%	Aug-09
	2007	52.5%	Aug-08
	2006	52.5%	Aug-07
	2005	52.5%	52.1%
Baseline: 51.0% (FY 2000-2001, based on 2002 HEDIS®)	*2004*	52.0%	51.3%
***2002 Baseline:** 45.0% (FY 1997-1998, based on 1999 HEDIS®)	*2003*	51.5%	51.3%
	*2002**	52.0%	52.2%

Data Source: The National Claims History (NCH) file is the data source used to track the mammography goal. The percentage of women age 65 and older with paid Medicare claims for mammography services during a biennial period will be calculated. The denominator consists of women who are enrolled in both Parts A and B on an FFS basis. Medicare beneficiaries who are enrolled in an HMO for more than a month in either year of the biennial period are not be included in the rate calculation. The baseline of 45 percent for 1997-98 includes mammography services paid for by Medicare for women ages 65 and older that were not enrolled in managed care.

Secondary data sources include the Medicare Current Beneficiary Survey (MCBS), the National Health Interview Survey (NHIS) and the Behavioral Risk Factor Surveillance System (BRFSS). The NHIS served as the primary data source for CMS' mammography goal through FY 2000.

Data Validation: The NCH is a 100 percent sample of Medicare claims. Claims submitted by providers to Medicare are checked for completeness and consistency. Duplicates are eliminated to ensure that women who have more than one mammogram within the two-year period do not contribute to over counting. Mammography utilization rates for age groups, race and counties are calculated and compared to previous years' data to check for any unusual changes in data values.

CMS will use secondary data sources to verify and validate the reported trends that are based on the NCH. The self-reported rates of mammography screening have historically been higher when based on these survey sources. Therefore, we cannot directly compare the rates from the secondary data sources with the reported rate based on claims data, but will compare year-to-year changes observed in each data source, to determine if equivalent rates of improvement are seen.

Cross Reference: This performance goal supports HHS Strategic Goals 1 and 3 and Healthy People 2010 – Initiative 3, and is linked to the Secretary's 500-Day Plan.

Discussion: CMS' performance goal is to increase the percentage of Medicare women age 65 and over who receive a mammogram at least every two years. By taking advantage of the lifesaving potential of mammography, we hope to ultimately decrease mortality from breast cancer in the Medicare population. Women over 65 face a greater risk of developing breast cancer than younger women, and a disproportionate number of breast cancer deaths occur among older African-American women. Encouraging breast cancer screening, including regular mammograms, is critical to reducing breast cancer deaths for those populations. The enactment of the Balanced Budget Act of 1997 expanded Medicare coverage to include annual screening mammograms for all Medicare eligible women effective January 1, 1998 and eliminated the Part B deductible. Effective April 1, 2001, enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 expanded Medicare coverage to include digital mammograms.

CMS' National Medicare Mammography Campaign is directed at improving women beneficiaries' knowledge of breast cancer screening and awareness of Medicare's annual screening mammography benefit. Health care providers are also targeted to improve their recommendation of breast cancer screening. More information on this campaign can be accessed at http://www.cms.hhs.gov/Mammography/05_CMS%20initiatives.asp. In the interest of attaining consistency with national standards, CMS adopted the breast cancer screening measure endorsed by the National Quality Forum (NQF). CMS expanded the billing codes for mammography to ensure that all Medicare-specific billing codes for digital mammograms are included in the numerator.

A technical claims processing issue was reported in recent years that might have adversely affected our ability to identify mammography services. All contractors may not have correctly processed claims when both a screening mammography and a computer image were billed. Corrective action resolved this issue. Aside from possible technical issues, payment policy may adversely affect mammography rates. Beneficiaries continue to cite copayment for mammography as a barrier to receipt of this service. Additionally, during 2001 and 2002, controversy regarding the benefits of screening mammography received broad coverage in the press. Attempts to reaffirm the recommendations for regular mammography screening by governmental agencies and national associations received less media attention. For example, the US Preventive Services Task Force and the National Cancer Institute (NCI) continue to recommend regularly-scheduled screening mammography for early detection. In light of recent trends, we have maintained our FY 2005 target for FY 2006 - FY 2008.

CMS' National Medicare Mammography Campaign will continue to work with sister agencies of the Department of Health & Human Services, including the Centers for Disease Control & Prevention, the Office on Women's Health and the NCI, and other federal and state-level organizations and contractors to promote screening mammography.

Quality Improvement Organizations

Long Term Goal: Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Hemoglobin A1c and Cholesterol (LDL) Testing

Efficiency Measure	CY	Targets	Results
1. Increase the rate of Hemoglobin A1c (HbA1c) testing 2. Increase the rate of Cholesterol (LDL) testing (*outcome*) **Baselines:** 04/01/2005 – 03/31/2006 1. A1c testing: 84.3% 2. Lipid testing: 78.1%	*2008*	A1c testing: 85.5% Lipid testing: 81.0%	Sep-09
	2007	A1c testing: 85.0% Lipid testing: 80.0%	Sep-08
	2006	Develop baselines and CY 2007 & CY 2008 targets	Goal met
	2005	N/A	N/A

Data Source: The National Claims History (NCH) file will be the primary data source. A systematic sample of patients aged 18-75 years who had a diagnosis of diabetes (type 1 and 2) with paid Medicare claims for HbA1c and LDL testing during the measurement year or year prior to the measurement year will be calculated. An age range of 18-75 years was selected because research evidence suggests that adult patients should be tested annually for HbA1c and LDL testing to prevent the costly co-morbidities associated with poor glucose and lipid control. This performance goal will report a measure rate of performance of testing for HbA1c and LDL testing separately. The denominator for each performance measure will consist of diabetic patients who had two face-to-face encounters with different dates of services in an ambulatory setting or nonacute inpatient setting or one face-to-face encounter in an acute inpatient or emergency room setting during the measurement year. The measurement period will be for one year, January 1-December 31.

Data Validation: The NCH is a 100 percent sample of Medicare claims submitted by providers to Medicare and is checked for completeness and consistency. Utilization rates for age groups, race and gender are calculated and compared to previous years' data to check for any unusual changes in data values.

Cross Reference: This performance goal supports HHS Strategic Goals 1 and 5 and Healthy People 2010 – Initiatives 5 and 12, and is linked to the Secretary's 500-Day Plan.

Discussion: Diabetes is a major public health problem that has been identified by the Secretary of DHHS for focused quality improvement. Diabetes is becoming more prevalent in all age groups. The increasing prevalence is multifactorial and can be attributed to higher detection rates, as well as increased rates of obesity and sedentary lifestyles in a large genetically at-risk population. According to the Centers for Disease Control and Prevention, from 1980 through 2004, the prevalence of diagnosed diabetes increased in all age groups. In general, throughout the time period, people aged 65-74 years had the highest prevalence (18.1 per 100 population in 2004), followed by people aged 75 or older (15.7 per 100 population in 2004), people aged 45-64 years (9.5 per 100 population in 2004), and people less than 45 years of age (1.2 per 100 population in 2004). In 2004, the prevalence of diagnosed diabetes among people aged 65-74 (16.7 percent) was approximately 12 times that of people less than 45 years of age (1.4 percent). Among U.S. adults greater than age 44, diagnosed diabetes increased approximately 55 percent from 1990 to 2004.

Multiple studies have demonstrated a relationship between good control of blood sugars as measured by hemoglobin A1c levels and protection against the development and/or progression of the devastating complications of diabetes. Cardiovascular complications of diabetes are common and cause heart attacks, strokes and lower extremity amputations. In fact, cardiovascular disease is the number one cause of death for patients

with diabetes. High levels of cholesterol, especially the LDL lipid fraction, as well as poor control of blood sugars are both associated with diabetes-related cardiovascular disease. Testing hemoglobin A1c and lipid levels and treating cholesterol and glucose levels to target levels have both been shown to significantly decrease the cardiovascular complications of diabetes. The American Diabetes Association and American Heart Association have common programs aimed at measuring and improving cholesterol and glucose control in patients with diabetes.

CMS has directed the Quality Improvement Organizations (QIOs) to improve the quality of care for Medicare beneficiaries in their respective States, and diabetes is a part of their quality improvement work on a statewide level. In addition QIOs are working with a focused group of physicians to improve care processes when they adopt and implement electronic health records (EHR) and care management processes in the physician office setting. Diabetes care management processes are one of several which physician practices may choose to implement with the help of the QIO.

Additionally, diabetes was one of the conditions measured in the Doctor's Office Quality project (DOQ), which ended in Sept 2005. This project assessed the feasibility for collecting data and defining quality in physician offices using three components: 1) clinical performance measures (including diabetes), 2) patient experience of care survey, and 3) an office system tool. The measures developed for the DOQ project were recently endorsed by the National Quality Forum (NQF) and accepted by the Ambulatory Quality Alliance (AQA). For this project, the CMS sampling methodology for collection of these measures included a broader denominator definition than the previously used HEDIS® measure definitions. Consequently, the CMS sampling methodology for collecting ambulatory care measures transitioned from the HEDIS® sampling methodology to the NQF-endorsed methodology with baselines developed and CY 2007/2008 targets set for the hemoglobin A1c and LDL measures.

In addition to the DOQ pilot, there are a number of other CMS demonstrations legislated in the Medicare Prescription Drug, Improvement, and Modernization Act that are using diabetes performance measures as the focus for quality improvement in physician offices under a variety of payment schemes. These demonstration projects are: Medicare Care Management Program (MCMP), Medicare Health Support (MHS), Physician Voluntary Reporting Program (PVRP), and Physician Group Practice (PGP). The performance measures for diabetes in these projects include the annual hemoglobin A1c and LDL testing measures as measures of quality diabetes care. The use of these measures in multiple projects is evidence of their efficacy for quality improvement and their value added.

Quality Improvement Organizations

Long Term Goal: Protect the Health of Medicare Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection			
Efficiency Measure	**FY**	**Target**	**Result**
Increase the percentage of patients who received preventive antibiotics within the recommended timeframe. (*outcome*)	*2008*	85.0%	Jun-09
	2007	82.0%	Jun-08
	2006	75.4%	Jun-07
	2005	72.5%	77.5%
	2004	66.6%	68.2%
Baseline for FY 2007-2008 targets: 77.5% (FY 2005)	*2003*	60.5%	61.6%
Baseline for FY 2003-2006 targets: 57.6% (FY 2001)	*2002*	N/A	60.0%
Data Source: Baseline State-level performance rates are calculated using data abstracted from up to 870 medical records sampled randomly in each State. Data collection for years following the initial baseline will use methods that reflect the evolution of CMS quality improvement activities toward reporting at the hospital level. Each successive year will include an increasing proportion of data that are collected by individual hospitals. A sample of these data will be validated by the Medicare quality improvement organization in each State. Ongoing surveillance sampling will continue through the entire QIO contract period. Data are collected by two clinical data abstraction centers that have been under contract with CMS for 7 years. An abstraction tool designed specifically for that purpose supports data collection by hospitals.			
Data Validation: The accuracy and reliability of data from the abstraction centers are monitored constantly through reabstraction of a sample of medical records. If the data collected by hospitals are used by CMS, the data will then be validated by each State's QIO and/or the clinical data abstraction centers. It was during this process that a flaw in the original abstraction was discovered. The original data were corrected, and baseline and targets recalculated at the same rates originally targeted.			
Cross Reference: This performance goal supports HHS Strategic Goals 1 and 5, and is linked to the Secretary's 500-Day Plan.			

Discussion: Postoperative surgical site infection (SSI) is a major cause of patient morbidity, mortality, and health care cost. SSI complicates an estimated 780,000 of nearly 30 million operations in the United States each year. For certain types of operation, rates of infection are reported as high as 20 percent. Each infection is estimated to increase a hospital stay by an average of 7 days and add an average of over $3,000 in hospital costs (1992 data). The incidence of infection increases intensive care unit admission by 60 percent, the risk of hospital readmission five-fold, and doubles the risk of death. Administration of appropriate preventive antibiotics just prior to surgery is effective in preventing infection. The reduction in the incidence of surgical site infection that is expected to result from improvement in the timing of antibiotic prophylaxis will primarily benefit Medicare beneficiaries through reduced morbidity and mortality. An additional benefit will be reduced need for and cost of rehospitalization for treatment of infections.

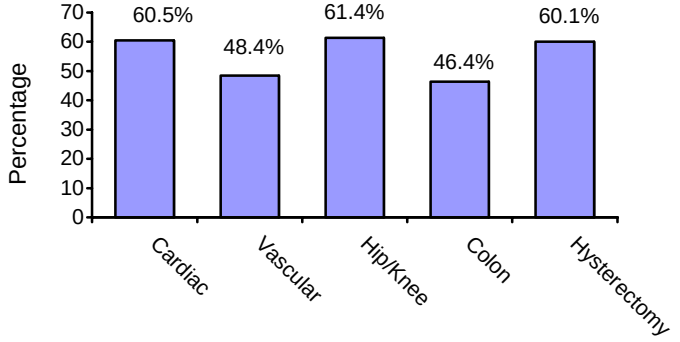
The goal of administering the antibiotic before surgery is to establish an effective level of the antibiotic in the body to prevent the establishment of infection during the time that the surgical incision is open. Studies performed in the 1960's and 1970's demonstrated that a common reason why the prevention failed was because the antibiotics were administered too far ahead of surgery (resulting in diminished antibiotic levels towards the end of surgery) or after the operation began (resulting in an absence of antibiotics towards the beginning of surgery). In a study of 2,847 surgery patients at The Latter Day

Saints (LDS) Hospital in Salt Lake City, Classen, et al. found that the lowest incidence of post-operative infection was associated with antibiotic administration within one hour prior to surgery. The risk of infection increased progressively with greater time intervals between administration and skin incision. This relationship was observed whether antibiotics preceded or followed skin incision.

Opportunities to improve postoperative care have been demonstrated. The actual systems within hospitals are often the cause of improper antibiotic timing. For example, at LDS Hospital, administration of the first antibiotic dose "on call" to the operating room was frequently associated with the antibiotic being administered too early. Restructuring the system resulted in an increase in appropriate timing from 40 percent of cases in 1985 to 99 percent of cases in 1998.

In 1999, CMS developed the national Medicare Surgical Infection Prevention (SIP) Project, which measured the frequency of antibiotic administration within the hour prior to five common types of major surgery where infection is the most likely to occur (see below). The chart below shows the percentage of specific surgeries where antibiotics were administered within the hour prior to surgery. The data from FY 2001 contributed to the baseline for subsequent measurement. While the data being collected have specific targets for the individual surgeries, CMS will only be reporting on the percentage of proper administration for the total of all five types of surgery shown below.

Percentage of Patients in 2001 who Received Preventive Antibiotics within the Recommended Timeframe by Surgery



SIP has evolved into the Surgical Care Improvement Partnership (SCIP) www.medqic.org/scip, which is a multifaceted coalition with the goal of reducing surgical complications, including SSI. The major national launch of this partnership to hospitals was held July 28, 2005, in San Diego, CA, although there have been many events signaling partnership activity since October 2004. In addition, August 2005 marked the beginning of the Nationwide- Quality Improvement Organizations' (QIO) 8th Scope of Work with expanded work in SSI and in particular the on-time administration of antibiotics.

Quality Improvement Organizations

Long Term Goal: Protect the Health of Medicare Beneficiaries by Increasing the Percentage of Dialysis Patients with Fistulas as Their Vascular Access for Hemodialysis.			
Efficiency Measure	**FY**	**Target**	**Result**
Protect the Health of Medicare Beneficiaries by Increasing the Percentage of Dialysis Patients with Fistulas as Their Vascular Access for Hemodialysis. **Baseline:** FY 2003: 33%	*2008*	51%	Nov-08
	2007	47%	Nov-07
	2006	40%	44.0%
	2005	N/A	40.2%
	2004	N/A	36.4%
Data Source: Data submitted by the dialysis facilities will be used as the data source for this measure. Large dialysis facilities submit directly to CMS through a file transfer. The 18 ESRD Networks collect data from independent dialysis facilities. (The baseline data includes 75% of independent facilities. We are moving toward 100% submittal by independent facilities.) As of September 2006, 97.0% of total facilities were reporting.			
Data Validation: Through the ESRD Clinical Performance Measures (CPM) project, ESRD Network staff will re-abstract the vascular access data from the records of a sample of patients to ensure that dialysis facilities are reporting data accurately.			
Cross Reference: This performance goal supports goal 5 of the HHS Strategic Plan and is linked to the Secretary's 500-Day Plan.			

Discussion: Hemodialysis is the most common treatment for End Stage Renal Disease (ESRD). Approximately 300,976 Medicare beneficiaries currently receive this treatment. Hemodialysis is a process of cleaning the blood of waste products when the kidneys can no longer perform this function. It requires removing the blood from the body, cleaning it, and returning it by means of a *vascular access*. Vascular access is one of the most critical issues in improving dialysis quality.

The three current types of vascular access are: fistula, catheter, and graft. Of the vascular access options, a fistula is generally the best access. An increased rate of fistulas for access would improve quality of life for patients by improving adequacy of dialysis and decreasing emergent treatment of complications and failures of grafts and catheters. Additionally, it is anticipated that the ESRD survival rate would improve because the complications of grafts and catheters can be fatal. Increasing the number of patients with fistulas as their access for dialysis would also decrease program costs associated with alternative forms of access such as graft revisions and care for infections, as well as emergency room usage and hospital stays for treatment of infections and failed catheters and grafts. About 25 to 50 percent of all hemodialysis patient admissions and hospital days are attributable to vascular access placement and related complications, which contributes over $1 billion to total Medicare inpatient costs.

CMS has identified the increased rate of fistulas as an Agency wide Breakthrough Initiative. To qualify as a breakthrough initiative, the project must meet certain criteria: there is a substantial gap between known good practice and actual practice and a very substantial improvement in performance seems possible. CMS intends to corral all its resources to institute this program and leverage change, including payment, coverage, measurement, patient education, demonstrations, survey and certification, and information technology.

As of September 2006, of the total number of hemodialysis patients (299,565) for whom access data is available, 44 percent (131,850) had a fistula as their primary access for hemodialysis. This represents an 11 percentage point increase from the FY 2003 baseline of 33 percent, and surpasses CMS' FY 2006 target of 40 percent, a percentage based on the National Kidney Foundation's Dialysis Outcomes Quality Initiative (KDOQI). As of July 2006, the KDOQI guideline was updated to maintain prevalent (remain on dialysis) functional fistula placement rates of greater than 65 percent of eligible patients. This goal, which centers on primarily activities in the dialysis facility, fosters more aggressive targets that are expected from the renal community at large where changes in the management of early chronic kidney disease is possible.

Activities for the Fistula First Breakthrough Initiative (FFBI) are progressing as scheduled with a series of milestone accomplishments to date. For example, a National Fistula First Coalition with over 75 representatives from various organizations from the renal community exists, with 18 separate organizations playing a leadership role in the 6 Task Forces; a surgical training package, including a video on how to perform a fistula procedure with supplemental material and training slides, has been completed and distributed; a web-based set of patient centered resources has been completed and a dedicated FFBI web page has been launched and is under redesign. The Web page (fistulafirst.org) will serve as the one place to stop for information on AV fistulas and links to material and resources available from the participating partners. Work that has been completed in FY 2006 included a branding strategy for the Coalition and a surgeon survey.

Future plans focus on continued coalition-building and marketing the FFBI mission and its messages; hosting regular meetings of task forces; development of action plans and evaluations for each task force and identified issues; agreeing to common language and definitions, core outreach/education messages and themes, to be used by all Coalition partners. Additionally, a cannulation training module (the "how-to" of accessing the fistula for dialysis) for practitioners is near completion. There are also program changes and policy decisions that are being considered in the areas of eligibility, coverage, and payment that will take longer to complete including a vascular access value-based purchasing program through CMS demonstrations, and a white paper to substantiate criteria for coverage and payment to support the initiative.

HCFAC (MIP)

Long Term Goal: Reduce the Percentage of Improper Payments Made Under the Medicare Fee-For Service Program			
Efficiency Measure	**FY**	**Target**	**Result**
Reduce the Percentage of Improper Payments Made Under the Medicare Fee-For-Service Program	*2009*	4.1%	Nov-09
	2008	4.2%	Nov-08
	2007	4.3%	Nov-07
	2006	5.1%	4.4%
	2005	7.9%	5.2%
Baseline: 2004: 10.1% (Recalculated in 2004 to reflect CMS' own CERT program (1996 OIG data: 14% error rate))	*2004*	4.8%	10.1%
	2003	5%	5.8%
	2002	5%	6.3%
Data Source: CMS assumed responsibility for measuring the Medicare fee-for-service error rate beginning in FY 2003 with oversight by the OIG. Error rate information for years preceding the FY 2003 report was compiled by the OIG.			
Data Validation: The CERT program is monitored for compliance by CMS through monthly reports from the contractors. In addition, the OIG periodically conducts reviews of CERT and its contractors.			
Cross Reference: This performance goal supports the President's Management Agenda, goals 3 and 8 of the HHS Strategic Plan, and is linked to the Secretary's 500-Day Plan.			

Discussion: The purpose of this goal is to continue to reduce the percentage of improper payments made under the fee-for-service program as reported in the CMS Financial Report. One of CMS' key goals is to pay claims properly the first time. This means paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries. Paying right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars.

The complexity of Medicare payment systems and policies, as well as the numbers of contractors, providers, and insurers involved in the Medicare fee-for-service program create vulnerabilities. CMS has implemented an Error Rate Reduction Plan designed to minimize these vulnerabilities and reduce the Medicare claims payment error rate.

The Comprehensive Error Rate Testing (CERT) program was initiated in FY 2003 and has produced a national error rate for each year since its inception. The OIG produced error rate information for years before those included in the FY 2003 report. In 2004, CMS began reporting gross error rates in addition to the net error rates previously reported. This change was necessary in order to comply with new Improper Payments Information Act (IPIA) requirements. As a transition, the FY 2004 report contained both net and gross numbers. Beginning in FY 2005, reports contained only gross numbers.

In addition to the national error rate, CERT findings include contractor-specific error rates, and provider compliance error rates which measure, respectively; the accuracy of the contractor's claims payments and processing activities, and providers' compliance with Medicare payment and billing requirements. These additional rates allow CMS to quickly identify emerging trends in managing Medicare contractor performance.

HCFAC (MIP)

Long Term Goal: Improve the Provider Enrollment Process			
Measure	**FY**	**Target**	**Result**
Improve the Provider Enrollment Process. **Baseline:** Develop a national enrollment system since current data sources for information on the enrollment process are limited.	*2008*	Implement PECOS-Web for all providers and suppliers, except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers; continue to make enhancements to PECOS; maintain fee-for-service processing timeliness standards; and publish a final rule that implements a provider enrollment appeals process.	Sep-08
	2007	Publish a proposed rule regarding the provider enrollment appeals process; continue to make enhancements to PECOS; and maintain fee-for-service processing timeliness standards.	Sep-07
	2006	Publish revised enrollment applications for all provider and supplier types; publish a Medicare enrollment regulation; continue to make enhancements to PECOS, and consistent with section 936 of MMA, develop a provider enrollment appeals process.	Goal Met
	2005	Redesign provider enrollment applications and continue planning web-enabled enrollment process. Enrollment regulation, including revalidation, published in final. Establish an acceptable level of pending enrollment actions and maintain that level of inventory.	Goal partially met. (Final regulation published April 21, 2006.)
	2004	Develop a web-enabled enrollment process via PECOS for both Part A and Part B providers/suppliers.	Goal not met
	2003	Implementation of Provider Enrollment Chain and Ownership System (PECOS) and revalidating 20 percent of Part A providers currently enrolled in the Medicare program using a new streamlined process to capture those providers that entered Medicare using the CMS-855 enrollment form or that entered Medicare prior to the use of the CMS-855 enrollment form.	Goal not met
	2002	Develop PECOS and implement the revised CMS-855 enrollment form and the regulation pertaining to establishing and maintaining billing privileges.	Goal met
Data Source: The Provider Enrollment, Chain and Ownership System (PECOS)			
Data Validation: We use annual contractor performance evaluation protocol to assess Medicare contractor provider enrollment performance. PECOS data will be verified during annual, onsite surveys of contractors and through reports available from PECOS.			
Cross Reference: This performance goal supports goals 3 and 8 of the HHS Strategic Plan, and is linked to the Secretary's 500-Day Plan.			

Discussion: This goal is aimed at improving Medicare's provider enrollment process by ensuring that only qualified individuals and organizations are enrolled are retain billing privileges in the Medicare program.

In FY 2008, we expect to implement PECOS-Web for all providers and suppliers, except DMEPOS suppliers, finalize the provider enrollment appeals process through regulation, and maintain processing timeliness standards.

In FY 2007, we expect to propose a provider enrollment appeals process through regulation, continue to make enhancements to PECOS, and maintain processing timeliness standards.

In FY 2006, we finalized requirements for enrolling and maintaining enrollment in the Medicare program on April 21, 2006. These regulations also require that all providers and suppliers periodically update and certify the accuracy of their enrollment information to enroll or maintain enrollment in the Medicare program. In addition, CMS issued revisions to the CMS-855 Medicare enrollment applications on May 1, 2006.

CMS will use the Provider Enrollment, Chain and Ownership System (PECOS) to capture Medicare enrollment information on all the Medicare fee-for-service providers and suppliers, except durable medical equipment suppliers. The PECOS database maintains enrollment information on Part A providers that bill fiscal intermediaries and Part B providers, including individual practitioners that bill carriers. Medicare fee-for-service contractors use PECOS to enroll new providers and suppliers into the Medicare program, update provider and supplier enrollment information, and process requests from individual health care practitioners for assignment of benefits.

HCFAC (MIP)

Long Term Goal: Improve the Effectiveness of the Administration of Medicare Secondary Payer (MSP) Provisions by Increasing the Number of Voluntary Data Sharing Agreements with Insurers or Employers			
Measure	**FY**	**Target**	**Result**
Improve the Effectiveness of the Administration of Medicare Secondary Payer (MSP) Provisions by Increasing the Number of Voluntary Data Sharing Agreements (VDSAs) with Insurers or Employers **Baseline:** As of FY 2002, CMS had negotiated six (6) VDSAs with employers and insurers.	*2008*	Sign 8 additional VDSAs	
	2007	Sign 8 additional VDSAs	
	2006	Sign 8 additional VDSAs	Goal met
	2005	Sign 4 additional VDSAs	Goal met
	2004	Sign two (2) additional VDSAs	Goal met
Data Source: CMS receives the Medicare Secondary Payer (MSP) data from those entities, identified above, that currently have a VDSA with CMS. The employer/insurer sends its files to the COB Contractor for processing in the prescribed CMS format, and files containing information on covered working individuals are transferred to CMS. Each file submission results in a unique response file being sent back to the employer that includes basic Medicare entitlement data. As of December 2005, CMS began collecting prescription drug coverage information that is primary and secondary to Medicare from these same sources, as well as Pharmacy Benefit Management companies.			
Data Validation: The COB Contractor edits and validates the data received by the employers/insurers through multiple independent processes before uploading any new MSP information to the Common Working File or, in the case of drug records, to the Medicare Beneficiary Database. These are two CMS databases used in the claims adjudication process. All records with an error are identified and sent back to the employer/plan indicating why the record could not be processed. Records that do not contain errors are processed accordingly.			
Cross Reference: This performance goal supports goal 8 of the HHS Strategic Plan and is linked to the Secretary's 500-Day Plan.			

Discussion: The purpose of this goal is to increase the number of VDSAs that CMS has with large employers and insurers for the purpose of exchanging employer or insurer health plan enrollment information for Medicare eligibility information. These data exchanges allow CMS to identify those Medicare beneficiaries who have group health coverage via their employment or via their spouse's employment that is primary to Medicare. The VDSA allows CMS to receive this health plan coverage information from employers or insurers on a current (quarterly) basis, which enables Medicare to correctly process Medicare claims for primary or secondary payment. For employers, a VDSA can be used to satisfy their statutory obligation, under 42 U.S.C. § 1395y(b)(5)(c), to complete questionnaires resulting from the Internal Revenue Service (IRS)/Social Security Administration (SSA)/CMS Data Match process; and to provide that information to CMS on a more current basis.

The quarterly, mutual exchange of employee/insurer coverage information for Medicare eligibility information enables all parties to correctly process claims for primary and secondary payment. Additional benefits to CMS include: (1) a significant reduction in costs and administrative efforts associated with dispute resolution and recovery of mistaken primary payments, (2) lower long term operating costs for collection and storage of employer coverage data than via the IRS/SSA/CMS Data Match Project, (3) more accurate coverage data on a more current basis than can be achieved through the

IRS/SSA/CMS Data Match process and (4) increased customer service to beneficiaries and our Medicare partners.

CMS has made great strides to sign VDSAs with large employers/insurers and has included the expansion of this initiative as part of CMS's goal to reduce the incidences of mistaken payments under the FY 2007 MSP comprehensive plan. The resources required to electronically exchange information with CMS on a cost effective basis limit the potential market for VDSAs to large employers and insurers. As of December 2006, including the 43 Plans under the BCBSA VDSA, CMS has signed 123 VDSAs with large insurers and large employers. Negotiations continue with numerous other interested employers and insurers.

In recognizing that the existing VDSA process could be leveraged to implement portions of the Medicare Modernization Act (MMA), CMS expanded both the size and scope of the VDSA process to meet the new coordination requirements related to the administration of the Medicare Part D drug benefit. Since the MSP provisions apply to Part D coverage, CMS expanded the VDSA process to include collection of employer group health plan (EGHP) prescription drug coverage that is primary to Medicare. CMS expanded the scope of the VDSA to include collection of employer sponsored retiree drug coverage information to assist Medicare Part D plans calculate their enrollees' true out of pocket (TrOOP) expenses. In addition, employers that claim the subsidy for their retirees covered by a retiree prescription drug plan can fulfill their reporting requirements to the Medicare Retiree Drug Subsidy contractor through their existing VDSA. All of these enhancements to the current VDSA process make the VDSA even more beneficial to our employer and insurer partners and we expect the number of new agreements to grow over the next few years. Finally, in recognizing that the new drug benefit will require CMS to coordinate benefits with entities that CMS has not had a need to coordinate benefits with in the past, CMS developed a new VDSA process to exchange MSP drug coverage information with pharmacy benefit management (PBM) companies. CMS has signed four PBM VDSAs and expects more to do so.

In addition to numerous print, mail and website promotions of VDSAs, CMS and the Coordination of Benefits (COB) Contractor have hosted or participated in numerous employer conferences and outreach programs. Due to these marketing efforts and word of mouth from current participants, requests for information about VDSAs have increased over the past several years. Also, many private healthcare data management companies and consultants are indirectly supplementing our marketing efforts by offering to implement VDSAs on behalf of their insurer and employer clients. These companies have the potential to bring many new VDSAs to CMS via single sources of contact, which should make implementation of new agreements easier for CMS. One of these consultants has persuaded nine of their large employer clients to sign VDSAs with CMS and is implementing these agreements on their clients' behalf.

HCFAC (MIP)

Long Term Goal: Reduce the Medicare Contractor Error Rates			
Measure	**FY**	**Target**	**Result**
Reduce the Medicare Contractor Error Rates by increasing the number of claims processed by contractors who have an error rate (including non-response claims) less than or equal to the previous fiscal year's actual national paid claims error rate. (*outcome*) **Baseline: 2004:** 10.1% **2005**: 5.2%	*2008*	100%	Nov-08
	2007	75%	Nov-07
	2006	50%	82.8%
	2005	25%	89.6%
	2004	Set baseline	Goal met
	2003	N/A	N/A
	2002	N/A	N/A
Data Source: Contractors receive a semi-annual error rate report from the CERT contractors and can use the information on a monthly basis to look for trends and outliers.			
Data Validation: The OIG will complete an audit of CERT on an annual basis to ensure compliance with the stated error rate process.			
Cross Reference: This performance goal supports the President's Management Agenda, goals 3 and 8 of the HHS Strategic Plan, and is linked to the Secretary's 500-Day Plan.			

Discussion: In FY 2003 the Comprehensive Error Rate Testing (CERT) program began producing the national fee-for-service error rate. In addition, CERT produces contractor-specific error rates and provider compliance error rates. The CERT program provides substantially greater detail and analysis of vulnerabilities in the current system than previous methods, which will help focus corrective actions.

CERT is a tool that CMS wants contractors to use to develop their medical review and provider education and training strategies. Contractors receive semi-annual error rate updates from the CERT contractors and can use the information to look for trends and outliers. Beginning in FY 2005, CMS considered the contractor specific error rate in contractor performance evaluations.

For each Medicare contractor, Medicare conducts reviews for a statistically valid sample of claims and determines whether the contractor paid the claim accurately. The reviews determine whether health care providers were underpaid or overpaid for the sampled claims. The results reflect not only the contractor's performance, but also the billing practices of the health care providers in their region.

The results lead to a contractor-specific error rate that Medicare tracks to promote improvements. Contractors then develop targeted error rate reduction plans to reduce payment errors through provider education, claims review and other activities.

By FY 2008, CMS intends to have all Medicare claims processed by contractors that have an error rate less than or equal to the previous year's actual national paid claims error rate. Critically important in reducing the contractor error rate is determining the root causes of error. Some errors may be caused by claims processing systems, unclear policies or CMS technical requirements. CMS will use the information obtained through this process to revise policies and instructions, and institute systems changes, as well as use CERT as a measure of performance.

HCFAC (MIP)

Long Term Goal: Decrease the Medicare Provider Compliance Error Rates			
Measure	**FY**	**Target**	**Result**
Decrease the Provider Compliance Error Rates by 20 percent over the previous fiscal year's level. (*outcome*) **Baseline:** See the Carrier-specific and Durable Medical Equipment Regional Carriers (DMERC)-specific provider compliance error rates (including non-response claims) listed in Tables 7 and 8 of the FY 2004 Improper Medicare Fee-for-Service Payment Report.	*2008*	Developmental. Set new baseline	Nov-08
	2007	Developmental. Revise methodology	Nov-07
	2006	20% decrease for Carriers & DMERCs	Goal not met
	2005	20% decrease	Goal partially met
	2004	Set baseline	Goal met
Data Source: Contractors receive a semi-annual error rate report from the CERT contractors and can use the information on a monthly basis to look for trends and outliers.			
Data Validation: The OIG will complete an audit of CERT on an annual basis to ensure compliance with the stated error rate process.			
Cross Reference: This performance goal supports the President's Management Agenda, goals 3 and 8 of the HHS Strategic Plan, and is linked to the Secretary's 500-Day Plan.			

Discussion: The Provider Compliance Error Rate is based on the compliance of submitted claims with Medicare rules and requirements before any reviews or edits are applied by the contractor. The provider compliance error rate is intended to show how well the contractors are educating the provider community since it measures how well providers prepared claims for submission. The sampled claims are subjected to detailed medical review and a compliance error rate is calculated based upon the dollar value ratio of claims submitted improperly to total claims. The Provider Compliance Error Rate is expected to measure the effectiveness of provider education and promote provider compliance.

However, since its inception, the error rate calculation methodology has changed several times. As well, the purpose and use of the provider compliance error rate has proven to be confusing to contractors and the public. In fact, the CERT program has identified several situations where a provider compliance error is being imposed and either the provider is doing everything correctly or there is nothing the contractor can do to prevent it. In addition, recent developments have shifted the purpose of the provider compliance error rate from medical review to provider education. Therefore, in order to make this performance measure more useful, consistent and meaningful, CMS is revising the methodology to make the provider compliance error rate an accurate estimate of the effectiveness of provider education. CMS expects to have a revised baseline in place for FY 2008.

Under the current methodology, this goal was not met for FY 2006. Due to systems limitations, CMS did not collect covered charge data from fiscal intermediaries (FIs) during this reporting period. CMS was therefore unable to produce this rate for FIs during the November 2006 reporting period. When compared to the November 2005 report, the provider compliance error rate for carriers decreased by 3 percent and increased 4 percent for DMERCs.

Medicaid

Long Term Goal: Estimate the Payment Error Rate in the Medicaid and State Children's Health Insurance Programs			
Measure	**FY**	**Target**	**Result**
Estimate the Payment Error Rate in the Medicaid and State Children's Health Insurance Programs (SCHIP) (*output*) **Baseline:** **a. Medicaid:** CMS sponsored a pilot program to estimate payment accuracy in the Medicaid program from FY 2002 - FY 2004 and to measure payment error in FY 2005. **b. SCHIP:** CMS sponsored a pilot program to estimate payment accuracy in SCHIP during FY 2003 – FY 2004 and to measure payment error in FY 2005.	*2008*	Report national Medicaid and SCHIP error rates in the FY 2009 Performance and Accountability Report (PAR) based on: **a. Medicaid:** 17 Medicaid States measured in FY 2008, and **b. SCHIP:** 17 SCHIP States measured in FY 2008.	Nov-09
	2007	**a. Medicaid:** Begin full implementation of measuring FFS, managed care and eligibility in the second set of 17 States for Medicaid. Report national error rate in FY 2008 PAR. **b. SCHIP:** Begin full implementation of measuring FFS, managed care and eligibility in the second set of 16 States for SCHIP. (Tennessee currently has not implemented SCHIP.) Report national error rate in FY 2008 PAR.	Nov-08
	2006	Begin to implement error measurement for Medicaid fee-for-service in 17 States. This Medicaid fee-for-service error rate will be reported in the FY 2007 PAR. (Each year 17 States will participate in the Medicaid measurement. At the end of a 3 year period each State will have been measured once and will rotate in that cycle in future years, e.g., the States selected in year one will be measured again in year four).	Nov-07
Data Source: In FY 2006, we implemented the Payment Error Rate Measurement (PERM) program in 17 States to measure Medicaid fee-for-service using a national contracting strategy to gather adjudicated claims data and medical policies from the States for purposes of conducting medical and data processing reviews on a sample of the claims paid in each State			
Data Validation: CMS, The Lewin Group and Livanta LLC are working with the 17 States to ensure that the Medicaid universe data and sampled claims are complete and accurate and contain the data needed to conduct the reviews.			
Cross Reference: This performance goal supports the President's Management Agenda as well as goal 8 of the HHS Strategic Plan, and is linked to the Secretary's 500-Day Plan.			

Discussion: The Improper Payments Information Act of 2002 (Public Law 107-300) requires each executive agency, in accordance with the Office of Management and Budget (OMB) guidance, to annually review all programs that it administers and identify programs that may be susceptible to significant improper payments. For those programs that are deemed to be susceptible to significant improper payments, the agency shall estimate the annual amount of improper payments, and submit those estimates to Congress before March 31 of the following applicable year.

This goal evolved from the former goal entitled "Assist States in Conducting Medicaid Payment Accuracy Studies for the purpose of Measuring and Ultimately Reducing Medicaid Payment Error Rates." The former goal explored the feasibility of developing a

methodology to estimate improper payments in the Medicaid and SCHIP programs and executed pilot projects to test this methodology.

CMS implemented a payment error rate measurement (PERM) pilot project in FY 2005. Under the pilot project, States produced a Medicaid and SCHIP error rate. In FY 2006, CMS implemented the PERM program in 17 States to produce a national Medicaid fee-for-service error rate. This Medicaid fee-for-service error rate will be reported in the FY 2007 Performance and Accountability Report (PAR). In FY 2007, we plan to nationally implement the PERM program in Medicaid and SCHIP. This PERM measurement for each program includes a fee-for-service, managed care, and eligibility component and the national error rates will be reported in the FY 2008 PAR.

Medicaid

Long Term Goal: Increase the number of States that demonstrate improvement related to access and quality health care through the Medicaid Quality Improvement Program			
Long-Term Measure	**FY**	**Target**	**Result**
The number of States that demonstrate improvement related to access and quality of health care. (*output*)	*2008*	15% of the States (8 States)	Mar-09
	2007	Baseline – number of States = 0	Feb-08
Data Source: States report quality improvement efforts via several vehicles including the State quality improvement strategies (CFR 438.204 Subpart D), External Quality Review Organizations (EQRO) Reports (CFR 438.310-438.70 Subpart E), Home and Community Based Services (HCBS) Waiver Quality Assessment reports (CFR 441.301- 441.303, 441.308, 447.200, 447.431), Medicaid Demonstration evaluation reports, performance measurement reporting, state report cards, clinical studies, targeted Performance Improvement Projects, and other vehicles. A combination of these data sources will be analyzed, when available and appropriate, to ensure a comprehensive review of State quality improvement activities.			
Data Validation: CMS has developed templates, assessment tools and protocols for review and validation of quality improvement strategies, selected EQRO requirements, and program evaluations.			
Cross Reference: This performance goal supports HHS Strategic Goals 3 and 5 and the President's Management Agenda, and is linked to the Secretary's 500-Day Plan.			

Discussion: In July 2005, CMS released a Quality Roadmap with the vision for the "right care for every person every time." The Roadmap outlined a plan of action to "implement, in close partnership with States, a strategy to improve the quality of care for Medicaid beneficiaries." Also in 2005, CMS established a Medicaid Quality Strategy to compliment the CMS Quality Roadmap. This commitment allows CMS to provide technical assistance to States regarding quality improvement, quality measurement, and External Quality Review.

The aim of the strategy includes supporting States in achieving safe, effective, efficient, timely, equitable and patient-centered care as outlined in the Institute of Medicines report *Crossing the Quality Chasm*. CMS plans to use information gained from these State-level quality improvements initiatives as the building blocks for the development of a larger, national-level quality framework.

An initial focus for CMS was to assess State quality strategy assessments (CFR 438.204 Subpart D) and State progress in EQRO reporting (CFR 438.310-438.70 Subpart E). Through a preliminary review of EQRO reports by CMS and continued receipt of State inquiries on EQRO and quality strategy requirements as outlined in the Code of Federal Regulations, there was sufficient evidence for the opportunity to improve efficiency and effectiveness in State quality improvement activities.

Through the new CMS Quality Roadmap initiatives and the Quality Strategy, CMS partners with states and other nationally recognized organizations to provide technical assistance and disseminate information on best practices identified through promoting fulfillment of quality strategy standards, EQRO reporting for performance improvement projects, and performance measurement reporting. Through technical assistance, States

are better able to assess and enhance quality strategies for improving health care to Medicaid beneficiaries. CMS also monitors available quality improvement data provided by States to promote improved beneficiary care. Consistent with the CMS Quality Strategy, CMS will continue to partner with States to improve health information technology, reduce disparities in health care, improve health literacy, improve access to care, improve health outcomes, and encourage payment for health care services based on quality and value.

In the fall of 2006, CMS provided a technical web-conference with State Medicaid representatives and regional CMS offices to discuss opportunities identified for improving State Medicaid Quality Program Strategies, Performance Improvement Projects, and Medicaid Demonstration Program evaluations. Technical assistance was provided through distribution and discussion of new Medicaid Quality Tool Kits recently developed by CMS. Additionally, the conference provided information on nationally recognized organizations such as Commonwealth Fund and the Center for Health Care Strategies, and their initiatives and opportunities for supporting States in improving the quality of their Medicaid programs.

Additional tools will be developed over the course of FY 2007, along with the development of tracking mechanisms for monitoring State's assessment of access and quality improvement.

Medicaid

Long Term Goal: Percentage of beneficiaries in Medicaid Managed Care Organizations and Health Insuring Organizations (MCOs + HIOs)			
Efficiency Measure	**FY**	**Target**	**Result**
Increase percentage of beneficiaries in Medicaid Managed Care Organizations and Health Insuring Organizations. Baseline: FY 2007	*2008*	45%	Mar-09
	2007	N/A	Mar-08
	2006	N/A	Mar-07
	2005	N/A	41.6%
	2004	N/A	40.7%
	2003	N/A	40.5%
	2002	N/A	39.8%
Data Source: Medicaid Managed Care Enrollment Report - The report is composed annually, using States reported data by the Centers for Medicare & Medicaid Services (CMS).			
Data Validation: The information is collected from State Medicaid Agencies with the assistance of CMS Regional Offices. Data validation is a joint effort of CMS Central and Regional Offices. Regional Offices are responsible to thoroughly review and validate the data before submitting the data to Central Office which performs the final review and validation of the data.			
Cross Reference: This performance goal supports the President's Management Agenda as well as goals 3 and 8 of the HHS Strategic Plan, and is linked to the Secretary's 500-Day Plan.			

Discussion: The purpose of this goal is to continue to track the percentage of enrollment of Medicaid beneficiaries in managed care. One of CMS' priorities is to work with States to explore cost-effective health delivery systems that increase efficiency, management, and the delivery of care.

The enrollment counts in the Medicaid Managed Care Enrollment Report are point-in-time counts, as of June 30 of each year. This point-in-time measure corresponds to the managed care enrollment counts captured by the States, and best reflects the ongoing monthly managed care enrollment activity.

The Medicaid managed care enrollment statistics are obtained by a survey, using an automated tool, the Medicaid Managed Care Data Collection System. CMS makes modifications annually based on the recommendations from States, regions, and central office staff to ensure the system is accurate and up-to-date.

Medicaid

Long Term Goal: Percentage of Beneficiaries who Received Home and Community-Based Services			
Outcome Measure	**FY**	**Target**	**Result**
Increase percentage of beneficiaries who receive home and community-based services. **Baseline:** FY 2007 (Data expected to be available end of FY 2009)	*2008*	+3% over FY 2007	Data expected to be available end of FY 2010
Data Source: Medicaid Statistical Information System (MSIS) – States submit quarterly files to CMS with demographic and eligibility characteristics on each individual in Medicaid, their service utilization and payments made for those services. The numerator is the number of beneficiaries who receive home and community-based services. The denominator is the total number of beneficiaries eligible for institutional level of care.			
Data Validation: MSIS data are submitted to CMS on 5 different files, an eligibility file and four files of claims: inpatient, long-term care, drugs and all other claims. The data files are subjected to quality assurance edits to ensure that the data are within acceptable error tolerances and a distributional review which verifies the reasonableness of the data. CMS contractors work directly with state staff to correct the data to ensure the files are accurate. The data are warehoused in CMS and a State Summary Data Mart provides users access to the information. Use of the data ensures the quality of cross State statistics.			
Cross Reference: This performance goal supports the President's Management Agenda as well as goals 3 and 8 of the HHS Strategic Plan, and is linked to the Secretary's 500-Day Plan.			

Discussion:

There is a growing body of evidence that home and community-based care is more cost-effective than institutional care and results in improved quality of care/quality of life for persons who are able to receive needed health and social services in homes or community-based home-like settings, instead of in institutions. A recent Georgetown University report indicated lower per capita costs for home and community-based beneficiaries than nursing home beneficiaries. Additionally, the Government Accountability Office found that the shift in home and community-based care has allowed some States to provide services to more people with the same dollars available.

The Deficit Reduction Act of 2005, through several of its provisions, acknowledged and reinforced the value of home and community-based services as alternatives to institutional care. Specifically, Section 6086 allows States to offer home and community-based services through their traditional Medicaid State plan program, without needing to apply for a Medicaid waiver. Section 6071 provides enhanced funding and technical assistance to states to increase/reinforce their efforts to relocate persons from institutions to community-based settings and provide appropriate, quality services. Both of these vehicles should facilitate the increase of persons receiving home and community-based services, compared to those receiving institutional care.

Medicaid

Long Term Goal: Percentage of Section 1115 demonstration budget neutrality reviews completed out of total number of operational demonstrations for which targeted budget reviews are scheduled.			
Measure	**FY**	**Target**	**Result**
Assure completion of targeted budget neutrality reviews for Section 1115 demonstrations. (*output*) **Baseline:** 2006 results for targeted reviews would become the baseline (data available March 2007).	*2010*	96%	Mar-2011
	2009	94%	Mar-2010
	2008	92%	Mar-2009
Data Source: CMS project officers conduct reviews of Section 1115 demonstration budget neutrality data.			
Data Validation: Section 1115 demonstrations are monitored for compliance by CMS through quarterly, annual, and ad hoc reports from the States. In addition, the Government Accountability Office periodically conducts reviews of Section 1115 demonstrations.			
Cross Reference: This performance goal supports the President's Management Agenda, goal 8 of the HHS Strategic Plan, and is linked to the Secretary's 500-Day Plan.			

Discussion: Under section 1115 of the Social Security Act, the HHS Secretary has the authority to grant waivers of Medicaid statutes so that States can test innovative reforms such as new healthcare delivery systems. The Administration maintains a policy that any state demonstration should be budget neutral; the demonstration should not create new costs for the Federal government. CMS is responsible for reviewing State compliance with budget neutrality for Medicaid demonstrations. CMS is in the process of developing the schedule of targeted reviews.

Medicaid

Long Term Goal: Medicaid Integrity Program, Percentage Return on Investment (ROI)			
Measure	**FY**	**Target**	**Result**
Increase return on investment of the Medicaid Integrity Program. *(outcome)* **Baseline:** Developmental	*2008*	>100%	Jan-09 – Partial Year
Data Source: Developmental. The Medicaid Integrity Contractors (MICs) will compile the data for the ROI calculation during audits where overpayments are identified and recouped.			
Data Validation: Data will be validated through CMS oversight of the MICs.			
Cross Reference: This performance goal supports the President's Management Agenda as well as goal 8 of the HHS Strategic Plan, and is linked to the Secretary's 500-Day Plan.			

Discussion: The purpose of this goal is to assure the implementation and success of the Medicaid Integrity Program (MIP). The numerator will include 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 MICs. Once the program is established, resources committed, and the MICs procured and in operation, the Return on Investment (ROI) performance measure is expected to be greater than 100 percent. The ROI for this program will be calculated on an annual basis.

When Congress passed this provision, it dramatically increased CMS' obligations and resources to help prevent, detect and reduce fraud, waste and abuse in Medicaid. Not only did Congress fund the MIP for the long-term through the Deficit Reduction Act of 2005, CMS must also hire 100 new full-time employees "whose duties consist solely of protecting the integrity of the Medicaid program." It also mandated CMS to enter into contractual agreements with eligible entities to conduct provider oversight by performing the following duties: 1) review provider claims to determine if fraud and abuse has occurred or has the potential to occur; 2) conduct provider audits based on these reviews and other trend analysis; 3) identify overpayments; and 4) conduct provider education.

CMS is also developing a structure to address the following critical functions: procure and provide oversight of the MICs; through a field operations component, provide strengthened state program integrity oversight, as well as support through technical assistance and training; and create a fraud research and detection component to provide statistical and data support, identify emerging fraud trends and conduct special studies as appropriate.

State Children's Health Insurance Program (SCHIP)

Long Term Goal: Decrease the Number of Uninsured Children by Working with States to Enroll Children in SCHIP and Medicaid

Efficiency Measure	FY	Target	Result
Decrease the Number of Uninsured Children by Working with States to Enroll Children in SCHIP and Medicaid **Baseline:** In 1997, the year SCHIP was enacted, there were 21,000,000 children enrolled in Medicaid, and none in SCHIP.	*2008*	Maintain enrollment at FY 2005 levels.	Mar-09
	2007	Maintain enrollment at FY 2005 levels.	Mar-08
	2006	Increase the number of children who are enrolled in regular Medicaid or SCHIP by 3%, or approximately 1,000,000 over the previous year.	Mar-07
	2005	Increase the number of children who are enrolled in regular Medicaid or SCHIP by 3%, or approximately 1,000,000 over the previous year.	Goal met
	2004	Maintain enrollment at FY 2003 levels.	Goal met
	2003	Increase enrollment 5% over 2002.	Goal met
	2002	Increase enrollment 1,000,000 over 2001.	Goal met

Data Source: States are required to submit quarterly and annual State Children's Health Insurance Program statistical forms to CMS through the automated Statistical Enrollment Data System (SEDS). Using these forms, States report quarterly on unduplicated counts of the number of children under age 19 who are enrolled in separate SCHIP programs, Medicaid expansion SCHIP programs, and regular Medicaid programs. The enrollment counts presented in this update are the sum of the unduplicated number of children ever enrolled in separate SCHIP programs, Medicaid expansion SCHIP programs, and regular Medicaid programs during the year.

The estimate of 21,000,000 for Medicaid enrollment for FY 1997 is based on CMS-2082 data edited by The Urban Institute and published in December 1999. Although CMS previously reported a 1997 baseline of 22,700,000 children enrolled in Medicaid, this was based on unedited CMS-2082 data and incomplete data reported by the States through SEDS. CMS and the States consider the 21,000,000 Medicaid enrollment figure to be a final estimate for 1997. This figure is also cited in the first annual report of the CMS-funded evaluation of SCHIP by Mathematica Policy Research (posted on the web at http://www.cms.hhs.gov/schip/sho-letters/mpr12301.asp).

The 1998-2002 Medicaid enrollment counts presented are estimates based on interim data submitted by the States through SEDS and are therefore subject to change when edited CMS-2082 data become available. In general, edited data for a fiscal year are available about two years after the end of the year. Capturing enrollment data for Medicaid children is also a challenge, because States do not always report Medicaid data as timely in SEDS as SCHIP enrollment data.

Data Validation: CMS will measure, to the extent possible, the unduplicated count of the number of children who are enrolled in any of the following programs: regular Medicaid; expansions of Medicaid through SCHIP; and separate SCHIP programs as reported by the States. While CMS considers an unduplicated count to be an appropriate measure for this goal and the unduplicated count can be measured within each program, some children may be enrolled in Medicaid at one point in the year and in SCHIP at another point, making it difficult to establish an accurate unduplicated count across all programs. Similarly, the SCHIP counts include some double counting of children in States that have combination programs. To the extent the data allows, CMS will closely monitor this issue.

Cross Reference: The performance goal supports HHS Strategic Goal 3 and the President's Management Agenda, and is linked to the Secretary's 500-Day Plan.

Discussion: The purpose of SCHIP as stated in Title XXI of the Social Security Act is, "to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children." Consistent with this purpose, and

to affirm our commitment to decreasing the number of uninsured children, CMS has established this goal to increase the number of children enrolled in SCHIP and Medicaid. Enacted through the Balanced Budget Act of 1997, SCHIP, under Title XXI of the Social Security Act, allocates nearly $40 billion over 10 years to extend health care coverage to low-income, uninsured children. This program represents the largest single expansion of health insurance coverage for children in more than 30 years and aims to improve the quality of life for millions of vulnerable children less than 19 years of age. As of September 1999, all States, territories and the District of Columbia had approved SCHIP plans in place. SCHIP enables States to establish separate SCHIP programs, expand existing Medicaid programs, or use a combination of both approaches.

While this goal focuses on enrolling children in Medicaid and SCHIP rather than on measuring uninsurance rates, there is overwhelming evidence that the rate of uninsurance in children has been reduced since the inception of SCHIP. Although estimates of insurance coverage for children vary, the U.S. Census Bureau's Current Population Survey (CPS) is the most widely cited source. The most recent CPS data (three-year rolling average for FYs 2003-2005) suggested that there were approximately 5.5 million children under the age of 19 at or below 200 percent of the Federal poverty level (FPL) who lacked health insurance coverage, down from over 7.5 million in 1997 (three-year rolling average for FYs 1996-1998). In addition, a recent Centers for Disease Control and Prevention survey found that the percentage of uninsured children dropped from 13.9 percent in 1997 to 8.9 percent in 2005.

The best available data show 21 million children ever enrolled in Title XIX Medicaid during FY 1997 (before the inception of SCHIP).

According to the Statistical Enrollment Data System (SEDS), more than 6.1 million children participated in SCHIP-funded coverage (either a separate child health program or a Medicaid expansion) and 30.4 million children participated in regular Medicaid in FY 2005. These numbers represent an increase in total enrollment of 1.1 million children, which meets the established target.

Future enrollment in Medicaid and SCHIP will depend on several factors. States' economic situations and corresponding changes to their Medicaid and SCHIP State plans. The effects of the recently enacted Deficit Reduction Act of 2005 (DRA) on Medicaid enrollment are unclear. SCHIP is due for reauthorization in FY 2007. Associated programmatic changes, along with funding levels, may effect SCHIP enrollment.

These factors have lead CMS to reevaluate its FY 2007 target and therefore resulted in CMS revising the FY 2007 target to maintain enrollment at the FY 2005 levels. The proposed FY 2008 target also maintains enrollment at the FY 2005 levels due to these same factors.

Year	Children Served by SCHIP (Title XXI)*	Children Served by Medicaid (Title XIX)*	Total Number of Children Served by SCHIP & Medicaid*	Yearly Increase in Number of Children Served by SCHIP & Medicaid	GPRA Target *(yearly increase in number of children served by SCHIP and Medicaid)*
1997	0	21,019,000 [2]	21,019,000	---	
1998	980,000	20,200,000	21,180,000	161,000	
1999	2,000,000	20,600,000	22,600,000	1,400,000	
2000	3,400,000	22,000,000	25,400,000	2,800,000	1,000,000
2001	4,600,000	*23,400,000*	*28,000,000*	*2,600,000*	1,000,000
2002	5,400,000	*25,900,000*	*31,300,000*	*3,300,000*	1,000,000
2003	6,000,000	*27,100,000*	*33,100,000*	*1,800,000* (6% increase)	5% (1,520,000)
2004	*6,100,000*	*29,300,000*	*35,400,000*	*2,300,000* (7% increase)	Maintain
2005	*6,100,000*	*30,400,000*	*36,500,000*	*1,100,000* (3.1% increase)	3% or (1,000,000)
2006	--	--	--	Mar 2007	3% or (1,000,000)
2007	--	--	--	Mar 2008	Maintain FY2005 enrollment
2008	--	--	--	Mar 2009	Maintain FY2005 enrollment

*Based on most recent data available as of January 2007.

Note: Italicized figures are estimates based on incomplete Title XIX data submitted by the States. Also, these numbers reflect new information compared to previous publications. Enrollment data previously published for some States may have been based on estimates rather than final State-reported data. In the case of Medicaid data, a number of States did not report Medicaid enrollment in SEDS until recently. Therefore, estimates were initially used, based on other historical Medicaid data. As final data become available, those Medicaid estimates are updated. In addition, some States report preliminary data for their quarterly reports, and refine those numbers as final data become available. For example, States that have retroactive eligibility update enrollment for previous quarters. For any State that is delayed in reporting enrollment data, estimates for this goal are used based on either the previous years' data for that State or data submitted through Medicaid Statistical Information System reporting until final data is reported in SEDS.

[2] Ku, Leighton and Brian Bruen, "The Continuing Decline in Medicaid Coverage," December 1999.

State Children's Health Insurance Program

Long Term Goal: Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP)			
Annual Measure	**FY**	**Target**	**Result**
Improve Health Care Quality Across and Medicaid and SCHIP (*outcome*) **Baseline:** Developmental	**State Children's Health Insurance Program**		
	2008	Disseminate best practices of States' quality improvement efforts.	Jun-08
	2007	Revise FY 2006 Annual report template to reflect States' quality improvement efforts.	Mar-07
	2006	Improve reporting by States on core performance measures in order to have at least 25% of States reporting four core performance measures in FY 2005 Annual Report.	Goal met
	2005	(a) Continue to collect core performance measurement data from States through the State annual reports; (b) Use the new automated State Annual Report Template System (SARTS) to analyze and evaluate performance data; and (c) Provide technical assistance to States on establishing baselines, measurement methodologies, and targets for SCHIP core measures.	Goal met
	2004	(a) Refine data submission, methodological processes, and reporting; (b) Produce 2002 performance measures in standardized reporting format; and (c) Collect 2003 data (baseline) from States.	Goal met
	2003	To begin working on States on the Performance Measurement Partnership Project. (a) Report on results of the meeting with States and identify a timeline for implementing recommendations; (b) Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging improvement; (c) Initiate action steps for implementing recommendations; and (d) Begin to implement core SCHIP performance measures.	Goal met
	Medicaid		
	2007	Goal discontinued	N/A
	2006	Collect, on a voluntary basis, 2003 performance measurement data from a minimum of 13 States, and continue to provide technical assistance to States to improve performance measurement calculation and reporting.	Goal Met
	2005	(a) Refine the strategy and work plan for the provision of technical assistance to States in performance measurement calculation and reporting. (b) Collect on a voluntary basis, 2002 performance measurement data from a minimum of 10 States; (c) Continue to provide technical assistance to improve State capability for performance measurement calculation and reporting, and to encourage voluntary reporting by additional States.	Goal met

Long Term Goal: Improve Health Care Quality Across Medicaid and the State Children's Health Insurance Program (SCHIP)			
Annual Measure	**FY**	**Target**	**Result**
	2004	(a) Continue to work with State representatives and update the timeline for implementing recommendations; (b) Continue to identify a strategy for improving health care delivery and/or quality; and (c) Continue action steps for implementing recommendations.	Goal met
	2003	(a) Report on the results of the meeting with State representatives and identify a timeline for implementing recommendations; and (b) Identify a strategy for improving health care delivery and/or quality, and specify measures for gauging improvement; and (c) Initiate action steps for implementing recommendations.	Goal met
Data Source: Developmental. Beginning in FY 2003, CMS began collecting SCHIP performance measures through the SCHIP annual reports. In addition, CMS created an automated web-based system -- SARTS, which allows States to input and submit their annual reports to CMS via the internet. This system also allows CMS to better analyze data submitted by States, including monitoring the progress States are making toward meeting their individual goals related to the SCHIP core performance measures. States began reporting in SARTS, on a voluntary basis, for the SCHIP FY 2003 Annual Reports. In 2003-2004, two States were piloted for assessing ability to report performance measurements via administrative data in MSIS. States were supportive of the effort, but continued to implement performance measures via other mechanisms, such as the Health Plan Employer Data and Information Set (HEDIS®) reporting. In 2005, performance measures publicly reported from ten States were evaluated in conjunction with State quality improvement initiatives.			
Data Validation: Developmental. CMS will monitor performance measurement data related to the SCHIP core performance measures through SARTS. In addition, State performance data submitted through SARTS will be monitored to assure that individual State goals are consistent with the approved Title XXI SCHIP State plan. In 2004, validity testing was performed on use of MSIS administrative data for performance measurement reporting, and was found not to be reliable in producing accurate results at the time.			
Cross Reference: This performance goal supports HHS Strategic Goals 3 and 5 and the President's Management Agenda, and is linked to the Secretary's 500-Day Plan.			

Discussion: The Performance Measurement Partnership Project (PMPP) is Medicaid's first effort to develop performance measures based on consensus and voluntary State participation. As part of this effort, seven HEDIS® measures were proposed by a workgroup of State Medicaid and SCHIP officials as performance indicators that States would report annually on a voluntary basis. The following are the seven proposed performance measures (SCHIP-related measures in bold):

Adult access to preventive/ambulatory health services; **Children's access to primary care practitioners**; Comprehensive diabetes care (HbA1c tests); Prenatal and postpartum care (prenatal visits); **Use of appropriate medications for children with asthma**; **Well child visits for children in the first 15 months of life**; and **Well child visits in the 3rd, 4th, 5th, and 6th years of life.**

A data collection tool for States to voluntarily report measurement data on the core set of performance measures as a pilot test was developed and cleared by OMB in May 2004. Results from the initial data collection effort supported the need for continued technical

assistance to States to improve State reporting capability and encourage voluntary reporting of performance measurement data by additional States.

CMS and States planned a strategy for the coordinated use of performance measures for Medicaid and SCHIP programs for quality improvement in both fee-for-service (FFS) and managed care delivery systems. Communications with States indicated they were supportive of this position. As CMS and States proceed to implement this mutually agreed upon strategy, multiple approaches to using performance measures to achieve improvements in health care quality were identified.

The need for additional time and work to develop specifications for reporting the performance measures for FFS delivery systems was identified. States were asked to report performance measurement values (on a voluntary basis) for the seven HEDIS® measures to CMS until such time as a unified data system can be used to calculate measures on behalf of States.

SCHIP

CMS and Mathematica Policy Research (MPR) continued to provide technical assistance to States in preparation for the FY 2005 annual reporting cycle, with an emphasis on helping States develop and/or implement quality improvement strategies. MPR analyzed the FY 2005 SCHIP Annual Reports, which included 48 certified annual reports with 30 States (60 percent of all States) reporting on four core performance measures and seven States reporting on three core performance measures. As a result of the MPR analysis, CMS has updated the FY 2006 SCHIP annual report template and SARTS to reflect states' quality improvement efforts.

States have shown dramatic improvement in reporting performance measures since the collection of the baseline data from FY 2003. The targets of this goal reflect the next steps-the collection, analysis, and dissemination of States' quality improvement strategies toward establishing and enhancing quality improvement in SCHIP nationwide.

Medicaid

Medstat, the project contractor, completed an analysis on the feasibility of using Medicaid Statistical Information System (MSIS) data to calculate the Medicaid performance measures. In 2004, results from two States targeted for specific reporting analysis suggested that MSIS can be used to calculate a current set of performance measures in States with predominantly fee-for-service Medicaid programs. MSIS data, however, has been found to be incomplete and inconsistent for some State-level reporting[3] For 2005-2006, Medstat collected publicly-reported HEDIS® and HEDIS-like data from 10 and 13 States respectively with longevity of quality measurement and/or documented interventions to impact performance. The thirteen States analyzed for 2006 showed the following results:

[3] Kaiser Commission on Medicaid Facts. "A Brief Overview of Our Medicaid Data Sources". January 2006. Accessible at: www.kff.org/medicaid/upload/OverviewMedicaidDataSources.pdf

Six States collected administrative Managed Care Organization (MCO) data to generate rates; Seven States use their own administrative data to generate measures; Two States reported all seven PMPP Measures; Rates remained relatively stable for 54 percent of measures; Non-PMPP measures represented 45 percent of all measures reported for the thirteen States; Almost 60 percent of the PMPP measures demonstrated an increase, compared to 55 percent of the non-PMPP measures; Measures with the largest increase include comprehensive diabetes testing, well child visits in the first 15 months of life and use of appropriate medications for asthma; The most frequent State-specific measures were related to prenatal care, well care, EPSDT and access; and eight PMPP States are included in National Committee for Quality Assurance (NCQA) Quality Compass data which provides benchmark data for Medicaid MCO plan performance; "Best Practices" that were identified included: comparison of performance measurement rates across three Medicaid models (MCO, PCCM and FFS); conducting multiple focused studies and quality improvement programs to improve rates; publishing consumer report cards or use of interactive web-based comparison of health plan performances; and use of value-based purchasing model or other incentives to improve health plan performance results including implementation of physician level incentives.

After several years of data collection evaluation efforts, it is evident the States continue to have great variation in system capabilities, quality improvement expertise, and performance measurement knowledge. The 2005 roll-out of the CMS Quality Improvement Road-Map with the vision for "the right care for every person every time," provided a timely opportunity to redefine and refocus the Medicaid Quality GPRA Goal.

The Performance Measurement Partnership Project completed measurement of State performance measurement reporting in September 2006 to broaden analysis beyond reporting and identify improvement in overall quality in Medicaid services. The final report, *Thirteen State Medicaid Core Performance Measure Reporting Summary: Highlighting Model Practices*, provides the findings. The conclusion of this part of the project also included a "Medicaid Quality Reporting Technical Assistance Web-Conference", which included presentation of the final results of the PMPP Project and future recommendations to State Medicaid representatives and CMS.

The current goal "To Improve Health Care Quality Across Medicaid" is scheduled for retirement in 2007 to be replaced by a new goal focusing on improvement of State quality strategies and reported quality improvement outcomes. The second part of the goal stated as "Improve Health Care Quality Across the State Children's Health Insurance Program (SCHIP)" will continue through 2008.

State Grants and Demonstrations

Long Term Goal: Accountability through Reporting in the Medicaid Infrastructure Grant Program			
Efficiency Measure	**FY**	**Target**	**Result**
By December 31st of the fiscal year prepare an annual report for the preceding calendar year on the status of the grantees in terms of the States' outcomes in providing employment supports for people with disabilities. **Baseline:** No such report previously produced.	*2008*	Annual report	Dec-08
	2007	Annual report	Dec-07
	2006	Annual report	Goal met
	2005	N/A	N/A
Data Source: CMS uses wage data from State unemployment insurance system; Medicaid enrollment and claims data from the State Medicaid Management Information System and the Medicaid Statistical Information System; SSA employment and disability status data; and Medicare claims data. In addition, States supply data through quarterly progress reports and an annual Medicaid Buy-in data report.			
Data Validation: Reports are complied using a cadre of large national data base sources. These statistical data bases are validated internally by the respective state/federal agency data and research personnel.			
Cross Reference: This performance goal supports HHS Strategic Goals 3 and 6, and is linked to the Secretary's 500-Day Plan.			

Discussion: The Ticket to Work and Work Incentives Improvement Act of 1999 provides the Centers for Medicare & Medicaid Services the responsibility for making grants to States for the following purpose: "to support the design, establishment, and operation of State infrastructures that provide items and services to support working individuals with disabilities" (Section 203 of the Ticket to Work and Work Incentives Improvement Act). These infrastructures include Medicaid State plan options to provide Medicaid assistance for workers with disabilities, to improve access for these workers to personal assistance services, training and outreach programs to equip State Medicaid workers to 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 establishment of Medicaid services for workers with disabilities (Medicaid Buy-In).

CMS has committed to providing an annual report describing the goals established by individual grantees, their accomplishments, and the problems or issues that have arisen. The report will include information on the States' efforts to adopt and improve the Medicaid Buy-In and their efforts to provide personal assistance services to people with disabilities both in their homes and on the job. As CMS moves into the sixth and seventh years of funding, it will focus on the States' activities to build comprehensive employment systems for people with disabilities within their States. A major portion of the report will focus on employment outcomes within the States. CMS will report on the job behavior of people with disabilities in each of the States.

To meet our FY 2006 target, the first of these reports was prepared and shared with participating States, summarizing their progress through December 31, 2005, the fifth year of this eleven year grant program. The report captures States progress in expanding services and supports including: (1) the provision of personal assistance services; (2) the provision of Medicaid type health insurance referred to as a Medicaid Buy-in; and (3) earnings data for workers with disabling conditions. Significant findings follow.

At the end of 2005, thirty-one States had Medicaid Buy-In programs in operation compared to eight states prior to passage of the Ticket legislation. One State (Missouri) terminated its Buy-in program during 2005, although efforts there have been renewed to reenact a Buy-in program

with a different set of eligibility rules. Several States reported that they are actively pursuing Buy-In programs.

In 1999, nearly 3,000 individuals were receiving benefits under a Medicaid Buy-in. At the end of 2005, that number jumped to more than 69,000 workers in 29 States with Medicaid Infrastructure Grant (MIG) projects receiving Medicaid benefits under the Buy-In options.

Based on the most recent years for which data are available (2003 and 2004), earnings of Buy-In participants for 27 States with both a MIG project and a Medicaid Buy-in, reveal that 66 percent of participants had reported earnings in 2004.

Although the average earnings for all participants is relatively low compared to average earnings for all workers, the annual earnings in a number of the MIG States is significantly higher. In 2004 in several MIG states reported earnings earned on average more than $10,000 a year. Also, 23 percent of participants nationally had annual earnings which were more than the annualized Substantial Gainful Activity level ($810 per month for 2004) for the Social Security Disability Insurance program

In its next annual report on the MIG program, CMS will build on this baseline of information to provide a more complete picture of the progress made by the States to encourage their citizens with disabilities to seek and retain employment.

Providing a report of this information will allow fellow grantees and interested stakeholders to judge the relative success of each grant. It will give examples of best practices and because of a heavy reliance on outcome measures, will allow States to assess long-term program improvements.

In terms of the content of the report (i.e., employment outcomes) several factors can influence the targets. Most importantly, the economy of the State will influence the availability of jobs. Efforts by the Social Security Administration around the Ticket to Work and other employment incentives can have an effect as well. Department of Labor Work Opportunity Centers, Vocational Rehabilitation programs, and other State and Federal government efforts can impact progress toward the outcomes reported.

CMS will use these reports to set conditions for future grants to the States. CMS believes that one of the strongest management tools it can employ is providing feedback to the grantees on their performance.

Clinical Laboratory Improvement Amendments

Long Term Goal: Improve Cytology Laboratory Testing			
Efficiency Measure	**FY**	**Target**	**Result**
Improve Cytology Laboratory Testing **Baseline**: Cytology proficiency testing (PT) data will be collected in CY 2006 to determine the percent enrollment and performance rate over time of cytotechnologists and pathologists.	*2008*	1. Enroll and test 90% of the applicable cytotechnologists and pathologists subject to PT. 2. Design and implement an effective database for tracking compliance for cytology PT requirements.	TBD
	2007	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.	CY 2006 data available Apr-07
Data Source: The primary data will be an Access database developed and managed by CMS. This database will monitor all laboratories performing gynecologic cytology testing, proficiency testing enrollment information, and performance results. Because this proficiency program is testing specific personnel, every individual who examines or interprets gynecologic cytology slides will be listed according to his/her employment site(s). Enrollment and performance data will also be maintained on an individual basis.			
Data Validation: CMS Central Office (CO) will maintain access of this database. Regional Office and State Agency representatives will be contacted directly by CO in the event of performance issues. The PT programs that provide the samples undergo an annual and ongoing review process coordinated by CMS with assistance from the Centers for Disease Control and Prevention, e.g., the PT data system and PT programs are monitored to ensure that PT data transmitted to CMS is accurate, complete, and timely.			
Cross Reference: This performance goal supports goal 5 of the HHS Strategic Plan, and is linked to the Secretary's 500-Day Plan.			

Discussion: Congress enacted the Clinical Laboratory Improvement Amendments (CLIA) of 1988 (Public Law 100-578) to amend CLIA '67 because there were significant problems in, among other things, enforcing compliance with CLIA '67 standards, ineffective proficiency testing (PT), inadequate oversight for cytology testing, and the proliferation of unregulated laboratories.

CLIA '67 did not regulate all laboratories performing testing on gynecologic specimens. It did not provide for a limit on the number of gynecologic cytology specimens (i.e., Pap

smears) that could be examined by an individual in a 24-hour period. Consequently, a number of "Pap Mills" appeared that produced Pap smear results that were erroneous and life threatening. (There is a direct relationship between a cytology test finding and the diagnosis of a specific clinical disease. Laboratory testing of gynecologic cytology specimens frequently provides the first indication of cervical cancer.) The examination and interpretation of gynecologic cytology specimens represents one of the most successful screening tests available to women and has resulted in a 75 percent decrease in deaths from cervical cancer since its introduction.

Regulations on cytology PT became effective September 1, 1992. Whereas, routine PT evaluates the laboratory's proficiency, cytology PT evaluates the proficiency of individuals who examine or interpret Pap smears. These cytology PT requirements remain in effect today.

Implementation of cytology PT has taken an extended period of time due to the absence of qualified national proficiency testing organizations, an insufficient number of referenced cytology testing materials, and significant technical difficulties. Currently, there are three CMS-approved cytology PT programs in the country for 2006. We anticipate the approval of additional programs in 2007.

This approval demonstrates CMS' continued dedication and commitment to improve one of the principal issues on women's health, that is, accurate and reliable gynecologic cytology specimen results. With the implementation of cytology PT on a national basis, CMS has implemented every provision of the CLIA law.

Currently, there are 3,800 laboratories certified in the subspecialty area of cytology. Laboratories must ensure that each cytotechnologist and pathologist examining gynecologic cytology preparations is enrolled in a CMS-approved Cytology Proficiency Testing program. Cytotechnologists and pathologists must be tested once per year and score at least 90 percent. Laboratories must ensure that individuals who do not obtain a score of 90 percent must be retested within the required timeframes. Laboratories must take the appropriate remedial actions for any individual who does not score at least 90 percent on a cytology proficiency test event.

Clinical Laboratory Improvement Amendments

Long Term Goal: Improve and Sustain Testing Accuracy in Laboratories Holding a CLIA Certificate of Waiver (CW) ***(Discontinued after FY 2006)***			
Efficiency Measure	**FY**	**Target**	**Result**
Increase the percentage of labs adhering to manufacturer's instructions **Baseline**: Average of FY 2003 and FY 2004: baseline data collected on a national scale for number of labs holding a certificate of waiver that do not follow manufacturer's instructions. a) **61.4% of labs** determined to be following the manufacturer's instructions upon initial visit; b) **13% of labs** revisited after an initial determination of failing to follow the manufacturer's instructions; and c) A total number of **56 labs** improved conformance with manufacturer's instructions, after an initial determination of non-conformance.	*2006*	**a) 5% increase** in percentage of labs determined to be following manufacturer's instructions upon initial visit **b) 50% increase** in number of labs revisited (after an initial determination of failing to follow manufacture's instructions); and **c) 40% increase** in absolute number of labs that improve their conformance with manufacturer's instructions after an initial determination of non-conformance.	a) Goal Met: 69% of labs (7.6% increase) b) Goal Met: 69% of labs revisited (56% increase) c) Goal Met: 353 labs Improved (530% increase)
	2005	To set target for FY 2006.	Goal met
	2004	To be determined. We will determine our FY 2004 target once we have reviewed baseline data.	Goal met
Data Source: Universe of labs selected from Online Survey, Certification and Reporting System (OSCAR). As of FY 2003, the State Surveyors Information System (SSIS) will be the primary source for data collection and reporting improvement. The SSIS is a web-based program developed and maintained by the CDC that provides a database to house, analyze, and retrieve information on waived labs.			
Data Validation: We continue to update and streamline SSIS to ensure that appropriate and consistent information is gathered, analyzed, and reported. Streamlining efforts have included upgrades to the questionnaire and extensive system edits to ensure accurate and reliable data, and improved reporting capabilities. Previously, these process improvements have resulted in unanticipated delays with retrieving and analyzing the data. To ensure the integrity of the data, we will maintain regular communication with the State surveyors, and the CDC.			
Cross Reference: This performance goal supports goal 5 of the HHS Strategic Plan, and is linked to the Secretary's 500-Day Plan.			

Discussion: Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988, establishing quality standards for all lab testing to ensure the accuracy, reliability, and timeliness of patient test results regardless of where the test was performed. Certificates are issued to labs based on the complexity of testing that they perform. Labs are issued a certificate of waiver if they perform only waived tests. A waived test is defined as a simple lab test that has been determined by the Secretary of the Department of Health and Human Services to have an insignificant risk of erroneous results. Labs performing waived tests are required by CLIA to follow manufacturer's instructions for performing the test, but they are not routinely surveyed.

Changes and Improvements over Previous Years

The following table shows the performance goals from FY 1999 to the present submission, FY 2008. (Following this chart is a section for the Revised Final FY 2007 Annual Performance Goals.) Our plan has evolved over time with goals reflecting administration priorities and major pieces of legislation, including the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and more recently the Deficit Reduction Act, passed in 2006.

Performance Goals by Program	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08
Medicare										
Improve satisfaction of Medicare beneficiaries with the health care services they receive	● ✓	● ✓	● ✓	● ✓	● ✓	● ✓	Ⓟ ✓	● ✓	✓	✓
Improve Medicare's administration of the beneficiary appeal process.		○ ✓	Ⓟ ✓	Ⓟ ✓	● ✓	● ✓	● ✓	● ✓	✓	✓
Implement the new Medicare Prescription Drug Benefit.						● ✓	● ✓	● ✓	✓	✓
Decrease the prevalence of restraints in nursing homes.	● ✓	● ✓	● ✓	● ✓	● ✓	○ ✓	● ✓	● ✓	✓	✓
Decrease the prevalence of pressure ulcers in nursing homes.		● ✓	○ ✓	○ ✓	○ ✓	● ✓	● ✓	● ✓	✓	✓
Percentage of States that survey all nursing homes at least every 15 months.										✓
Percentage of States that survey all home health agencies at least every 36 months.										✓
Percentage of States for which CMS makes a non-delivery deduction from the State's subsequent year survey and certification funds.										✓
Improve beneficiary telephone customer service.		○ ✓	● ✓	Ⓟ ✓	● ✓	● ✓	● ✓	● ✓	✓	✓
Sustain Medicare payment timeliness consistent with statutory floor & ceiling requirements.		● ✓	● ✓	● ✓	● ✓	● ✓	● ✓	● ✓	✓	✓
Increase the use of electronic commerce/standards in Medicare.	● ✓	● ✓	Ⓟ ✓	● ✓	Ⓟ ✓	Ⓟ ✓	● ✓	Ⓟ ✓	✓	✓
Maintain CMS' improved rating on financial statements.	● ✓	● ✓	● ✓	● ✓	● ✓	● ✓	● ✓	● ✓	✓	✓
Implement Medicare contracting reform.							● ✓	● ✓	✓	✓
Develop and implement an enterprise architecture.		● ✓	Ⓟ ✓	● ✓	Ⓟ ✓	● ✓	● ✓	● ✓	✓	✓
Strengthen and maintain diversity at all levels of CMS.					● ✓	● ✓	● ✓	● ✓	✓	✓
Implement Regional Preferred Provider Organizations (PPOs).								● ✓	✓	✓
Assure the purchase of quality, value, and performance in State Survey and Certification activities.						● ✓	● ✓	● ✓	✓	
Assess the relationship between CMS research investments and program improvements.	● ✓	Ⓟ ✓	● ✓	● ✓	● ✓	● ✓	● ✓	● ✓		

Performance Goals by Program	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08
Improve CMS' information systems security.		○ ✓	Ⓟ ✓	Ⓟ ✓	○ ✓	Ⓟ ✓	● ✓	● ✓		
Implement the new Medicare endorsed prescription drug card.						● ✓	● ✓			
Improve effectiveness of dissemination of Medicare information to beneficiaries. (Beginning FY 2001: fee-for-service component split as a new goal.)			● ✓	● ✓	● ✓	Ⓟ ✓	● ✓			
Improve beneficiary understanding of basic features of the Medicare program.			● ✓	● ✓	● ✓	○ ✓	● ✓			
Improve CMS oversight of Medicare fee-for-service contractors.			● ✓	● ✓	● ✓	● ✓				
Increase referral of eligible delinquent debt for cross servicing.				○ ✓	Ⓟ ✓	● ✓				
Develop new Medicare payment systems in fee-for-service and Medicare Advantage.	● ✓	● ✓	● ✓	● ✓	● ✓	● ✓				
Improve CMS' management structure.					● ✓	● ✓				
Increase awareness about the opportunity to enroll in the Medicare Savings Programs.				● ✓	● ✓	○ ✓				
Improve the management of the Survey and Certification budget development and execution process.			● ✓	● ✓	● ✓					
Improve CMS' workforce planning.				● ✓	Ⓟ ✓					
Implement CMS Restructuring Plan to create a more citizen-centered organization.					● ✓					
Enroll beneficiaries into managed care plans timely. FY 2002-2003: Process Medicare Advantage Organization elections in compliance with the BBA beneficiary election provisions.	○ ✓	● ✓	● ✓	○ ✓						
Improve effectiveness of dissemination of Medicare information to beneficiaries in fee-for-service. (FY 2000, combined with the National *Medicare & You* Education Program beneficiary information goal,)		● ✓	● ✓	● ✓						
Ensure compliance with HIPAA requirements through the use of policy form reviews.		● ✓	● ✓							
Increase health plan choices available to Medicare beneficiaries (removed in FY 2001 to focus on areas under CMS' control.)	○ ✓	● ✓								
Ensure millennium compliance (readiness) of CMS computer systems.	● ✓	● ✓								
Quality Improvement Organizations										
Protect the health of Medicare beneficiaries age 65 years and older by increasing the percentage of those who receive an annual vaccination for influenza and a lifetime vaccination for pneumococcal.	● ✓	● ✓	Ⓟ ✓	○ ✓	○ ✓	Ⓟ ✓	○ ✓	🕓 ✓	✓	✓

Performance Goals by Program	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08
Improve early detection of breast cancer among Medicare beneficiaries age 65 years and older by increasing the percentage of women who receive a mammogram.	● ✓	● ✓	● ✓	● ✓	○ ✓	○ ✓	○ ✓	🕓 ✓	✓	✓
Improve the care of diabetic beneficiaries by increasing the rate of hemoglobin A1c and cholesterol (LDL) testing.								● ✓	✓	✓
Protect the health of Medicare beneficiaries by optimizing the timing of antibiotic administration to reduce the frequency of surgical site infection.					● ✓	● ✓	● ✓	🕓 ✓	✓	✓
Protect the health of Medicare beneficiaries by increasing the percentage of dialysis patients with fistulas as their vascular access for hemodialysis.								● ✓	✓	✓
Improve the care of diabetic beneficiaries by increasing the rate of diabetic eye exams.			● ✓	● ✓	● ✓	○ ✓	○ ✓			
Improve heart attack survival rates.		○ ✓	○ ✓	○ ✓						
Medicare Integrity Program										
Reduce the percentage of improper payments made under the Medicare fee-for-service program.	● ✓	● ✓	○ ✓	○ ✓	○ ✓	○ ✓	● ✓	● ✓	✓	✓
Improve the provider enrollment process.				Ⓟ ✓	Ⓟ ✓	○ ✓	Ⓟ ✓	● ✓	✓	✓
Improve the effectiveness of the administration of Medicare Secondary Payer (MSP) provisions by increasing the number of voluntary data sharing agreements with insurers or employers.						● ✓	● ✓	● ✓	✓	✓
Reduce the Medicare contractor error rate.						● ✓	● ✓	● ✓	✓	✓
Decrease the Medicare provider compliance error rates.						● ✓	Ⓟ ✓	○ ✓	✓	✓
Assist States in conducting Medicaid payment accuracy studies for the purpose of measuring and ultimately reducing Medicaid payment error rates.			○ ✓	● ✓	● ✓	● ✓	Ⓟ ✓			
Develop and implement methods for measuring program integrity outcomes.			● ✓	Ⓟ ✓	● ✓					
Increase Medicare Secondary Payer liability & no-fault dollar recoveries. Focus changed beginning FY 2001 to increase Medicare Secondary Payer credit balance recoveries and/or decrease recovery time. FY 2003: Improve the process of credit balance recoveries.		● ✓	● ✓	● ✓	● ✓					
Assess program integrity customer service.				● ✓	● ✓					
Improve the effectiveness of program integrity activities through the successful implementation of the Comprehensive Plan for Program Integrity. Goal was completed in FY 2001.			Ⓟ ✓							
Improve the efficiency of the medical review of claims. (Goal discontinued, focus change from quantity to quality.)		○ ✓								

Performance Goals by Program	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08
Reduce the percentage of Medicare home health services provided for which improper payment is made.	● ✓	○ ✓								
Increase the ratio of recoveries identified to audit dollars spent.		● ✓								
Medicaid										
Estimate the Payment Error Rate in the Medicaid and SCHIP Programs.								🕓 ✓	✓	✓
Increase the number of States that demonstrate improvement related to access and quality health care through the Medicaid Quality Improvement Program.										✓
Percentage of beneficiaries in Medicaid Managed Care Organizations.										✓
Percentage of beneficiaries who receive home and community-based services.										✓
Percentage of Medicaid Section 1115 demonstration budget neutrality reviews completed out of total number of operational demonstrations for which targeted budget reviews are scheduled.										✓
Medicaid Integrity Program, Percentage Return on Investment.										✓
*Improve the quality of health care for Medicaid beneficiaries through demonstrated enhancements to overall state quality strategies.									✓	
Improve health care quality across Medicaid and the State Children's Health Insurance Program (SCHIP). (In FY 2007, Medicaid & SCHIP are separate goals.*)					Ⓟ ✓	● ✓	● ✓	● ✓		
Increase the percentage of Medicaid two-year old children who are fully immunized. (FY 1999: Work with States to develop Medicaid program performance goals.)	● ✓	● ✓	● ✓	● ✓	● ✓	● ✓	● ✓			
Provide to States linked Medicare and Medicaid data files for dually eligible beneficiaries.	● ✓	● ✓	● ✓	● ✓						
Improve access to care for elderly & disabled Medicare beneficiaries who do not have public or private supplemental insurance.	● ✓	● ✓	Ⓟ ✓							
State Children's Health Insurance Program										
Decrease the number of uninsured children by working with States to enroll children in SCHIP and Medicaid.	● ✓	● ✓	● ✓	● ✓	● ✓	● ✓	● ✓	🕓 ✓	✓	✓
*Improve health care quality across Medicaid and the State Children's Health Insurance Program (SCHIP) **Medicaid through FY 2006*									✓	✓
State Grants & Demonstrations										
Accountability through reporting in the Medicaid Infrastructure Grant Program.								● ✓	✓	✓
Clinical Laboratory Improvement Amendments (CLIA)										
Improve cytology laboratory testing.									✓	✓

Performance Goals by Program	FY 99	FY 00	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08
Improve and sustain testing accuracy in laboratories holding a CLIA certificate of waiver.						● ✓	● ✓	● ✓		
Improve/sustain laboratory testing accuracy	● ✓	● ✓	● ✓	● ✓	● ✓					

*In FY 2007, Medicaid & SCHIP are separate goals.

✓ **Goal in identified year**
● **Goal met**
○ **Goal not met**
Ⓟ **Goal partially met**
🕓 **Final data pending**

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Revised Final FY 2007 Annual Performance Goals

MEDICARE PROGRAM

Improve Medicare's Administration of the Beneficiary Appeals Process

Original FY 2007 Target
Medicare Advantage: Enhance Medicare Appeals System (MAS) functionality and develop the fourth increment of the MAS
FFS: Enhance MAS functionality and develop the fourth increment of the MAS

Revised Final FY 2007 Target
Medicare Advantage: Enhance MAS functionality and support major maintenance releases
FFS: Enhance MAS functionality and support major maintenance releases

Rationale
The FY 2007 goal was changed to reflect the "support (of) major maintenance releases" because the last "Increment" for the Medicare Appeals System (MAS) was Increment C. CMS thought the naming process would continue and have Increment D, however, this was not done and we now only have major maintenance releases.

Implement the New Medicare Prescription Drug Benefit

Original FY 2007 Target
1. a. 50.9 percent
   b. 54.1 percent
   c. 29.3 percent
2. TBD

Revised Final FY 2007 Target
1. a. 62 percent
   b. 64 percent
   c. 45 percent
2. Publish Part D sponsor performance metrics on the Medicare Prescription Drug Plan Finder (MPDPF) tool

Rationale
Concerning our targets measuring beneficiary awareness and knowledge of the new Medicare prescription drug program, we were able to increase our targets for FY 2007 based on the current progress we have made with these targets.

The systems target was developed to assist beneficiaries making enrollment decisions for the FY 2007 plan year. To help achieve this, CMS collected, analyzed and published the results of performance analysis on the Medicare Prescription Drug Plan Finder tool.

Increase the Use of Electronic Commerce/Standards in Medicare

Original FY 2007 Target

(a) EMC rates: intermediaries – 98 percent and carriers – 90 percent. (b) Targets for electronic claims status and ERA will be set based on data collected in FY 2006. (c) Reduce the base line FY 2005 paper remittance advice volume by 50 percent for both intermediaries and carriers. (d) Develop initial goal for eligibility query. (e) Obtain 100 percent EFT for all physicians, suppliers and providers with the exception of providers waived via the Administrative Simplification Compliance Act (ASCA).

Revised Final FY 2007 Target

(a) EMC rates: intermediaries – 99 percent; carriers – 92 percent. (b) ERA rates: intermediaries – 55 percent; carriers – 37 percent. (c) Electronic claims status volume will increase by 5 percent from the FY 2006 level. (d) Eligibility query: Number of Internet users will increase to 1,000. (e) Obtain 100 percent Electronic Funds Transfer (EFT) for all new providers; and convert remaining physicians, suppliers, and providers not currently utilizing EFT to electronic payment.

Rationale

The changes to the FY 2007 targets for Electronic Media Claims and Electronic Remittance Advice were due to their actual performance in FY 2006. These targets performed better than expected because of the various measures CMS took to reduce the amount of paper used and to increase electronic usage.

The target for reducing the paper remittance volume was removed from the goal because the objective of this goal is to maintain, and, in the long-run, increase the percentage of activities accomplished electronically, rather than on paper form, telephone, or through another manual process.

Changes to the FY 2007 target for EFT are the result of competing priorities. CMS is committed to leading an IT modernization for an E-health system to achieve increased operational efficiency and better services. Moving to a fully electronic payment system will expedite payment to providers and conserve vital Medicare dollars.

Strengthen and Maintain Diversity at all Levels of CMS

Original FY 2007 Target

Increase representation of EEO groups in areas where they demonstrate under representation

Original Baseline

Comparing the CMS Workforce with the National Civilian Labor Force (CLF), in FY 2000, certain Equal Employment Opportunity (EEO) groups exhibited disparity in representation in the CMS workforce.

Revised Final FY 2007 Target
Increase representation of EEO groups in areas where agency participation is less than the National and/or Federal baseline

Revised Baseline
Comparing the CMS Workforce with the 2000 National Civilian Labor Force (CLF).

Rationale
The intent of the goal remains the same. The changes reflect the current language being used in the field.

Implement Regional PPOs

Original FY 2007 Target
Through the addition of regional PPOs, the span of coordinated care options will increase so they extend to 90 percent of Medicare beneficiaries.

Revised Final FY 2007 Target
Through the addition of regional PPOs, the span of coordinated care options will increase so they extend to 87 percent of Medicare beneficiaries.

Rationale
The FY 2007 target has been modified to reflect the trend of the current marketplace.

QUALITY IMPROVEMENT ORGANIZATIONS

Protect the Health of Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those Who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal

Original FY 2007 Target
Nursing Home Subpopulation (Influenza Vaccination) – TBD
Pneumococcal Vaccination – 69 percent

Revised Final FY 2007 Target
Nursing Home Subpopulation (Influenza Vaccination) – 74 percent
Pneumococcal Vaccination – 69 percent

Rationale
Currently, through the Medicare Current Beneficiary Survey (MCBS), annual estimates of immunization coverage among facility-dwelling persons with Medicare are available. CMS will use MCBS data for the nursing home influenza target until the utility of the Minimum Data Set measure for this group can be determined.

Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Hemoglobin A1c and Cholesterol (LDL) Testing

Original Baseline
Developmental

Original FY 2007 Target
TBD

Revised Final Baselines
A1c testing: 84.3 percent
Lipid testing: 78.1 percent

Revised Final FY 2007 Targets
A1c testing: 85.0 percent
Lipid testing: 80.0 percent

Rationale
This goal was originally developmental. Recent data are now available to set baselines and targets.

Protect the Health of Medicare Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection

Original Baseline
57.6 percent (FY 2001)

Original FY 2007 Target
78.4 percent

Revised Final Baseline
77.5 percent (FY 2005)

Revised Final FY 2007 Target
82.0 percent

Rationale
Based on recent data showing improved performance, we set a new baseline for FY 2007 and beyond and a new FY 2007 target.

Protect the Health of Medicare Beneficiaries by Increasing the Percentage of Dialysis Patients with Fistulas as Their Vascular Access for Hemodialysis

Original FY 2007 Target
43 percent

Revised Final FY 2007 Target
47 percent

Rationale
Based on recent data showing improved performance, we set a new FY 2007 target.

MEDICARE INTEGRITY PROGRAM

Decrease the Medicare Provider Compliance Error Rates

Original FY 2007 Target
20 percent decrease

Revised Final FY 2007 Target
Developmental. Revise methodology.

Rationale
To make this performance measure more useful, consistent and meaningful. CMS is revising the methodology to make the provider compliance error rate an accurate estimate of the effectiveness of provider education. CMS expects to have a revised baseline in place for FY 2008.

Improve the Effectiveness of the Administration of Medicare Secondary Payer (MSP) Provisions by Increasing the Number of Voluntary Data Sharing Agreements with Insurers or Employees

Original FY 2007 Target
Sign 10 additional VDSAs

Revised Final FY 2007 Target
Sign 8 additional VDSAs

Rationale
Due to resource constraints being placed on CMS and its COB contractor by the ongoing implementation issues associated with the new Part D prescription drug benefit, marketing and development efforts associated with developing new VDSA partnerships have been curtailed. In addition, these same implementation issues are impacting resources at our potential new insurer and employer VDSA partners in that they are being forced to delay implementing VDSAs with CMS until the overall Part D prescription

drug benefit program is more stable. For these reasons, we are slightly reducing our GPRA goal in FY 2007 from signing 10 new VDSAs to signing 8 new VDSAs.

MEDICAID

Estimate the Payment Error Rate in the Medicaid and State Children's Health Insurance Programs

Original F 2007 Target
Provide National Medicaid fee-for-service error rate for the FY 2007 Performance and Accountability Report (PAR) based on FY 2006 data and begin to implement the complete error measurement process for Medicaid and SCHIP.

Revised Final FY 2007 Target
a. Medicaid: Begin full implementation of measuring FFS, managed care and eligibility in the second set of 17 States for Medicaid. Report national error rate in FY 2008 PAR.
b. SCHIP: Begin full implementation of measuring FFS, managed care and eligibility in the second set of 16 States for SCHIP. (Tennessee currently has not implemented SCHIP.) Report national error rate in FY 2008 PAR.

Rationale
Target information is clarified in more detail.

Increase the Number of States that Demonstrate Improvement Related to Access and Quality Health Care through the Medicaid Quality Improvement Program (formerly Improve the Quality of Health Care for Medicaid beneficiaries through demonstrated Enhancements to Overall State Quality Strategies)

Original FY 2007 Target
Following technical assistance from CMS, demonstrate that a minimum of 5 States with Managed Care Organizations (MCOs) and/or Prepaid Inpatient Health Plans (PIHPs): (a) Submit enhancements to State Quality Strategies, and (b) Demonstrate improved beneficiary performance reporting.

Revised Final FY 2007 Target
Baseline – number of States = 0

Rationale
The original measure was changed during the Medicaid PART discussions. This long-term measure tracks the number of States participating in the Medicaid Quality Improvement Program (MQIP). MQIP is a CMS program that provides technical assistance to States to bolster their targeted health quality improvement projects. State participation in MQIP is voluntary. CMS plans to use State participation in MQIP to

assess State quality improvement projects. These results will be used as the building blocks for the development of a larger, national-level quality framework.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Decrease the Number of Uninsured Children by Increasing Enrollment in Medicaid and State Children's Health Insurance Program

Original FY 2007 Target
Increase the number of children who are enrolled in regular Medicaid or SCHIP by 3 percent, or approximately 1,000,000 over the previous year.

Revised Final FY 2007 Target
Maintain enrollment at FY 2005 levels.

Rationale
Future enrollment in Medicaid and SCHIP will depend on several factors. States' economic situations and corresponding changes to their Medicaid and SCHIP state plans to address budget issues may lead to decreases in enrollment for some States. The effects of the recently enacted Deficit Reduction Act of 2005 (DRA) on Medicaid enrollment are unclear. SCHIP is due for reauthorization in FY 2007. Associated programmatic changes, along with funding levels, may effect SCHIP enrollment. These factors have lead CMS to reevaluate its FY 2007 target. CMS proposes a more realistic FY 2007 goal of maintaining enrollment at the FY 2005 levels.

CLINICAL LABORATORY IMPROVEMENT AMENDMENTS

Improve Cytology Laboratory Testing

Original FY 2007 Target
Complete the analysis of the initial year of cytology PT and promulgate appropriate regulatory changes to address issues. Target will be set based on CY 2006 data.

Revised Final FY 2007 Target
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.

Rationale
To provide a more detailed description of the target.

Program Assessment Rating Tool Summary
CY 2002 – CY 2006
(Dollars in Millions)

Program	FY 2007 Estimate	FY 2008 Estimate	FY 2008 +/- FY 2007	Narrative Rating
CY 2002 PARTs				
Medicare Integrity Program (Mandatory)	$744	$756	+$12	
Proposed 1/ (Discretionary)	$0	$183	+$183	Effective
State Children's Health Insurance Program 2/	$5,040	$5,040	$0	Moderately effective
CY 2003 PARTs				
Medicare Program	$435,065	$463,319	+$28,254	Moderately effective
State Children's Health Insurance Program 2/	$5,040	$5,040	$0	Adequate
CY 2004/2005 PARTs: Not applicable for CMS				
CY 2006 PARTs				
Medicaid	$168,255	$206,886	+$38,631	Adequate

1/ Discretionary cap adjustment proposal from the FY 2008 President's Budget.
2/ SCHIP funding sunsets after FY 2007; program needs reauthorization. Funding level of $5,040,000,000 is in CMS baseline for FY 2008 and beyond; however, under current law, CMS has no budget authority to access this funding.

Summary PART Narratives

Medicare:
Medicare received a Moderately Effective score as a result of the PART evaluation. The PART summary can be viewed at www.ExpectMore.gov. We are taking the following actions to improve the performance of the program: continuing to focus on sound program and financial management; continuing timely implementation of the Medicare Prescription Drug, Improvement, and Modernization Act, with specific attention to preventing fraud, waste, and abuse; and increasing efforts to link Medicare payment to provider performance, including differential payments for better performance.

In response to the PART process, the CMS budget request will fund initiatives that support efforts to increase program performance. Funding requests will support further implementation of the HIGLAS project, provide oversight for Medicare Administrative Contractors, link Medicare payment to performance through demonstration projects, and support continued implementation of the Medicare Prescription Drug benefit.

Medicare Integrity Program:
OMB evaluated the Medicare Integrity Program (MIP) for the FY 2004 budget process, and it received an Effective score. The PART summary can be viewed at www.ExpectMore.gov. We are taking the following actions to improve the performance of the program: continue developing and implement safeguards to protect the Medicare Advantage program and the Medicare Prescription Drug Benefit against fraud, waste and abuse and 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.

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 the detail of error rates through increased sampling size and rolling month error rates.

State Children's Health Insurance Program:
The State Children's Health Insurance Program received an Adequate score in the FY 2005 cycle. The PART summary can be viewed at www.ExpectMore.gov. As a result of the PART findings, CMS developed an SCHIP action plan to address certain concerns. 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.

In response to the PART evaluation, CMS is using portions of its budget request to fund initiatives that support efforts to increase program performance. The budget includes

funds that will measure quality improvement on core performance measures, reduce the number of uninsured children and reduce SCHIP improper payments.

Medicaid:
Medicaid received an Adequate score in the FY 2006 cycle. The PART summary will be available at www.ExpectMore.gov in the near future. CMS is developing new goals and will develop an improvement plan as a result of the PART assessment. In response to the PART evaluation, CMS is using portions of its budget request to fund initiatives that support efforts to increase program performance.

DETAIL OF FULL COST*

The full cost estimates included in these charts show the funds expended by CMS to support agency GPRA goals representing each program. The estimates below display the allocation of CMS' budgetary resources among its representative GPRA goals. The information in this section is part of a multi-year effort to improve the integration of budget and program performance information.

*Assumes mandatory budgetary resources equals the amount needed to cover mandatory obligations. Discretionary budgetary resources equals estimated obligations + no-year carryforward + estimated user fee obligations.

MEDICARE

Dollars in Millions

FY 2008 Annual Performance Goals	Program Category	FY 2006	FY 2007	FY 2008
Medicare: Program Level		**$387,642.4**	**$434,618.5**	**$462,765.2**
Medicare: Full Cost		**$387,642.4**	**$434,618.5**	**$462,765.2**
Improve satisfaction of Medicare beneficiaries with the health care services they receive. Implement the new Medicare prescription drug benefit. Implement regional PPOs	**Benefits 1/**	$382,605.0	$429,715.0	$457,688.0
Improve Medicare's administration of the beneficiary appeal process. Maintain CMS' improved rating on financial statements. Percentage of States for which CMS makes a non-delivery deduction from the State's subsequent year survey and certification funds.**	**Financial Mgmt. 2/**	$2,591.3	$2,560.2	$2,644.2
Decrease the prevalence of restraints in nursing homes. Decrease the prevalence of pressure ulcers in nursing homes. Percentage of States that survey all nursing homes at least every 15 months.** Percentage of States that survey all home health agencies at least every 36 months.**	**Quality 3/**	$268.7	$266.5	$299.5

FY 2008 Annual Performance Goals	Program Category	FY 2006	FY 2007	FY 2008
Sustain Medicare payment timeliness consistent with statutory floor & ceiling requirements. Improve beneficiary telephone customer service. Increase the use of electronic commerce/standards in Medicare. Implement Medicare contracting reform Develop and implement enterprise architecture. Strengthen and maintain diversity at all levels of CMS.	**Other Admin. 4/**	$2,177.3	$2,076.8	$2,133.4
CMS Allocated Full Cost		**$387,642.4**	**$434,618.5**	**$462,765.2**
Percentage Allocated		**100.00%**	**100.00%**	**100.00%**

**Goal was developed during the Medicaid PART process.

1/ Benefits dollars derived from the sum of HI Benefits outlays + SMI Benefits outlays + ESRD Networks outlays + Prescription Drug Benefits outlays. Includes the Medicare Drug Demonstration (MMA Sec. 641) and Stabilization Fund.

2/ Financial Management dollars derived from the sum of Treasury obligations + MMA low-income determinations (including SSA MMA obligations) + allocated Program Management (Medicare Operations) obligations, including COB User Fees and Recovery Audit Contractors.

3/ Quality dollars derived from the sum of allocated Program Management (Survey & Cert. + 1/2 R,D&E) obligations.

4/ Other Administration dollars derived from the sum of Federal Admin. obligations + Revitalization Plan obligations + 1/2 Research obligations. This amount also includes the transfer to SSA + other Non-CMS Administration (excluding SSA, Treasury) + MA/PDP and Sale of Data User Fees.

QUALITY IMPROVEMENT ORGANIZATIONS

Dollars in Millions

FY 2008 Annual Performance Goals	Program Category	FY 2006	FY 2007	FY 2008*
Quality Improvement Organizations: Program Level		**$812.3**	**$214.2**	**$336.3**
Quality Improvement Organizations: Full Cost		**$812.3**	**$214.2**	**$336.3**
Protect the health of Medicare beneficiaries age 65 years and older by increasing the percentage of those who receive an annual vaccination for influenza and a lifetime vaccination for pneumococcal. Improve early detection of breast cancer among Medicare beneficiaries age 65 years and older by increasing the percentage of women who receive a mammogram. Improve the care of diabetic beneficiaries by increasing the rate of hemoglobin A1c and cholesterol (LDL) testing Protect the health of Medicare beneficiaries by optimizing the timing of antibiotic administration to reduce the frequency of surgical site infection. Protect the health of Medicare beneficiaries by increasing the percentage of dialysis patients with fistulas as their vascular access for hemodialysis.	**Quality 1/**	$812.3	$214.2	$336.3
CMS Allocated Full Cost		**$812.3**	**$214.2**	**$336.3**
Percentage Allocated		**100.00%**	**100.00%**	**100.00%**

* Funding numbers in FY 2008 are estimates; they have not been finalized and are subject to change.

1/ QIO quality dollars derived from the sum of QIO obligations + allocated Program Management obligations.

HEALTH CARE FRAUD AND ABUSE CONTROL

Dollars in Millions

FY 2008Annual Performance Goals	Program Category	FY 2006	FY 2007	FY 2008
Health Care Fraud and Abuse Control: Program Level		**$1,224.0**	**$1,148.3**	**$1,354.7**
Health Care Fraud and Abuse Control: Full Cost		**$1,224.0**	**$1,148.3**	**$1,354.7**
Reduce the percentage of improper payments made under the Medicare fee-for-service program. Improve Medicare's administration of the beneficiary appeal process. Assure the purchase of quality, value, and performance in State Survey and Certification activities. Reduce the Medicare contractor error rate. Improve the provider enrollment process. Improve the effectiveness of the administration of Medicare Secondary Payer (MSP) provisions by increasing the number of voluntary data exchange agreements with insurers or employers. Improve the Medicare provider compliance rate.	**Financial Mgmt. 1/**	$1,224.0	$1,148.3	$1,354.7
CMS Allocated Full Cost		**$1,224.0**	**$1,148.3**	**$1,354.7**
Percentage Allocated		**100.00%**	**100.00%**	**100.00%**

1/ HCFAC financial management dollars derived from the sum of HCFAC obligations + allocated Program Management obligations.

MEDICAID
Dollars in Millions

FY 2008 Annual Performance Goals	Program Category	FY 2006	FY 2007	FY 2008
Medicaid: Program Level		**$194,790.4**	**$192,016.8**	**$204,051.6**
Medicaid: Full Cost		**$194,790.4**	**$192,016.8**	**$204,051.6**
Decrease the number of uninsured children by working with States to enroll children in SCHIP and Medicaid.	**Benefits 1/**	$184,522.5	$181,959.3	$193,871.0
Estimate the payment error rate in the Medicaid and State Children's Health Insurance programs. Percentage of Medicaid Section 1115 Demonstration Budget Neutrality Reviews completed out of total number of operational demonstrations for which targeted budget reviews are scheduled. Percentage of beneficiaries in Medicaid Managed Care Organizations. Percentage of beneficiaries who receive home and community-based services. Medicaid Integrity Program, percentage return on investment.	**Financial Mgmt. 2/**	$5,121.5	$4,987.7	$5,051.1
Increase the number of States that demonstrate improvement related to access and quality health care through the Medicaid Quality Improvement Program.	**Quality 3/**	$5,146.4	$5,069.8	$5,129.5
CMS Allocated Full Cost		**$194,790.4**	**$192,016.8**	**$204,051.6**
Percentage Allocated		**100.00%**	**100.00%**	**100.00%**

1/ Benefits dollars derived from the sum of Net MAP obligations (including effects of new legislation) + VFC obligations.

2/ Financial Management dollars derived from the sum of Fraud Control Units obligations + 1/2 allocation of S&L Administration obligations + 1/2 of allocated Program Management obligations. Low income determinations booked to Medicare.

3/ Quality dollars derived from the sum of Medicaid Survey & Certification obligations + 1/2 allocation of S&L Administration obligations + 1/2 of allocated Program Management obligations. Note, 4% of S&L Administration allocated to quality functions has been transferred to the SCHIP program for the shared "Partnership" goal in FY 2006. Low income determinations booked to Medicare.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

Dollars in Millions

FY 2008 Annual Performance Goals	Program Category	FY 2006	FY 2007	FY 2008
SCHIP: Program Level		**$4,949.2**	**$5,191.7**	**$5,044.8**
SCHIP: Full Cost		**$4,949.2**	**$5,191.7**	**$5,044.8**
Decrease the number of uninsured children by working with States to enroll children in SCHIP and Medicaid	**Benefits 1/**	$4,538.8	$5,186.9	$5,040.0
Improve health care quality across Medicaid and the State Children's Health Insurance Program (SCHIP).	**Quality 2/**	$410.5	$4.9	$4.8
CMS Allocated Full Cost		**$4,949.2**	**$5,191.7**	**$5,044.8**
Percentage Allocated		**100.00%**	**100.00%**	**100.00%**

1/ Benefits dollars derived from SCHIP benefits obligations.

2/ Quality dollars derived from the sum of allocated Program Management obligations + 4% of Medicaid S&L Administration allocated to SCHIP quality functions for the shared "Partnership" goal in FY 2006.

STATE GRANTS & DEMONSTRATIONS

Dollars in Millions

FY 2008 Annual Performance Goals	Program Category	FY 2006	FY 2007	FY 2008
State Grants & Demonstrations: Program Level		**$2,516.5**	**$824.0**	**$788.3**
State Grants & Demonstrations: Full Cost		**$2,516.5**	**$824.0**	**$788.3**
Accountability through reporting in the Medicaid Infrastructure Grant Program.	**Quality 1/**	$255.2	$53.6	$52.6
CMS Allocated Full Cost		**$255.2**	**$53.6**	**$52.6**
Percentage Allocated		**10.14%**	**6.51%**	**6.67%**

1/ State Grants quality dollars derived from the sum of State Grant obligations (TWWIIA, Background Checks, Health Infrastructure) + allocated Program Management obligations. Excludes funds for Undocumented aliens and DRA, as these are more of a benefits and other/unrelated expense.

CLIA

Dollars in Millions

FY 2008Annual Performance Goals	Program Category	FY 2006	FY 2007	FY 2008
CLIA: Program Level		**$42.7**	**$43.0**	**$43.0**
CLIA: Full Cost		**$42.7**	**$43.0**	**$43.0**
Improve cytology laboratory testing	**Quality 1/**	$42.7	$43.0	$43.0
CMS Allocated Full Cost		**$42.7**	**$43.0**	**$43.0**
Percentage Allocated		**100.00%**	**100.00%**	**100.00%**

1/ Quality dollars assume 100% of the budgeted CLIA obligations, only. The other items are left unallocated, since CMS presents a single CLIA goal to reflect this program category. No PM obligations allocated, since CLIA is self-financing.

FY 2008 CMS Performance Goal Linkage to HHS Strategic Plan

A key concept underpinning the GPRA law is the close linkage of an agency's strategic plan, annual performance goals, and its budget. The next two pages illustrate the linkages of the FY 2008 annual performance goals to the FY 2004-2009 HHS Strategic Plan.

LINK OF FY 2008 CMS PERFORMANCE GOALS AND THE FY 2004-2009 HHS STRATEGIC PLAN

FY 2008 Performance Goals	HHS Strategic Plan Goal*							
	1	2	3	4	5	6	7	8
Medicare								
Improve Satisfaction of Medicare Beneficiaries with the Health Care Services			✓		✓			
Improved Medicare's Administration of the Beneficiary Appeals Process					✓			
Implement the New Medicare Prescription Drug Benefit			✓		✓			
Decrease the Prevalence of Restraints in Nursing Homes			✓		✓			
Decrease the Prevalence of Pressure Ulcers in Nursing Homes			✓		✓			
Improve Beneficiary Telephone Customer Service			✓					
Percentage of States that Survey All Nursing Homes at Least Every 15 Months					✓			✓
Percentage of States that Survey All Home Health Agencies at Least Every 36 Months					✓			✓
Percentage of States for Which CMS Makes a Non-Delivery Deduction From the State's Subsequent Year Survey and Certification Funds								✓
Sustain Medicare Payment Timeliness Consistent with Statutory Floor and Ceiling Requirements			✓					
Increase the Use of Electronic Commerce/Standards in Medicare			✓		✓			
Maintain CMS' Improved Rating on Financial Statements								✓
Implement Medicare Contracting Reform					✓			✓
Develop and Implement an Enterprise Architecture					✓			
Strengthen and Maintain Diversity at all Levels of CMS								✓
Implement Regional PPOs			✓					
Quality Improvement Organizations								
Protect the Health of Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those Who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal	✓		✓					
Improve Early Detection of Breast Cancer Among Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Women Who Receive a Mammogram	✓		✓					
Improve the Care of Diabetic Beneficiaries by Increasing the Rate of Hemoglobin A1c and Cholesterol (LDL) Testing	✓				✓			
Protect the Health of Medicare Beneficiaries by Optimizing the Timing of Antibiotic Administration to Reduce the Frequency of Surgical Site Infection	✓				✓			
Protect the Health of Medicare Beneficiaries by Increasing the Percentage of Dialysis Patients with Fistulas as Their Vascular Access for Hemodialysis	✓				✓			

FY 2008 Performance Goals	HHS Strategic Plan Goal*							
	1	2	3	4	5	6	7	8
Health Care Fraud and Abuse Control (Medicare Integrity Program)								
Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Services Program			✓					✓
Improve the Provider Enrollment Process			✓					✓
Improve the Effectiveness of the Administration of Medicare Secondary Payer (MSP) Provisions by Increasing the Number of Voluntary Data Sharing Agreements with Insurers or Employers								✓
Reduce the Medicare Contractor Error Rate			✓					✓
Decrease the Medicare Provider Compliance Rate			✓					✓
Estimate the Payment Error Rate in the Medicaid and State Children's Health Insurance Programs								✓
Medicaid								
Increase the Number of States that Demonstrate Improvement Related to Access and Quality Health Care Through the Medicaid Quality Improvement Program			✓		✓			
Percentage of Beneficiaries in Medicaid Managed Care Organizations			✓					✓
Percentage of Beneficiaries Who Receive Home and Community-Based Services			✓					✓
Percentage of Medicaid Section 1115 Demonstration Budget Neutrality Reviews Completed Out of Total Number of Operational Demonstrations for Which Targeted Budget Reviews Are Scheduled								✓
Medicaid Integrity Program, Percentage Return on Investment								✓
State Children's Health Insurance Program								
Decrease the Number of Uninsured Children by Working with States to Enroll Children in SCHIP and Medicaid			✓					
Improve Health Care Quality Across the State Children's Health Insurance Program (SCHIP)					✓			
State Grants & Demonstrations								
Accountability through Reporting in the Medicaid Infrastructure Grant Program			✓			✓		
Clinical Laboratory Improvement Amendments (CLIA)								
Improve Cytology Lab Testing					✓			

* DHHS Strategic Goals

Goal 1 – Reduce the major threats to the health and well-being of Americans.

Goal 2 – Enhance the ability of the Nation's health care system to effectively respond to bioterrorism and other public health challenges.

Goal 3 – Increase the percentage of the Nation's children and adults who have access to health care services and expand consumer choices.

Goal 4 – Enhance the capacity and productivity of the Nation's health science research Enterprise.

Goal 5 – Improve the quality of health care services.

Goal 6 – Improve the economic and social well-being of individuals, families, and communities, especially those most in need.

Goal 7 – Improve the stability and healthy development of our Nation's children and youth.

Goal 8 – Achieve excellence in management practices.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES				
Centers for Medicare & Medicaid Services				
FY 2008 MANDATORY STATE/FORMULA GRANTS				
(dollars in thousands)				
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program				
	FY 2006	**FY 2007**	**FY 2008**	**Difference**
STATE/TERRITORY	**Actual**	**Appropriation**	**Estimate**	**+/- 2007**
Alabama	$64,182	$74,295	$74,295	$0
Alaska	9,100	11,535	11,535	0
Arizona	107,366	127,859	127,859	0
Arkansas	43,796	49,308	49,308	0
California	646,682	790,789	790,789	0
Colorado	57,951	71,545	71,545	0
Connecticut	34,535	39,891	39,891	0
Delaware	9,045	11,058	11,058	0
District of Columbia	9,557	11,709	11,709	0
Florida	249,330	296,067	296,067	0
Georgia	129,458	165,874	165,874	0
Hawaii	12,404	15,314	15,314	0
Idaho	20,611	24,316	24,316	0
Illinois	225,395	209,767	209,767	0
Indiana	73,000	93,469	93,469	0
Iowa	33,096	36,230	36,230	0
Kansas	27,490	36,542	36,542	0
Kentucky	57,764	70,115	70,115	0
Louisiana	77,133	89,586	89,586	0
Maine	11,928	15,172	15,172	0
Maryland	62,419	66,961	66,961	0
Massachusetts	81,306	73,335	73,335	0
Michigan	117,165	149,383	149,383	0
Minnesota	46,515	48,613	48,613	0
Mississippi	123,498	60,495	60,495	0
Missouri	64,245	72,140	72,140	0
Montana	12,558	15,736	15,736	0
Nebraska	32,591	21,892	21,892	0
Nevada	41,896	52,056	52,056	0
New Hampshire	9,193	10,779	10,779	0
New Jersey	139,970	105,206	105,206	0
New Mexico	42,157	52,045	52,045	0
New York	272,452	340,807	340,807	0
North Carolina	113,067	136,117	136,117	0
North Dakota	6,346	7,738	7,738	0

	FY 2006	**FY 2007**	**FY 2008**	**Difference**
STATE/TERRITORY	**Actual**	**Appropriation**	**Estimate**	**+/- 2007**
Ohio	124,632	157,997	157,997	0
Oklahoma	57,371	70,828	70,828	0
Oregon	46,887	56,734	56,734	0
Pennsylvania	134,097	173,554	173,554	0
Rhode Island	33,619	13,983	13,983	0
South Carolina	55,545	70,651	70,651	0
South Dakota	8,372	10,354	10,354	0
Tennessee	80,407	97,460	97,460	0
Texas	454,742	557,980	557,980	0
Utah	32,208	40,486	40,486	0
Vermont	4,818	5,753	5,753	0
Virginia	72,303	94,070	94,070	0
Washington	64,706	79,883	79,883	0
West Virginia	23,350	27,517	27,517	0
Wisconsin	55,764	69,563	69,563	0
Wyoming	5,881	6,942	6,942	0
Subtotal	**4,319,903**	**4,987,499**	**4,987,499**	**0**
Indian Tribes				
Migrant Program				
American Samoa	546	630	630	0
Guam	1,592	1,838	1,838	0
Marshall Islands				
Micronesia				
Northern Mariana Islands	501	578	578	0
Palau				
Puerto Rico	41,675	48,090	48,090	0
Virgin Islands	1,183	1,365	1,365	0
Subtotal	**45,497**	**52,501**	**52,501**	**0**
Total States/Territories	**4,365,400**	**5,040,000**	**5,040,000**	**0**
Technical Assistance				
State Penalties				
Contingency Fund				
Other Adjustments				
Subtotal Adjustments				
TOTAL RESOURCES	**$4,365,400**	**$5,040,000**	**$5,040,000**	**$0**

FY 2008 President's Budget
Centers for Medicare & Medicaid Services
Program Management

Detail Of Full-Time Equivalent (FTE) Employment

COMPONENT	FY 2006 Actual	FY 2007 Curr. Rate	FY 2008 Pres. Bgt.
Office of the Administrator	39	37	37
Office of Operations Management	216	206	207
Office of E-Health Standards and Services	16	15	15
Office of External Affairs	191	182	183
Office of Legislation	47	45	45
Office of Equal Opportunity and Civil Rights	20	19	19
Office of Research, Development & Information	135	129	129
Office of the Actuary	82	78	78
Office of Clinical Standards and Quality	198	189	190
Office of Strategic Operations and Reg. Affairs	150	143	144
Office of Information Services	401	383	384
Office of Financial Management	384	367	368
Office of Acquisition and Grants Management	102	97	98
Office of Beneficiary Information Services	57	54	55
Office of Policy	14	13	13
Center for Beneficiary Choices	306	278	293
Center for Medicare Management	398	383	381
Center for Medicaid and State Operations	361	345	346
Consortia	55	53	53
Regional Offices	1,454	1,400	1,392
Total, CMS 1/	**4,626**	**4,419**	**4,428**

1/ Reflects Program Management-funded FTEs only. Excludes FTEs for HCFAC/Medicaid PI activities.

FY 2008 President's Budget
Centers for Medicare & Medicaid Service
Program Managemen

Detail of Positions

	2006 Actual	2007 Curr. Rate	2008 Pres. Bgt.
Executive Level I			
Executive Level II			
Executive Level III	1	1	1
Executive Level IV			
Executive Level V			
Subtotal	1	1	1
Total - Executive Level Salary	$152,000	$156,000	$161,000
Total - ES	60	60	60
Total - ES Salary	$9,054,000	$9,313,000	$9,584,000
GS-14/15	984	944	968
GS-13	2,063	1,978	2,029
GS-12	881	845	867
GS-11	164	157	161
GS-10	1	1	1
GS-9	138	132	135
GS-8	24	23	24
GS-7	170	163	167
GS-6	37	35	36
GS-5	28	27	28
GS-4	7	7	7
GS-3	3	3	3
GS-2	1	1	1
GS-1	3	3	3
Subtotal	4,504	4,319	4,430
Total staffing, end of year 1/	4,678	4,486	4,602
Direct FTE's	4,554	4,344	4,344
Reimburseable FTE's	72	75	84
Total full-time equivalent usage 1/, 2/	4,626	4,419	4,428
	FY 2006	FY 2007	FY 2008
Average ES salary	$150,900	$155,217	$159,733
Average GS/GM grade	13.4	13.4	13.4
Average GS/GM salary	$85,012	$88,883	$90,417

1/ Reflects staffing funded in the Program Management account, only.

2/ At this time, CMS is not requesting any new positions in FY 2008.

Budget and Performance Crosswalk

(Dollars in Millions)

Adjusted for Rounding Errors

Performance Program	Budget Activity	FY 2006	FY 2007	FY 2008
	Medicare (HI, SMI, Drug)	$384,590.0	$431,553.5	$459,618.5
	Program Management	$3,052.4	$3,065.0	$3,146.7
Medicare	**Subtotal**	**$387,642.4**	**$434,618.5**	**$462,765.2**
	Medicare (HI, SMI, Drug)	$784.5	$186.5	$307.7
	Program Management	$27.9	$27.7	$28.6
QIO	**Subtotal**	**$812.3**	**$214.2**	**$336.3**
	HCFAC	$1,194.0	$1,118.0	$1,324.0
	Program Management	$30.0	$30.3	$30.7
HCFAC	**Subtotal**	**$1,224.0**	**$1,148.3**	**$1,354.7**
	Medicaid	$194,607.0	$191,840.9	$203,885.7
	Program Management	$183.4	$175.9	$165.9
Medicaid	**Subtotal**	**$194,790.4**	**$192,016.8**	**$204,051.6**
	SCHIP	$4,538.8	$5,186.9	$5,040.0
	Medicaid	$405.7	$0.0	$0.0
	Program Management	$4.8	$4.9	$4.8
SCHIP	**Subtotal**	**$4,949.2**	**$5,191.7**	**$5,044.8**
	State Grants & Demo's.	$2,514.9	$822.4	$786.7
	Program Management	$1.6	$1.6	$1.6
State Grants & Demo's.	**Subtotal**	**$2,516.5**	**$824.0**	**$788.3**
	Program Management	$42.7	$43.0	$43.0
CLIA	**Subtotal**	**$42.7**	**$43.0**	**$43.0**
CMS		**$591,977.5**	**$634,056.6**	**$674,383.9**

Summary of Full Cost 1/

(Dollars in Millions)

Performance Program Area	FY 2006	FY 2007	FY 2008
Medicare	387,642.4	434,618.5	462,765.2
Benefits	*382,605.0*	*429,715.0*	*457,688.0*
Financial Management	*2,591.4*	*2,560.2*	*2,644.2*
Quality	*268.7*	*266.5*	*299.5*
Other Administration	*2,177.3*	*2,076.8*	*2,133.5*
Quality Improvement Organizations	812.3	214.2	336.3
Quality	*812.3*	*214.2*	*336.3*
Health Care Fraud and Abuse Control	1,224.0	1,148.3	1,354.7
Financial Management	*1,224.0*	*1,148.3*	*1,354.7*
Medicaid	194,790.4	192,016.8	204,051.6
Benefits	*184,552.5*	*181,959.3*	*193,871.0*
Financial Management	*5,121.5*	*4,987.7*	*5,051.1*
Quality	*5,146.4*	*5,069.8*	*5,129.5*
State Children's Health Insurance Program	4,949.2	5,191.7	5,044.8
Benefits	*4,538.7*	*5,186.9*	*5,040.0*
Quality	*410.5*	*4.8*	*4.8*
State Grants and Demonstrations	2,516.5	824.0	788.3
Quality 2/	*255.2*	*53.6*	*52.6*
CLIA	42.7	43.0	43.0
Quality	*42.7*	*43.0*	*43.0*
Full Cost Total	591,977.5	634,056.6	674,383.9

1/ Full cost data for the measures under each performance program area are shown as non-adds. The sum of full costs of performance measures may not equal the full cost of the performance program area, to the extent the program has elements for which there are no current measures.

2/ Excludes State Grants and Demonstrations funding pertaining to payments for undocumented aliens, High-Risk Pools, SPAPs and funding provided by the Deficit Reduction Act.

Information Technology

Funding for CMS' information technology (IT) investments is spread across several CMS budget accounts and a mix of discretionary, mandatory, and user fee resources. These varied funds sources for IT activities reflect the breadth of the CMS programs they support, including Medicare, Medicaid, SCHIP, and associated quality-assurance and program safeguards. This chapter is intended to provide a high-level overview of IT activities funded and discussed throughout various parts of this budget submission.

The FY 2008 estimate for CMS' discretionary Program Management appropriation, which is the primary focus of this budget submission and the narrative below, includes $676.9 million for IT investments. This figure excludes basic claims processing costs incurred by contractors in our Medicare operations. The table below shows the IT budget by CMS account. Amounts shown are estimates subject to funds availability and to further vetting through CMS' IT investment management process. 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.

Information Technology Budget Summary Table
Dollars in Thousands

Funds Source	FY 2007 President's Budget	FY 2008 President's Budget
Medicare Operations	$609,027	$647,614
Federal Administration	21,900	21,700
Survey & Certification	3,063	2,940
Research	7,949	4,649
CMS Revitalization Plan	22,765	-
Subtotal, Program Management Appropriation 1/	**$664,704**	**$676,903**
CLIA (user fees)	2,015	2,040
Health Care Fraud & Abuse Account (HCFAC) 2/	35,490	44,347
Quality Improvement Organizations (QIOs) 2/	65,208	71,423
Total, CMS IT Portfolio 3/	**$767,417**	**$794,713**

1/ The IT amounts above for FYs 2007-2008 include CMS' contributions to two HHS-wide IT funds.

2/ The HCFAC and the QIO program are funded with "mandatory" dollars and operate on separate budget cycles from CMS' discretionary Program Management appropriation. QIO estimates are placeholders pending development of the next QIO scope of work. HCFAC and QIO funds are also subject to annual apportionment by the Office of Management and Budget (OMB).

3/ In addition to the amounts shown above, the HHS Exhibit 53 includes approximately $1.6 billion in FY 2008 for the Medicaid Management Information System (MMIS) and other Medicaid-related systems, which are funded separately via the annual Medicaid appropriation. These funds are for the Federal share of IT funding administered by the States for MMIS design, development, and operation, as well as non-MMIS automated data processing activities.

Program Description

CMS' information technology (IT) investments support a broad range of Medicare, Medicaid, and other program activities, including basic operational needs as well as ongoing support of provisions of legislation such as the Medicare Modernization Act (MMA) of 2003 and the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The CMS request also includes funding to support the President's Management Agenda e-Government initiatives and Departmental enterprise information technology initiatives identified through the HHS strategic planning process.

CMS Program Management Appropriation

Medicare Operations

The Medicare Operations line item in CMS' Program Management appropriation funds the vast majority of the Agency's IT activities, including:

- maintenance of Medicare fee-for-service (FFS) claims processing shared systems;
- support for Medicare FFS data center processing, Medicare managed care systems maintenance, infrastructure and network support including the Medicare data communications network (MDCN) and operations of the Common Working File (CWF);
- development and ongoing operations and maintenance of the Healthcare Integrated General Ledger and Accounting System (HIGLAS);
- support for the Consolidated Information Technology Infrastructure Contract (CITIC), which supports numerous Medicare program applications as well as CMS mid-tier and mainframe operations at the CMS data center;
- ongoing systems security activities at Medicare contractors; and
- continued development and ongoing operations and maintenance for systems needed to implement numerous MMA provisions, including the Medicare prescription drug benefit, the Medicare Advantage program, contracting reform, and Medicare fee-for-service improvements.

The FY2008 Medicare Operations budget includes $10 million for certain IT modernization activities that were previously funded out of the CMS Revitalization Plan, which was a separate line item in CMS' Program Management appropriation in the FY 2007 President's Budget. These activities include:

- *Integrated data repository (IDR)* - to consolidate and reorganize data, yielding improved data reliability as existing data marts and extracts are phased out. The IDR will also expand access to CMS data by employing more powerful technology that is capable of handling the sheer size and complexity of CMS' Medicare and Medicare data.
- *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.
- *Medicare Claims Processing Redesign (MCPR)* – for planning to continue modernizing from Medicare's existing, stove-piped FFS claims processing systems to more flexible

applications that improve efficiency, support interoperability, and are scalable to handle the increased Medicare workloads associated with the retirement of the baby boom generation.

- *Personal Health Records (PHR)* – to support planning and design activities to ensure that CMS systems are positioned to exchange data and work with the Personal Health Record (PHR) solutions that evolve in the larger, health care marketplace.
- *CMS Enterprise Architecture (EA)* – to continue maturing CMS' enterprise architecture, including building business process models for all major IT investments and CMS lines of business. The business process models enable EA to conduct business architecture reviews up front to ensure that proposed IT investments do no duplicate, interfere, or contradict any other investment that has already been proposed, is currently under development, or is in production.

Federal Administration

The Federal Administration portion of the Program Management appropriation also 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 processed by all 50 States, the District of Columbia, and the five territories (Puerto Rico, Virgin Islands, American Samoa, Northern Mariana Islands, and Guam.)

In addition to the $21.7 million shown in the table at the beginning of this chapter, beginning in FY 2008 the service and supply fund activity within the Federal Administration line item includes a total of $1,870,000 for CMS' share of costs for the HHS enterprise email system and the new HHS Consolidated Acquisition System (HCAS). HCAS is a Department-wide contract management system that will integrate with HHS' Unified Financial Management System (UFMS). Both HCAS and the UFMS are described in detail in the PMA chapter of this submission.

Survey and Certification

The Survey and Certification activity in CMS' Program Management budget also provides some IT funding, primarily for operation and maintenance of systems that 6,500 State surveyors use to track and report the results of surveys of nursing homes, home health agencies, and a variety of other kinds of healthcare facilities.

Research
IT funding within the Research budget is for the IT portion (data management and processing) of the Medicare Current Beneficiary Survey (MCBS).

Additional Sources of IT Funding for CMS Programs

A portion of the user fees collected under the Clinical Laboratory Improvement Amendments of 1988 pays for information systems that support the CLIA program.

IT funding from the Medicare Integrity Program (MIP) budget within the Health Care Fraud and Abuse Account (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.

IT activities funded from the Quality Improvement Organization (QIO) program budget include the QIO Standard Data Processing System (SDPS), clinical data abstraction centers (CDACs), the Quality Improvement & Evaluation System (QIES), and QIO-related operations at the CMS data center.