DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2010

Centers for Medicare & Medicaid Services

Justification of Estimates for Appropriations Committees

Introduction

The FY 2010 Congressional Justification is one of several documents that fulfill the Department of Health and Human Services' (HHS) performance planning and reporting requirements. HHS achieves full compliance with the Government Performance and Results Act of 1993 and Office of Management and Budget Circulars A-11 and A-136 through the HHS agencies' FY 2010 Congressional Justifications and Online Performance Appendices, the Agency Financial Report, and the HHS Citizens' Report. These documents are available at http://www.hhs.gov/asrt/ob/docbudget/index.html.

The FY 2010 Congressional Justifications and accompanying Online Performance Appendices contain the updated FY 2008 Annual Performance Report and FY 2010 Annual Performance Plan. The Agency Financial Report provides fiscal and high-level performance results. The HHS Citizens' Report summarizes key past and planned performance and financial information.

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

Message from the Acting Administrator

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2010 performance budget. Our programs will touch the lives of over 98 million Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries in FY 2010. We take our role very seriously, as our oversight responsibilities impact millions of people and have grown dramatically over the last few years.

FY 2010 will be a year of transformation and modernization for CMS. We will finalize our efforts to improve program efficiency and quality of services through Medicare contracting reform, continue implementation of ICD-10 healthcare coding changes, expand our program integrity activities, especially for the Medicare Advantage and Medicare Part D Prescription Drug programs, and implement quality health care through our value-based purchasing and health promotion initiatives.

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

Our resource needs are principally driven by workloads that grow annually and by our role in leading national efforts to improve healthcare quality and access to care. Our FY 2010 Program Management request reflects a 7.3 percent increase over the enacted FY 2009 level. This reflects the transfer of the High Risk Pools activity from Program Management to the State Grants and Demonstrations account. While our needs are growing, we continue to look for efficiencies to offset escalating costs. We have also included two user fee proposals which would recover some of the costs of recertifying healthcare facilities who wish to participate in the Medicare program and all of the costs of revisiting facilities following a complaint and subsequent finding of a deficiency.

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

On behalf of our beneficiaries, I thank you for your continued support of CMS and its FY 2010 budget request.

/Charlene Frizzera/

Charlene Frizzera

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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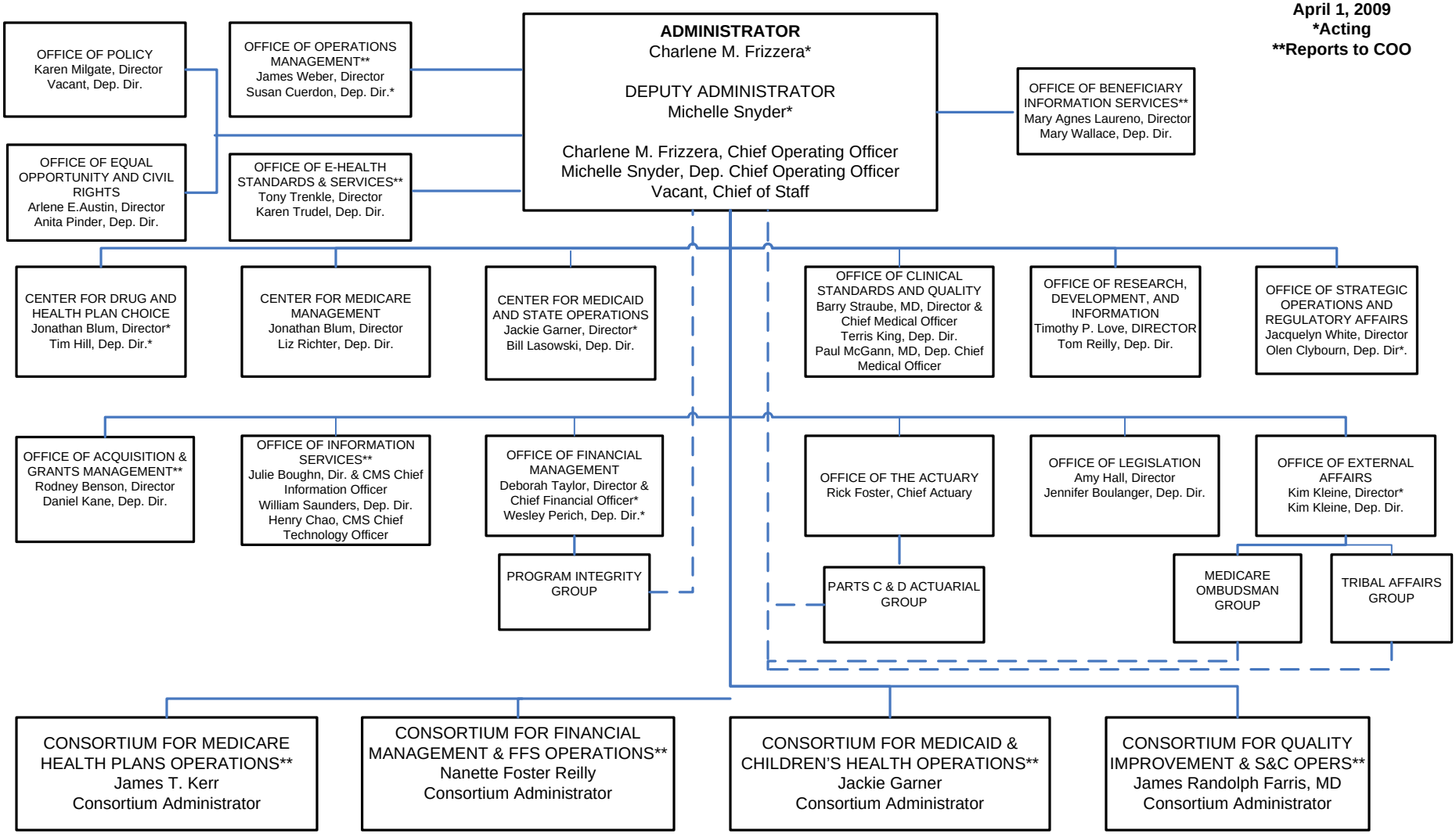
For alternate text document, go to http://www.cms.hhs.gov/CMSLeadership/

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

APPROVED LEADERSHIP

As of April 1, 2009
***Acting**
****Reports to COO**



EXECUTIVE SUMMARY

Agency Overview

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

Recent legislation has significantly expanded CMS' responsibilities. In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) made sweeping changes to the Medicare program including the addition of a prescription drug benefit, the most significant expansion of this program since its inception in 1965. In 2005, Congress passed the Deficit Reduction Act (DRA) with 98 provisions impacting Medicare and Medicaid including changes in Medicare reimbursements, Medicaid prescription drug reforms, CHIP allotments, cost-sharing, and benefits. The Tax Relief and Health Care Act of 2006 (TRHCA) established a physician quality reporting program and quality improvement initiatives and enhanced CMS' program integrity efforts through the Recovery Audit Contractor (RAC) program. The Medicare, Medicaid, SCHIP Extension Act of 2007 (MMSEA) continued physician quality reporting and extended the CHIP, Transitional Medical Assistance (TMA), and other programs. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) extended and expanded the physician quality reporting program, established incentives for reporting on electronic prescribing and renal dialysis quality measures, enhanced beneficiary services, and improved access to health care.

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

The American Recovery and Reinvestment Act of 2009 (ARRA or "Recovery Act"), enacted on February 17, 2009, is intended to restore economic growth and strengthen America's middle class. Among other things, the Recovery Act is designed to stimulate the economy through measures that preserve and improve access to affordable health care. ARRA directly impacts CMS and its work. CMS will advocate the adoption of health information technology by incentivizing the use of electronic health records by Medicare and Medicaid providers. We will advance wellness and prevention by helping reduce the incidence of healthcare-acquired infections. ARRA also temporarily increases the Federal Medical Assistance Percentage (FMAP) and the Disproportionate Share Hospital (DSH) allotment for States and Territories, extends the Transitional Medical Assistance (TMA) and Qualified Individual (QI) programs, and provides protections for Native Americans under Medicaid and CHIP.

CMS remains the largest purchaser of health care in the United States. For more than 40 years, Medicare and Medicaid have helped pay the medical bills of millions of older and low-income Americans, providing them with reliable health benefits. We expect to serve over 98 million beneficiaries in FY 2010, almost one in three Americans. Medicare and Medicaid combined pay about one-third of the Nation's health expenditures. Few programs, public or private, have such a positive impact on so many Americans.

CMS outlays more benefits than any other Federal agency and we are committed to administering our programs as efficiently as possible. In FY 2010, benefit costs are expected to total $803.1 billion. Non-benefit costs, which include administrative costs such as Program Management, Medicaid State and local administration, non-CMS administrative costs, the Health Care Fraud and Abuse Control account (HCFAC), the Quality Improvement Organizations (QIO), and the Clinical Laboratory Improvement Amendments program (CLIA), among others, are estimated at $21.2 billion or 2.6 percent of total benefits. CMS' non-benefit costs are minute when compared to Medicare benefits and the Federal share of Medicaid and CHIP benefits. Remarkably, Program Management costs are only one-half of one percent of these benefits.

Vision

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

Mission

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

CMS anticipates playing a major role in implementing the following key health reform efforts:

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

- Prevention and Wellness: The Recovery Act provides $1 billion in preventive care and wellness benefits to help move beyond treating the sick to preventing illness and improving health. Recent research has shown that implementation of the CDC's

Healthcare Acquired Infection (HAI) prevention recommendations can reduce these infections by 70 percent. This will not only save lives and reduce suffering, but reduce healthcare costs, especially in the Medicare and Medicaid programs. Of the $1 billion included in the bill, CMS will receive a total of $10 million--$1 million in FY 2009 and $9 million in FY 2010--to increase State surveys and certifications of the Nation's ambulatory surgical centers to help ensure that proper HAI controls are in place.

Overview of Budget Request

For FY 2010, CMS' request totals $503,670.1 million for its annually-appropriated accounts which include Program Management, the discretionary adjustment to the HCFAC account, Grants to States for Medicaid, and Payments to the Health Care Trust Funds. In total, this represents an increase of $45,350.0 million over FY 2009. Major activities within each of these four accounts are discussed in more detail below.

CMS Annually-Appropriated Accounts
($ in millions)

Accounts	FY 2009 Omnibus	FY 2010 Request	+/- FY 2009
Program Management - Discretionary	$3,230.4	$3,465.5	+$235.1
Program Management - Mandatory	$75.0	$0.0	-$75.0
Subtotal, Program Management	$3,305.4	$3,465.5	+$160.1
Comparable Transfer (State High-Risk Pools Grants)	-$75.0	$0.0	+$75.0
Comparable Program Management Total	$3,230.4	$3,465.5	+$235.1
HCFAC Discretionary	$198.0	$311.0	+$113.0
Grants to States for Medicaid	$257,147.7	$292,662.5	+$35,514.8
Payments to Health Care Trust Funds	$197,744.0	$207,231.1	+$9,487.1
Grand Total (Comparable)	$458,320.1	$503,670.1	+$45,350.0

Program Increases

Program Management (Comparable) (+$235.1 million):

- **Medicare Operations (+$98.1 million)**
  CMS requests $2,363.9 million, an increase of $98.1 million, to pay fee-for-service claims, keep our systems running, finish the final contractor and data center transitions under contracting reform, continue transitioning contractors onto the Healthcare Integrated General Ledger Accounting System (HIGLAS), make progress implementing the new ICD-10 coding system, provide education and outreach to our beneficiaries and providers, and implement selected provisions in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

- **Federal Administration: (+$56.4 million)**
  The request of $697.8 million, an increase of $56.4 million, supports a CMS staffing level of 4,276 direct FTEs, including a 2.0 percent estimated pay raise in 2010. This staffing level reflects an increase of 159 FTEs above the FY 2009 enacted level. The

additional staffing will allow us to maintain our traditional workloads, and to implement recent mandatory legislation including the TRHCA, MMSEA, and the MIPPA.

- **Survey and Certification: (+$53.8 million)**
  The FY 2010 request of $346.9 million, an increase of $53.8 million, will maintain the statutorily-mandated survey frequencies for long-term care facilities and home health agencies and allow surveys of all other facilities at the Administration's policy levels. CMS is proposing two user fees for this account: a revisit user fee and a recertification fee. Fees would be requested as mandatory spending authority and would increase the funds available for facility surveys. More information on these proposals can be found in the Program Management section of this document, following the appropriations language analysis.

- **Research, Demonstration, and Evaluation**: **(+$26.8 million)**
  CMS requests $57.0 million in FY 2010, an increase of $26.8 million, to support ongoing activities, including the Medicare Current Beneficiary Survey and Real Choice Systems Change grants, as well as new research that will evaluate payment reforms, investigate ways to provide higher quality care at lower costs, improve beneficiary education, and better align payments with costs. The request does not continue any earmarks.

Health Care Fraud and Abuse Control Account (+$113.0 million)

CMS is requesting $311.0 million in HCFAC discretionary funding, an increase of $113.0 million above the FY 2009 enacted level, for program integrity activities. These funds will be used to safeguard the Medicare program, including Medicare Advantage and Medicare Part D prescription drug programs, against fraud, waste, and abuse, and to expand financial management oversight of the Medicaid program.

Grants to States for Medicaid (+$35.5 billion)

The FY 2010 Medicaid request is $292.7 billion, an increase of $35.5 billion over the FY 2009 estimate. This amount includes: $277.5 billion in medical assistance benefits, an increase of $26.3 billion over the FY2009 level; $12.4 billion for administrative functions including funding for Medicaid State survey and certification and the State Medicaid fraud control units; $3.3 billion for the Centers for Disease Control and Prevention's Vaccines for Children program; and an estimated reduction of $562.5 million in offsetting collections from Medicare Part B for the Qualified Individual (QI) program which impacts the total amount needed for our FY 2010 Medicaid appropriation. The requested level reflects the impact of the recently-enacted Recovery Act, primarily due to the temporary increase in the FMAP. In total, the FY 2010 request includes $42.7 billion in net Budget Authority for Recovery Act provisions, an increase of $6.0 billion over the FY 2009 level.

Payments to the Health Care Trust Funds (+$9.5 billion)

The FY 2010 request for Payments to the Health Care Trust Funds account--$207.2 billion--reflects an overall increase of $9.5 billion above the FY 2009 estimate. This account provides the Supplementary Medical Insurance (SMI) Trust Fund with the general fund contribution for the cost of the SMI program. It transfers payments from the General Fund to the Hospital Insurance and SMI Trust Funds, as well as to the Medicare Prescription Drug Account (Medicare Part D), in order to make the Medicare trust funds whole for

certain costs, initially borne by the trust funds, which are properly charged to the General Fund.

CONCLUSION

CMS' FY 2010 request for its four annually-appropriated accounts—Program Management, the discretionary part of the HCFAC account, Grants to States for Medicaid, and Payments to the Health Care Trust Funds—is $503.7 billion, an increase of $45.4 billion.

Our discretionary request includes $3,465.5 million for Program Management and $311.0 million for HCFAC. The Program Management request will allow CMS to manage and oversee its substantial ongoing workloads for traditional fee-for-service and the newer Medicare Advantage and Medicare Part D prescription drug programs, along with many important projects including finalizing contracting reform transitions, making significant progress with implementing ICD-10 coding changes, increasing the number of healthcare facility surveys, and initiating new research and demonstration activities. The HCFAC request will enable CMS to mitigate vulnerabilities in the Parts C and D programs and to improve financial management oversight in Medicaid.

The Medicaid request includes $42.7 billion needed to implement Recovery Act provisions in FY 2010. This mainly includes temporary increases in the FMAP and DSH allotments, as well as an extension of the TMA program.

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

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

Activity	FY 2008 Appropriation 1/	FY 2009 Omnibus	FY 2010 President's Budget Request
Medicare Operations	$2,197,293,000	$2,265,715,000	$2,363,862,000
Rescission (P.L. 110-161)	($38,387,000)	$0	$0
Medicare, Medicaid and SCHIP Ext. Act (P.L. 110-173)	$115,000,000	$0	$0
Medicare Improvements for Patients and Providers Act (P.L. 110-275)	$20,000,000	$182,500,000	$35,000,000
Net Medicare Operations BA	**$2,293,906,000**	**$2,448,215,000**	**$2,398,862,000**
Federal Administration	$642,354,000	$641,351,000	$697,760,000
Rescission (P.L. 110-161)	($11,222,000)	$0	$0
Supplemental Appropriation (Medicaid Reg. Study; P.L. 110-252)	$5,000,000	$0	$0
Children's Health Insurance Program Reauthorization Act (P.L. 111-3)	$0	$5,000,000	$0
Net Federal Administration BA	**$636,132,000**	**$646,351,000**	**$697,760,000**
State Survey & Certification	$286,186,000	$293,128,000	$346,900,000
Rescission (P.L. 110-161)	($5,000,000)	$0	$0
Net State Survey & Certification BA	**$281,186,000**	**$293,128,000**	**$346,900,000**
Research	$31,857,000	$30,192,000	$56,978,000
Rescission (P.L. 110-161)	($556,000)	$0	$0
Net Research BA	**$31,301,000**	**$30,192,000**	**$56,978,000**
High-Risk Pool Grants	$50,000,000	$0	$0
Rescission (P.L. 110-161)	($873,000)	$0	$0
Net High-Risk Pool Grants BA	**$49,127,000**	**$0**	**$0**
Appropriation/BA C.L. (Discretionary; 0511)	**$3,151,652,000**	**$3,230,386,000**	**$3,465,500,000**
High-Risk Pool Grants 2/	$0	$75,000,000	$0
Appropriation/BA C.L. (Mandatory; 0511)	**$0**	**$75,000,000**	**$0**
Subtotal, Appropriation/BA C.L. (Disc. + Mand.; 0511)	**$3,151,652,000**	**$3,305,386,000**	**$3,465,500,000**
Comparable Transfer (High-Risk Pool Grants)	($49,127,000)	($75,000,000)	$0
Comparable Appropriation (Disc. + Mand.; 0511)	**$3,102,525,000**	**$3,230,386,000**	**$3,465,500,000**
Supplemental Appropriation (P.L. 110-252; Discretionary)	**$5,000,000**	**$0**	**$0**
MMSEA FY 08/ MIPPA FY 08-10/CHIPRA FY 09 (Mandatory)	**$135,000,000**	**$187,500,000**	**$35,000,000**
Total, Appropriation/BA C.L. (Comparable; 0511)	**$3,242,525,000**	**$3,417,886,000**	**$3,500,500,000**
Est. Offsetting Collections from Non-Federal Sources:			
User Fees, C.L.	$158,427,000	$178,514,000	$170,604,000
Recovery Audit Contracts, C.L. 3/	$413,300,000	$30,000,000	$259,000,000
Subtotal, New BA, C.L. (Comparable; 0511) 4/	**$3,814,252,000**	**$3,626,400,000**	**$3,930,104,000**
No/Multi-Year Carryforward (C.L. FY 1998 - FY 2007) 5/	$88,157,000	$19,444,000	$0
Program Level, Current Law (Comparable; 0511)	**$3,902,409,000**	**$3,645,844,000**	**$3,930,104,000**
Proposed Law User Fees (Recertification/Revisit) 6/	$0	$0	$9,446,000
Program Level, Proposed Law (Comparable; 0511)	**$3,902,409,000**	**$3,645,844,000**	**$3,939,550,000**
American Recovery and Reinvestment Act (ARRA; P.L. 111-5):			
Section 4103 Medicare Incentives	$0	$100,000,000	$100,000,000
Section 4201 Medicaid Incentives	$0	$40,000,000	$40,000,000
Section 4301 Medicare Moratoria	$0	$2,000,000	$0
Total, ARRA Appropriation/BA C.L. (Mandatory; 0510) 7/	**$0**	**$142,000,000**	**$140,000,000**
Total, Prog. Mgt. Approp./BA (Comparable; All Sources)	**$3,242,525,000**	**$3,559,886,000**	**$3,640,500,000**
Total Prog. Mgt. Program Level, P.L. (Comparable; All Sources)	**$3,902,409,000**	**$3,787,844,000**	**$4,079,550,000**
HCFAC Discretionary	**$0**	**$198,000,000**	**$311,000,000**
CMS FTEs: 8/			
Direct (Federal Administration)	4,231	4,117	4,276
Reimbursable (CLIA, CoB, RAC)	88	111	126
Subtotal, Prog. Mgt. FTEs, C. L. (0511)	**4,319**	**4,228**	**4,402**
ARRA Implementation 9/	0	50	100
Total, Prog. Mgt. FTEs, C. L. (0511 + 0510)	**4,319**	**4,278**	**4,502**
Medicaid Financial Management (HCFAC)	90	90	90
MIP Discretionary (HCFAC)	0	0	25
Medicaid Integrity (State Grants)	74	93	100
Total, CMS FTEs, Current Law	**4,483**	**4,461**	**4,717**

1/ Reflects net enacted budget authority (BA) in FY 2008, after all rescissions, transfers and reprogrammings.

2/ The FY 2009 High-Risk Pool Grants were rebased as mandatory. In FY 2010, High-Risk Pools activity will be transferred to the State Grants and Demonstrations account.

3/ The decrease in FY 2009 Recovery Audit Contractor costs results from a partial year of collections.

4/ Excludes $15,529,000 for other reimbursable activities carried out by the Program Management account.

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

6/ Reflects CMS' legislative proposals to collect new recertification and revisit user fees, beginning in FY 2010.

7/ Includes funds directly appropriated to the CMS Program Management account, only. Excludes transfers of discretionary budget authority.

8/ FY 2008 reflects actual FTE consumption.

9/ In the FY 2010 Budget Appendix, the ARRA FTE are included within the direct Program Management staffing level.

Appropriations Language

Centers for Medicare & Medicaid Services

Program Management

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the Public Health Service Act (`PHS Act'), and the Clinical Laboratory Improvement Amendments of 1988, not to exceed **[**$3,305,386,000,**]** *$3,465,500,000,* to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act; together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary of Health and Human Services pursuant to section 302 of the Tax Relief and Health Care Act of 2006; and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until expended: Provided, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation: Provided further, That **[**$35,700,000,**]** *$35,681,000,* to remain available through September 30, **[**2010,**]** *2011,* shall be for contract costs for the Healthcare Integrated General Ledger Accounting System: Provided further, That **[**$108,900,000,**]** *$65,600,000,* to remain available through September 30, **[**2010,**]** *2011,* shall be for the Centers for Medicare **[**and**]** *&* Medicaid Services (`CMS') Medicare contracting reform activities: *Provided further, That $81,600,000, shall remain available through September 30, 2011 for purposes of carrying out provisions of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. No. 110-275):* Provided further, That funds appropriated under this heading shall be available for the Healthy

Start, Grow Smart program under which the CMS 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 is directed to collect fees in fiscal year **[**2009**]** *2010* from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act**[**: Provided further, That $4,542,000 shall be used for the projects, and in the amounts, specified under the heading `Program Management' in the explanatory statement described in section 4 (in the matter preceding division A of this consolidated Act): Provided further, That $75,000,000 is available for the State high risk health insurance pool program as authorized by the State High Risk Pool Funding Extension Act of 2006**]**.

Program Management

Language Analysis

Language Provision	Explanation
For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the Public Health Service Act (`PHS Act'), and the Clinical Laboratory Improvement Amendments of 1988, not to exceed **[**$3,305,386,000,**]** *$3,465,500,000,* to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act;	Provides an appropriation from the HI and SMI Trust Funds for the administration of the Medicare, Medicaid and Children's Health Insurance programs. The HI Trust Fund will be reimbursed for the General Fund share of these costs through an appropriation in the Payments to the Health Care Trust Funds account.
together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary of Health and Human Services pursuant to section 302 of the Tax Relief and Health Care Act of 2006; and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until expended:	Provides funding for the Clinical Laboratory Improvement Amendments program, which is funded solely from user fee collections. Authorizes the collection of fees for the sale of data, and other authorized user fees and offsetting collections to cover administrative costs, including those associated with providing data to the public, and other purposes. All of these collections are available to be carried over from year to year, until expended.
Provided, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation:	Authorizes the crediting of HMO user fee collections to the Program Management account.
Provided further, That **[**$35,700,000,**]** *$35,681,000,* to remain available through September 30, **[**2010,**]** *2011,* shall be for contract costs for the Healthcare Integrated General Ledger Accounting System:	Authorizes $35,681,000 of this appropriation to be available for obligation over two fiscal years, for the development of the Healthcare Integrated General Ledger Accounting System.

Program Management

Language Analysis

Language Provision	Explanation
Provided further, That **[**$108,900,000,**]** $65,600,000, to remain available through September 30, **[**2010,**]** *2011,* shall be for the Centers for Medicare **[**and**]** *&* Medicaid Services (`CMS') Medicare contracting reform activities:	Authorizes $65,600,000 of this appropriation to be available for obligation over two fiscal years for contracting reform activities.
Provided further, That $81,600,000, shall remain available through September 30, 2011 for purposes of carrying out provisions of the Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. No. 110-275):	Authorizes $81,600,000 of this appropriation to be available for obligation over two fiscal years for MIPPA implementation activities.
Provided further, That funds appropriated under this heading shall be available for the Healthy Start, Grow Smart program under which the CMS 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 *Healthy Start, Grow Smart* program in FY 2010.
Provided further, That the Secretary is directed to collect fees in fiscal year **[**2009**]** *2010* from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act	Authorizes the collection of user fees from Medicare Advantage organization for costs related to enrollment, dissemination of information and certain counseling and assistance programs.

Program Management

Language Analysis

Language Provision	Explanation
[: Provided further, That $4,542,000 shall be used for the projects, and in the amounts, specified under the heading `Program Management' in the explanatory statement described in section 4 (in the matter preceding division A of this consolidated Act):	Eliminates funding for mandated research projects included in the FY 2009 Program Management appropriation.
Provided further, That $75,000,000 is available for the State high risk health insurance pool program as authorized by the State High Risk Pool Funding Extension Act of 2006].	Eliminates the separate language provision for high-risk pool grant activities included in the FY 2009 Program Management appropriation.

Program Management Proposed Law Summary

CMS' President's Budget request includes two proposed mandatory user fees totaling $9.4 million in FY 2010. Collections associated with these user fees will increase our Program Management program level on a dollar-for-dollar basis. These proposals are described below:

Medicare Survey and Certification Revisit User Fees ($9.4 million):

CMS requests authority to charge providers user fees to recover the full costs of revisit surveys within the Medicare program. Revisit surveys are conducted to verify that deficiencies cited during initial certification, recertification or substantiated complaint surveys have been corrected. Holding providers accountable for the costs of revisit surveys will create an additional incentive for facilities to correct deficiencies and provide high quality care. If adopted, this legislative proposal would reinstate CMS' previously-enacted revisit fees and make the authority to collect them permanent. Our proposed revisit fees will be initially priced on a national average per facility type, followed by subsequent refinements to account for facility size, scope and severity of cited deficiencies. The fees collected will be returned to CMS for use in conducting revisit surveys and shall remain available for obligation until expended.

Medicare Survey and Certification Recertification User Fee ($0 in FY 2010):

CMS requests authority to charge entities, including dually-participating Medicare and Medicaid providers, a fee to partially cover the cost of recertification surveys required for ongoing participation in the Medicare program. Under this proposal, one third of the cost of a recertification survey will be charged, after a three year phase-in. This user fee would share the burden of paying for regular surveys between providers and the Federal government. CMS will establish fee amounts that reflect the unit cost of a recertification survey, adjusted by facility size and other factors as determined by CMS. In general, the fee amounts will vary by State, since survey costs also vary by State.

These fees will be collected through the Medicare claims payments systems or through the HIGLAS system as accounts receivable. CMS believes that it would not be able to collect any funds in FY2010 based on the lead-time needed to implement this proposal in the rulemaking and regulatory process. If enacted, this proposal will be phased in over three years, beginning in FY 2011. In the first year, providers will be charged 11% of the cost of a recertification survey. In the second year, providers will be charged 22% of the cost; and in the third year, providers will be charged 33% of the cost.

CMS Program Management
Proposed Law Summary

Activity	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget
Medicare Operations	$2,293,906,000	$2,448,215,000	$2,398,862,000
Approp. Offset, Prop. Law	$0	$0	$0
Approp., Net Prop. Law	$2,293,906,000	$2,448,215,000	$2,398,862,000
User Fees, Prop. Law	$0	$0	$0
Subtotal, Approp.+ P.L. User Fees	$2,293,906,000	$2,448,215,000	$2,398,862,000
Federal Administration	$636,132,000	$646,351,000	$697,760,000
Approp. Offset, Prop. Law	$0	$0	$0
Approp., Net Prop. Law	$636,132,000	$646,351,000	$697,760,000
User Fees, Proposed Law	$0	$0	$0
Subtotal, Approp.+ P.L. User Fees	$636,132,000	$646,351,000	$697,760,000
State Survey & Certification	$281,186,000	$293,128,000	$346,900,000
Approp. Offset, Prop. Law	$0	$0	$0
Approp., Net Prop. Law	$281,186,000	$293,128,000	$346,900,000
User Fees, Prop. Law	$0	$0	$9,446,000
Subtotal, Approp.+ P.L. User Fees	$281,186,000	$293,128,000	$356,346,000
Research, Demonstration & Evaluation	$31,301,000	$30,192,000	$56,978,000
Approp. Offset, Prop. Law	$0	$0	$0
Approp., Net Prop. Law	$31,301,000	$30,192,000	$56,978,000
User Fees, Proposed Law	$0	$0	$0
Subtotal, Approp.+ P.L. User Fees	$31,301,000	$30,192,000	$56,978,000
High-Risk Pools	$0	$0	$0
Approp. Offset, Prop. Law	$0	$0	$0
Approp., Net Prop. Law	$0	$0	$0
User Fees, Proposed Law	$0	$0	$0
Subtotal, Approp.+ P.L. User Fees	$0	$0	$0
Subt. Approp., Net Prop. Law	**$3,242,525,000**	**$3,417,886,000**	**$3,500,500,000**
Subt. User Fees, Prop. Law	**$0**	**$0**	**$9,446,000**
Total Approp. + P.L. User Fees	**$3,242,525,000**	**$3,417,886,000**	**$3,509,946,000**

CMS Program Management
Amounts Available for Obligation

	FY 2008 Actual	FY 2009 Omnibus	FY 2010 PB
Trust Fund Discretionary Appropriation:			
Appropriation (L/HHS)	$3,207,690,000	$3,230,386,000	$3,465,500,000
Across-the-board reductions (L/HHS)	-$56,038,000	$0	$0
Subtotal, Appropriation (L/HHS)	$3,151,652,000	$3,230,386,000	$3,465,500,000
Comparable transfer from: (CMS)	-$49,127,000	$0	$0
Subtotal, adjusted trust fund discr. appropriation	$3,102,525,000	$3,230,386,000	$3,465,500,000
Trust Fund Mandatory Appropriation:			
Appropriation (L/HHS)	$0	$75,000,000	$0
MMSEA (PL 110-173)	$55,000,000	$0	$0
MIPPA (PL 110-275)	$20,000,000	$182,500,000	$35,000,000
Subtotal, trust fund mand. appropriation	$75,000,000	$257,500,000	$35,000,000
Comparable transfer from: (CMS)	$0	-$75,000,000	$0
Subtotal, adjusted trust fund mand. appropriation	$75,000,000	$182,500,000	$35,000,000
Discretionary Appropriation:			
Supplemental (PL 110-252)	$5,000,000	$0	$0
Mandatory Appropriation:			
MMSEA (PL 110-173)	$60,000,000	$0	$0
CHIPRA (PL 111-3)	$0	$5,000,000	$0
Subtotal, trust fund mand. appropriation	$60,000,000	$5,000,000	$0
Offsetting Collections from Non-Federal Sources:			
CLIA user fees	$48,322,000	$43,000,000	$43,000,000
Coordination of benefits user fees	$34,738,000	$67,163,000	$51,030,000
MA/PDP user fees	$61,570,000	$66,100,000	$74,300,000
Revisit user fees	$7,912,000	$0	$0
Sale of data user fees	$5,886,000	$2,251,000	$2,274,000
Recovery audit contracts	$413,300,000	$30,000,000	$259,000,000
Subtotal, offsetting collections 1/	$571,728,000	$208,514,000	$429,604,000
Unobligated balance, start of year	$206,522,000	$293,271,000	$122,642,000
Unobligated balance, end of year	-$293,271,000	-$122,642,000	-$122,642,000
Prior year recoveries	$9,420,000	$0	$0
Unobligated balance, lapsing	-$12,351,000	$0	$0
Total obligations 1/, 2/, 3/	**$3,724,573,000**	**$3,797,029,000**	**$3,930,104,000**
American Recovery and Reinvestment Act (ARRA):			
Trust Fund Mandatory Appropriation:			
ARRA (PL 111-5)	$0	$2,000,000	$0
Mandatory Appropriation:			
ARRA (PL 111-5)	$0	$140,000,000	$140,000,000
Unobligated balance, start of year	$0	$0	$91,000,000
Unobligated balance, end of year	$0	-$91,000,000	-$98,000,000
Prior year recoveries	$0	$0	$0
Unobligated balance, lapsing	$0	$0	$0
Total obligations	**$0**	**$51,000,000**	**$133,000,000**

1/ Excludes the following amounts for reimbursable activities carried out by this account: 2008 $15,529,000.
2/ Obligations adjusted for comparability purposes.
3/ Excludes funding provided by the American Recovery and Reinvestment Act (ARRA; PL 111-5).

CMS Program Management
Summary of Changes

2009	
Total estimated budget authority	$3,417,886,000
(Obligations)	($3,588,515,000)
2010	
Total estimated budget authority	$3,500,500,000
(Obligations)	($3,500,500,000)
Net Change	**$82,614,000**

	2009 Estimate		Change from Base	
	FTE	Budget Authority	FTE	Budget Authority
Increases:				
A. Built-in:				
1. FY 2010 Pay Raise @ 2.0 Percent				$8,087,000
2. Annualization of FY 2009 Pay Raise				$6,219,000
3. Rent and Mortgage				$1,200,000
Subtotal, Built-in Increases				**$15,506,000**
A. Program:				
1. Medicare Operations		$2,448,215,000		$200,675,000
2. Federal Administration	4,117	$646,351,000	159	$40,903,000
3. State Survey & Certification		$293,128,000		$53,772,000
4. Research		$30,192,000		$33,828,000
Subtotal, Program Increases				**$329,178,000**
Total Increases				**$344,684,000**
Decreases:				
A. Program:				
1. Medicare Operations		$2,448,215,000		($250,028,000)
2. Federal Administration		$646,351,000		($5,000,000)
3. State Survey & Certification		$293,128,000		$0
4. Research		$30,192,000		($7,042,000)
Subtotal, Program Decreases				**($262,070,000)**
Net Change				**$82,614,000**

American Recovery and Reinvestment Act (ARRA):

2009	
Total estimated budget authority	$142,000,000
(Obligations)	($51,000,000)
2010	
Total estimated budget authority	$140,000,000
(Obligations)	($133,000,000)
Net Change	**($2,000,000)**

Increases:				
A. Built-in:				
1. FY 2010 Pay Raise @ 2.0 Percent				$128,000
2. Annualization of FY 2009 Pay Raise				$77,000
B. Program:				
1. Medicare and Medicaid HIT	50	$142,000,000	50	$6,617,000
Decreases:				
A. Program:				
1. Medicare and Medicaid HIT		$142,000,000		($8,822,000)
Net Change				**($2,000,000)**

CMS Program Management

Budget Authority by Activity

(Dollars in thousands)

	FY 2008 Actual	FY 2009 Omnibus	FY 2010 PB
1. Medicare Operations	$2,197,293	$2,265,715	$2,363,862
MMSEA (PL 110-173)	$115,000	$0	$0
MIPPA (PL 110-275)	$20,000	$182,500	$35,000
Enacted Rescission	-$38,387	$0	$0
Subtotal, Medicare Operations	$2,293,906	$2,448,215	$2,398,862
(Obligations)	($2,224,683)	($2,613,551)	
2. Federal Administration	$642,354	$641,351	$697,760
Supplemental (PL 110-252)	$5,000	$0	$0
CHIPRA (PL 111-3)	$0	$5,000	$0
Enacted Rescission	-$11,222	$0	$0
Subtotal, Federal Administration	$636,132	$646,351	$697,760
(Obligations)	($630,629)	($651,644)	
3. State Survey & Certification	$286,186	$293,128	$346,900
Enacted Rescission	-$5,000	$0	$0
Subtotal, State Survey & Certification	$281,186	$293,128	$346,900
(Obligations)	($280,816)	($293,128)	
4. Research, Demonstration & Evaluation	$31,857	$30,192	$56,978
Enacted Rescission	-$556	$0	$0
Subtotal, Research, Demonstration & Evaluation	$31,301	$30,192	$56,978
(Obligations)	($31,464)	($30,192)	
5. Revitalization Plan	$0	$0	$0
(Obligations)	($4,528)	$0	
6. High-Risk Pool Grants	$50,000	$75,000	$0
Enacted Rescission	-$873	$0	$0
Comparability Adjustment	-$49,127	-$75,000	$0
Subtotal, High-Risk Pool Grants	$0	$0	$0
(Obligations)	$0	$0	
7. User Fees	$158,427	$178,514	$170,604
(Obligations)	($139,258)	($178,514)	
8. Recovery Audit Contracts	$413,300	$30,000	$259,000
(Obligations)	($413,195)	($30,000)	
Total, Budget Authority 1/	**$3,814,252**	**$3,626,400**	**$3,930,104**
(Obligations) 1/	**($3,724,573)**	**($3,797,029)**	
FTE	**4,319**	**4,228**	**4,402**

1/ Excludes $15,529,000 for other reimbursable activities carried out by the Program Management account.

American Recovery and Reinvestment Act (ARRA):

1. ARRA Implementation	**$0**	**$142,000**	**$140,000**
(Obligations)	**$0**	**($51,000)**	**($133,000)**
FTE	**0**	**50**	**100**

CMS Program Management
Authorizing Legislation

	2009 Amount Authorized	FY 2009 Appropriations Act	2010 Amount Authorized	2010 President's Budget
Program Management:				
1. Research:				
a) Social Security Act, Title XI				
- Section 1110	Indefinite	Indefinite	Indefinite	Indefinite
- Section 1115 1/	$2,200,000	$2,200,000	$2,200,000	$2,200,000
b) P.L. 92-603, Section 222	Indefinite	Indefinite	Indefinite	Indefinite
2. Medicare Operations:				
Social Security Act, Sections 1816 & 1842	Indefinite	Indefinite	Indefinite	Indefinite
3. State Certification:				
Social Security Act, Title XVIII, Section 1864	Indefinite	Indefinite	Indefinite	Indefinite
4. Administrative Costs:				
Reorganization Act of 1953	Indefinite	Indefinite	Indefinite	Indefinite
5. High-Risk Pool Grants:				
Trade Act of 2002; High-Risk Pool Funding Extension Act of 2006	Indefinite	Indefinite	Indefinite	Indefinite
6. CLIA 1988:				
Section 353, Public Health Service Act	Indefinite	Indefinite	Indefinite	Indefinite
7. MA/PDP:				
Balanced Budget Act of 1997, Section 1857(e)(2) Balanced Budget Refinement Act of 1999 Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA)	2/	2/	2/	2/
8. Coordination of Benefits:				
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA)	Indefinite	Indefinite	Indefinite	Indefinite
9. Recovery Audit Contractors:				
Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA) Tax Relief and Health Care Act of 2006 (PL 109-432 TRHCA)	Indefinite	Indefinite	Indefinite	Indefinite
Unfunded authorizations:				
Total request level	$0	$0	$0	$0
Total request level against definite authorizations	$0	$0	$0	$0

1/ The total authorization for section 1115 is $4.0 million. CMS' request includes $2.2 million in FY 2010.

2/ The MMA limits authorized user fees to an amount computed by a statutory formula.

American Recovery and Reinvestment Act (ARRA):				
1. ARRA Implementation:				
American Recovery and Reinvestment Act of 2009 (PL 111-5)	$142,000,000	$142,000,000	$140,000,000	$0

CMS Program Management
Appropriations History Table

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
2001				
Trust Fund Appropriation:				
Base	$2,086,302,000	$1,866,302,000	$2,018,500,000	$2,246,326,000
Rescissions (P.L. 106-554)	$0	$0	$0	($4,164,000)
Transfers (P.L. 106-554)	$0	$0	$0	($564,000)
Subtotal	$2,086,302,000	$1,866,302,000	$2,018,500,000	$2,241,598,000
2002				
Trust Fund Appropriation:				
Base	$2,351,158,000	$2,361,158,000	$2,464,658,000	$2,440,798,000
Rescissions (P.L. 107-116/206)	$0	$0	$0	($8,027,000)
Subtotal	$2,351,158,000	$2,361,158,000	$2,464,658,000	$2,432,771,000
2003				
Trust Fund Appropriation:				
Base	$2,538,330,000	$2,550,488,000	$2,559,664,000	$2,581,672,000
Rescissions (P.L. 108-7)	$0	$0	$0	($16,781,000)
Subtotal	$2,538,330,000	$2,550,488,000	$2,559,664,000	$2,564,891,000
2004				
Trust Fund Appropriation:				
Base	$2,733,507,000	$2,600,025,000	$2,707,603,000	$2,664,994,000
Rescissions (P.L. 108-199)	$0	$0	$0	($28,148,000)
MMA (PL 108-173)				$1,000,000,000
Subtotal	$2,733,507,000	$2,600,025,000	$2,707,603,000	$3,636,846,000
2005				
Trust Fund Appropriation:				
Base	$2,746,127,000	$2,578,753,000	$2,756,644,000	$2,696,402,000
Rescissions (P.L. 108-447)	$0	$0	$0	($23,555,000)
Subtotal	$2,746,127,000	$2,578,753,000	$2,756,644,000	$2,672,847,000
2006				
General Fund Appropriation:				
DRA (PL 109-171)	$0	$0	$0	$38,000,000
Trust Fund Appropriation:				
Base	$3,177,478,000	$3,180,284,000	$3,181,418,000	$3,170,927,000
Rescissions (P.L. 109-148/149)	$0	$0	$0	($91,109,000)
Transfers (P.L. 109-149)	$0	$0	$0	$40,000,000
DRA (PL 109-171)	$0	$0	$0	$36,000,000
Subtotal	$3,177,478,000	$3,180,284,000	$3,181,418,000	$3,155,818,000
2007				
Trust Fund Appropriation:				
Base	$3,148,402,000	$3,153,547,000	$3,149,250,000	$3,141,108,000
TRHCA (PL 109-432)	$0	$0	$0	$105,000,000
Subtotal	$3,148,402,000	$3,153,547,000	$3,149,250,000	$3,246,108,000
2008				
General Fund Appropriation:				
MMSEA (PL 110-173)	$0	$0	$0	$60,000,000
Supplemental (PL 110-252)	$0	$0	$0	$5,000,000
Trust Fund Appropriation:				
Base	$3,274,026,000	$3,230,163,000	$3,248,088,000	$3,207,690,000
Rescissions (P.L. 110-161)	$0	$0	$0	($56,038,000)
MMSEA (PL 110-173)	$0	$0	$0	$55,000,000
MIPPA (PL 110-275)	$0	$0	$0	$20,000,000
Subtotal	$3,274,026,000	$3,230,163,000	$3,248,088,000	$3,226,652,000
2009				
General Fund Appropriation:				
CHIPRA (PL 111-3)	$0	$0	$0	$5,000,000
Trust Fund Appropriation:				
Base	$3,307,344,000	$3,270,574,000	$3,260,998,000	$3,305,386,000
MIPPA (PL 110-275)	$0	$0	$0	$182,500,000
Subtotal	$3,307,344,000	$3,270,574,000	$3,260,998,000	$3,487,886,000
General Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$140,000,000
Trust Fund Appropriation (ARRA):				
ARRA (PL 111-5)	$0	$0	$0	$2,000,000
2010				
Trust Fund Appropriation:				
Base	$3,465,500,000			

CMS Program Management
Budget Authority by Object

	2009 Estimate	2010 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$393,582,000	$424,077,000	$30,495,000
Other than full-time permanent (11.3)	$13,630,000	$12,955,000	($675,000)
Other personnel compensation (11.5)	$7,550,000	$7,992,000	$442,000
Military personnel (11.7)	$8,512,000	$8,671,000	$159,000
Special personnel services payments (11.8)	$0	$0	$0
Subtotal personnel compenstion	**$423,274,000**	**$453,695,000**	**$30,421,000**
Civilian benefits (12.1)	$100,310,000	$107,738,000	$7,428,000
Military benefits (12.2)	$4,384,000	$4,467,000	$83,000
Benefits to former personnel (13.0)	$0	$0	$0
Total Pay Costs	**$527,968,000**	**$565,900,000**	**$37,932,000**
Travel and transportation of persons (21.0)	$8,112,000	$9,100,000	$988,000
Transportation of things (22.0)	$0	$0	$0
Rental payments to GSA (23.1)	$25,000,000	$25,200,000	$200,000
Communication, utilities, and misc. charges (23.3)	$0	$0	$0
Printing and reproduction (24.0)	$2,578,000	$3,200,000	$622,000
Other Contractual Services:			
Advisory and assistance services (25.1)	$0	$0	$0
Other services (25.2)	$90,413,000	$106,130,000	$15,717,000
Purchase of goods and services from government accounts (25.3)	$1,140,000	$1,140,000	$0
Operation and maintenance of facilities (25.4)	$0	$0	$0
Research and Development Contracts (25.5)	$25,192,000	$54,478,000	$29,286,000
Medical care (25.6)	$2,721,919,000	$2,720,888,000	($1,031,000)
Operation and maintenance of equipment (25.7)	$0	$0	$0
Subsistence and support of persons (25.8)	$0	$0	$0
Subtotal Other Contractual Services	**$2,838,664,000**	**$2,882,636,000**	**$43,972,000**
Supplies and materials (26.0)	$664,000	$1,064,000	$400,000
Equipment (31.0)	$100,000	$100,000	$0
Land and Structures (32.0)	$9,800,000	$10,800,000	$1,000,000
Investments and Loans (33.0)	$0	$0	$0
Grants, subsidies, and contributions (41.0)	$5,000,000	$2,500,000	($2,500,000)
Interest and dividends (43.0)	$0	$0	$0
Refunds (44.0)	$0	$0	$0
Total Non-Pay Costs	**$2,889,918,000**	**$2,934,600,000**	**$44,682,000**
Total Budget Authority by Object Class	**$3,417,886,000**	**$3,500,500,000**	**$82,614,000**
American Recovery and Reinvestment Act (ARRA)			
Personnel compensation:			
Full-time permanent (11.1)	$4,809,000	$9,926,000	$5,117,000
Civilian benefits (12.1)	$1,603,000	$3,308,000	$1,705,000
Other Contractual Services:			
Other services (25.2)	$133,588,000	$126,766,000	($6,822,000)
Medical care (25.6)	$2,000,000	$0	($2,000,000)
Total Budget Authority by Object Class	**$142,000,000**	**$140,000,000**	**($2,000,000)**

CMS Program Management
Salaries and Expenses

	2009 Estimate	2010 Estimate	Increase or Decrease
Personnel compensation:			
Full-time permanent (11.1)	$393,582,000	$424,077,000	$30,495,000
Other than full-time permanent (11.3)	$13,630,000	$12,955,000	($675,000)
Other personnel compensation (11.5)	$7,550,000	$7,992,000	$442,000
Military personnel (11.7)	$8,512,000	$8,671,000	$159,000
Special personnel services payments (11.8)	$0	$0	$0
Subtotal personnel compenstion	**$423,274,000**	**$453,695,000**	**$30,421,000**
Civilian benefits (12.1)	$100,310,000	$107,738,000	$7,428,000
Military benefits (12.2)	$4,384,000	$4,467,000	$83,000
Benefits to former personnel (13.0)	$0	$0	$0
Total Pay Costs	**$527,968,000**	**$565,900,000**	**$37,932,000**
Travel and transportation of persons (21.0)	$8,112,000	$9,100,000	$988,000
Transportation of things (22.0)	$0	$0	$0
Rental payments to Others GSA (23.2)	$0	$0	$0
Communication, utilities, and misc. charges (23.3)	$0	$0	$0
Printing and reproduction (24.0)	$2,578,000	$3,200,000	$622,000
Other Contractual Services:			
Advisory and assistance services (25.1)	$0	$0	$0
Other services (25.2)	$90,413,000	$106,130,000	$15,717,000
Purchase of goods and services from government accounts (25.3)	$1,140,000	$1,140,000	$0
Operation and maintenance of facilities (25.4)	$0	$0	$0
Research and Development Contracts (25.5)	$25,192,000	$54,478,000	$29,286,000
Medical care (25.6)	$2,721,919,000	$2,720,888,000	($1,031,000)
Operation and maintenance of equipment (25.7)	$0	$0	$0
Subsistence and support of persons (25.8)	$0	$0	$0
Subtotal Other Contractual Services	**$2,838,664,000**	**$2,882,636,000**	**$43,972,000**
Supplies and materials (26.0)	$664,000	$1,064,000	$400,000
Total Non-Pay Costs	**$2,850,018,000**	**$2,896,000,000**	**$45,982,000**
Total Salary and Expense	**$3,377,986,000**	**$3,461,900,000**	**$83,914,000**
Direct FTE	**4,117**	**4,276**	**159**
American Recovery and Reinvestment Act (ARRA):			
Personnel compensation:			
Full-time permanent (11.1)	$4,809,000	$9,926,000	$5,117,000
Civilian benefits (12.1)	$1,603,000	$3,308,000	$1,705,000
Other Contractual Services:			
Other services (25.2)	$133,588,000	$126,766,000	($6,822,000)
Medical care (25.6)	$2,000,000	$0	($2,000,000)
Total Salary and Expense	**$142,000,000**	**$140,000,000**	**($2,000,000)**
Direct FTE	**50**	**100**	**50**

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2008 Actual	2009 Estimate	2010 Estimate
Office of the Administrator			
Direct FTEs	20	19	20
Reimbursable FTEs	0	0	0
Subtotal	20	19	20
Center for Drug and Health Plan Choice			
Direct FTEs	277	270	280
Reimbursable FTEs	3	6	6
Subtotal	280	276	286
Center for Medicaid and State Operations			
Direct FTEs	294	286	297
Reimbursable FTEs	30	35	42
Subtotal	324	321	339
Center for Medicare Management			
Direct FTEs	427	415	432
Reimbursable FTEs	0	1	1
Subtotal	427	416	433
Office of the Actuary			
Direct FTEs	78	76	79
Reimbursable FTEs	0	0	0
Subtotal	78	76	79
Office of Acquisition & Grants Management			
Direct FTEs	107	104	108
Reimbursable FTEs	2	3	3
Subtotal	109	107	111
Office of Beneficiary Information Services			
Direct FTEs	54	53	55
Reimbursable FTEs	0	0	0
Subtotal	54	53	55
Office of Clinical Standards and Quality			
Direct FTEs	196	191	198
Reimbursable FTEs	0	0	0
Subtotal	196	191	198
Office of E-Health Standards and Services			
Direct FTEs	17	17	17
Reimbursable FTEs	0	0	0
Subtotal	17	17	17
Office of External Affairs			
Direct FTEs	206	200	208
Reimbursable FTEs	0	0	0
Subtotal	206	200	208
Office of Equal Opportunity and Civil Rights			
Direct FTEs	20	19	20
Reimbursable FTEs	0	0	0
Subtotal	20	19	20
Office of Financial Management			
Direct FTEs	357	347	361
Reimbursable FTEs	19	26	28
Subtotal	376	373	389

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2008 Actual	2009 Estimate	2010 Estimate
Office of Information Services			
Direct FTEs	354	344	358
Reimbursable FTEs	4	4	4
Subtotal	358	348	362
Office of Legislation			
Direct FTEs	38	37	38
Reimbursable FTEs	0	0	0
Subtotal	38	37	38
Office of Operations Management			
Direct FTEs	187	182	189
Reimbursable FTEs	0	0	0
Subtotal	187	182	189
Office of Policy			
Direct FTEs	11	11	11
Reimbursable FTEs	0	0	0
Subtotal	11	11	11
Office of Research, Development and Information			
Direct FTEs	130	126	131
Reimbursable FTEs	0	0	0
Subtotal	130	126	131
Office of Strategic Operations and Regulatory Affairs			
Direct FTEs	141	137	142
Reimbursable FTEs	0	0	0
Subtotal	141	137	142
Consortia			
Direct FTEs	1,317	1,282	1,331
Reimbursable FTEs	30	36	42
Subtotal	1,347	1,318	1,373
Total, CMS Program Management FTE 1/, 2/	**4,319**	**4,228**	**4,402**
American Recovery and Reinvestment Act (ARRA):			
Total, CMS Program Management FTE	**0**	**50**	**100**

1/ In FY 2009, CMS' FTE usage decreases by 91 FTEs from FY 2008 levels. This decrease is based on absorbing the costs of the FY 2009 pay raise, and is allocated across CMS components.

2/ In FY 2010, CMS' FTE usage increases by 174 FTEs over FY 2009 levels. This increase will allow allow us to maintain growing workloads in the Medicare, Medicaid and Children's Health Insurance Programs.

Average GS Grade

2005	13.3
2006	13.4
2007	13.4
2008	13.4
2009	13.4

CMS Program Management
Detail of Positions

	2008 Actual	2009 Estimate	2010 Estimate
Subtotal, EX	0	1	1
Total - Exec. Level Salaries	$0	$163,000	$167,000
Subtotal	65	65	65
Total - ES Salary	$10,331,000	$10,817,000	$11,109,000
GS-15	437	439	460
GS-14	586	589	617
GS-13	2,070	2,082	2,181
GS-12	710	714	748
GS-11	129	130	136
GS-10	1	1	1
GS-9	140	141	148
GS-8	12	12	13
GS-7	128	129	135
GS-6	21	21	22
GS-5	16	16	17
GS-4	9	9	9
GS-3	1	1	1
GS-2	0	0	0
GS-1	2	2	2
Subtotal	4,262	4,286	4,491
Total - GS Salary	$390,434,000	$410,743,000	$447,364,000
Average ES salary	$158,938	$166,415	$170,908
Average GS grade	13.4	13.4	13.4
Average GS salary	$91,608	$95,834	$99,613

Program Management
Summary of Request

The Program Management account provides the funding needed to administer and oversee CMS' programs, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), the Clinical Laboratory Improvement Amendments (CLIA), the Quality Improvement Organizations (QIO), State Grants and Demonstrations, and the Health Care Fraud and Abuse Control (HCFAC) account. In FY 2010, there are four line items in the Program Management account—Medicare Operations, Federal Administration, Medicare Survey and Certification, and Research--each one with a distinct purpose.

- Medicare Operations primarily funds the contractors that process fee-for-service claims as well as the IT infrastructure and operational support needed to run this program. It also funds activities for the newer Medicare Advantage and Medicare Prescription Drug programs as well as legislative mandates (e.g., beneficiary outreach, HIPAA, contracting reform) and other initiatives (e.g., ICD-10) which improve and enhance CMS' programs.

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

- Medicare Survey and Certification (S&C) pays State surveyors to inspect health care facilities to ensure that they meet Federal standards for health, safety, and quality. In FY 2010, CMS is proposing two new user fees for the S&C activity: a recertification survey fee and a revisit survey fee. Additional information about these fees can be found in the Proposed Law section of this book.

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

CMS' FY 2009 Program Management appropriation included $75.0 million for the State High-Risk Pool Grants, a line item that was added to Program Management in FY 2008. This activity, previously funded through our State Grants and Demonstrations account, provides grants to States to make health insurance coverage available for certain individuals who are at risk for being uninsured. In FY 2010, CMS is again requesting funding for this activity through its State Grants and Demonstrations account.

CMS' FY 2010 current law Program Management request totals $3,465.5 million, a $235.1 million increase over the FY 2009 enacted level when adjusted for the transfer of the High-Risk Pool Grant activity. In addition, CMS expects to collect $9.4 million from its proposed revisit survey fee in FY 2010. These user fee collections would remain available until expended for additional survey and certification costs. Our proposed law request is $3,474.9 million, an increase of $244.5 million over the comparable FY 2009 enacted level. The table below, and the following language, presents CMS' FY 2010 request for the line items within Program Management:

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

Line Item	FY 2009 Enacted	FY 2010 Request	+/- FY 2009
Medicare Operations	$2,265.7	$2,363.9	+$98.1
Federal Administration	$641.4	$697.8	+$56.4
State Survey & Certification	$293.1	$346.9	+$53.8
Research	$30.2	$57.0	+$26.8
State High-Risk Pool (HRP) Grants	$75.0	$0.0	-75.0
CMS PM Approp., C.L.	**$3,305.4**	**$3,465.5**	**+$160.1**
Comparability Transfer (HRP Grants)	-$75.0	$0.0	+$75.0
Comparable PM Total	**$3,230.4**	**$3,465.5**	**+$235.1**
FTEs – Program Management Direct	4,117	4,276	+159

- Medicare Operations: $2,363.9 million, a $98.1 million increase over the FY 2009 enacted level. Nearly half of the request funds the ongoing workloads of the Medicare contractors who process fee-for-service claims, respond to provider inquiries, and handle appeals. The remainder will allow CMS to oversee the Medicare Advantage and Medicare Part D prescription drug programs, pay for information technology needed to run the Medicare programs, and implement major initiatives which enhance and improve the program. In FY 2010, CMS expects to complete transitions to the new Medicare Administrative Contractors as part of contracting reform, increase the number of contractors using HIGLAS, and continue implementing a new healthcare coding system--ICD-10—which will help reduce payment errors, facilitate our value-based purchasing program, and enhance electronic claims processing.

- Federal Administration: $697.8 million, a $56.4 million increase over the FY 2009 enacted level. This request will cover payroll for 4,276 direct FTEs, an additional 159 FTEs. The extra staffing will allow us to maintain our traditional workloads, and to implement recent mandatory legislation including the TRHCA, MMSEA, and the MIPPA. The payroll estimate assumes a 2-percent cost of living allowance in calendar year 2010. Our request for non-payroll categories reflects an increase of $18.5 million over the FY 2009 enacted level. This will allow CMS to adequately cover increases in rent, administrative systems, and contracts and interagency agreements.

- Survey and Certification: $346.9 million, a $53.8 million increase over the FY 2009 enacted level. This funding will allow CMS to maintain the statutorily-mandated frequency levels for nursing homes and home health agencies and keep other facility survey frequencies at Administration policy levels. Our request also includes a proposal to collect user fees for both recertification surveys and revisit surveys. If enacted, we expect to collect $9.4 million in revisit user fees in FY 2010; these collections would increase our program level and remain available for additional survey costs. In FY 2011, revisit fee collections would increase and we would begin to collect recertification fees.

- Research, Demonstration, and Evaluation: $57.0 million, an increase of $26.8 million over the FY 2009 enacted level. This level will provide: $30.0 million to create a robust agenda for demonstration projects that, if successful, could eventually be implemented more broadly to improve the efficiency and quality of services, as well

as improve the fiscal status of the Medicare program; $14.8 million for the Medicare Current Beneficiary Survey, an increase of $2.3 million above the FY 2009 level to restore the annual funding required to operate and maintain this survey; $9.7 million, $3.0 million below the FY 2009 level, for continuing research activities including the Electronic Health Record demonstration, ESRD disease management, prospective payment systems, and others; and $2.5 million for Real Choice Systems Change grants, a decrease of $2.5 million below the FY 2009 enacted level. The request does not continue any earmarks.

- State High-Risk Pool Grants: CMS is not requesting funding for this activity in its FY 2010 Program Management account. Instead, we are requesting $75.0 million in mandatory money through the State Grants and Demonstrations account. We have adjusted the FY 2009 column to reflect this proposed transfer.

Medicare Operations

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request[1]	FY 2010 +/- FY 2009
BA	$2,197,293,000	$2,265,715,000	$2,363,862,000	+$98,147,000
Rescission (P.L. 110-161)	($38,387,000)	$0	$0	$0
Net BA	$2,158,906,000	$2,265,715,000	$2,363,862,000	+$98,147,000

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

FY 2010 Authorization - One Year

Allocation Method - Contracts

OVERVIEW

Program Description and Accomplishments

Established in 1965, the Medicare program provides hospital and supplemental medical insurance to Americans age 65 and older and to disabled persons, including those with end-stage renal disease. The program was expanded in 2003 to include a voluntary prescription drug benefit. Since 1966, Medicare enrollment has increased from 19 million to about 46 million beneficiaries. Medicare benefits, the payments made to providers for their services, are permanently authorized. They are explained more fully in the Medicare Benefits chapter in the "Other Accounts" section of this book. The Medicare Operations account discussed here is funded annually through the Program Management appropriation. CMS uses these funds to administer the Medicare program, primarily to pay contractors to process providers' claims, to fund beneficiary outreach and education, to maintain the IT infrastructure needed to support various claims processing systems, and to continue programmatic improvements.

Medicare Parts A and B

The original Medicare program consisted of two parts: Part A or Hospital Insurance, financed primarily by payroll taxes; and Part B or Supplemental Medical Insurance, which provides optional coverage for a monthly premium. The original program reflected a fee-for-service approach to health insurance. Historically, Medicare contractors known as fiscal intermediaries (FIs) and carriers have handled Medicare's claims administration activities. The FIs processed Part A workloads and the carriers processed Part B workloads. As part of CMS' contracting reform initiative, CMS will replace FIs and

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

carriers with 15 Medicare Administrative Contractors, or MACs, that will process both Parts A and B workloads. This initiative is described more fully later in this chapter.

Medicare Parts C and D

CMS also administers and oversees the Medicare Part C and Part D programs. Part C, also known as Medicare Advantage (MA), offers comprehensive Part A and B medical benefits in a managed care setting through private health care companies such as Health Maintenance Organizations, Preferred Provider Organizations, private fee-for-service plans, and special needs plans. Many MA plans offer Part D, as well as additional services, such as prescription drugs, vision and dental benefits. As of April 2009, over ten million beneficiaries - approximately 25% of those enrolled in both Part A and Part B, - were enrolled in MA plans. CMS anticipates that by FY 2010, over eleven million beneficiaries – approximately 26% of those enrolled in both Part A and Part B, - will be enrolled in MA plans.

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

Program Assessment

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

Funding History

FY 2005	$1,730,920,000
FY 2006	$2,147,242,000
FY 2007	$2,159,242,000
FY 2008	$2,158,906,000
FY 2009	$2,265,715,000

Budget Request

CMS' FY 2010 President's Budget request for Medicare Operations is $2,363.9 million, an increase of $98.1 million above the FY 2009 appropriation. Almost half of the Medicare Operations account funds ongoing fee-for-service activities at the FIs, carriers, and MACs, such as processing claims, responding to provider inquiries, and handling appeals. The remainder funds fee-for-service support and systems activities, operational costs for the new Medicare Advantage and Part D programs, outreach and

education, contracting reform, and initiatives that will improve and enhance the entire Medicare program such as HIGLAS, ICD-10, and MIPAA.

Activity	FY 2009 Omnibus	FY 2010 President's Budget Request	Difference
Medicare Parts A and B:			
FI/Carrier/MAC Ongoing Operations	1,033.5	1,048.7	15.2
FFS Operations Support	50.1	64.4	14.3
Claims Processing Investments	86.5	79.0	-7.5
Contracting Reform	108.9	65.6	-43.3
Competitive Bidding for Part B Drugs	0.0	2.0	2.0
Medicare Parts C and D:			
IT Systems Investments	102.7	105.9	3.2
Oversight and Management	41.5	46.4	4.9
Managed Care Appeal Reviews	5.9	7.5	1.6
Activities Supporting All Parts of Medicare:			
NMEP[2]	318.3	315.6	-2.7
HIGLAS	162.1	161.0	-1.1
CFO Audit	8.0	8.5	0.5
QIC Appeals (BIPA 521/522)	56.3	59.7	3.4
HIPAA	27.9	25.8	-2.1
ICD-10 & Version 5010	40.3	62.5	22.2
MIPPA	0.0	81.6	81.6
Other IT Investments	223.8	229.7	5.9
Total	**$2,265.7**	**$2,363.9**	**$98.1**

MEDICARE PART A AND B OPERATIONS

Program Description and Accomplishments

FI/Carrier/MAC Ongoing Operations

This category reflects the Medicare contractors' ongoing workloads including processing claims, enrolling providers in the Medicare program, handling provider reimbursement services, processing appeals, responding to provider inquiries, educating providers about the program, and administering the participating physicians/supplier program (PARDOC). These activities are described in more detail below. The Medicare contractors no longer answer general beneficiary inquiries; this activity has been consolidated under the 1-800-MEDICARE number funded through the National *Medicare & You* Education Program (NMEP). This is discussed later in the chapter.

[2] Funding for beneficiary inquiries has been combined with the NMEP under the Beneficiary Contact Center/1-800-MEDICARE

- *Bills/Claims Payments* – The Medicare contractors are responsible for processing and paying Part A bills and Part B claims correctly and timely. Currently, almost all providers submit their claims in electronic format: 99.8 percent for Part A and 96.3 percent for Part B in March of 2009. Although most Part A claims have been electronic for well over a decade, Part B claims have been slower to convert to this format. In FY 2002, for example, only 83.7 percent of Part B claims were electronic. The Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) and the Administrative Simplification Compliance Act (ASCA) of 2005 both had a major impact on the increase in electronic claims. HIPAA established national standards for Electronic Data Interchange (EDI) for the transmission of health care data. Electronic claims must meet HIPAA requirements. ASCA, with limited exceptions, prohibited payments for Medicare services or supplies that were not billed electronically. Through the use of EDI, both Medicare and health care providers can process transactions faster and at a lower cost.

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

- *Provider Enrollment* – CMS and its Medicare contractors, including carriers, fiscal intermediaries, and Part A and Part B Medicare Administrative Contractors, are responsible for enrolling providers and suppliers in the Medicare program and ensuring that these providers and suppliers continue to meet Federal Regulations and State licensing standards. The enrollment process includes a number of verification processes to ensure that Medicare is only paying qualified providers and suppliers. In addition, the Medicare program requires that all newly enrolling providers and suppliers or providers and suppliers making a change in enrollment obtain Medicare payments by electronic funds transfer.

  CMS has implemented the Internet-based Provider Enrollment, Chain and Ownership System (PECOS) to help streamline the enrollment process. This new system, funded through the Medicare Integrity Program appropriation, allows physicians and non-physician practitioners the opportunity to complete and submit their enrollment application via the Internet, make changes to their information, and review their information to ensure its accuracy. In CY 2009, CMS will implement a similar process for organization providers and suppliers, except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. Internet-based PECOS will be made available to DMEPOS suppliers in CY 2010.

- *Provider Reimbursement Services* – Medicare Part A providers are required to file a cost report on an annual basis. In addition to determining the payment amount for items paid on cost, the cost report is used to finalize prospective payment system

(PPS) add-on payments such as graduate medical education (GME), indirect medical education (IME), disproportionate share (DSH), and bad debt payments. The contractor's provider reimbursement area performs the following activities, most requiring substantial manual effort:

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

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

- Maintaining files and systems: The FIs/MACs must maintain a "pricer" file that contains provider-specific data used to calculate the provider's claims payment. This file contains information such as the disproportionate share adjustment percentage, capital data, periodic interim payment (PIP) indicator, wage index, indirect medical education (IME) adjustment, etc. The contractors also maintain the provider statistical and reimbursement system (PS&R) which contains all the claims information to settle cost reports; and the system for tracking audit and reimbursement (STAR) which tracks the cost report from its due date through the settlement, reopening, and appeal processes.

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

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

- Identifying delinquent debt: Debts that are more than 180 days delinquent can be referred to the Department of Treasury (DOT) for further collection in accordance with the Debt Collection Improvement Act of 1996. Historically, CMS refers about 98% of its eligible delinquent debt to DOT for collection. Although Treasury attempts to collect these debts, the Medicare contractors continue to maintain and report these receivables. Medicare contractors provide DOT with any updates to the debt balance and debt status. After Treasury

completes its collection processes, and has been unable to collect the debt, it is returned to the Medicare contractor for final disposition.

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

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

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

  In each fiscal year 2007 and 2008, the contractors processed 2.7[3] million redeterminations. This is a decrease from the volume received in FY 2006. Much of this drop in volume is due to the implementation of a provision in the MMA of 2003 which allows claims denied to minor errors and omissions to be processed as a clerical error reopening (rather than a telephone redetermination which was the previous, more costly, method for handling most of these claims issues). While the overall redeterminations workload has decreased in recent fiscal years, reopenings activities have increased. In FY 2008, CMS' contractors processed approximately 3 million non-clerical error reopenings and 5.5 million clerical error reopenings.

  Although the volume has decreased, the cost per redetermination has increased due to the increasingly complex nature of the types of claims appealed. One example is the recent transition of reviews of inpatient hospital claims and error rate reviews from the Quality Improvement Organizations (QIOs) to the FIs and MACs. Previously, the QIOs handled the appeals of these denials. Now, the FIs and MACs

[3] The 1st level appeals activities noted in this document do not include the Recovery Audit Contractor (RAC) appeals workload which began in FY 2007. That workload is being tracked, reported, and funded separately.

are processing them. The complex nature of these inpatient hospital cases requires additional time to properly review the medical records, thereby increasing the average unit cost of a redetermination.

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

  In FY 2008, our contractors responded to over 57 million telephone inquiries, about 500,000 written inquiries, as well as rare walk-in inquiries from two million providers. The contractors utilize Interactive Voice Response (IVR) systems to automate about 65% of their telephone inquiries. This frees up customer service representatives to handle the more complex questions. Overall, call volumes are stabilizing, despite the many new initiatives underway at CMS, due to our improved/expanded National and contractor outreach efforts. CMS believes that providers are getting the information they need through other sources, thus we expect calls to grow very modestly in FY 2010.

- *Participating Physician/Supplier Program (PARDOC)* – This program helps reduce the impact of rising health care costs on beneficiaries by increasing the number of enrolled physicians and suppliers who "participate" in Medicare. Participating providers agree to accept Medicare-allowed payments as payment in full for their services. To support this program, the Carriers or MACs conduct an annual enrollment process, monitor compliance with the limiting charge to ensure that the providers are not billing beneficiaries more than Medicare allows, and disseminate information on the participating providers.

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

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

- *Provider Outreach and Education* – The goal of Provider Outreach and Education (POE) is to reduce the claims payment error rate by helping providers to manage Medicare-related matters on a daily basis and properly bill the Medicare program. The Medicare contractors educate providers and their staffs about the fundamentals

of the program, policies and procedures, new initiatives, and significant changes including any of the more than five-hundred change requests that CMS issues each year. The contractors also identify potential issues through analyses of provider inquiries, claim submission errors, medical review data, Comprehensive Error Rate Testing data, and the Recovery Audit Contractors (RAC) data.

The Medicare contractors are required to provide critical training and technical assistance to individual physicians and suppliers as part of their delivery of timely, accurate and understandable educational services and products about the fee-for-service Medicare program. CMS encourages the contractors to be innovative in their approach and to use a variety of strategies and methods for disseminating information including using print, Internet, telephone, CD-ROM, educational messages on the general inquiries line, face-to-face instruction, and presentations in classrooms and other settings.

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

- *Enterprise Data Centers* – The Enterprise Data Centers (EDCs) are the foundation of the infrastructure that will eventually support all CMS production data center operations. Traditionally, FI's and carriers have either operated their own data centers or contracted out for these services. As part of the contracting reform initiative, CMS is reducing the number of legacy (FI and carrier) data centers from 20 separate small centers to three large enterprise data centers (EDCs). CMS manages these EDC contracts. The vision is to have all production applications, including Part C/D systems, hosted in one of the EDCs. Migrating the entire national fee-for-service claims processing workload is a significant undertaking that touches many stakeholders. This migration is currently underway. By FY 2010, all FFS claims processing operations will be housed at the three EDCs. This estimate covers the operations and maintenance costs associated with these three enterprise data center contracts.

Fee-for-Service Operations Support

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

- *Provider Toll-Free Lines* – Section 1874(A)(g)(3) of the Social Security Act requires CMS to offer toll-free telephone service to providers. CMS maintains over 500 toll-free telephone numbers in order to deliver accurate, consistent, and timely information on over 57 million telephone inquiries received each year at the Medicare contractors' provider contact centers. These include numbers for: general provider inquiries; responding to questions about provider enrollment, electronic data interchange, and Medicare secondary payer issues; and testing, development, and

routing. Only the costs of the toll-free lines are in this category. The costs of answering the inquiries, including customer service representatives' salaries, are included in Ongoing Operations under Provider Inquiries.

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

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

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

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

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

Claims Processing Investments

CMS' claims processing systems currently process approximately 1.2 billion Part A and B claims each year. They are a major component of our overall information technology costs. The claims processing systems: receive, verify, and log claims and adjustments; perform internal claims edits and claim validation edits; complete claims development and adjudications; maintain pricing and user files; and generate reports. Funds cover ongoing systems maintenance and operations. The main systems include:

- *Part A, Part B and DME processing systems* – The contractors currently use standard systems for processing Part A, Part B, and DME claims. Historically, the contractors used one of several different processing systems. A few years ago, CMS converted the Medicare contractors to one of three selected standard systems. This has provided a more controlled processing environment and reduced the costs of maintaining multiple systems.
- *Common Working File (CWF)* – This system verifies beneficiary eligibility and conducts prepayment review and approval of claims from a national perspective. The CWF is the only place in the claims processing system where full individual beneficiary information is housed.
- *Systems Integration Testing Program* – CMS conducts systems testing of FFS claims processing systems in a fully-integrated, production-like approach that includes data exchanges with all key systems. This investment allows CMS to monitor and control system testing, costs, standardization, communication, and flexibility across systems.

Budget Request

FI/Carrier/MAC Ongoing Operations

The FY 2010 President's Budget request for FI/Carrier/MAC Ongoing Operations is $1,048.7 million, $15.2 million above the FY 2009 appropriation.

This funding will allow the FIs, carriers, and MACs to process their workloads accurately, in a timely manner, and in accordance with CMS' program requirements. FY 2010 will still be a transitional year for the Medicare contractors as we phase out the remaining legacy contractors (FIs and carriers), finish implementing the new MACs, and transition all FFS workloads to the new EDCs. This level of funding will allow CMS to make a smooth and orderly transition between the two business processes. This funding level also covers a projected 2.6 percent increase in claims volume.

In FY 2010, CMS' contractors expect to:

- process 1.2 billion claims
- handle 3.5 million redeterminations
- answer 58 million provider inquiries.

The following table displays claims volumes and unit costs for the period FY 2006 to FY 2010. The unit costs reflect the total funds provided to our contractors in the Ongoing Operations line for claims processing/data centers, appeals, inquiries, enrollment, outreach and education, provider reimbursement, and PARDOC. In prior years, we calculated a unit cost that reflected claims processing activities only. With the transition from FI's and Carriers to the A/B MACs, we are no longer able to isolate claims processing costs or associate them with Part A or Part B claims. As a result, we are

showing a bottom-line unit cost that encompasses all of the contractor activities required to process a claim to final payment, including those mentioned above. CMS has significantly reduced its unit cost over the last several years. We remain committed to achieving efficiencies in our fee-for-service operations.

Volume (in millions)	**FY 2006 Actual**	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Estimate**	**FY 2010 Estimate**
Part A	185.4	185.7	187.1	191.1	194.9
Part B	969.7	970.0	987.8	1,012.9	1,040.5
Total	**1,155.1**	**1,155.7**	**1,174.9**	**1,204.0**	**1,235.4**
Unit Cost (in dollars)					
Total	**$1.02**	**$0.98**	**$0.87**	**$0.86**	**$0.85**

Fee-for-Service Operations Support

The FY 2010 President's Budget request for fee-for-service operations support is $64.4 million, $14.3 million more than the FY 2009 appropriation.

- *Provider Toll-Free Lines*: $8.5 million, the same as the FY 2009 appropriation to maintain the operations of the toll-free line.
- *National Provider Education, Outreach, and Training*: $7.5 million, the same as the FY 2009 appropriation to maintain provider education activities and update the Medicare Learning Network (MLN) educational products.
- Medicare Beneficiary Ombudsman: $1.3 million, $0.1 million more than the FY 2009 appropriation.
- *Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens*: $7.2 million, $2.7 million more than the FY 2009 appropriation to process claims expected in FY 2010.
- *Other Operational Costs:* $39.9 million, $11.5 million more than the FY 2009 appropriation. This increase includes funding for the following:
    - The HSPD-12 activity includes developing links between the logical access systems at CMS and the logical access systems at the Department, as well as personal identification verification (PIV) card maintenance fees.
    - CMS has added a number of new requirements to its Medicare Financial Management Manual which the Medicare contractors are required to implement in FY 2009. These include performing more detailed, stringent reviews of extended repayment schedule requests and providing more specific direction on Medicaid offsets before referral to the Department of the Treasury. FY 2010 funds will support training, revisions to internal control processes, and establishment of new procedures so that the contractors remain compliant.
    - The Star Rating for Nursing Homes includes the design, implementation, and ongoing maintenance of the national "five-star" system that rates and compares the quality of care for each of the nation's 16,000 nursing homes. This information is posted on CMS' *Nursing Home Compare* website which is located within the http://www.medicare.gov website.

In addition, the FY 2010 President's Budget request will support the limitation on recoupment activity, the A-123 assessment, running the Physician Scarcity &

Improvement to Health Professional Shortage Area (HPSA) bonus program, and numerous other activities which support fee-for-service operations.

The following table displays provider toll-free line call volumes historically and projected for FY 2009 and FY 2010:

Provider Toll-Free Line Call Volume

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Estimate	FY 2010 Estimate
Completed Calls	55.2 million	54.4 million	57.1 million	57.6 million	58.2 million

Claims Processing Investments

The FY 2010 President's Budget request for claims processing investments is $79.0 million, a decrease of $7.5 million below the FY 2009 appropriation. This funding level reflects efficiencies gained from having standardized claims processing systems.

CONTRACTING REFORM

Program Description and Accomplishments

Medicare contracting reform changes the face of the traditional Medicare program by integrating Parts A and B under a single contract authority, known as a Medicare Administrative Contractor or MAC, using competitive acquisition procedures under the Federal Acquisition Regulation (FAR), and enabling a re-engineering of business processes. CMS has made strong progress implementing Medicare contracting reform in accordance with section 911 of the Medicare Modernization Act (MMA).

To date, CMS has fully implemented all four Durable Medical Equipment (DME) MACs. In addition, seven A/B MACs are fully operational; four are under bid protest; two are under corrective action, and two are in the process of being implemented. CMS will closely monitor the implementation of the resulting contracts throughout FY 2009. All of the "first-generation" MACs should be fully operational by FY 2010.

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

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

DME MAC Regions A & B	Awarded January 2006. Fully operational since July 2006.
DME MAC Region D	Awarded January 2006. Protest resolved May 2006. Fully operational since October 2007.
DME MAC Region C	Initially awarded January 2006; bid protest activity finally resolved January 2007. Fully operational since June 2007.
A/B MAC J 3	Awarded July 2006. Fully operational since May 2007.
Cycle I A/B MAC RFP 1	RFP released in September 2006. Three A/B MAC jurisdictions: o J 4 MAC awarded August 2007. o J 5 MAC awarded September 2007. o J 12 MAC awarded in October 2007 (corrective action taken). All are fully operational.
Cycle I A/B MAC RFP 2	RFP released in December 2006. Four A/B MAC jurisdictions: o J 1 awarded in October 2007 (fully operational). o J 13 awarded March 2008 (fully operational). o J 2 awarded May 2008 (under corrective action). o J 7 awarded June 2008 (under corrective action) CMS will complete full implementation of each jurisdiction within 12 months of completion of corrective action.
Cycle II A/B MAC RFP 1 & RFP 2	RFP released August 2007. Five A/B MAC Jurisdictions: o J 6 awarded January 2009 (bid protest ongoing) o J 8 awarded January 2009 (bid protest ongoing) o J 9 awarded September 2008 (fully operational) o J 10 awarded January 2009, (implementation ongoing) o J 11 awarded January 2009 (bid protest ongoing) o J 14 awarded November 2008 (implementation ongoing) o J 15 awarded January 2009 (bid protest ongoing) Four of these contracts (J6, 11, 14 & 15) provide for Medicare home health and hospice claims processing requirements. CMS will complete full implementation of each jurisdiction within 12 months following award (or resolution of bid protest).

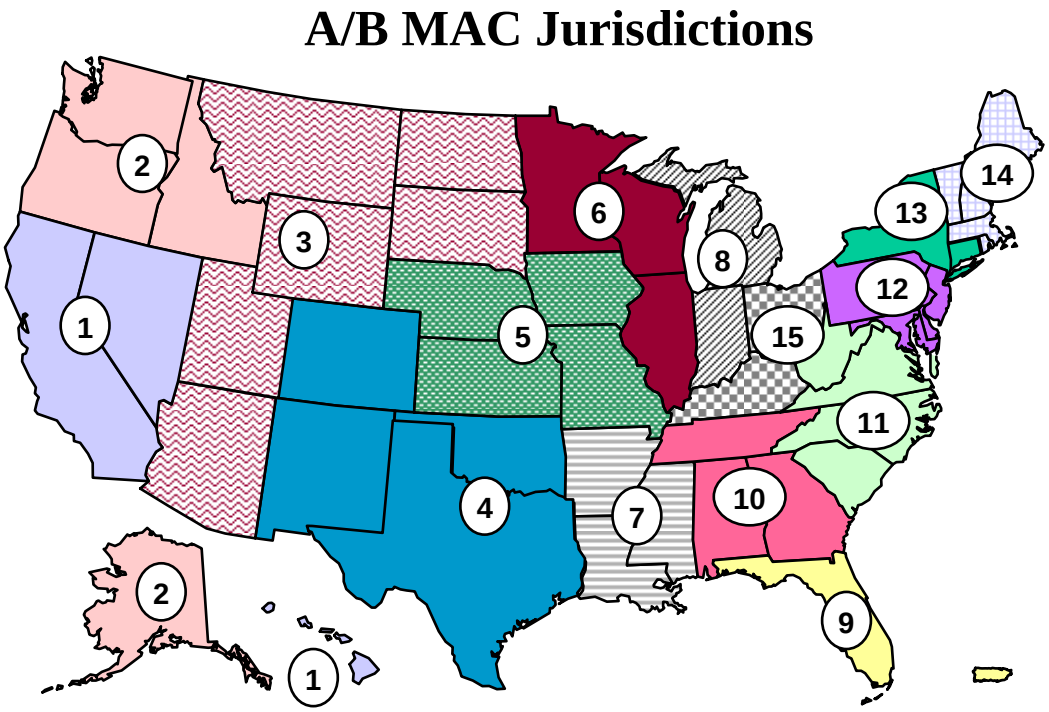
In FY 2008, CMS implemented 31.5 percent of the FFS workload (across five MAC contracts), bringing the total FFS workload implemented to 40.6 percent. For FY 2009, CMS has reduced its implementation target from 85 percent to 74 percent. Our target for FY 2010 is to implement all MAC contracts.

In FY 2008, CMS awarded an additional six MAC contracts, for a total award of 62.3 percent of the FFS workload. (However, CMS has suspended performance on two of these MAC contracts due to GAO bid protests.) All MAC contracts have now been awarded, however, MAC award protests have caused months of delays in certain jurisdictions. CMS believes that the present delays in MAC awards, provided CMS' mitigating actions are effective, will not have a material impact on anticipated program savings. (Please refer to the key performance outcomes table at the end of this chapter for further information on performance.)

CMS has also made significant progress in reducing the number of data centers operated by the FI's and carriers from 20 small centers to three large enterprise data centers (EDCs). CMS expects to achieve administrative efficiencies from this

consolidation. It will also create greater performance, security, reliability, and control over this operation. In addition, the EDC infrastructure gives CMS greater flexibility in meeting current and future data processing challenges. This is critical as the FFS claims workload continues to grow and applications require a more stable environment. By FY 2010, all FFS claims processing operations will be housed at the three EDCs. This request will cover the remaining transitions and project management costs. In addition, the contractor management information system, a web-based workload tracking system, is included in the contracting reform estimate.

The following map displays the A/B MAC jurisdictions:



Budget Request

The FY 2010 President's Budget request for contracting reform is $65.6 million, $43.3 million less than the FY 2009 appropriation. This level includes:

- $44.7 million for contractor transitions, a $38.1 million decrease in funding for legacy contractor transition and termination costs. This reflects the implementation of the final round of "first generation" MAC awards.
- $11.6 million for information technology investments, including the final data center transitions, a web-based workload tracking system, and the shared system change management system. This is $2.2 million less than the FY 2009 appropriation due to a reduction in the number of EDC transitions; and
- $9.3 million for several activities that support contracting reform implementation, including a provider satisfaction survey required by the MMA. This funding level is $3.0 million less than the FY 2009 appropriation mainly due to a decreased need for business expertise, external validation, and implementation support in this final year.

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

COMPETITIVE BIDDING

Program Description and Accomplishments

- Section 302(b)(1) of the MMA authorized the establishment of a new DME competitive acquisition program which replaced the current fee schedule payment amounts for selected items in certain areas with payment amounts based on competitive bids.

  CMS initiated the first phase of this program in 2007 in ten metropolitan statistical areas (MSAs). CMS had planned to add 70 MSAs in FY 2008 and then expand to additional areas in 2009. However, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted on July 15, 2008, delayed this initiative and made several changes to the program. MIPPA terminated the competitive bidding contracts previously signed for Round 1. It delayed Round 1 until 2009, reduced the number of Round 1 MSA's from ten to nine, and delayed Round 2 until 2011. MIPPA requires CMS to create an ombudsman position to respond to complaints and inquiries made by suppliers and individuals. MIPPA also provided earmarked funds for implementing the revised DME competitive bidding program. As a result, we are not requesting funding for this activity through our annual Program Management appropriation.

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

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

  During this postponement, CMS plans to seek feedback on the CAP from participating physicians, potential vendors, and other interested parties. CMS will assess the information and consider implementing changes to the CAP before proceeding with another bid solicitation later in 2009. As part of the process, CMS hopes to hear from the public about a range of issues, including, but not limited to, the categories of drugs provided under the CAP, the distribution of areas that are

served by the CAP, and procedural changes that may increase the program's flexibility and appeal to potential vendors and physicians.

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

Budget Request

The FY 2010 President's Budget request for Part B competitive bidding is $2.0 million, an increase of $2.0 million above the FY 2009 appropriation due to the postponement of the CAP activity in FY 2009.

MEDICARE PART C AND D OPERATIONS

Program Description and Accomplishments

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

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

In FY 2009, CMS began reporting on a GPRA performance goal that focuses on the Medicare Prescription Drug Benefit's enrollment of beneficiaries in Part D. This measure assesses the increase of Medicare beneficiaries with prescription drug coverage from Part D or other sources. The enrollment performance data is now reported by fiscal year instead of calendar year (CY) as previously reported and reflects our effort to be consistent in reporting fiscal year data. The enrollment baseline for FY 2007 (CY 2006 data) was approximately 90 percent, reflecting the initial success of the Medicare prescription drug program. FY 2008 enrollment levels remained at 90 percent. As a result, the FY 2009 target was set at 91 percent. Given the high rates of enrollment, it is becoming increasingly challenging to increase the enrollment rates further. This is evident in the final FY 2009 data, which showed the enrollment data remaining at 90 percent. The target will remain at 91 percent for FY 2010.

CMS also measures two other aspects of Medicare's prescription drug benefit in this GPRA goal: (1) a beneficiary survey measuring knowledge of the benefit; and (2) a management/ operations component involving Part D sponsor performance metrics published on the Medicare Prescription Drug Plan Finder (MPDPF) tool. For more information on these performance measures, please refer to the key performance outcomes table at the end of this chapter and the Online Performance Appendix at http://www.cms.hhs.gov/performancebudget/downloads/CMSOPA01302008.pdf.

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

Parts C and D IT Systems Investments

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

- *Medicare Advantage Prescription Drug Payment System*: processes payments for the prescription drug program.
- *Medicare Beneficiary Database*: contains beneficiary demographic and entitlement information.
- *Retiree Drug Subsidy System*: collects sponsor applications, drug cost data, and retiree data; processes this information in order to pay retiree drug subsidies to plan sponsors.
- *Risk Adjustment System*: uses demographic and diagnostic data to produce risk adjustment factors to support payments to MA plans.
- *Health Plan Management System*: manages the MA and Part D plan enrollment process, including the application process; bid and benefit package submission; plan monitoring and oversight; and other activities.

Oversight and Management

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

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

Managed Care Appeal Reviews

CMS contracts with an independent reviewer to conduct reconsiderations of adverse MA plan determinations and coverage denials made by Medicare Health Plans and Programs of All-inclusive Care for the Elderly (PACE) organizations. This review stage represents the first level of appeal for the beneficiaries in these plans. All second level reviews are done by the Qualified Independent Contractors (QICs) (explained in the Activities Supporting All Parts of Medicare section later in this chapter).

Budget Request

The FY 2010 President's Budget request for Medicare Part C and Part D operations is $159.8 million. This funding level is $9.7 million more than the FY 2009 appropriation level. This increase is explained below:

- *Part C/D IT Systems Investments*: $105.9 million, an increase of $3.2 million over the FY 2009 appropriation. As MA and Part D plan participation continues to grow, the Part C/D systems must grow as well to accommodate the flow of additional information. This request funds the contracts needed to operate and maintain these various systems. In addition, the FY 2010 request will support some limited replacements of end of life equipment in the Baltimore Data Center.

  The FY 2010 President's Budget request also funds improved customer service support for the MMA help desk which provides technical and operational system support for users of several Medicare Advantage and Part D systems.

- *Oversight and Management*: $46.4 million, $4.9 million over the FY 2009 appropriation. The increase is due to increases in the Point of Sale Facilitated Enrollment (POS-FE) contract; the joint process contract for dual eligible-low income subsidy beneficiaries; and plan application reviews.

- *Managed Care Appeal Reviews:* $7.5 million, an increase of $1.6 million over the FY 2009 appropriation due to an increase in workload activities.

ACTIVITIES SUPPORTING ALL PARTS OF MEDICARE

NATIONAL MEDICARE AND YOU EDUCATION PROGRAM (NMEP)

Program Description and Accomplishments

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

Beneficiary Materials

This category includes the annual *Medicare & You* handbook, initial enrollment packages, and other beneficiary materials. These informational materials will continue to build beneficiary awareness of changes in the Medicare program, and promote Agency resources where beneficiaries can get more information (1-800-MEDICARE, http://www.medicare.gov) or get help (via SHIP counselors). These materials will also provide a clear differentiation of Medicare plans to beneficiaries, assure accountability of plans for performance requirements, comply with formulary guidance, and ensure effective data is present.

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

beneficiaries. Updates to rates and plan information occur semi-annually for the monthly mailings to newly eligible beneficiaries.

The chart below displays the number of *Medicare & You* handbooks distributed for FY 2006 – 2008 and the estimated distribution for FY 2009 -2010. The yearly distribution includes the number of handbooks mailed to beneficiary households in October, handbooks pre-ordered for partners and warehouse stock to fulfill incoming requests, and handbooks mailed monthly throughout the year to newly eligible beneficiaries.

The *Medicare & You* Handbook Yearly Distribution

	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Estimate	FY 2010 Estimate
Number of Handbooks Distributed	39.3 million	40.3 million	41.9 million	42.9 million	44.0 million

Beneficiary Contact Center/1-800-MEDICARE

The 1-800-MEDICARE national toll-free line provides beneficiaries with access to customer service representatives (CSR) in order to answer questions regarding the Medicare program. The toll-free line is available 24 hours a day, 7 days a week, in both English and Spanish. For the past ten years, this line has provided beneficiaries with responses to general inquiries about Medicare.

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

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

We are constantly looking at ways to improve the efficiency of the 1-800 MEDICARE operation. In 2008, we implemented BCC command centers and real time schedule adherence to develop and monitor in real time the most effective schedules across the lines of business and hours of operation and to ensure that CSRs are following them. We also continue to implement cost saving technologies such as "Co-browse," which improves the efficiency of the interaction between senior and junior level CSRs.

The "1-800-MEDICARE/Beneficiary Contact Center Call Volume Offered" table below represents the actual and estimated call volumes from FY 2006 through FY 2010. CMS estimates the number of calls received in a fiscal year based on a number of factors including historical trends and analysis, growth in the program, and the increase in the

senior population. In FY 2010, CMS expects to receive 28.1 million calls to the 1-800-MEDICARE toll-free line. All calls are initially answered by the Interactive Voice Response (IVR) system. The average monthly wait time for callers to speak to a CSR would be 5 minutes during the open-enrollment period and 8 minutes during the remainder of the fiscal year.

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

	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Estimate	FY 2010 Estimate
Number of Calls[4]	42.3 million	29.0 million	27.4 million	26.9 million	28.1 million

Internet

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

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

The http://www.medicare.gov is the Agency's public beneficiary-focused website with a variety of real-time, interactive, decision-making tools that enable Medicare beneficiaries and their caregivers to receive information on their benefits, plans, and medical options. The site has a monthly release schedule for updates and data refreshes. This website includes four separate quality tools, eleven other complex applications, and MyMedicare.gov (most available in English and Spanish). MyMedicare.gov is a portal for beneficiaries to track and receive personalized information regarding their Medicare health and prescription drug plan, preventive services, claims, and drug details and cost share information. The Medicare Options Compare (formerly Medicare Personal Plan Finder), the Medicare Prescription Drug Plan Finder, Hospital Compare, Nursing Home Compare, and the Medicare Eligibility tool are included under this initiative. The website serves as an effective and efficient communication channel and provides self-service

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

options for U.S. citizens, beneficiaries, and caregivers to have access to accurate and consistent information on the Medicare program to use on a daily basis for important decision-making purposes. This website is an integral part of CMS' goals of modernization, contracting reform, accelerated use of electronic health information, and managing the Medicare prescription drug benefit. Without this investment, beneficiaries and 1-800-MEDICARE would be unable to conduct prescription drug plan enrollments. CMS would be unable to meet legislative mandates to provide accurate and critical information online to the public.

In FY 2010, CMS estimates approximately 460 million page views to http://www.medicare.gov, approximately a 3% increase in traffic from the page views anticipated in FY 2009. CMS expects page views to grow as the Medicare beneficiary population increases, beneficiaries and their caregivers become more internet savvy, and we continue to implement more self-service features for beneficiaries to use maximizing their health and quality of care decisions.

	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Estimate	FY 2010 Estimate
Number of http://www.medicare.gov Page Views	403.0 million	425.0 million	434.0 million	447.0 million	460.0 million

Community-Based Outreach

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

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

CMS has built an extensive partnership network that will help establish a more permanent grassroots Medicare program. CMS has also worked collaboratively with the Administration on Aging to enhance its capacity to provide local assistance through its extensive network of providers. CMS plans to focus on promoting high quality care and

raising the level of awareness about chronic diseases to help to close the prevention gap for beneficiaries.

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

Program Support Services

This activity includes a multimedia advertising campaign, assessment activities, consumer research, production of NMEP materials in different formats (such as Braille and audio), and electronic and composition services for the Handbook.

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

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

Program Support Services also provides funding for the *Medicare & You* Handbook support activities such as consumer testing (mentioned above), electronic, and composition support, translation services, and providing the Handbook in other formats such as Braille and audio.

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

	FY 2009 Appropriation	FY 2010 President's Budget	Description of Activity in FY 2010
Beneficiary Materials	$48.9 M ($30.9M PM) ($18.0M UF)	$54.1 M ($36.1M PM) ($18.0M UF)	National handbook with comparative information in English and Spanish (national & monthly mailing); initial enrollment packages to new beneficiaries; targeted materials only to the extent that funding is available after payment of the handbook.
Beneficiary Contact Center/ 1-800-MEDICARE	$267.2 M ($219.1M PM) ($48.1M UF)	$265.4 M ($209.1M PM) ($56.3M UF)	Call center and print fulfillment services available with 24 hours a day, 7 days a week access to customer service representatives for 12 months. Includes funding previously allotted to FFS Medicare contractors for claims-related inquiries.
Internet	$17.1 M ($14.6M PM) ($2.5M QIO**)	$20.6 M ($18.1M PM) ($2.5M QIO**)	Maintenance and updates to existing interactive websites to support the CMS initiatives for health & quality of care information; software licenses.
Community-based Outreach	$54.9 M ($47.4M PM) ($7.5M MIPPA)	$43.3 M ($43.3M PM)	SHIP grants and support; collaborative grassroots coalitions; and training on Medicare for partner and local community based organizations, providers, and Federal/State/local agencies that provide assistance to people with Medicare in their communities.
Program Support Services	$14.3 M ($6.3M PM) ($8.0M QIO**)	$17.1 M ($9.1M PM) ($8.0M QIO**)	National advertising campaign, support services to include Handbook support contracts such as Braille, Audio and translation support; minimal level of consumer research and assessment for planning, testing, and evaluating communication efforts to include efforts for targeted populations such as LIS.
Total	$402.4 M ($318.3M PM) ($7.5M MIPPA) ($66.1M UF) ($10.5M QIO)[6]	$400.4 M[5] ($315.6M PM)[5] ($74.3M UF) ($10.5M QIO)[6]	**Key to Abbreviations:** PM – Program Management MIPPA – Medicare Improvements for Patients and Providers Act UF – User Fee QIO – Quality Improvement Organizations

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

Budget Request

The FY 2010 President's Budget Program Management request for NMEP totals $315.6 million, a decrease of $2.7 million below the FY 2009 appropriation.

The BCC/1-800-MEDICARE line now reflects funding previously provided to the Medicare contractors for their beneficiary claims-related inquiry workload. This function was consolidated under the NMEP beginning in FY 2007. The following bullets highlight the FY 2010 Program Management level:

- Beneficiary Materials: $36.1 million
- Beneficiary Contact Center/1-800-MEDICARE: $209.1 million
- Internet: $18.1 million
- Community-Based Outreach: $43.3 million
- Program Support Services: $9.1 million

In addition to Program Management funding, the budget request also includes $74.3 million in user fees and $10.5 million in QIO funding, bringing the NMEP total to $400.4 million. The chart on the preceding page provides additional detail on these activities.

Beneficiary Materials

The FY 2010 President's Budget request for Beneficiary Materials is $36.1 million, approximately 11 percent of the NMEP program level funding. This is an increase of $5.2 million above the FY 2009 appropriation level. This estimate is based on historical publication usage data and current market prices for printing and mailing. The increase in the funding level is due to expected increases in beneficiary population, printing costs, and mailing costs. In FY 2008, CMS added an additional section to the 2009 *Medicare & You* handbook on planning for end-of-life care. The section includes important information on advance directives including living wills, durable powers of attorney, and after death wishes. Furthermore, more plans participated in the Medicare Advantage and Medicare Part D prescription drug programs. These two factors have increased the number of pages in the book and impacted the overall printing and postage costs. CMS must comply with the legal mandates for this activity (see next paragraph) and must ensure that beneficiaries have access to this information so that they can make informed health care decisions.

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

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

For the FY 2010 President's Budget, CMS is requesting $209.1 million, approximately 66 percent of the NMEP program level funding, for the 1-800-MEDICARE/BCC activities. This reflects a decrease of $10.0 million from the FY 2009 appropriation. This decrease is partially offset by higher NMEP user fees resulting from increases in Medicare Advantage plan enrollments. Despite increasing call volumes, the overall funding level declines due to improved operational efficiency at the BCCs resulting from technological enhancements such as the BCC command centers, real time schedule adherence, and the Co-browse function. CMS also expects increased efficiencies within the BCC by promoting the use of other NMEP education tools such as the *Medicare & You* handbook and the Internet. We expect a greater number of beneficiaries will take advantage of these other forms of education. This funding level will allow the BCC to operate at a 5-minute average speed of answer (ASA) for the open-enrollment period, and an 8-minute ASA for the remainder of the fiscal year.

Internet

For the FY 2010 President's Budget request, $18.1 million or approximately 6 percent of the NMEP program level funding will be spent on Internet activities. This funding level represents an increase of $3.5 million above the FY 2009 appropriation. The increase will be used for ongoing maintenance costs, renewing software licenses, and database support, as well as support for the Part D prescription drug plan and fall enrollment period requirements. This includes an increasing number of health plans, expanded agency programs, and ongoing security, testing, and monitoring activities. This funding will also support several tools that require complex data updates (e.g. Medicare Prescription Drug Plan Finder) that are necessary to ensure that accurate and consistent information is provided to U.S. citizens, Medicare beneficiaries, and health care professionals for decision-making purposes on a daily basis.

Community-Based Outreach

For the FY 2010 President's Budget request, $43.3 million or approximately 14 percent of the NMEP program level funding will be spent on community-based outreach activities. This funding level represents a decrease of $11.6 million below the FY 2009 appropriation. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) provided the SHIPs with an additional $7.5 million in FY 2009 and the FY 2009 Omnibus report language recommended an additional $5.7 million for SHIPs. These two increases make it appear that CMS is significantly reducing SHIP funding in FY 2010. However, CMS is proposing a level that is consistent with historical requests for the SHIPs.

Program Support Services

For the FY 2010 President's Budget request, $9.1 million or approximately 3 percent of the NMEP program level funding will be spent on Program Support Services activities. This funding level represents an increase of $2.8 million from the FY 2009 appropriation level. This request will maintain the National Advertising Campaign, consumer research and assessment, and other activities required to support the Medicare & You Handbook, such as producing Braille and audio versions and providing electronic and composition support.

ACCOUNTING AND AUDITS

Program Description and Accomplishments

Healthcare Integrated General Ledger and Accounting System (HIGLAS)

HIGLAS implementation will yield significant improvements and benefits to the Nation's Medicare program which will strengthen the Federal government's fiscal management and program operations/management of the Medicare fee-for-service program. HIGLAS provides the capability for CMS and DHHS to achieve compliance with the Federal Financial Management Improvement Act (FFMIA) of 1996. HIGLAS directly supports DHHS efforts to meet compliance goals of FFMIA by encompassing all CMS program dollars (Medicare, Medicaid, Children's Health Insurance Program (CHIP) and administrative program accounting) on HIGLAS by FY 2012. The FFMIA requires each agency to implement and maintain financial management systems that comply with federal requirements and accounting standards. HIGLAS is a critical success factor towards ensuring DHHS meets FFMIA compliance requirements. In addition, transitioning Medicare contractors to HIGLAS enables CMS to resolve a material weakness identified in the CFO audits related to the accounting of Federal dollars. Through further implementation of HIGLAS at the Medicare Administrative Contractors (MACs) and the continued development and implementation of administrative program accounting functions at CMS central office, CMS continues to make progress in achieving the goals tracked by DHHS and OMB.

To date, CMS has deployed HIGLAS at fourteen Medicare fee-for-service contractors, achieving 62% of full FFMIA compliance including Medicaid and Children's Health Insurance Program (CHIP) federal funding. In 2009, HIGLAS will facilitate numerous workload splits and renames in support of the Agency's MAC implementation efforts. The transitioning of Medicare contractor claims processing workloads to the MAC environment also includes the movement of existing HIGLAS financial workload and data from one HIGLAS organization to another. In many cases, the existing HIGLAS workload must be moved to multiple MAC jurisdictions. When a single existing HIGLAS Medicare contractor/organization is split among multiple MACs, it results in a "workload split." A "rename" occurs when workload in an existing HIGLAS contractor/organization is moved in its entirety to a MAC. CMS currently remains on track in FY 2009 with HIGLAS-MAC planned transition activities, and expects to meet the Agency's FY 2010 integrated transition schedule. During FY 2010, CMS anticipates achievement of substantial FFMIA compliance with the planned transition of two additional MAC organizations onto HIGLAS as well as the incorporation of Medicare Part C and Part D accounting transactions to HIGLAS.

CFO/Financial Statement Audits

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

Budget Request

The FY 2010 President's Budget request for audits and HIGLAS is $169.5 million, a decrease of $0.6 million from the FY 2009 appropriation. These efforts are critical to support: the Agency's clean opinion on the CFO audit; the "One HHS" goal to improve financial management; the ability of the Department to realize its UFMS goals and objectives; and the ability to meet OMB-mandated Federal Financial Management Improvement Act (FFMIA) compliancy requirements for CMS and HHS.

- *HIGLAS*: $161.0 million, a decrease of $1.1 million from the FY 2009 appropriation level. This includes ongoing operational and maintenance costs, as well as the data center costs and costs associated with transitioning two additional MACs to HIGLAS. HIGLAS will continue to develop its administrative program accounting functionality, including incorporation of Medicare Part C and Part D accounting transactions in HIGLAS during FY 2010.

- *CFO/Financial Statement Audits:* $8.5 million, an increase of $0.5 million due to an expected increase in the cost of audits based on the General Services Administration's rate schedules.

QUALIFIED INDEPENDENT CONTRACTOR (QIC) APPEALS

Program Description and Accomplishments

Section 521 of the Benefits Improvement and Protection Act of 2000 (BIPA) requires CMS to contract with qualified independent contractors (QICs) to adjudicate second level appeals of adverse claims determinations. The QICs replaced the hearing officer function previously performed by the FIs and carriers for Part B appeals and assumed a new Part A workload. Previously, FIs reviewed Part A appeals and then sent requests for second-level Part A reviews to an administrative law judge (ALJ). Now, the QICs adjudicate all second level Part A and Part B appeals.

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

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

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

Budget Overview

The FY 2010 President's Budget request for QIC appeals (BIPA sections 521 and 522) is $59.7 million, $3.4 million more than the FY 2009 appropriation. The QICs received approximately 400,000 reconsideration requests in FY 2008[7]. CMS believes this increase is a result of increased familiarity by the provider community regarding the reconsiderations process. In FY 2010, CMS anticipates a slight increase in the ongoing QIC workload and is committed to expanding the QICs responsibilities for case file imaging, consistent with the Administration's electronic health record initiative. These activities will result in the need for a minimal increase in QIC funding.

- *QIC Costs*: $51.5 million, an increase of $3.0 million above the FY 2009 appropriation. The request covers the expected QIC costs of processing appeals, including the new inpatient hospital and error rate review workloads.
- *National Coverage Determinations (NCDs):* $0.2 million, the same as the FY 2009 appropriation.
- *Medicare Appeals System (MAS):* $8.0 million, $0.4 million more than the FY 2009 appropriation. This request includes costs of developing security mechanisms to control MAS administration and access to appeals data.

The request also covers the expected QIC costs of processing appeals, including the new HPMP and inpatient hospital workloads.

The following chart details the number of QIC appeals historically and projected for FY 2009 and FY 2010:

QIC Appeals Workloads

Fiscal Year	FY 2006 Actual	FY 2007 Actual	FY 2008 Actual	FY 2009 Estimate	FY 2010 Estimate
QIC Appeals	178,680	358,443	400,000	420,000	428,000

HIPAA ADMINISTRATIVE SIMPLIFICATION

Program Description and Accomplishments

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addressed the

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

security and privacy of health data. As the industry adopts these standards for the efficiency and effectiveness of the nation's health care system, it will improve the use of electronic data interchange. The President's Budget request covers several HIPAA activities for which CMS is responsible:

- *National Provider Identifier (NPI) & National Plan and Provider Enumeration System (NPPES)* - HIPAA requires the assignment of a unique national provider identifier (NPI) to all covered health care providers. CMS is the agency responsible for enumerating providers by assigning NPIs. CMS developed the NPPES to process the NPI applications and to make any subsequent changes to the data of enumerated providers. CMS estimated that there are approximately 2.3 million covered health care providers who must obtain NPIs and approximately 3.7 million non-covered providers who may seek NPIs. Currently, over 2.6 million providers have been enumerated with NPIs. Provider enumeration workload estimates are based on 1.6 percent of the prior year for new providers plus the number of non-covered providers who wish to obtain an NPI. In addition, we estimate that 12.6 percent of all enumerated providers will submit changes to their records annually. So far, over one million changes have been made by enumerated providers.
- *HIPAA Claims-Based Transactions* – HIPAA requires CMS to provide a standard health care eligibility inquiry and response system to providers and health care institutions. CMS' "270/271" system provides eligibility information to fee-for-service providers to assist them with the services they provide to Medicare beneficiaries and in the processing of Medicare claims.
- *HIPAA Electronic Data Interchange (EDI)* – This project supports the monitoring and management of Medicare fee-for-service contractor compliance with HIPAA EDI requirements. Methods used to perform these contractor oversight activities include: data collection via the Division of Data Interchange Standards' (DDIS) data website, data collected from files uploaded by contractors to the web site, reports generation, website Help Desk support for contractors and CMS central office, ad-hoc reporting, compliance investigation, reporting, and trouble shooting.
- *HIPAA Outreach, Enforcement, Compliance Reviews, & Pilots* – This project includes outreach programs for covered entities and other affected organizations, as well as enforcement efforts:
    - Outreach efforts include national HIPAA roundtable discussions, web support, conferences, and educational materials. Outreach efforts also include HIPAA On-Line (HOL), an outreach tool developed to publicize HIPAA protections. It is a free, interactive internet-based program that provides timely, correct information to consumers and employers.
    - Enforcement activities consist of investigative contractor activity to support HIPAA administrative standards, including a website for electronic submission of complaints; assistance with evaluating technical complaints; and managing the correspondence to and from complainants and the entities against which the complaint is filed. Another enforcement tool is the administrative simplification enforcement tool (ASET), a web-based application that provides online complaint filing and management to parties who wish to file a HIPAA complaint. HIPAA enforcement also includes a HIPAA identification tracking system (HITS) tool which compiles statistics and generates reports for use in managing the complaint process. The system currently has information about 1,200 complaints.

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

Budget Request

The FY 2010 President's Budget program management request for HIPAA Administrative Simplification is $25.8 million, a decrease of $2.1 million below the FY 2009 appropriation. This request includes the following activities:

- *NPI & NPPES*: $9.4 million, $1.9 million below the FY 2009 appropriation. At this level, CMS can comply with current NPI standards, continue its current enumeration workload, and complete the following activities:
  - Resolution and correction of data inconsistencies between NPPES and the IRS. The NPI Enumerator contacts all providers whose data do not match IRS' records and resolves the issue. This work is ongoing as part of CMS' responsibility for ensuring the inclusion of accurate, correct data in NPPES.
  - Dissemination via download capability from the Internet of the monthly NPPES file. CMS is required by Federal Notice to make this file available via the Internet each month.
  - Utilization of SSA's Death Master File to verify the death of providers who have been assigned NPI numbers.
- *HIPAA Claims-Based Transactions*: $13.2 million, $0.5 million below the FY 2009 appropriation. CMS is making changes to its information technology infrastructure in FY 2009 to provide this beneficiary eligibility information on a real-time basis. This application is considered mission critical as it provides beneficiary health care eligibility information to health care providers and institutions, as well as assists in determining how Medicare should be billed for the services rendered. This application will be completed in FY 2010.
- *HIPAA Electronic Data Interchange (EDI):* $0.5 million, virtually the same as the FY 2009 appropriation. This funding level allows CMS to be in compliance with the HIPAA EDI standard stated in the previous section.
- *HIPAA Outreach, Enforcement, Compliance Reviews, & Pilots:* $2.7 million, approximately $0.3 million more than the FY 2009 appropriation. Ongoing support for this activity will be necessary for the foreseeable future. Outreach, enforcement, and compliance reviews are critical for security as increasing amounts of protected health information are available electronically. Furthermore, the industry needs time to test and use new HIPAA standards via pilots so that any technical issues associated with the use of a new version can be addressed first.

ICD-10 AND VERSION 5010 INITIATIVE

Program Description and Accomplishments

Since the late 19th century, the industrialized world has used a common system for coding diagnoses. These codes are almost always required on health care claims. ICD-10 is the tenth revision of the International Classification of Diseases, a classification system of diseases, injuries, and medical conditions that was developed by the World Health Organization (WHO). Although ICD-10 has been in use in much of the

industrialized world since 1995, the United States, including CMS, still uses ICD-9-CM, an older version developed by the WHO about 30 years ago.

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

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

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

The ICD-9 code set does not provide the level of specificity needed for value-based purchasing. A value-based purchasing program considers both quality and cost of care over an appropriate period of time. Specific and accurate data is vital to the success of the program. ICD-10 provides very specific data about a patient's diagnosis and the procedures that were performed. As a result, payers can ascertain if additional services were performed because of provider error; this will lead to cost savings when a payer refuses to pay for provider errors.

CMS estimates that it will eventually run out of ICD-9 procedure codes, diminishing the ability to capture new technology. As a result, providers will not be able to submit electronic claims, as required by HIPAA, for new procedures and payers and CMS will not be able to remain HIPAA-compliant. CMS has prolonged the life of ICD-9 by placing new technologies in unrelated chapters. However, this makes it difficult for medical coders to find these new procedures.

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

Version 5010 accommodates the increased space required for the ICD-10 code sets. On January 16th, 2009, two Rules were published with the effective date of March17th, 2009, mandating the move to newer versions of the HIPAA-specified industry-standard formats for electronic claims, claims eligibility or status inquiries and responses, remittance advices, and other administrative transactions (5010 & ICD-10). These new formats include data requested by industry, eliminate redundant data, and provide more consistent instructions to providers for the use of the transactions. They are also a

prerequisite for moving to ICD-10 diagnosis and procedure codes, which are of greater length than ICD-9 codes.

In 2008, CMS began a multi-year effort to convert all systems that deal with claims data to the new HIPAA 5010 formats for electronic claims and claims-related transactions, completing a gap analysis of the format changes and initiating an impact assessment of what systems throughout Medicare will require modification to accommodate the new data. Systems requiring modification fall into three major categories: 1) "Front-End" systems maintained by Medicare Administrative Contractors in 15 jurisdictions, who exchange electronic transactions with providers and clearing houses and introduce these transactions into the claims processing systems; 2) the "core" claims eligibility, history, adjudication, and financial systems for Medicare Parts A and B; and 3) all "downstream" systems that contain claims data, such as risk adjustment, payment analysis, and national utilization databases. Systems development has begun on modifications to core systems and several downstream systems, and will soon begin on the front-end systems. Systems development will be completed in 2010, and testing and integration will continue through 2010 and into 2011. All health care plans must be ready to accept the new transactions by January 1, 2011, and discontinue use of the current transaction formats by December 31, 2011. All health care providers must be ready to use the new transactions by January 1, 2012.

Budget Request

The FY 2010 President's Budget Program Management request for ICD-10 and Version 5010 is $62.5 million, an increase of $22.2 million above the FY 2009 appropriation. This request includes funding to develop and initiate an industry-wide provider education and outreach strategy; to conduct code and policy analysis in order to update CMS processes that utilize ICD codes; to develop and initiate program management support for ICD-10 implementation activities such as monitoring and tracking of industry compliance; to initiate updating Medicare FFS core processing systems; and initiate updating CMS downstream systems that utilize ICD-10 codes. This request also continues with the implementation of modifications for the Front End Systems.

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

Program Description and Accomplishments

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

MIPPA provided CMS with $307.5 million in Program Management funding. Of this total, $167.5 million was earmarked for three specific provisions: DME Competitive Bidding, State Health Insurance and Assistance Program grants, and a contract with a consensus-based entity for performance measurement work. The remaining $140.0 million was intended to cover more than 40 other provisions.

Several of the other provisions mandate major new initiatives such as section 132, which makes incentive payments to professionals who successfully use E-prescribing, and section 153 which makes payments to renal dialysis providers and facilities who successfully report on End-Stage Renal Disease (ESRD) quality performance measures. Some expand existing programs such as section 131 which extends the Physician Quality Reporting program through 2010, establishes a physician feedback program to provide confidential reports that measure the resources used in furnishing care to Medicare beneficiaries, and requires a plan for transitioning to a value-based purchasing program for covered professional services under Medicare.

These three provisions--Physician Payment and Quality Improvements (Section 131) and incentives for E-Prescribing (section 132) and Renal Dialysis quality measures (section 153)--together require significantly more resources than were made available in the bill. As a result, CMS focused on funding sections 131 and 132 for two years--FY 2009 and FY 2010—with $110 million of the $140 million. With the remaining $30 million, CMS plans to fund an ESRD bundled payment system and cover systems requirements, provider outreach, and several provisions that can be implemented with a small amount of money.

Without additional funding, we will not be able to implement ESRD pay-for-performance (P4P), a major component of the new value-based purchasing program. We will also not have adequate funds for raising kidney disease awareness, implementing specialized Medicare Advantage plans for special needs individuals, addressing health care disparities, implementing the federal payment levy program, or ensuring accreditation for Medicare hospitals.

CMS is requesting funding for the following MIPPA provisions in FY 2010:

- <u>Section 153: ESRD P4P</u>

  MIPPA enacted the first End Stage Renal Disease (ESRD) pay-for-performance (P4P) program, a nationwide program designed to identify specified quality measures for dialysis facilities; establish performance standards for renal services providers and renal dialysis facilities; and establish procedures for making this information available to the public. This quality payment program becomes effective January 1, 2012. Providers of ESRD services must meet quality metrics endorsed by a consensus based, standard-setting body by demonstrating improvement or high levels of achievement. Facilities that do not meet the specified requirement will receive a payment reduction of up to 2.0 percent, as determined by the Secretary.

  In order to make payment determinations by January 2012, CMS must begin now to develop the program and build the necessary infrastructure. Based on our experience with other quality/P4P programs, including hospital value-based purchasing and the physician quality reporting initiatives, we will need to have numerous activities--including measure development; business, systems, and technical requirements; financial accounting and reporting; and provider education and support--completed prior to January 2012. These activities require a significant amount of funds. CMS has already begun planning for this work. However, we will need funding in FY 2010 (and in FY 2011) if we are to implement this important new program by the MIPPA deadline.

- Section 152: Kidney Disease Education and Awareness

  MIPPA requires the Secretary to establish pilot projects in at least three states to increase chronic kidney disease awareness and screening. CMS must print and mail kidney disease awareness materials to approximately 5 million beneficiaries in three states and to CMS' partners in those states. However, printing and mailing costs for this provision are unfunded. CMS has allocated $230,000 from the $140 million in available MIPPA funding to conduct a limited information campaign with its partners and stakeholders. It would not be able to do the direct mailings required by MIPPA.

- Section 164: Specialized Medicare Advantage (MA) Plans for Special Needs Individuals

  MIPPA restricts enrollment in special needs plans (SNPs) to special needs individuals and imposes additional requirements for all SNPs, including collecting and reporting of data related to the care management requirements. By January 2010, CMS must be able to oversee the plans' quality improvement programs (QIPs), compile data on SNP models of care and determine if they meet the MIPPA standards, provide technical assistance to State Medicaid offices for greater coordination of benefits for vulnerable dually-eligible beneficiaries, develop standards for provider network adequacy based on medical complexity, develop parameters for plan benefit packages having specialized benefits and services, and make the necessary systems changes to ensure that only qualified beneficiaries are enrolled.

  CMS has allocated a total of $4.0 million for this work from the $140 million provided in MIPPA. With these funds, CMS will be able to examine existing QIPs, collect and analyze self-reported data on SNP models of care, conduct research on provider network requirements to deliver specialized medical services, conduct market research to develop parameters for specialized benefits and services, and create a Resource Center for states and stakeholder organizations to use to develop best practice documents. However, without additional funds:
  - QIPs for non-network products will lag behind those of more experienced and monitored network products (such as HMOs, PPOs) resulting in substandard care for those in non-network products;
  - CMS will not be able to compile information on SNPs models of care, leaving vulnerable beneficiaries with less targeted care management interventions;
  - CMS will not have evidence-based criteria on which to assess adequacy of specialized provider networks and targeted benefits and services for special needs individuals;
  - CMS will be unable to improve the coordination of Medicare and Medicaid benefits in most States, resulting in continued beneficiary confusion, duplicate provider billing, and under-utilization of important benefits.

- Section 185: Addressing Health Care Disparities

  MIPPA requires the collection and evaluation of data on disparities in health care services and performance based on race, ethnicity, and gender. Of the $140 million made available by MIPPA, CMS has allocated $2.0 million for this provision. At this funding level, CMS would have to limit its analysis to a small number of measures from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and the Healthcare Effectiveness Data Information Set (HEDIS), mainly for

Part C. CMS would produce a limited number of comparable measures for the fee-for-service population using claims data. Extensive analysis for multiple provider settings will not be feasible. Part D analysis will be limited. We cannot do analytic work needed to address significant inaccuracy in the coding of race/ethnicity in CMS's current administrative data.

- Section 125: Ensuring Accreditation for Medicare Facilities--$1.8 million.

  In addition to revoking the unique hospital deeming authority of the Joint Commission on Accreditation of Health Organizations, MIPPA expands CMS' required annual report to Congress from a current review of the Joint Commission hospital program to a review of all seven CMS-recognized accreditation organizations (AO) and their 14 approved programs. The evaluation of the AO's performance and their programs is based, in large part, on CMS' Validation Survey Program.

  An expanded report to Congress requires CMS to expand the Validation Survey Program for all deemed provider/supplier types. The deemed provider/supplier types include: hospitals; critical access hospitals; ambulatory surgery centers; home health agencies; and hospices. Unless the numbers of validation surveys conducted by deemed program type and by AO increase significantly, CMS will not be able to gather a sufficient amount of data. As a result, the analysis of these surveys and any resulting disparity rates will be anecdotal at best and will not be a reliable measure of AO performance or of the comparability of their survey findings with those of the State Agencies.

  An expanded report to Congress will also result in a larger workload related to an increase in the collection and analysis of survey data across all AOs and their programs, as well as the compilation and analysis of data on other AO activities and performance measures suitable for inclusion in the report to Congress.

  CMS has allocated $1.8 million of the $140 million provided by MIPPA for the activities in this section. These funds will allow CMS to expand somewhat the Validation Survey Program and increase the numbers of validation surveys conducted but not to a point where we can rely on the data collected or calculate a reliable disparity rate based on that data.

- Section 189: Federal Payment Levy Program

  MIPPA requires CMS to fully implement the federal payment levy program for Medicare payments by offsetting Medicare fee-for-service payments to recoup tax debts owed by Medicare providers as well as non-tax debts owed to other Federal agencies. CMS has allocated $1.1 million of the $140 million to recoup tax debts. Without additional funding, CMS will be unable to offset non-tax debts.

Budget Request

The FY 2010 President's Budget request for the following unfunded MIPPA mandates is $81.6 million:

- Section 153: ESRD P4P -- $67.6 million. CMS developed its estimate based on benchmarks from previous quality incentive activities. This funding is needed to:
    - develop the concept, strategy, and methodology for performance measurement including measure development and maintenance as well as selection criteria for measures and endorsement of measures;
    - develop a business processing model with business requirements and a performance score methodology;
    - finish business requirements and begin technical requirements, including data submission, data validation methodology and process, data infrastructure and end-user support, and data management;
    - build and test the IT infrastructure;
    - add renal dialysis data to CMS' systems and make all necessary systems changes;
    - develop financial accounting and reporting capabilities;
    - develop a provider education and outreach program,
    - develop a plan to implement the In-Center Hemodialysis Consumer Assessment of Health Plans Survey. CMS has worked with the Agency for Healthcare Research and Quality to develop this survey and secured the National Quality Forum's endorsement.

- Section 152: Kidney Disease Education and Awareness --$4.9 million. This funding will enable CMS to mail kidney disease awareness materials to 5 million beneficiaries. This estimate assumes about $1.00 for printing and postage costs for each mailing.

- Section 164: Specialized Medicare Advantage (MA) Plans for Special Needs Individuals --$3.9 million. This funding will allow CMS to effectively monitor all MA plans' quality improvement programs, provide significant technical assistance to SNPs on Models of Care improvement, assure that SNPs render specialized services and benefits delivered by providers with required expertise, and provide the extensive assistance necessary to move most, if not all, States in Medicare-Medicaid benefit integration.

- Section 185: Addressing Health Care Disparities--$2.7 million. CMS estimates that it needs an additional $2.7 million in order to improve the coding of race/ethnicity in our administrative data, and analyze and display the data needed to address health care disparities in additional important provider settings (e.g., nursing homes).

- Section 125: Ensuring Accreditation for Medicare Facilities--$1.4 million. With an additional $1.4 million, CMS will be able to significantly increase the numbers of validation surveys conducted. The funds will allow CMS to conduct the analysis of survey findings and calculate a disparity rate that is a more reliable measure of accreditation organization performance and comparability of their findings with the findings of State Agencies.

- Section 189: Federal Payment Levy Program--$1.1 million. This will allow CMS to implement levies on non-tax debts against Medicare provider payments. Without this funding, CMS will not be in full compliance with this provision.

OTHER INFORMATION TECHNOLOGY SUPPORTING ALL PARTS OF MEDICARE

Program Description and Accomplishments

Enterprise IT Activities

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

- the Medicare Data Communications Network, the secure telecommunications network that supports transaction processing and file transmission;
- hardware maintenance and software licensing;
- developing and maintaining the mission critical database systems that house the data required by the CMS business community to perform its core functions; and
- the Modern Data Environment, a cornerstone of the Agency's data environment, will transition CMS from a claims-centric data warehouse orientation to a multi-view data warehouse orientation capable of integrating data on beneficiaries, providers, health plans, and claims. Without this repository, CMS must extract data from different locations, often resulting in inconsistent and slow answers to queries and costly analyst intervention.

In addition, this section also includes the CMS enterprise data and database management investment. This investment allows for the addition of databases, establishing consistent application of data policies and processes in using CMS' data; and assuring the security of data resources as CMS moves to the Enterprise Data Center environment. CMS plans to increase the number of applications that use the "individuals authorized access to CMS computer systems (IACS)" system to authenticate users and meet HSPD-12 requirements. This provides greater security for data and systems, and accelerates the retirement of the Enterprise User Administration (EUA).

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

Infrastructure Investments

This section includes several key IT infrastructure projects, including:

- *The virtual call center strategy*, a critical project that has greatly increased the overall efficiency and effectiveness of the 1-800 call center service delivery. Through this project, CMS is able to standardize the management of the Medicare beneficiary call center operations with best practice technology and process improvements, allowing for optimal customer service.
- *The web hosting project* which covers the transitions of MMA web-hosted applications--such as the Medicare Advantage Prescription Drug Payment System, Premium Withhold System, Medicare Beneficiary Suite of Systems, and the Risk Adjustment System--to an Enterprise Data Center (EDC). The EDCs

are designed to support the increased security and reliability that are required in the long term; the Baltimore Data Center (BDC), which currently houses these systems, cannot sustain growing workloads. Maintaining systems at the BDC greatly increases the risk of system failure.

Budget Request

The FY 2010 President's Budget request for other information technology investments supporting all parts of Medicare is $229.7 million, $5.9 million greater than the FY 2009 appropriation. This category includes two major IT investment activities: enterprise and infrastructure.

- *Enterprise IT Activities*: $210.0 million, $10.4 million more than the FY 2009 appropriation. This increase covers inflationary increases in the CITIC contract and will also fund the transition of the Next Generation Desktop to the enterprise identity management system: Individuals Access to CMS Systems (IACS).
- *Infrastructure Investments*: $19.7 million, $4.5 million less than the FY 2009 appropriation. This funding level will support the activities of the virtual call center strategy as well as the web hosting project.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
MCR 3.1b: Beneficiary Survey: Percentage of beneficiaries that know that out-of-pocket costs will vary by the Medicare prescription drug plan.	FY 2008: 75% (Target Exceeded)	71%	72%	+1
MCR 3.1c: Beneficiary Survey: Percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same prescription drugs.	FY 2008: 69% (Target Exceeded)	60%	61%	+1
MCR 3.2: Program Management / Operations.	FY 2009: Published the 2008 High Risk Medication patient safety measure (Target Met)	Add "Patient Safety" measures and refresh all report card measures	N/A	N/A
MCR 3.3: Enrollment: Increase percentage of Medicare beneficiaries with prescription drug coverage from Part D or other sources.	FY 2009: 90% (Target Not Met)	91%	91%	Maintain
MCR 10.1: Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims in a millennium compliant environment for Fiscal Intermediaries.	FY 2008: 99.8% (Target Exceeded)	95%	95%	Maintain
MCR 10.2: Maintain payment timeliness at the statutory requirement of 95% for electronic bills/claims in a millennium compliant environment for Carriers.	FY 2008: 98.8% (Target Exceeded)	95%	95%	Maintain
MCR 12: Maintain an unqualified opinion.	FY 2008: Goal Met (Target Met)	Maintain	Maintain	N/A
MCR 13.1: Award Medicare FFS Workload to MACs.	FY 2009: Award 100% (Target Met)	Award 100%	N/A	N/A
MCR 13.2: Implement Medicare FFS Workload to MACs.	FY 2008: 40.6% (Target Not Met but Improved)	74%	100%	+26
Program Level Funding ($ in millions)	**N/A**	**$108.9**	**$65.6**	**-$43.3**

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Federal Administration

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009
BA	$642,354,000	$641,351,000	$697,760,000	+$56,409,000
Recission (P.L. 110-161)	($11,222,000)	$0	$0	$0
Supplemental	$5,000,000	$0	$0	$0
Net BA	$636,132,000	$641,351,000	697,760,000	+$56,409,000
Direct FTEs	4,231	4,117	4,276	159

Authorizing Legislation – Reorganization Act of 1953

FY 2010 Authorization – One Year

Allocation Method – Various

Program Description and Accomplishments

The Centers for Medicare & Medicaid Services (CMS) oversees three of the nation's largest health care programs: Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). CMS is the largest purchaser of health care in the United States and expects to serve over 98 million beneficiaries in FY 2010. In FY 2008, CMS spent $660 billion on benefits and other costs, more than any other government agency, including the Department of Defense.

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

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

CMS employs approximately 4,560 Federal employees working in Baltimore, Maryland; Washington, DC; ten regional offices located throughout the country; and three anti-fraud field offices located in Miami, Los Angeles, and New York. Employees in Baltimore and Washington: write health care policies and regulations; set payment rates; develop national operating

systems for the Medicare, Medicaid, and CHIP programs; provide funding and guidelines for the Medicare contractors and monitor their performance; develop and implement customer service improvements; provide education outreach to Medicare providers; work with State insurance companies; implement guidelines to fight fraud, waste, and abuse; and assist law enforcement agencies in the prosecution of fraudulent activities. Regional Office employees provide services to Medicare contractors; accompany State surveyors to hospitals, nursing homes, labs, and other health care facilities to ensure compliance with CMS health and safety standards; assist States on Medicaid and CHIP issues; and work with healthcare providers, beneficiaries, and the general public on outreach awareness about the Medicare, Medicaid, and CHIP programs. We also have staff in our new fraud "hot spot" offices in areas known to have high incidences of fraud and abuse. They can quickly detect and respond to emerging schemes to defraud the Medicare program.

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

Personnel Compensation and Benefits

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

CMS' staffing level and related compensation and benefits expenses are largely workload-driven. Over the last decade, CMS' core workload has increased dramatically due to major legislative and Secretarial initiatives. These include the Ticket to Work and Work Incentives Improvement Act (TWWIIA); the Balanced Budget Refinement Act (BBRA); the Benefits Improvement and Protection Act (BIPA); the Trade Act; the Medicare Modernization Act (MMA); the Deficit Reduction Act (DRA); the Tax Relief and Health Care Act (TRHCA), the Medicare, Medicaid and SCHIP Extension Act (MMSEA); and the Medicare Improvements for Patients and Providers Act (MIPPA); the completion of activities mandated by the HIPAA and the Balance Budget Act (BBA); and the concurrent implementation of a number of Secretarial priorities, including value-based purchasing, price transparency, consumer choice, e-health initiatives, and enhanced beneficiary outreach. The Agency's recent staffing levels have made it difficult to keep pace with the volume of new activities and initiatives. The FY 2009 Omnibus bill includes funding to support 4,117 direct full-time equivalents (FTEs). Ten years ago, in FY 1999, CMS utilized 4,139 direct FTEs, a slightly higher staffing level.

Other Objects

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

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

- Rent, Communication & Utilities

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

- Central Office Building Loan

This category provides funding to pay the General Service Administration (GSA) for the principal and interest on 44 construction loans for our headquarters facility in Baltimore, Maryland. Prior to the construction of this new facility in 1995, CMS housed staff in 15 different buildings located around Baltimore. To improve management, enhance communications, and promote productivity, CMS proposed a facility that would house all of its Baltimore-based employees in one location. Congress approved the single-site construction project in FY 1989. Groundbreaking ceremonies were held in July 1993 and construction was completed in March 1995. The 30-year loan for CMS' Central Office building will be paid in full in 2025.

- Service and Supply Fund

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

- Human Resources (DHHS)

CMS reimburses the Department for its share of the costs of the Baltimore Human Resources Center (BHRC). In 2007, the Department developed the "One HHS" initiative to eliminate duplication of effort and achieve economies of scale. As part of this initiative, it consolidated personnel activities, previously performed separately by each Operating Division within the Department, and created the BHRC, which now provides HR services to CMS. The BHRC consists of three divisions: Workforce Relations, Client Services, and Strategic Programs.

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

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

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

- Administrative Services

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

- Information Technology (IT)

This category funds CMS' administrative system operations, including telecommunications, systems security, videoconferencing, web hosting, satellite services, and a portion of the Baltimore data center costs. It also covers the costs of several systems that support grants and contract administration as well as financial management, data management, and document management services. In addition, Federal Administration IT funding supports CMS' Medicaid data systems that provide access to Medicaid eligibility and utilization claims data processed by all 50 States, the District of Columbia, and the five territories. Finally, a portion of this category helps to support the DHHS Service and Supply Fund's e-mail and financial management systems.

- Inter-Agency Agreements

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

- An IA with the Department of Treasury (DOT) for the Medicare Premium Billing and Collection Operation Lockbox: The DOT performs several functions related to Medicare premium collections including customer service, mail processing and sorting, and keying into the CMS Lockbox Remittance System that make it easier for Medicare beneficiaries to make premium payments to the Federal Government. This service is intended for beneficiaries who do not receive a monthly benefit check (e.g., Social Security, Office of Personnel Management, or Railroad Retirement Board) from which Medicare premiums can be deducted and who are not a part of a State Buy-in Agreement or formal group payer arrangement;
- An IA with the Department of Labor for administering and paying CMS' annual share of worker's compensation benefits resulting from a workplace injury or death of an employee. These benefit payments are required by law. FY 2009 charges for workers' compensation benefits are expected to be $1.4 million;
- An IA with the Department of Justice for performing background checks on new job applicants; and,
- An IA with the Internal Revenue Service for providing CMS with financial data on corporations, partnerships, and sole proprietorships from its Actuarial Information System: The data provide CMS with critical information on changes in health care spending and on Medicare and Medicaid spending by region and by State.

- Supplies and Equipment

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

- Administrative Contracts and Intra-Agency Agreements

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

- Medicare Market Basket & Price Index Studies: This contract supports CMS actuaries in developing and maintaining market basket updates and price indexes for the Medicare program. CMS uses the updates and indices to calculate and revise payment rates for the Medicare providers. Market basket updates are legislatively required for the optimal adjustment of payment rates to providers. Inadequate rates could cause providers to drop out of the program, and overpayments will have negative consequences on the trust funds.
- Legal services with the Office of General Counsel (OGC): CMS reimburses the OGC for the legal services and guidance it provides on ethics activities and on legislative, programmatic, and policy issues related to CMS' programs. This contract allows CMS to implement policies and run its programs. In FY 2008, CMS paid $7.8 million for these services. OGC calculates the charge and informs CMS of the amount it must pay. This

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

- Tribal Training and Outreach: In support of HHS' priorities, CMS is committed to working with the Tribal governments to improve the health care of American Indians and Alaska Natives (AI/ANs). Several contracts enable CMS to continue its work with the Indian Health Service (IHS) to provide ongoing outreach and education to (AI/ANs), facilitate AI/AN enrollment in CMS' programs, enhance our relationship with the IHS and the Tribes, and conduct satellite training for providers in remote areas. The satellite activity is designed to break down cultural barriers and reach out to the Tribal populations who are geographically isolated. Using satellite broadcasts, CMS can provide specialized interactive training to Indian health care providers, efficiently and cost-effectively. To date, CMS has provided support for satellite installation at 120 Tribes and Urban Indian health facilities.
- Security services with the Department of Homeland Security (DHS): This contract pays the DHS for the Federal Protective Service (FPS) agents who provide security guard services to our facilities and employees. Under Presidential Decision Directive 63 and Homeland Security Presidential Directive 7, CMS is classified as a Critical Infrastructure facility. The Department of Justice has classified CMS as a Level IV facility (on a scale where Level I is the lowest vulnerability and Level V is the highest). These ratings require specific security measures at each level.
- Healthy Start, Grow Smart: This program prints and disseminates a series of 13 brochures in English, Spanish, Chinese, and Vietnamese to Medicaid-eligible pregnant women, mothers of Medicaid-eligible pregnant women, and mothers of Medicaid-enrolled babies. CMS partners with States to distribute these brochures at the time of birth, and then monthly over the first year of the child's life. Each publication focuses on activities that stimulate infant brain development and build the skills these children need to be successful in school. This category funds the printing and postage costs for the brochures.

- Training

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

- Travel

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

- Conducting performance reviews of the fiscal intermediaries, carriers, and new Medicare Administrative Contractors or MACS who handle the administrative processes needed to run the Medicare fee-for-service program. These contractors are located throughout the country and CMS staff must travel to their locations. Reviews and oversight ensure that the contractors are carrying out their responsibilities properly, in accordance with CMS policies and regulations. CMS has always conducted on-site performance reviews but, now that the new MACs can earn incentive payments, these reviews are critical to ensuring that the incentives are appropriate.
- Working with the States on Medicaid and CHIP issues. CMS staff travels to the States to develop and implement new applications for Medicaid eligibility systems, provide systems training, review quality improvement activities, provide technical assistance, ensure compliance with statutory and regulatory changes and requirements, identify innovations and best practices, and investigate Medicaid financial/reimbursement issues in preparation for the CFO audits.
- Overseeing the Medicare Survey and Certification process for healthcare facilities, such as nursing homes, to ensure that these facilities are not only following the State guidelines but also complying with federal guidelines.

- Printing and Postage

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

The next largest expense in this category, almost one-fourth of the total, is for printing notices in the Federal Register and Congressional Record. The law requires CMS to publish regulations that adhere to notice and comment rulemaking procedures. In FY 2007, CMS spent over $3.0 million publishing regulations related to legislation enacted by the Medicare Modernization Act of 2003. Since then, several major pieces of authorizing legislation involving CMS's programs have been enacted. Each piece of legislation requires CMS to publish regulations that implement the numerous provisions in these bills.

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

Funding History

2005	$581,493,000
2006	$633,065,000
2007	$642,355,000
2008	$636,132,000
2009	$641,351,000

Budget Request

The FY 2010 President's Budget request for the Federal Administration line totals $697,760,000. This reflects an increase of $56,409,000 over the FY 2009 appropriated level. This increase consists of $37,932,000 for pay increases and $18,477,000 for non-pay increases.

Personnel Compensation and Benefits ($565.9 million): CMS' FY 2010 President's Budget request includes $565.9 million to support 4,276 FTEs, a 159 FTE increase over the projected FY 2009 staffing level. The additional staffing will allow us to maintain our traditional workloads, and to implement recent mandatory legislation including the TRHCA, MMSEA, and the MIPPA. Our FY 2010 request excludes staffing requirements resulting from the CHIPRA and the ARRA. CMS' FY 2010 payroll estimate includes a 2-percent cost of living allowance.

Rent, Communication & Utilities ($25.2 million): The Rent, Communication & Utilities estimate for FY 2010 is $25.2 million, an increase of $0.200 million. This is a virtual straightline of the FY 2009 funding level.

Building Loans ($10.8 million): The FY 2010 estimate for Building Loans is $10.8 million, a $1.0 million increase over FY 2009. This increase is due to GSA billing CMS for a pro-rata share of the amortized acquisition cost of the San Francisco Federal building in which we are renting space for our Regional Office.

Service and Supply Fund ($14.0 million): The FY 2010 Service and Supply Fund estimate for FY 2010 is $14 million, an increase of $0.870 million due to a change in the photocopying equipment contract. CMS used to contract this rental service through the Department of Treasury under an intra-agency agreement. Beginning in FY 2010, DHHS will provide CMS with this service and CMS will reimburse DHHS.

BHRC Human Resources Support ($9.0 million): The FY 2010 BHRC Human Resources Support estimate is $9 million, an increase of $0.841 million due to inflation.

Administrative Service ($5.0 million): The FY 2010 Administrative Service estimate is $5 million, an increase of $0.736 million to support the daily operation of CMS's headquarter and regional offices such as building maintenance and repairs, medical/health services, machine repairs, mailroom services, and the Baltimore/DC shuttle.

Administrative Information Technology (IT; $25.5 million)): The FY 2010 Administrative IT estimate is $25.5 million, an increase of $5.0 million. This increase will allow CMS to upgrade its systems in order to meet the agency's mission and to remain efficient. With this increase, CMS will be able to replace critical hardware/software programs that have become antiquated; fund CMS' share of the Department's Grants Solution System for tracking purposes; and invest in CMS' telecommunications systems to keep up with advances in technology. CMS has been unable to make these upgrades and, as a result, risks experiencing network failure.

Inter-Agency Agreements ($1.1 million): The FY 2010 estimate in this category is $1.1 million, which is the same as last year for contractual arrangements for goods or services with other agencies outside of DHHS.

Supplies and Equipment ($1.2 million): The FY 2010 estimate is $1.2 million, an increase of $0.400 million due in large part to the expected increase in supplies and equipment needed for the new employees being hired in FY 2010.

Administrative Contracts and Intra-Agency Agreements ($24.8 million): The administrative contracts and Intra-Agency Agreements estimate for FY 2010 is $24.8 million, an increase of $6.8 million. CMS has historically underfunded or short-cycled many contracts funded within this line. With the additional funding, we will be able to fully-fund a variety of essential contracts and intra-agency agreements. The increase also reflects cost of living increases for ongoing contractual arrangements.

Training ($2.9 million): The training estimate for FY 2010 is $2.9 million, an increase of $1.0 million. We expect to see an increase in training due to ongoing mandatory training courses required by the EEOC, recertification of specialty employees including actuaries and nurses, and updated leadership training for managers. Additional funding is also needed to provide comprehensive training for new employees being hired in FY 2010.

Travel ($9.1 million): The travel estimate for FY 2010 is $9.1 million, an increase of $0.988 million due to increases in the cost of transportation, lodging and per-diem. Travel costs are incurred as an essential part of CMS' oversight responsibilities. CMS conducts a variety of mandated site visits to contractors, States, healthcare facilities, and other providers.

Printing and Postage ($3.3 million): The printing and postage estimate for FY 2010 is $3.3 million, an increase of $0.676 million. Since the passage of the Medicare Modernization Act in 2003, we have experienced an increase in the number of regulations and notices published in the Federal Register and Congressional Record. With the recent passage of the MMSEA, MIPPA, CHIPRA, and ARRA, we expect this trend to continue.

Federal Administration Summary
(Dollars in thousands)

Object of Expense	FY 2009 Appropriation	FY 2010 President's Budget Request	Increase or Decrease
Personnel Compensation	$527,968	$565,900	+$37,932
Rent, Communication & Utilities	$25,000	$25,200	+$200
Central Office Loan	$9,800	$10,800	+$1,000
Service/ Supply Fund	$13,130	$14,000	+$870
Human Resources	$8,159	$9,000	+$841
Administrative Services	$4,264	$5,000	+$736
Administrative IT	$20,477	$25,477	+$5,000
Inter-Agency Agreements	$1,140	$1,140	$0
Supplies and Equipment	$764	$1,164	+$400
Administrative Contracts and Intra-Agency Agreements	$17,975	$24,741	+$6,766
Training	$1,938	$2,938	+$1,000
Travel	$8,112	$9,100	+$988
Printing and Postage	$2,624	$3,300	+$676
Total, Federal Administration	**$641,351**	**$697,760**	**+$56,409**

Medicare Survey and Certification Program

	FY 2008 Appropriation	FY 2009 Omnibus[1]	FY 2010 President's Budget Request[1]	FY 2010 +/- FY 2009
BA	$286,186,000	$293,128,000	$346,900,000	+$53,772,000
Rescission (P.L. 110-161)	($5,000,000)	$0	$0	$0
Net BA	$281,186,000	$293,128,000	$346,900,000	+$53,772,000
Proposed Law:				
Revisit User Fee	$0	$0	$9,446,000	+$9,446,000
Recert User Fee	$0	$0	$0	$0
Proposed Program Level	$281,186,000	$293,128,000	$356,346,000	+$63,218,000

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

FY 2010 Authorization - One Year

Allocation Method - Contracts

Program Description and Accomplishments

In order to secure quality care for the elderly, one of the Nation's most vulnerable populations, CMS requires that all facilities seeking participation in Medicare and Medicaid undergo an inspection when they initially enter the program and on a regular basis thereafter. To conduct these inspection surveys, CMS contracts with State survey agencies in each of the 50 States, the District of Columbia, Puerto Rico, and two territories. Utilizing over 6,500 surveyors across the country, state survey agencies inspect providers and determine their compliance with specific Federal health, safety, and quality standards. In FY 2008, about 90 percent of Medicare participating nursing home facilities were cited for health deficiencies. The average number of health deficiencies per survey was approximately seven. This demonstrates the profound importance of regular, comprehensive inspections of health care facilities.

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

[1] Does not include Recovery Act funding.

Direct Survey Costs

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

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

CMS has worked in recent years to evaluate the performance of State survey agencies and ensure that surveys and complaint investigations are performed in accordance with CMS and statutory requirements. CMS uses the State Performance Standards System (SPSS), developed in 2002, to track State performance on measures such as adequacy of documentation and promptness of reporting survey results, as well as conformance with expected survey frequencies. For example, the percentage of nursing homes surveyed at mandated frequencies has increased from about 97.0 percent in 2002 to 99.9 percent in 2006, and the percent of home health agencies surveyed at mandated frequencies rose from 92.0 percent in 2002 to 99.7 percent in 2006. CMS has a performance measure to assess CMS' and survey partners' success in meeting the core statutory obligations for carrying out nursing home surveys with routine frequency. The measure tracks the percentage of States that survey nursing homes every 15 months. CMS exceeded its FY 2008 target with a result of 96 percent. Targets for FY 2009 and FY 2010 are 85 percent and 90 percent, respectively. To meet these targets, CMS must ensure that proper operational controls, such as training and regulations, are in place. In addition, CMS issues an annual Mission and Priority Document, which states the agency's policies and the statutory survey frequency requirements to meet these targets.

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

CMS has two performance measures related to the quality of care in nursing homes to assess the effectiveness of these and other survey and certification activities in nursing homes. Goals to decrease the prevalence of restraints and pressure ulcers in nursing homes are clinically significant and are closely tied to the care given to beneficiaries. Since implementation of the restraints measure, the prevalence of restraints has declined from 17.2 percent of residents in 1996 to 4 percent in FY 2008. The FY 2008 result means that between the end of FY 2003 and the end of FY 2008, there are almost 50 percent fewer nursing home residents in restraints each day.

Nursing homes' recent progress in reducing restraint use has accelerated due to the new and intense collaboration between survey and certification and the Quality Improvement Organizations, as well as careful work between CMS and nursing homes in the *Advancing Excellence in America's Nursing Homes* national campaign. In addition, CMS is working to improve surveyor training so that surveyors will be better able to detect inappropriate restraint use. Because efforts have been more successful than anticipated, CMS lowered its FY 2009 target from 6.0 percent to 5.1 percent.

After many years of little or no progress, CMS has met targets to reduce the prevalence of pressure ulcers in nursing homes since FY 2004, including FY 2008, where we exceeded our target of 8.5 percent with an actual prevalence of 8.0 percent. The Regional Offices (ROs) have taken the lead in pressure ulcer reduction initiatives with activities that include monthly teleconferences to discuss problems and progress with this initiative. New survey guidance and follow up with States has increased the focus on pressure ulcer reduction.

The prevalence of pressure ulcers is increased if hospitals do not implement standards of practice to prevent the formation of pressure ulcers. Nonetheless, a decrease in the prevalence of pressure ulcers of even 0.1 percentage point represents more than 1,000 fewer nursing home residents with a pressure ulcer. Because recent results have been more successful than anticipated, CMS lowered its FY 2009 target from 8.5 percent to 8.2 percent. The success of the efforts can be attributed to greater collaboration between State survey agencies and Quality Improvement Organizations and the national *Advancing Excellence in America's Nursing Homes* campaign.

Support Contracts and Information Technology

Support Contracts

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

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

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

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

Information Technology

CMS maintains several information technology systems that are necessary for survey and certification activities. The OSCAR (Online Survey, Certification, and Reporting System) and FOSS (Federal Oversight/Support Survey System) are, respectively, the state and federal workload database systems that are essential to the daily operation of the Survey and Certification program.

CMS has developed and is implementing an improved data driven standard survey system to be used in the certification of nursing homes that participate in the Medicare/Medicaid programs. This survey system is called the "Quality Indicator Survey" (QIS) and is in response to concerns identified by CMS, GAO and OIG regarding the current survey process. The nature of the concerns focus on the lack of uniformity in the manner in which compliance with federal requirements is assessed for the 15,900 Medicare and Medicaid nursing homes that must be surveyed each year. The new QIS process uses

both off site and on site information to develop computer generated quality care indicators. The quality of care indicators are used to compare the nursing homes delivery of care with national norms. The QIS requires surveyors to use computers on site during the survey as the survey team gathers information, generates quality care indicators and identifies those areas that are triggered for investigation in stage II of the survey. Approximately 5,000 state and federal surveyors will require training on the new survey process. In addition, transition to the QIS requires significant technology upgrades to support this refined survey process.

The American Recovery and Reinvestment Act (ARRA) allocated funds to the Department of Health and Human Services (HHS) for healthcare-associated infection (HAI) prevention. A total of $10 million will be used by CMS to significantly expand the awareness of proper infection control technique among ambulatory surgical centers (ASCs) and State agencies, increase the extent to which infection control deficiencies are both identified and remedied, and prevent future serious infections in ambulatory surgical centers by:

1) Expanding State Survey Agency (SA) inspection capability and frequency for onsite surveys of Ambulatory Surgery Centers (ASCs) nationwide,

2) Using a new infection control survey tool developed by the Centers for Disease Control and CMS,

3) Improving the survey process through the use of tracer methodologies, and

4) Using multi-person teams for ASCs over a certain size or complexity.

ASCs in the United States have been the fastest growing provider type participating in Medicare, increasing in number by more than 38% between 2002 and 2007. A 2008 Hepatitis C outbreak in Nevada was traced to poor infection control practices at various ASCs (potentially affecting more than 50,000 people). Follow-up surveys throughout Nevada found infection control deficiencies at more than 40% of the ASCs. A CMS pilot program tested the above survey process improvements in three States in 2008 and demonstrated superior results in the identification and remedy of serious infection control deficiencies. The particular focus on ASCs for this funding was chosen because the available tool was developed and tested for ASCs, because ASCs have not been surveyed with the frequency and attentiveness to infection control that is needed (about once every ten years on average nationally), and because of the likely continuing infection control deficiencies in this setting. The ARRA funds will enable the application of the above four-component new survey process nationwide.

Funding History

FY 2005	$258,735,000
FY 2006	$258,128,000
FY 2007	$258,128,000
FY 2008	$281,186,000
FY 2009	$293,128,000

Budget Request

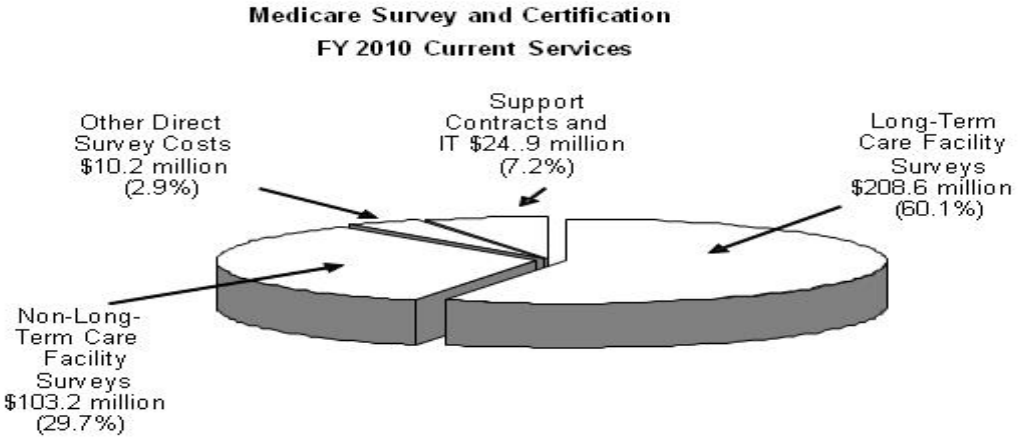
CMS' FY 2010 request for Medicare Survey and Certification is $346.9 million, an increase of $53.8 million, or 18% above the FY 2009 President's Budget level. With facilities growth and inflation, this

increase is needed to provide survey frequencies consistent with statutory and policy requirements. As described below in more detail, $311.8 million of this amount will support direct survey costs, $10.2 million will support additional costs related to direct surveys, and $24.9 million will be used for support contracts and information technology.

The FY2010 request also includes two proposed user fees for charging providers for recertification and revisits. The recertification fee would charge entities a fee to cover the cost of recertification surveys required for participation in the Medicare program. The revisit user fee would charge providers a fee to recover the costs associated with the Medicare program's revisit surveys. The revisit user fee was originally proposed in the FY2007 President's Budget and enacted on September 19, 2007. CMS' authority to assess the fee expired on December 25, 2007. The revisit user fee has been proposed in the FY2008 and FY2009 Congressional Justification budget requests. More information on the user fee proposals can be found in the Program Management section of this document, following the appropriations language analysis.

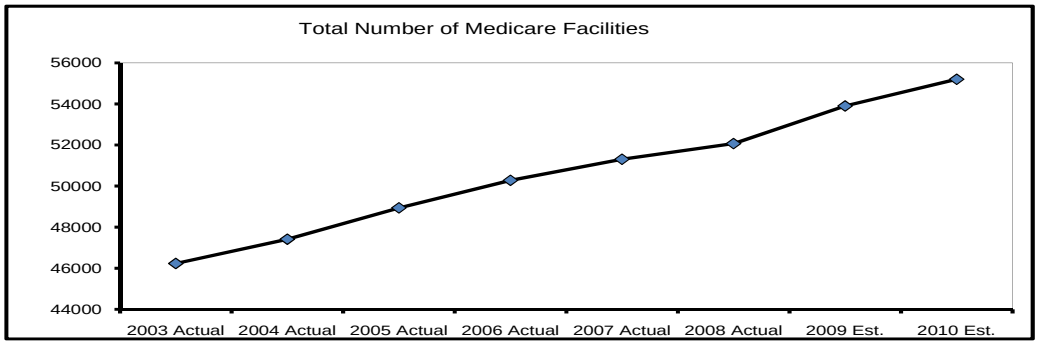
About 93 percent of the requested funding will go to State survey agencies. This funding will be used for performance of mandated Federal inspections of long-term care facilities (e.g., nursing homes) and home health agencies, as well as Federal inspections of hospitals, Organ Transplant Facilities and ESRD facilities. This funding also supports CMS' policy levels for the surveys of Hospices, Outpatient Physical Therapy, Outpatient Rehabilitation, Portable X-Rays, Rural Health Clinics and Ambulatory Surgery Centers. The budget also includes funding for continued program support contracts to strengthen quality improvement and national program consistency, make oversight of accrediting organizations more effective, and implement key recommendations made by the Government Accountability Office (GAO).

The following pie chart breaks down the program request to show direct survey costs for long-term care and non-long term care facilities, other direct survey costs, support contracts, and information technology (IT). With inflation and workload growth consuming all available funds needed to keep mandatory survey frequencies near policy levels, the proportion devoted to support contracts and IT has decreased.



Direct Survey Costs - $311.8 million

The FY 2010 President's Budget includes $311.8 million for direct survey costs, about a $47.5 million increase over the FY2009 President's Budget level. Between FY 2003 and FY 2010, the number of Medicare-certified facilities increased by 19%, from 46,232 facilities in FY 2003 to an estimated 55,203 facilities in FY 2010, as shown in the following graph. In recent years, survey frequencies have been higher than once every 10 years for many facility types. The increase in funding requested will allow CMS to restore more rigorous survey frequencies of at least once every six years for all facility types. The 2010 request also funds surveys of organ transplant centers which were surveyed for the first time in FY 2007. The FY 2010 complaint investigations costs are $85.3 million, which is included in FY 2010 President's Budget request.



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

Direct Survey Costs (dollars in millions)

Provider Type	FY 2008 Enacted	FY 2009 President's Budget	FY 2010 President's Budget
Skilled Nursing Facility (SNF)	$10.9	$10.5	$12.3
SNF/NF (dually-certified)	$164.0	$174.0	$196.4
Home Health Agencies	$29.5	$28.9	$31.7
Accredited HHA's			$1.1
Accredited Hospitals	$16.6	$19.2	$20.3
Non-accredited Hospitals	$10.8	$10.8	$15.9
Ambulatory Surgery Centers[2]	$3.2	$2.6	$4.2
ESRD Facilities	$11.7	$10.2	$17.3
Hospices	$4.1	$4.7	$6.7
Outpatient Physical Therapy	$1.1	$1.0	$1.9
Outpatient Rehabilitation	$0.3	$0.2	$0.5
Portable X-Rays	$0.1	$0.1	$0.2
Rural Health Clinics	$1.4	$1.2	$1.9
Transplant Centers	$0.7	$0.8	$1.5
Subtotal, Direct Survey Costs	**$254.4**	**$264.3**	**$311.8**
Other Direct Survey Costs	$10.9	$9.4	$10.2
Total, Direct Surveys[3]	**$265.3**	**$273.7**	**$322.0**

CMS' FY 2010 President's Budget request provides for inspections of long-term care facilities and home health agencies at the levels required by statute. The FY 2010 target is for 90 percent of States to survey nursing homes at least every 15 months. To meet the FY 2010 targets, CMS ensures that proper operational controls, such as training and regulations, are in place. These targets are also affected by the program's overall approved and appropriated budget level for FY 2010. In addition, CMS will issue an annual Mission and Priority Document, which states the agency's policies and the statutory survey frequency requirements. The following chart includes updated frequency rates for fiscal years 2008 through 2010.

[2] Does not include ARRA funding.

[3] Total may not add due to rounding.

Type of Facility	Recertification FY 2008 Enacted	Recertification FY 2009 Enacted	Recertification FY 2010 President's Budget
Long-Term Care Facilities	Every Year	Every Year	Every Year
Home Health Agencies	Every 3 Years	Every 3 Years	Every 3 Years
Accredited Hospitals	1% Per Year	1% Per Year	2% Per Year
Non-Accredited Hospitals	Every 5 Years	Every 5 Years	Every 3 Years
Organ Transplant Facilities	Every 3 Years	Every 3 Years	Every 3 Years
ESRD Facilities	Every 4 Years	Every 4.6 Years	Every 3 Years
Hospices	Every 10 Years	Every 11.5 yrs	Every 6 yrs
Outpatient Physical Therapy	Every 10 Years	Every 11.5 yrs	Every 6 yrs
Outpatient Rehabilitation	Every 10 Years	Every 11.5 yrs	Every 6 yrs
Portable X-Rays	Every 10 Years	Every 11.5 yrs	Every 6 yrs
Rural Health Clinics	Every 10 Years	Every 11.5 yrs	Every 6 yrs
Ambulatory Surgery Centers [4]	Every 10 Years	Every 11.5 yrs	Every 6 yrs

CMS expects to complete a total of over 25,300 initial and recertification inspections in FY 2010, as shown in the Surveys and Complaint Visits table below. In addition, CMS estimates 58,000 visits in response to complaints. As the Survey and Complaint Visit table shows, the majority of both surveys and complaint visits in FY 2010 are projected to be in nursing homes. These surveys will contribute to achieving our nursing home quality goals to decrease the prevalence of restraints and pressure ulcers in nursing homes. CMS is encouraged by recent downward trends. The 2010 restraints target is set at 3.8 percent. CMS' ability to continue to lower restraint use is impacted by QIO efforts and other efforts that contribute to this goal, such as the Advancing Excellence in America's Nursing Homes campaign. The target for pressure ulcers for FY 2010 is 8.1 percent. The prevalence of pressure ulcers is increased if hospitals do not implement standards of practice to prevent the formation of pressure ulcers.

4 Assuming the full budget request is received, with ARRA funding, the FY 2010 recertification will be every 3 years.

Survey and Complaint Visit Table

	FY 2009 Enacted Level (Survey and Investigations)				FY 2010 President's Budget Level (Survey and Investigations)			
Type of Facility	**Total Recert Surveys**	**Total Initial Surveys**	**Total Complaint Visits**	**Total Surveys and Visits**	**Total Recert Surveys**	**Total Initial Surveys**	**Total Complaint Visits**	**Total Surveys and Visits**
Skilled Nursing Facility (SNF)	897	38	674	1,609	873	42	895	1,810
SNF/NF (dually-certified)	14,177	208	36,313	50,698	14,396	171	49,272	63,839
Home Health Agencies	2,662	706	1,494	4,862	2,785	648	1,660	5,093
Accredited Hospitals	45	-	4,506	4,551	148		4,220	4,368
Non-accredited Hospitals	359	252	532	1,143	580	151	630	1,361
ESRD Facilities	1,082	207	575	1,864	1,747	216	575	2,538
Transplant Centers		24		24	7	70	51	128
Hospices	255	235	546	1,036	464	235	575	1,274
Outpatient Physical Therapy	260	183	6	449	498	173	10	681
Outpatient Rehabilitation	53	57	7	117	95	43	7	145
Portable X-Rays	50	34	4	88	94	35	7	136
Rural Health Clinics	327	266	18	611	638	223	15	876
Ambulatory Surgery Centers	387	318	103	808	719	307	95	1,121
Total	**20,554**	**2,528**	**44,778**	**67,860**	**23,044**	**2,314**	**58,012**	**83,370**

The FY 2010 direct survey cost estimate also includes $10.2 million, a $.8 million increase from the FY 2009 President's Budget, in other direct survey costs for several continuing activities:

- Minimum Data Set (MDS) State program costs, including system maintenance and ongoing collection and storage of data used in the development and testing of program improvement projects ($5 million);
- Outcome and Assessment Information Set (OASIS) State program costs, including providing training to all home health agency providers on the OASIS, operating the system, running reports, and providing technical support ($4 million);
- Validation Support. This includes conducting validation surveys of the non-long term care accredited facilities; HHA, ASC, and Hospice ($1.2 million).

Support Contracts and Information Technology - $24.9 million

Support Contracts

Support contracts, managed internally by CMS, constitute approximately $21.7 million of the FY 2010 Presidents budget. This is an increase of $5.3 million from the FY 2009 appropriations level. The largest category in support contracts continues to be surveyor training. The increase in the FY 2010 request will provide funds for the evaluation/support of the Quality Indicator Survey (QIS) and improving nursing home enforcement. For Federally directed surveys that substitute for State surveys on psychiatric hospitals and for comparative surveys, CMS is requesting $2.2 million. In FY 2010, we estimate that we will fund 160 surveys of psychiatric hospitals, (an increase of five surveys from FY 2009), as well as federal monitoring surveys, both to be performed by contractors.

Information Technology

The Medicare Survey and Certification request includes approximately $3.2 million in IT funding, for activities such as maintenance and enhancements to the OSCAR system and the FOSS redesign. The OSCAR system enhancements will upload and convert the data from the current system to the new Quality Improvement and Evaluation System (QIES). The QIES system records and tracks key information on the survey and certification process and quality of healthcare for over 240,000 Medicare, Medicaid, and Clinical Laboratory Improvement Amendments (CLIA) providers. Although the OSCAR system is being redesigned, the legacy system must be maintained as well. The FOSS redesign will integrate the database into ASPEN, develop a user's operational manual and post it on the CMS website, and revise FOSS reports for the State Performance Standard Report.

This FY2010 request will provide $0.8 million in IT for the continued implementation of the Quality Indicator Survey (QIS). CMS has completed a multi-state demonstration and evaluation of the QIS and is proceeding with national implementation on a State-by-State basis. Since the QIS training for each surveyor is extensive, and since each surveyor needs to have a tablet PC computer, additional States are selected for QIS implementation as funds become available to CMS for hardware and training. The QIS is currently in the process of being programmed into the CMS data systems, which is slated to become operational in December, 2009. Currently there are ten States that are in the process of QIS implementation. Connecticut has completed full statewide implementation, and CMS has begun the training of two additional States. Five other States are in the planning stage for beginning implementation over the next year. As CMS proceeds with QIS implementation, we are also designing upgrades and additional features and survey types, which are expected to be programmed into the new CMS QIS data system in summer of 2010. Ongoing system support and maintenance will be necessary. The cost to fully implement QIS in three years would be $20 million, plus an additional $2-$3 million for annual operating costs.

Outcomes and Output Table

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
MCR 4: Decrease the prevalence of restraints in nursing homes.	FY 2008: 4% (Target Exceeded)	5.1%	3.8%	-1.3
MCR 5: Decrease the prevalence of pressure ulcers in nursing homes.	FY 2008: 8% (Target Exceeded)	8.2%	8.1%	-0.1
MCR 6: Percentage of States that survey nursing homes at least every 15 months.	FY 2008: 96% (Target exceeded)	85%	90%	+5
MCR 7: Percentage of States that survey HHAs at least every 36 months.	FY 2008: 94% (Target exceeded)	75%	80%	+5
MCR 8: Percentage of States for which CMS makes a non-delivery deduction from the State's subsequent year survey and certification funds.	FY 2008: 75% (Target Exceeded)	75%	80%	+5
Program Level Funding ($ in millions).	N/A	$293,128,000	$346,900,000	$53,772,000

CFDA NUMBER/PROGRAM NAME: 93.777 STATE SURVEY AND CERTIFICATION OF HEALTH CARE PROVIDERS AND SUPPLIERS			
STATE/TERRITORY	**FY 2008 Actual**	**STATE/TERRITORY**	**FY 2008 Actual**
Alabama	$4,105,762	Indian Tribes	$0
Alaska	$766,178	Migrant Programs	$0
Arizona	$3,302,047	American Samoa	$0
Arkansas	$4,391,784	Puerto Rico	$513,287
California	$30,858,995	Virgin Islands	$0
Colorado	$4,488,164	**Subtotal**	**$513,287**
Connecticut	$4,944,142	**Total States/Territories**	**$266,460,380**
Delaware	$724,969	Technical Assistance	$0
District Of Columbia	$805,259	Other Adjustments (specify)	$0
Florida	$9,346,134	Subtotal Adjustments	$0
Georgia	$4,927,837	**TOTAL RESOURCES**	**$266,460,380**
Hawaii	$984,130		
Idaho	$1,513,641		
Illinois	$11,023,914		
Indiana	$6,314,641		
Iowa	$2,675,892		
Kansas	$3,501,402		
Kentucky	$4,381,600		
Louisiana	$4,637,226		
Maine	$7,351,732		
Maryland	$3,205,686		
Massachusetts	$2,138,197		
Michigan	$7,668,189		
Minnesota	$7,304,025		
Mississippi	$1,779,298		
Missouri	$8,906,503		
Montana	$1,672,116		
Nebraska	$2,369,096		
Nevada	$1,739,421		
New Hampshire	$986,222		
New Jersey	$6,362,480		
New Mexico	$1,812,652		
New York	$11,492,815		
North Carolina	$6,662,597		
North Dakota	$1,299,036		
Ohio	$14,294,324		
Oklahoma	$4,170,509		
Oregon	$3,065,442		
Pennsylvania	$9,439,889		
Rhode Island	$1,677,013		
South Carolina	$2,574,961		
South Dakota	$1,305,792		
Tennessee	$3,682,340		
Texas	$29,301,460		
Utah	$1,635,198		
Vermont	$727,067		
Virginia	$3,558,599		
Washington	$5,518,131		
West Virginia	$1,943,890		
Wisconsin	$5,654,941		
Wyoming	$953,755		
Subtotal	**$265,947,093**		

Research, Demonstration and Evaluation

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009
BA	$31,301,000	$30,192,000	$56,978,000	+$26,786,000

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

FY 2010 Authorization - One Year

Allocation Method - Contracts, Competitive Grants/Cooperative Agreements

Program Description and Accomplishments

The Research, Demonstration and Evaluation (RD&E) program supports CMS' key role as a beneficiary-centered purchaser of high-quality health care at a reasonable cost. CMS develops, implements and evaluates a variety of innovative research and demonstration projects to expand efforts that improve the efficiency of payment, delivery, access and quality of our health care programs that will serve over 98 million beneficiaries in FY 2010.

Our research and demonstration activities have significantly contributed to major program reforms and improvements. Research investments of $28 million to revamp hospital, skilled nursing facility, and durable medical equipment payments yielded an estimated $64 billion in program savings over 10 years, according to actuary estimates.

Many of the Medicare payment systems developed and tested under CMS' RD&E program have been adopted by State Medicaid programs and private payors. Payment systems based on our development of diagnosis-related groups is the most common form of hospital payment in the United States today. We also developed a system of risk-adjusted payment for managed care organizations and End Stage Renal Disease (ESRD) enrollees and a risk-adjusted model to pay Part D prescription drug plans.

Our demonstrations have had major influences on the evolution of the Medicare managed care program and Congress has enacted numerous changes to the services and benefits provided under our programs because of our RD&E activities, including hospice care, rural swing-bed program for small rural hospitals, and the Medicaid 1915(b) waiver program.

CMS continues to invest in innovative research and demonstration projects to slow the rapid growth of health care spending and improve the efficiency and quality of our health care programs.

Medicare Current Beneficiary Survey (MCBS)

The MCBS is a continuous, multipurpose survey that represents our Medicare population. The survey's design aids CMS' administration to monitor and evaluate the Medicare program. The survey's focus is on health care use, cost and source of payment. The MCBS is the only source of multi-dimensional person-based information about the characteristics of the Medicare population and their access to and satisfaction with Medicare services and information about the program. The MCBS data is of importance to the actuaries and ultimately to decision-makers who craft legislation. One of the prime users of MCBS data is the Congressional Budget Office, in developing legislative estimates. The use of MCBS data was most clear in the policy research that preceded the Part D drug benefit. Internal CMS researchers and policy analysts worked with researchers from the University of Maryland and Rutgers University to project the consequences of alternative policies for the Medicare population and the Medicare budget. MCBS has been important in CMS payment policy for the demographics used to calculate the Adjusted Average Per Capita Cost (AAPCC), define risk adjustment formulas and evaluate outcomes of managed care payments. One recent study found unexplained variations in risk-adjustment payments, leading to the inclusion of health status as an element in the payment formula. MCBS is also used for program monitoring. It is a major basis for the annual Trustees' Report developed by the Office of the Actuary as well as the calculations in the National Health Accounts. MCBS also allowed CMS researchers to monitor the level of prevention and determine how preventive medical care and preventive self-care can be fostered. The MCBS data is now positioned to serve as a means to monitor the Part D program both in terms of understanding the interface between the beneficiary population and that of the CMS and to supplement and give meaning to the claims files. MCBS also feeds into the Agency's measurement of annual Government Performance and Results Act (GPRA) goal attainment, whether it is the level of flu and pneumococcal immunization or the level of understanding of the program. CMS completed the 2006 access to care file and the 2005 Cost and Use user files for the MCBS.

Other Activities

The implementation and evaluation of demonstration activities including mandated activities continue CMS' ongoing efforts to test potential future improvements in Medicare coverage, expenditures, delivery, access and quality of care. In 2008, CMS released four Reports to Congress including Medicare Hospital Gainsharing Demonstration; Evaluation of Home Health Independence Demonstration; Third Report on the Evaluation of the Medicare Coordinated Care Demonstration; and the Final Report on the Evaluation of Medicare Disease Management Programs. CMS also implemented two new demonstrations in FY 2008: Senior Risk Reduction Demonstration; and, the Home Health Pay for Performance Demonstration. CMS also began data collection in markets for the Post Acute Care Payment Reform Demonstration mandated under DRA. The Chronic Conditions Warehouse (CCW) is designed to support studies to improve the quality of care and reduce the costs for chronically ill beneficiaries. CMS loaded 100-percent of Medicare 2007 data into the CCW.

CMS' commitment to the Value-Driven Health Care Initiative is supported through demonstrations conducted in multiple provider settings and research on quality and efficiency. Our research activities will inform the agency on how to develop and implement initiatives that promote value in health care and will provide policymakers with information

on the impacts of performance incentives. The Acute Care Episode (ACE) demonstration, a project that supports value-driven health care, assesses the benefits of the global payment methodology tied with competitive bidding, gainsharing and rebates to beneficiaries to encourage selection coupled with program transparency to both market the program and provide quality and outcome information to the public.

The Electronic Health Records (EHR) demonstration is a five-year initiative that promotes high-quality care through the adoption and use of electronic health records. Under the demonstration, practices will be eligible to earn incentive payments for the implementation and adoption of health information technology in their practice and achieving specified standards on clinical performance measures for diabetes, congestive heart failure, coronary artery disease and the provision of preventive health services. Recruitment of practices began in September 2008. For more information go to http://www.cms.hhs.gov/DemoProjectsEvalRpts.

CMS continues to evaluate and refine our prospective payment systems as they proceed through successive stages of implementation. CMS' research budget also meets the crosscutting research needs of the wider health research community through grant programs for Historically Black Colleges and Universities (HBCUs) and Hispanic researchers. In FY 2008, CMS awarded new and continued HBCU and Hispanic research grants. Also, the Research Data Assistance Center (ResDAC) develops and enhances the capabilities or expertise of the overall health services research system.

Real Choice Systems Change Grants (RCSC)

RCSC grants are intended to support States' efforts to create enduring systems reforms that enable people to live independent lives in the community. Since 2001, approximately $306 million in RCSC grants have been awarded to States. States have made great strides in creating and maintaining effective systems that support real people as a result of this funding. The grants have enabled the States to: develop infrastructure to transition nursing home residents into home and community–based care; develop programs to increase the numbers and training of personal care assistants; implement new quality assurance and quality improvement programs; change State organizational structures to improve the delivery of home and community-based services; test Money Follows the Person (MFP) models, the forerunner of the MFP demonstration program; and, help States to rebalance long-term care systems by addressing the need for single point of entry to access services. In 2008, CMS awarded 6 grants to States to develop and implement person-centered hospital discharge planning models, help increase the use of home and community-based services and reduce the reliance on nursing homes and other institutional settings.

Funding History

FY 2005	$77,494,000
FY 2006	$57,420,000
FY 2007	$57,420,000
FY 2008	$31,301,000
FY 2009	$30,192,000

Budget Request

The FY 2010 President's Budget request for RDE is $57.0 million; an increase of $26.8 million above the FY 2009 Omnibus level. This request supports:

- $30.0 million for new demonstrations and pilot programs to:
    - evaluate payment reforms;
    - investigate ways to provide higher quality care at lower costs;
    - improve beneficiary education and understanding of benefits offered; and,
    - better align payments with costs.
- $14.8 million for the MCBS; an increase of $2.3 million above the FY 2009 Omnibus level to restore the annual funding required to operate and maintain the only source of information on all characteristics about the Medicare program;
- $9.7 million for continuing research activities; a decrease of $3.0 million from the FY 2009 Omnibus level. These continued activities include:
    - mandated and non-mandated demonstration activities including Medicare health care quality and Medicare care management performance, ACE, EHR, Premier, ESRD disease management, and physician group practice demonstrations;
    - prospective payment systems activities and the HBCU and Hispanic Health Services Research Grants programs; and,
    - data collection and dissemination tools maintenance including the CCW and ResDAC.
- $2.5 million for the RCSC grants; a decrease of $2.5 million from the FY 2009 Omnibus level. CMS is currently assessing how best to support States' efforts through grant funding in 2009.

This request does not include any earmarks.

State High-Risk Pool Grants

	FY 2008 Appropriation	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009
BA	$49,127,000	$75,000,000	$0	-$75,000,000
Adjustment for Comparability	-$49,127,000	-$75,000,000	$0	+$75,000,000
Adjusted BA	$0	$0	$0	$0

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

Allocation Method - Grants

Program Description and Accomplishments

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

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

The Consolidated Appropriations Act of 2008 (P.L. 110-161) appropriated $49.1 million for State high-risk health insurance pools for FY 2008 in CMS' discretionary Program Management account. The Omnibus Appropriations Act of 2009 (P.L. 111-8) appropriated $75.0 million for the State high-risk pools in CMS' Program Management account in FY 2009. CMS is proposing to transfer this activity to the State Grants and Demonstrations account for FY 2010. The table on the following two pages displays the FY 2008 grant appropriation allocated by State.

FY 2008 Operational Grants

State	Applicant	Award Amount
Alabama	Alabama Health Insurance Plan	$1,383,432
Alaska	Alaska Comprehensive Health Insurance Association	$686,427
Arkansas	Arkansas Comprehensive Health Insurance Plan	$923,943
Colorado	CoverColorado	$1,810,579
Connecticut	Connecticut Health Reinsurance Association	$1,179,518
Idaho	Idaho Individual High Risk Reinsurance Pool	$966,948
Illinois	Illinois Comprehensive Health Insurance Plan	$2,997,696
Indiana	Indiana Comprehensive Health Insurance Association	$1,706,495
Iowa	Iowa Comprehensive Health Association	$713,258
Kansas	Kansas Health Insurance Association	$1,085,624
Kentucky	Kentucky Access	$1,688,275
Louisiana	Louisiana Health Plan	$1,437,094
Maryland	Maryland Health Insurance Plan	$2,301,233
Minnesota	Minnesota Comprehensive Health Association	$3,442,001
Mississippi	Mississippi Comprehensive Health Insurance Risk Pool Association	$1,414,808
Missouri	Missouri Health Insurance Pool	$1,491,340
Montana	Montana Comprehensive Health Association	$1,054,073
Nebraska	Nebraska Comprehensive Health Insurance Pool	$1,195,503
New Hampshire	New Hampshire Health Plan	$882,252
New Mexico	New Mexico Medical Insurance Pool	$1,440,929
North Dakota	Comprehensive Health Association of North Dakota	$730,531
Oklahoma	Oklahoma Health Insurance High Risk Pool	$1,392,608
Oregon	Oregon Medical Insurance Pool	$2,680,650
South Carolina	South Carolina Health Insurance Pool	$1,444,730
South Dakota	South Dakota Risk Pool	$724,609
Texas	Texas Health Insurance Risk Pool	$6,276,063
Utah	Utah Comprehensive Health Insurance Pool	$1,393,329
Washington	Washington State Health Insurance Pool	$1,617,258
Wisconsin	Wisconsin Health Insurance Risk-Sharing Plan	$2,561,169

State	Applicant	Award Amount
Wyoming	Wyoming Health Insurance Pool	$504,125
TOTAL		$49,126,500

Funding History

FY 2008	$49,127,000
FY 2009	$75,000,000

Budget Request

CMS is not requesting FY 2010 funding for this activity in its Program Management account. CMS proposes funding the High Risk Pools at $75 million in FY 2010 through the State Grants and Demonstrations account.

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Medicaid

Appropriation Language

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, [$149,335,031,000] *$220,962,465,000* to remain available until expended.

For making, after May 31, [2009] *2010,* payments to States under title XIX of the Social Security Act for the last quarter of fiscal year [2009] *2010* for unanticipated costs, incurred for the current fiscal year, such sums as may be necessary.

For making payments to States or in the case of section 1928 on behalf of States under title XIX for the first quarter of fiscal year [2010] *2011,[$71,700,038,000] $86,789,382,000* 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, $220,962,465,000 to remain available until expended.	This section provides a one-year appropriation for Medicaid. This appropriation is in addition to the advance appropriation of $71.7 billion to be provided for the first quarter of FY 2010 under the Omnibus Appropriations Act of 2009. 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, 2010, payments to States under title XIX of the Social Security Act for the last quarter of fiscal year 2010 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 2010 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 2011, $86,789,382,000 to remain available until expended.	This section provides an advanced appropriation for the first quarter of fiscal year 2011 to ensure continuity of funding for the Medicaid program in the event a regular appropriation for fiscal year 2011 is not enacted by October 1, 2010. It makes clear that the language provides budget authority to the Vaccines for Children program during the first quarter of a fiscal year.
Payment under title XIX may be made for any quarter with respect to a State plan or plan amendment in effect during such quarter, if submitted in or prior to such quarter and approved in that or any subsequent quarter.	This section makes clear that funds are available with respect to State plans or plan amendments only for expenditures on or after the beginning of the quarter in which a plan or amendment is submitted to the Department of Health and Human Services for approval.

Medicaid Program
Appropriation
Amounts Available for Obligation
(dollars in thousands)

	2008 Actual	2009 Estimate	2010 Estimate
Appropriation Annual	$206,885,673	$216,627,700	$292,662,503
Appropriation Indefinite	0	40,520,003	0
Unobligated balance, start of year	4,007,661	8,988,360	0
Unobligated balance, end of year	(8,988,360)	0	0
Recoveries of Prior Year Obligations	11,713,045	0	0
Offsetting Collections	396,717	475,000	562,500
Total Gross Obligations	$214,014,737	$266,611,063	$293,225,003
Medicare Part B Transfer	(396,612)	(475,000)	(562,500)
VFC Program Collection	(105)	0	0
Obligations Incurred but not Reported	(2,405,387)	(3,747,000)	(2,899,000)
Total Net Obligations	$211,212,633	$262,389,063	$289,763,503

Medicaid Program
Summary of Changes
(dollars in thousands)

2009 Budget Authority		$216,627,700
2010 Estimated Appropriated Budget Authority		$292,662,503
Net Change		$76,034,803
Explanation of Changes	2009 Current Base Budget Authority	FY 2010 Change From Base Budget Authority
Program Increases		
Medical Assistance Payments	$206,700,000	$67,712,500
State Administration	10,061,993	687,203
Fraud Control Units	195,300	9,765
State Certification	228,798	1,848
State and Local Administration Financial Adj.	287,007	816,397
Medicare Improvement for Patients & Providers Act, P.L. 110-275	0	242,500
Fostering Connections to Success Act of 2008 P.L. 110-351	0	15,000
Emergency Economic Stabilization Act of 2008 P.L. 110-343	0	60,000
Children's Health Insurance Program Reauthorization Act P.L 111-3	0	501,000
5010/ICD-10	0	92,922
Vaccines for Children Program	2,766,230	557,540
TMA, Abstinence Education, and QI Programs Extension Act	-55,000	55,000
Administrative Actions	-2,225,000	2,225,000
Unobligated Balance End of Year	0	0
Financial Management Reviews	-682,000	136,000
Supplemental Appropriations Act 2008, P.L. 110-252	190,000	-249,000
Unobligated Balance Start of Year	-4,140,628	4,140,628
Total Program Increases	$213,326,700	$77,004,303
Program Decreases		
Offsetting Collections From Medicare Part B	0	-562,500
QI Supplemental Funding Act of 2008, P.L. 110-379	0	-5,000
Obligations Incurred But Not Reported	3,231,000	-332,000
Medicare, Medicaid and SCHIP Extension Act	70,000	-70,000
Total Program Decreases	3,301,000	-969,500
TOTAL	**$216,627,700**	**$76,034,803**

Medicaid Program
Authorizing Legislation

	2009 Amount Authorized	2009 President's Budget	2010 Amount Authorized	2010 Budget Request
Grants to States for Medicaid (Social Security Act, title XIX, Section 1901)	Indefinite	$253,769,792,000	Indefinite	$289,338,733,000
Vaccines for Children Program (Social Security Act, title XIX, Section 1928)		$3,377,911,000		$3,323,770,000
Total Appropriations		$257,147,703,000		$292,662,503,000

Medicaid Program

Appropriations History Table

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
2000	114,820,998,000	114,820,998,000	114,820,998,000	117,744,046,209	1/
2001	124,175,254,000	124,175,254,000	124,175,254,000	129,418,807,224	2/
2002	143,029,433,000	143,029,433,000	143,029,433,000	147,340,339,015	3/
2003	158,692,155,000	158,692,155,000	158,692,155,000	164,550,765,542	4/
2004	176,753,583,000	176,753,583,000	182,753,583,000	182,753,583,000	
2005	177,540,763,000	177,540,763,000	177,540,763,000	177,540,763,000	
2006	215,471,709,000	215,471,709,000	215,471,709,000	215,471,709,000	
2007	200,856,073,000	------	------	168,254,782,000	5/
2008	206,885,673,000	206,887,673,000	206,885,673,000	206,885,673,000	
2009	216,627,700,000	------	------	216,627,700,000	
2010	292,662,503,000				

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

Medicaid
(Dollars in Thousands)

	FY 2008 Appropriations	FY 2009 Omnibus	FY 2010 President's Budget Request	FY 2010 +/- FY 2009 Omnibus
Medical Assistance Payments (MAP)	$197,827,321	$211,975,000	$231,708,500	$19,733,500
MAP, Recovery Act	0	35,490,000	42,912,500	$7,422,500
Obligations Incurred by Providers But Not Yet Reported (IBNR)	$2,405,387	$2,522,000	$2,719,000	$197,000
IBNR, (Recovery Act)	0	$1,225,000	$180,000	($1,045,000)
Vaccines for Children	$2,719,702	$3,377,911	$3,323,770	($54,141)
State & Local Administration (SLA), Survey and Certification, and Fraud Control Units	$11,062,327	$12,021,152	$12,351,633	$330,481
State & Local Administration, (Recovery Act)	0	0	$29,600	$29,600
Obligations (gross)	$214,014,737	$229,896,063	$250,102,903	$20,206,840
Obligations (gross), Recovery Act		$36,715,000	$43,122,100	$6,407,100
Unobligated Balance, Start of Year	($4,007,661)	($8,988,360)	0	$8,988,360
Unobligated Balance, End of Year	$8,988,360	$0	$0	$0
Recoveries of Prior Year Obligations	($11,713,045)	$0	$0	$0
Appropriation Budget Authority (gross)	$207,282,390	$257,622,703	$293,225,003	$35,602,300
Offsetting Collections	($396,717)	($475,000)	($562,500)	($87,500)
Total Budget Authority (net)	$206,885,673	$257,147,703	$292,662,503	$35,514,800
Indefinite Authority	0	($40,520,003)	0	$40,520,003
Advanced Appropriation	($65,257,617)	($67,292,669)	($71,700,038)	($4,407,369)
Annual Appropriation	$141,628,056	$149,335,031	$220,962,465	$71,627,434

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

FY 2009 Authorization - Public Law 111-8

Allocation Method - Formula Grants

Program Description and Accomplishments

Authorized under title XIX of the Social Security Act, Medicaid is generally a means-tested health care entitlement program financed by States and the Federal Government that provides health care coverage to low-income families with dependent children, pregnant women, children, and aged, blind and disabled individuals. In addition, Medicaid provides long-term care supports to seniors and individuals with disabilities. States have considerable flexibility in structuring their Medicaid programs within broad Federal guidelines governing eligibility, provider payment levels, and benefits. As a result, Medicaid programs vary widely from State to State.

The Federal Government and States share the cost of the program. The State share varies from State to State. In FY 2008, the average State share was approximately 43 percent, with the remaining 57 percent provided by the Federal Government. All 50 States, the District of Columbia, and the five territories (Puerto Rico, Virgin Islands, American Samoa, Northern Mariana Islands, and Guam) have elected to establish Medicaid programs.

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

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

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

As a result of a program assessment, CMS implemented new performance measures that assess health quality, improve program management and protect program integrity. CMS is also executing improvement actions: working with the States to measure, track, and improve quality of care in Medicaid while moving toward a national framework for Medicaid quality; reducing fraud, waste, and abuse in the Medicaid program and improving overall program integrity; and working with States to establish baseline data for the Medicaid performance measures.

To ensure that Medicaid beneficiaries gain access to and receive quality of care with their benefit dollars, CMS has developed a long-term measure to increase the number of States that have the ability to assess improvements in access and quality of health care through implementation of the Medicaid Quality Improvement Program (MQIP). The MQIP provides technical assistance to States regarding quality improvement, quality measurement, and External Quality Review and bolsters their targeted health quality improvement projects. The CMS will track State participation in quality improvement efforts and disseminate tools to provide guidance in achieving objectives in areas of evidence-based care, health disparities and program evaluation.

In FY 2007, the baseline year, CMS began a thorough review of data sources and data collection tools to document State quality activities. Comprehensive, individualized Quality Assessment Reports (QARs), the primary vehicle for improving States' ability to assess quality and access to care, were developed for both informational purposes and validation of State quality activities. CMS completed eight QARs to meet its FY 2008 target. CMS is on schedule to complete nine QARs in FY 2009.

This measure is highly dependent upon maintaining a collaborative partnership with States and other key stakeholders as the activities are voluntary and resources are limited. The CMS plans to use the information gained from these State-level quality improvement initiatives as the building blocks for the development of a larger, national-level quality framework. Next steps include determination of quality measures to strengthen quality of care, health outcomes and access to benefits across the continuum of care for all populations served.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), (P.L. 111-3) outlines measure sets, tools and technical assistance that will be provided for voluntary State collection, submission and reporting on child health measures. While CHIPRA focuses on children, it supports this performance measure by requiring the development of a National Medicaid and CHIP Quality Framework, which will demonstrate improvement in State programs. With increased funding, CMS may revise this measure to reflect the infusion of new resources. As CHIPRA implementation unfolds, CMS will continually assess options for revising these targets.

The American Recovery and Reinvestment Act (ARRA), (P.L. 111-5), intended to provide economic stimulus to the economy, was signed into law on February 17, 2009. ARRA contains Medicaid provisions to provide a temporary increase in the Federal Medical Assistance Percentages (FMAPs) from October 1, 2008 through December 31, 2010, a temporary increase in the Disproportionate Share Hospital (DSH) allotments, extension of moratoria on certain Medicaid regulations, an extension of transitional medical assistance, extension of the qualifying individual program, protections for Indians under Medicaid and CHIP, and monies for health information technology (HIT). A more detailed explanation of these ARRA provisions can be found in the "Adjustments to the Actuarial Estimates for Medical Assistance Payments for Legislation" section.

Medicaid Integrity Program

Section 6034 of the DRA requires the Secretary to promote Medicaid integrity by contracting with eligible entities to carry out certain specified activities including reviews, audits, identification of overpayments, and education. CMS established a 5-year Comprehensive Medicaid Integrity Plan (CMIP) to combat fraud, waste and abuse

beginning in FY 2006. An updated CMIP was published in June 2008 covering FYs 2008 to 2012. Building upon the accomplishments of the first several years, CMS will hire additional employees by the end of FY 2009. CMS has already hired audit and review contractors and will soon hire education contractors.

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

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

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

Vaccines for Children

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

Medicaid Survey and Certification

The Medicaid survey and certification inspection program for nursing facilities and intermediate care facilities for the mentally retarded ensures that Medicaid beneficiaries are receiving quality care in a safe environment. In order to secure quality care for the elderly, one of the Nation's most vulnerable populations, CMS requires that all facilities seeking participation in Medicaid undergo an inspection when they initially enter the program and on a regular basis thereafter. To conduct these inspection surveys, CMS contracts with State survey agencies in each of the 50 States, the District of Columbia, Puerto Rico, and two territories. Utilizing over 6,500 surveyors across the country, State survey agencies inspect

providers and determine their compliance with specific Federal health, safety, and quality standards.

Medicaid Fraud Control Units (MFCUs)

Medicaid Fraud Control Units (MFCUs) are required by each State agency operating the Medicaid program. The MFCUs investigate State law violations and review and prosecute cases involving neglect or abuse of beneficiaries in nursing homes and other facilities. The MFCU must be part of the State Attorney General's office or coordinate with that office and must have authority to prosecute Statewide or be able to refer to local prosecutors.

Managed Care

One of the most significant developments for the Medicaid program has been the growth of managed care as an alternative service delivery method. Prior to 1982, 99 percent of Medicaid recipients received coverage through fee-for-service arrangements. Since the passage of the Omnibus Budget Reconciliation Act of 1981 and the Balanced Budget Act of 1997, the number of Medicaid recipients enrolled in managed care organizations has vastly increased. As of June 30, 2008 nearly 71 percent of all Medicaid beneficiaries (more than 33.4 million) in 48 States, the District of Columbia, and Puerto Rico were enrolled in some type of managed care delivery system. States continue to experiment with various managed care approaches in their efforts to reduce unnecessary utilization, contain costs, improve access to services, and achieve greater continuity of care.

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

The Balanced Budget Act of 1997 increased State flexibility to enroll certain Medicaid groups on a mandatory basis (with the exception of special needs children, Medicare beneficiaries, and Native Americans) into managed care through a State plan amendment. The 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 health care reform demonstrations in 28 States (Arizona, Arkansas, California, Colorado, Delaware, Florida, Hawaii, Idaho, Indiana, Iowa, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Jersey, New Mexico, New York, Oklahoma, Oregon, Rhode Island, Tennessee, Utah, Vermont, Virginia, and Wisconsin) and the District of Columbia. CMS has also approved one sub-State health reform demonstrations (Kentucky) and 22 demonstrations specifically related to family planning (Alabama, Arkansas, California, Florida, Iowa, Illinois, Louisiana, Michigan, Minnesota, Mississippi, Missouri, New Mexico, North Carolina, Oregon, Oklahoma, Pennsylvania, South Carolina, Texas, Virginia, Washington, Wisconsin and Wyoming).

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

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

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

Enactment of sections 6041, 6042, and 6043 of the Deficit Reduction Act of 2005 (DRA) provides State Medicaid agencies with increased flexibility to implement premium and cost sharing requirements for certain Medicaid recipients. This authority builds on current authority States already have under section 1916 of the Social Security Act to implement nominal premiums and cost sharing amounts. Sections 6041, 6042, and 6043 of the DRA provide States with additional State plan flexibility to implement alternative premiums for certain recipients and to implement alternative cost sharing for certain medical services (e.g. non-preferred drugs under section 6042 and for non-emergency use of the emergency room under section 6043). These sections also update nominal cost sharing amounts under section 1916 and provide States options with respect to enforceability of premiums and cost sharing for certain recipients.

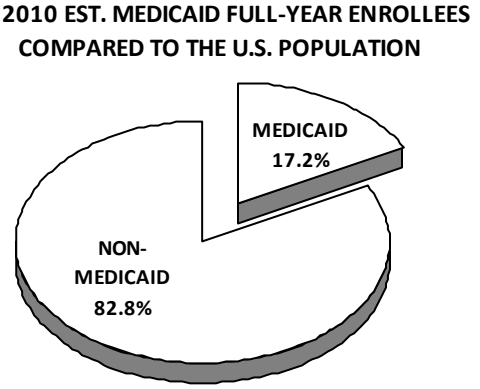
Recipients

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

Medicaid Enrollment (Person-Years in Millions)

	FY 2008	FY 2009	FY 2010	Estimate +/- FY 2009 to FY 2010
Aged	4.6	4.7	4.8	.1
Disabled	8.3	8.6	8.9	.3
Adults	11.0	11.9	12.4	.5
Children	23.3	24.9	26.2	1.3
Territories	1.0	1.0	1.0	.0
Total	48.2	51.1	53.3	2.2

According to our projections of Medicaid enrollment in FY 2010, as shown in the pie chart, 17.2 percent, or 53.3 million, of the projected 310.2 million U.S. population, will be enrolled in Medicaid for the equivalent of a full year during FY 2010. In FY 2010 Medicaid will provide coverage to more than one out of every five children in the Nation.

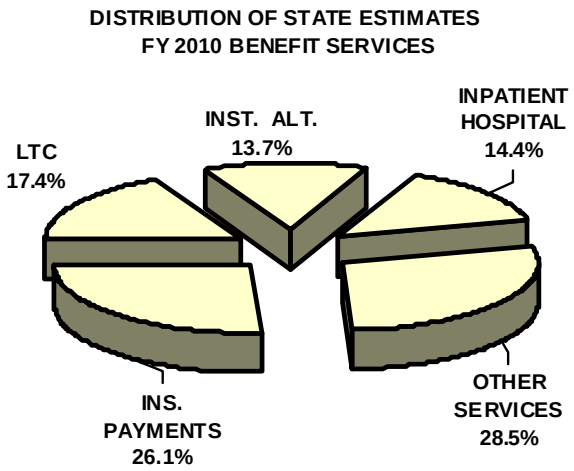


CMS projects that in FY 2010, children and non-disabled adults under age 65 will represent 74 percent of the Medicaid population excluding the Territories, but account for approximately 35 percent of the Medicaid benefit outlays, excluding disproportionate share hospital (DSH) payments. In contrast, the elderly and disabled populations are estimated to make up about 26 percent of the Medicaid population excluding the Territories, yet account for approximately 65 percent of the non-DSH benefit outlays. Medicaid is the largest payer for long-term care for all Americans.

Benefit Services

As displayed in the table on the following page, medical assistance payments independent of the ARRA legislation are projected to increase $19.4 billion, or 9.1 percent, from $212.1 billion in FY 2009 to 231.5 billion in FY 2010. Including additional ARRA monies, the estimate increases $26.4 billion or 10.7 percent, from $247.6 billion for FY 2009 to $274.0 billion for FY 2010.

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 $56.3 billion in funding for FY 2010, representing 26.1 percent of the State-submitted benefit estimates for FY 2010. The second largest FY 2010 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 2010 estimates totaling $37.5 billion or about 17.4 percent of Medicaid benefits. The next largest category of Medicaid services for FY 2010 are inpatient hospital services exclusive of disproportionate hospital payment adjustments ($30.7 billion), followed by institutional alternative services such as home health, personal care, home and community-based care ($29.4 billion). Together these 4 benefit service categories for health insurance payments, long-term care services, inpatient hospital services, and institutional alternative services account for over 71.6 percent of the State estimated cost of the Medicaid program for FY 2010.



According to the State estimates received in November 2008, the fastest growing service category is prescription drugs, which displays a growth of $1.2 billion, 11.8 percent, between FY 2009 and FY 2010. States expect the health insurance payments category, which includes Medicare premiums, coinsurance and deductibles, primary care case management, group and prepaid health plans, managed care organizations, and other premiums, to grow by $3.9 billion, or 7.4 percent, between FY 2009 and FY 2010. The States estimated increases in this service category account for 46.1 percent of the total FY 2010 benefit growth. Rising enrollments and shifts in how services are paid, e.g., from fee-for-service to capitated plans, explain this growth.

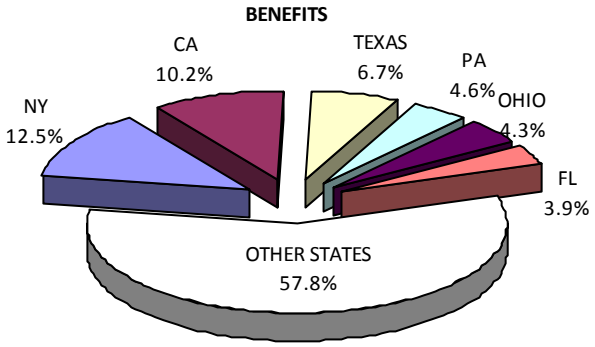
Estimated Benefit Service Growth, FY 2009 to FY 2010
November 2008 State-Submitted Estimates and Actuarial Adjustments
(dollars in thousands)

Major Service Category	Est. FY 2009	Est. FY 2010	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)	$52,396,911	$56,277,224	$3,880,313	7.4%	46.1%

Major Service Category	Est. FY 2009	Est. FY 2010	Dollar Growth	Annual Percent Growth	Percent Of State Estimate Growth
Institutional Alternatives (Personal care, home health, and home and community-based care)	$28,290,371	$29,445,977	$1,155,606	4.1%	13.7%
Other (Targeted case management, hospice, all other services, and collections)	$12,232,628	$12,804,848	$572,220	4.7%	6.8%
Long-Term Care (Nursing facilities, intermediate care facilities for the mentally retarded)	$36,325,680	$37,512,404	$1,186,724	3.3%	14.1%
Outpatient Hospital	$7,926,031	$7,970,645	$44,614	0.6%	0.5%
Prescribed Drugs (Prescribed drugs and drug rebate offsets)	$9,974,860	$11,156,297	$1,181,437	11.8%	14.0%
Inpatient Hospital (Regular payments –inpatient hospital and mental health facilities)	$30,107,667	$30,658,465	$550,798	1.8%	6.0%
Physician/Practitioner/Dental	$11,238,107	$11,537,348	$299,241	2.7%	3.6%
Other Acute Care (Clinics, lab & x-ray, Federally-qualified health clinics and early periodic screening, and diagnostic treatment	$8,315,911	$8,265,615	-$50,296	-0.6%	-0.6%
DSH Payments (Adjustment Payments - inpatient hospital and mental health facilities)	$9,851,063	$9,615,431	-$235,632	-2.4%	-2.8%
TOTAL STATE ESTIMATES (Excludes Medicare Part B Transfer)	$207,095,328	$215,517,297	$8,421,969	4.1%	100.0%
Adjustments	$5,004,672	$15,982,703	NA	NA	NA
Total Medicaid Benefits	$212,100,000	$231,500,000	$19,400,000	9.1%	NA
Total Recovery Act Benefits	$35,490,000	$42,500,000	$7,010,000	19.7%	NA
TOTAL	$247,590,000	$274,000,000	$26,410,000	10.7%	NA

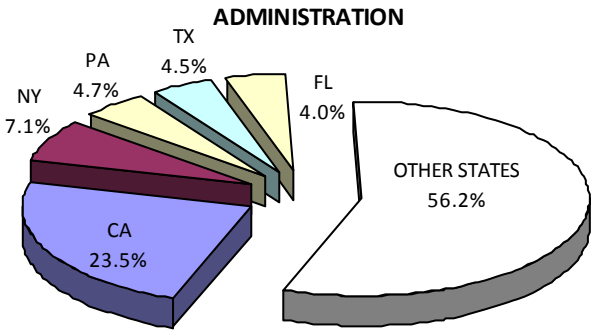
Distribution of Benefit Monies

According to the State-submitted estimates, $215.5 billion will be required to fund their Medicaid benefit programs during FY 2010. As displayed, New York, California, Texas, Pennsylvania, Ohio, and Florida account for $90.7 billion, or over 42.2 percent, of the State-submitted estimates for benefits for FY 2010.



Distribution of State and Local Administration Monies

The State-submitted estimates for FY 2010 State and local administration costs total $10.7 billion. This represents about 4.7 percent of the total State-submitted estimates for Medicaid costs for FY 2010. As displayed, California, New York, Pennsylvania, Texas, and Florida account for $4.7 billion or 43.8 percent of expenditures for State and local administration.



Funding History (Appropriation)

FY 2006	$215,471,709,000
FY 2007	$168,254,782,000
FY 2008	$206,885,673,000
FY 2009	$216,627,700,000
FY 2010	$292,662,503,000

Budget Request

CMS estimates its FY 2010 appropriation for Grants to States for Medicaid is $292.7 billion, an increase of $76.1 billion above the FY 2009 level of $216.6 billion. This appropriation is composed of $221.0 billion in monies for FY 2010 and $71.7 billion in advance appropriation monies from the FY 2009 Omnibus Appropriation.

Under current law, the estimated Medicaid net budget authority request for FY 2010 is $292.7 billion in appropriated monies. This budget authority request is composed of $71.7 billion from the FY 2009 appropriation and $221.0 billion in FY 2010

appropriated monies. These monies, together with an estimated offsetting collection of $562.5 million from Medicare Part B for the Qualified Individuals (QI) program will fund $293.2 billion in anticipated FY 2010 Medicaid obligations. These obligations are composed of:

- $274.6 billion in Medicaid medical assistance benefits;
- $2.9 billion for benefit obligations incurred but not yet reported;
- $12.4 billion for Medicaid administrative functions including funding for Medicaid State survey and certification and the State Medicaid fraud control units; and
- $3.3 billion for the Centers for Disease Control and Prevention's Vaccines for Children program.

This submission is based on projections from State-submitted estimates and the CMS' Office of the Actuary using Medicaid expenditure data through the first two quarters of FY 2008. The projections incorporate the economic and demographic assumptions promulgated by the Office of Management and Budget for use with the FY 2010 President's Budget.

Under current law, the estimated Federal share of Medicaid outlays is estimated to be $289.8 billion in FY 2010. This represents an increase of 10.4 percent over the estimated net outlay level of $262.4 billion for FY 2009. Medicaid person-years of enrollment, which represent full-year equivalent Medicaid enrollment, are projected to increase approximately 4.4 percent during this time period.

Medical Assistance Payments (MAP)

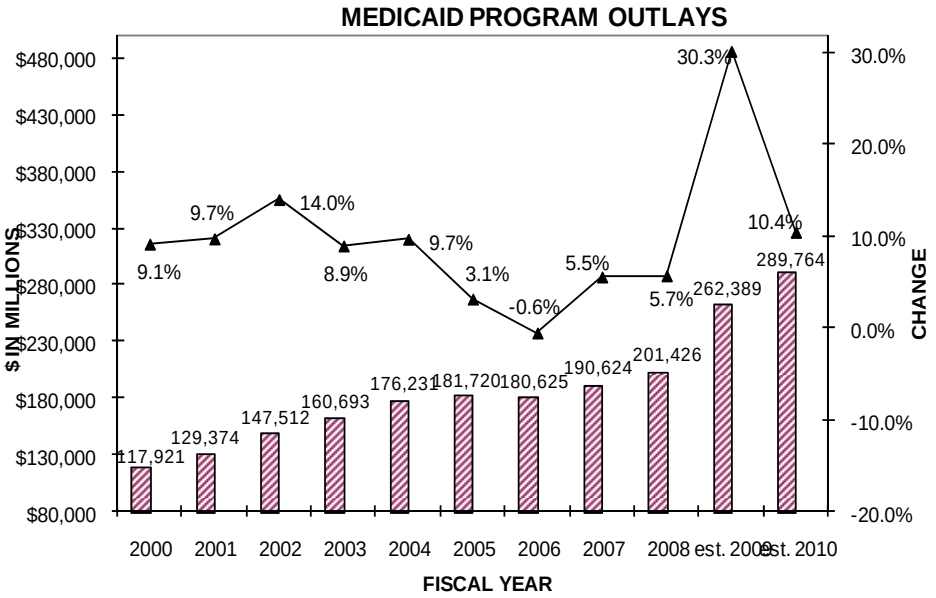
In order to arrive at an accurate estimate of Medicaid expenditures, adjustments have been made to the November 2008 State estimates. These adjustments reflect actuarial estimates, recent legislative impacts, Medicaid financial disallowances, and CMS financial management reviews.

Actuarial Adjustments to the State Estimates for Medical Assistance Benefits

The November 2008 State estimates for MAP of $215.5 billion in FY 2010 are the first State-submitted estimates for FY 2010. 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 2010. Using the first three quarters of FY 2008 State-reported expenditures as a base, expenditures for FY 2009 and FY 2010 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 2008 State-submitted estimates.



In the mid 1990s, the factors impacting the historical growth in the Medicaid program began to moderate as a result of an improving economy, legislative restrictions on tax and donation programs and DSH payments, and welfare reform. The slower program outlay growth averaged about 3.5 percent in FY 1996 and FY 1997. By the early part of this decade, Medicaid program cost growth accelerated with a sharp increase in enrollment due primarily to the downturn in the economy, as well as growth in medical prices and utilization. Medicaid capitation premiums, long-term care and prescription drugs were among the most significant sources of expenditure growth. The fast growth in the recent period has abated as enrollment growth has slowed and as the Federal government and the States have taken steps to curb the growth of Medicaid expenditures. Additionally, with the advent of the Medicare Part D benefit in 2006, spending on prescription drugs decreased as those costs shifted to Medicare. Thus, spending in 2006 actually decreased 0.6 percent. Actual FY 2008 spending increased compared to actual FY 2007 spending and was driven by spending on inpatient hospital care, managed care and group health premiums, home and community-based waivers, and prescription drugs. Projected growth rates of Federal expenditures in 2009 and 2010 are expected to be affected by two major factors: faster enrollment growth rates as a result of the economic recession, and temporary higher Federal match rates (part of the American Recovery and Reinvestment Act of 2009).

Adjustments to the Actuarial Estimates for Medical Assistance Payments for Legislation

Supplemental Appropriations Act of 2008, P.L. 110-252

(Estimated FY 2010 savings are $59 million)

This legislation provides that each State implement an asset verification program and extends previous implementation moratoria.

Medicare Improvement for Patients and Providers Act of 2008 P.L. 110-275

(Estimated FY 2010 costs are $242.5 million)

This legislation extends authorization for the Qualified Individuals (QI) and Transitional Medical Assistance (TMA) programs through December 31, 2009 and June 30, 2009 respectively. In addition, it extends the authority for disproportionate share hospital (DSH) provisions funding under section 1923 of the Social Security Act for Tennessee and Hawaii through December 31, 2009.

Fostering Connections to Success Act of 2008, P.L. 110-351
(Estimated FY 2010 costs are $15 million)

This legislation requires States to work with their Medicaid programs to better coordinate for the medical needs of children in foster care. It includes a requirement for States to include a schedule for when health care screening will be conducted. States are also required to provide a description of how medical needs will be monitored and treated and how Medicaid information concerning these children will be updated and shared.

Emergency Economic Stabilization Act of 2008, P.L. 110-343
(Estimated FY 2010 costs are $60 million)

This legislation provides mental health parity for all financial requirements, it removes coverage limitations that impact patients suffering from mental health and substance abuse disorders.

Qualified Individuals (QI) Supplemental Funding Act of 2008, P.L. 110-379
(Estimated FY 2010 savings are $5 million)

This legislation provided supplemental funding for the QI program in FYs 2008 and 2009. In addition, it requires States to have their mechanized Medicaid claims processing system and information retrieval systems provide matching through the Public Assistance Reporting Information System (PARIS) facilitated by the Secretary of Health and Human Services. This matching will include matching with medical assistance programs operated by other States.

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

The Children's Health Insurance Program Reauthorization Act (CHIPRA) was signed into law in February 2009 and was effective on April 1, 2009. CHIPRA provides substantial additional Federal funding to States to provide increases in health care coverage for uninsured children. It improves benefits, provides additional tools and resources for increasing outreach and enrollment, and creates a child health quality initiative.

Impact of CHIPRA on Medicaid
(Estimated FY 2010 costs are $80 million)

CHIPRA Sections 101, 102,103, and 104 are all expected to impact the Medicaid program. Section 101 extends and provides funding for CHIP through FY 2013. Section 102 provides revisions to the State allotment formulas to reflect States' previous funding needs. Section 103 creates a Child Enrollment Contingency Fund to provide States additional funding beyond the amount allotted for a year. Section 104 creates a Performance Bonus payment system that provides additional Federal monies to States for significantly increasing enrollment of eligible children in Medicaid and CHIP. In combination these provisions of CHIPRA are estimated to impact the cost of the Medicaid program in FY 2010.

CHIPRA Citizenship Documentation Requirements
(Estimated FY 2010 costs are $350 million)

Section 211 impacts the Medicaid program by revising the citizenship documentation requirements established by the Deficit Reduction Act of 2005 (DRA) to allow an alternate process for verifying citizenship and identity. This section of CHIPRA revises the citizenship documentation requirements to assure eligible individuals are provided access to health care.

CHIPRA Option to Eliminate the 5-Year Delay for Legal Immigrants
(Estimated FY 2010 costs are $46 million)

Section 214 of CHIPRA provides States the option to provide Medicaid and CHIP eligibility to legal immigrant children and pregnant women without requiring a 5-year waiting period.

FMAP Adjustment to State per Capita Income for Disproportionate Employer Pension Contributions
(No FY 2010 budget impact)

Section 614 revises the Medicaid FMAP formula by defining and disregarding any significantly disproportionate employer pension or insurance fund contribution to the calculation of a State's per capita income.

Disproportionate Share Hospital (DSH) Allotment Extensions for Tennessee and Hawaii
(Estimated FY 2010 costs are $25 million)

Section 616 extends the DSH allotments for Tennessee and Hawaii through the first quarter of FY 2012.

Non-pregnant Childless Adults
(CHIP Section 2111 as amended by CHIPRA).

CHIPRA prohibits new demonstrations for childless adults and terminates existing demonstrations for coverage of childless adults funded through CHIP by December 31, 2009. If a current demonstration would expire prior to that date, an extension is available through December 31, 2009, only if requested by September 30, 2009. Under CHIPRA, States with existing demonstrations may also request, by September 30, 2009, a Medicaid demonstration project that meets statutory budget neutrality standards for continued funding and coverage.

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

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

Temporary Increase in Medicaid FMAP (Section 5001)
(Estimated FY 2010 costs are $41.4 billion)

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

Temporary Increase in DSH Allotments During Recession (Section 5002)
(Estimated FY 2010 costs are $520 million)

This provision provides a temporary 2.5 percent increase in the DSH allotments to States for both FY 2009 and FY 2010.

Extension of Moratoria on Certain Medicaid Regulations
(No FY 2010 budget impact)

This provision extends the current moratoria on regulations for optional targeted case management services, school administration and transportation services and provider taxes through June 30, 2009. In addition it establishes new moratoria through June

2009 for the Medicaid outpatient hospital regulation which became effective December 2008.

Extension of Transitional Medical Assistance (TMA) (Section 5004)
(Estimated FY 2010 costs are $480 million)

TMA was created to provide health coverage to families transitioning to the workforce. TMA helps low-income families with children transition to jobs by allowing them to keep their Medicaid coverage for a limited period of time after a family member receives earnings that would make them ineligible for regular Medicaid. This provision extends the TMA program from July 1, 2009 through December 31, 2010.

Extension of the Qualified Individual (QI) Program (section 5005)
(Estimated FY 2010 costs are $412.5 million)

The Qualified Individual (QI) program was created to pay the Medicare Part B premiums of low-income Medicare beneficiaries with incomes between 120 and 135 percent of the Federal poverty level. In addition, QIs are deemed eligible for the Medicare Part D low-income subsidy program. States currently receive 100 percent Federal funding for the QI program. This provision extends the QI program through December 31, 2010.

Protection for Indians under Medicaid and CHIP (Section 5006)
(Estimated FY 2010 costs are $10 million)

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

Interactions of the Temporary Increase of Medicaid FMAP With Other Medicaid Provisions
(Estimated FY 2010 costs are $90 million)

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

Incurred but not Reported Obligations Associated with the Medicaid ARRA Provisions
(Estimated FY 2010 costs are $180 million)

The FY 2010 estimate of $180 million represents the increase in the liability for ARRA associated costs for Medicaid medical services incurred but not paid from October 1, 2009 to September 30, 2010. The Medicaid liability is developed from estimates received from the States. The Medicaid estimate represents the net of unreported expenses incurred by the States less amounts owed to the States for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases.

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

The FY 2010 estimate of $2.7 billion represents the increase in the liability for Medicaid medical services incurred but not paid from October 1, 2009 to September 30, 2010. The Medicaid liability is developed from estimates received from the States. The Medicaid estimate represents the net of unreported expenses incurred by the States less amounts owed to the States for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases.

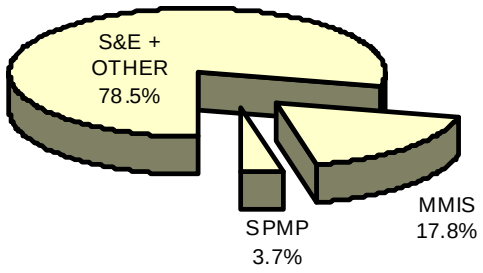
Vaccines for Children (VFC) Program

The nation's childhood immunization coverage rates are at high levels for every vaccine and for all vaccination series measures. As childhood immunization coverage rates increase, cases of vaccine preventable diseases decline significantly. In addition to the health benefits of vaccines, they also provide significant economic value. An economic evaluation in the December 2005 issue of the Archives of Pediatrics and Adolescent Medicine entitled, "Economic Evaluation of the 7-Vaccine Routine Childhood Immunization Schedule in the US, 2001" of the impact of seven vaccines (DTaP, Td, Hib, polio, MMR, hepatitis B, and varicella) routinely given as part of the childhood immunization schedule found that the vaccines are cost-effective. Routine childhood vaccination with these seven vaccines prevent over 14 million cases of disease and over 33,500 deaths over the lifetime of children born in any given year, and result in an annual cost savings of $10 billion in direct medical costs and over $40 billion in indirect societal costs.

The current FY 2010 estimate for the Vaccines for Children (VFC) program is $3.3 billion. Through this budget, VFC will continue to leverage commercial best practices to address all aspects of vaccine procurement, ordering, distribution, and management and achieve efficiencies through the VMBIP. Vaccine management and accountability needs have grown dramatically since the inception of the VFC program. As of June 2008, all 64 immunization program grantees (reflects all Section 317 grantees, 61 of these grantees are eligible to participate in the VFC program) have transitioned to VMBIP's centralized vaccine distribution. VMBIP has increased overall program efficiency through inventory reduction and increased visibility of the location of vaccines throughout the program, enhancing CDC's ability to address public health emergencies such as vaccine shortages. VMBIP also provides accountability at the individual immunization provider level.

State and Local Administration (ADM)

STATE ESTIMATES FOR FY 2010



In November 2008 the States estimated the Federal share of State and local administration outlays to be $10.6 billion for FY 2009 and $10.7 billion for FY 2010. The FY 2010 estimate is composed of $1.9 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 $8.4 billion for salaries, fringe benefits, training, and other State and local administrative costs. These other costs include quality

improvement organizations, pre-admission screening and resident review, nurse aide training and competency evaluation programs, and all other general administrative costs. CMS adjusted the FY 2010 State-submitted estimates of $10.7 to reflect a growth rate more consistent with recent expenditure history and current economic conditions relative to the conditions when States submitted estimates ($1.1 billion). In addition the State estimates were also adjusted to reflect recent legislation (ARRA) ($29.6 million), and recent regulatory actions (ICD-10 regulation, $92.9 million). After these adjustments the FY 2010 estimate for State and local administration is $11.9 billion.

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

Health Information Technology, (HIT) (Section 4201)
(FY 2010 estimate is $29.6 million for State and Local Administration)

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

Adoption of Version 5010 and ICD-10 Medical Data Codes
(FY 2010 estimate is $92.9million)

Version 5010 is an updated version of the health care transactions standard. It is more specific in requiring data that is needed, collected, and transmitted in a transaction. Version 5010 accommodates the ICD-10 code sets and has an earlier compliance date than ICD-10 in order to ensure adequate testing time.

ICD-10 represents a substantial change in the way States will operate their information technology systems. Many State Medicaid programs base their claims payment systems on ICD- 9. The switch from ICD-9 to ICD-10 will expand the number of potential treatment codes from approximately 24,000 to over 200,000. The new classification system provides significant improvements through more detailed information and the flexibility to expand in order to capture additional advancements in medicine by providing greater specificity and clinical information, updates to medical terminology and classification of diseases, and provide better medical data. The ICD-10 code changes to State Medicaid systems associated with implementing ICD-10 include planning activities, gap analysis, business process re-engineering, systems design, development and testing and implementation activities. In addition, States and their providers will see an increased need in staffing levels; internal training; outreach and provider education; support for provider and beneficiary inquiries; and/or external contractor or consultant assistance in supporting the transition. States will also need to re-determine rates for the new coding and develop crosswalks to ICD-10. Providers will also need to be trained on the appropriate coding and billing procedures in order to utilize new coding and claiming methodologies.

<u>Medicaid State Survey and Certification</u>

The purpose of survey and certification inspections for nursing facilities and intermediate care facilities for the mentally retarded in FY 2010 is to ensure that Medicaid beneficiaries

are receiving quality care in a safe environment. The current FY 2010 estimate for Medicaid State survey and certification is $230.6 million. This represents an increase of $3.8 million above the current FY 2009 estimate of $226.8 million. This increased funding level includes monies to support increasing workload requirements, costs associated with survey and certification activities covering over 21,000 Medicaid participating facilities with nearly 22,000 health and life safety code annual certifications as well as over 48,000 complaint survey investigations, and direct State survey costs associated with nursing home quality.

State Medicaid Fraud Control Units (MFCUs)

The Medicaid Fraud Control Units mission is to investigate and prosecute Medicaid provider fraud and patient abuse and neglect. In FY 2010, State Medicaid fraud control unit operations are estimated to require $205.1 million. This represents an increase of $9.8 million over the estimated FY 2009 funding level of $195.3 million. Currently, 49 States and the District of Columbia participate in the Medicaid fraud control unit grant program.

Although the cases that the MFCUs engage in the abuse and neglect of beneficiaries in Medicaid sponsored facilities usually would not result in monetary gains to the State Medicaid programs, the pursuit of such cases by the SMFCUs is necessary in providing a measure of protection to vulnerable Medicaid beneficiaries.

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

Impact of Proposed Legislation

1. Home Visitation

   This Administration for Children and Families (ACF) proposal creates a Home Visitation program, using mandatory funding, which would provide funds to States for evidence-based home visitation programs for low-income families, many of which are enrolled in Medicaid. Research including several randomized control trial studies showed one particular model of home visitation resulted in Medicaid savings from reductions in preterm births, emergency room use and subsequent births. Expanding home visitation programs is estimated to save Medicaid $77 million over five years and $664 million over ten years. There are also minimal savings for CHIP $4 million over five and ten years.

   Five-year budget savings for Medicaid: $77 million

   Five-year budget savings for CHIP: $4 million

	FY 2009	FY 2010
Home Visitation		-$1,200,000
TOTAL		-$1,200,000

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
MCD 1.1: Estimate the Payment Error Rate in the Medicaid Program	FY 2007: Goal Met (Target Met)	Report national error rates in FY 2010 PAR based on 17 States measured in FY 2009.	Report national error rates in the FY 2011 PAR based on 17 States measured in FY 2010	N/A
MCD 1.2: Estimate the Payment Error Rate in CHIP	FY 2008: Goal not met. Calculation of error rates suspended pending publication of final regulation (Target Not Met)	Publish Final Regulation in accordance with Section 601 of CHIPRA	Report national error rates in the FY 2011 PAR based on 17 CHIP States measured in FY 2010	N/A
MCD 2: Increase the Number of States that Have the ability to Assess Improvements in Access and Quality of Health Care through Implementation of the Medicaid Quality Improvement Program.	FY 2008: 8 States (Target Met)	9 States	10 States	+1
MCD 3: Percentage of Beneficiaries in Managed Care Organizations and Health Insuring Organizations (MCOs+HIOs)	FY 2007: 45.6% (Baseline)	46%	47%	+1
MCD 4: Percentage of Beneficiaries who Receive Home and Community-Based Services	N/A	3% over prior FY	3% over prior FY	Maintain
MCD 5: Percentage of Section 1115 demonstration budget neutrality reviews completed	FY 2006: 100% (Baseline)	94%	96%	+2
Program Level Funding ($ in millions)	N/A	$220,432,703	$249,952,903	+29,520,200
Recovery Act Level Funding ($ in millions)	N/A	$ 36,715,000	$ 42,709,600	+5,994,600

FY 2010 MANDATORY STATE/FORMULA GRANTS
(dollars in thousands)
CFDA No/Program Name: 93.778 Medical Assistance Program+ARRA

State/Territory	FY 2008 Estimate	FY 2009 Estimate	FY 2010 Estimate	Difference +/- 2009
Alabama	$2,933,298	$3,012,424	$3,170,548	$158,124
Alaska	693,060	798,022	848,087	50,065
Arizona	5,241,442	6,409,014	6,878,380	469,366
Arkansas	2,608,079	2,990,829	3,199,082	208,253
California	22,901,995	28,390,714	29,368,072	977,358
Colorado	1,714,405	2,215,648	2,241,806	26,158
Connecticut	2,333,440	3,293,162	3,239,545	-53,617
Delaware	579,728	748,323	929,881	181,558
District of Columbia	1,099,879	1,298,150	1,316,685	18,535
Florida	8,458,589	10,837,964	10,564,602	-273,362
Georgia	5,235,411	5,975,139	6,162,106	186,967
Hawaii	722,263	913,753	867,644	-46,109
Idaho	885,347	1,077,845	1,175,495	97,650
Illinois	6,214,988	6,990,705	7,368,001	377,296
Indiana	4,092,440	4,468,291	4,884,752	416,461
Iowa	1,771,595	2,121,295	2,282,465	161,170
Kansas	1,464,864	1,637,856	1,631,522	-6,334
Kentucky	3,581,586	3,997,622	4,148,728	151,106
Louisiana	4,574,560	5,179,171	5,562,554	383,383
Maine	1,518,266	1,782,635	1,751,560	-31,075
Maryland	3,081,523	3,943,487	4,144,026	200,539
Massachusetts	6,313,281	7,736,916	7,275,508	-461,408
Michigan	6,088,555	7,535,642	7,728,651	193,009
Minnesota	3,763,920	4,674,179	5,040,801	366,622
Mississippi	3,161,235	3,385,595	3,660,881	275,286
Missouri	4,809,741	5,509,576	6,057,919	548,343
Montana	618,669	663,198	675,511	12,313
Nebraska	1,012,736	1,165,013	1,232,644	67,631
Nevada	745,911	936,238	1,007,799	71,561
New Hampshire	690,611	794,644	849,990	55,346
New Jersey	5,057,379	5,882,319	6,210,589	328,270
New Mexico	2,319,457	2,578,072	2,741,928	163,856
New York	24,442,430	31,166,299	32,190,544	1,024,245
North Carolina	6,758,759	7,946,996	8,450,197	503,201
North Dakota	401,451	433,946	458,823	24,877
Ohio	8,280,589	9,973,509	10,582,491	608,982
Oklahoma	2,543,972	2,962,718	2,987,294	24,576
Oregon	2,141,336	2,710,755	2,783,514	72,759
Pennsylvania	9,393,774	11,402,051	11,875,203	473,152
Rhode Island	996,847	1,209,306	1,237,689	28,383
South Carolina	3,078,094	3,441,966	3,443,670	1,704
South Dakota	457,444	506,011	505,998	-13

FY 2010 MANDATORY STATE/FORMULA GRANTS
(dollars in thousands)
CFDA No/Program Name: 93.778 Medical Assistance Program+ARRA

State/Territory	FY 2008 Estimate	FY 2009 Estimate	FY 2010 Estimate	Difference +/- 2009
Tennessee	4,984,871	5,319,105	5,690,759	371,654
Texas	14,979,886	16,267,411	16,940,954	673,543
Utah	1,125,224	1,317,364	1,430,564	113.200
Vermont	660,848	787,399	806,697	19,298
Virginia	2,889,595	3,105,271	3,340,665	235,394
Washington	3,688,210	4,976,351	5,299,604	323,253
West Virginia	1,785,678	2,020,068	2,117,311	97,243
Wisconsin	3,288,507	3,905,755	4,088,361	182,606
Wyoming	274,064	305,629	341,498	35,869
Subtotal	**208,477,832**	**248,701,351**	**258,789,598**	**10,088,247**
American Samoa	8,620	12,017	12,017	0
Guam	12,748	18,503	18,503	0
Northern Mariana Islands	4,779	6,600	6,600	0
Puerto Rico	280,612	406,464	406,464	0
Virgin Islands	15,006	18,901	18,901	0
Subtotal	**321,765**	**462,485**	**462,485**	**0**
Total States/Territories	**208,799,597**	**249,163,836**	**259,252,083**	**10,088,247**
Survey & Certification	207,370	226,791	230,646	3,855
Fraud Control Units	186,000	195,300	205,065	9,765
Vaccines for Children	2,719,702	3,377,911	3,323,770	-54,141
Medicare Part B Transfer	396,612	475,000	562,500	87,500
Incurred But Not Reported	2,405,387	3,747,000	2,899,000	-848,000
VFC Collection	105	0	0	0
Adjustments	(700,036)	9,425,225	26,751,939	17,326,684
TOTAL RESOURCES	**$214,014,737**	**$266,611,063**	**$293,225,003**	**$26,613,940**

Medicaid Program
Budget Authority by Object

	2009 Estimate	2010 Estimate	Increase or Decrease
CMS - Grants to States			
Grants to States, Subsidies and Contributions	$253,769,792,000	$289,338,733,000	$35,568,941,000
CDC - Vaccines For Children			
Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance	$3,377,911,000	$3,323,770,000	($54,141,000)
Total Budget Authority	$257,147,703,000	$292,662,503,000	$35,514,800,000

Medicaid Program
Medicaid Requirements
(dollars in thousands)

	2009 Estimate	2010 Estimate
November 2008 State Estimates		
MAP and ADM	$217,736,895	$226,236,893
State Certification	226,791	230,646
Fraud Control Units	195,300	205,065
Total Unadjusted Estimates	$218,158,986	$226,672,604
Adjustments		
American Recovery and Reinvestment Act (ARRA)	$36,715,000	$43,122,100
Medicare Improvement for Patients & Providers Act, P.L. 110-275	200,000	242,500
Fostering Connections to Success Act of 2008, P.L. 110-351	15,000	15,000
Emergency Economic Stabilization Act of 2008, P.L.110-343	10,000	60,000
State and Local Administration Financial Adj.	938,433	1,103,404
QI Supplemental Funding, P.L. 110-379	0	-5,000
Obligations Incurred But Not Reported	2,522,000	2,719,000
CHIPRA, P.L. 111-3	150,000	501,000
5010/ICD-10	19,061	92,922
Financial Management Reviews	-500,000	-546,000
Actuarial adjustments	5,004,672	15,982,703
Supplemental Appropriations Act, 2008, P.L. 110-252	0	-59,000
Total Adjustments	45,074,166	63,228,629
Vaccines For Children Program	$3,377,911	$3,323,770
Current Law Requirement	$266,611,063	$293,225,003
Unobligated Balances		
Start of Year	-8,988,360	0
End of Year	0	0
Gross Budget Authority	$257,622,703	$293,225,003
Offsetting Collections	-475,000	-562,500
Appropriation/Net Budget Authority	$257,147,703	$292,662,503

MEDICAID

(State-Submitted Estimates with Actuary Adjustments)

MEDICAL ASSISTANCE PAYMENTS BY TYPE OF SERVICE CATEGORY

(dollars in thousands)

	FY 2009 Amount	FY 2009 Percentage	FY 2010 Amount	FY 2010 Percentage
Insurance Payments - MCOs	38,689,911	18.68%	$41,744,835	19.37%
Nursing Facility	28,797,767	13.91%	29,970,223	13.91%
Inpatient Hospital - Regular Payments	28,440,608	13.73%	28,687,010	13.31%
Home and Community Based Care	18,877,639	9.12%	19,727,795	9.15%
Prescribed Drugs	15,053,177	7.27%	16,507,781	7.66%
All Other	9,352,341	4.52%	9,882,090	4.59%
Outpatient Hospital	7,926,031	3.83%	7,970,645	3.70%
Inpatient Hospital DSH	8,062,593	3.89%	7,820,184	3.63%
Physician	6,965,331	3.36%	7,059,754	3.28%
Personal Care	6,545,704	3.16%	6,708,050	3.11%
Insurance Payments - Part B Premiums	5,085,553	2.46%	5,216,945	2.42%
Clinic	4,940,114	2.39%	4,724,954	2.19%
ICF/MR Public	4,889,506	2.36%	5,227,087	2.43%
Insurance Payments - Prepaid Health Plans	4,548,419	2.20%	4,519,483	2.10%
Mental Health Facilities	2,979,494	1.44%	3,022,698	1.40%
ICF/MR Private	2,579,312	1.25%	2,698,323	1.25%
Dental	2,497,147	1.21%	2,628,081	1.22%
Home Health	2,103,158	1.02%	2,244,498	1.04%
Mental Health Facilities - DSH	1,788,470	0.86%	1,795,247	0.83%
Targeted Case Management	1,693,464	0.82%	1,779,271	0.83%
Insurance Payments - Part A Premiums	1,618,388	0.78%	1,700,879	0.79%
Other Practitioners	1,570,131	0.76%	1,602,363	0.74%
Federal Qualified Health Center	1,347,316	0.65%	1,390,632	0.65%
Hospice	1,297,072	0.63%	1,377,190	0.64%
Insurance Payments - Medicaid Other	1,267,350	0.61%	1,497,573	0.69%
Lab & Radiological	908,973	0.44%	945,542	0.42%
EPSDT Screening Services	667,348	0.32%	710,302	0.33%
Emergency Services Undocumented Aliens	548,738	0.26%	593,771	0.28%
Insurance Payments - Group Health Plan	498,369	0.24%	529,715	0.25%
Medicare Coins & Deduct	452,160	0.22%	494,185	0.23%
Rural Health Clinics	381,164	0.18%	440,083	0.20%
Functionally Disabled Elderly	369,881	0.18%	382,051	0.18%
Program of All-Inclusive Care Elderly	271,896	0.13%	286,338	0.13%
Primary Care Case Management Services	86,315	0.04%	88,196	0.04%
Sterilizations	67,601	0.03%	65,547	0.03%
Medicaid Coins & Deduct - Group Health	8,337	0.00%	8,305	0.00%
Abortions	75	0.00%	75	0.00%
Collections and Adjustments	(1,003,208)	-0.48%	(1,178,920)	-0.55%
Drug Rebate Offset	(5,078,317)	-2.45%	(5,351,484)	-2.48%

MEDICAID

(State-Submitted Estimates with Actuary Adjustments)

MEDICAL ASSISTANCE PAYMENTS BY TYPE OF SERVICE CATEGORY

(dollars in thousands)

	FY 2009 Amount	FY 2009 Percentage	FY 2010 Amount	FY 2010 Percentage
Total State-Submitted Estimates	$207,095,328	100.00%	$215,517,297	100.00%
Part B Premiums - Qualified Individual Program	475,000		562,500	
Actuary Adjustments	4,529,672		15,420,203	
Total	$212,100,000		$231,500,000	

Payments to the Health Care Trust Funds

Appropriations Language

For payment to the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as provided under sections 217(g), 1844, and 1860D-16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, section 278(d) of Public Law 97-248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, **[**$195,383,000,000**]** *$207,231,070,000*.

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

Payments to the Health Care Trust Funds

Language Analysis

Language Provision	Explanation
For payment to the Federal Hospital Insurance and the Federal Supplementary Medical Insurance Trust Funds, as provided under sections 217(g), 1844 and 1860D-16 of the Social Security Act, sections 103(c) and 111(d) of the Social Security Amendments of 1965, section 278(d) of Public Law 97-248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, $207,231,070,000.	Provides a one-year appropriation from general revenues to make the HI and SMI Trust funds whole for certain costs initially borne by the trust funds which are properly charged to general funds, and to provide the SMI Trust Fund with the general fund contribution for the cost of the SMI program.
In addition, for making matching payments under section 1844, and benefit payments under section 1860D-16 of the Social Security Act, not anticipated in budget estimates, such sums as may be necessary.	Provides indefinite authority for paying the general revenue portion of the Part B premium match and provides resources for the Part D prescription drug benefit program in the event that the annual appropriation is insufficient.

Payments to the Health Care Trust Funds

Amounts Available for Obligation

	FY 2008 Appropriation	FY 2009 Appropriation	FY 2010 Estimate
Appropriation: Annual	$188,445,000,000	$195,383,000,000	$207,231,070,000
Lapse in Supplemental Medical Insurance	-816,139,000	---	--
Indefinite Annual Appropriation	5,000,000,000	2,361,000,000	--
Lapse in General Revenue Part D: Federal Administration	-354,972,000	-51,000,000	--
Adjustment in Expired Accounts	---	---	---
Lapse in General Revenue Part D: Benefits	-11,141,672,000	-167,000,000	--
Lapse in Quinquennial Adjustment	---	-42,000,000	---
Total Obligations	$181,132,217,000	$197,484,000,000	$207,231,070,000

Payments to the Health Care Trust Funds

Summary of Changes

2009 Appropriation

Total Budget Authority - $197,744,000,000

2010 Estimate

Total Budget Authority - $207,231,070,000

Net Change - + $9,487,070,000

Changes	FY 2009 Appropriation	Change from Base Budget Authority
Federal Payment for Supplementary Medical Insurance	$147,716,000,000	+ $5,344,000,000
Indefinite Annual Appropriation	2,361,000,000	(2,361,000,000)
Hospital Insurance for the Uninsured	351,000,000	(765,000,000)
Hospital Insurance for Uninsured Federal Annuitants	263,000,000	+9,000,000
Program Management Administrative Expenses	281,000,000	+ 57,070,000
General Revenue for Part D (Drug) Benefit	44,999,000,000	+8,181,000,000
General Revenue for Part D Federal Administration	547,000,000	(63,000,000)
Part D: State Low-Income Determination	---	---
Reimbursement for HCFAC	198,000,000	+113,000,000
Quinquennial Adjustment	1,028,000,000	(1,028,000,000)
Net Change	$197,744,000,000	+ $9,487,070,000

Payments to the Health Care Trust Funds

Budget Authority by Activity

(Dollars in thousands)

	FY 2008	FY 2009	FY 2010
Supplementary Medical Insurance	$140,704,000	$147,716,000	$153,060,000
Indefinite Annual Appropriation	5,000,000	2,361,000	
Indefinite Authority for Supplementary Medical Insurance under “such sums”	---	---	---
Hospital Insurance for Uninsured	269,000	351,000	(414,000)
Hospital Insurance for Uninsured Federal Annuitants	237,000	263,000	272,000
Program Management Administrative Expenses	192,000	281,000	338,070
General Revenue for Part D Benefit	46,299,000	44,999,000	53,180,000
General Revenue for Part D Federal Administration	744,000	547,000	484,000
Part D: State Low-Income Determination	---	---	---
Reimbursement for HCFAC	---	198,000	311,000
Quinquennial Adjustment	---	1,028,000	---
Total Budget Authority	$193,445,000	$197,744,000	$207,231,070

Payments to the Health Care Trust Funds

Authorizing Legislation

	2009 Amount Authorized	2009 Budget Estimate	2010 Amount Authorized	2010 Budget Estimate
Payments to the Health Care Trust Funds (sections 217(g), 201(g), 1844, and 1860D-16 of the Social Security Act, section 103(c) of the Social Security Amendments of 1965, and section 278(d) of Public Law 97-248)	$197,744,000,000	$197,744,000,000	N/A	$207,231,070,000
Total Budget Authority	$197,744,000,000	$197,744,000,000	N/A	$207,231,070,000

Annual Budget Authority by Activity

	FY 2008 Appropriation	FY 2009 Appropriation	FY 2010 Estimate	FY 2010 +/- FY 2009
BA	$193,445,000,000	$197,744,000,000	$207,231,070,000	+$9,487,070,000

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

Allocation Method - Direct federal/intramural

Program Description and Accomplishments

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

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

Hospital Insurance for the Uninsured: This includes Medicare benefits, administrative costs, and related interest for payments made on behalf of beneficiaries who were not insured for Medicare at the beginning of the program but were deemed to be so under transitional provisions of the law; and

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

This appropriation also reimburses the HI Trust Fund for:

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

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

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

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

Quinquennial Adjustment

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

Funding History

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

FY 2005	$114,608,900,000
FY 2006	$177,742,200,000
FY 2007	$188,389,975,000
FY 2008	$193,445,000,000
FY 2009	$197,744,000,000

Budget Request

Hospital Insurance for the Uninsured

The FY 2010 estimate of -$414 million for Hospital for the Uninsured is $765 million less than the FY 2009 appropriated request of $351 million. This represents an historical adjustment for the costs of this diminishing group.

Hospital Insurance for the Uninsured Federal Annuitants

The FY 2010 estimate of $272 million for Hospital Insurance for Uninsured Federal Annuitants is $9 million more than the FY 2009 appropriated request of $263 million.

Program Management Administrative Expenses

The FY 2010 estimate of $338 million to reimburse the HI Trust Fund for Program Management administrative expenses not attributable to Medicare, is $57 million more than the FY 2009 appropriated request of $281 million.

Federal Contribution for SMI

The estimate of $153.0 billion for the FY 2010 Federal Contribution for SMI is a net increase of $5.3 billion over the FY 2009 appropriated request. The cost of the Federal match continues to rise from year to year because of beneficiary and program cost growth.

General Revenue for Part D (Benefits)

The FY 2010 estimate of $53.2 billion for General Revenue for Part D (Benefits) is $8.2 billion more than the FY 2009 appropriated request of $45 billion. This estimate reflects updated data on the Part D benefit and the ability to begin using some actual data in actuarial estimates.

General Revenue for Part D Federal Administration

The FY 2010 estimate of $484 million for General Revenue for Part D Federal Administration is $63 million less than the FY 2009 appropriated request of $547 million. This decrease represents increased experience in Part D Federal Administration, resulting in lower costs.

Permanent Budget Authority

(dollars in thousands)

	FY 2008 Appropriation	FY 2009 Appropriation	FY 2010 Estimate	FY 2010 +/- FY 2009
Tax on OASDI Benefits	$11,733,000,000	$12,147,000,000	$15,344,000,000	+ $3,197,000,000
SECA Tax Credits	33,000	---	---	---
HCFAC, FBI	120,937,000	126,258,242	126,258,242	---
HCFAC, Criminal Fines	5,340,000	200,000,000	200,000,000	---
HCFAC, Civil Penalties and Damages: Administration	16,431,000	10,000,000	10,000,000	---
General Revenue for Transitional Drug Assistance Account	42,000	---	---	---
Transitional Assistance Outlays for Benefits (non-add)	42,000	---	---	---
Total BA	$11,875,783,000	$12,483,258,242	$15,680,258,242	+ $3,197,000,000

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

Allocation Method - Direct federal/intramural

Program Description and Accomplishments

A permanent indefinite appropriation of general funds for the taxation of Social Security benefits is made to the HI Trust Fund through the Payments to the Health Care Trust Funds account. In addition, the following permanent appropriations associated with the Health Care Fraud and Abuse Control (HCFAC) account will pass through the Payments to the Health Care Trust Funds account: FBI, criminal fines, and civil monetary penalties. FBI activities include prosecuting health care matters, investigations, financial and performance audits, inspections, and other evaluations. Criminal fines and civil monetary penalties are fines collected from health care fraud cases and reported as appropriations from the trust fund for HCFAC activities. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 provided funds for transitional assistance to low income beneficiaries under the Transitional Prescription Drug Card program until FY 2006. There is no new budget authority after FY 2006, and final Transitional Assistance benefit outlays from the General Fund were made in FY 2007. Administrative outlays for Transitional Assistance may continue into FY 2008.

Payments to the Health Care Trust Funds
Budget Authority by Object

	FY 2008 Appropriation	FY 2009 Appropriation	FY 2010 Estimate
Grants, subsidies and contributions: Non-Drug	$140,704,000,000	$147,716,000,000	$153,060,000,000
Indefinite Annual Appropriation	5,000,000,000	2,361,000,000	---
Lapse in Supplementary Medical Insurance [Estimated; non-add]	-816,139,000	---	---
Grants, subsidies and contributions: Drug	46,299,000,000	44,999,000,000	53,180,000,000
Lapse in Part D: Benefits [Estimated; non-add]	-11,141,672,000	---	---
Insurance claims and indemnities	506,000,000	614,000,000	-142,000,000
Administrative costs-General Fund Share	936,000,000	1,026,000,000	1,133,070,000
Lapse in Part D: Federal Administration [Estimated; non-add]	-354,972,000	-51,000,000	---
Adjustment in Expired Accounts	---	---	---
Quinquennial Adjustment	---	1,028,000,000	---
Total Budget Authority	$193,445,000,000	$197,744,000,000	$207,231,070,000

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Medicare Benefits

	FY 2008 Appropriation	FY 2009 Appropriation	FY 2010 Estimate	FY 2010 + / - FY 2009
Outlays	$454,300,596,000	$497,012,000,000	$515,832,000,000	+$18,820,000,000

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

Authorizing Legislation - Title XVIII of the Social Security Act

FY 2009 Authorization - Indefinite

Allocation Method - Direct Federal

Program Description and Accomplishments

Established in 1965 as title XVIII of the Social Security Act, Medicare was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people aged 65 and over. In 1972, the program was expanded to cover the disabled, people with end-stage renal disease (ESRD) requiring dialysis or kidney transplant, and people age 65 or older who elect Medicare coverage. In December 2003, the President signed the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), P.L. 108-173, which was designed to improve and modernize the Medicare program, including the addition of a drug benefit. Based on current efforts to implement the American Recovery and Reinvestment Act of 2009 (ARRA), P.L. 111-5, Medicare will add significant new funding and incentives for physician and hospital expansion in electronic health records and quality information, beginning in FY 2011. Implementation of these ARRA provisions will build on Medicare's ongoing transformation into an active purchaser of high quality services. Refer to ARRA chapter for more information.

Medicare processes over one billion fee-for-service (FFS) claims a year and is the Nation's largest purchaser of health care (and within that, of managed care), and accounts for approximately 14 percent of the Federal Budget. Medicare is a combination of four programs: Hospital Insurance, Supplementary Medical Insurance, Medicare Advantage, and the Medicare Prescription Drug Benefit. Since 1966, Medicare enrollment has increased from 19 million to over 98 million beneficiaries in 2010.

Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. The HI program pays for hospital, skilled nursing facility, home health, and hospice care and is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the HI trust fund, and invested in U.S. Treasury securities.

Supplementary Medical Insurance, also known as SMI or Medicare Part B and Medicare Part D, is voluntary and available to nearly all people aged 65 and over, the disabled, and people with ESRD who are entitled to Part A benefits. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy, outpatient prescription drugs, and other services not covered by HI. The SMI coverage is optional and beneficiaries are subject to monthly premium payments. Beginning January, 2007, Part B premiums are income-related for individuals with incomes greater than $80,000.00 or couples with income(s) greater than $160,000.00. About 94 percent of HI enrollees elect to enroll in SMI to receive Part B benefits. The SMI program is financed primarily by transfers from the general fund of the U.S. Treasury and by monthly premiums paid by beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the SMI trust fund, and invested in U.S. Treasury securities.

The Medicare Advantage (MA) program, also known as Medicare Part C, created in 2003 by the MMA, is designed to provide more health care coverage choices for Medicare beneficiaries. Those who are eligible because of age (65 or older) or disability may choose to join an MA plan if they are entitled to Part A and enrolled in Part B, if there is a plan available in their area. Those who are eligible for Medicare because of ESRD may join an MA plan only under special circumstances. All MA plans are currently paid a per capita premium, and must provide all Medicare covered services. Further, with the exception of regional preferred provider organizations, MA plans assume full financial risk for care provided to their Medicare enrollees. Many MA plans offer additional services such as prescription drugs, vision, and dental benefits to beneficiaries, which are not available under Part A or B. MA plans have an estimated 10.7 million enrollees in 2009.

The Prescription Drug Benefit Program also was created by the MMA, and constitutes the most significant change to the Medicare program since its inception in 1965. The prescription drug benefit is funded through the SMI account and provides for an optional prescription drug benefit (Medicare Part D) for individuals who are entitled to or enrolled in Medicare benefits under Part A and Part B. Beneficiaries who qualify for both Medicare and Medicaid (“dual eligibles”) automatically receive the Medicare drug benefit. The statute also provides for assistance with premiums and cost sharing to full benefit dual-eligibles and qualified low-income beneficiaries. In general, coverage for this benefit is provided under private prescription drug plans, which offer only prescription drug coverage, or through Medicare Advantage plans which integrate prescription drug coverage with the general health care coverage they provide to Medicare beneficiaries. In addition, plan sponsors of employer and union plans offering a prescription drug benefit that is actuarially equivalent to Part D are able to apply for the retiree drug subsidy program to fund some of their costs. Part D benefits are funded through premiums paid by beneficiaries and general fund subsidies.

Passage of the MMA prompted modifications in the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) to include measurement of experience and satisfaction with the care and services provided through the new Medicare Prescription Drug Plans as well as the Medicare Advantage (MA) and Medicare Fee for Service (MFFS). As a result, we developed four related measures to monitor beneficiary satisfaction with access to medical care and prescription drugs for both MA and MFFS. The four specific measures are as follow:

- Percent of persons with Medicare Advantage (MA) Plans report they usually or always get needed care right away as soon as they thought they needed it

- Percent of persons with Medicare Fee-for-Service (MFFS) report they usually or always get needed care right away as soon as they thought they needed it

- Percent of persons with MA Plans report that it is usually or always easy to use their health plan to get the medicines their doctor prescribed

- Percent of persons with MFFS and a standalone drug plan report it is usually or always easy to use their Medicare prescription drug plan to get the medicines their doctor prescribed

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

Outlays History

FY 2004	$295,336,410,000
FY 2005	$333,426,214,000
FY 2006	$375,174,976,000
FY 2007	$434,591,000,000
FY 2008	$454,300,596,000
FY 2009*	$497,012,000,000
*Under Current law	

Budget Estimates

The budget estimates for Medicare benefits for FY 2010, by trust fund account, is shown in the following table.

	Amount	Increase over FY 2009
HI	$251,203,000,000	$9,337,000,000
SMI – Part B	$200,498,000,000	$221,000,000
SMI – Part D	$64,131,000,000	$9,262,000,000
Total	$515,832,000,000	$18,820,000,000

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

The estimate for FY 2010 is an increase of $18,820,000,000 over FY 2009. The increase is due to growth in enrollment, services costs, and utilization.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
MCR 1.1a: Percent of beneficiaries in Medicare Advantage (MA) who report access to care	FY 2008: 90% (Target Met)	90%	90%	Maintain
MCR 1.1b: Percent of beneficiaries in Medicare fee-for-service (MFFS) who report access to care.	FY 2008: 90% (Target Met)	90%	90%	Maintain
MCR 1.2a: Percent of beneficiaries in MA who report access to prescription drugs.	FY 2008: 93% (Target Exceeded)	91%	91%	Maintain
MCR 1.2b: Percent of beneficiaries in MFFS who report access to prescription drugs.	FY 2008: 91% (Target Exceeded)	90%	91%	+1
Program Level Funding	N/A	$497,012,000,000	$515,832,000,000	$18,820,000,000

Children's Health Insurance Program

	FY 2008 Appropriation	FY 2009[1] Appropriation	FY 2010 Appropriation	FY 2010 +/- FY 2009
State allotments (CHIPRA of 2009, P.L. 111-3)		$10,562,000,000	$12,520,000,000	$1,958,000,000
Medicare, Medicaid and CHIP Extension Act of 2007, P.L 110-173	$5,040,000,000			
Additional funding for States	$1,600,000,000			
Total Budget Authority for State Allotments	**$6,640,000,000**	**$10,562,000,000**	**$12,520,000,000**	**$1,958,000,000**
FY 2005/8 (Available through FY 2008)	$106,975,320			
FY 2006/9 (Available through FY 2009)		$38,299,548		
CHIP Performance Bonus Payments (P.L. 111-3)	-	$3,225,000,000	$3,185,000,000	-$40,000,000
Child Health Quality Improvement (P.L. 111-3)	-	$45,000,000	$45,000,000	-
Total Budgetary Resources	**$6,746,975,320**	**$13,870,299,548**	**$15,750,000,000**	**$1,918,000,000**
Total Outlays	**$6,900,071,000**	**$8,466,000,000**	**$9,895,000,000**	**$1,429,000,000**

Child Enrollment Contingency Fund

	FY 2008 Appropriation	FY 2009 Appropriation	FY 2010 Appropriation	FY 2010 +/- FY 2009
Child Enrollment Contingency Fund[2]	-	$2,112,400,000	$2,064,826,000	-$47,574,000
Interest		$52,426,000	$68,160,000	$15,734,000
Total Budgetary Resources	-	**$2,164,826,000**	**$2,132,986,000**	**-$31,840,000**
Total Outlays	-	**$100,000,000**	**$200,000,000**	**$100,000,000**

[1] CHIPRA reduces the time-frame for States to spend their allotments from 3 years to 2 years for FY 2009 and beyond.

[2] The Child Enrollment Contingency Fund will be set up as a separate interest-bearing account in the United States Treasury Department.

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

FY 2010 Authorization - Funding expires after September 30, 2013

Allocation Method - Formula Grants

Program Description and Accomplishments

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

In 2007, ten years after CHIP was created, States reported that 7.1 million children were enrolled in the program. CHIPRA legislation, which reauthorized CHIP through September 30, 2013, increased funding by $44 billion through 2013 to maintain State programs and to cover more insured children. In response to the funding increase, CMS developed a performance measure to decrease the number of uninsured children by working with States to enroll children in CHIP. We exceeded our FY 2008 target to increase enrollment by 2 percent over the FY 2006 baseline enrollment figure. The FY 2006 baseline was 6,600,000 and our FY 2008 result was 7,368,479, an increase of over 11 percent. Since CMS substantially exceeded its FY 2008 target, we have established FY 2008 as the new baseline beginning with FY 2009. For FY 2009 and FY 2010, we will aim to increase enrollment over the FY 2008 baseline by one percent and five percent, respectively. This long-term measure proposes to steadily increase enrollment through 2013, although enrollment can be affected by States' economic situations, programmatic changes, and reporting accuracy and timeliness.

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

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

- CHIP Performance Bonus Payments – creates an incentive for States to enact policies that promote enrollment and retention of eligible children. States receive bonus payments for the increase on a per child basis equal to a portion of the State's annual Medicaid per capita expenditure on children. Performance bonus payments are funded initially with a $3.2 billion appropriation and in future years by any unobligated national allotment, unexpended State allotments, unexpended set-asides for childless adults, and unexpended Child Enrollment Contingency Fund amounts.

- Child Health Quality Improvement in Medicaid and CHIP – requires the Secretary to identify and publish a recommended core set of child health quality measures for use under Medicaid and CHIP by January 2010. Examples include developing a standardized reporting format that encourages States to voluntarily report information regarding the quality of pediatric health care, encouraging the development and dissemination of a model electronic health record format for children enrolled in the State plan under title XIX or XXI, and several grants and contracts to develop and test these quality measures. A total of $225 million ($45 million per year for FYs 2009-2013) will be appropriated for the Secretary to carry out these activities.

- Child Enrollment Contingency Fund – this fund is established in the Treasury of the United States, and is used to increase allotments to States that exceed their allotment due to a higher-than-expected child enrollment. Beginning in FY 2009, a State may qualify for a contingency fund payment if it projects a funding shortfall for the fiscal year and its average monthly child enrollment exceeds its target average number of enrollees for the fiscal year.

  The fund receives an initial appropriation equal to 20 percent of the FY 2009 national allotment ($2.1 billion). In FYs 2009-2013, the bill appropriates the amount necessary to make payments to eligible States, but not to exceed 20 percent of the total annual appropriation for CHIP. Any amounts in excess of the aggregate cap will be made available for CHIP Performance Bonus Payments. Also, the contingency fund will be invested in interest bearing securities of the United States. The income derived from these investments constitutes a part of the fund.

- Coverage for Pregnant Women - CHIPRA gives States the option to provide coverage to targeted low-income pregnant women under the CHIP State plan if certain conditions are met. Infants born to these women are automatically eligible for Medicaid or CHIP, through age one. States may choose to apply presumptive eligibility to these pregnant women under CHIP.

- Non-Pregnant Childless Adults and Parents of Targeted Low-Income Children - CHIPRA prohibits new demonstrations for childless adults and terminates existing demonstrations for coverage of childless adults funded through CHIP by December 31, 2009. If a current demonstration would expire prior to that date, an extension is available through December 31, 2009, only if requested by September 30, 2009. Under CHIPRA, States with existing demonstrations may also request, by September 30, 2009, a Medicaid demonstration project that meets statutory budget neutrality standards for continued funding and coverage.

  Existing CHIP demonstrations that provide coverage for parents may continue through September 30, 2011. If a State has a demonstration that would expire before

October 1, 2011, the State may request an automatic extension of the demonstration through September 30, 2011. The enhanced FMAP is available under title XXI of the Act for coverage of parents under these conditions for the third and fourth quarters of FY 2009, FY 2010, and FY 2011. CHIPRA then provides limited payments through a block grant for existing demonstrations covering parents through FY 2012 or FY 2013, subject to the demonstration terms and conditions as well as child outreach-related requirements stipulated in statute.

- Dental Benefit Packages - CHIPRA includes new protections to expand coverage of dental services necessary to prevent disease, promote oral health, restore health and function, and treat emergency conditions. These protections may be satisfied through a State-defined dental benefit package or through one of three dental benchmark benefit packages. These dental benchmarks are 1) the supplemental dependent dental plan most frequently selected under the Federal Employees Health Benefit Plan in the past two years (MetLife); 2) the State employee dependent dental benefit that has been selected most frequently by employees seeking dependent coverage in the past two years; or 3) the dental benefit plan provided by the State's largest insured commercial non-Medicaid plan of dependent covered lives that is offered in the State involved.

CHIPRA provisions affecting other accounts include:

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

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

- Improved Availability of Public Information Regarding Enrollment of Children in CHIP and Medicaid – please refer to the Program Management chapter for more detailed information.

- Verification of Declaration of Citizenship or Nationality – please refer to the Medicaid chapter for more detailed information.

- Option to Eliminate 5-Year Ban On Immigrants – please refer to the Medicaid chapter for more detailed information.

- Extension of Medicaid Disproportionate Share Hospital (DSH) Allotments for Tennessee and Hawaii – please refer to the Medicaid chapter for more detailed information.

- The Federal Medical Assistance Percentage (FMAP) provision and Transitioning Childless Adults to Medicaid after CY 2009 – please refer to the Medicaid chapter for more detailed information.

Performance Measurement

CMS is committed to improving quality of care and program integrity in CHIP, as illustrated by our efforts to track and improve performance in these areas. Our past efforts have resulted in dramatic improvement in States' reporting of CHIP health quality performance measures through the Performance Measurement Partnership Project, which is detailed in

the measure to Improve Health Care Quality Across CHIP. CMS met its FY 2008 target; six promising practices were identified and posted to the CMS CHIP promising practices Website. In FY 2009, CMS will concentrate efforts on any State that does not provide quantifiable and measurable performance measures in annual reports. CMS has established a target for FY 2010 to lead efforts to develop a National Quality Framework for the CHIP program. CMS will also develop a consensus-based quality framework that States can use to create high-quality "systems" of care. CMS will engage CHIP directors throughout the country to help develop the framework that will be used as a guide for assessing current State quality programs and future improvements.

Recent CHIPRA legislation appropriated $45 million annually for a number of activities aimed at improving child health quality: establishment of voluntary child health quality measures; demonstration projects for improving child health quality through evaluating new performance measures, health information technology, and provider-based models such as care management; and also development of a model electronic health record. CMS will work with State CHIP Programs to establish a National CHIP Quality Framework to provide guidance on aligning and integrating efforts where feasible, but also determine opportunities for focused efforts to improve health outcomes specific to CHIP as State health information systems and exchanges evolve.

CMS is also aiming to increase program integrity through its nationally implemented Payment Error Rate Measurement (PERM) program. The PERM measurement includes a fee-for-service, managed care and eligibility component for the CHIP program. We are currently developing a regulation addressing CHIP PERM, as required by section 601 of CHIPRA. We expect to continue full implementation of these measurements and to report a national error rate after the regulation is published. A national error rate will be reported no earlier than six months after publication of the regulation.

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

State Allotment Funding History

FY 2002	$3,115,200,000
FY 2003	$3,175,200,000
FY 2004	$3,175,200,000
FY 2005	$4,082,400,000
FY 2006	$4,082,400,000
FY 2007	$5,040,000,000
FY 2008	$6,640,000,000
FY 2009	$10,562,000,000
FY 2010	$12,520,000,000

Budget Request

From FY 1998 through FY 2007, the Balanced Budget Act of 1997 (BBA) (P.L. 105-33) authorized and appropriated $40 billion for CHIP allotments to States, Territories, Commonwealths, and the District of Columbia. The Balanced Budget Refinement Act of 1999 (BBRA) (P.L. 106-113) authorized and appropriated additional funding for CHIP allotments to Commonwealths and Territories. The Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3) authorized funding for States, Commonwealths, and Territories in the amount of $10,562,000,000 in FY 2009 and $12,520,000,000 in FY 2010. Funding to States increased by $44 billion over five years, and $68.9 billion over 10 years. Additional provisions added through CHIPRA include Performance Bonus Payments, the Child Enrollment Contingency Fund, and Child Health Quality Improvement in Medicaid and CHIP. Information regarding additional provisions provided by CHIPRA can be found in the State Grants and Demonstrations, Medicaid, and Program Management chapters.

Proposed Law

The Budget proposes creating a Home Visitation program[3], funded on the mandatory side, which would provide funds to States for evidence-based home visitation programs for low-income families, many of which are enrolled in Medicaid. Research including several randomized control trial studies showed one particular model of home visitation resulted in Medicaid savings from reductions in pre-term births, emergency room use, and subsequent births. Expanding home visitation programs is estimated to save Medicaid $77 million over five years and $664 million over ten years. There are also minimal savings for CHIP in the amount of $4.4 million over five and ten years.

[3] The Home Visitation program is an Administration for Children and Families Program.

OUTCOMES AND OUTPUTS TABLE

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
CHIP 2: Improve Health Care Quality Across CHIP	FY 2008: Goal met. CMS analyzed States' responses to four clinical performance measures and communicated findings to States. Six promising practices from four States were posted to CMS website. CMS provided technical assistance to States and provided States with a reporting "checklist" on performance measures and has included CHIP performance quality improvement information in the Medicaid Quality Assistance reports provided to States. (Target Met)	Work with low performers. A "low performer" is any State that doesn't provide quantifiable and measurable performance measures in their FY 2006 CHIP annual report.	CMS will lead efforts to develop a National Quality Framework for CHIP. The target is to develop a consensus-based quality framework that States can use to create high-quality "systems" of care. States will be able to use the Framework as a guide for assessing their current quality programs and for determining next steps for future improvement.	N/A
CHIP 3: Decrease the Number of Uninsured Children by Working with States to Enroll Children in CHIP*)*	FY 2008: 7,368,479 children (Target Exceeded)	+1% over FY 2008 7,442,164 children	+5% over 2008 7,736,903 children	+294,739
MCD 1.2: Estimate the Payment Error Rate in CHIP	FY 2007: Goal Met (Target Met)	Publish final Regulation in accordance with section 601 of CHIPRA	Report national error rates in the FY 2011 PAR based on 17 CHIP States measured in FY 2010	N/A
Program Level Funding ($ in millions)	N/A	$10,562,000,000	$12,520,000,000	+$1,958,000,000

FY 2009 MANDATORY STATE/TERRITORY FORMULA GRANTS CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program (dollars in Thousands)			
State/Territories	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Estimate**
ALABAMA	**$74,295**	**72,328**	**$140,301**
ALASKA	**15,699**	**11,187**	**$24,565**
ARIZONA	**127,859**	**142,957**	**$171,080**
ARKANSAS	**49,308**	**47,544**	**$133,750**
CALIFORNIA	**790,789**	**789,164**	**$1,552,910**
COLORADO	**71,545**	**71,545**	**$100,696**
CONNECTICUT	**39,891**	**38,810**	**$45,645**
DELAWARE	**11,058**	**12,760**	**$15,096**
D.C.	**11,709**	**12,057**	**$14,180**
FLORIDA	**296,067**	**301,724**	**$356,091**
GEORGIA	**287,179**	**167,924**	**$302,055**
HAWAII	**15,314**	**15,243**	**$20,887**
IDAHO	**24,316**	**23,803**	**$44,515**
ILLINOIS	**390,740**	**208,344**	**$344,562**
INDIANA	**93,469**	**97,385**	**$137,585**
IOWA	**50,231**	**33,177**	**$65,255**
KANSAS	**36,542**	**36,635**	**$57,164**
KENTUCKY	**70,115**	**68,237**	**$126,014**
LOUISIANA	**89,586**	**84,083**	**$207,403**
MAINE	**17,161**	**15,450**	**$39,272**
MARYLAND	**111,401**	**72,403**	**$194,774**
MASSACHUSETTS	**153,634**	**73,335**	**$321,659**
MICHIGAN	**149,383**	**147,082**	**$221,124**
MINNESOTA	**52,819**	**48,613**	**$83,960**
MISSISSIPPI	**84,028**	**60,989**	**$192,939**
MISSOURI	**72,140**	**77,618**	**$158,829**
MONTANA	**15,736**	**15,922**	**$32,989**
NEBRASKA	**21,892**	**21,377**	**$41,955**
NEVADA	**52,056**	**51,072**	**$61,368**
NEW HAMPSHIRE	**10,779**	**10,657**	**$14,845**
NEW JERSEY	**210,050**	**105,519**	**$505,395**
NEW MEXICO	**52,045**	**52,045**	**$280,720**
NEW YORK	**340,807**	**328,680**	**$433,473**
NORTH CAROLINA	**136,117**	**136,117**	**$241,660**
NORTH DAKOTA	**7,738**	**7,889**	**$15,822**
OHIO	**157,997**	**157,858**	**$285,275**
OKLAHOMA	**70,828**	**70,828**	**$151,400**
OREGON	**56,734**	**60,116**	**$100,198**
PENNSYLVANIA	**173,554**	**168,758**	**$310,309**
RHODE ISLAND	**40,939**	**13,958**	**$69,525**
SOUTH CAROLINA	**70,651**	**71,017**	**$106,863**
SOUTH DAKOTA	**10,354**	**10,504**	**$20,656**
TENNESSEE	**97,460**	**99,842**	**$156,629**

FY 2009 MANDATORY STATE/TERRITORY FORMULA GRANTS CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program (dollars in Thousands)			
State/Territories	**FY 2007 Actual**	**FY 2008 Actual**	**FY 2009 Estimate**
VIRGINIA	**94,070**	**90,339**	**$175,860**
WASHINGTON	**79,883**	**79,883**	**$94,284**
WEST VIRGINIA	**27,517**	**25,666**	**$43,263**
WISCONSIN	**69,715**	**69,563**	**$204,276**
WYOMING	**6,942**	**6,373**	**$11,327**
Subtotal - States	**$5,594,361**	**$4,987,500**	**$9,372,502**
		.	
Territories			
PUERTO RICO	**48,090**	**48,090**	**$148,643**
GUAM	**1,838**	**1,838**	**$5,177**
VIRGIN ISLANDS	**1,365**	**1,365**	**$3,329**
AMERICAN SAMOA	**630**	**630**	**$1,332**
N. MARIANA ISLANDS	**578**	**578**	**$1,221**
Subtotal - Territories	**52,501**	**52,500**	**$159,702**
TOTAL ALL	**$5,646,862**	**$5,040,000**	**$9,532,204**
Technical Assistance			
State Penalties			
Contingency Funds			
Other Adjustments *	**43,138**	**1,114,027**	**1,029,796**
Subtotal Adjustments			
Total Resources	**$5,690,000**	**6,154,027**	**10,562,000**

* FY 2007 and FY 2008 include additional funds appropriated in P.L. 110-173 for States that have projected expenditures in excess of available funding, which has been awarded.

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Appropriations Language

Centers for Medicare & Medicaid Services

Health Care Fraud and Abuse Control

In addition to amounts otherwise available for program integrity and program management, [$198,000,000] *$311,000,000, to remain available through September 30, 2011*, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act, of which [$147,038,000] *$220,320,000* shall be for the Medicare Integrity Program at the Centers for Medicare and Medicaid Services, *including administrative costs*, to conduct oversight [of] activities for Medicare Advantage and the Medicare Prescription Drug Program authorized in title XVIII of the Social Security Act[, including] *and for* activities listed in section 1893[(b)] of such Act; of which [$18,967,000] *$29,790,000* shall be for the Department of Health and Human Services Office of Inspector General *to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act*; of which [$13,028,000] *$31,100,000* shall be for the Medicaid and [State] Children's Health Insurance Program ([SCHIP] *CHIP*) program integrity activities; and of which [$18,967,000] *$29,790,000* shall be for the Department of Justice *to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act: Provided*, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year [2009] *2010* shall include measures of the operational efficiency and impact on fraud, waste, and abuse in the Medicare, Medicaid, and [SCHIP] *CHIP* programs for the funds provided by this appropriation. *(Department of Health and Human Services Appropriations Act, 2009.)*

Language Analysis

Language Provision	Explanation
In addition to amounts otherwise available for program integrity and program management, [$198,000,000] *$311,000,000, to remain available through September 30, 2011*, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act,	Authorizes appropriation to be available for obligation over two fiscal years.
of which [$147,038,000] *$220,320,000* shall be for the Medicare Integrity Program at the Centers for Medicare and Medicaid Services, *including administrative costs*, to conduct oversight [of] activities for Medicare Advantage and the Medicare Prescription Drug Program authorized in title XVIII of the Social Security Act[, including] *and for* activities listed in section 1893[(b)] of such Act;	Provides funding, including administrative costs, for the Medicare Integrity Program.
of which [$18,967,000] *$29,790,000* shall be for the Department of Health and Human Services Office of Inspector General *to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act*;	Provides funding for the Office of Inspector General, and limits activities to those authorized under the original HIPAA statute.
of which [$13,028,000] *$31,100,000* shall be for the Medicaid and [State] Children's Health Insurance Program ([SCHIP] *CHIP*) program integrity activities;	Provides funding for Medicaid and CHIP program integrity activities.
and of which [$18,967,000] *$29,790,000* shall be for the Department of Justice *to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act:*	Provides funding for the Department of Justice, and limits activities to those authorized under the original HIPAA statute.
Provided, That the report required by section 1817(k)(5) of the Social Security Act for fiscal year [2009] *2010* shall include measures of the operational efficiency and impact on fraud, waste, and abuse in the Medicare, Medicaid, and [SCHIP] *CHIP* programs for the funds provided by this appropriation. *(Department of Health and Human Services Appropriations Act, 2009.)*	Provides that the annual report on discretionary spending in the HCFAC account include specified information about activities funded from this appropriation.

Health Care Fraud and Abuse Control

Mandatory	FY 2008 Actual	FY 2009 Enacted	FY 2010 Estimate	FY 2010 +/- FY 2009
Medicare Integrity Program (MIP)	$720,000,000	$720,000,000	$720,000,000	$0
Medi-Medi	$36,000,000	$48,000,000	$60,000,000	$12,000,000
FBI	$120,937,000	$126,258,000	$126,258,000	$0
DoJ Wedge	$53,622,000	$55,328,000	$55,328,000	$0
OIG	$169,736,000	$177,205,000	$177,205,000	$0
HHS Wedge	$31,839,000	$33,892,000	$33,892,000	$0
Subtotal	$1,132,134,000	$1,160,683,000	$1,172,683,000	$12,000,000
Discretionary Allocation Adjustment				
Medicare Integrity Program (MIP)	$0	$147,038,000	$220,320,000	$73,282,000
DoJ	$0	$18,967,000	$29,790,000	$10,823,000
OIG	$0	$18,967,000	$29,790,000	$10,823,000
CMS	$0	$13,028,000	$31,100,000	$18,072,000
Subtotal	$0	$198,000,000	$311,000,000	$113,000,000
Total	**$1,132,134,000**	**$1,358,683,000**	**$1,483,683,000**	**$125,000,000**

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

FY 2010 Authorization - Expired

Allocation Method - Other

Program Description and Accomplishments

Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the Health Care Fraud and Abuse Control (HCFAC) program to detect, prevent, and combat health care fraud, waste, and abuse. HCFAC is comprised of three separate funding streams: 1) the Medicare Integrity Program (MIP); 2) the HCFAC account; and 3) the Federal Bureau of Investigation (FBI). MIP includes funding for medical review, benefit integrity, provider and health maintenance organization audits, Medicare secondary payer activities, and provider education and training. The HCFAC account includes funding for the OIG and a "wedge" amount (the difference between the amount OIG receives and the total amount in the account) that is available to the Department of Health and Human Services (HHS) and the Department of Justice (DoJ). The statute requires the Secretary and Attorney General to annually negotiate the HHS and DoJ allocations for the account. The FBI account includes funding for health care fraud enforcement. The Tax Relief and Health Care Act of 2006 (TRHCA) provided a CPI-U inflationary adjustment for fiscal years 2007 through 2010 to the OIG, wedge, and FBI streams, the first increase since 2002.

TRHCA set OIG funding in FY 2007 at a minimum of $160 million plus the CPI-U adjustment.

Reducing fraud, waste, and abuse is a top priority for CMS. We strive in every case to pay the right amount, to a legitimate provider, for covered, reasonable, and necessary services provided in the appropriate setting to an eligible beneficiary. CMS follows four parallel strategies in carrying out our program oversight activities. They are: prevention, early detection, coordination, and enforcement.

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

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

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

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

The Medicare Integrity Program underwent a program assessment in 2002. As a result of the program assessment, CMS continues to develop and implement safeguards to protect the Medicare Advantage (Part C) program and the Medicare prescription drug benefit (Part D) against fraud, waste, and abuse. We also continue implementation of contracting reform authority to move claims processing contractors to performance-based contracts that tie payments to success in reducing the claims payment error rate.

Funding History

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

Budget Request

The FY 2010 request for the Health Care Fraud and Abuse Control program is $1,483,683,000. It is an increase of $125 million above the FY 2009 appropriation. This includes $1,173 million in permanent, mandatory funds and $311 million in discretionary funds.

The HCFAC program has a ten-year history of recouping improper and fraudulent payments and a solid track record on returns to the Medicare trust funds. The historical return on investment for the life of the MIP program has been about 13 to 1. Our HCFAC discretionary cap adjustment proposal is also projected to generate mandatory savings. These funds will supplement existing mandatory HCFAC and Medicaid Program Integrity funds and strengthen HHS and DoJ efforts to combat health care fraud and abuse, predominantly in the Part D drug benefits program, Medicare Advantage, and the Medicaid program.

The following detailed information explains the program activities within HCFAC.

MEDICARE INTEGRITY PROGRAM (MIP)/PROGRAM INTEGRITY

Program Description and Accomplishments

A few examples of Medicare Integrity Program activities include:

Medicare Drug Integrity Contractors (MEDICs): Oversight is an integral part of CMS' financial management strategy, and a high priority is placed on detecting and preventing fraud, waste and abuse (FWA). With the implementation of the Medicare prescription drug benefit, it became necessary for CMS to effectively deal with any issues related to potential FWA in the Part D program and to ensure that they are minimized. CMS developed a Medicare Part D integrity contractor scope of work that strives to address all areas of potential fraud, waste and abuse related to the Part D benefit, including any new or emerging problems. The MEDICs are responsible for performing program safeguard functions to detect and prevent fraud, waste and abuse and to mitigate vulnerabilities associated with Part D.

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

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

Comprehensive Error Rate Testing (CERT): CMS developed the Comprehensive Error Rate Testing (CERT) program to produce Medicare FFS national paid claim error rates specific to contractor, service type, and provider type. The program calls for independent reviewers to periodically review a systematic random sample of claims that are identified after they are accepted into the claims processing system at carriers, fiscal intermediaries, and MACs.

These sampled claims are then followed through the system to their final disposition. The independent reviewers medically review claims that contractors paid; the same independent reviewers validate claims that affiliated contractors/program safeguard contractors

(ACs/PSCs) denied to ensure that the decision was appropriate. The decisions of the independent reviewers are entered into a tracking database. Annual reports are produced that provide the basis for program planning, evaluation and corrective actions.

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

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

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

CMS expects to reduce the national paid claims error rate to 3.4 percent by FY 2010. CMS has maintained great success over the years in reducing the national error rate. In addition to the national error rate, CERT findings include contractor-specific error rates which measure the accuracy of the contractor's claims payments and processing activities. These additional rates allow CMS to quickly identify emerging trends in managing Medicare contractor performance.

One Program Integrity (One PI): One PI --- a project undertaken in FY 2006 --- will, for the first time, provide a centralized source of standardized Medicaid data across multiple States, integrated with data from Medicare Parts A, B, and D. One PI will gather data from a wide variety of sources, transform the data into standard data models (the extract, transform, and load, or ETL, layer), integrate data, add valuable information such as reference data and acceptable practice standards, and store the results in a data repository. Users will access the information through a secure portal, using a standard set of analytic tools. The availability of a centralized source for accessing the tremendous volume of data on claims, providers, and beneficiaries will enable consistent, reliable, and timely analyses. This will, in turn, improve the ability to detect fraud, waste, and abuse in the Medicare and Medicaid programs. This transition will be complete in September 2009 and users will be able to access Medicare NCH data and two States' Medicaid data via the Business Objects and Advantage Suite applications. Funding for FY 2010 will be used to model and load shared systems claims data into the data repository used by One PI, add new system users, perform operations and maintenance on the One PI system, build new Medicare and Medicaid reports, add new analytical tools to the system and work on standardizing Medicaid data.

National Supplier Clearinghouse (NSC): The NSC reviews and processes applications received from organizations and individuals seeking to become suppliers of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) in the Medicare program. This

process includes: a) on-site visits to the prospective supplier to determine that they meet required supplier standards, b) checking that the supplier has all applicable licenses, c) checking that the supplier and its principals are not ineligible by virtue of being on the General Service Administration (GSA) and/or Office of Inspector General (OIG) listings; and, d) checking that the supplier meets the accreditation and surety bond requirements.

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

Fraud Hot Spots: CMS currently has three field offices in high vulnerability areas of the country (New York City, Los Angeles and Miami). In addition to establishing an on-the-ground presence in those areas, the benefit of Program Integrity field offices has been significant due to their ability to have "feet on the street" and get out in the areas which are most impacted by fraud and abuse. Staffs in these offices conduct in-person interviews with beneficiaries and providers to verify whether or not services have been rendered and if those services met Medicare coverage guidelines. They also work with law enforcement to help increase prosecutions and provide direct support to DoJ strike force efforts.

Field office staff can be deployed more rapidly and often less expensively/more efficiently than contractor staff. As CMS employees, they can travel “on demand” without issuing contract modifications and without the high overhead costs associated with contractor activities.

CMS proposes to add 25 additional staff in the field. A dedicated number of these would form a rapid response team which would be deployed to high-risk areas when potential vulnerabilities are identified. These staff will be deployed from the three existing regional field offices, and CMS’ Central Office.

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

1. Coverage Conditions

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

2. Coding Conditions
3. Other (e.g., payment) Conditions

Benefit Integrity (BI): BI activities deter and detect Medicare fraud through concerted efforts with the OIG, the Government Accountability Office, the Department of Justice, and other CMS partners. In support of BI, CMS conducts proactive data analysis to identify patterns of fraud and make appropriate referrals to law enforcement. CMS follows up on beneficiary complaints that indicate fraud, and supports law enforcement as cases are negotiated.

Provider Audit: Auditing is CMS' primary instrument to safeguard payments made to institutional providers who are paid on an interim basis and whose costs are settled through the submission of an annual Medicare cost report. The audit process includes the timely receipt and acceptance of provider cost reports, desk review and audit of those cost reports, and the final settlement of the provider cost reports. In addition, the audit/settlement process determines that providers are paid properly in accordance with CMS regulation and instructions for areas such as Graduate Medical Education, disproportionate share hospital payments, bad debts and other cost reimbursable items. The audit process includes such administrative functions as intermediary hearings and appeals to the Provider Reimbursement Review Board. The audit effort also reviews data reported in the Medicare cost reports for a specific provider type such as end-stage renal dialysis facilities.

HMO Audits: CMS contracts with managed care organizations (MCOs) to provide services to Medicare enrollees on a cost reimbursement basis. The agency determines the monthly payments that are made to these MCOs on a prepayment basis and is responsible for the proper settlements of final cost reports. To ensure accurate reimbursement, CMS contracts with an independent CPA firm to audit cost reports submitted for settlement. CMS' performance goal is to increase the ratio of recoveries to audit dollars spent.

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

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

Program Safeguard Contractors: CMS contracts with 10 program safeguard contractors (PSCs) to perform certain program safeguard functions including benefit integrity work and to a lesser extent, medical review, local provider education and cost report audits.

As part of contracting reform specified in the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the PSC task orders will be aligned with the Medicare Administrative Contractors (MACs) through shifting workload and competition. The contracting strategy being implemented in FY 2008-FY 2009 will create seven Zone Program Integrity Contractors (ZPICs) with an emphasis on designated high-risk fraud

areas. Single contracts (Indefinite Delivery/Indefinite Quantity) will be issued for each zone with separate task orders for: 1) Medicare Parts A, B, durable medical equipment (DME) and home health, 2) Medicare-Medicaid data analysis, 3) Medicare Parts C and D, and 4) cost report audit. This strategy will increase the ability to look at providers across all benefit categories; achieve economies of scale through the consolidation of contractor management; data/IT requirements; facility costs, etc.; streamline CMS costs in acquisition, management and oversight; and, provide for better coordination and fewer resources required for the States.

As of February 2, 2009, three ZPICs have been awarded; Zones 4, 5, and 7. Zones 4 and 7 are fully operational and Zone 5 is currently under a stay of performance due to a protest by one of the offerors. Zones 1 and 2 are still in various phases of the procurement process and are targeted to be awarded in the spring of 2009. Zones 3 and 6 should be awarded prior to September 30, 2009.

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/ZPICs meet on a regular basis with the OIG and DoJ staff. This includes participation in fraud task forces, educational sessions and formal meetings to review the status of cases, discuss identified fraud schemes and ensure that each others needs are met. In addition the PSCs/ZPICs are frequently called upon to perform medical review or data analysis for cases initiated by OIG or the FBI.

Medicare/Medicaid Data Match Project (Medi-Medi): The Medi-Medi program examines the health care claims data from two programs that share many common beneficiaries and providers to look for billing patterns that may be indicative of potential fraud, waste or abuse that may not be evident when provider billings from either program are viewed in isolation.

Discretionary Allocation Adjustment: The FY 2010 Budget includes an increase for the discretionary allocation adjustment to strengthen program integrity in the Medicare and Medicaid programs including: establishing additional HHS Program Integrity Field Offices and regional call centers; increasing funding for program integrity demonstrations; increasing capacity to identify excessive payments in fee-for-service Medicare; development of early warning systems and other intelligent processes for identifying problems, and strengthen program integrity activities in Medicare Advantage and Medicare Part D. The FY 2010 budget also includes a proposal to consolidate Medicare Part A, Medicare Part B, Medicare Advantage, Medicare Part D, and Medicaid program integrity efforts within an Office of Program Integrity, which will report directly to the Administrator.

MIP Budget Request

The FY 2010 request includes mandatory funding of $720,000,000 and discretionary funding of $220,320,000 for MIP, an increase of $73,282,000 over FY 2009. The request includes mandatory funding of $60,000,000 for the Medi-Medi program. The $60,000,000 for Medi-Medi is in addition to the $720,000,000 for MIP.

FEDERAL BUREAU OF INVESTIGATION (FBI)

Program Description and Accomplishments

The FBI is the primary investigative agency involved in the fight against health care fraud that has jurisdiction over both the Federal and private insurance programs. The FBI leverages its resources in both the private and public arenas through investigative partnerships with various Federal, State and local agencies.

Budget Request

The FY 2010 request includes mandatory funding $126,258,000 for the FBI. It is equal to the FY 2009 appropriation.

DEPARTMENT OF JUSTICE WEDGE (DoJ)

Program Description and Accomplishments

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

Budget Request

The FY 2010 request includes mandatory funding of $55,328,000 and discretionary funding of $29,790,000 for DoJ, an increase of $10,823,000 over the FY 2009 level.

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

OFFICE OF INSPECTOR GENERAL (OIG)

Program Description and Accomplishments

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

Budget Request

The FY 2010 request includes mandatory funding of $177,205,000 and discretionary funding of $29,790,000 for OIG, an increase of $10,823,000 over FY 2009.

OIG will use FY 2010 funding for two major purposes. First, they plan to expand the Medicare Fraud and Abuse Task Force model currently in operation in South Florida. Second, OIG will create a health information technology operations center that will provide the technology infrastructure and analytic capabilities for advanced analysis of large volumes of health care data to identify instances of fraud, waste, and abuse. See the OIG's justification for additional information.

HHS WEDGE FUNDING FOR MEDICARE AND MEDICAID CROSSCUTTING PROJECTS

Program Description and Accomplishments

In addition to MIP, CMS also will use resources from the wedge funds to carry out fraud and abuse activities. As noted at the beginning of this section, decisions about wedge funding levels for DoJ and the HHS agencies are made by negotiation and agreement between the Attorney General and the Secretary of HHS. CMS anticipates the continued development of a number of Medicare and crosscutting fraud and abuse projects, as well as the Medicaid projects, using HCFAC funding in FY 2010.

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

Payment Error Rate Measurement (PERM): In FY 2006, CMS nationally implemented the PERM program in order to comply with the Improper Payments Information Act of 2002 (IPIA). PERM enables States to identify the causes of improper payments in their claims payment systems and eligibility processes, and to address them with the appropriate corrective actions. CMS created a 17-State rotation cycle so that each State will participate in PERM once every 3 years. CMS uses a national contracting strategy consisting of three contractors to perform statistical calculations, medical records collection, and medical/data processing review of selected State Medicaid and CHIP fee-for-service (FFS) and managed care claims. Starting in FY 2007, CMS expanded PERM to include reviews of FFS and managed care claims, as well as beneficiary eligibility, in both the Medicaid and CHIP programs.

Budget Request

The FY 2010 request includes mandatory funding of $33,892,000 and discretionary funding of $31,100,000 for HHS Wedge, an increase of $18,072,000 over FY 2009.

In FY 2010 and beyond, CMS will continue to measure fee-for-service and managed care payment error rates for both the Medicaid and CHIP programs. CMS will also calculate and report on beneficiary eligibility error rates for both programs even though the States conduct the actual reviews. Since a full measurement cycle spans 26 months, FY 2010 PERM funding will be used to fund the FY 2009, FY 2010, and FY 2011 measurement cycles. The results of the FY 2010 PERM cycle will be included in the FY 2011 Performance and Accountability Report (PAR). For further information on this performance measure, see the outcomes table in the Medicaid section of this budget document.

Medicaid and CHIP Financial Management: CMS FY 2010 funding for Medicaid and CHIP financial management will be utilized for projects such as: enhancement of the current financial management review of State Medicaid/CHIP programs; and, strengthening financial management staffing.

Budget Proposals to Change the HCFAC Account

For FY 2010, the budget proposes the following changes to the HCFAC account to streamline its administration: (1) splitting the current funding provided jointly to HHS and DoJ into separate funding streams; (2) eliminating the annual negotiations process between the two Departments; and (3) changing the due date of the annual HCFAC report from January 1 to June 1.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
MIP 1: Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program	FY 2008: 3.6% (Target Exceeded)	3.5%	3.4%	-0.1
MIP 4: Percentage of Contractors with an error rate less than or equal to the previous year's national paid claims error rate	FY 2007: 78.7% (Target Exceeded)	90%	95%	+5
Program Level Funding ($ in millions)	**N/A**	**$768**	**$780**	**+ $12**

State Grants and Demonstrations

	FY 2008 Appropriation	FY 2009 Appropriation	FY 2010 Estimate	FY 2010 +/- FY 2009
Ticket to Work and Work Incentives Improvement Act (TWWIIA)				
Sec. 203 – Medicaid Infrastructure Grants	$43,834,000	$45,763,000	$45,763,000	$0
Sec. 204 – Demonstration to Maintain Independence & Employment	$0	$0	$0	$0
Subtotal – TWWIIA	**$43,834,000**	**$45,763,000**	**$45,763,000**	**$0**
Medicare Modernization Act (MMA)				
Federal Reimbursement of Emergency Health Services for Undocumented Aliens	$250,000,000	$0	$0	$0
Subtotal – MMA	**$250,000,000**	**$0**	**$0**	**$0**
Deficit Reduction Act (DRA)				
Site Development Grants-Rural Programs of All-Inclusive Care for the Elderly (PACE)	$0	$0	$0	$0
Drug Surveys & Reports[1]	$5,000,000	$5,000,000	$5,000,000	$0
Expansion of State Long-Term Care (LTC) Partnership Program	$3,000,000	$3,000,000	$3,000,000	$0
Alternate Non-Emergency Network Providers	$0	$0	$0	$0
Demonstration Projects Regarding Home and Community-Based Alternatives to Psychiatric Residential Treatment Facilities for Children	$37,000,000	$49,000,000	$53,000,000	+$4,000,000
Money Follows the Person (MFP) Demonstration	$298,900,000	$348,900,000	$398,900,000	+$50,000,000

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

	FY 2008 Appropriation	FY 2009 Appropriation	FY 2010 Estimate	FY 2010 +/- FY 2009
MFP Evaluations & Technical Support	$1,100,000	$1,100,000	$1,100,000	$0
Medicaid Transformation Grants	$75,000,000	$0	$0	$0
Medicaid Integrity Program	$50,000,000	$75,000,000	$75,000,000	$0
Subtotal – DRA	**$470,000,000**	**$482,000,000**	**$536,000,000**	**+$54,000,000**
Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)				
Grants to Improve Outreach and Enrollment	$0	$100,000,000	$0	-$100,000,000
Application of Prospective Payment System	$0	$5,000,000	$0	-$5,000,000
Subtotal – CHIPRA	**$0**	**$105,000,000**	**$0**	**-$105,000,000**
Appropriations/BA	**$763,834,000**	**$632,763,000**	**$581,763,000**	**-$51,000,000**
Comparability Adjustment— High-Risk Pools	$49,127,000	$75,000,000	$0	-$75,000,000
Adjusted Appropriations/BA	**$812,961,000**	**$707,763,000**	**$581,763,000**	**-$126,000,000**
Proposed Legislation				
High-Risk Pool Grants	$0	$0	$75,000,000	+$75,000,000
Total, including Proposed Law	**$812,961,000**	**$707,763,000**	**$656,763,000**	**-$51,000,000**

Authorizing Legislation - Ticket to Work and Work Incentives Improvement Act of 1999, Public Law 106-170; Medicare Modernization Act of 2003, Public Law 108-173; Deficit Reduction Act of 2005, Public Law 109-171; Tax Relief and Health Care Act of 2006, Public Law 109-432; Child Health Insurance Program Reauthorization Act of 2009, Public Law 111-3

Allocation Method - Grants, Other

Program Description and Accomplishments

The State Grants and Demonstrations account provides Federal funding for a diverse group of grant programs and other activities established under several legislative authorities. The grants assist in providing State-infrastructure support and services to targeted populations. Targeted populations include working individuals with disabilities, undocumented aliens, the medically uninsurable, the homeless and eligible Medicaid beneficiaries.

Other activities under State Grants and Demonstrations include Medicaid oversight to combat fraud, waste and abuse, improving the effectiveness and efficiency in providing Medicaid, establishing or delivering programs of the all-inclusive care for the elderly services in rural areas, expanding private long-term care insurance programs, establishing alternate non-emergency service providers, and modernizing Medicaid programs to be

more sustainable while helping individuals achieve independence. The Children's Health Insurance Program Reauthorization Act of 2009, State Grants and Demonstrations have expanded State Grants and Demonstrations programs to include underserved children. The programs include outreach grants to increase enrollment and participation in the Children Health Insurance Program as well as transition grants for the application of the Medicaid prospective payment system for services provided by Federally-qualified health centers and rural health clinics.

Funding History

FY 2005	$535,500,000
FY 2006	$2,565,520,000
FY 2007	$698,049,000
FY 2008	$812,961,000
FY 2009	$707,763,000

Budget Overview

The various grant and demonstration programs are appropriated Federal funds through several legislative authorities. The legislation, which authorizes the grant or demonstration program, determines the amount and period of availability of funds. The following is a description of each grant and demonstration program and its associated funding.

Ticket to Work and Work Incentives Improvement Act Grant Programs

Program Description and Accomplishments

Title II of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA - P.L. 106-170) established two grant programs starting in FY 2001: the Medicaid Infrastructure Grants and the Demonstration to Maintain Independence & Employment (DMIE).

Medicaid Infrastructure Grants (Section 203)

The Medicaid Infrastructure Grants, section 203 of the TWWIIA, provide funding to States to build the infrastructure necessary to support working individuals with disabilities. These infrastructures include:

- Medicaid State plan options to provide Medicaid assistance for workers with disabilities,
- Improved worker access to personal assistance services, and
- Training and outreach programs for State Medicaid workers so they can provide better service to workers with disabilities in terms of eligibility for Medicaid and other work incentives.

A major goal of the program is to support the expansion of Medicaid coverage for workers with disabilities (also known as "Medicaid buy-in"). With this infrastructure funding, grant

recipients make systemic changes to help individuals with disabilities gain employment and retain their health care coverage. These changes include, but are not limited to, creating Medicaid buy-in programs and enhancing State personal assistance service programs.

A key performance measure in the State Grants and Demonstrations Program relates to the Ticket to Work and Work Incentives Improvement Act (TWWIIA) of 1999. The annual target for this measure is to prepare an annual report (new in 2006 covering calendar year 2005) on TWWIIA.

To meet our FY 2008 target, the third of these annual reports was prepared, summarizing the progress of Medicaid Infrastructure Grant (MIG) States during calendar year 2007. The report is available at: **http://www.cms.hhs.gov/TWWIIA/03_MIG.asp#TopOfPage**, and focuses primarily on quantitative data currently available for all States with MIG funding, using selected measures that are expected to be reported reliably and consistently over time.

In its next annual report on the MIG program, CMS will highlight continuing achievements in these existing measures, and will build on this report using any additional data collected from States. Though the data now measure many aspects of MIG performance, as more information is collected, future reports will provide a more complete picture of the types of activities supported by MIG funding and the effect this funding has on people with disabilities who want to work. CMS will use these reports to set conditions for future grants to the States, and believes that one of the strongest management tools it can employ is providing feedback to the grantees on their performance.

Through FY 2009, a total of 50 entities (49 States and the District of Columbia) have been approved for Medicaid Infrastructure Grants. By 2009, 34 States, who also received MIG funding, had created Medicaid buy-in programs for working adults with disabilities. As of November 30, 2008, there were 83,694 workers receiving Medicaid benefits under the buy-in options. A total of 24 States applied for and received continuation grant awards in FY 2009. Sixteen States received new competitive grant awards in FY 2008. In addition, Nebraska continued to carry out employment goals for the working disabled population by spending previous grant awards in FY 2009 through a no-cost extension of funding.

Demonstration to Maintain Independence & Employment (Section 204)

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

Since inception of the section 204 grant program, eight States (Rhode Island, Texas, Mississippi, Louisiana, Kansas, Hawaii, Minnesota, Iowa) and the District of Columbia have been awarded DMIE funding. Currently, only Texas, Kansas, Minnesota, Hawaii and the District of Columbia are actively participating in the demonstration grant program. These

demonstration grant programs provide Medicaid-equivalent services to targeted populations of working individuals with potentially disabling conditions, including individuals with mental illness, HIV/AIDS, diabetes, and other high-risk physical conditions. The table on the following page lists the grant awards by State.

Budget Overview

The Medicaid Infrastructure Grant Program (section 203) is authorized for 11 years beginning in fiscal year 2001 with an appropriation of $150,000,000 for the first 5 years. Beginning in FY 2006, the funding level is tied to the CPI-U. Of the $42.8 million appropriated for FY 2007, $35.6 million had been granted to the States as of July 30, 2007. Of the $44 million appropriated for FY 2008, $40.3 had been granted to States. Of the $45 million appropriated in FY 2009, $64.5 million had been granted to States (which included $19.5 million in carryover funding from previous years). Any remaining funding rolls over into the FY 2010 funding appropriation. In FY 2010 section 203 of TWWIIA authorizes and appropriates $46,142,000 for 100 percent Federally-funded Medicaid Infrastructure Grants to States.

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

Demonstration to Maintain Independence and Employment Grants – Sec. 204

State		2007 Approved***	2008 Approved
District of Columbia		$0	$3,283,990
Texas		$18,653,124	$0
Kansas		$0	$0
Minnesota		$0	$0
Hawaii		$8,718,073	$0
Iowa		$0	$500,000
Louisiana	(grant closed out in 2007)	$0	N/A
	Total	$27,371,197	$3,783,990
	***Budgeted funds that are unspent in one year can be drawn down in subsequent years, per the Ticket to Work Legislation.		

FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FOR UNDOCUMENTED ALIENS

Program Description and Accomplishments

Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) (MMA) provides funding to eligible providers for furnishing emergency health services to undocumented and certain other aliens.

The Secretary of the Department of Health and Human Services must directly pay hospitals, physicians, and ambulance providers for their otherwise un-reimbursed costs of providing services required by section 1867 of the Social Security Act (Emergency Medical Treatment and Labor Act (EMTALA)[2] and related hospital inpatient, outpatient, and ambulance services. Aliens for which providers may seek reimbursement include undocumented aliens, aliens paroled into the United States at a U.S. port of entry for the purpose of receiving such services, and Mexican citizens permitted temporary entry to the United States with a laser visa.

Eligible hospitals include hospitals with EMTALA obligations (generally, Medicare-participating hospitals that have emergency departments), including critical access hospitals and Indian Health Service facilities, whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as described in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). Eligible physicians include doctors of medicine, doctors of osteopathy, and within certain statutory restrictions on the scope of services they may provide, doctors of podiatric medicine, doctors of optometry, chiropractors or doctors of dental surgery. Eligible ambulance suppliers include State-licensed providers of ambulance services.

As of March 2009, Section 1011 provides funding to 2,165 hospitals, 50,116 physicians, and 504 ambulance providers across the Nation. To date, Section 1011 has disbursed $596,200,567 in provider payments, in response to 860,000 claims.

Budget Overview

Section 1011 of the MMA appropriated $250 million per year during fiscal years 2005 through 2008. Two-thirds of these funds ($167 million) were allocated 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) were allocated to the six States with the largest number of undocumented alien apprehensions. State allocations are based on data provided by the Department of Homeland Security. Funds appropriated shall remain available until expended.

[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.

SITE DEVELOPMENT GRANTS FOR RURAL PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) PROGRAMS AND FUNDING FOR PACE OUTLIERS

Program Description and Accomplishments

Section 5302 of the DRA established the Rural Programs of All-Inclusive Care for the Elderly (PACE) program in order to promote the development of the PACE provider program in rural service areas. The PACE is a capitated benefit that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. PACE was developed to address the needs of long-term care clients, providers, and payers. For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than be institutionalized. Capitated financing allows providers to deliver all services participants need rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems.

At the end of FY 2006, CMS awarded 15 organizations individual grants of $500,000 each to start and operate a PACE provider in a rural geographic area. Awardees have access to the grant award only after executing a signed three-way agreement between the PACE provider, the State, and CMS prior to September 30, 2008. By the end of FY 2008 CMS had executed signed PACE agreements with all of the organizations except for one of the organizations which withdrew from the grant program. The grant from the withdrawn awardee was redistributed among the remaining 14 awardees as supplemental awards. All the awardees are operational rural PACE providers having enrolled Medicare and Medicaid beneficiaries and providing services to these individuals.

This grant program also provides technical assistance, outreach, and education to State agencies and provider organizations interested in serving rural areas. Additionally, the grant provide cost outlier protection to awardees for recognized outlier costs equal to 80 percent of costs exceeding $50,000 for an eligible outlier participant with a $100,000 participant payment limitation and a $500,000 PACE provider payment limitation for a 12-month period. As of March 1, 2009, no awardees have requested payment for cost outlier protection.

Budget Overview

Section 5302 of the DRA appropriated $7.5 million for FY 2006 for rural PACE site development grants. On September 28, 2006, CMS made rural PACE provider grant awards in the amount of $500,000 each to 15 awardees in 13 States. All appropriated funds are available for expenditure through FY 2008. Additionally, grant dollars may also be used to cover expenses as outlined in the DRA for delivering PACE program services in a rural area.

The Tax Relief and Health Care Act of 2006 (P.L. 109-432) established cost outlier protection funding for rural PACE pilot sites and appropriated $10 million in FY 2006 to be available for obligation through FY 2010. Congress intended that the outlier fund would provide additional monies to rural PACE pilot sites that incur more than $50,000 in recognized costs in a 12-month period for PACE program eligible individuals residing in the

rural areas. Any services offered need to be provided under a contract between a pilot site and the provider. Each rural PACE cannot receive more than $500,000 in total outlier expenses in a 12-month period with costs incurred during its first three years of operation.

DRUG SURVEYS AND REPORTS

Program Description and Accomplishments

Section 6001(e) of the DRA provides that the Secretary may contract with a vendor to conduct a survey of retail prices for covered outpatient prescription drugs. The contract may include a provision to update the Secretary each time a therapeutically equivalent drug becomes available; the Secretary then has seven days to determine if the drug is eligible for inclusion on the federal upper limit[3] list. In addition, the provision provides that the Secretary shall provide information obtained on retail survey prices to States on at least a monthly basis.

Budget Overview

The DRA appropriated $5 million dollars for each of fiscal years 2006 through 2010 to carry out this requirement. CMS provides the overall leadership for the survey. This provision was delayed awaiting the publication of the average manufacturer price (AMP) information. However AMP became subject to an injunction by the DC District Court which prevents the publication of this data. Also, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), P.L. 110-275 was passed in July 2008 which also included a provision that prevents the publication of AMP data. Because the States cannot obtain the AMP data necessary to evaluate and reconsider their payment levels, the retail drug surveys and reports activities have been temporarily suspended until the moratorium is over and the injunction has been lifted.

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

Program Description and Accomplishments

Section 6021 of the Deficit Reduction Act provides expansion authority for Long-Term Care (LTC) Partnership programs and the establishment of a National Clearinghouse for LTC Information. The DRA authorized and appropriated a total of $1 million for the period of fiscal years 2006 through 2010 for reporting on the Partnership for LTC and $3 million for each of fiscal years 2006 through 2010 for the establishment of a National Clearinghouse for Long-Term Care information.

[3] Federal reimbursements to States for State spending for certain outpatient prescription drugs are subject to ceilings called Federal upper limits (FULs). The FUL applies, in the aggregate, to payments for multiple source drugs – those that have one or more therapeutically equivalent drug versions. The DRA expanded the FUL listed multiple source drugs to include those with one or more equivalents.

The Partnership for Long-Term Care (LTC):

This was enacted under section 6021 of the DRA and established authority for all States to implement LTC insurance plans that provide a dollar-for-dollar disregard, both for eligibility and estate recovery, of assets or resources equal to the amount of insurance benefits paid on behalf of the individual. This could help individuals prepare financially for future health care needs by allowing individuals to protect their assets while remaining eligible for Medicaid if their long-term care needs exceed the period covered by their private insurance policy. Previously, only four States had programs under which resources could be disregarded in return for the purchase and use of an LTC insurance policy (California, Connecticut, Indiana, and New York). As of July 28, 2008, CMS has approved 26 Medicaid State plan amendments implementing the DRA provision related to the LTC partnership. The States that have opted to operate Partnership for Long-Term Care programs since the passage of Deficit Reduction Act of 2005 are:

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

Alabama and Maryland are pending.

The National Clearinghouse for Long-Term Care Information:

At least 70 percent of people over age 65 will require some long-term care services at some point in their lives. And, contrary to what many people believe, Medicare and private health insurance programs do not pay for the majority of long-term care services that most people need; planning for LTC is essential. The LTC Clearinghouse serves the following functions:

- Educates consumers with respect to the availability and limitations of coverage for long-term care under the Medicaid program;
- Provides contact information for obtaining State-specific information on long-term care coverage, including eligibility and estate recovery requirements under State Medicaid programs;
- Provides objective information to assist consumers with the decision-making process for determining whether to purchase LTC insurance or to pursue other private market alternatives for purchasing long-term care;
- Provides contact information for additional objective resources on planning for long-term care needs; and
- Maintains a list of States with State long-term care insurance partnerships under the Medicaid program that provide reciprocal recognition of long-term care insurance policies issued under such partnerships.

The LTC Clearinghouse will be managed by a collaborative workgroup from CMS, the Assistant Secretary for Planning and Evaluation (ASPE) within HHS, and the Administration on Aging (AoA). These federal entities are working with individual States to offer a consistent message about planning ahead for long-term care. The LTC Clearinghouse is

established through an intra-agency agreement as provided in the legislation and its target audience is consumers from age 45-65 within the existing participating States. The two major components of the National Clearinghouse for Long-Term Care Information are the "Own Your Future" Long-Term Care Awareness Campaign and a national website.

"Own Your Future" campaign update: Starting as a demonstration project in January 2005 in five States, the "Own Your Future" campaign is an aggressive education and outreach effort designed to promote long-term care planning. As of April 2008, it has expanded to 18 State-specific campaigns within four phases of the campaign. The 18 States that have participated to date are: Arkansas, Georgia, Idaho, Kansas, Maryland, Michigan, Missouri, Nebraska, Nevada, New Jersey, Ohio, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Virginia, and Washington. Colorado, Iowa, Kentucky, and Washington, D.C. will be launching campaigns in 2009. The campaign consists of four parts:

1. Direct mail supported by the State Governor in which a letter discussing the importance of long-term care planning, signed by the Governor, is sent to every household with members between 45-65 years of age. The letter includes a tri-fold brochure which provides additional information about long-term care planning, and encourages each target household to order an "Own Your Future" Planning Kit for Long-Term Care. The Planning Kit is available at no cost to the consumer.
2. State-specific information about local planning resources and information on long-term care services. This incorporated into the Planning Kit for Long-Term Care. HHS covers the cost of producing and collating these materials.
3. A Governor's press conference to launch the campaign. The press conference is held concurrent with the mailing of the Governor's letter. The purpose of the press conference is to generate local media interest in the Campaign and reinforce the message being sent to targeted households through the direct mail effort.
4. A follow-up postcard to remind individuals who have not yet requested the Long-Term Care Planning Kit to submit a request.

Website: The National Clearinghouse for Long-Term Care Information website (located at http://www.longtermcare.gov) was launched in the fall of 2006. The website supports the "Own Your Future" campaign and contains educational information regarding long-term care and provides a number of resources to assist in the planning process including interactive tools such as a savings calculator and contact information for a range of programs and services. The website also provides information about Medicare's limited coverage of, and payment for, long-term care services and supports.

Budget Overview

The DRA authorized and appropriated $1 million total for the period of fiscal years 2006 through 2010 for reporting on the Partnership for LTC and $3 million for each of fiscal years 2006 through 2010 for the establishment of a national clearinghouse for long-term care information.

ALTERNATE NON-EMERGENCY NETWORK PROVIDERS

Program Description and Accomplishments

Section 6043 of the DRA enacted the Emergency Room Co-Payments for Non-Emergency Care. This provision adds a new subsection 1916A(e) to the Social Security Act, which provides a State option to impose higher cost sharing for non-emergency care furnished in a hospital emergency department without a waiver, and adds a new subsection 1903(y) authorizing Federal grant funds for States to use for the establishment of alternate non-emergency service providers, or networks of such providers.

States may not use funds as the State's share of the Medicaid program costs or to supplement disproportionate share hospital (DSH) payments. Grant applicants are limited to the 51 State Medicaid agencies and the Medicaid agencies in the Federal territories.

Budget Overview

The DRA made available a total of $50,000,000 over four years (FY 2006-2009) for the establishment of alternate non-emergency service providers or networks of such providers to provide non-emergency care. CMS released one solicitation on August 15, 2007 available for all four years (FY 2006, FY 2007, FY 2008 and FY 2009). CMS made awards on April 17, 2008 to 20 States (Colorado, Connecticut, Georgia, Illinois, Indiana, Louisiana, Massachusetts, Maryland, Michigan, Missouri, New Jersey, North Carolina, North Dakota, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, and Washington). These awards are designed to avoid unnecessary emergency room through improved physician care and strategies to decrease re-admission.

DEMONSTRATION PROJECTS REGARDING HOME AND COMMUNITY-BASED ALTERNATIVE TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN

Program Description and Accomplishments

Over the last decade, psychiatric residential treatment facilities (PRTFs) have become the primary provider for youths with serious emotional disturbances requiring an institutional level of care. However, since they are not recognized as hospitals, nursing facilities, or intermediate care facilities for the mentally retarded, many States have been unable to use the 1915(c) waiver authority to provide home and community-based alternatives to care, which would keep youth in their homes and with their families.

Section 6063 of the DRA addressed this issue by authorizing ten States to develop demonstration programs that provide home and community-based services to youth as alternatives to institutionalization in PRTFs.

To participate in this demonstration, Medicaid eligible individuals must be under the age of 21 and require the need for a PRTF as defined in the State's Medicaid State plan. For the

purposes of this demonstration, youth are defined as "any child, adolescent or young adult under the age of 21." Further, States may elect to add additional criteria to carve out or target a specific sub-population to receive home and community-based services under this demonstration.

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

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

Budget Overview

The DRA provided ten States with up to $218 million for a period of five years (through FY 2011) to develop demonstration programs. One million dollars of the project funding is made available for required interim and final evaluation reports.

CMS made awards totaling $21 million in FY 2007 to ten States. Funds not expended in each grant year will continue to be available in subsequent fiscal years of the demonstration. CMS also awarded a contract for the national evaluation in April 2007 for $904,422 and a modification in of $93,690 in FY 2008 totaling $ 998,112.

The DRA provided $37 million for FY 2008. CMS will award these funds as supplemental grants to the 10 States based on the funding requested in the PRTF 1915 (c) demonstration waiver application submissions. States may request supplemental funding at any time during the fiscal year as the number of children enrolled increases. In FY 2009 $49 million was authorized and appropriated. In FY 2010 the DRA provides for an additional $53 million.

State	2007 Awards	FY2008-11 Request	5 Yr. Request
AK	$555,805	$7,266,579	$7,822,384
IN	$3,817,063	$17,386,288	$21,203,351
MT	$360,482	$4,614,497	$4,974,979
MS	$784,726	$51,104,631	$51,889,357
VA	$3,172,117	$12,052,509	$15,224,626
KS	$4,899,534	$11,577,857	$16,477,391
MD	$3,374,487	$19,602,975	$22,977,462
FL	$2,104,693	$6,902,029	$9,006,722

State	2007 Awards	FY2008-11 Request	5 Yr. Request
SC	$741,584	$20,026,083	$20,767,667
GA	$1,189,509	$17,753,778	$18,943,287
Totals	$21,000,000	$168,287,226	$189,287,226

MONEY FOLLOWS THE PERSON (MFP) REBALANCING DEMONSTRATION

Program Description and Accomplishments

For more than a decade, States have been asking for the tools to modernize their Medicaid programs. With the enactment of Section 6071 of the DRA, States now have new options to rebalance their long-term support programs, allowing their Medicaid programs to be more sustainable while helping individuals achieve independence. Specifically, the MFP demonstration will support State efforts to:

- Rebalance their long-term support system so that individuals have a choice of where they live and receive services.
- Transition individuals from institutions who want to live in the community.
- Promote a strategic approach to implement a system that provides person centered services and a quality management strategy that ensures the provision of, and improvement of such services in both home and community-based settings and institutions.

The demonstration provides for enhanced Federal medical assistance percentage (FMAP) for 12 months for qualified home and community-based services for each person transitioned from an institution to the community during the demonstration period. Eligibility for transition is dependent upon residence in a qualified institution. The State may establish the minimum timeframe for residence between six months and two years. The State must continue to provide community-based services after the 12-month demonstration period for as long as the person needs community services and is Medicaid eligible.

The table on the following pages shows awards that were made in FY 2007 and FY 2008. The FY 2008 amount reflects awards made through September 10, 2008.

Budget Overview

Section 6071 of the DRA authorized and appropriated a total of $1.75 billion for the MFP Rebalancing Demonstration over the period January 1, 2007 through FY 2011. States that participate in the MFP demonstration will also be awarded an enhanced FMAP rate to transition people from the institutional setting to a home or community-based setting of their choice. The enhanced FMAP will increase the regular FMAP rate by the number of percentage points equal to 50 percent of the difference between their State share and 100 percent. The provision appropriated $250 million for the portion of FY 2007 that began

on January 1, 2007, and ended on September 30, 2007. Of the $1.75 billion total, up to $2.4 million of the amount appropriated over the FY 2007 and FY 2008 period can be used to carry out technical assistance and quality assurance activities and is made available through FY 2011. An additional $1.1 million from each year's appropriation in FY 2008 through FY 2011 can be used to carry out evaluation and a required report to Congress.

In 2007, CMS committed $1,435,709,479 in grants to 31 States. With these funds, States propose to transition nearly 38,000 individuals out of institutional settings over the five-year demonstration period. Additionally, CMS awarded both evaluation and quality assurance contracts.

Money Follows the Person Rebalancing Demonstration Grants (as of January 2009)

State	***5 Year Award/ Commitment*** (from initial award letter)*	***FY2007 Award Amount Year #1***	***FY 2008 Supplemental Award Amount Year #2***	***FY 2009 Supplemental Award Amount Year #3***	***Balance of 5 Yr. Award/ Commitment*** (Award/Commitment minus Cumulative Award Total)
AR	$20,923,775	$139,519	$2,238,630	$3,691,722	$14,853,904
CA	$130,387,500	$90,000	$6,759,447	$34,746,117	$88,791,936
CT	$24,207,383	$1,313,823	$872,140	$1,316,930	$20,704,490
DE	$5,372,007	$132,537	$77,466	$1,437,901	$3,724,103
DC	$26,377,620	$2,546,569	$899,477	$12,005,987	$10,925,587
GA	$34,091,671	$480,193	$1,996,315	$12,090,030	$19,525,133
HI	$10,263,736	$231,250	$744,073	$2,752,645	$6,535,768
IL	$55,703,078	$5,563,000	$5,848,886	$2,174,858	$42,116,334
IN	$21,047,402	$860,514	$1,987,368	$9,047,446	$9,152,074
IA	$50,965,815	$307,933	$9,237,500	$5,138,766	$36,281,616
KS	$36,787,453	$102,483	$14,728,321	$2,855,751	$19,100,898
KY	$49,831,580	$4,973,118	$0	$10,000,000	$34,858,462
LA	$30,963,664	$524,000	$1,871,320	$1,075,543	$27,492,801
MD	$67,155,856	$6,693,780	$9,960,463	$5,654,195	$44,847,418
MI	$67,834,348	$2,034,732	$814,612	$4,948,062	$60,036,942
MO	$17,692,006	$3,398,225	$4,678,317	$2,313,590	$7,301,874
NE	$27,538,984	$202,500	$3,762,783	$2,463,804	$21,109,897
NH	$11,406,499	$297,671	$2,925,523	$840,581	$7,342,724
NJ	$30,300,000	$3,800,000	$3,271,780	$10,421,308	$12,806,912
NY	$82,636,864	$192,981	$8,836,013	$0	$73,607,870
NC	$16,897,391	$16,055	$886,202	$3,467,615	$12,527,519
ND	$8,945,209	$18,089	$962,319	$2,741,475	$5,223,326
OH	$100,645,125	$2,079,488	$7,732,213	$19,978,270	$70,855,154
OK	$41,805,358	$3,526,428	$1,431,518	$12,679,149	$24,168,263
OR	$114,727,864	$80,785	$7,987,292	$21,880,386	$84,779,401
PA	$98,196,439	$130,609	$3,775,506	$17,433,222	$76,857,102
SC	$5,768,496	$34,789	$942,208	$0	$4,791,499
TX	$142,700,353	$143,401	$7,407,946	$25,763,836	$109,385,170
VA	$28,626,136	$8,275	$1,557,350	$5,702,917	$21,357,594
WA	$19,626,869	$108,500	$1,799,000	$7,070,816	$10,648,553

Money Follows the Person Rebalancing Demonstration Grants (as of January 2009)

State	*5 Year Award/ Commitment* (from initial award letter)*	*FY2007 Award Amount Year #1*	*FY 2008 Supplemental Award Amount Year #2*	*FY 2009 Supplemental Award Amount Year #3*	*Balance of 5 Yr. Award/ Commitment* (Award/Commitment minus Cumulative Award Total)
WI	$56,282,998	$8,020,388	$9,294,459	$0	$38,968,151
Total	**$1,435,709,479**	**$48,051,635**	**$125,286,447**	**$241,692,922**	**$1,020,678,475**

MEDICAID TRANSFORMATION GRANTS

Program Description and Accomplishments

This program is authorized by Section 6081 of the DRA which added a new subsection, 1903 (z) to title XIX of the Social Security Act. This section provides new grant funds to States for the adoption of innovative methods to improve effectiveness and efficiency in providing medical assistance under Medicaid. Grant money may be awarded for a variety of approaches, including reducing patient error rates through health information technology, improving rates of estate collection, reducing waste, fraud and abuse including improper payment rates as measured by the annual Payment Error Rate Measurement program, implementing medication risk management programs, reducing expenditures for covered outpatient drugs with high utilization and substituting generic drugs, and developing methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital and clinic systems. Grantees must report on cost savings, use of the grant funds and any clinical improvements in beneficiary health status, as appropriate.

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

Budget Overview

The DRA authorized and appropriated $75 million for grants for FY 2007 and $75 million for FY 2008. On January 25, 2007, CMS awarded 32 Medicaid Transformation Grants to 26 States totaling $97,040,144. CMS released a second Medicaid Transformation Grant solicitation on April 26, 2007 to award the remaining $52,959,856. CMS awarded 17 Medicaid Transformation Grants to 16 States plus Puerto Rico on September 28, 2007.

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

There is no new budget authority for FY 2010.

Table A: FY 2007 Medicaid Transformation Grants, Round 1

	Round 1 (Awarded 1/25/07)		
State Name	**Project Name**	**Total Funded**	**Category**
Alabama	Together for Quality - Health Information Systems (HIE/EHR)	$7,587,000	Health Information Technology
Arizona*	Medicaid Health Information Exchange and Utility Project	$11,749,500	Health Information Technology
Arkansas	Electronic Verification of Proof of Citizenship	$285,513	Fraud, Waste & Abuse
Connecticut	Health Information Exchange and e-Prescribing	$5,000,000	Quality & Health Outcomes
District of Columbia	Comprehensive Medicaid Integration (HIE/EHR)	$9,864,000	Health Information Technology Quality & Health Outcomes
Florida	GenRx Expansion (e-Prescribing)	$1,737,861	E-Prescribing
Hawaii*	Open Vista ASP Network (HIE/EHR)	$3,188,535	Health Information Technology Quality & Health Outcomes
Illinois	Predictive Modeling System	$4,849,200	Quality & Health Outcomes Fraud, Waste & Abuse
Indiana*	Medicaid Estate Recovery Centralization and Automation Project	$124,880	Health Information Technology Medicaid Estate Recovery
Kansas	Using Predictive Modeling Technology to improve Preventive Healthcare in the Disabled Medicaid Population	$906,664	Quality & Health Outcomes

	Round 1 (Awarded 1/25/07)		
State Name	**Project Name**	**Total Funded**	**Category**
Kentucky	Health Information Partnership (HIE/EHR)	$4,987,583	Health Information Technology
Maryland	Automated Fraud and Abuse Tracking	$576,228	Fraud, Waste & Abuse
Massachusetts	Secure Verification of Citizenship through Automation of Vital Records	$3,950,440	Citizenship
Michigan	One Source Credentialing	$5,208,759	Quality & Health Outcomes
Michigan	Expansion of Vital Records Automation and Integration into Medicaid	$3,929,317	Citizenship
Minnesota	Communication and Accountability for Primary Care Systems (HIE/EHR)	$2,843,340	Quality & Health Outcomes
Mississippi*	As One - Together for Health (HIE/EHR)	$1,688,000	Health Information Technology
Montana*	Enhancing EHR - Clinical Decision Making	$1,481,152	Quality & Health Outcomes
New Jersey	Medical Information for Children (HIE/EHR)	$1,516,900	Health Information Technology
New Mexico	e-Prescribing	$855,220	e-Prescribing
New Mexico	Electronic Health Record Project	$712,301	Health Information Technology
North Dakota	Web-based Electronic Pharmacy Claim Submission Interface	$75,000	e-Prescribing
Rhode Island*	IT Infrastructure Transformation	$725,253	Fraud, Waste & Abuse
Tennessee	E-Prescription Pilot Project	$674,204	e-Prescribing
Texas	Electronic Health Passport for Foster Care	$4,000,000	Health Information Technology
Utah	Developing a Pharmacotherapy Risk Management System with an Electronic Surveillance Tool	$2,881,662	Risk Management

	Round 1 (Awarded 1/25/07)		
State Name	**Project Name**	**Total Funded**	**Category**
West Virginia	Healthier Medicaid Members through Personal Responsibility	$917,560	Quality & Health Outcomes
West Virginia	Healthier Medicaid Members through a Stronger Medicaid Program	$1,731,680	Health Information Technology
West Virginia	Healthier Medicaid Members through Health Systems Improvement (HIE/EHR)	$3,895,730	Health Information Technology
West Virginia	Healthier Medicaid Members through Applied Technology	$1,766,280	Health Information Technology
West Virginia	Healthier Medicaid Members through Enhanced Medication Management	$4`,287,110	Health Information Technology Quality & Health Outcomes
Wisconsin*	Health Information Exchange Initiative	$3,043,272	Health Information Technology
	Round 1Total Funding Awarded	$97,040,144	

*Received MT Grants in both Round 1 and Round 2

Table B: FY 2007 Medicaid Transformation Grants, Round 2

	Round 2 (Awarded 9/28/07)		
State Name	**Project Name**	**Total Funded**	**Category**
Arizona*	Transparency - Value Driven Decision Support Tool Box	$4,411,300	Health Information Technology Quality & Health Outcomes
Arkansas	Touch: Telemedicine Outreach Utilizing Collaborative Healthcare (Neonatal Outcomes)	$1,458,826	Quality & Health Outcomes
Delaware	Delaware e-Prescribing Pilot	$1,018,065	e-Prescribing
Georgia	Health Information Transparency Website	$3,929,855	Health Information Technology

	Round 2 (Awarded 9/28/07)		
State Name	**Project Name**	**Total Funded**	**Category**
Hawaii*	Enhanced Electronic Health Record and Information Exchange	$1,815,000	Health Information Technology
Indiana*	Health Information Exchange Services to Improve the Effectiveness and Efficiency in Providing Medical Assistance Under Medicaid	$1,294,689	Health Information Technology Quality & Health Outcomes
Mississippi*	A Healthy Mississippi - Moving Forward Enhancing Program Integrity	$1,750,700	Fraud, Waste & Abuse
Missouri	Web-Based Tool for Home and Community Based Services	$1,940,175	Health Information Technology Quality & Health Outcomes
Montana*	Improving Lien and Estate Recoveries	$601,126	Medicaid Estate Recovery
Nevada	Building Value Through a Nevada Medicaid Data Warehouse	$29,207	Health Information Technology
North Carolina	Neonatal Outcomes Improvement Project	$1,019,550	Quality & Health Outcomes
Ohio	Neonatal Outcomes Improvement Project	$2,154,948	Quality & Health Outcomes
Oklahoma	Online Enrollment Process	$6,146,640	Health Information Technology
Oregon	The Health Record Bank of Oregon (HIE)	$5,500,093	Health Information Technology Quality & Health Outcomes
Pennsylvania	Implementing Predictive Modeling For High Risk Populations	$4,811,320	Risk Management

	Round 2 (Awarded 9/28/07)		
State Name	**Project Name**	**Total Funded**	**Category**
Puerto Rico	Reduction of Fraud and Abuse through Validation of Demographic and Socioeconomic Data with the Use of Electronic Data Exchanges	$4,267,231	Fraud, Waste & Abuse Health Information Technology
Rhode Island*	Medicaid Health Information Exchange Integration Initiative	$2,765,265	Health Information Technology Quality & Health Outcomes
Washington	Second Generation Fraud and Abuse Detection System	$5,948,000	Fraud, Waste & Abuse
Wisconsin*	Healthcare Quality and Patient Safety - Value Driven Health Care Initiative	$2,097,866	Health Information Technology Quality & Health Outcomes
	Round 2 Total Funding Awarded	$52,959,856	
	Total 2007 Medicaid Transformation Grant Awards	$150,000,000	

*Received MT Grants in both Round 1 and Round 2

Budget Overview

The DRA authorized and appropriated $75 million for grants for FY 2007 and $75 million for FY 2008. CMS released a State Medicaid Director Letter/Grant Solicitation to States on July 25, 2006. On January 25, 2007, CMS awarded 32 Medicaid Transformation Grants to 26 States totaling $98,059,694. CMS released a second Medicaid Transformation Grant solicitation on April 26, 2007 to award the remaining $51,940,306. CMS awarded 17 Medicaid Transformation Grants to 16 States plus Puerto Rico on September 28, 2007.

There is no new budget authority for FY 2010.

MEDICAID INTEGRITY PROGRAM

Program Description and Accomplishments

On February 8, 2006, section 6034 of the DRA of 2005 (P.L. 109-171) established the Medicaid Integrity Program in section 1936 of the Social Security Act. With the passage of this legislation, Congress provided CMS with the much needed opportunity to raise awareness of Medicaid program integrity by increasing resources to help CMS in its efforts to prevent, detect, and reduce fraud, waste, and abuse in the $300 billion per year program. Specifically, the legislation provided CMS with resources to establish the Medicaid Integrity Program, CMS' first national strategy to detect and prevent Medicaid fraud and abuse. The statute provided CMS with the authority to hire 100 full-time equivalent employees to provide support to States. CMS established a 5-year Comprehensive Medicaid Integrity Plan (CMIP) to combat fraud, waste and abuse beginning in FY 2006. The first CMIP was published in August 2007 and covered FYs 2007 to 2011. The most recent CMIP was released in June 2008 and covers FYs 2008-2012.

To assure the implementation and success of the plan CMS is measuring the percentage return on investment (ROI) of the Medicaid Integrity Program. To calculate the ROI, the numerator is the annual total Federal dollars of identified overpayments in accordance with the relevant Medicaid overpayment statutory and regulatory provisions. The denominator is the annual Federal funding of the Medicaid integrity contractors.

The FY 2008 ROI, which was calculated with a partial year of data, was 300 percent. Although CMS exceeded its FY 2008 target using three months of data, we are uncertain if the ROI will be similar when the data covers an entire year. CMS set annual ROI targets at greater than 100 percent for both FY 2009 and FY 2010.

Congress mandated that CMS enter into contractual agreements with eligible entities to conduct provider oversight by reviewing provider claims to determine if fraud and abuse has occurred or has the potential to occur, conducting provider audits based on these reviews and other trend analysis, identifying overpayments and conducting provider education. In December 2007, MIP awarded umbrella contracts for Review of Providers and Audit and Identification of Overpayments. The contractors began conducting audits in September 2008.

Building upon the accomplishments of the first several years, activities in FY 2009 will include hiring the remaining Medicaid integrity staff, conducting audits of provider claims, conducting oversight reviews, and providing technical support and assistance to State Medicaid integrity programs. The program will also address OIG's concerns that CMS establish fraud referral performance standards for State Medicaid agencies and increase efforts to ensure that States enforce existing policies relating to the proper documentation of pediatric dental services, while providing assistance to States to promote provider awareness and documentation requirements.

Budget Overview

The statute appropriated $5 million in FY 2006, $50 million in FYs 2007 and 2008, and $75 million in FY 2009 and each year thereafter. Funds appropriated remain available until expended.

GRANTS TO IMPROVE OUTREACH AND ENROLLMENT

Program Description and Accomplishments

In February 2009, section 201 of the Children's Health Insurance Program Reauthorization Act was signed establishing a grant program to conduct outreach and enrollment efforts designed to increase the enrollment and participation of eligible children. The grants are proposed to target geographical areas with high rates of eligible but unenrolled children, including children who reside in rural areas; or racial and ethnic minorities and health disparity populations, including those proposals that address cultural and linguistic barriers to enrollment.

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

1. The establishment of partnerships with the Secretary of Education and the Secretary of Agriculture to develop national campaigns to link the eligibility and enrollment systems for the assistance programs each Secretary administers that often serve the same children;

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

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

4. The establishment of joint public awareness outreach initiatives with the Secretary of Education and the Secretary of Labor regarding the importance of health insurance to building strong communities and the economy;

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

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

There is also provided within this statute ten percent of the funds appropriated to be used to award grants to Indian Health Service providers and urban Indian organizations receiving funds under Title V of the Indian Health Care Improvement Act for outreach to, and enrollment of, children who are Indians.

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

Budget Overview

The statute appropriated a total of $100 million for fiscal years 2009 through 2013. From the amounts made available, ten percent is to be set aside for the National Enrollment Campaign, and an additional ten percent is to be set aside for outreach to Indian children.

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

Program Description and Accomplishments

In February 2009, the Children's Health Insurance Program Reauthorization Act was signed establishing transition grants to States with State child health plans under CHIP that are operated separately from the State Medicaid plan under title XIX of the Social Security Act (including any waiver of such plan), or in combination with the compliance with the requirement of section 2107 (e) (1) (D) of the Social Security Act (as added by subsection (a)) to apply the prospective payment system established under section 1902 (bb) of such Act (42 U.S.C. 1396a(bb)) to services provided by Federally-qualified health centers and rural health clinics.

Budget Overview

The statute appropriated $5 million for fiscal year 2009. The funding is to remain available until expended.

PROPOSED LEGISLATION

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

Health insurance high-risk pools are special programs created by State legislatures to provide a safety net for the "medically uninsurable" population. High-risk pools provide private insurance to those with pre-existing conditions that cannot get health insurance in the private market. Congress appropriated $90 million in FY 2006 for grants to: partially cover losses incurred by States in connection with the operation of the pools, provide supplemental consumer benefits, and fund the start-up costs for new State high-risk pools. Although appropriations for operational losses and supplemental consumer benefits bonus grants were authorized for FY 2007-2010, no funds were actually appropriated for FY 2007 or subsequent years. The Consolidated Appropriations Act, 2008 (P.L. 110-161) directed CMS to provide $50 million (before an across-the-board rescission) for State High-Risk Health Insurance Pools in FY 2008, and the Omnibus Appropriations Act, 2009 provided $75 million in FY 2009, which was administered in Program Management.

CMS is proposing $75 million for State High-Risk Health Insurance Pools activities in FY 2010.

Outcomes and Outputs Table

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
SGD1: Prepare an annual report by December 31 for the preceding calendar year on the status of grantees in terms of States' outcomes in providing employment supports for people with disabilities.	FY 2008: Annual Report on CY 2007 produced. (Target Met)	Annual Report on 2008	Annual Report on 2009.	N/A
SGD2: Medicaid Integrity Program, Percentage Return on Investment	FY 2008: 300% (Target Exceeded)	ROI>100%	ROI>100%	Maintain
Program Level Funding ($ in millions)	NA	$46	$46	$0

Clinical Laboratory Improvement Amendments of 1988

	FY 2008 Enacted	FY 2009 Appropriation	FY 2010 President's Budget Request	FY 2010 +/- FY 2009
BA	$43,000,000	$43,000,000	$43,000,000	0
FTEs	60	71	84	+13

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

FY 2010 Authorization - One Year

Allocation Method - Contracts

Program Description and Accomplishments

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) establish quality standards for laboratory testing to ensure the accuracy, reliability, and timeliness of patient test results regardless of where the test is performed. CLIA strengthens quality performance requirements under the Public Health Service Act and extend these requirements to all laboratories that test human specimens to diagnose, prevent, or treat illness or impairment. CLIA applies to all sites which perform laboratory testing either on a permanent or temporary basis, such as physician office laboratories (POLs); hospitals; nursing facilities; independent laboratories; end-stage renal disease facilities; ambulatory surgical centers; rural health clinics; insurance laboratories; Federal, State, city and county laboratories; and community health screenings. CLIA provisions are based on the complexity of performed tests, not the type of laboratory where the testing occurs. Thus, laboratories performing similar tests must meet similar standards, whether located in a hospital, doctor's office, or other site. In accordance with CLIA regulation, CMS will continue its partnership with the States to certify and to inspect approximately 19,336 laboratories during the FY 2009-2010 survey cycle.

Laboratories exempt from routine Federal inspections include those performing waived tests only, laboratories in which specified practitioners perform only certain microscopic tests, laboratories accredited by approved independent accrediting organizations, and laboratories in States that approve or license clinical laboratories under their own standards. Waived laboratories perform only simple testing and are not generally subject to CLIA requirements, with the exception of following manufacturers' instructions and paying applicable certification fees. Laboratories which are accredited, or which operate in exempt States, are inspected by the accrediting organization or the State at the same frequency as CMS-certified laboratories, namely every 2 years. The accrediting organizations and exempt States have standards considered equal to or more stringent than those required under the CLIA statute. Laboratories that are subject to Federal surveys (those performing nonwaived testing) can choose to be surveyed either by CMS or by one of the six CMS-approved private accrediting organizations. The CMS survey process is outcome-oriented and utilizes an educational approach to assess compliance.

Currently, 210,367 laboratories are registered with the CLIA program. Approximately 172,941 or 82.2 percent, of these laboratories are classified as waived or provider-performed microscopy laboratories and are not subject to routine onsite inspection. The largest number of laboratories, physician office laboratories (POLs), account for approximately 109,093, or 51.9 percent, of the laboratories registered under the CLIA program. Approximately 90,064 or 82.6 percent, of the POLs perform testing classified as waived or as provider-performed microscopy. We project this population will grow at a rate of 3.5 percent for the FY 2009-2010 survey cycle.

Effective October 31, 2003, the authority for CLIA test categorization was transferred to the Food and Drug Administration (FDA), which enables laboratory device manufacturers to submit applications to only one agency for both device approval and categorization. CMS, the CDC, the FDA, and the States remain focused on the mission to improve the accuracy of tests administered in our Nation's laboratories, thereby improving health care for all. CMS, the CDC, and the FDA have reevaluated the program, procedures, responsibilities, and time lines to continually achieve greater efficiencies, while ensuring that requirements reflect the current standard of practice in laboratory medicine. By being flexible and results-oriented, the CLIA program has remained successful in the dynamic health care environment.

Budget Request

The FY 2010 CLIA budget request for CMS is $56,400,000. The CLIA program is a 100-percent user fee-financed program. The budget development methodology is based upon the number of CLIA laboratories, the levels of State agency workloads, and survey costs. CMS determines national State survey workloads by taking the total number of laboratories and subtracting waived laboratories, laboratories issued certificates of provider-performed microscopy, State-exempt laboratories, and accredited laboratories. CMS then sets the national State survey workload at 100 percent of the laboratories to be inspected in a 2-year cycle. Workloads projected for the FY 2009-2010 cycle include surveys of 19,336 non-accredited laboratories, State validation surveys of 809 accredited laboratories, and approximately 1,409 follow-up surveys and complaint investigations.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
CLIA1: Percent of pathologists receiving an initial passing score of 90% or greater in gynecologic cytology proficiency testing	FY 2008: Data available August 2009	94%	94.5%	.5
Program Level Funding ($ in millions)	**N/A**	**$43**	**$43**	**0**

Quality Improvement Organizations

	FY 2008 Apportionment	FY 2009 Apportionment	FY 2010 Apportionment	FY 2010 +/- FY 2009
BA	$388,400,000	$569,000,000	$142,000,000	-$427,000,000

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

FY 2010 Authorization - Active

Allocation Method - Contracts

To date $1,099.4 million is the amount approved by OMB for the 9th Statement of Work (SOW). In addition to the apportioned amounts shown above—estimates for FY 2009 and FY 2010 include an increase in reimbursable authority from $1 million to $3 million, $4.9 million carried forward from the 8th SOW, and FY 2009 has an additional $1 million to support Katrina and Rita affected areas.

Program Description

Under the Quality Improvement Organization (QIO) program, CMS maintains contracts with independent community-based organizations to ensure that medical care paid for under the Medicare program is reasonable and medically necessary, meets professionally recognized standards of health care, and is provided in the most economical setting. In addition, through the Quality Improvement Organizations and other State and local partners, CMS collaborates with health care providers and suppliers to promote improved health status, including quality improvement in nursing homes.

The QIO responsibilities are specifically defined in the portion of the contract called the Statement of Work (SOW). Each SOW is three years in duration and each SOW can vary the activities the QIOs perform. Because many of the contracts are awarded late in the first of the three years in each cycle, funding patterns tend to vary substantially from year to year. The QIO program is funded directly from the Medicare trust funds, rather than through the annual Congressional appropriations process.

CMS monitors several key performance measures reflecting efforts to ensure beneficiaries receive the high-quality care they need and depend on. Because the focus may change from SOW to the next, targets and performance measures must be periodically reassessed.

Budget Overview

FY 2010 will be the third and final year of the recently initiated 9th Statement of Work. CMS has allocated $1,099,350,000 for QIO direct and support contracts in the 9th SOW. The funding for these contracts will be obligated at different times during the three-year SOW. The 9th SOW began in August 2008, i.e., fiscal year 2008.

CMS management of the 9th SOW QIO program will include active monitoring and reporting of QIO activities, including semi-annual reports that will be provided to OMB consistent with the management agreement. The 9th SOW is significantly different than any previous QIO contract. It holds all QIOs to specific predefined performance targets; continued work/funding for each quality improvement effort (Patient Safety, Care Transitions, and Prevention) will be predicated on meeting 18-month performance targets. QIOs that meet their18-month targets will be measured again at 28 months.

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

Prevention efforts will emphasize evidence-based and cost-effective care proven to prevent and/or slow the progression of disease. Prevention work will impact health care programs, products, polices, practices, community norms, and linkages and will produce higher quality of care for Medicare beneficiaries and significant cost savings. Over time, as disease is mitigated and its progression slowed through preventive measures such as early testing, immunization, and effective and timely intervention, the Nation will see a healthier Medicare population emerge. This downstream impact will be most evident in the reduction of chronic kidney disease (CKD) and decrease in the rate of progression to kidney failure.

Work in the Care Transitions theme will reduce the unnecessary re-hospitalizations of Medicare beneficiaries that both harm patients and unnecessarily strain the Medicare trust funds. Collaborations among QIOs, community coalitions, and professional groups, utilizing chartered value exchanges, publication of performance, and value-based purchasing will achieve what none of the parties alone could accomplish.

Patient safety efforts will address major areas of patient harm for which there is evidence of how to improve and a record of QIO success in improving safety. This work will be predicated on the reduction or elimination of patient harm that is more likely a result of the patient's interaction with the health care system than an attendant disease process. The Patient Safety theme will increase the value of health care services as it produces higher quality care for Medicare beneficiaries. QIO activities for the Patient Safety theme will focus on five topics: Improving inpatient surgical safety; reducing rates of nosocomial methicillin-resistant Staphylococcus aureus (MRSA) infections; improving drug safety; reducing rates of pressure ulcers; and reducing rates of use of physical restraints. QIOs will work with providers to achieve the following: 23,610 fewer restraints, 43,303 fewer patients with pressure ulcers in nursing homes and hospitals, 7,875 fewer MRSA infections, and 14,252 fewer postoperative deaths due to surgical site infection, venous thromboembolic events, or perioperative myocardial infarction.

To prepare for the oversight of the QIOs, CMS has developed a Management Information System (MIS) to capture QIO performance information. CMS will analyze information from the MIS to determine if QIOs have met their targets. In addition, towards the end of the 9th SOW, CMS will evaluate the QIO program to evaluate its effectiveness and efficiency.

With specified, predefined performance targets in the 9th SOW and pertinent oversight efforts, CMS will be able to more precisely evaluate each QIO's performance. The following table reflects key annual QIO measures, including those related to the 9th SOW.

Outcomes and Outputs Tables

Measure	Most Recent Result	FY 2009 Target	FY 2010 Target	FY 2010 +/- FY 2009
QIO 1.1: Increase nursing home sub-population flu Immunization	FY 2007: 79.2% (Target Exceeded)	80%	80.5%	+0.5
QIO 3.1: Increase hemoglobin A1c testing rate	FY 2007: 86% (Target Exceeded)	86%	86.5%	+0.5
QIO 3.2: Increase cholesterol(LDL) testing rate	FY 2007: 80.25% (Target Exceeded)	81%	81.5%	+0.5
QIO4: Increase percentage of timely antibiotic administration	FY 2007: 88.2% (Target Exceeded)	89%	90.5%	+1.5
QIO6.1: Methodology for aggregating QIO performance with clinical outcome measures at the theme level	FY 2009: Methodology developed. (Target Met)	Develop methodology	N/A	N/A
QIO6.2: Management Information System (MIS)	FY 2009: MIS implemented (Target Met)	Implement MIS	N/A	N/A
QIO6.3: Care Transitions, Patient Safety, and Prevention themes	N/A	Establish baselines and targets	Perform and respond to 18-month QIO contract evaluation	N/A
QIO6.4: Beneficiary Protection theme	N/A	N/A	Establish baseline and FY 2011 targets	N/A
Program Level Funding ($ in millions)	N/A	$569.0	$142.0	-$427.0

American Recovery and Reinvestment Act (ARRA)

	FY 2009 Estimate	FY 2010 Estimate	FY 2010 +/- FY 2009
Program Management:			
Health IT Implementation	$140,000,000	$140,000,000	0
HAI Surveys	1,000,000	9,000,000	+8,000,000
Claims Reprocessing	2,000,000	0	-2,000,000
Total Program Management	**$143,000,000**	**$149,000,000**	**+$6,000,000**
Medicaid Provisions	36,715,000,000	42,709,600,000	+5,994,600,000
CMS Total, ARRA	**$36,858,000,000**	**$42,858,600,000**	**+$6,000,600,000**

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

Allocation Method - Formula Grants, Contracts

The American Recovery and Reinvestment Act of 2009 (ARRA or "Recovery Act"), signed into law on February 17, 2009, is intended to restore economic growth and strengthen America's middle class. Among other things, the Recovery Act is designed to stimulate the economy through measures that preserve and improve access to affordable health care while transforming and modernizing the Nation's health care system.

ARRA directly impacts CMS and its mission. The Act provides CMS with $140 million in FY 2009 and FY 2010 to implement Medicaid and Medicare incentives to encourage the adoption and use of certified electronic health records (EHRs). These incentive payments begin in FY 2011. Medicaid Health IT incentives provide enhanced Federal financial participation (FFP) of 100 percent for payments to providers for the purchase, maintenance, and use of EHRs, and 90 percent FFP for State and local administrative expenses. Under Medicare, initial incentive payments for each qualified physician for meaningful use of certified EHRs would be a maximum of $18,000, decreasing to zero by 2015. For hospitals, incentive payments will vary based on patient days, hospital discharges, and charity care. Medicare providers who are not meaningful users of certified EHRs will receive reduced payments.

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

ARRA increases the Federal share of Medicaid through various provisions, including:

- Federal Medical Assistance Percentage (FMAP): ARRA provides a temporary increase in the FMAP rate from October 1, 2008 through December 31, 2010. This provision increases the FMAP in three ways. First, States are held harmless for any decreases from their base FY 2008 FMAP rate through the first quarter of FY 2011. Second, ARRA provides a general 6.2 percentage point increase in the rates for all States. Third, ARRA provides an additional increase for States facing high growth in unemployment, revised quarterly to reflect new

State unemployment data. Commonwealths and Territories have the option of a 30-percent increase in their Medicaid caps or a 6.2 percentage point increase in their FMAP rates combined with a 15-percent increase in their Medicaid cap.

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

- Extension of the Transitional Medical Assistance (TMA) Program: The TMA was created to provide health coverage to families transitioning to the workforce. It helps low-income families with children transition to jobs by allowing them to keep their Medicaid coverage for a limited period of time after a family member receives earnings that would make them ineligible. ARRA extends the TMA from July 1, 2009 through December 31, 2010.

- Extension of the Qualified Individual (QI) Program: The QI program was created to pay the Medicare Part B premiums of low-income Medicare beneficiaries with incomes between 120 percent and 135 percent of the Federal poverty level. QIs are also deemed eligible for the Medicare Part D low-income subsidy program. States currently receive 100 percent Federal funding for the QI program. ARRA extends the QI program through CY 2010. The estimated FY 2010 offsetting collections ($412.5 million) are not reflected in the chart below.

- Protections for American Indians/Alaskan Natives (AI/AN): ARRA increases protections for Native Americans under Medicaid and CHIP. This provision eliminates cost sharing requirements on AI/ANs when services are provided from an Indian health care provider or from a contract health services provider. It also exempts certain properties from being counted as an asset when determining Medicaid and CHIP eligibility or estate recovery. This provision also requires States to consult on an ongoing basis with Indian Health Programs to maintain access to care.

The chart below identifies ARRA's impact on the Federal share of Medicaid in FYs 2009 - 2010:

Medicaid Activity	**FY 2009 Estimate**	**FY 2010 Estimate**	**FY 2010 +/- FY 2009**
FMAP	$35,200,000,000	$41,400,000,000	+$6,200,000,000
DSH	250,000,000	520,000,000	+270,000,000
IBNR	1,225,000,000	180,000,000	-1,045,000,000
HIT State & Local Administration	0	29,600,000	+29,600,000
TMA Program Extension	30,000,000	480,000,000	+450,000,000
QI Program Extension [1/]	0	0	0
Native American Protections	5,000,000	10,000,000	+5,000,000
Interaction of FMAP Increase With Other Medicaid Provisions	5,000,000	90,000,000	+85,000,000
Total Medicaid [1/]	**$36,715,000,000**	**$42,709,600,000**	**+$5,994,600,000**

1/ The chart reflects net budget authority (BA) and excludes the offsetting collections from the QI program, estimated to be $0 in FY 2009 and $412.5 million in FY 2010. The FY 2010 gross BA estimate is $43,122,100,000.

Centers for Medicare & Medicaid Services

Resource Summary

	Budget Authority ($ in Millions)			
	FY 2008 Appropriation	FY 2009 Estimate	FY 2010 Request	FY 2010+/- FY 2009
Drug Resources by Function:				
Treatment	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Total	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Drug Resources by Decision Unit:				
Centers for Medicare & Medicaid Services	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Total	$ 0.0	$ 0.0	$ 0.0	$ 0.0
Drug Resources Personnel Summary				
Total FTEs (direct only)	0	0	0	0

Program Summary

Mission

The Centers for Medicare & Medicaid Services' (CMS) mission is to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries. Through its coverage of screening and brief intervention services for those at risk for substance abuse, the Medicare and Medicaid programs assist in achievement of the goals of the National Drug Control Strategy.

Budget

CMS was designated as a National Drug Control Program Agency in 2007. As statutorily required of agencies so designated, the FY 2009 CMS budget submission to the congressional appropriations committees in February 2008 included a budget decision unit (Resource Summary). As described below, CMS has complied with the request of the Office of National Drug Control Policy (ONDCP) to establish two new Healthcare Common Procedure Coding System (HCPCS) codes for alcohol and drug screening and brief intervention (SBI).

Staff from ONDCP has requested estimates from CMS actuaries of the value of SBI services that might be identified if a certain number of States voluntarily elected to use the new codes. These estimates were intended to be illustrative of various levels of participation by the States. It is important to distinguish between these estimates and the CMS budget in which no additional appropriated funds are being sought for drug intervention or treatment. The HCPCS codes may be used to quantify the value of the services rendered, but only for those States electing to use them and not the national total. Furthermore, the Federal Government pays only a share of the Medicaid-covered services; the States also pay a share of the costs for SBI.

Healthcare Common Procedure Coding System (HCPCS) Codes

CMS has provided States the ability to report on early intervention and treatment for substance abuse. On January 1, 2007, two new HCPCS codes were introduced to facilitate the reporting of Medicaid costs for alcohol and drug screening and brief intervention (SBI). These codes are available for health care providers and States to use, though there is no requirement to do so.

The first code, H0049, is for alcohol and/or drug screening. The cost for a screening is dependent on where and how it is carried out. The screening, a preventative service, is generally accomplished using a brief questionnaire concerning a patient's alcohol or drug use. It can be carried out in various settings, most likely a physician's office or a hospital emergency room. Based on data provided to CMS, the average cost of a screening a beneficiary is $21.00.

The second code, H0050, covers a brief intervention that generally occurs right after the screening. The brief intervention is a 15- to 30-minute brief counseling session with a health professional intended to help motivate the beneficiary to develop a plan to moderate their alcohol or drug use. The cost of the intervention depends on both the amount of time involved and the treatment. Based on data provided to CMS, the average cost of an intervention is $61.50.

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

Some States began to implement the use of the new HCPCS codes during FY 2008. The amount of spending that would be captured by the use of these codes is dependent on the number and relative size of States which opt to use them. CMS' Office of the Actuary has estimated that if only 4 or 5 States used the codes, identified Medicaid expenditures would be $75 million annually. If as many as 20 States participated, identified expenditures would grow to $265 million. State's implementing these SBI reporting codes are responsible for determining their own reimbursement cost schedule. These actuarial cost estimates assume:

- A 10 percent effective participation rate for FY 2008, FY 2009 and FY 2010;
- An average cost of $21.00 per each screening of a beneficiary;
- An average cost of $61.50 per each brief intervention; and
- A 15 percent probability that a given screening will lead to an intervention.

Performance and Reporting

In addition to submitting a budget decision unit, organizations designated as National Drug Control Program Agencies are directed to relate their programs with the strategic plan, annual performance plan and annual performance report. During the previous Administration, CMS implemented the HCPCS codes but did not establish goals or measures. CMS will explore the appropriateness of measures for this activity with its new leadership in the coming months.

CMS Program Management
Programs Proposed for Elimination

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

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Information Technology

Funds Source	FY 2008 Actual	FY 2009 Appropriation	FY 2010 Appropriation	FY 2010 +/- FY 2009
Medicare Operations 1/	$569,215,000	$742,961,225	$786,625,927	$43,664,702
Federal Administration	21,366,000	24,240,000	29,240,000	5,000,000
Survey & Certification	3,416,000	3,540,000	3,245,000	(295,000)
Research	4,649,000	5,700,000	5,700,000	-
Revitalization Plan	-	-	-	-
Subtotal, Program Management Appropriation	**$598,646,000**	**$776,441,225**	**$824,810,927**	**$48,369,702**
Coordination of Benefits (COB) User Fee 2/	-	38,000,000	31,050,000	(6,950,000)
CLIA User Fees	2,040,000	2,040,000	2,040,000	--
Health Care Fraud & Abuse Account (HCFAC)	31,229,000	31,229,000	31,229,000	--
Quality Improvement Organizations (QIOs) 2/	76,827,000	99,001,000	103,220,000	4,219,000
Total, CMS IT Portfolio	**$ 708,742,000**	**$946,711,225**	**$992,349,927**	**$45,638,702**

1/ Starting in FY 2009, all enterprise data center (EDC) costs are included in Medicare Operations IT. Prior to the development of the enterprise data centers (EDCs), data center costs were included in the bills/claims payment line in Medicare Operations non-IT. This accounts for $114.7 M of the FY 2010 estimate and $89.9 M in FY 2009.
2/ The HCFAC and the QIO program are funded with mandatory dollars and operate on separate budget cycles from CMS' discretionary Program Management appropriation. The estimates shown are subject to change.

Program Description and Accomplishments

As shown in the table above, funding for CMS' information technology (IT) investments is spread across several budget resources, including the program management appropriation, user fees, and the HCFAC and QIO programs. IT activities support various programs that CMS oversees, including Medicare, Medicaid, CHIP, and associated quality-assurance and program safeguards. This chapter provides an overview of IT activities funded and discussed throughout various parts of this budget submission. Additional information can be found in those specific narratives. Further information on specific IT projects can be found within CMS's Exhibit 53 and Exhibit 300s, which can be viewed at www.hhs.gov/exhibit300.

CMS Program Management Appropriation

CMS' IT investments support a broad range of basic operational needs as well as provisions of legislation. The CMS request supports Departmental enterprise IT initiatives identified through the HHS strategic planning process. The following investments are organized similarly to the exhibit 300 portfolios, with an explanation of the type of investments in each.

Medicare Operations

IT Investment portfolios and activities include:

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

- *Beneficiary Enrollment, Plan Payment, and E-Services* includes the Medicare Advantage enrollment and plan payment systems such as the premium withhold system, risk adjustment system, and the Medicare Advantage Prescription Drug Payment System (MARx). Our public internet sites www.cms.hhs.gov , www.medicare.gov, and the virtual call center strategy are also included.

- *Data Management Operations* supports the beneficiary enrollment database; Medicare beneficiary database suite of systems; and CMS enterprise data administration.

- *Claims Processing* operates and maintains the Medicare fee-for-service claims processing systems and the Common Working File (CWF), a major component of the Medicare claims processing function.

- *Healthcare Integrated General Ledger Accounting System (HIGLAS)* includes development, operational, and maintenance costs for CMS' new financial management system.

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

- *Infrastructure* supports the Consolidated Information Technology Infrastructure Contract (CITIC), which maintains numerous Medicare program applications as well as CMS mid-tier and mainframe operations at the CMS data center; and ongoing systems security activities at Medicare contractors.

- *Claims Interoperability and Standards* provides for the continued standardization of certain electronic transactions required by HIPAA-enacted administrative simplification provisions.

- *Other Investments* includes:

    - *ICD-10 and Version 5010***-** ICD-10 is the biggest change in American healthcare standard coding systems in over 30 years. Each year that Medicare continues to use the current ICD-9 code set, the more likely it becomes that claims could be paid inaccurately, increasing costs and placing the Medicare trust fund at risk. The ICD-9 code set does not provide detailed information concerning a patient's diagnosis, the procedure or test that a provider orders. This makes detailed medical review necessary to detect if a claim was improperly paid. The ICD-10 code set is much more specific, making it easier to detect if a claim was appropriately billed. Although ICD-10 will not eliminate all fraud, waste, and abuse, CMS believes its increased specificity will make it more difficult for fraud, waste, and abuse to occur.

As discussed in the Medicare Operations section of this budget submission, implementing ICD-10 will impact every system, process and transaction that contains or uses a diagnosis code. Also, in order to implement ICD-10, the current version of the HIPAA transactions must be upgraded from version 4010 to 5010. Version 5010 accommodates the increased space required for the ICD-10 code sets.

- *Individuals Authorized Access to the CMS Computer Services (IACS)* - additional hardware and software support services to control access to a growing number of web-based applications, while accommodating more users.

- Also, the CMS request includes activities to support the e-Gov initiatives and Departmental enterprise information technology initiatives identified through the HHS strategic planning process.

Federal Administration

The Federal Administration portion of the Program Management appropriation funds a variety of IT activities that support CMS' IT infrastructure and daily CMS operations, including:

- voice and data telecommunication costs;
- web-hosting and satellite services;
- ongoing systems security activities on the CMS enterprise; and
- systems that support essential functions such as grants and contract administration, financial management, data management, and document management services.

The Federal Administration activity is also CMS' only source of funding for IT systems to support the Medicaid program. CMS' Medicaid data systems provide access to all Medicaid eligibility and utilization claims data. In addition, the service and supply fund activity within the Federal Administration line item includes CMS' share of costs for the HHS Unified Financial Management System (UFMS).

Survey and Certification

The Survey and Certification line item in CMS' Program Management budget provides IT funding primarily for operation and maintenance of systems that approximately 6,500 State surveyors use to track and report the results of healthcare facility surveys. In addition, the FY 2010 request supports the continued automated implementation of the Quality Indicator Survey (QIS), a new initiative that will utilize information technology to support quality in the survey process.

Research

IT funding within the Research line item covers data management and processing of the Medicare Current Beneficiary Survey and the chronically ill Medicare beneficiary research, data, and demonstration project.

HCFAC

IT funding from the MIP budget within the HCFAC account pays for a portion of CWF operating costs, as well as the ongoing operations and maintenance of systems related to audit tracking, Medicare secondary payer work, medical review, and other benefit integrity activities. Examples of MIP-funded systems include the fraud investigation database and the Medicare exclusion database. Another potential source of IT funding is HCFAC "wedge" money. CMS and other HHS operating divisions compete for these dollars, which are subject to annual negotiation and allocated by the Secretary of HHS.

QIO

Lastly, IT activities funded from the QIO program budget include the QIO Standard Data Processing System (SDPS), the Quality Improvement & Evaluation System (QIES), and QIO-related operations at the CMS data center.

Budget Request

CMS Program Management Appropriation – the total FY 2010 request for program management IT is $824,810,927 million, $48.4 million more than the FY 2009 appropriation. The program management request includes:

- *Medicare Operations* - $786.6 million, a $43.6 million increase. Mainly due to an increase in EDC operation costs ($25 million), ICD-10/5010 preparation work ($6 million), Part C/D IT systems operation costs ($7 million), Medicare/Medicaid website maintenance costs ($3 million) and HSPD-12 workload costs ($3 million).
- *Federal Administration* - $29.2 million, a $5.0 million increase in administrative IT costs.
- *Survey and Certification* - $3.2 million, a slight decrease.
- *Research* - $5.7 million, no change.

Additional Sources of IT Funding for CMS Programs

In FY 2010, a portion of the Part D coordination of benefits (COB) user fee will be used to fund Part D systems costs. The FY 2010 request proposes collection of $31 million in COB user fees for this purpose. In addition, a portion of the user fees collected under the Clinical Laboratory Improvement Amendments of 1988 pays for information systems that support the CLIA program.

Lastly, the FY 2010 estimate includes $31.2 million for HCFAC IT and $103.2 million for QIO IT. The HCFAC and the QIO program are funded with mandatory dollars and operate on separate budget cycles from CMS' discretionary Program Management appropriation. The estimates are subject to change.

FY 2010 HHS Enterprise Information Technology Fund: E-Gov Initiatives

OPDIV Allocation Statement:

The **CMS** will contribute **$7,758,773** of its **FY 2010** budget to support Department enterprise information technology initiatives as well as 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 E-Government 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.

Of the amount specified above, **$1,526,930.16** is allocated to support E-Government initiatives for **FY 2010**. This amount supports E-Government initiatives as follows:

FY 2010 HHS Contributions to E-Gov Initiatives*	**CMS**
Line of Business - Federal Health Architecture (FHA)	$1,100,820.92
Line of Business - Human Resources	$9,848.09
Line of Business - Grants Management	$1,210.19
Line of Business - Financial	$32,334.25
Line of Business - Budget Formulation and Execution	$21,502.30
Line of Business - IT Infrastructure	$36,214.40
Disaster Assistance Improvement Plan	$325,000.00
E-Gov Initiatives Total	**$1,526,930.16**

*The total for all HHS FY 2010 inter-agency E-Government and Line of Business contributions for the initiatives identified above, and any new development items, is not currently projected by the Federal CIO Council to increase above the FY 2009 aggregate level. Specific levels presented here are subject to change, as redistributions to meet changes in resource demands are assessed.

Prospective benefits from these initiatives are:

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

Lines of Business-Federal Health Architecture: Creates a consistent Federal framework that improves coordination and collaboration on national Health Information

Technology (HIT) Solutions; improves efficiency, standardization, reliability and availability to improve the exchange of comprehensive health information solutions, including health care delivery; and, to provide appropriate patient access to improved health data. HHS works closely with federal partners, state, local and tribal governments, including clients, consultants, collaborators and stakeholders who benefit directly from common vocabularies and technology standards through increased information sharing, increased efficiency, decreased technical support burdens and decreased costs.

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

Lines of Business-Grants Management: Supports end-to-end grants management activities promoting improved customer service; decision making; financial management processes; efficiency of reporting procedure; and, post-award closeout actions. 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 –**Financial Management:** Supports efficient and improved business performance while ensuring integrity in accountability, financial controls and mission effectiveness by enhancing process improvements; achieving cost savings; standardizing business processes and data models; promoting seamless data exchanges between Federal agencies; and, strengthening internal controls.

Lines of Business-Budget Formulation and Execution: Allows sharing across the Federal government of common budget formulation and execution practices and processes resulting in improved practices within HHS.

Lines of Business-IT Infrastructure: 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.

Disaster Assistance Improvement Plan (DAIP): The DAIP, managed by Department of Homeland Security, assists agencies with active disaster assistance programs such as HHS to reduce the burden on other federal agencies which routinely provide logistical help and other critical management or organizational support during disasters.

Significant Items of Interest to Congress
FY 2009 Senate Appropriations Committee Report Language
(Senate Report 110-410)

Item

Methicillin-resistant Staphylococcus Aureus [MRSA] - Of the total amount provided for HCQO the Committee has included $5,000,000 for activities to identify and reduce the spread of Methicillin-resistant Staphylococcus Aureus [MRSA] and other healthcare-associated infections. The Committee is concerned about the prevalence of these preventable infections and has provided a second year of funding for this initiative at AHRQ due to its expertise with patient safety and quality of care issues. The Committee encourages AHRQ to continue its collaboration with the Centers for Disease Control and Prevention [CDC] and the Centers for Medicare and Medicaid Services [CMS]. (p. 140)

Action Taken or to be Taken

CMS is working to reduce hospital acquired Methicillin-resistant Staphylococcus aureus [MRSA] infection and transmission rates as part the 9th Statement of Work for the Quality Improvement Organization [QIO] program. In a unique collaboration between the CMS, the CDC and AHRQ, CMS is utilizing the expertise of the QIOs to provide technical assistance to hospital units choosing to work with the QIOs on MRSA reduction. Measure of the QIOs progress is being captured utilizing the CDC's National Healthcare Safety Network, Multi-Drug Resistant Organism Module [NHSN-MDRO]. The AHRQ has also provided master training to the QIOs on TeamSTEPPS, a team work methodology that has proven effective in other areas of healthcare where patient outcomes are dependent upon greater communication. CMS, through the QIO program, is targeting reduction of MRSA infections in approximately 440 hospital units nationwide.

Data collection for MRSA infection and transmission began February 1, 2009. The CDC's electronic system for capturing MRSA rates, the Multi-drug Resistant Module [MDRO] became available March 13, 2009. QIOs are in the process of establishing their connection with the module so that data can be entered to further assess progress on this important initiative.

Item

Models of Primary Health Care Delivery - The Committee is aware of several models of health care delivery that are improving patient outcomes; decreasing utilization of inpatient services, emergency room care and specialty services; and improving patient satisfaction. The Committee encourages CMS to make resources available for entities to develop models of primary health care delivery and demonstrate their effectiveness in improving delivery and decreasing per patient costs for Medicaid populations. (p. 143)

Action Taken or to be Taken

CMS is supporting States in their use of medical homes in their Medicaid programs to deliver patient-centered access to primary care services, which have shown promise in improving patient outcomes; decreasing utilization of inpatient services, emergency room care, acute care and specialty services; and improving patient satisfaction. CMS accomplishes this by providing States with guidance and technical assistance on the development and implementation of their medical homes. In addition, CMS has identified promising practice medical home models at the State level and has disseminated that information through its website http://www.cms.hhs.gov/MedicaidCHIPQualPrac/MCPPDL/list.asp

CMS has also examined opportunities to leverage the Medicare Medical Home Demonstration to ascertain whether the model can be applied to the Medicaid population. CMS has actively participated in the Federal workgroup, facilitated by the Office of Disabilities, Department of Health & Human Services, on the conceptualization and development of the medical home model across the life span.

Item

Coverage for Type 1 Diabetes Patients – Advances in medicine have enabled increasing numbers of type 1 diabetes patients to live with this disease for more than 50 years. Recent advances in continuous glucose monitoring technology have the potential to revolutionize the way diabetes is managed on a daily basis. While the research is underway, the Committee urges CMS not to make premature coverage decisions related to such items as durable medical equipment or any associated services or supplies, nor take actions that would delay the private adoption of these technologies. (p. 144)

Action Taken or to be Taken

Currently, home blood glucose monitors are covered as durable medical equipment (DME) under the Medicare program. CMS established new Healthcare Procedure Coding System (HCPCS) Level II codes, effective January 1, 2008, to identify continuous glucose monitoring system components. These new codes are available for assignment by non-Medicare insurers.

Item

Reimbursement Rates for Human Pancreatic Islets – Access to human pancreatic islets at a reasonable cost is vital to basic research on the causes and mechanisms of diabetes. If organs used to procure islets for research are not reimbursed at a reasonable rate, the cost could curtail much needed basic research on islet function in health and disease. The Committee urges CMS to address the issue of reimbursement rates for human pancreatic islets in a manner that will facilitate their research and/or clinical use. (p. 144)

Action Taken or to be Taken

Section 733 of the MMA requires that Medicare pay for the "routine costs as well as transplantation and appropriate related items and services" incurred on behalf of Medicare beneficiaries participating in the NIH clinical trial of islet cell transplantation. CMS' reimbursement rate for human pancreatic islets reflects these costs including costs for immunosuppressive drugs, follow-up care, costs of the islet cell isolation for the clinical trial, and the pancreata that are procured for the transplant. It has been suggested that CMS allocate a lesser amount for the costs of such pancreata because the current rate results in a higher cost for obtaining all organs from a given donor, for all payers. However, reducing the reimbursement rate for human pancreatic islets will not adequately cover the costs incurred for Medicare beneficiaries. We recommend that additional funding be provided to cover these costs at comparable rates for non-Medicare participants in the NIH clinical trial.

Item

LTACH Quota Limits - As early as September 2004 this Committee stated that long-term acute care hospitals play a vital role in the Medicare continuum of care and that admission decisions should be made on the basis of well-defined and objective patient and hospital admissions criteria. The Committee is concerned that the CMS guidelines set arbitrary quota limits for the number of patients which an LTACH can accept from

any one hospital. Patients who need access to LTACHs are among the most vulnerable of the sick. This Committee has previously stated that the decision as to which patients should go into a LTACH should be made by physicians based on well-defined patient and hospital admissions criteria—not on arbitrary quotas. The Medicare Payment Advisory Commission [MEDPAC] in its March 22, 2007 letter to CMS warned that arbitrary criteria increase the risk of unintended consequences. The Committee remains concerned that 4 years have passed and CMS has not yet developed these criteria. (p. 144-145)

Action Taken or to be Taken

CMS has not imposed quota limits for the number of patients which a long-term care hospital (LTCH) can accept. We believe this reference is a misunderstanding of a CMS policy that is commonly referred to as the "25 percent rule". This rule was not designed to impose patient quota limits on LTCHs; rather, it is a payment threshold adjustment implemented by CMS to discourage patient-shifting between an acute care hospital and a LTCH for the purpose of receiving two Medicare payments (one payment under the IPPS and another payment under the LTCH PPS) for what is essentially one episode of care.

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

RTI's research to date (both Phase I and Phase II) is posted on the CMS website at: "http://www.cms.hhs.gov/LongTermCareHospitalPPS/02a_RTIReports.asp#TopOfPage"

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

Item

Welcome to Medicare Physical Exam - The Committee is concerned regarding low utilization rates for the ''Welcome to Medicare Physical Exam,'' and how this is impacting the number of Medicare beneficiaries that receive referrals for abdominal aortic aneurysm (AAA) screening benefit and other preventive services. The American Heart Association estimates that if Medicare beneficiaries who are at risk for AAA receive this

one-time, cost- effective ultrasound screening, it will prevent over 15,000 deaths per year. The Committee urges CMS to launch a public relations campaign to educate individuals who are about to become Medicare eligible, and their families, regarding the need to get ‘‘Welcome to Medicare Physical Exam." This exam allows America’s seniors to learn ways to prevent illness if they do become ill, to treat the problem early before it becomes too severe. It provides an opportunity to educate our seniors of the importance of leading a healthy lifestyle through good nutrition, regular physical activity and not smoking, all factors that can prevent individuals from developing chronic diseases and reducing their quality of life. (p. 145)

Action Taken or to be Taken

CMS is committed to increasing utilization of the “Welcome to Medicare” exam by promoting its availability through an outreach and education campaign that will encourage utilization of the benefit through cost-effective strategies. We plan to initiate the campaign in 2009 through a variety of tactics such as:

- Conducting pre-outreach research, including an on-line “conversation map” to increase effectiveness of the on-line promotion.
- Utilizing new technology to reach the incoming Medicare population through the development of a webpage dedicated to new Medicare enrollees on the http://www.medicare.gov website to help promote the exam and other Medicare benefits.
- Leveraging online media strategies, such as web banner ads, blogging, etc. to promote awareness of the exam.
- Engaging employers and SSA to find ways to reach other new enrollees who are retirees or those who elect to sign up for SSA/Medicare benefits after they turn 65.
- Outreach to providers so they are aware of recent statutory changes in the exam benefit (including waiver of the Part B deductible) and will promote it to their patients.
- Conducting post-launch research to determine effectiveness of strategies.

CMS also notifies beneficiaries of the “Welcome to Medicare Physical Exam” in their initial enrollment package and in the *Medicare & You* handbook, under the “Medicare’s Covered Services” section.

Item

Advanced Directives in Medicare Handbook - The Committee directs CMS to include in the next publication of ‘‘Medicare & You’’ information regarding the importance of writing and updating advance directives and living wills (p. 146)

Action taken or to be taken

The 2009 Medicare & You handbook, which was mailed to beneficiary households in October of 2008, includes a new section on planning for end-of-life care. The section encourages people with Medicare to work with a family member, friend, or health care provider to make important decisions that could affect health issues in the future. Specifically, it includes information on advance directives including living wills, durable powers of attorney, and after-death wishes. The handbook refers people to their health care provider, attorney, local Office on Aging, State health department, and www.longtermcare.gov for additional information. The draft 2010 Medicare & You handbook also includes this information.

Item

Technical Assistance to States to Collect Prescription Drug Data in Lieu of Granting More Waivers-The Committee notes that the Deficit Reduction Act now requires that States capture data on certain prescription drugs administered by physicians under Medicaid and use that data to collect rebate dollars available from drug manufacturers. The Committee understands that States do not always adequately collect that data, which if collected, could result in savings to the Medicaid program. The Committee encourages CMS to provide technical assistance to States on technologies available to collect this data in lieu of granting more waivers. (p.146)

Action taken or to be Taken

For the period January through June 2008, thirty-eight (38) States requested and were granted extensions to allow time to make necessary changes to their Medicaid Management Information Systems (MMIS) to collect data and allow extra time for their providers to prepare their billing systems to implement the prescription administered drug data requirements. CMS offered enhanced funding to States for development costs to modify their MMIS and provided technical assistance and advice to States that requested such assistance. Currently, all extensions have expired, no new ones have been granted and States are in the process collecting the physician administered drug data and billing manufacturers for rebates.

Item

Health Care Fraud and Abuse Control – The Committee encourages CMS to invest in efforts to apply data mining and warehousing methodologies to detect fraud, waste, and abuse. Data mining is increasingly being used to extract relevant information from large data bases, like those maintained by CMS. The Committee has included funds for CMS to expand its efforts, begun in 2006, to link Medicare claims and public records data and to initiate new demonstration projects using data mining technologies. The Committee requests that CMS make recommendations to the Committee on how linking CMS data might be used to enhance the Medicare and Medicaid Integrity Programs to reduce fraud and abuse and to better screen providers. (p. 146)

Action Taken or to be Taken

Advanced algorithms and other data mining techniques are used to identify those Medicaid providers with aberrant billing practices. The sharing of the results of this data analysis CMS-wide enables us to leverage resources to respond to cross-cutting program integrity issues.

In FY 2008, CMS began the development of the Medicaid Integrity Group Data Engine, the first national database of Medicaid claims. The data engine will, in the near future, allow the storage of up to 30 terabytes of Medicaid claims and related data. In addition, data models to predict suspect provider behavior will be built to target specific provider types (e.g., physician, pharmacy, dental).

CMS has also been working to identify additional data elements to be captured in the Medicaid Statistical Information System (MSIS) data for program integrity use. Data from both systems have been combined into a common dataset, known as “MSIS Plus”. CMS is collaborating with external program integrity partners (e.g., HHS OIG and U.S. Department of Justice) to include data elements that are applicable to the efforts of all.

The CMS has invested in a powerful information technology solution to detect fraud, waste, and abuse across Medicaid and Medicare Parts A, B, and D. With the inclusion of integrated and matched national data, business intelligence tools, and an estimated 250 terabyte platform when fully built, the One Program Integrity System (One PI) allows for a superior level of efficiency and innovation in data mining and monitoring.

Of tremendous benefit is the One PI's ability to routinely use business analytical tools to mine episodes-of-care data, which shows the exact periods of time that treatment is given by a Medicare/Medicaid provider. The data could be used to detect "up-coding"—use of a higher classification of disease than is warranted by a beneficiary's condition. With this type of episode data, CMS would also be able to detect other wasteful activities; such as providers who consistently see patients more frequently than average or who consistently order an unusual number of tests.

One PI will enable CMS' program integrity contractors to routinely use mass screening—such as payment thresholds exceeded, or laboratory tests with no relevant diagnoses—and notify the appropriate contractor for follow-up action. This automation will allow contractors to better focus their efforts on detecting more advanced forms of fraud, waste, and abuse using detection tools such as multi-dimensional analysis, predictive modeling, scoring, and link analysis.

One PI will have the ability to leverage work across the One PI community including multiple States, contractors, or jurisdictions. Because One PI will load Medicaid data in a standard data model, screening runs and analyses that are now developed for a single State can be utilized for all the States in the One PI System. The matching and standardization of Medicaid data across the States will help identify fraud that crosses State borders or identify providers who move from State to State.

Significant Items of Interest to Congress
FY 2009 Draft House Appropriations Committee Report Language
(Draft House Report 110-XXX)

Item

State High Risk Insurance Pools - The Committee provides $75,000,000 for a second important health care access program--State High Risk Insurance Pools, which is $25,873,000 or 52.7 percent above fiscal year 2008. The fiscal year 2009 budget requests this funding as a mandatory rather than discretionary program dependent upon action by the authorizing committees. Currently, 33 States operate high-risk pools that act as the health insurers of last resort for almost 200,000 individuals who have lost, or who are ineligible, for group insurance coverage and who are medically high-risk and unable to purchase individual health insurance in the commercial market. The program also produces the side benefit of reducing costs for those with health insurance by providing coverage to individuals who would otherwise be uninsured and very costly to care for-thus reducing the cost-shifting that results in higher premiums to those with coverage. High-risk pools are a successful public/private partnership. All high-risk pool participants pay a monthly premium, capped at 125 to 200 percent of the average market premium. Insurers and health care providers support the program through assessments and some States contribute to their pools. Federal funding allows States with high-risk pools to reduce premiums charged to participants and to improve benefits. The Committee is committed to expanding existing safety net programs that provide health care to uninsured and disadvantaged populations. (p. 13-16)

Action Taken or to be Taken

CMS will release a grant solicitation to the current High Risk Pool Grantees that do not have an operational losses grant or bonus grant program. CMS will also release a request to the current High Risk Pool Grantees that have an operational losses and bonus grants program in place for supplemental funding. These funding amounts follow the formulas outlined in the State High Risk Pool Funding Extension Act and the language outlined in the FY 2009 Appropriations Bill. CMS anticipates that awards will be made no later than September 30, 2009.

Item

Medicare State Health Insurance Program (SHIP) - The $5,700,000 or 14.5 percent increase over fiscal year 2008 for the SHIP will support health insurance counseling in every State to help the 45.5 million Medicare beneficiaries understand and utilize their Medicare benefits, including Medicare preventative benefits. The budget request provided only a $2,599,000 increase for the program. (p. 13-16)

Action Taken or to be Taken

CMS strongly supports the State Health Insurance Assistance Program (SHIP). The current FY 2009 funding for SHIP is $52.5 million. CMS has allocated $45.0 million of this amount from its' annual appropriation and $7.5 million is provided from the Medicare Improvements for Patients and Providers Act of 2008.

(Dollars displayed in Millions)

	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Funding from CMS PM account (includes MMA funding in FY 2004-2005)	$12.5	$21.4	$31.7	$32.7	$34.2	$39.3	$45.0
Funding from Other Legislation						$15.0	$ 7.5
TOTAL funding for SHIPs	$12.5	$21.4	$31.7	$32.7	$34.2	$54.3	$52.5

The chart above clearly displays CMS' commitment to funding SHIPs, as the funding from CMS' annual appropriation (Program Management – PM account) dramatically increased during FY 2004 and 2005 with the receipt of Medicare Modernization Act (MMA) funding and CMS has provided an increased funding level even post-MMA funding. The chart also displays an additional $15 million in FY 2008 from the *Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 and* $7.5 million in FY 2009 from the *Medicare Improvements for Patients and Providers Act of 2008*.

Plans for FY 2009 include:

- April 1, 2009 - grant awards were provided to States with no reduction of funding from CMS from the prior year.
- June 1, 2009 – grant awards to States of an additional $7.5 million from the *Medicare Improvements for Patients and Providers Act (MIPPA) of 2008*. This legislation provides for an allocation based on a percentage of low-income beneficiaries and a percentage of rural beneficiaries.
- September 2009 – grant awards to States based on performance.

Item

Healthcare-Acquired Infections (HAIs) - The Committee believes that combating HAIs is an urgent public health issue that demands greater attention. The Committee includes $1,000,000 within the Office of the Secretary to ensure that HHS engages in a stronger, coordinated effort, involving CDC, the Centers for Medicare and Medicaid Services (CMS), and the Agency for Health Research and Quality (AHRQ), to reduce HAIs. The Committee expects the Secretary to use these funds to collaborate with outside experts, as well as experts within at CMS, CDC, and AHRQ, to conduct a thorough review of HAI activities across the Department and to develop an action plan for reducing HAIs in the U.S. This action plan shall identify data deficiencies, additional activities needed for a strengthened, coordinated public health response, timelines and benchmarks for improved outcomes, new enforcement mechanisms that may be needed, and short- and long-term budget estimates for carrying out the action plan. This information will be critical for the Committee to make an informed, appropriate response to this urgent problem. (p. 18-19)

Action Taken or to be Taken

In 2008, the Department of Health and Human Services began a concerted, Departmental-wide effort to approach the issue of Healthcare-Associated Infections. The goal of this effort was to marshal the extensive and diverse resources of HHS and cooperate effectively with public and private sector partners to accomplish the large-scale prevention of healthcare-associated infections. HHS has also undertaken several inter-agency initiatives to improve and expand HAI prevention efforts. One of these was the establishment of the HHS Steering Committee for the Prevention of Healthcare-

Associated Infections. The Steering Committee included senior-level representatives from the Offices and Operating Divisions of HHS and was chaired by the Principal Deputy Assistant Secretary for Health. The Steering Committee was charged with developing the "HHS Action Plan to Prevent Healthcare-Associated Infections". HHS, including the AHRQ, OASPA, ASPE, CDC, CMS, FDA, NIH, ONC and the OPHS, issued the Action Plan in January 2009. The Action Plan established national goals and outlined key actions for enhancing and coordinating HHS-supported efforts to reduce HAI. In addition, the plan outlined opportunities for collaboration with external partners. HHS is currently in the process of synthesizing the comments received from the public and revising the Action Plan in the spring of 2009.

CMS also continues to move forward with various Medicare and Medicaid initiatives designed to prevent HAIs. On July 31, 2008, CMS issued a State Medicaid Directors Letter encouraging States to adopt a payment policy as a complimenting measure to Medicare's payment policy on Hospital Acquired Conditions. We continue to work with States to implement their policy so that it provides adequate payment protection of adverse events in an inpatient setting for both dual eligible and Medicaid populations. Data is currently being collected on the number of States implementing Never Event payment policies, the level of sophistication of these polices (e.g. use of Medicare, NQF or State identified HAIs, HACs and Never Events) and coordination of these policies and issues related to development and implementation. We will subsequently use this information to make an informed decision on broader policy and guidance to States on Never Events.

Item

Immunization and Respiratory Diseases - In addition, the current Vaccines for Children (VFC) is expected to provide $2,766,230,000 in vaccine purchases and distribution support in fiscal year 2009. The Committee notes that there are other Federal programs that provide immunizations to children, including the State Children's Health Insurance Program (SCHIP), the Maternal and Child health Block Grant, and Community Centers. (p. 109)

Action Taken or to be Taken

CMS will work with CDC to ensure that children receive necessary vaccinations.

Item

Diabetes - In order to incentivize and improve long-term health outcomes for Medicare and VA beneficiaries, among others, the Committee encourages AHRQ, in collaboration with CDC and NIH, to prioritize the development of a case mix adjustment methodology that can be used with performance measurement of blood glucose control. The Committee encourages AHRQ to conduct a feasibility study on the state of the art in developing such a tool and a plan, with set timelines, for producing a validated methodology for use by CMS and the VA health care systems, at a minimum, in those program's quality reporting initiatives. (p. 188)

Action Taken or to be Taken

Currently CMS does not use any blood glucose control measures in its quality reporting initiatives that require case mix adjustment. However, CMS looks forward to using a validated case-mix adjustment methodology when available from AHRQ as CMS revises its quality measures and/or develops new outcome measures related to blood glucose control.

Item

One-on-One Counseling for Dual Eligibles with Mental Disabilities - The Committee commends CMS for its initial community-based activities for a Medicare education and outreach campaign directed toward dual eligible persons. The Committee is aware, however, that there is considerable evidence that low-income dual eligible persons with mental disabilities continue to need direct help with Medicare Part D enrollment. The Committee urges CMS to increase the share of funds for one-on-one pharmaceutical benefits counseling that are provided for counseling of dual eligible persons through community-based organizations and safety net community mental health centers. (p. 191)

Action Taken or to be Taken

Beginning with its FY2007 grant funding, SHIPs were instructed to use a portion (5%) of their funding specifically to provide one-on-one pharmaceutical counseling to low-income dual eligible persons with mental disabilities. SHIPs utilize Area Agencies on Aging (AAA), community mental health centers and other community based organizations in providing counseling and assistance for this population. CMS provided SHIPs training, tip sheets, and tools that were developed to assist counselors and SHIP program directors in counseling and developing community mental health referral networks. During the FY2007 and FY2008 National SHIP Directors' Conferences, information on serving beneficiaries with mental disabilities was presented. The conference provided the opportunity to share "best practices" from SHIPs, the mental health community and other partners. CMS put into place a mechanism for SHIPs to track the numbers of client contacts made and the networks developed. SHIPs continue to report difficulty/sensitivity around identifying and counseling duals with mental disabilities.

In FY 2009, CMS will take the following steps.

- As part of the FY 2009 grant process, CMS required that SHIPs submit program budgets that demonstrate that at least 5 percent of Federal SHIP funding will be directed toward outreach to increase one-on-one pharmaceutical benefits counseling to low-income dual eligible persons with mental disabilities.

- In FY 2009, CMS expects SHIPs to build upon the activities begun in 2007 and to continue to foster local partnership efforts, including relationships with the mental health community, and to engage in outreach to better reach, inform, and assist beneficiaries with disabilities.

- As part of the 2008 grant report process, CMS required SHIPs to describe their progress on efforts to enhance one-on-one pharmaceutical benefits counseling to low-income dual eligible persons with mental disabilities as part of the mid-year reports required of all SHIPs. From these reports, counseling and outreach practices implemented by SHIPs will be shared in FY2009 among the SHIP network via the SHIPTalk website.

- In 2009, CMS will require SHIPs to continue to build capacity to serve the needs of duals with mental disabilities.

- During FY2008, SHIPs reported on the development of coalitions and training with their State and county community mental health agencies. In some

instances, referral systems have been developed between the state or local SHIP and the community health network. SHIPs have provided counseling and training on Medicare benefits, while community mental health providers have provided sensitivity training and referral networks for SHIPs. In 2009, SHIPs will continue their work with CMS Regional Offices to expand their mental health networks, using the SHIP-Technical Assistance Program (TAP) pilot project developed by the Office of the Medicare Ombudsman as a model for network expansion.

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

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

- CMS will expand the network of support for SHIPs to engage mental health coalitions such as the National Coalition on Mental Health and Aging.

Item

Coverage for Type 1 Diabetes Patients – Advances in medicine have enabled increasing numbers of type 1 diabetes patients to live with this disease for more than 50 years. Recent advances in continuous glucose monitoring technology have the potential to revolutionize the way diabetes is managed on a daily basis. While the research is underway, the Committee urges CMS not to make premature coverage decisions related to such items as durable medical equipment or any associated services or supplies, nor take actions that would delay the private adoption of these technologies. (p. 144)

Action Taken or to be Taken

Currently, home blood glucose monitors are covered as durable medical equipment (DME) under the Medicare program. CMS established new Healthcare Procedure Coding System (HCPCS) Level II codes, effective January 1, 2008, to identify continuous glucose monitoring system components. These new codes are available for assignment by non-Medicare insurers.

Item

Reimbursement Rates for Human Pancreatic Islets – Access to human pancreatic islets at a reasonable cost is vital to basic research on the causes and mechanisms of diabetes. If organs used to procure islets for research are not reimbursed at a reasonable rate, the cost could curtail much needed basic research on islet function in health and disease. The Committee urges CMS to address the issue of reimbursement rates for human pancreatic islets in a manner that will facilitate their research and/or clinical use. (p. 144)

Action Taken or to be Taken

Section 733 of the MMA requires that Medicare pay for the “routine costs as well as transplantation and appropriate related items and services” incurred on behalf of Medicare beneficiaries participating in the NIH clinical trial of islet cell transplantation.

CMS' reimbursement rate for human pancreatic islets reflects these costs including costs for immunosuppressive drugs, follow-up care, costs of the islet cell isolation for the clinical trial, and the pancreata that are procured for the transplant. It has been suggested that CMS allocate a lesser amount for the costs of such pancreata because the current rate results in a higher cost for obtaining all organs from a given donor, for all payers. However, reducing the reimbursement rate for human pancreatic islets will not adequately cover the costs incurred for Medicare beneficiaries. We recommend that additional funding be provided to cover these costs at comparable rates for non-Medicare participants in the NIH clinical trial.

Item

Multilingual Helplines - The Committee is aware of the language, outreach, and education barriers faced by more than one million Asian and Pacific Islander seniors attempting to access CMS programs. In order to support outreach efforts, the Committee encourages CMS to sustain its multilingual helplines to improve access to CMS programs. (p.193)

Action Taken or To Be Taken

The 1-800-MEDICARE helpline provides assistance to Asian-Americans and people with limited English proficiency by providing an interpreter when requested or a need is identified by the 1-800 MEDICARE Customer Service Representative. Also, the National Asian Pacific Center on Aging (NAPCA) operates a multi-language helpline center offering assistance to Chinese, Korean, Vietnamese, and English-speaking elders. NAPCA, a strong partner of CMS, helps Asian-American Medicare beneficiaries to sign up for Part D and apply for Limited Income Subsidy (LIS). NAPCA receives private funding for its helpline.

CMS translated its photo novella on LIS into Chinese, Korean, and Vietnamese, and included NAPCA's direct helpline numbers on the brochure.

In addition, CMS has implemented a pilot that will test methods and tools to enhance the communication capacity of organizations that do not have staff with the language skills needed to effectively assist individuals with limited English proficiency (LEP). As a part of the project, participating organizations (e.g., State Health Insurance Assistance Programs, Area Agencies on Aging, and local community-based organizations) are testing methods to assist beneficiaries with LEP, including obtaining interpretation assistance from local ethnic partners and 1-800-MEDICARE. Although the pilot targets the Korean community, the final toolkit will help organizations to communicate with any individual with LEP. The toolkit being tested allows the organizations to educate Korean-Americans on Medicare covered preventive services and other Medicare-related information through use of guidelines, translated publications, an in-language DVD, and educational efforts such as presentations and partnering.

During the fall of 2008, CMS held 6 AAPI focus groups (one beneficiary and one caregiver group for each of the following AAPI groups: Chinese, Korean, and Vietnamese). The groups discussed their knowledge of the Medicare program and preferences for Medicare messages, including pictures used with the messages. The findings will enable CMS to communicate more effectively with these communities.

CMS currently is arranging for listening sessions with AAPI partners this spring to address their communities' concerns and issues related to LEP.

CMS has translated numerous Medicare publications into Chinese, Korean, and Vietnamese languages. These materials are posted on the AAPI page of CMS' Partner Web Site, which has a direct link to CMS' multi-language publication site.

CMS conducts outreach campaigns to educate AAPI beneficiaries about important Medicare issues (e.g., Part D enrollment, LIS, preventive services). The campaigns include earned media such as local events in AAPI communities and paid media such as in-language radio announcements and print ads.

Item

Aging Network Support Activities - Aging and Disability Resource Centers (ADRCs) are currently operating in 43 States and Evidence-Based Disease Prevention programs are being implemented in 24 States. The funding provided is intended to sustain and expand these efforts through a coordinated approach that will provide States with enhanced tools for redirecting their long-term care systems to make them more responsive to the needs and preferences of older people and their caregivers. In implementing these activities, the Committee encourages the Administration on Aging (AoA) to continue its close partnership efforts with the Centers for Medicare and Medicaid Services (CMS), the National Institute on Aging, the Centers for Disease Control and Prevention (CDC), and other agencies. (p. 213-214)

Action Taken or to be Taken

On July 15th, 2008, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) was passed by Congress and became law (P.L. 110-275). Section 119 of this legislation provides a total of $25 million for beneficiary outreach activities.

- $7.5 million to State Health Insurance Assistance Programs (SHIPs);
- $7.5 million to States for Area Agencies on Aging (AAAs) and for Native American programs;
- $5 million for State ADRC programs;
- $5 million for a resource center to help coordinate efforts to inform older Americans about benefits available under Federal and State programs through a web-based decision tool, providing a best practice clearinghouse and provide training and technical assistance to state and local programs.

Federal funding under MIPPA section 119 will be administered by the AoA and the CMS.

In an effort to coordinate funding opportunities for states and their SHIPs, AAAs and ADRCs, CMS partnered with the AoA and released a joint program announcement and grant application "Medicare Beneficiary Outreach and Assistance Program" for $25 million of this funding. A joint review of applications received for funding was conducted. Funds will be distributed by June 1, 2009.

The activities of these programs and collection of information on "best practices" will be monitored through the national resource center, funded at $5 million. The AoA will be administering a contract for the national resource center.

Section 119 of MIPPA also allows $5 million for AAAs and ADRCs under reprogrammed funds from the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007. The

$5 million is reprogrammed under Section 119 of MIPPA, but is funded from the MMSEA. These funds are included in the AOA and CMS joint program announcement and will be distributed with the other funds in this announcement by June 1, 2009.

Item

Healthcare-Acquired Infections (HAIs) - The Committee believes that combating HAIs is an urgent public health issue that demands greater attention. The Committee includes $1,000,000 within the Office of the Secretary to ensure that HHS engages in a stronger, coordinated effort, involving CDC, the Centers for Medicare and Medicaid Services (CMS), and the Agency for Health Research and Quality (AHRQ), to reduce HAIs. The Committee expects the Secretary to use these funds to collaborate with outside experts, as well as experts within at CMS, CDC, and AHRQ, to conduct a thorough review of HAI activities across the Department and to develop an action plan for reducing HAIs in the U.S. This action plan shall identify data deficiencies, additional activities needed for a strengthened, coordinated public health response, timelines and benchmarks for improved outcomes, new enforcement mechanisms that may be needed, and short- and long-term budget estimates for carrying out the action plan. This information will be critical for the Committee to make an informed, appropriate response to this urgent problem. (p. 18-19)

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Significant Items of Interest to Congress
FY 2009 Joint Explanatory Statement
(Accompanying H.R. 1105 AND S. 3230)

Item
Medicare SHIPs - The bill provides $45,000,000 for the State Health Insurance Program. (p.103)

Action Taken or to be Taken
CMS strongly supports the State Health Insurance Assistance Program (SHIP). The current FY 2009 funding for SHIP is $52.5 million. CMS has allocated $45.0 million of this amount from its' annual appropriation and $7.5 million is provided from the Medicare Improvements for Patients and Providers Act of 2008.

(Dollars displayed in Millions)

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TOTAL funding for SHIPs	$12.5	$21.4	$31.7	$32.7	$34.2	$54.3	$52.5

The chart above clearly displays CMS' commitment to funding SHIPs, as the funding from CMS' annual appropriation (Program Management – PM account) dramatically increased during FY 2004 and 2005 with the receipt of Medicare Modernization Act (MMA) funding and CMS has provided an increased funding level even post-MMA funding. The chart also displays an additional $15 million in FY 2008 from the Medicare, Medicaid, and SCHIP Extension Act (MMSEA) of 2007 and $7.5 million in FY 2009 from the Medicare Improvements for Patients and Providers Act of 2008.

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- September 2009 – grant awards to States based on performance.

Item
"Medicare & You" Handbook - The Centers for Medicare & Medicaid Services (CMS) is directed to include in the next publication of "Medicare & You" information regarding the importance of writing and updating advance directives and living wills. (p. 103)

Action Taken or to be Taken
The 2009 Medicare & You handbook, which was mailed to beneficiary households in October of 2008, includes a new section on planning for end-of-life care. The section encourages people with Medicare to work with a family member, friend, or health care provider to make important decisions that could affect health issues in the future.

Specifically, it includes information on advance directives including living wills, durable powers of attorney, and after death wishes. The handbook refers people to their health care provider, attorney, local office on aging, state health departments, and www.longtermcare.gov for additional information. The draft 2010 Medicare & You handbook also includes this information.

Item

Health Care Fraud and Abuse – The bill includes $198,000,000 above the fiscal year 2008 level and the same as the budget request. This level includes funding for CMS to expand its efforts to link Medicare claims and public records data and to initiate new demonstration projects using data mining technologies. (p. 103)

Action Taken or to be Taken

The CMS has invested in a powerful information technology solution to detect fraud, waste, and abuse across Medicaid and Medicare Parts A, B, and D. With the inclusion of integrated and matched national data, business intelligence tools, and an estimated 250 terabyte platform when fully built, the One Program Integrity System (One PI) allows for a superior level of efficiency and innovation in data mining and monitoring.

Of tremendous benefit is the One PI's ability to routinely use business analytical tools to mine episodes-of-care data, which shows the exact periods of time that treatment is given by a Medicare/Medicaid provider. The data could be used to detect "up-coding"—use of a higher classification of disease than is warranted by a beneficiary's condition. With this type of episode data, CMS would also be able to detect other wasteful activities; such as providers who consistently see patients more frequently than average or who consistently order an unusual number of tests.

One PI will enable CMS' program integrity contractors to routinely use mass screening—such as payment thresholds exceeded, or laboratory tests with no relevant diagnoses—and notify the appropriate contractor for follow-up action. This automation will allow contractors to better focus their efforts on detecting more advanced forms of fraud, waste, and abuse using detection tools such as multi-dimensional analysis, predictive modeling, scoring, and link analysis.

One PI will have the ability to leverage work across the One PI community including multiple States, contractors, or jurisdictions. Because One PI will load Medicaid data in a standard data model, screening runs and analyses that are now developed for a single State can be utilized for all the States in the One PI System. The matching and standardization of Medicaid data across the States will help identify fraud that crosses State borders or identify providers who move from State to State.

SIGNIFICANT ITEM OF INTEREST TO CONGRESS FOR INCLUSION IN THE FY 2010 CONGRESSIONAL JUSTIFICATION AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009

Item

Funding to Strengthen the HIT Infrastructure - The Secretary shall, using amounts appropriated under section 3018, invest in the infrastructure necessary to allow for and promote the electronic exchange and use of health information for each individual in the United States consistent with the goals outlined in the strategic plan developed by the National Coordinator (and as available) under section 3001. The Secretary shall invest funds through the different agencies with expertise in such goals, such as ONCHIT, HRSA, AHRQ, CMS, CDC, and IHS as follows: (1) Health information technology architecture that will support the nationwide electronic exchange and use of health information in a secure, private, and accurate manner, including connecting health information exchanges, and which may include updating and implementing the infrastructure necessary within different agencies of the DHHS to support the electronic use and exchange of health information. (2) Development and adoption of appropriate certified electronic health records for categories of health care providers not eligible for support under title XVIII or XIX of the Social Security Act for the adoption of such records. (3) Training on and dissemination of information on best practices to integrate health information technology, including electronic health records, into a provider's delivery of care, consistent with best practices learned from the HIT Research Center developed under section 3012(b), including community health centers receiving assistance under section 330, covered entities under section 340B, and providers participating in one or more of the programs under titles XVIII, XIX, and XXI of the Social Security Act (relating to Medicare, Medicaid, and the SCHIP). (4) Infrastructure and tools for the promotion of telemedicine, including coordination among Federal agencies in the promotion of telemedicine. (5) Promotion of the interoperability of clinical data repositories or registries. (6) Promotion of technologies and best practices that enhance the protection of health information by all holders of individually identifiable health information. (7) Improvement and expansion of the use of health information technology by public health departments. (p 132-133)

Action Taken or to be Taken

CMS is a member of the HHS HIT Workgroup, Task Force #3 (Infrastructure) along with representation from HRSA, AHRQ, CDC NIH, SAMHSA, IHS, and ASPE. The Task Force has had several meetings to discuss the strategy for approaching these items. The plan is to continue these discussions over the next several weeks to evaluate all potential options before laying out a plan for moving forward. We will then closely monitor our implementation activities to adhere to the plan and coordinate with the other HHS agencies to meet the statutory requirements.