# DEPARTMENT OF HEALTH AND HUMAN SERVICES


## FISCAL YEAR 2018

# Centers for Medicare & Medicaid Services

***Justification of Estimates for Appropriations Committees***

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

## Message from the Administrator

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2018 performance budget. In FY 2018, over 143 million Americans will rely on the programs CMS administers including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Exchanges.

CMS is committed to moving toward a healthcare system that will drive costs down, give Americans more choices, and put patients and doctors in control of their healthcare. To achieve this, we will empower patients and doctors to make decisions about their healthcare. We will reduce burdensome regulations so that doctors and providers can focus on providing high quality health care to their patients. Our policies will build a patient-centered system of care that increases competition, quality and access. We want to empower patients to take ownership of their health and ensure patients have the flexibility and information to make choices as they seek care.

CMS will usher in a new era of state flexibility and local leadership. We will be able to focus on stabilizing and streamlining the implementation of Federal rules regarding individual market insurance by empowering states and providing them with greater flexibility. Because the states are in the best position to assess the unique needs of their populations and drive reforms, this shift will result in better healthcare outcomes. CMS will hold states accountable for achieving outcomes and results.

CMS supports innovative approaches to improve quality, accessibility and affordability. CMS resource needs are principally driven by workloads and our role in leading national efforts to improve healthcare quality, accessibility, and outcomes in the most cost-effective manner. With this performance budget, CMS will have the opportunity to strengthen the integrity and sustainability of Medicare and Medicaid by investing in activities to prevent fraud, waste, and abuse. Additional investments in program integrity allow CMS to promote high quality and efficient health care by moving from a "pay-and-chase" model toward identifying and preventing fraudulent or improper payments.

This performance budget will allow us to focus on improving the experience providers, patients, caregivers, and the states have with CMS in a way that we can anticipate their needs and better serve them. CMS will provide patients and providers with the tools and information they need to make decisions that work best for them.

On behalf of all those we serve, I thank you for your continued support of CMS and its FY 2018 performance budget.

Seema Verma

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Central Office Org Chart Text Version

Consortia Org Chart Text Version

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## CENTERS FOR MEDICARE & MEDICAID SERVICES

**APPROVED LEADERSHIP**
**As of May 1, 2017**
*** Acting**

OFFICE OF EQUAL OPPORTUNITY AND CIVIL RIGHTS
Anita Pinder, Director
Alaina Jenkins, Dep. Dir.

OFFICE OF COMMUNICATIONS
Mary Wallace, Director*
Mary Wallace, Dep. Dir.
Vacant, Dep. Dir.

OFFICE OF LEGISLATION
Jennifer Boulanger, Director*
Jennifer Boulanger, Dep. Dir.

FEDERAL COORDINATED HEALTH CARE OFFICE
Tim Engelhardt, Director
Sara Vitolo, Dep. Dir.

OFFICE OF MINORITY HEALTH
Cara V. James, Director
Madeleine Shea, Dep. Dir.

OFFICE OF THE ACTUARY
Paul Spitalnic, Chief Actuary

OFFICE OF STRATEGIC OPERATIONS AND REGULATORY AFFAIRS
Kathleen Cantwell, Director
Olen Clybourn, Dep. Dir.

OFFICE OF FINANCIAL MANAGEMENT
Jennifer Main, Director & Chief Financial Officer
Megan Worstell, Dep. Dir.

Seema Verma
ADMINISTRATOR

Vacant
PRINCIPAL DEPUTY ADMINISTRATOR

Vacant
CHIEF OF STAFF

Patrick Conway, M.D.
DEPUTY ADMINISTRATOR FOR INNOVATION AND QUALITY

Karen Jackson
DEPUTY CHIEF OPERATING OFFICER

OFFICE OF ENTERPRISE DATA AND ANALYTICS
Christine Cox, Director & CMS Chief Data Officer*
Allison Oelschlaeger, Dep. Dir.*

OFFICE OF HUMAN CAPITAL
Elisabeth Handley, Director
Scott Giberson, Dep. Dir.

OPERATIONS

Karen Jackson, Deputy Chief Operating Officer OAGM—

Melissa Starinsky, Director

OIT—George Hoffmann, Director & Chief Information Officer*

OSSO—James Weber, Director

CFMFFSO--Nanette Foster Reilly, Consortium Administrator

CMCHO—Jackie Garner, Consortium Administrator

CMHPO—James T. Kerr, Consortium Administrator

CQISCO—Renard Murray, Consortium Administrator OHI—

Randy Brauer, Director

CENTER FOR CLINICAL STANDARDS AND QUALITY

Kate Goodrich, M.D., Director & CMS Chief Medical Officer
Jean Moody-Williams, Dep. Dir.
Debbie Hattery, Dep. Dir.
Shari Ling, M.D., Dep. Chief Medical Officer

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OFFICE OF CLINICIAN ENGAGEMENT
Shari Ling, M.D., Dir.*

CENTER FOR MEDICARE AND MEDICAID INNOVATION

Patrick Conway, M.D., Deputy Administrator for Innovation and Quality & Director
Amy Bassano, Dep. Dir.
Arrah Tabe-Bedward, Dep. Dir.

CENTER FOR MEDICARE

Vacant
Deputy Administrator and Director

Cynthia Tudor, Ph.D.
Deputy Center Director

Elizabeth Richter
Deputy Center Director

CENTER FOR MEDICAID AND CHIP SERVICES

Tim Hill
Deputy Administrator and Director*

Tim Hill
Deputy Center Director

Deidre Gifford, M.D.
Deputy Center Director

CENTER FOR PROGRAM INTEGRITY

Jonathan Morse
Deputy Administrator and Director*

Jonathan Morse
Deputy Director

George Mills, Jr.
Deputy Director

CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT

Jeff Wu
Deputy Administrator and Director*

Vacant
Deputy Center & Policy Director

Karen Shields
Deputy Center & Operations Director

Jeff Wu
Associate Deputy Director for Policy

Bobby Saxon
Chief Technology Officer

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# EXECUTIVE SUMMARY

## Agency Overview

The Centers for Medicare & Medicaid Services (CMS) is an Operating Division within the Department of Health and Human Services (HHS). CMS oversees two of the largest Federal health care programs —Medicare and Medicaid – as well as the Children's Health Insurance Program (CHIP) and Health Insurance Exchanges. CMS' programs will touch the lives of more than 143 million beneficiaries and consumers in FY 2018. CMS takes its role very seriously, as our oversight responsibilities impact millions of citizens and continue to grow dramatically.

As a committed steward of public funds, CMS is dedicated to moving toward a health care system that will drive down costs, give Americans more choices, and put patients and doctors in control of their health care. To achieve this, we will empower patients and doctors to make decisions about their health care while reducing burdensome regulations and building a patient-centered system of care that increases competition, quality, and access.

CMS works closely with beneficiaries, health care providers, state governments, contractors, community groups, and others to provide oversight as well as foster innovation and collaboration. Through such collaboration, CMS will usher in a new era of state flexibility and local leadership. Because the states are in the best position to assess the unique needs of their populations and drive reforms, this shift will result in better health care outcomes.

CMS touches the lives of Americans by providing coverage that offers peace of mind, transforms health care by reducing disparities, strengthens program integrity by reducing fraud, waste, and abuse, and promoting innovation. CMS supports innovative approaches to improve quality, accessibility and affordability. CMS resource needs are principally driven by workloads and our role in leading national efforts to improve health care quality, accessibility, and outcomes in the most cost-effective manner.

CMS will strengthen the integrity and sustainability of Medicare and Medicaid by investing in activities to prevent fraud, waste, and abuse. CMS will focus on stabilizing and streamlining the implementation of Federal rules regarding individual market insurance by empowering states and providing them with greater flexibility. Because the states are in the best position to assess the unique needs of their populations and drive reforms, this shift will result in better health care outcomes. CMS is modernizing our programs to address the changing needs of the people we serve, while leveraging innovation and technology to drive better care for millions of Americans.

## Overview of Budget Request

CMS requests funding for four annually-appropriated accounts including Program Management (PM), discretionary Health Care Fraud and Abuse Control (HCFAC), Grants to States for Medicaid, and Payments to the Health Care Trust Funds. The table on the next page displays CMS' FY 2016 Final, FY 2017 Annualized Continuing Resolution (CR), and FY 2018 President's Budget request for these accounts.

CMS' resource needs are principally driven by workloads that grow annually and by its role in leading national efforts to improve efficiency, health care quality, and access to care. The FY 2018 budget request reflects a level of funding that will allow CMS to focus on base operations; maintain and improve its traditional activities in Medicare, Medicaid, and CHIP programs.

**CMS Annually-Appropriated Accounts**
**(Dollars in Millions)**

| Accounts | FY 2016 Final | FY 2017 Annualized CR | FY 2018 President's Budget | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| Program Management | $3,970.8 | $3,967.2 | $3,588.0 | ($379.2) |
| | | | | |
| HCFAC – Discretionary | $681.0 | $681.0 | $751.0 | $70.0 |
| | | | | |
| Grants to States for Medicaid 1/ | $366,672.3 | $379,049.2 | $410,017.8 | $30,968.6 |
| | | | | |
| Payments to Health Care Trust Funds 1/ | $309,943.1 | $314,025.7 | $323,497.3 | $9,471.6 |
| | | | | |
| **Grand Total 1/** | **$681,271.1** | **$697,723.1** | **$737,854.1** | **$40,131.0** |

**1/ Totals may not add, due to rounding. The FY 2017 Annualized CR amount excludes indefinite authority.**

## Key Initiatives

### Reduce Costs through Contract Efficiencies

The FY 2018 Budget assumes savings throughout all budgetary accounts by seeking contract efficiencies across administrative operations. CMS will achieve contract efficiencies by leveraging existing resources and eliminating duplicative work. CMS will work towards modernizing our programs to address the changing needs of the people we serve, leveraging innovation and technology to drive better care. Additionally, CMS will work to maximize contractor productivity by streamlining policies and processes while ensuring that CMS' rules and regulations encourage doctors and providers to better serve our beneficiaries and consumers.

### Prioritize Customer Service

The FY 2018 Budget highlights CMS activities which directly impact our beneficiaries and consumers. To achieve this goal, CMS will continue to prioritize programs that directly touch the lives of the people we serve and help them make quality decisions about their health care.

### Invest in Program Integrity

The FY 2018 Budget proposes a $70 million increase over the FY 2017 Annualized CR level to strengthen the integrity and sustainability of Medicare and Medicaid by investing in activities to prevent fraud, waste, and abuse and promote high quality and efficient health care. In particular, CMS is proposing to re-engineer its approach to oversight of Medicaid and CHIP and the expectations for the states to improve federal and state accountability. In recent years, additional funding for the HCFAC program has allowed the CMS to shift away from a "pay-and-chase" model toward identifying and preventing fraudulent or improper payments. The return on investment for HCFAC law enforcement activities was $5 returned for every $1 expended from 2014-2016.

### Stabilize and Streamline the Federal Exchange

The FY 2018 President's Budget request for the Federal Exchanges is $1,693.6 million at the program level. The program level includes $471.1 million in discretionary appropriations that includes $18.4 million in Federal Administration, $1,187.5 million in anticipated user fee collections, and $35 million in other resources. Overall, CMS will streamline Exchange operations and provide States with greater flexibility. While Congress works to pass legislation to repeal and replace Obamacare, the Administration remains committed to stabilizing the Exchanges through greater flexibility, reduced burden, and strengthened partnerships.

### Strengthen the Federal Workforce

The FY 2018 Budget supports a staff level that will enable CMS to successfully carry out all of the Secretary's priorities and focus on improving CMS' traditional programs-- Medicare, Medicaid and CHIP.

## Proposed Law Discretionary

### Survey and Certification Re-Visit and Complaint Investigation Fee

CMS proposes a discretionary fee for revisits that occur as a result of deficiencies found during initial certification, recertification, or substantiated complaint surveys. In addition, CMS will also charge facilities a fee for substantiated complaint surveys resulting in findings cited at the level of immediate jeopardy or actual harm. The collections would supplement the Program Management funding for the Survey and Certification program. Collections are estimated at $25.6 million in FY 2018.

## FY 2018 Budget Request

### Program Management

In FY 2018, CMS requests $3,588.0 million in appropriated funding. CMS' request reflects funding needed to process Medicare claims payments and maintain unprecedented growth in CMS' traditional programs. CMS' budget request supports the Agency's priorities of empowering patients and providers, providing flexibility to state and local communities, supporting innovative approaches to improve quality, accessibility and affordability and improving the customer experience.

- Program Operations:

  CMS' FY 2018 budget request for Program Operations totals $2,441.3 million, a $378.2 million decrease from the FY 2017 Annualized CR level. Most of the funding within the Program Operations line supports CMS' traditional Medicare operations. This funding level will allow CMS to process nearly 1.3 billion fee-for-service claims and related workloads, maintain information technology operations, ensure that the appealed claim backlog remains stagnant, maintain the 1-800 call centers, oversee Part C and D plans, and provide outreach and education to millions of beneficiaries and consumers. Further, the FY 2018 request includes funding for Medicaid and CHIP operations. CMS remains committed to reviewing operational contracts to find efficiencies while maintaining high quality customer service to our beneficiaries.

  In FY 2018, CMS requests $471.1 million in discretionary budget authority for Federal Exchange operations, including $452.7 million for Program Operations and $18.4 million in Federal Administration. Additionally, CMS anticipates collecting $1.2 billion in user fee revenue to support Exchange operations for a total program level of $1.7 billion.

- Federal Administration:

  The FY 2018 Federal Administration request is $722.5 million, which funds the majority of CMS' federal staff salaries and benefits. This request provides adequate funding to support a federal FTE level that promotes effective management and oversight of CMS programs. CMS will strengthen its workforce by aligning talent and skill set with workload and utilizing available learning opportunities, such as training, to enhance efficient use of federal staff time and improve the quality of our work. Strengthening the core of our Agency, the federal staff, will foster CMS goals of supporting innovative approaches and improving the CMS customer experience.

- Survey and Certification:

  The FY 2018 CMS request for state survey and certification activities, is $406.1 million, an increase of $9.5 million above the FY 2017 Annualized CR level. In addition, CMS proposes $25.6 million in estimated revisit fee collections for a total survey and certification program level of $431.7 million. This request supports surveys of hospices, outpatient physical therapy, outpatient rehabilitation, portable X-rays, rural health clinics, community mental health centers, and ambulatory surgery centers. The budget also supports contracts to strengthen quality improvement and national program consistency, to promote gains in efficiency, to make oversight of accrediting organizations more effective, and to implement key recommendations made by the Government Accountability Office (GAO).

**Health Care Fraud and Abuse Control**

CMS requests $751.0 million in discretionary HCFAC funding in FY 2018, an increase of $70 million above the FY 2017 Annualized CR level. This funding will allow CMS and its law enforcement partners to continue investing in activities that will reduce fraud in Medicare, Medicaid, and CHIP. This includes ongoing investments in the oversight of Medicare Parts C and D; state-of-the-art analytic technology to detect and prevent improper

payments; support for Medicare Strike Forces, used to identify and prosecute fraudulent providers; and pre-enrollment provider screening.

CMS is proposing to re-engineer its approach to oversight of Medicaid and CHIP and the expectations for the states to improve federal and state accountability. This approach will promote fiscal integrity and program improvement, enhance IT systems, and other capacities to support data collection, analytics, and efficient oversight.

**Grants to States for Medicaid**

The FY 2018 Medicaid request is $410.0 billion, an increase of $31.0 billion above the FY 2017 enacted level. Continued increases in grants to states are required as more individuals enroll in Medicaid. This appropriation consists of $284.8 billion for FY 2018 and $125.2 billion in an advance appropriation from FY 2017. These funds will finance $411.0 billion in estimated gross obligations in FY 2018. These obligations consist of:

- $383.2 billion in Medicaid medical assistance benefits;
- $2.4 billion for benefit obligations incurred but not yet reported;
- $20.8 billion for Medicaid administrative functions including Medicaid survey and certification and State fraud control units; and
- $4.6 billion for the Centers for Disease Control and Prevention's Vaccines for Children program.

**Payments to the Health Care Trust Funds**

The FY 2018 request for Payments to the Health Care Trust Funds account totals $323.5 billion, an increase of $9.5 billion above the FY 2017 Annualized CR level. This account transfers payments from the General Fund to the trust funds in order to make the Supplementary Medical Insurance (SMI) Trust Fund and the Hospital Insurance (HI) Trust Fund whole for certain costs, initially borne by the trust funds, which are properly chargeable to the General Fund. The largest transfer provides the General Fund contribution to the SMI Trust Fund for the General Fund's share of the SMI program. Other transfers include payments from the General Fund to the HI and SMI Trust Funds, including the Medicare Prescription Drug Account, for costs such as general revenue for prescription drug benefits, HCFAC, and other administrative costs that are properly chargeable to the General Fund. The change in CMS' request for FY 2018 is largely driven by increases for the General Fund contributions for the SMI Trust Fund.

**Conclusion**

CMS' FY 2018 request for its four annually-appropriated accounts—Program Management, discretionary HCFAC, Grants to States for Medicaid, and Payments to the Health Care Trust Funds—is $737.9 billion in FY 2018, an increase of $40.1 billion above the FY 2017 Annualized CR level.

CMS' FY 2018 total appropriated request for Program Management is $3.6 billion. This funding will allow CMS to continue its traditional activities in the Medicare, Medicaid, and CHIP programs.

CMS requests $751.0 million in discretionary HCFAC funds. This funding will be devoted to maintaining and improving oversight programs related to early detection and prevention, and reducing improper payments.

CMS remains committed to finding efficiencies within base workloads, to safeguarding its programs, and to providing beneficiaries, stakeholders, and health care consumers with high quality levels of service.

## Overview of Performance

CMS supports the Administration's goals to make government more effective, efficient, and customer-focused in managing and delivering HHS programs by implementing the Government Performance and Results Act of 1993 (GPRA) and GPRA Modernization Act of 2010 (GPRA-MA). CMS performance measures highlight fundamental program purposes and focus on the agency's role as an efficient and effective steward of taxpayer dollars. CMS continues to track many of the measures included in the FY 2017 plan.

CMS uses performance information to identify opportunities for improvement and to shape and improve its programs. The use of performance measures also provides a method of clear communication of CMS programmatic objectives to partners, such as states and national professional organizations. Performance data are extremely useful in shaping policy and management choices in both the short and long term.

This performance budget includes a new format, the CMS FY 2018 Performance Appendix section, which is designed to create a more complete presentation of performance commitments, accomplishments, and trends.

# Discretionary All-Purpose Table (Comparable)
# The Centers for Medicare & Medicaid Services
### Dollars in Thousands

| | FY 2016 Final | FY 2017 Annualized CR | FY 2018 President's Budget | FY 2018 + / - FY 2017 |
|---|---|---|---|---|
| Program Operations | $2,820,864 | $2,819,453 | $2,441,274 | ($378,179) |
| Federal Administration | $732,533 | $731,140 | $722,533 | ($8,607) |
| State Survey & Certification | $397,334 | $396,579 | $406,135 | $9,556 |
| Research | $20,054 | $20,016 | $18,054 | ($1,962) |
| **Subtotal, Appropriation/BA Current Law (Discretionary; 0511)** | **$3,970,785** | **$3,967,188** | **$3,587,996** | **($379,192)** |
| MIPPA (Mandatory; P.L. 110-275) | $2,796 | $2,793 | $3,000 | $207 |
| ARRA (P.L. 111-5) | $60,580 | $0 | $0 | $0 |
| ACA (P.L. 111-148/111-152) | $329 | $559 | $600 | $41 |
| PAMA (P.L. 113-93) | $5,592 | $5,586 | $6,000 | $414 |
| IMPACT (P.L. 113-185) | $19,882 | $19,861 | $18,625 | ($1,236) |
| MACRA (P.L. 114-10) | $216,000 | $196,441 | $163,000 | ($33,441) |
| **Total, Mandatory Appropriation/BA C.L. (Mandatory; 0511)** | **$305,179** | **$225,240** | **$191,225** | **($34,015)** |
| | | | | |
| **Total, Appropriation/BA Current Law (0511)** | **$4,275,964** | **$4,192,428** | **$3,779,221** | **($413,207)** |
| Proposed Law Appropriation (Mandatory) 1/ | $0 | $0 | $13,000 | $0 |
| **Total, Appropriation/BA Proposed Law (0511)** | **$4,275,964** | **$4,192,428** | **$3,792,221** | **($413,207)** |
| *Est. Offsetting Collections from Non-Federal Sources:* | | | | |
| User Fees and Reimbursements, C.L. | $201,807 | $208,709 | $208,715 | $6 |
| Exchange User Fees, C.L. | $1,154,513 | $1,309,063 | $1,187,500 | ($121,563) |
| Risk Corridors, C.L. | $362,000 | $102,732 | $102,732 | $0 |
| Recovery Audit Contracts, C.L. | $478,109 | $217,854 | $305,000 | $87,146 |
| **Subtotal, New BA, Current Law 2/** | **$6,472,393** | **$6,030,786** | **$5,583,168** | **($447,618)** |
| No/Multi-Year Carryforward (C.L. FY 1998 - FY 2011) 3/ | $436,840 | $0 | $0 | $0 |
| **Program Level, Current Law (0511)** | **$6,909,233** | **$6,030,786** | **$5,583,168** | **($447,618)** |
| Proposed Law Discretionary User Fees 4/ | $0 | $0 | $25,596 | $25,596 |
| **Program Level, Proposed Law (0511)** | **$6,909,233** | **$6,030,786** | **$5,621,764** | **($422,022)** |
| | | | | |
| **HCFAC Discretionary** | **$681,000** | **$681,000** | **$751,000** | **$70,000** |
| **Non-CMS Administration 5/** | **$1,897,000** | **$1,893,000** | **$2,142,000** | **$249,000** |
| **CMS FTEs:** | | | | |
| Direct (Federal Administration) | 4,518 | 4,525 | 4,370 | -155 |
| Reimbursable (CLIA, CoB, RAC, Marketplace) | 188 | 267 | 267 | 0 |
| **Subtotal, Program Management FTEs** | **4,706** | **4,792** | **4,637** | **-155** |
| Affordable Care Act (Mandatory) | 21 | 19 | 17 | -2 |
| ARRA Implementation (Mandatory) | 78 | 73 | 73 | 0 |
| Other Direct (PAMA, IMPACT, MACRA) (Mandatory) | 60 | 74 | 74 | 0 |
| **Total, Program Management FTEs, Current Law** | **4,865** | **4,958** | **4,801** | **-157** |
| Program Management, Proposed Law | 0 | 0 | 0 | 0 |
| **Total, Program Management FTEs** | **4,865** | **4,958** | **4,801** | **-157** |
| Affordable Care Act (Mandatory) | 573 | 649 | 651 | 2 |
| HCFAC Mandatory | 256 | 245 | 188 | -57 |
| HCFAC Discretionary | 250 | 280 | 357 | 77 |
| Medicaid Integrity (State Grants; Mandatory) | 80 | 120 | 100 | -20 |
| Demonstrations | 6 | 11 | 11 | 0 |
| QIO | 208 | 232 | 232 | 0 |
| **Total, CMS FTEs 6/** | **6,238** | **6,495** | **6,340** | **-155** |

1/ Includes proposal for extension of SHIPs funding
2/ Includes user fees and reimbursables supporting CMS program management.
3/ Reflects remaining no-year and multi-year funding within the traditional Program Management account (75-0511), excluding user fees.
4/ CMS' FY 2018 request includes a discretionary revisit user fee for the Survey & Certification Program.
5/ Includes funds for the SSA, DHHS/OS, the Medicare Payment Advisory Commission (MedPAC).
6/ Excludes staffing funded from indirect cost allocations.

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# Program Management

## Appropriations Language

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare *&* Medicaid Services, not to exceed **[**$3,669,744,000**]** *$3,587,996,000*, 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 will 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 pursuant to section **[**302 of the Tax Relief and Health Care Act of 2006;**]** *1893(h) of the Social Security Act*, and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until **[**September 30, 2021**]** *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 the Secretary is directed to collect fees in fiscal year **[**2017**]** *2018* from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act.

# Program Management

## Language Analysis

| Language Provision | Explanation |
|---|---|
| For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare *&* Medicaid Services, not to exceed **[**$3,669,744,000**]** *$3,587,996,000*, 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 a one-year appropriation from the HI and SMI Trust Funds for the administration of the Medicare, Medicaid, Children's Health Insurance, and consumer information and insurance oversight and protection programs. The HI Trust Fund will be reimbursed for the General Fund share of these costs through an appropriation in the Payments to the Health Care Trust Funds account. |
| together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section **[**302 of the Tax Relief and Health Care Act of 2006;**]** *1893(h) of the Social Security Act,* and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until **[**September 30, 2021**]** *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 the Secretary is directed to collect fees in fiscal year **[**2017**]** *2018* 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. |

**General Provision**

| Language Provision | Explanation |
| --- | --- |
| Sec. 221. Notwithstanding section of 1864(e) of the Social Security Act (42 U.S.C. 1395aa(e)), the Secretary of Health and Human Services shall charge fees upon health care facilities or entities in cases where such facilities or entities have been cited for deficiencies during initial certification, recertification, or substantiated complaint surveys to cover all or a portion of the costs incurred for conducting substantiated complaint surveys and revisit surveys on such health care facilities or entities. Such fees shall be available to supplement funding for such surveys and shall be credited to the "Department of Health and Human Services, Centers for Medicare and Medicaid Services, Program Management" account, to remain available until expended." | Authorizes the collection of user fees from providers who had previously been cited for deficiencies in care, and required a revisit, as well as facilities that experience a substantiated complaint survey that result in immediate jeopardy or actual harm. Since this is proposed as an amendment to the Social Security Act, the authority to collect fees is contingent on their appropriation, so that collections will be classified as discretionary. |

## CMS Program Management
**Amounts Available for Obligation**

| | FY 2016 Final | FY 2017 Annualized CR | FY 2018 President's Budget |
|---|---|---|---|
| **Trust Fund Discretionary Appropriation:** | | | |
| Appropriation (L/HHS) | $3,970,785,000 | $3,967,188,000 | $3,587,996,000 |
| **Trust Fund Mandatory Appropriation:** | | | |
| ACA (PL 111-148/152) | $329,000 | $559,000 | $600,000 |
| PAMA/SGR (PL 113-93) | $5,592,000 | $5,586,000 | $6,000,000 |
| IMPACT Act (PL 113-185) | $19,882,000 | $19,861,000 | $18,625,000 |
| MACRA (PL 114-10) | $216,000,000 | $196,441,000 | $163,000,000 |
| Subtotal, trust fund mand. Appropriation 1/ | $241,803,000 | $222,447,000 | $188,225,000 |
| **Mandatory Appropriation:** | | | |
| MIPPA (PL 110-275) | $2,796,000 | $2,793,000 | $3,000,000 |
| ACA (PL 111-148/152) | $0 | $0 | $0 |
| Subtotal, trust fund mand. Appropriation 1/ | $2,796,000 | $2,793,000 | $3,000,000 |
| **Offsetting Collections from Non-Federal Sources:** | | | |
| CLIA user fees | $46,600,000 | $46,550,000 | $50,000,000 |
| Coordination of benefits user fees | $27,960,000 | $27,930,000 | $30,000,000 |
| MA/PDP user fees | $85,271,000 | $80,500,000 | $80,200,000 |
| Sale of data user fees | $7,526,000 | $7,660,000 | $7,800,000 |
| Provider enrollment user fees | $22,932,000 | $24,093,000 | $25,133,000 |
| Marketplace user fees | $1,143,247,000 | $1,283,620,000 | $1,170,000,000 |
| Risk adjustment administration | $11,266,000 | $25,443,000 | $17,500,000 |
| Recovery audit contracts | $478,109,000 | $217,854,000 | $305,000,000 |
| Risk corridors | $362,000,000 | $102,732,000 | $102,732,000 |
| Nursing home CMPs/Other | $11,518,000 | $21,976,000 | $15,583,000 |
| Subtotal, offsetting collections 1/ | $2,196,429,000 | $1,838,358,000 | $1,803,948,000 |
| **Total obligations 1/, 2/** | **$6,411,813,000** | **$6,030,786,000** | **$5,583,169,000** |
| **American Recovery and Reinvestment Act (ARRA):** | | | |
| **Mandatory Appropriation:** | | | |
| ARRA (PL 111-5) | $65,000,000 | $0 | $0 |
| Sequester | -$4,420,000 | $0 | $0 |
| **Total obligations** | **$60,580,000** | **$0** | **$0** |

1/ Current law display. Net of sequester and Pop up authority.
2/ Excludes funding provided by the American Recovery and Reinvestment Act (ARRA; PL 111-5).

**Summary of Changes**

| | |
|---|---|
| **2017** | |
| Total estimated budget authority 1/ | $3,967,188,000 |
| (Obligations) 1/ | ($3,967,188,000) |
| **2018** | |
| Total estimated budget authority 1/ | $3,587,996,000 |
| (Obligations) 1/ | ($3,587,996,000) |
| **Net Change** | **($379,192,000)** |

| | FTE | 2017 Estimate Budget Authority | FTE | Change from Base Budget Authority |
|---|---|---|---|---|
| **Increases:** | | | | |
| A. Built-in: | | | | |
| 1. Pay Raise | | | | $0 |
| 2. Annualization of Pay Raise | | | | $0 |
| **Subtotal, Built-in Increases 1/** | | | | **$0** |
| B. Program: | | | | |
| 1. Program Operations | | $2,819,453,000 | | $54,220,000 |
| 2. Federal Administration | | $731,140,000 | | $15,384,000 |
| 3. State Survey & Certification | | $396,579,000 | | $35,700,000 |
| 4. Research | | $20,054,000 | | |
| **Subtotal, Program Increases 1/** | | | | **$105,304,000** |
| **Total Increases 1/** | | | | **$105,304,000** |
| **Decreases:** | | | | |
| A. Built-in: | | | | ($23,991,000) |
| 1. One Day Less Pay | | | | $0 |
| **Subtotal, Built-in Decreases 1/** | | | | **($23,991,000)** |
| B. Program: | | | | |
| 1. Program Operations | | $2,819,453,000 | | ($432,399,000) |
| 2. Federal Administration | 4,525 | $731,140,000 | (155) | $0 |
| 3. State Survey & Certification | | $396,579,000 | | ($26,144,000) |
| 4. Research | | $20,016,000 | | ($1,962,000) |
| **Subtotal, Program Decreases 1/** | | | | **($460,505,000)** |
| **Total Decreases 1/** | | | | **($484,496,000)** |
| **Net Change 1/** | | | | **($379,192,000)** |

1/ Reflects enacted discretionary funds, only. Excludes budget authority and staffing from mandatory funds.

**CMS Program Management**
**Budget Authority by Activity**
(Dollars in Thousands)

| | FY 2016 Final | FY 2017 Annualized CR | FY 2018 President's Budget |
|---|---|---|---|
| **1. Program Operations** | $2,515,864 | $2,514,453 | $2,441,274 |
| Additional Medicare Operations Funding | $305,000 | $305,000 | $0 |
| MIPPA (PL 110-275) | $3,000 | $3,000 | $3,000 |
| PAMA/SGR (PL 113-93) | $6,000 | $6,000 | $6,000 |
| IMPACT Act (PL 113-185) | $13,000 | $13,000 | $13,000 |
| MACRA (PL 114-10) | $216,000 | $211,000 | $163,000 |
| Sequester | -$1,496 | -$16,077 | $0 |
| **Subtotal, Program Operations** | **$3,057,368** | **$3,036,376** | **$2,626,274** |
| (Obligations) | ($3,021,546) | ($3,041,000) | ($2,698,000) |
| **2. Federal Administration** | $732,533 | $731,140 | $722,533 |
| Sequester | $0 | $0 | $0 |
| **Subtotal, Federal Administration** | **$732,533** | **$731,140** | **$722,533** |
| (Obligations) | ($762,532) | ($762,532) | ($735,000) |
| **3. State Survey & Certification** | $397,334 | $396,579 | $406,135 |
| IMPACT Act (PL 113-185) | $8,333 | $8,333 | $5,625 |
| Sequester | -$567 | -$575 | $0 |
| **Subtotal, State Survey & Certification** | **$405,100** | **$404,337** | **$411,760** |
| (Obligations) | ($409,753) | ($420,000) | ($429,000) |
| **4. Research, Demonstration & Evaluation** | $20,054 | $20,016 | $18,054 |
| ACA (PL 111-148/152) | $353 | $600 | $600 |
| Sequester | -$24 | -$41 | $0 |
| **Subtotal, Research, Demonstration & Evaluation** | **$20,383** | **$20,575** | **$18,654** |
| (Obligations) | ($84,853) | ($31,054) | ($29,054) |
| **5. User Fees** | **$1,373,597** | **$1,536,660** | **$1,297,863** |
| Sequester | -$92,894 | -$105,501 | $0 |
| Sequester Pop-Up | $75,617 | $86,613 | $98,352 |
| **Subtotal, User Fees** | **$1,356,320** | **$1,517,772** | **$1,396,215** |
| (Obligations) | ($1,525,337) | ($1,482,020) | ($1,779,243) |
| **6. Recovery Audit Contracts** | **$512,993** | **$234,000** | **$305,000** |
| Sequester | -$34,884 | -$16,146 | $0 |
| **Subtotal, Recovery Audit Contracts** | **$478,109** | **$217,854** | **$305,000** |
| (Obligations) | ($105,625) | ($103,980) | ($185,757) |
| **7. Risk Corridors** | **$362,000** | **$102,732** | **$102,732** |
| Sequester | $0 | $0 | $0 |
| **Subtotal, Risk Corridors** | **$362,000** | **$102,732** | **$102,732** |
| (Obligations) | ($5,400,000) | ($5,917,000) | $0 |
| **Total, Budget Authority 1/** | **$6,411,813** | **$6,030,786** | **$5,583,168** |
| **(Obligations) 1/** | **($11,309,646)** | **($11,757,586)** | **($5,856,054)** |
| **FTE 1/** | **4,865** | **4,958** | **4,801** |

1/ Reflects CMS' current law request.

**American Recovery and Reinvestment Act (ARRA):**

| | | | |
|---|---|---|---|
| **1. ARRA Implementation** | **$65,000** | **$0** | **$0** |
| Sequester | -$4,420 | $0 | $0 |
| **Subtotal, ARRA** | **$60,580** | **$0** | **$0** |
| (Obligations) | ($144,250) | ($72,986) | ($25,584) |
| **FTE** | **87** | **79** | **79** |

**CMS Program Management**
**Authorizing Legislation**

| | FY 2017 Amount Authorized | FY 2017 Annualized CR | FY 2018 Amount Authorized | FY 2018 President's Budget |
|---|---|---|---|---|
| **Program Management:** | | | | |
| **1. Research:** | | | | |
| a) Social Security Act, Title XI | | | | |
| - Section 1110 | Indefinite | Indefinite | | |
| - Section 1115 1/ | $ 2,000,000 | $ 2,000,000 | | |
| b) P.L. 92-603, Section 222 | Indefinite | Indefinite | | |
| c) P.L. 90-248, Section 402 | Indefinite | Indefinite | | |
| d) Social Security Act, Title XVIII | Indefinite | Indefinite | | |
| **2. Program Operations:** | | | | |
| Social Security Act, Titles XI, XVIII, XIX and XXI | Indefinite | Indefinite | Indefinite | Indefinite |
| a) Social Security Act, Title XI | | | | |
| - Section 1110 | | | Indefinite | Indefinite |
| - Section 1115 1/ | | | $ 2,000,000 | $ 2,000,000 |
| b) P.L. 92-603, Section 222 | | | Indefinite | Indefinite |
| c) P.L. 90-248, Section 402 | | | Indefinite | Indefinite |
| d) Social Security Act, Title XVIII | | | Indefinite | Indefinite |
| **3. State Certification:** | | | | |
| Social Security Act, Title XVIII, Section 1864 | Indefinite | Indefinite | Indefinite | Indefinite |
| **4. Administrative Costs:** | | | | |
| Reorganization Act of 1953 | Indefinite | Indefinite | Indefinite | Indefinite |
| **5. CLIA 1988:** | | | | |
| Section 353, Public Health Service Act | Indefinite | Indefinite | Indefinite | Indefinite |
| **6. MA/PDP:** | | | | |
| Social Security Act, Section 1857(e)(2) Balanced Budget Refinement Act of 1999 Medicare Prescription Drug, Improvement and Modernization Act of 2003 | 2/ | 2/ | 2/ | 2/ |
| **7. Coordination of Benefits:** | | | | |
| Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA) | Indefinite | Indefinite | Indefinite | Indefinite |
| **8. Provider Enrollment:** | | | | |
| Patient Protection and Affordable Care Act P.L. 111-148/152 Section 6401, amended | 2/ | 2/ | 2/ | 2/ |
| **9. Exchanges:** | | | | |
| Patient Protection and Affordable Care Act P.L. 111-148/152 Sections 1311 and 1321; 31 USC 9701. | Indefinite | Indefinite | Indefinite | Indefinite |
| **10. Recovery Audit Contractors:** | | | | |
| Medicare Prescription Drug, Improvement and Modernization Act of 2003 (PL 108-173; MMA) Tax Relief and Health Care Act of 2006 (PL 109-432 TRHCA) | Indefinite | Indefinite | Indefinite | Indefinite |
| **Unfunded authorizations:** | | | | |
| Total request level | $ - | $ - | $ - | $ - |
| Total request level against definite authorizations | $ - | $ - | $ - | $ - |

1/ The total authorization for section 1115 is $4.0 million. CMS' share of this funding is estimated at $2.0 million in FY 2018.
2/ Limits authorized user fees to an amount computed by formula.

## CMS Program Management
## Appropriations History Table

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| **2007** | | | | |
| Trust Fund Appropriation: | | | | |
| Base | $3,148,402,000 | $3,153,547,000 | $3,149,250,000 | $3,141,108,000 |
| TRHCA (PL 109-432) | $0 | $0 | $0 | $105,000,000 |
| Subtotal | $3,148,402,000 | $3,153,547,000 | $3,149,250,000 | $3,246,108,000 |
| **2008** | | | | |
| General Fund Appropriation: | | | | |
| MMSEA (PL 110-173) | $0 | $0 | $0 | $60,000,000 |
| Supplemental (PL 110-252) | $0 | $0 | $0 | $5,000,000 |
| Trust Fund Appropriation: | | | | |
| Base | $3,274,026,000 | $3,230,163,000 | $3,248,088,000 | $3,207,690,000 |
| Rescissions (P.L. 110-161) | $0 | $0 | $0 | ($56,038,000) |
| MMSEA (PL 110-173) | $0 | $0 | $0 | $55,000,000 |
| MIPPA (PL 110-275) | $0 | $0 | $0 | $20,000,000 |
| Subtotal | $3,274,026,000 | $3,230,163,000 | $3,248,088,000 | $3,226,652,000 |
| **2009** | | | | |
| General Fund Appropriation: | | | | |
| CHIPRA (PL 111-3) | $0 | $0 | $0 | $5,000,000 |
| Trust Fund Appropriation: | | | | |
| Base | $3,307,344,000 | $3,270,574,000 | $3,260,998,000 | $3,305,386,000 |
| MIPPA (PL 110-275) | $0 | $0 | $0 | $182,500,000 |
| Subtotal | $3,307,344,000 | $3,270,574,000 | $3,260,998,000 | $3,487,886,000 |
| General Fund Appropriation (ARRA): | | | | |
| ARRA (PL 111-5) | $0 | $0 | $0 | $140,000,000 |
| Trust Fund Appropriation (ARRA): | | | | |
| ARRA (PL 111-5) | $0 | $0 | $0 | $2,000,000 |
| **2010** | | | | |
| General Fund Appropriation: | | | | |
| ACA (PL 111-148/152) | $0 | $0 | $0 | $251,600,000 |
| Trust Fund Appropriation: | | | | |
| Base **1/** | $3,465,500,000 | $3,463,362,000 | $3,431,500,000 | $3,470,242,000 |
| MIPPA (PL 110-275) | $0 | $0 | $0 | $35,000,000 |
| ACA (PL 111-148/152) | $0 | $0 | $0 | $95,300,000 |
| Subtotal | $3,465,500,000 | $3,463,362,000 | $3,431,500,000 | $3,600,542,000 |
| General Fund Appropriation (ARRA): | | | | |
| ARRA (PL 111-5) | $0 | $0 | $0 | $140,000,000 |
| **2011** | | | | |
| General Fund Appropriation: | | | | |
| MIPPA (PL 110-275) | $0 | $0 | $0 | $3,000,000 |
| ACA (PL 111-148/152) | $0 | $0 | $0 | $60,000,000 |
| MMEA (PL 111-309) | $0 | $0 | $0 | $200,000,000 |
| Trust Fund Appropriation: | | | | |
| Base **1/** | $3,646,147,000 | $3,470,242,000 | $3,470,242,000 | $3,470,242,000 |
| Rescissions (P.L. 112-10) | $0 | $0 | $0 | ($6,940,000) |
| MIPPA (PL 110-275) | $0 | $0 | $0 | $35,000,000 |
| ACA (PL 111-148/152) | $0 | $0 | $0 | $527,750,000 |
| Subtotal | $3,646,147,000 | $3,470,242,000 | $3,470,242,000 | $4,026,052,000 |
| General Fund Appropriation (ARRA): | | | | |
| ARRA (PL 111-5) | $0 | $0 | $0 | $140,000,000 |
| **2012** | | | | |
| General Fund Appropriation: | | | | |
| MIPPA (PL 110-275) | $0 | $0 | $0 | $3,000,000 |
| ACA (PL 111-148/152) | $0 | $0 | $0 | $110,000,000 |
| Trust Fund Appropriation: | | | | |
| Base **1/** | $4,396,973,000 | $3,173,005,000 | $4,044,876,000 | $3,879,476,000 |
| Rescissions (P.L. 112-74) | $0 | $0 | $0 | ($7,249,000) |
| MIPPA (PL 110-275) | $0 | $0 | $0 | $35,000,000 |
| ACA (PL 111-148/152) | $0 | $0 | $0 | $25,302,000 |
| Subtotal | $4,396,973,000 | $3,173,005,000 | $4,044,876,000 | $3,932,529,000 |
| General Fund Appropriation (ARRA): | | | | |
| ARRA (PL 111-5) | $0 | $0 | $0 | $140,000,000 |

**CMS Program Management**
**Appropriations History Table**

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| **2013** | | | | |
| General Fund Appropriation: | | | | |
| MIPPA (PL 110-275) | $0 | $0 | $0 | $3,000,000 |
| ACA (PL 111-148/152) | $0 | $0 | $0 | $110,000,000 |
| Transfers | $0 | $0 | $0 | $453,803,000 |
| Sequestration | $0 | $0 | $0 | ($5,763,000) |
| Trust Fund Appropriation: | | | | |
| Base **1/** | $4,820,808,000 | $0 | $4,370,112,000 | $3,872,227,000 |
| Transfers (P.L. 113-6) | $0 | $0 | $0 | $113,588,000 |
| Rescissions (P.L. 113-6) | $0 | $0 | $0 | ($7,656,000) |
| Sequestration | $0 | $0 | $0 | ($194,827,000) |
| ATRA (PL 112-240) | $0 | $0 | $0 | $17,500,000 |
| ACA (PL 111-148/152) | $0 | $0 | $0 | $25,440,000 |
| Sequestration | $0 | $0 | $0 | ($2,190,000) |
| Subtotal | $4,820,808,000 | $0 | $4,370,112,000 | $3,824,082,000 |
| General Fund Appropriation (ARRA): | | | | |
| ARRA (PL 111-5) | $0 | $0 | $0 | $140,000,000 |
| Sequestration | $0 | $0 | $0 | ($7,140,000) |
| **2014** | | | | |
| General Fund Appropriation: | | | | |
| MIPPA (PL 110-275) | $0 | $0 | $0 | $3,000,000 |
| ACA (PL 111-148/152) | $0 | $0 | $0 | $110,000,000 |
| Sequestration | $0 | $0 | $0 | ($8,136,000) |
| Trust Fund Appropriation: | | | | |
| Base | $5,217,357,000 | $0 | $5,217,357,000 | $3,669,744,000 |
| Additional Medicare Ops. (PL 113-76) | $0 | $0 | $0 | $305,000,000 |
| Transfers (P.L. 113-76) | $0 | $0 | $0 | $118,582,000 |
| Sequestration | $0 | $0 | $0 | ($1,584,000) |
| ACA (PL 111-148/152) | $0 | $0 | $0 | $25,341,000 |
| PAMA/SGR (PL 113-93) | $0 | $0 | $0 | $48,500,000 |
| Sequestration | $0 | $0 | $0 | ($1,825,000) |
| Subtotal | $5,217,357,000 | $0 | $5,217,357,000 | $4,163,758,000 |
| General Fund Appropriation (ARRA): | | | | |
| ARRA (PL 111-5) | $0 | $0 | $0 | $140,000,000 |
| Sequestration | $0 | $0 | $0 | ($10,080,000) |
| **2015** | | | | |
| General Fund Appropriation: | | | | |
| MIPPA (PL 110-275) | $0 | $0 | $0 | $3,000,000 |
| ACA (PL 111-148/152) | $0 | $0 | $0 | $50,000,000 |
| Sequestration | $0 | $0 | $0 | ($3,869,000) |
| Trust Fund Appropriation: | | | | |
| Base | $4,199,744,000 | $0 | $0 | $3,669,744,000 |
| Additional Medicare Ops. (PL 113-235) | $0 | $0 | $0 | $305,000,000 |
| ACA (PL 111-148/152) | $0 | $0 | $0 | $5,559,200 |
| Sequestration | $0 | $0 | $0 | ($408,000) |
| PAMA/SGR (PL 113-93) | $0 | $0 | $0 | $6,000,000 |
| MACRA (PL 114-10) | $0 | $0 | $0 | $204,500,000 |
| IMPACT Act (PL 113-185) | $0 | $0 | $0 | $107,333,000 |
| Subtotal | $4,199,744,000 | $0 | $0 | $4,297,728,200 |
| General Fund Appropriation (ARRA): | | | | |
| ARRA (PL 111-5) | $0 | $0 | $0 | $140,000,000 |
| Sequestration | $0 | $0 | $0 | ($10,220,000) |

## CMS Program Management
## Appropriations History Table

| | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation |
|---|---|---|---|---|
| **2016** | | | | |
| General Fund Appropriation: | | | | |
| MIPPA (PL 110-275) | $0 | $0 | $0 | $3,000,000 |
| Sequestration | $0 | $0 | $0 | ($204,000) |
| Trust Fund Appropriation: | | | | |
| Base | $4,245,186,000 | $0 | $0 | $3,665,785,000 |
| Additional Medicare Ops. (PL 113-235) | $0 | $0 | $0 | $305,000,000 |
| ACA (PL 111-148/152) | $0 | $0 | $0 | $353,000 |
| Sequestration | $0 | $0 | $0 | ($1,883,000) |
| PAMA/SGR (PL 113-93) | $0 | $0 | $0 | $6,000,000 |
| MACRA (PL 114-10) | $0 | $0 | $0 | $216,000,000 |
| IMPACT Act (PL 113-185) | $0 | $0 | $0 | $21,333,000 |
| Subtotal | $4,245,186,000 | $0 | $0 | $4,212,588,000 |
| General Fund Appropriation (ARRA): | | | | |
| ARRA (PL 111-5) | $0 | $0 | $0 | $65,000,000 |
| Sequestration | $0 | $0 | $0 | ($4,420,000) |
| **2017** | | | | |
| General Fund Appropriation: | | | | |
| MIPPA (PL 110-275) | $0 | $0 | $0 | $3,000,000 |
| Sequestration | $0 | $0 | $0 | ($207,000) |
| Trust Fund Appropriation: | | | | |
| Base **1/** | $4,109,549,000 | $0 | $0 | $3,967,188,000 |
| ACA (PL 111-148/152) | $0 | $0 | $0 | $600,000 |
| Sequestration | $0 | $0 | $0 | ($16,486,377) |
| PAMA/SGR (PL 113-93) | $0 | $0 | $0 | $6,000,000 |
| MACRA (PL 114-10) | $0 | $0 | $0 | $211,000,000 |
| IMPACT Act (PL 113-185) | $0 | $0 | $0 | $21,333,000 |
| Subtotal | $4,109,549,000 | $0 | $0 | $4,189,634,623 |
| **2018** | | | | |
| General Fund Appropriation: | | | | |
| MIPPA (PL 110-275) | $0 | $0 | $0 | $3,000,000 |
| Sequestration | $0 | $0 | $0 | $0 |
| Trust Fund Appropriation: | | | | |
| Base **2/** | $3,587,996,000 | $0 | $0 | $0 |
| ACA (PL 111-148/152) | $0 | $0 | $0 | $600,000 |
| Sequestration | $0 | $0 | $0 | $0 |
| PAMA/SGR (PL 113-93) | $0 | $0 | $0 | $6,000,000 |
| MACRA (PL 114-10) | $0 | $0 | $0 | $163,000,000 |
| IMPACT Act (PL 113-185) | $0 | $0 | $0 | $18,625,000 |
| Subtotal | $3,587,996,000 | $0 | $0 | $188,225,000 |

**1/** Based on Annualized CR

**CMS Program Management**
**Appropriations Not Authorized by Law**

| Program | Last Year of Authorization | Authorization Level in Last Year of Authorization | Appropriations in Last Year of Authorization | Appropriations in FY 2017 |
|---|---|---|---|---|

CMS Program Management has no appropriations not authorized by law.

## Program Management
## Summary of Request

The Program Management account provides the funding needed to administer and oversee CMS' traditional 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, as well as the Federal Exchanges and private health insurance provisions and consumer protections mandated by Obamacare. The FY 2018 request includes funding for CMS' Program Management line items-Program Operations, Federal Administration, and State Survey and Certification.

- Program Operations primarily funds the contractors that process Medicare fee-for-service claims as well as the IT infrastructure and operational support needed to run our programs. It supports the Medicare Advantage and Medicare Prescription Drug programs, beneficiary and consumer outreach programs, quality improvement activities and ongoing research. It also funds IT enhancements for the Medicaid and CHIP programs as well as activities, including the Federal Exchanges.

- Federal Administration pays for the salaries of CMS employees and for the expenses (rent, building services, equipment, supplies, etc.).

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

CMS' FY 2018 Program Management request is $3,588.0 million, a decrease of $379.2 million below the FY 2017 Annualized CR level. The table below, and the following language, provides additional detail on each of these levels for the FY 2018 request.

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

| Line Item | FY 2016 Final | FY 2017 Annualized CR | FY 2018 President's Budget | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| Program Operations | $2,820.8 | $2,819.5 | $2,441.3 | -$378.2 |
| Federal Administration | $732.5 | $731.1 | $722.5 | -$8.6 |
| Survey & Certification | $397.3 | $396.6 | $406.1 | $9.5 |
| Research | $20.1 | $20.0 | $18.1 | -$1.9 |
| **Program Management 1/** | **$3,970.7** | **$3,967.2** | **$3,588.0** | **-$379.2** |
| Direct FTEs – Federal Administration | 4,518 | 4,525 | 4,370 | -155 |

1/ Numbers may not add, due to rounding.

## FY 2018 Request

**Program Management**: CMS' Program Management request is $3,588.0 million, a decrease of $378.2 million below the FY 2017 Annualized CR level. The following language provides additional detail on CMS' FY 2017 discretionary request:

- Program Operations:

  CMS' FY 2018 budget request for Program Operations totals $2,441.3 million, a decrease of $378.2 million below the FY 2017 Annualized CR. The majority of the Program Operations account funds CMS' traditional Medicare operations. This funding level will allow CMS to process nearly 1.3 billion fee-for-service claims and related workloads, keep our systems running, transition contractors onto the Healthcare Integrated General Ledger Accounting System (HIGLAS), maintain our 1-800 call centers, oversee Part C and D plans, and to provide outreach and education to millions of beneficiaries and consumers. Further, the FY 2017 request includes funding for Medicaid and CHIP operations and for ongoing research projects including the Medicare Current Beneficiary Survey (MCBS).

  Program Operations also includes funds for many provisions mandated by Obamacare. These provisions enhance all three existing health care programs—Medicare, Medicaid, and CHIP. CMS' discretionary Program Operations request includes $452.7 million to fund operations at the Exchanges in 2018, including enrollment, outreach and education. In addition, CMS anticipates collecting $1.2 billion in user fee revenue from all sources, along with $18.4 million in the Federal Administration line, to fund Exchange operations at a program level of $1.7 billion in FY 2018.

- Federal Administration:

  CMS requests a total of $722.5 million for Federal Administration in FY 2018. Of this request, $650.7 million supports 4,370 direct FTEs.

  The remaining request supports administrative information technology, communication, utilities, rent and space requirements, as well as administrative contracts and inter-agency agreements.

- Survey and Certification:

  The FY 2018 CMS request for state survey and certification activities is $406.1 million, an increase of $9.5 million above the FY 2017 Annualized CR level. In addition, CMS proposes $25.6 million in estimated revisit fee collections for a total survey and certification program level of $431.7 million. This request supports surveys of hospices, outpatient physical therapy, outpatient rehabilitation, portable X-rays, rural health clinics, community mental health centers, and ambulatory surgery centers. The budget also supports contracts to strengthen quality improvement and national program consistency, to promote gains in efficiency, to make oversight of accrediting organizations more effective, and to implement key recommendations made by the Government Accountability Office (GAO).

# Program Operations
(Dollars in Thousands)

| | FY 2016 Final | FY 2017 Annualized CR | FY 2018 President's Budget | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| BA | $2,820.864 | $2,819.453 | $2,441.274 | ($378.179) |

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

**Medicaid** Authorizing Legislation – Social Security Act, Title XIX, Section 1901

**Children's Health Insurance Program** Authority Legislation – Social Security Act, Title XXI

**Affordable Care Act** Authorizing Legislation – Patient Protection and Affordable Care Act (Public Law 111–148) consolidating the amendments made by title X of the Act and the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152).

**FY 2018 Authorization** – One Year/Multi-Year

**Allocation Method** – Contracts, Competitive Grants, Cooperative Agreements

**OVERVIEW**

CMS administers and oversees the Nation's largest ongoing health care programs. These programs include the Medicare program, established in 1965 for Americans age 65 and older and for disabled persons, including those with end-stage renal disease (ESRD); the Medicaid program, also established in 1965, for low-income families and aged, blind, and disabled individuals; and the Children's Health Insurance Program (CHIP), established in 1997, for low-income children in families with incomes above the Medicaid eligibility levels.

Program Operations primarily funds the contractors that process Medicare fee-for-service claims, as well as the IT infrastructure and operational support. It supports the Medicare Advantage and Medicare Prescription Drug programs, beneficiary and consumer outreach programs, quality improvement activities, and ongoing research. It also funds operations and enhancements in the Medicaid and CHIP programs as well as insurance market reform, oversight, and operational contracts supporting the Exchange.

As the primary account funding the operations for CMS' programs, Program Operations plays a direct role in achieving the Agency's strategic priorities, by promoting efficiency in care, reforming the health care delivery system, decreasing medical costs and payment error rates, reducing appeals and reducing burdens and regulations to those who serve our beneficiaries.

## Program Description and Accomplishments

### Medicare

Authorized in 1965 under title XVIII of the Social Security Act, the Medicare program provides hospital and supplemental medical insurance to Americans age 65 and older and to disabled persons, including those with end-stage renal disease. The program was expanded in 2006 with the introduction of a voluntary prescription drug benefit, Part D. Medicare enrollment has increased from 19 million in 1966 to 60 million beneficiaries expected in FY 2018. Medicare benefits, that is, the payments made to providers, health plans, and drug plans for their services, are permanently authorized. The Medicare administrative expenses discussed in this chapter are funded annually through the Program Management appropriation.

For Medicare Parts A and B, CMS pays contractors to process providers' claims, funds beneficiary outreach and education, maintains the information technology (IT) infrastructure needed to support various claims processing systems, and makes programmatic improvements such as the Healthcare Integrated General Ledger and Accounting System (HIGLAS), the administrative simplification provisions enacted in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and others.

For Medicare Parts C and D, CMS funds certification of payments, and audits Medicare Advantage (MA), joint MA-prescription drug plans (MA-PDP), and standalone prescription drug plans (PDP).

### Medicaid and CHIP

Authorized in 1965 under title XIX of the Social Security Act, Medicaid is a means-tested health care entitlement program financed jointly 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. Medicaid also provides community based long-term care services and supports to seniors and individuals with disabilities, as well as institutional care and long-term care services. As a result, Medicaid programs vary widely from state to state. The grants made to states for the Federal share of Medicaid services and state administration of this program is appropriated annually. The funding for Medicaid included in the Program Operations chapter covers certain administrative expenses such as Medicaid systems support, managed care review and oversight, demonstration management, and other program-related initiatives.

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 was 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 who are less than 19 years of age.

### Private Health Insurance Protections and Programs

CMS conducts market oversight of compliant health insurance plans. CMS works in close collaboration with States and issuers on medical loss ratio rules, oversight of state-based Exchanges, financial assistance eligibility determination, and risk adjustment. In States that

have elected not to administer particular programs, CMS operates Federal Exchanges on their behalf.

**Funding History**

| Fiscal Year | Budget Authority |
|---|---|
| FY 2014 | $2,943,405,000 |
| FY 2015 | $2,824,823,000 |
| FY 2016 | $2,824,823,000 |
| FY 2017 Annualized CR | $2,819,453,000 |
| FY 2018 President's Budget | $2,441,274,000 |

**Budget Request: $2,441.3 Million**

CMS' FY 2018 budget request for Program Operations is $2,441.3 million, a decrease of $378.2 million below the FY 2017 Annualized CR Level. This request will allow CMS to continue operating Medicare, Medicaid, CHIP, and private health insurance programs. The decrease in our funding request reflects a drive to achieve greater programmatic efficiency by using data to drive decision making and leveraging our experience and existing systems to avoid duplication. We will continue to invest in high priority activities with a focus on high quality service for our beneficiaries and participating providers.

**Program Operations**
(Dollars in Millions)

| Activity | FY 2016 Final | FY 2017 Annualized CR | FY 2018 President's Budget | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| **Program Operations** | | | | |
| **I. Medicare Parts A&B** | | | | |
| Ongoing Operations | $932.626 | $861.165 | $885.385 | $24.220 |
| FFS Operations Support | $48.997 | $77.000 | $57.000 | ($20.000) |
| Claims Processing Systems | $57.256 | $75.776 | $75.776 | -- |
| DME/Part B Competitive Bidding | $56.200 | $32.066 | $12.066 | ($20.000) |
| Contracting Reform | $14.081 | -- | -- | -- |
| **II. Other Medicare Operational Costs** | | | | |
| Accounting & Audits | $104.059 | $120.726 | $100.726 | ($20.000) |
| QIC Appeals (BIPA 521/522) | $87.192 | $86.505 | $86.505 | -- |
| HIPAA Administrative Simplification | $20.829 | $28.984 | $23.083 | ($5.901) |
| ICD-10/5010 | $30.000 | -- | -- | -- |
| **III. Medicaid & CHIP** | | | | |
| Medicaid & CHIP Initiatives | $28.606 | $44.668 | $44.668 | -- |
| **IV. Health Care Planning & Oversight** | | | | |
| Part C&D IT Systems Investments | $57.697 | $39.792 | $39.792 | -- |
| Oversight & Management | $59.800 | $64.125 | $51.225 | ($12.900) |
| Federal Exchange | $733.262 | $691.700 | $452.700 | ($239.000) |
| **V. Health Care Quality** | | | | |
| Health Care Improvement Initiatives | $72.552 | $47.218 | $22.218 | ($25.000) |
| **VI. Outreach & Education** | | | | |
| Beneficiary Outreach/NMEP | $172.898 | $265.161 | $255.161 | ($10.000) |
| Provider Outreach | $20.692 | $22.611 | $6.113 | ($16.498) |
| Consumer Outreach | $3.890 | $4.251 | -- | ($4.251) |
| **VII. Information Technology** | | | | |
| IT Investments | $320.227 | $357.705 | $328.856 | ($28.849) |
| **TOTAL[1]** | **$2,820.864** | **$2,819.453** | **$2,441.274** | **($378.179)** |

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

## I. MEDICARE - PARTS A AND B

### Program Description and Accomplishments

### Ongoing Operations

CMS processes claims for our beneficiaries through the Medicare Administrative Contractors (MAC). A MAC is a private healthcare insurer that has been awarded a geographical jurisdiction to process Medicare Part A and B medical claims or Durable Medical Equipment claims for Medicare Fee-for-Service. In addition to processing Part A and Part B claims, MACs enroll providers in the Medicare program, handle provider reimbursement services, process first-level appeals, respond to provider inquiries, educate providers about the program, and administer the participating physicians/supplier program (PARDOC). These are the primary contracts for managing Medicare and are mission critical for the success of the Agency.

The following table displays claims volumes for the period FY 2012 to FY 2018.

**FFS Claims Volume**
(Claim Count in Millions)

| | FY 2012 Actual | FY 2013 Actual | FY 2014 Actual | FY 2015 Actual | FY 2016 Actual | FY 2017 Estimate | FY 2018 Estimate |
|---|---|---|---|---|---|---|---|
| Part A | 207.3 | 207.6 | 210.0 | 213.3 | 252.9 | 255.4 | 258.0 |
| Part B | 1,011.9 | 1,006.3 | 1,003.0 | 1,009.2 | 1,045.6 | 1,056.1 | 1,066.6 |
| **Total** | **1,219.2** | **1,213.9** | **1,213.0** | **1,222.5** | **1,298.5** | **1,311.5** | **1,324.6** |

### Budget Request: $885.4 Million

The FY 2018 budget request for Ongoing Operations is $885.4 million, an increase of $24.2 million above the FY 2017 Annualized CR Level. This request allows the contractors to process their workloads accurately, in a timely manner, and in accordance with CMS' program requirements.

In FY 2018, CMS' contractors expect to:

- Process nearly 1.3 billion claims;
- Handle 3.3 million redeterminations (does not assume efficiencies from Medicare appeals proposals);
- Answer 34.4 million toll-free inquiries.

The MACs activities are described in more detail below.

*Bills/Claims Payments* – The MACs are responsible for processing and paying nearly 1.3 billion Part A bills and Part B claims correctly and timely. The MACs handle bills/claims from the wide range of healthcare providers, including hospitals, skilled nursing facilities, home health agencies, physicians, and other providers. Currently, almost all providers submit their claims in electronic format. The MACs also utilize electronic funds transfer to make the vast majority of Medicare benefit payments.

*Provider Enrollment* – CMS is responsible for both enrolling providers and suppliers into the Medicare program and ensuring that they continue to meet the enrollment requirements for their provider or supplier type. The enrollment process includes a number of verification processes to ensure that Medicare is only paying qualified providers and suppliers.

*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 hospital (DSH), and bad debt payments. The MACs provider reimbursement areas perform many other payment review activities, maintains claims information systems, and is responsible for making determinations of status.

*Medicare Appeals* – The statutorily mandated Medicare appeals process affords beneficiaries, providers, and suppliers the opportunity to dispute an adverse contractor determination, including coverage and payment decisions. The first level of appeal begins at the MAC with a redetermination of the initial decision. MAC personnel not involved in the original determination review the original claim and any new information, make the decision to determine if the original determination should be changed and handle any reprocessing activities. MACs generally are required to issue a decision within 60 days of receipt of an appeal request.

In FY 2016, the MACs processed 3.4 million redeterminations and are expected to process 3.2 million in FY 2017. CMS estimates the MACs will process over 3.3 million redeterminations in FY 2018 reflecting steady growth in the number of redeterminations as seen in prior fiscal years.

*Provider Inquiries* – CMS coordinates 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 can respond to telephone and written (letters, e-mail, fax) inquiries. The primary goal of the PCC is to deliver timely, accurate, accessible, and consistent information to providers in a courteous and professional manner. These practices are designed to help providers understand the Medicare program and, ultimately, bill for their services correctly.

*Participating Physician/Supplier Program (PARDOC)* – This program helps reduce the impact of rising health care costs on beneficiaries by increasing the number of enrolled physicians and suppliers who “participate” in Medicare. Participating providers agree to accept Medicare-allowed payments as payment in full for their services. The MACs conduct an annual enrollment process and also monitor limiting charge compliance to ensure that beneficiaries are not being charged more than Medicare allows.

*Provider Outreach and Education* – The goal of Provider Outreach and Education is to reduce the Medicare error rate by helping providers manage Medicare-related matters on a daily basis and properly bill the Medicare program. The Medicare contractors are required to educate providers and their staffs about the fundamentals of the program, policies and procedures, new initiatives, and significant changes including any of the more than 500 change requests that CMS issues each year. They also identify potential issues through analyses of provider inquiries, claim submission errors, medical review data, Comprehensive Error Rate Testing (CERT) data, and the Recovery Audit Program data.

**Fee-for-Service Operations and Systems Support**

This account serves as the primary operations support center for the management of Medicare Parts A and B. These contracts support a myriad of critical functions centered on improving Part A and Part B FFS information, education, service initiatives, coverage and payment policies, health care quality, and general administrative and legislative actions. Many of these activities promote accountability, communication, coordination and aid the decision-making for programmatic and functional issues across the organization. These activities help to ensure the effective management of CMS' programs.

**Budget Request: $57.0 Million**

The FY 2018 budget request for fee-for-service operations support is $57.0 million, a decrease of $20.0 million below the FY 2017 Annualized CR Level. The decrease is primarily attributed to less funding needed to re-compete the MAC contracts in FY 2018. The Medicare Modernization Act stipulated that the MAC contracts must be re-competed at a minimum of every 5 years. MACRA increased the time between contract re-competes to every 10 years, therefore, CMS will achieve savings by eliminating contractor transition costs.

CMS also offers several additional critical services supporting the Medicare fee-for-service program accounted for in this request. Some of these include:

- *Contracting Reform*: $8.2 million. Medicare contracting reform changed the face of the traditional Medicare program by integrating Parts A and B fee-for-service claims contracting under a single contract authority, known as a Medicare Administrative Contractor or MAC, using competitive acquisition procedures under the Federal Acquisition Regulation (FAR). Funding is requested to support the transition, termination and implementation costs associated with transitioning from incumbent Medicare Administrative Contractors (MACs) to their successor MACs. For FY 2018, CMS anticipates there will be only one A/B MAC re-compete in accordance with the revised MAC procurement schedule that we are establishing due to MACRA - this will be the scheduled A/B MAC Jurisdiction F contract re-compete.

- *Printing and Postage*: $9.5 million. This contract provides for the printing and postage costs associated with direct billing of Medicare Part A, Part B and Part D Income-Related Monthly Adjusted Amount (IRMAA) premiums for beneficiaries who may not receive a monthly Social Security Administration (SSA), Office of Personnel Management (OPM), or Railroad Retirement Board (RRB) benefit check from which the premiums are deducted and are not part of a State Buy-in Agreement or Formal Group Payer Arrangement. This funds CMS' ongoing FFS printing and postage needs.

- *Cost Contract Audits*: $1.5 million. CMS has 179 contract awards with firms who have cost reimbursable contracts requiring necessary steady state audit efforts to comply with the Federal Acquisition Regulations (FAR) and Departmental Supplemental Regulations (HHSAR). The GAO and OIG have identified CMS' lack of compliance with the FAR and HHSAR regarding mandatory audits and proper internal controls. This activity supports the effort needed to perform audits required by law during the contract acquisition life cycle to comply with FAR and HHSAR.

- *Bundled ESRD PPS*: $4.0 million. CMS has developed the capacity to monitor claims and assessment data to examine key aspects of our payment programs. This payment monitoring capacity allows for program officials to analyze the effects of changes to the payment system on beneficiary utilization, health outcomes and care delivery. CMS will continue with our work to expand and update these claims surveillance programs as well as develop a broader monitoring framework to address spending variation across the Medicare program.

- *A-123 Internal Controls Assessment*: $1.8 million. 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 requires the Administrator to submit a statement of assurance on internal controls over financial reporting. Funding supports a Certified Public Accountant (CPA) firm to conduct a rigorous assessment of the CMS internal controls over financial reporting. This assessment includes performing internal control reviews (formerly SAS 70 audits) for Title XVIII Medicare contractors.

- *Medicare Beneficiary Ombudsman*: $1.4 million. The legislative mandate for the creation of a Medicare Ombudsman (MMA Section 923) requires the Medicare Beneficiary Ombudsman to provide assistance to Medicare beneficiaries with handling their inquiries, complaints, grievances, and appeals, and to provide recommendations for improvement in the administration of the Medicare program. The requested funding is for existing contract support for a wide variety of activities, including development of the Medicare Ombudsman annual report to the Secretary and to Congress.

- *Actuarial Services*: $1.1 million. This contract provides additional actuarial services for the numerous ad hoc requests that the Office of the Actuary is unable to handle due to time constraints and staff shortages including modeling. This contract also assists CMS in providing actuarial cost estimates for various demonstrations and other issues required by provisions of the law.

- *Medicare HEDIS Quality of Care Performance Measures*: $1.4 million. This contract provides for the proper oversight and management of MA organizations (MAOs) and Special Needs Plans (SNPs) quality performance by developing and improving specific HEDIS measures for MAOs and SNPs and reviewing and approving SNP Models of Care (MOC). CMS will work on developing and testing new quantifiable outcome measures that will provide more specific information about MA plans' (including SNPs) ability to provide a high level of care coordination and its impact on enrollee health outcomes. This activity is critical for CMS to be able to evaluate SNPs' ability to effectively coordinate care for older and/or disabled adults and to develop tangible SNP models of care outcome measures.

- *Home Health PPS Refinement*: $2.1 million. CMS will conduct a study on home health agency (HHA) costs involved in providing ongoing access to care to low-income Medicare beneficiaries or beneficiaries in medically underserved areas and in treating beneficiaries with high levels of illness. This current funding request will enable us to further investigate whether changes to the payment system are warranted and provide contractor support towards proposing and finalizing refinements to the home health prospective payment system (HH PPS).

**Claims Processing Systems**

CMS' claims processing systems currently process nearly 1.3 billion Part A and Part B claims each year, and these systems are a major component of our overall information technology costs. The claims processing systems receive, verify, and log claims and adjustments, perform internal claims edits and claim validation edits, complete claims development and adjudications, maintain pricing and user files, and generate reports. The request covers ongoing systems maintenance and operations.

**Budget Request: $75.8 Million**

The FY 2018 President's Budget request for claims processing systems is $75.8 million, the same level of funding as the FY 2017 Annualized CR. This request funds the ongoing costs associated with maintaining claims processing systems. This involves integration and regression testing for claims adjudication, payments, and remittance advices that support various system interfaces, which is essential in ensuring accurate payments. Additionally, CMS must make software changes to the claims processing systems including four quarterly releases that control, implement, and update software changes due to legislative mandates that dictate the amount of payment for services or coverage levels. These system changes aid in supporting the MAC functionality for the Medicare Fee-for-Service (FFS) Program.

The main systems include:

- *Part A, Part B and DME Claims 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. 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.

- *Fiscal Intermediary Shared System (FISS)* – FISS is a critical component of FFS program, processing millions of Medicare claims a year. This is the shared system used to process Medicare Part A claims, including outpatient claims submitted under Part B. It interfaces directly with the Common Working File (CWF) System for verification, validation, and

payment authorization. FISS must also implement changes needed to support the Medicare Administrative Contractor (MAC) authority for the Medicare FFS Program.

- *Multi Carrier System (MCS)* – MCS is the shared system used to process over 1 billion Medicare Part B claims for physician care, durable medical equipment, and other outpatient services nationwide. It interfaces directly with the CWF.

**DME Competitive Bidding**

Section 302(b)(1) of the MMA authorized the establishment of a new Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) acquisition program which replaces the current Medicare Part B fee schedule payment amounts for selected items in certain areas with payment amounts based on competitive bidding. Under the MMA, the DMEPOS Competitive Bidding Program was to be phased in so that competition under the program would first occur in ten metropolitan statistical areas (MSAs) in 2007. MIPPA and the ACA subsequently amended and expanded the program to cover 100 MSAs, and the ACA mandated that all areas of the country must be subject either to DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. The program sets more appropriate payment amounts for DMEPOS items while ensuring continued access to quality items and services, which will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

**Budget Request: $12.1 Million**

The FY 2018 budget request for DME competitive bidding is $12.1 million, a decrease of $20.0 million below the FY 2017 Annualized CR Level.

- *Competitive Bidding Implementation Contractor (CBIC):* $9.3 million. The budget request will fund operations and maintenance for the Round 2 Re-Compete MSAs. In FY 2017, CMS began a two year cycle for re-competing the Round 1 and Round 2 contracts into one consolidated round, hence the reason for the substantial increase in funding need in FY 2017. The consolidated round goes into effect in FY 2019.

- *DME Bidding Systems*: $2.8 million. This system collects bids from DMEPOS for competitive bidding of equipment. The data collected by the DBidS application will be used by the Competitive Bidding Implementation Contractor (CBIC) who will make recommendations to CMS on the selection of certain suppliers by DME product and Competitive Bidding Area. CMS will use these recommendations to award contracts to DME suppliers who supply DME to Medicare beneficiaries. The funding request supports ongoing operations and maintenance. Funding this system is necessary to ensure beneficiaries maintain access to high quality equipment and supplies at a fair price.

## II. OTHER MEDICARE OPERATIONAL COSTS

**Accounting and Audits**

HIGLAS is a single, integrated dual-entry accounting system that standardizes and centralizes Federal financial accounting functions for all of CMS' programs. It reduced 50 separate accounting/payment systems for Medicare and Medicaid into one system. The main objective of this effort was to leverage the use of commercial off the shelf (COTS) software in the federal

government to increase automation, increase efficiency, and maximize economies of effort to centralize management and save millions of taxpayer dollars that fund Medicare and Medicaid each year, while at the same time eliminating redundant and inefficient / ineffective manual processes. HIGLAS is a component of the Department of Health and Human Services (HHS) Unified Financial Management System (UFMS), and CMS continues to closely coordinate efforts with HHS to ensure HIGLAS core financial data integration with UFMS. The unification of the financial systems is aimed at improving data consolidation and financial reporting capabilities for all of HHS.

**Budget Request: $100.7 Million**

The FY 2018 President's budget request for HIGLAS and the CFO audit is $100.7 million, an $18.3 million decrease from the FY 2017 Annualized CR level. In FY 2018, CMS will support the production and application maintenance of HIGLAS. There is no request for funding in FY 2018 for additional development, modernization, or enhancements to HIGLAS.

- *HIGLAS*: $90.8 million. This request supports operations and maintenance costs for the Healthcare Integrated General Ledger Accounting System.

  HIGLAS implementation has yielded significant improvements and benefits to the Nation's Medicare program by strengthening the Federal government's fiscal management and program operations/management. HIGLAS provided the capability for CMS and HHS to achieve compliance with the Federal Financial Management Improvement Act (FFMIA) of 1996. HIGLAS was a critical success factor in ensuring HHS met FFMIA compliance requirements. All of CMS' core program dollars are accounted for in HIGLAS. Payment dollars are comprised of all CMS lines of business which include the Health Insurance Exchange payments beginning January 2014. The FY 2015 gross program dollars processed through HIGLAS exceeded $1.3 trillion. HIGLAS continues to enhance CMS' oversight of all financial operations, in order to achieve accurate, reliable, and timely financial accounting and reporting for all of CMS' programs and activities. In addition, HIGLAS enables CMS to resolve material weaknesses identified in the CFO audits related to the accounting of Federal dollars.

  The HIGLAS effort has significantly improved the ability of CMS to perform Medicare accounting transactions. These improvements and benefits attributable to HIGLAS include reduced costs due to elimination of redundant individual Medicare financial record systems, improvements in automated Medicare debt collection/referral activities, creation of audit trails for every Medicare transaction/payment/claim in HIGLAS, improved Medicare financial audit ability, and improved capability for CMS to more systematically and efficiently recover identified Medicare contractor overpayments. Moreover, HIGLAS implementation has resulted in better internal financial controls across Medicare contractor operations. Implementation of HIGLAS has had a significant and positive impact on the amount of additional interest earned (saved) in the Medicare Trust Funds. Internal CMS analysis has shown that Medicare contractors transitioned to HIGLAS are collecting monies quicker than in a pre-HIGLAS environment. This is a direct result of efficiencies gained in the process of offsetting or "netting" receivables that are owed by Medicare providers to the government.

- *CFO/Financial Statement Audits:* $9.9 million. This funding is necessary to pay for the CFO audit, a legislative mandate, which ensures CMS financial statements are reasonable, that our internal controls are adequate, and that we comply with laws and regulations. The cost of the audit is funded through an interagency agreement between CMS and HHS and is

based upon the General Services Administration (GSA) rate schedules and federal audit requirements.

CMS is required under OMB Bulletin A-136 to prepare annual and quarterly financial statements. The yearly CMS financial statements must be audited annually in accordance with the Government Management Reform Act of 1994 and OMB Bulletin No. 07-04. Our goal is to maintain an unqualified audit opinion, which indicates that our financial statements present fairly in all material respects, the financial position, net costs, social insurance, changes in net position, budgetary resources, and financing of CMS.

**Qualified Independent Contractor Appeals (QIC)**

Section 521 of the Benefits Improvement and Protection Act of 2000 (BIPA) requires CMS to contract with Qualified independent contractors (QICs) to adjudicate second level appeals resulting from an adverse re-determination of a claim by a Medicare Administrative Contractor (MAC) during the first level of appeal. QICs must process Medicare Parts A and B claim appeals within 60 calendar days of receipt. If a QIC is unable to complete the appeal within the mandated timeframe, then it must notify the appellant that it cannot timely complete the appeal and offer the appellant an opportunity to escalate the appeal to an Administrative Law Judge (ALJ). This program ensures that our beneficiaries' providers have the opportunity to continue seeking payment for services in the event of an initial adverse claim determination and is essential to maintain provider participation in Medicare.

**Budget Request: $86.5 Million**

The FY 2018 budget request for QIC appeals (BIPA section 521) is $86.5 million, the same as the FY 2017 Annualized CR Level. CMS requests:

- *QIC Operations*: $80.3 million. This request includes annual operational costs and activities to advance the Departmental priority of adjudicating Medicare appeals at the second level in the appeals process.

The table below includes a breakout of the estimated reconsiderations workload for FYs 2012 – 2018. These projections were formulated based upon a review and extrapolation of early FY 2016 data and consideration to the projected Medicare beneficiary growth rates in the out years. As in previous years, we will continue to review and analyze workload trends and adjust as necessary.

**QIC Appeals Workload**
**(Volume in claims)**

| | FY 2012 Actual | FY 2013 Actual | FY 2014 Actual | FY 2015 Actual | FY 2016 Actual | FY 2017 Estimate | FY 2018 Estimate |
|---|---|---|---|---|---|---|---|
| QIC Appeals | 758,921 | 1,000,013 | 1,112,192 | 1,138,997 | 917,286 | 943,094 | 969,756 |
| % Increase from Previous Year | 45.9% | 31.8% | 11.2% | 2.4% | -19.5% | 2.8% | 2.8% |

With well over 100 million claims denied each year, it is difficult to pinpoint a single cause for the increase in appeal receipts and the corresponding decrease that occurred in FY 2016. CMS believes extenuating circumstances created the large increases between fiscal years 2013 and 2015 which subsided in FY 2016. Due to the growing appeal backlog, CMS also initiated several administrative actions that may have contributed to the decrease in claims following several years of uncontrolled growth. These initiatives include, but are not limited to, the following:

- QIC Demonstration: In January 2016, CMS launched a demonstration with durable medical equipment suppliers that will allow the suppliers the opportunity to discuss their denied claim with the QIC. In addition to the discussion, the appellant will have the opportunity to submit additional documentation to support their claim and receive feedback and education on CMS policies and requirements. This discussion allowed the QIC to address claims currently pending at OMHA that based on the discussion can now be reopened and favorably paid to the appellant.

- Settlement Facilitation Conferences: Office of Medicare Hearings and Appeal (OMHA) staff who have been trained in mediation techniques are facilitating settlement conferences between CMS and appellants that have a certain number of claims and amount-in-controversy in dispute. These conferences bring those appellants and CMS together to discuss administratively settling the appeals.

- Hospital Appeals Settlements: CMS offered hospitals an option to administratively resolve appeals of certain inpatient hospital claim denials. This administrative settlement provided an opportunity for HHS to reduce the pending appeals by resolving a large number of homogenous claims for a pre-determined percentage of the claim in dispute.

The following chart details the percentage of appeals completed timely by type from FY 2007 through FY 2016:

| FY | Reconsiderations (2nd Level of Appeal) | |
|---|---|---|
| | Part A | Part B |
| 2007 | 99.90% | 72.28% |
| 2008 | 99.89% | 99.69% |
| 2009 | 99.82% | 99.01% |
| 2010 | 99.96% | 99.87% |
| 2011 | 99.96% | 92.76% |
| 2012 | 82.23% | 88.99% |
| 2013 | 21.47% | 99.75% |
| 2014 | 92.44% | 99.89% |
| 2015 | 97.89% | 98.46% |
| 2016 | 94.27% | 99.82% |

- *Medicare Appeals System (MAS)*: $6.2 million. Another important part of the BIPA reforms was the creation of the Medicare Appeals System (MAS). MAS' goal is to support the appeals process for the FFS, Medicare Advantage, and Prescription Drug Programs. MAS is a system that tracks and records Medicare appeals through multiple levels of the appeal process. The system leverages processes and consolidates data to allow users across appeal levels to realize benefits of reusable, centralized data. The system supports

standard processing of appeals and availability of data to other appeal levels while allowing stakeholders and user groups to shape procedures at their desired level. CMS maintains the system and implements all necessary system changes.

CMS plans to continue the expansion of MAS to every MAC. The MAS continues to be an integral part of CMS' management and oversight of MAC and QIC appeals. Access to real-time appeals data allows CMS to closely monitor workload trends and contractor performance. MAS has improved the appeals process by providing one centralized system for processing; reducing time and costs associated with storing, shipping, and maintaining paper files, and storing reporting metrics to identify and understand processing bottlenecks. There are currently more than 1,300 MAS users, with new user requests coming in daily. To date, users have processed more than 2,300,000 appeals using MAS.

**HIPAA Administrative Simplification**

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) required the Secretary of HHS to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addressed the security and privacy of health data. As the industry adopts these standards for the efficiency and effectiveness of the nation's health care system, it will improve the use of electronic data interchange which serves as one of CMS' long standing goals for the nation's healthcare.

**Budget Request: $23.1 Million**

The FY 2018 budget request for HIPAA Administrative Simplification is $23.1 million, a decrease of $5.9 million below the FY 2017 Annualized CR Level. Funding is requested for the following activities:

- *NPI & NPPES*: $5.2 million. HIPAA requires the assignment of a unique national provider identifier (NPI) to all covered health care providers and non-covered health care providers who apply and are eligible for NPIs. This project covers the operational support for issuing NPIs, a national customer service call center to assist providers in obtaining their NPI, and operational costs for the National Plan and Provider Enumeration System (NPPES) system. CMS built NPPES to assign NPIs and process NPI applications. Providers are required to keep their NPPES data current by submitting timely updates. Approximately 12.6 percent of the covered health care providers need to furnish updates annually. Non-covered health care providers also furnish updates to their NPI data. As such, the process of assigning NPIs and furnishing updates to the NPI data continues indefinitely. Currently, over 4.3 million NPIs have been assigned and over 4.9 million changes have been applied to the NPPES records of enumerated providers.

- *HIPAA Claims-Based Transactions and Electronic Data Interchange (EDI)*: $10.0 million. The Medicare program responds to electronic requests for eligibility information from providers and health care institutions using the adopted standard. CMS built the Health Eligibility Transaction System (HETS) which provides eligibility information to fee-for-service providers to assist them with properly billing for the services they provide to Medicare beneficiaries and in the processing of Medicare claims. CMS provides institutions and other health care providers with beneficiary eligibility information. This systems application is considered mission critical as it provides eligibility information on a real-time basis as well as assists in determining how Medicare should be billed for the services rendered. The request

will support the maintenance and operation of this eligibility system as well as allow CMS to be in compliance with the HIPAA EDI standard.

- *HIPAA Enforcement*: $1.7 million. CMS manages the administrative simplification enforcement and certification provisions of HIPAA. The CMS enforcement contractor provides complex, analytical, and technical support for HIPAA administrative simplification enforcement and certification. The contractor's support includes the complete suite of case management services for complaints, managing the certification of compliance process, and monitors compliance with corrective action plans (CAPs) and enforces required timelines. The contractor also maintains and prepares statistical reports and analyses, and periodically performs process upgrades and system enhancements. The contractor is also charged with tracking and monitoring complaint submission, and providing technical assistance in analyzing complex complaints HIPAA transactions and potential violations.

- *HIPAA Administrative Simplification Enumeration and Audit of Health Plans*: $2.4 million. CMS is responsible for driving the enumeration of Health Plans as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). CMS estimates that as many as 130,000 health plans may need to be enumerated. CMS is responsible for ensuring that Medicare and Medicaid, other federal payers, as well as commercial payers are progressing towards compliance for Health Plan Identifier (HPID) enumeration.

  Funding is required to support the HPID analysis, national enumeration system, enumeration process, and technical guidance to industry on the enumeration policy and implementation. Contractor support is needed to assist health plans with the enumeration process, responding to questions, inquiries, complaints or requests for assistance or record maintenance. As new standards are adopted by the Secretary and health plans make needed changes to their enumeration based upon purchase and sale of health plan components, acquisitions, and mergers, health plans will need continued support with enumeration.

- *EDI Pilot of Health Care Attachments Standard and Analysis of the Return on Investment of the Electronic Funds Transfers Standard and Operating Rules*: $3.8 million. CMS develops and adopts policies pertaining to the ANSI standards for conducting health care financial and administrative transactions on behalf of the HHS Secretary for mandatory use by health plans, health care providers, and clearinghouses. These requirements are foundational for healthcare reform and support CMS' E-Health Initiative to achieve better care, better health, and lower costs through greater interoperability, ease of data sharing, and lower costs through operational efficiencies. The request will support contractor activities to manage the pilot enrollment process, vet possible participants, collect any required documentation, and conduct the regular meetings that would be required with all of the pilot participants.

## III. MEDICAID, CHIP, and BASIC HEALTH PROGRAM INITIATIVES

### Program Description and Accomplishments

**Medicaid, CHIP, and Basic Health Program Operations**

CMS serves as the operational and policy center for the formulation, coordination and evaluation of all national program policies and operations relating to Medicaid, the Children's Health Insurance Program (CHIP), and the Basic Health Program (BHP). Medicaid is the means-tested health care program for low-income Americans, administered by CMS in partnership with the States. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally enacted to provide medical assistance to recipients of cash assistance. At the time, cash assistance was provided to low-income families and children through the Aid to Families with Dependent Children (AFDC) program, while the Supplemental Security Income (SSI) program provided cash assistance to low-income aged, blind and disabled individuals. Over the years, Congress incrementally expanded Medicaid well beyond these original traditional populations. Today, following implementation of the Affordable Care Act (ACA), Medicaid is the primary source of health care for a larger population of low-income adults and families, pregnant women, people of all ages with disabilities, and people who require long-term care services. Medicaid and CHIP enrollment is expected to be more than 77 million in FY 2018 with more than 1 in 5 Americans enrolled in Medicaid or CHIP.

### Budget Request: $44.7 Million

The FY 2018 budget request for Medicaid, CHIP, and BHP operations is $44.7 million, the same as the FY 2017 Annualized CR Level. Funding in this section includes support for administrative activities necessary to effectively operate Medicaid, CHIP, and BHP.

- *Medicaid and CHIP Business Information Solution (MACBIS):* $10.0 million. MACBIS is a CMS enterprise-wide initiative to ensure the data infrastructure and information technologies that support Medicaid and CHIP are commensurate to their role as the nation's largest health insurer. CMS requests funding to transform Medicaid and CHIP information and data gathering, submission, storage and extraction processes from a multi-layered and manual paper based process to an electronic, automated process that provides CMS, its Federal partners, the states and other stakeholders the ability to monitor, evaluate and analyze Medicaid and CHIP program performance. CMS is working with states to improve Medicaid and CHIP data and data analytic capacity through MACBIS. Because MACBIS upgrades are needed for a variety of Medicaid programs, the costs of MACBIS are borne by a variety of accounts in addition to Program Operations.

- *Medicaid Systems Support:* $16.2 million. This focuses on collecting, managing and housing Medicaid related data for the administration of the Medicaid and CHIP program at the Federal level to produce statistical reports, support Medicaid related research, and assist in the detection of fraud and abuse in the Medicaid programs. This request will aid in funding the operation and maintenance for the Medicaid & Child Health Budget and Expenditure System (MBES), Medicaid Drug Rebate/Federal Upper Limit System, and Medicaid IT Architecture (MITA) among others. Operation and maintenance includes maintaining (upgrading hardware, operating systems, etc.) the system infrastructure to support the systems. In addition, enhancements are applied to applications as changes to statutory requirements change. All of these systems are mission critical to administering the Medicaid and CHIP program.

- *Section 1115 Demonstration Management, Transitioning, and Waiver Transparency*: $1.3 million. Section 1115 of the Social Security Act provides broad authority to CMS and states under Medicaid and the Children's Health Insurance Program (CHIP) to design, implement and test new approaches to coverage, payment and service delivery, with the intention of improving whether and how low-income people receive health care, the quality and outcomes of that care, and its cost to the Federal government and to states. Currently 38 States operate at least one demonstration under 1115 waivers, and a growing number of states operate most or their entire Medicaid program under section 1115 authority. Funding will aid in conducting front-end assessments of 1115 demonstration designs as well as in oversight and management of post-approval state deliverables. This work represents ongoing operational cost.

- *Survey of Retail Prices*: $4.4 million. The Survey of Retail Prices initiative involves a pharmacy survey to aid states in efficiently reimbursing pharmacies for prescription drugs. The purpose of this project is to perform a monthly nationwide survey of retail community pharmacy invoice drug prices and to provide states with on-going pricing files. The resulting prices derived from this survey have been developed into the National Average Drug Acquisition Cost (NADAC). The NADAC files are posted on Medicaid.gov and are updated weekly. These files provide state Medicaid agencies with an array of covered outpatient drug prices concerning acquisition costs for covered outpatient drugs. The state agencies have begun to implement the NADAC as their approved State Plan reimbursement methodology. CMS requests ongoing operations funding for this fixed price contract, which collects pharmacy acquisition costs as reflected in Part II of the survey. The NADAC will also continue to assure that the Federal Medicaid program is paying more accurately for prescription drugs and will help states effectively implement the final outpatient drug rule.

- *Learning Collaborative:* $1.6 million. These are forums for facilitating consultation between CMS and States with the goal of designing the programs, tools and systems needed to ensure that high-performing State health insurance programs are in place and are equipped to handle the fundamental changes brought about by the ACA. The learning collaborative process enables participants to identify gaps in knowledge and technical skills, engage existing subject matter authorities to help address the challenges associated with implementing program changes and create a supportive environment that encourages the adoption of promising practices and problem-solving strategies. The Learning Collaborative approach is envisioned as a way to build States' confidence and support efforts to test, evaluate and implement ideas that will help States and federal agencies make progress toward the goals of the new health care system.

- *The National Home and Community Based Services (HCBS) Quality Enterprise*: $3.0 million. This funding goes to helping states increase access to high quality, lower-cost non institutionally-based long-term care services. The Home and Community Based (HCB) Settings Characteristics Contract Project was initiated at the end of FY 2014 and assists CMS in the review and monitoring of Statewide Transition Plans (Plans). CMS will be working with states to give them additional time to come into compliance with new regulations published in January 2014, and this project is part of CMS's efforts to work with states in this area. The HCB Settings Characteristics Contract Project is also the vehicle used to assist CMS in the development of necessary tools, protocols and guidance materials to ensure consistent national implementation of these new requirements.

CMS requests funds for a contractor to provide support to CMS in the review of these 50 Statewide Transition Plans, assist CMS in the development of criteria and guidance for the submission of environmental scans and other requirements to ensure that states are in compliance with the home and community-based settings characteristics. In addition to reviewing Statewide Transition Plans, contractors will conduct on-site reviews, education and training, and data analysis activities as states implement changes required by the regulation.

- *Managed Care Review and Oversight*: $3.5 million. CMS began this project in 2013 to advise states with their managed care programs and help CMS monitor new and existing programs. Adding to concerns over monitoring expansion, CMS was cited in GAO report number GAO-10-810 for having inconsistent oversight processes in place for managed care programs. CMS implemented this project to increase our oversight and technical assistance to states to address the new needs created by managed care expansion and GAO concerns.

  This funding will allow CMS to perform increased federal oversight, including oversight of network adequacy, transparency, and new quality measures. CMS plans to provide technical assistance to states, create new tools, or update existing tools to aid with Medicaid Managed Care. CMS will be reviewing the impact of the final managed care rule published in 2016; however, in the meantime, CMS anticipates receiving more requests from States for technical assistance and guidance. The success of the program is dependent on CMS's ability to help States understand the guidelines of the final rule in order to protect beneficiaries under the new regulatory framework.

- *Other Medicaid and CHIP Activities*: $4.7 million. CMS has many other operational contracts supporting Medicaid and CHIP. These activities include support for CHIPRA grants, Medicaid Access regulation support, and evaluations and technical assistance for Medicaid related programs.

## IV. HEALTH CARE PLANNING AND OVERSIGHT

### Program Description and Accomplishments

CMS administers and oversees private health plans including Medicare Advantage (MA) (Part C) and Medicare prescription drug benefit (Part D) programs as well as private insurance market reform and oversight activities established under the ACA.

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

**<u>Part C and D Information Technology (IT) Systems Investments</u>**

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

- *Medicare Advantage Prescription Drug Payment System (MARx)* – This system supports the Medicare Modernization Act (MMA) Title I and Title II requirements for beneficiary

enrollment and calculation of payments. The MARx also supports the Premium Withhold System (PWS).

- *Medicare Beneficiary Database Suite of Services (MBDSS)* – This project contains beneficiary demographic and entitlement information. The MBDSS stores Low-Income Subsidy (LIS) beneficiary status. It also derives Part D eligibility periods, processes state files for the State Phase Down Billing System and deeming process, deems beneficiaries eligible for LIS, and assigns LIS beneficiaries to a Part D drug plan.

- *Drug Data Processing System (DDPS)* – This system collects the prescription drug event (PDE) data for each Medicare Part D claim and is used to generate invoices to prescription drug manufacturers for the coverage gap discount program (CGDP).

- *Payment Reconciliation System (PRS)* – This system takes prospective payment data from MARx, the PDEs from DDPS, and direct and indirect remuneration (DIR) reports from the Health Plan Management System (HPMS) to calculate final reconciliation payments for Part D sponsors.

- *Integrated Data Repository (IDR)* – The IDR stores data from multiple CMS systems and programs for analytic and operational purposes.

- *Retiree Drug Subsidy System* – This system collects sponsor applications, drug cost data, and retiree data, and processes this information in order to pay retiree drug subsidies to plan sponsors. This system supports drug plan sponsors' participation in the Retiree Drug System program through data center hosting, hardware/software maintenance, system technical support, data/database administration and system security testing.

- *Risk Adjustment System* – This system uses demographic and diagnostic data to produce risk adjustment factors to support payments to MA and Part D plans.

**Budget Request: $37.8 Million**

The FY 2018 President's Budget request for Parts C and D IT Systems Investments is $37.8 million, the same funding level as the FY 2017 Annualized CR. This request supports ongoing systems maintenance and operations. The request validates Parts C and D IT systems services contracts, which supports the daily business activities, business deliveries, and ongoing operational enhancements for a variety of systems. These activities include data center hosting, hardware/software maintenance, system technical support, database administration, and system security testing.

**Oversight and Management of Health Plans**

CMS oversees the private health insurance companies that offer health care coverage through our private plans. Oversight and management activities needed to run the Part C, Part D, and private insurance programs include obtaining actuarial estimates, reviewing bids from the prescription drug and MA plans, approving new plan applicants for the new contract year, reviewing formularies and benefits, monitoring current plan performance, reconciling prior year plan payments, and expanding and supporting Part D enrollment of low-income beneficiaries. Many of the Parts C and D and private insurance oversight and management activities require

contractor support. These activities are an integral part to the Agency in order to ensure that our beneficiaries are receiving the health care service that they expect from our programs.

**Budget Request: $51.2 Million**

The FY 2018 budget request for Oversight and Management is $51.2 million, a decrease of $12.9 million below the FY 2017 Annualized CR Level.

- *Medicare Parts C and D*: $49.8 million. This funding supports audits, actuarial reviews, estimates of Medicare Advantage and Prescription Drug Plans, the Retiree Drug Subsidy (RDS) Program, and the on-going Medicare Part C and Part D reconsideration contracts. This also funds ongoing ACA initiatives such as closing the Medicare Part D coverage gap, reforming MA plan payments, and making improvements to Part D plan operations.

  Oversight and management also includes Part C and Part D appeal reviews. CMS contracts with an independent reviewer to conduct reconsiderations of adverse MA plan determinations, late enrollment penalties (LEP), and coverage denials made by Medicare Advantage and PDP plans. This review stage represents the second level of appeal for the beneficiaries in these plans. All second level reviews are done by the Qualified Independent Contractors (QICs).

  The Parts C and D appeals workload history is presented below:

**QIC Appeals Workload for Parts C/D**

| | FY 2013 Actual | FY 2014 Actual | FY 2015 Actual | FY 2016 Actual | FY 2017 Estimate | FY 2018 Estimate |
|---|---|---|---|---|---|---|
| Part C Appeals | 122,948 | 72,190 | 43,488 | 55,048 | 59,946 | 64,142 |
| Part D Benefit Appeals | 21,780 | 23,064 | 31,895 | 34,387 | 36,000 | 37,000 |
| Part D LEP appeals | 38,468 | 40,639 | 49,388 | 45,989 | 47,000 | 48,000 |

- *Rate Review:* $1.4 million. CMS is responsible for monitoring health insurance premium increases and ensuring States have appropriate mechanisms to review potentially unreasonable health insurance premium increases, defined as increases of more than 10 percent over the previous year. Since 2014, CMS has monitored rate increases for private individual and small group markets. To assist in this monitoring function, CMS released final rules that add a reporting threshold for any rate increase above zero as well as amend the standards for health insurance issuers and States regarding reporting, utilization, and collection of data for the program. Proposed rates undergo an actuarial review by either a State, or, if a State is unable to review the proposed increases, then by CMS. Information on all proposed rate increases, as well as any justifications for increases found to be unreasonable, are made available to the public on Healthcare.gov. A copy of the rules and data template can be found at: http://cciio.cms.gov/resources/regulations/index.html.

  Funding supports review of submissions of all rates where CMS is the primary rate review regulator for compliance with federal rating rules. Funding also supports the actuarial review of proposed rate increases of 10 percent or greater in the states where CMS is the primary rate review regulator. The funding will also be used to support the maintenance of the consumer facing rate review tool.

## Federal Exchanges

The Federal Exchanges allow individuals and small businesses to compare health plan options, see if financial assistance with premiums and cost sharing is available, and purchase coverage.

States have the option of operating an individual or small business exchange and the risk adjustment program or allowing CMS to operate these activities on their behalf. In the individual market, states can create a State-based Exchange (SBE) or can elect to use the Federally-facilitated Exchange (FFE). SBEs can partner with CMS to use portions of the federal platform, such as enrollment, to leverage functionality and resources and are referred to as State-based Exchange on the federal platform (SBE-FP). In an SBE-FP arrangement, a State retains the authority for health plan certification, use of the federal enrollment platform, and works in conjunction with CMS on outreach activities. States that elect to use the FFE may conduct their own outreach and/or plan management activities using a partnership model.

CMS has responsibilities on behalf of all Exchanges for the following core functions:

- Determining consumers' eligibility for financial assistance through the Exchange or other health insurance programs, including initial determinations for Medicaid and the Children's Health Insurance Program (CHIP);
- Ensuring proper payment of financial assistance in the form of advanced payment of the premium tax credit (APTC) and cost-sharing reduction (CSR) to issuers where a consumer is determined eligible;
- Operating a quality rating system for display on Exchange websites; and
- Conducting certification and oversight of SBEs.

If a state elects to use the FFE, CMS oversees these additional functions:

- Certifying qualified health plans (QHPs) and stand-alone dental plans (SADPs) after reviewing health plan benefits and rates;
- Providing consumers the ability to apply for coverage or an exemption from the personal responsibility payment, conducting enrollment reconciliation with issuers, conducting appeals, and assisting with APTC reconciliation; and
- Educating consumers about the Exchange including the open enrollment period (OEP), coverage options, and providing assistance to consumers.

Independently, states can choose to operate their own Small Business Health Option Program (SHOP). SHOP provides an exchange for small businesses to provide coverage to their employees using a single portal that allows the employer to select coverage options, to pay the employer portion of the premiums, and allows employees to enroll in coverage. When operating as the Federally Facilitated SHOP (FF-SHOP), CMS is responsible for the full range of eligibility determination, enrollment, appeals, and reconciliation activities. When a State elects to operate a SHOP, CMS provides technical assistance and analytic support.

For the 2017 OEP, CMS operated the FFE on behalf of 34 states and provided enrollment support for Arkansas, Kentucky, Nevada, New Mexico, and Oregon, as SBE-FPs along with 40 SHOPs. For the 2018 OEP, CMS does not anticipate any changes. CMS will operate the risk adjustment program on behalf of all the states.

In FY 2018, CMS will continue to focus on streamlining operations through automation, reducing issuer burden, and providing high quality customer service. CMS proposes to increase the use

of state and issuer partnerships to facilitate enrollment, while maintaining a strong consumer focus. At the same time, CMS will work to strengthen partnerships with states through greater coordination and deference to traditional state roles in regulating insurance products.

**Budget Request: $1,693.6 million of which $452.7 million is funding through discretionary Program Operations**

The FY 2018 President's budget request for the Federal Exchanges is $1,693.6 million at the program level of which $471.1 million is discretionary appropriations including $452.7 million in Program Operations, $18.4 million in Federal Administration, $1,187.5 million in anticipated user fee collections, and $35 million in other resources.

While Congress works to pass legislation to repeal and replace Obamacare, the Administration remains committed to stabilizing the markets through greater flexibility, reduced burden, and strengthened partnerships. In FY 2018, CMS will focus on stabilizing the Federal Exchanges by empowering states to make the best decisions for their health care markets through greater flexibility and control. As noted in the *Patient Protection and Affordable Care Act: Market Stabilization Final Rule* (82 FR 18346), this includes allowing for greater variance in actuarial values and deferring to states to apply network adequacy standards. Responding to issuer concerns, CMS will be accelerating a planned reduction to the OEP from ending on January 31 to December 15. Furthermore, CMS will begin verifying all special enrollment period applications and will allow issuers to apply new premium payments to any outstanding debts a consumer may have with that insurer or an insurer in the same control group. Building on existing partnerships with states and issuers, CMS will allow states and issuers to conduct outreach activities, while CMS will focus on FFE consumers.

- *Health Plan Bid Review, Management, and Oversight:* $31.1 million of which $0 million is funded through discretionary appropriations. CMS oversees the annual certification process for QHPs and SADPs offered on the individual and small group markets. CMS supports the process by developing operational guidance, creating tools, and providing technical assistance to issuers on certification requirements. CMS certifies agents and brokers to participate in the FFE.

  In FY 2018, CMS will focus on identifying ways to reduce issuer burden by and providing greater flexibility in meeting minimum requirements.

- *Payment and Financial Management:* $32.9 million of which $16.9 million is funded through discretionary appropriations. States and issuers supply a range of enrollment, premium, and claims data for calculating financial payments across multiple Exchange activities using Health Insurance Oversight System (HIOS). Federal Exchange-related payment leverages the Healthcare Integrated General Ledger Accounting System (HIGLAS) and financial management processes such as reporting and debt management.

  In FY 2018, CMS will continue to administer financial assistance payments on behalf of all Exchanges and operate the risk adjustment program. CMS will complete closeout of the reinsurance and risk corridor programs.

  The Risk Adjustment Program balances the risk pool of compliant plans in the individual and small group markets by transferring premium revenue from plans with below-average actuarial risk to plans with above-average actuarial risk. CMS uses a complex model to calculate a relative risk score, which is a measure of the anticipated cost of care. The risk

adjustment data validation (RADV) program conducts reviews and audits of issuer provided data on healthcare costs. States that operate a SBE may operate a risk adjustment program using a CMS certified methodology.

In FY 2018, CMS will implement modifications to better estimate the risk associated with enrollees who are not enrolled for a full 12 months, to use prescription drug data to update the predictive ability of the risk adjustment models, and to establish transfers that will better account for the cost of high cost enrollees.

- *Eligibility and Enrollment:* $321.6 million of which $84.6 million is funded through discretionary appropriations. This activity allows consumers to submit applications for coverage during the OEP, special enrollment periods (SEPs) or exemptions from the individual shared responsibility payment using electronic or paper applications. Electronic applications are processed through HealthCare.gov where eligibility for financial assistance, Medicaid and CHIP, or an exemption is verified through the Data Services Hub.

  When consumer provided information does not match electronic data sources, data match issues, or inconsistencies will be generated. CMS reviews consumer submitted supporting documentation to resolve the issue. Consumers have the opportunity to appeal determinations for financial assistance, SEPs, and exemption eligibility. Appeal activities include processing incoming documents, reviewing appeal requests and supporting documentation, requesting information and documents from appellants, general case management, and ensuring staff remain current on relevant laws, policies, and guidelines.

  CMS works with issuers to reconcile enrollment, resolving discrepancies identified using analytics or issuer identified issues. This process ensures only consumers who pay their monthly premium remain enrolled in coverage and that issuers receive the appropriate amount of financial assistance payments.

  In FY 2018, CMS anticipates continued efficiency gains from previous investments that have reduced manual processes and allowed for greater information sharing between processes. CMS will conduct 100 percent special enrollment period pre-enrollment verification based on prior program integrity analysis.

- *Consumer Information and Outreach:* $573.5 million of which $0 million is funded through discretionary appropriations. CMS ensures consumers are fully supported not only during open enrollment, but throughout the plan year using mail, phone, and the website.

  The consumer call center is the primary means for consumers to ask questions, get help with online tools, complete an application, and get help with tax form questions, life changes and inconsistencies. The call center offers support in over 200 languages and is open 24 hours a day 7 days a week. A specialized center provides complex call resolutions and is staffed by experts in resolving multiple issues. Through the Government Printing Office (GPO), CMS prints and mails pertinent consumer notices including application status, data matching issues, and appeals.

  CMS conducts traditional media and direct mail as well as digital media public education and outreach campaigns leading up to and during the OEP to encourage participation in the FFE and FF-SHOP. CMS provides over 100 print and electronic educational publications in English and Spanish on a wide variety of topics including enrollment basics, financial assistance, individual responsibility payment, exemptions, and appeals. Many consumers

have limited experience with health insurance, and this activity provides educational materials on understanding their benefits, how to use their coverage, and what costs they are responsible for. Year round on the ground community based support is available through Navigators and Assisters that supply impartial information to consumers on enrolling, selecting a plan, and assisting with data inconsistency and tax issues.

In FY 2018, the shortened OEP (November 1 – December 15) will allow CMS to reduce call center costs, while maintaining current service levels. CMS will continue to fund Navigator grants, but will focus on empowering state and rely more heavily on agents and brokers to conduct outreach and education more consistent with their traditional roles in health insurance markets.

- *Information Technology (IT):* $636.0 million of which $342.2 million is funded through discretionary appropriations. The IT environment is built on a virtual data center and cloud based approach that supports consumer facing websites, issuer facing electronic data exchanges, and back end systems. The IT infrastructure is designed to support peak volumes ensuring a smooth user experience. New technical architecture and software code is integrated into existing production environments using a comprehensive end to end testing methodology that ensures existing performance levels are maintained or improved. CMS administers a comprehensive IT security program that is designed to prevent and detect intrusions into the environments. The Federal Exchanges leverage existing Enterprise Shared Services, discussed in the IT chapter, including Enterprise Identity Management (EIDM), the Enterprise Portal, the Business Rules Enterprise Services (BRES), and the Enterprise Eligibility Service (EES). Major applications are discussed below:

    - *Data Services Hub* – Provides a query based verification service for information supplied by the consumer during the application process with Federal entities and private data sources. Verified data includes citizenship or immigration status, income, household size, and eligibility for Medicare, veterans', or federal employee benefits.

    - *Health Insurance Oversight System (HIOS)* – Serves as the primary data collection system for issuer oversight and plan information. The system collects issuer data on claims for risk adjustment, rate review justifications, and medical loss ratio reporting for oversight activities.

    - *Federal Health Care Exchanges (HIX)* – Provides the back end functionality of the Federal Exchanges including plan management, eligibility and enrollment, and financial management including premium management for FF-SHOP.

    - *HealthCare.gov Web Portal* – HealthCare.gov is the consumer facing online resource that allows consumers to search and compare health insurance plans, enroll in coverage, receive financial assistance determinations, upload documents, and submit appeals and exemptions.

    In FY 2018, CMS will see movement to a steady state in IT operations resulting in reduced costs and development needs.

- *Exchange Quality:* $4.0 million of which $4.0 million is funded through discretionary budget authority. CMS uses a star rating system based on clinical quality measures and an enrollee satisfaction survey to give consumers easy to comparable quality metrics on QHPs.

In FY 2018, CMS will continue to conduct aggregation of quality measures and conduct the enrollee satisfaction surveys to ensure consumer have access to reliable information.

- *Small Business Health Option Program (SHOP):* $11.5 million of which $0 million is funded through discretionary appropriations. SHOPs provide small businesses with less than 50 employees the option of providing health insurance to their employees through a simplified shopping and payment experience. Employers with fewer than 25 full-time equivalent employees may be eligible for small business tax credits when purchasing coverage through SHOP.

  In FY 2018, CMS will continue operations, while reducing the burden on issuers, agents and brokers, and consumers in order to make plans more readily available.

- *Other Activities:* $9.3 million of which $5.0 million is funded through discretionary appropriations. This activity includes overall Federal Exchange operations and some program integrity activities. CMS is actively working to identify potential areas of waste, fraud, and abuse through proactive analytics. CMS has implemented an improper payment risk assessments for APTC, CSR, and Basic Health Program payment accuracy in accordance with existing statues. CMS is also focused on SEPs, consumer identity theft, and agent-brokers.

  In FY 2018, CMS will continue to work proactively with issuers, consumers, and other partners to identify emerging program integrity issues.

- *Administration:* $73.8 million which is funded through $18.4 million in discretionary appropriations. Supports administrative activities across Federal Exchange activities. In FY 2018, CMS will continue to streamline operations, while ensuring effective oversight of the program.

## V. HEALTH CARE QUALITY

### Program Description and Accomplishments

**Health Care Quality Improvement Initiatives**

CMS is committed to improving the quality and value of health care provided to beneficiaries and consumers through value-based purchasing (VBP) programs and other CMS health care quality initiatives. In FY 2018, CMS plans to perform activities that achieve the development of a coordinated quality improvement strategy aimed at sharing savings across care channels, reducing hospital readmissions, and increasing availability of information on performance. VBP programs help CMS to transform the healthcare industry to one from pay for service to pay for quality. This not only helps our beneficiaries receive high quality of care but also creates a more efficient and better healthcare service experience.

**Budget Request: $22.2 Million**

The FY 2018 budget request for health care quality improvements is $22.2 million, a decrease of $25.0 million below the FY 2017 Annualized CR Level.

- *Medicare Shared Savings Program*: $15.1 million. The Medicare Shared Savings Program was implemented in January 2012 to help doctors, hospitals, and other health care providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs). With 480 ACOs serving over 9 million beneficiaries, we believe the Shared Savings Program improves the health of individuals and communities while lowering the growth in Medicare expenditures. CMS continues to expand the program, which maintains strong industry interest. The FY 2018 funding request will support the second option year of two contracts: the Application and Coordinator Support Contract and Compliance and Communications Contract.

- *Medicare Data for Performance Measurement:* $6.0 million. Under current law, the Secretary is required to establish a process to certify qualified entities (QEs) who will combine standardized extracts of Medicare Parts A, B, and D claims data with other sources of claims data to evaluate and report on the performance of providers of services and suppliers on measures of quality, efficiency, effectiveness, and resource use. The funding requested will support contracts focused on three major areas: program management, data preparation and distribution, and technical assistance.

- *Hospital Readmission Reduction Program*: $0.6 million. Funding is essential to continue with implementation of this provision. Current law requires the Secretary to reduce payments to hospitals that have a high rate of readmissions, beginning on or after October 1, 2012. The provision also requires the Secretary to make readmission rates for a hospital publicly available. In addition, the provision directs the Secretary to establish a program for eligible hospitals to improve their readmission rates through the use of patient safety organizations not later than 2 years after enactment.

  The law allows CMS to expand the readmission measures used in the Hospital Readmissions Reduction Program in FY 2015. Funding is needed to calculate hospital-specific readmission rates, calculate the hospital-specific payment adjustment factor for excess readmissions and engage in rulemaking in order to maintain the current measures.

- *Appropriate Use Criteria for Advanced Imaging Services:* $0.5 million. The Protecting Access to Medicare Act (PAMA) established a new program that will require professionals to consult appropriate use criteria (AUC) when ordering advanced diagnostic imaging services. The program has four major milestones: specifying AUC for use in the program; identifying qualified clinical decision support (CDS) mechanisms; requiring AUC information to be reported on claims; and identifying outlier ordering professionals who will be subject to prior authorization. Funding is required to continue implementing this program in a manner that does not place a substantial burden on providers while at the same timing improving quality of care for patients.

## VI. OUTREACH AND EDUCATION

### Program Description and Accomplishments

**National Medicare Education Program (NMEP)**

The National Medicare Education Program (NMEP) was established to implement provisions of the Balanced Budget Act of 1997 and continues under the Medicare Modernization Act of 2003. Its focus is to enlist national and local organizations to support and participate in educating the public about Medicare. This is CMS' primary vehicle to educate Medicare beneficiaries and their caregivers so they can make informed health care decisions. The program is comprised of five major activities including: beneficiary materials, the beneficiary contact center or 1-800-MEDICARE, internet services, community-based outreach, and program support services. The NMEP program is vital for the success of our programs and is the basis for providing excellent customer service to our beneficiaries and providers.

**National Medicare Education Program Budget Summary**
(Dollars in Millions)

| NMEP Category | Funding Source | FY 2016 Final | FY 2017 CR | FY 2018 PB | Description of Activity in FY 2018 |
|---|---|---|---|---|---|
| **Beneficiary Materials** | **Total** | **$41.3** | **$54.9** | **$50.5** | National Handbook with comparative information in English and/or 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. |
| | PM | $8.9 | $19.9 | $20.5 | |
| | Postage | $32.4 | $35.0 | $30.0 | |
| **Beneficiary Contact Center/1-800-MEDICARE** | **Total** | **$211.1** | **$294.7** | **$279.8** | Call center and print fulfillment services available with 24 hours a day, 7 days a week access to customer service representatives. |
| | PM | $125.8 | $214.2 | $199.3 | |
| | User Fees | $85.3 | $80.5 | $80.5 | |
| **Internet** | **Total** | **$24.1** | **$20.1** | **$20.1** | Maintenance and updates to existing interactive websites to support the CMS initiatives for health & quality of care information; software licenses; enhancements to the on-line capabilities of MyMedicare.gov. |
| | PM | $20.7 | $20.1 | $20.1 | |
| | QIO | $3.4 | (TBD) | (TBD) | |
| **Community-Based Outreach** | **Total** | **$1.6** | **$1.9** | **$2.1** | Collaborative grassroots coalitions; training on Medicare for partner and local community based organizations, providers, and Federal/State/local agencies; and partnership building efforts that provide assistance to Medicare beneficiaries in their communities. |
| | PM | $1.6 | $1.9 | $2.1 | |
| **Program Support Services** | **Total** | **$15.8** | **$9.0** | **$13.2** | A multi-media Medicare education campaign, support services to include Handbook support contracts such as Braille, audio and translation support; minimal level of consumer research and assessment for planning, testing, and evaluating communication efforts to include efforts for targeted populations such as Low Income Subsidy. |
| | PM | $15.8 | $9.0 | $13.2 | |
| | **Total** | **$293.9** | **$380.6** | **$365.7** | |
| | **PM** | **$172.8** | **$265.2** | **$255.2** | |
| | **User Fees** | **$85.3** | **$80.5** | **$80.5** | |
| | **Postage** | **$32.4** | **$35.0** | **$30.0** | |
| | **QIO** | **$3.4** | (TBD) | (TBD) | |

**Budget Request: $225.2 Million**

The FY 2018 budget authority request for NMEP is $225.2 million, a decrease of $10.0 million below the FY 2017 Annualized CR Level. The following activities are funded within the Program Operations request:

- *Beneficiary Materials*: The total FY 2018 request is $50.5 million, $20.5 million in budget authority. This estimate is based on historical publication usage data and current market prices for printing and mailing. This request supports the printing and mailing of the *Medicare & You* handbook. The *Medicare & You* handbook satisfies numerous legal mandates including BBA Section 1851 (d) and MMA Section 1860(d) to provide print information to current and newly eligible beneficiaries about Medicare coverage options and available services, including plan comparison information for Medicare Advantage and prescription drug plans. The handbook is updated annually and mailed to all current beneficiary households every October. Updates to rates and plan information occur as needed for monthly mailings to newly-eligible beneficiaries.

  The costs associated with this funding are printing/postage for the monthly mail contract (English or Spanish handbook to new enrollees), printing/postage for the October mailing (English or Spanish handbook to all current beneficiary households), large print English and Spanish handbooks, freight (shipping the handbook to local mail facilities, thus saving on postage costs), and on-site quality monitoring by Government Printing Office personnel.

The chart below displays the actual number of *Medicare & You* handbooks distributed for fiscal years 2012 through 2016 and the estimated distribution for fiscal years 2017 and 2018. 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**
(Handbooks Distributed in Millions)

| | FY 2012 Actuals | FY 2013 Actuals | FY 2014 Actuals | FY 2015 Actual | FY 2016 Actual | FY 2017 Estimate | FY 2018 Estimate |
|---|---|---|---|---|---|---|---|
| **Number of Handbooks Distributed** | 40.8 | 42.3 | 42.0 | 43.7 | 45.4 | 47.0 | 48.6 |

- *1-800-MEDICARE/Beneficiary Contact Center (BCC):* $199.3 million in budget authority. The 1-800-MEDICARE national toll-free line provides beneficiaries with access to customer service representatives (CSRs) who are trained to answer questions regarding the Medicare program. The toll-free line is available 24 hours a day, 7 days a week. This line provides beneficiaries with responses to both general and claim-specific Medicare questions. CSRs respond to inquiries including, but not limited to: authorizations, benefit periods, claims (including denials, filing or status), election periods, deductibles, coverage, eligibility and enrollment, complaints, plan comparisons, prescription drug benefit enrollment and disenrollment, appeal status, etc. Beneficiaries can also use 1-800-MEDICARE to report fraud allegations.

1-800-MEDICARE CSRs use a variety of call center tools to help beneficiaries, their families, and caregivers make informed health care decisions and to provide both general and personalized customer service in a real-time environment. CMS is continuously exploring new options for streamlining processes and timeframes at 1-800-MEDICARE while seeking to preserve efficiencies and cost-effectiveness.

The following table displays call volume experienced from FYs 2012 through 2015 and the number of calls we expect to receive in FYs 2016 through 2018. In FY 2018, CMS expects to receive 27.3 million calls to the 1-800-MEDICARE toll-free line. All calls are initially answered by the Interactive Voice Response (IVR) system. Approximately 30 percent of the calls are handled completely by IVR.

**1-800-MEDICARE/Beneficiary Contact Center Call Volume**
(Call Volume in Millions)

| | FY 2012 Actuals | FY 2013 Actuals | FY 2014 Actuals | FY 2015 Actual | FY 2016 Actual | FY 2017 Estimate | FY 2018 Estimate |
|---|---|---|---|---|---|---|---|
| Number of Calls | 25.6 | 25.4 | 25.0 | 26.2 | 25.0 | 26.0 | 27.3 |

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

- *Internet*: $20.1 million. The Internet budget funds operations and maintenance for three websites:

  The http://www.cms.gov website is the Agency's public website for communicating with providers, professionals, researchers, and the press on a daily basis. It supports a variety of critical CMS initiatives, including outreach and education, delivery of materials to stakeholders electronically, and data collection.

  The http://www.medicare.gov website is the Agency's public beneficiary-focused website with a variety of real-time, interactive, decision-making tools. These tools enable Medicare beneficiaries and their caregivers to obtain information on their benefits, plans, and medical options. The Medicare Plan Finder, Hospital Compare, Nursing Home Compare, and the Medicare Eligibility tool are included under this activity. The website serves as an effective and efficient communication channel and provides self-service options for U.S. citizens, beneficiaries, and caregivers.

  Beneficiaries also have access to the http://www.mymedicare.gov website to review and update their online account. Beneficiaries can log into mymedicare.gov, a secure website, and check their claims within 24 hours of the processing date. In addition, beneficiaries can use the website to view upcoming available preventive services, a Medicare Summary Notice, or enrollment information, update their email address and add emergency contact information. Beneficiaries also can generate an On-the-Go Report which allows them to download personalized health information and share with their healthcare providers.

In FY 2018, CMS estimates 332 million page views to http://www.medicare.gov, approximately a two percent increase in traffic from the page views anticipated in FY 2017. CMS expects page views to grow as the Medicare beneficiary population increases, beneficiaries and their caregivers become more internet savvy, and as CMS continues to implement more self-service features for beneficiaries to use, maximizing their health and quality of care decisions.

www.Medicare.gov **Page Views**
(Page Views in Millions)

| | FY 2012 Actuals | FY 2013 Actuals | FY 2014 Actuals | FY 2015 Actual | FY 2016 Actual | FY 2017 Estimate | FY 2018 Estimate |
|---|---|---|---|---|---|---|---|
| Number of http://www.medicare.gov Page Views | 270.0 | 266.9 | 294.0 | 308.0 | 316.5 | 325.0 | 332.0 |

- *Community-Based Outreach:* $2.1 million. CMS relies heavily on community-level organizations, State and Federal agencies, providers, and other partners to serve as trusted sources of CMS administered program information for consumers, particularly for hard-to-reach populations, and must provide these partners with accurate and up-to-date information and tools that equip them to effectively counsel and assist their constituencies.

  FY 2018 funding is for continued support and maintenance of the new Learning Management System and all related tasks. This funding will also provide the resources needed to support face-to-face sessions, web-based training, and regularly scheduled live- and pre-recorded webinars required to educate stakeholders to ensure eligible individuals enroll in CMS programs and make optimum use of their benefits.

- *Program Support Services:* $13.2 million. This activity provides funding for accessible materials for low vision/blind and disabled beneficiaries (audio, Braille and large print and e-reader designs), electronic and composition support for the Medicare &You (M&Y) Handbook, mail file creation for the statutory October mailing of the M&Y Handbook, NMEP consumer research and assessment (including consumer testing of the M&Y handbook), a publication ordering web site for partners that support the Medicare education program, support for the Advisory Panel on Outreach and Education (APOE), and the creation/dissemination of mobile applications for accessing NMEP products and information. This funding also supports the multi-media education program.

  The Multi-Media Medicare Education Campaign raises beneficiary awareness about the coverage options, benefits, and services available through Medicare. It is designed to help people with Medicare and those who help them (caregivers including family and friends, information intermediaries, and others) maximize the use of their Medicare benefits to maintain their health, resulting in healthier beneficiaries and lower costs for Medicare. The campaign also promotes Medicare's official information sources including 1-800-MEDICARE, medicare.gov, mymedicare.gov, Medicare & You Handbook, and other localized partners and resource.

In addition to the Program Management request, the NMEP budget request assumes approximately $80.5 million in user fees and $30.0 million is postage fees bringing the total FY

2018 budget request for NMEP to $365.7 million, a decrease of $15.0 million below the total FY 2017 Annualized CR program level.

## Provider Outreach

Provider outreach activities allow the Agency to connect with providers through a variety of means. Per section 1874(A) (g) (3) of the Social Security Act, CMS is required to offer a toll-free telephone service to providers. CMS maintains toll-free numbers for general provider inquiries and questions about enrollment, electronic claims, and Medicare secondary payer issues. Additionally, CMS disseminates information through the Medicare Learning Network® (MLN) to educate providers on Medicare policy and operations and other CMS-administered programs. CMS also conducts national outreach campaigns and products to ensure consistency in the training and resources of healthcare providers and their billing and practice administration staff.

### Budget Request: $6.1 Million

The FY 2018 budget request for Provider Outreach is $6.1 million, a decrease of $16.5 million below the FY 2017 Annualized CR Level.

- *Provider Toll-Free Service*: $3.1 million. The minutes of telephone service, which drive costs, are projected to remain flat through FY 2017. The costs of the toll-free lines and support contracts are included in this category. The costs of answering the inquiries, including customer service representatives, are included in Ongoing Operations under Provider Inquiries. As part of the Provider Customer Service Program (PCSP), the Medicare Administrative Contractors (MACs) currently handle more than 34 million calls and over half a million written inquiries annually from providers. This request provides funding for the telephone service, technical telecommunications support contracts, quality assurance monitoring, and oversight reporting database maintenance.

In FY 2018, contractors are expected to respond to 34.4 million telephone inquiries and 600,000 written inquiries (which include rare walk-in inquiries) from 2 million FFS providers. In an effort to drive efficiency, the contractors utilized Interactive Voice Response (IVR) systems to automate approximately 64 percent of their telephone inquiries. Increased utilization of the IVR frees up customer service representatives to handle the more complex questions.

The following table displays provider toll-free line call volumes from FY 2012 through FY 2018 (estimated):

**Provider Toll-Free Service Call Volume**
(Call Volume in Millions)

| | FY 2012 Actual | FY 2013 Actual | FY 2014 Actual | FY 2015 Actual | FY 2016 Actual | FY 2017 Estimate | FY 2018 Estimate |
|---|---|---|---|---|---|---|---|
| Completed Calls | 38.8 | 35.6 | 34.4 | 34.4 | 34.2 | 34.4 | 34.4 |

- *National Provider Education, Outreach, and Training*: $3.0 million. Educational products/services are branded as part of the MLN and include MLN Matters® national articles, MLN publications (e.g., fact sheets, quick-reference charts, and booklets), web-based training courses, educational tools and podcasts. MACs and Regional Office (RO) staff are required to use MLN products to promote consistency in their outreach efforts. This promotes consistency and reduces costs associated with MACs and ROs developing their own materials. MLN products are commonly developed in response to recommendations in OIG and GAO reports.

  Funding will support the development and dissemination of Medicare fee-for-service (FFS) educational information on Medicare policy and operations. This also supports fulfillment activities related to requests for hard copy products and other operational support to perform related outreach and education.

## VII. INFORMATION TECHNOLOGY

### Enterprise IT Activities

Enterprise IT activities encompass CMS' critical systems that support ongoing operations, primarily the Infrastructure Hosting & Centralized Communication Services (IHCCS), the Virtual Data Center (VDC) Infrastructure Enterprise Services (VIES), the CMS Enterprise Compute Services (CECS), and Large Scale Data Repository (LSDR) Task Orders. These VDC task orders support the day-to-day operations and maintenance activities of CMS' enterprise-wide infrastructure, including managing the mainframe, network, voice and data communications, as well as backing up CMS' mission critical applications and managing CMS' hardware and software. Other enterprise IT activities include:

- *Ongoing enterprise activities* – Supports all application needs, such as enterprise-wide identity management and standards development. Also includes application hosting and infrastructure, software testing, helpdesk, security testing, database maintenance, and storage costs.

- *The Medicare Data Communications Network* – Supports transaction processing and file transmission through a secure telecommunications network.

- *Hardware maintenance and software licensing* – Consists of ongoing safeguarding maintenance and software application certification.

- *Development and Maintenance of Mission Critical Database Systems* – Includes databases that house the data required by CMS to perform its core functions.

- *Modern Data Environment* – Transitions CMS from a claims-centric data warehouse orientation to a multi-view data warehouse orientation capable of integrating data on beneficiaries, providers, health plans, and claims. Without this repository, CMS must extract data from different locations, often resulting in inconsistent and slow answers to queries and costly analyst intervention.

- *CMS enterprise data and database management investment* – Allows for the addition of databases, the establishment of consistent application of data policies and processes, and a heightening of data security 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 Homeland Security Presidential Directive 12 (HSPD-12) requirements. This provides greater security for data and systems, and accelerates the retirement of the Enterprise User Administration (EUA).

- *The Enterprise Information Technology Fund* – Supports Department-wide enterprise information technology and government-wide E-Government initiatives. Operating Divisions help to finance specific HHS enterprise information technology programs and initiatives, identified through the HHS Information Technology Capital Planning and Investment Control process, and the government-wide E-Government initiatives. The HHS enterprise initiatives meet cross-functional criteria and are approved by the HHS IT Investment Review Board based on funding availability and business case benefits. Development is collaborative in nature and achieves HHS enterprise-wide goals that produce common technology, promote common standards, and enable data and system interoperability.

**IT Infrastructure**

Key IT infrastructure projects include:

- *Infrastructure Investments* – CMS will prepare technical infrastructure (i.e., hardware capacity, network connectivity, and software) to accommodate the development, integration, testing, validation and Integrated Data Repository (IDR) environments, as well as high availability and corresponding disaster recovery for implementation. Funding is also needed for contractor support for infrastructure upgrades, project management, additional CPU capacity to support application growth resulting from legislative changes to existing systems, expansion of IDR platform by 20 terabytes, growth of mid-tier and mainframe direct access storage device (DASD) to support growth of databases (20 terabytes), and network connectivity for up to 50 new business partners.

- *Virtual Call Center* – This critical project has greatly increased the overall efficiency and effectiveness of the 1-800-MEDICARE call center. 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 greatly improved customer

service. The funding level for the FY 2018 request supports current ongoing contract costs.

- *The Web Hosting project* – This project covers the transitions of MMA web-hosted applications to an Enterprise Data Center (EDC). These applications include the Medicare Advantage Prescription Drug Payment System, Premium Withhold System, the Medicare Beneficiary Suite of Systems, and the Risk Adjustment System. The EDCs are designed to support the increased security and reliability that are required in the long term.

**Non-Exchange IT**

This request supports the enterprise architecture and security structure of the Affordable Care Act implementation.

**CMS Shared Services**

This request will support CMS's continued development and operation of shared services, i.e. IT applications and infrastructure that will meet the programmatic needs of multiple business units. Specific shared services include Master Data Management, Enterprise Identity Management, Enterprise Portal, and Business Rules Enterprise Services. Note that the Program Operations request for funding for shared services represents only a portion of the total need. Costs are also allocated to other (mandatory) funding sources, such as CMMI, HCFAC, and QIOs.

**Budget Request: $328.9 Million**

The FY 2018 President's Budget request for information technology investments supporting all Program Operations is $328.9 million, a decrease of $28.9 million below the FY 2017 Annualized CR Level. This category includes four major IT investment activities, as shown in the table below.

**IT Investments Request**
(Dollars in Millions)

| Activity | FY 2016 Final | FY 2017 Annualized CR | FY 2018 President's Budget | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| Enterprise IT Activities | $258.3 | $286.5 | $258.0 | ($28.5) |
| Infrastructure Investments | $26.8 | $30.7 | $30.7 | $ - |
| Non-Exchange IT | $13.1 | $13.4 | $13.4 | $ - |
| Shared Services | $21.9 | $27.1 | $26.8 | ($0.3) |
| **Total Program Ops Request 1/** | **$320.2** | **$357.7** | **$328.9** | **($28.8)** |

1/ Totals may not add due to rounding.

- *Enterprise IT Activities*: $258.0 million, a decrease of $28.5 million below the FY 2017 Annualized CR Level. This funding is necessary to continue ongoing IT operations, including making necessary investments to existing systems that support improvements in the effectiveness and efficiency of CMS program management operations. These activities provide the operational support to manage the Agency's data environment for mission critical and enterprise-wide CMS IT strategies. One such area is the Baltimore Data Center (BDC), which supports all facets of CMS business operations. Funding also supports the ongoing operational costs of ICD-10.

- *Infrastructure Investments*: $30.7 million, the same funding level as the FY 2017 Annualized CR. This funding support the CMS Information Security Program (ISP), which provides services to ensure systems and beneficiary data are protected and meet CMS' federal requirements. The majority of these requirements stem from the Federal Information Security Management Act of 2002 (FISMA), which requires that all agencies have a risk-based information security program that covers all systems and data, and includes contractors and business partners who operate systems on behalf of the agency. The increase in funding also supports the virtual call center project.

- *Non-Exchange IT*: $13.4 million, the same funding level as the FY 2017 Annualized CR. CMS continues to find efficiencies that support the Enterprise Architecture (EA) structure of business processes and align them with the core goals and strategic direction of the Affordable Care Act.

- *Shared Services*: $26.8 million, a decrease of $0.3 million below the FY 2017 Annualized CR Level. Funding is needed to cover the program management allocation for key shared services including Master Data Management, Enterprise Identity Management, the Enterprise Portal, and Business Rules Enterprise Services. Shared services enable CMS programs to utilize common services, such as Medicare eligibility verification, identity proofing, authentication, and data services, reducing redundant development, and leveraging efficiencies of scale.

# Federal Administration

(Dollars in Thousands)

| | FY 2016 Final | FY 2017 Annualized CR | FY 2018 President's Budget | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| BA | $732,533 | $731,140 | $722,533 | ($8,607) |
| FTE 1/ | 4,518 | 4,525 | 4,370 | (155) |

1/Excludes staffing funded from indirect cost allocations.

Authorizing Legislation – Reorganization Act of 1953
Authorization Status – Permanent
FY 2018 Authorization – One Year; No separate authorization of appropriations
Allocation Method - Various

**Program Description and Accomplishments**

CMS oversees Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), the Nation's largest health insurance programs. CMS' focus is to ensure effective operations and to strengthen these programs by investing in significant activities to implement Secretarial initiatives and achieve the Agency's mission. In addition, CMS is currently responsible for implementing Obamacare mandates. As the largest purchaser of health care in the United States, CMS expects to serve almost 131 million beneficiaries in these traditional programs.

The Federal Administration account funds the majority of CMS' staff and operating expenses for routine activities such as planning, implementing, evaluating and ensuring accountability in a variety of health care financing programs. Remaining staff are funded through different budget accounts and are not included in the Federal Administration request. Staff funded from these other fund sources can only work on specific programs and activities.

CMS will continue to utilize indirect cost allocation methodology that enables the Agency to use other fund sources to offset some costs that would otherwise be funded out of the Federal Administration account.

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

and other health care programs; and conduct outreach and education activities for health care providers, beneficiaries, and the general public. CMS also has staff in the 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.

Funding within the Federal Administration account covers employee compensation and benefits, and other objects of expense including rent, utilities, information technology, contracts, supplies, equipment, training, and travel. These categories are discussed below in more detail.

Personnel Compensation and Benefits:

CMS' personnel compensation and benefits expense includes costs for: civilian and Commissioned Corps 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, the Center for Medicare and Medicaid Innovation, direct appropriations from recent legislation, Clinical Laboratory Improvement Amendment (CLIA) User Fees, Exchange User fees, Coordination of Benefits (CoB) User Fees, and other reimbursable efforts including Recovery Audit Contractors (RAC) activities. This section discusses direct staffing and payroll requirements associated only with the Federal Administration line.

CMS' staffing level and related compensation and benefits expense is largely workload-driven. CMS' core workloads will increase due to major legislative and Secretarial initiatives.

Other Objects:

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

Most of these costs—including rent, communications, utilities; the Central Office building loan; and CMS' share of Departmental costs such as the Service and Supply Fund; Office of General Counsel support; and the Federal Protective Services contracts—are determined by the Department or another government agency. Other costs—including IT infrastructure costs, building maintenance, and most of our inter- and intra-agency agreements—are essential for carrying out our mission as a government agency. It is important to note that the Federal Administration account only covers a portion of these costs, as CMS' other fund sources contribute based on usage.

CMS' FY 2018 request has been prepared in accordance with Executive Order 13771, Reducing Regulation and Controlling Regulatory Costs.

- Mortgage, Rent & Building Services

This category provides funding for the 30-year loan for CMS' Central Office headquarters building. Also, this category funds rent and building operational costs for CMS' offices in Baltimore, Maryland; Bethesda, Maryland; Washington, DC; the ten Regions; and the two anti-fraud field offices in New York and Los Angeles. Costs include space rental, utilities, grounds maintenance, snow removal, cleaning, trash removal, and office relocations. These costs are non-negotiable. The General Services Administration (GSA) calculates the charge and informs CMS of the amount it must pay. Most of the items in this category reflect contract labor costs, such as grounds maintenance, cleaning, and trash and snow removal. Other items, such as utilities, increase every year due to inflation.

- Service and Supply Fund

This category funds CMS' share of the Department of Health and Human Services' (DHHS) Program Support Center (PSC) and other non-PSC shared expenses. These services include payroll, financial management, and e-mail systems used throughout the Department; regional mail support; small business operations; web communication; support provided to the Office of the Secretary's audit resolution staff; and other services related to the 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 to eliminate duplication of functions, thus achieving economies of scale.

- Administrative Services

This category funds contracts for activities that support the daily operation of CMS' Central, and Regional offices including building and machine maintenance and repairs, employee medical and health services, space enhancements and transportation costs for shipping and receiving Agency documents. This category also includes expenses needed to comply with the Americans with 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. While the Rent, Communication and Utilities category covers most standard-level utility charges, the data center utility cost is over and above the GSA standard-level user charge for this activity and must be paid separately.

- Information Technology (IT)

This category funds CMS' administrative system operations, including telecommunications, systems security, Continuity of Operations Planning (COOP) and disaster recovery, 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.

- 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 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; and,

- An IA with the Office of Personnel Management (OPM) for background investigations of new employees and contractor personnel.

- Supplies and Equipment

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

- Administrative Contracts and Intra-Agency Agreements

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

- Legal services with the Office of General Counsel (OGC): CMS reimburses the OGC for the legal services and guidance it provides on ethics activities and on legislative, programmatic, and policy issues related to CMS' programs.

- 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.

- Security services with the Department of Homeland Security (DHS) and Guard Services: This contract pays the DHS for the Federal Protective Service (FPS) agents who provide law enforcement for our facilities and employees. Presidential Decision Directive 63 and Homeland Security Presidential Directive 7 classify CMS as a Critical Infrastructure Facility. The Department of Justice has classified CMS as Level IV facility (on a scale where Level I is the lowest vulnerability and Level V is the highest). These ratings require that specific security measures be in place. In addition, CMS also has guard service contracts that provide building security. Most of the guard contracts provide 24 hour service.

- 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. In addition, funds are required for ongoing core courses for employees such as Reasonable Accommodation, Alternative Dispute Resolution, and Equal Employment Opportunity (EEO) and Whistle Blower Protection.

- Travel

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

- Printing and Postage

The largest expense in this category 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. Historically, one major piece of new authorizing legislation involving CMS' programs is enacted annually. Each piece of legislation requires CMS to publish regulations that implement the numerous provisions in these bills.

The remaining printing requests include funding needed for postage meters for routine correspondence and printing of required reports, such as the CMS Financial Report.

**Funding History**

| Fiscal Year | Budget Authority |
|---|---|
| FY 2014 | $732,533,000 |
| FY 2015 | $732,533,000 |
| FY 2016 | $732,533,000 |
| FY 2017 Annualized CR | $731,140,000 |
| FY 2018 President's Budget | $722,533,000 |

## Budget Overview and Supported Activities

### FY 2018 Request ($722.5 million):

Personnel Compensation and Benefits ($650.7 million): The FY 2018 President's Budget request includes $650.7 million to support 4,370 direct FTEs, a decrease of 155 FTEs below the FY 2017 Annualized CR level of 4,525 FTEs. With this level of staff, CMS will be able to support operations effectively and efficiently, carrying out all the Secretary's priorities and focusing on improving the performance of CMS's traditional programs-- Medicare, Medicaid and CHIP. The reduction in workforce will occur through natural attrition across the Agency, so there will not be a major impact to any particular center or office.

Mortgage, Rent, & Building Services ($5.1 million): The FY 2018 President's Budget request for mortgage, rent, and building services is $5.1 million, the same as the FY 2017 Annualized CR level. The requested amount excludes the portion of the total cost that is being covered by CMS' other fund sources through indirect cost allocations.

Service and Supply Fund ($4.6 million): The FY 2018 President's Budget request for the services and supply fund is $4.6 million, the same as the FY 2017 Annualized CR level. The requested amount excludes the portion of the total cost that is being covered by CMS' other fund sources through indirect cost allocations.

Administrative Services ($7.0 million): The FY 2018 President's Budget request for administrative services is $7.0 million, a $1.8 million increase above the FY 2017 Annualized CR level of $5.2 million. However, the request does not represent an overall increase in funding after taking into account other fund sources that are being used to support administrative services through indirect allocations. This funding will allow CMS to ensure that adequate resources are available for contracts that support our daily operations and associated expenses. In addition, this funding will allow CMS to continue to support the "right-sizing" initiative and on-going construction projects. Through the right-sizing initiative, CMS plans to smart size approximately 30,000 square feet and reduce the number of leases in central and regional offices.

Administrative Information Technology ($40.2 million): The FY 2018 President's Budget request for administrative IT is $40.2 million, the same as the FY 2017 Annualized CR level. This level will continue to fund 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 requested amount excludes the portion of the total cost that is being covered by CMS' other fund sources through indirect cost allocations.

Inter-Agency Agreements ($3.1 million): The FY 2018 President's Budget request for inter-agency agreements is $3.1 million, the same as the FY 2017 Annualized CR level. This level will allow CMS to maintain the inter-agency agreements CMS currently has with other agencies and to ensure mandatory activities, such as background investigations in accordance with the HSPD-12 project, are adequately funded.

Supplies and Equipment ($1.0 million): The FY 2018 President's Budget request for supplies and equipment is $1.0 million, the same as the FY 2017 Annualized CR level.

Administrative Contracts and Intra-Agency Agreements ($4.7 million): The FY 2018 President's Budget request for administrative contracts and intra-agency agreements is $4.7 million, a $0.1 million decrease below the FY 2017 Annualized CR level. This level will allow CMS to continue funding a majority of our mandatory contracts within the Federal Administration line such as legal services with the Office of General Counsel and Federal Protective Services with the Department of Homeland Security. This level will also support contract resources required for the HSPD-12 expansion project, thereby ensuring regulatory compliance. The requested amount excludes the portion of the total cost that is being covered by CMS' other fund sources through indirect cost allocations.

Training ($2.1 million): The FY 2018 President's Budget request for training is $2.1 million, the same as the FY 2017 Annualized CR level. The requested amount excludes the portion of the total cost that is being covered by CMS' other fund sources through indirect cost allocations.

Travel ($1.9 million): The FY 2018 President's Budget request for travel is $2.0 million, the same as the FY 2017 Annualized CR level. This level will allow CMS to continue to cover costs and timely implementation and completion of mandatory trainings. The requested amount excludes the portion of the total cost that is being covered by CMS' other fund sources through indirect cost allocations.

Printing and Postage ($2.1 million): The FY 2018 President's Budget request for printing and postage is $2.2 million, the same as the FY 2017 Annualized CR level.

**Federal Administration Discretionary Summary /1**
(Dollars in Thousands)

| Objects of Expense | FY 2017 Annualized CR | FY 2018 President's Budget | FY 2018 +/- FY2017 |
|---|---|---|---|
| Personnel Compensation | $661,000 | $650,668 | ($10,332) |
| Rent, Communications and Utilities | $5,100 | $5,100 | $0 |
| Service and Supply Fund | $4,600 | $4,600 | $0 |
| Administrative Services | $5,159 | $7,000 | $1,841 |
| Administrative IT | $40,181 | $40,181 | $0 |
| Inter-Agency Agreements | $3,100 | $3,100 | $0 |
| Supplies and Equipment | $1,000 | $1,000 | $0 |
| Administrative Contracts and Intra-Agency Agreements | $4,789 | $4,673 | ($116) |
| Training | $2,093 | $2,093 | $0 |
| Travel | $1,959 | $1,959 | $0 |
| Printing and Postage | $2,159 | $2,159 | $0 |
| Subtotal, Non-Pay Objects of Expense (non-add) | $70,140 | $71,865 | $1,725 |
| **Total, Federal Administration 1/** | **$731,140** | **$722,533** | **($8,607)** |

1/ Reflects CMS' discretionary Federal Administration request, only, and excludes costs that are borne by other budget accounts.

# Medicare Survey and Certification

(Dollars in Thousands)

| | FY 2016 Final | FY 2017 Annualized CR | FY 2018 President's Budget | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| BA | $397,334 | $396,579 | $406,135 | $9,556 |

Authorizing Legislation - Social Security Act (SSA), title XVIII,
Section 1864 FY 2018 Authorization - One Year
Allocation Method – Contract Agreements

**Program Description and Accomplishments**

In order to secure quality care for the elderly, one of the Nation's most vulnerable populations and for millions of other Americans who rely on the U.S. health care system, CMS requires all facilities seeking participation in Medicare and Medicaid to undergo an inspection when they initially enter the program and on a regular basis thereafter. To conduct these surveys, CMS contracts with State Survey Agencies and private entities in each of the 50 States, the District of Columbia, Puerto Rico, and other U.S. territories. Using about 7,000 surveyors across the country, State Survey Agencies inspect providers and determine their compliance with specific Federal health, safety, and quality standards.

| Provider Type | Percent of Facilities with Cited Deficiencies, FY 2016 | Examples of deficiencies |
|---|---|---|
| Nursing Homes | 91 percent, with the average number of deficiencies sited per survey at 5.9 | Abuse, avoidable injury from falls or pressure ulcers, infection control lapses, and deaths from medication errors. |
| Dialysis Facilities | 74 percent | Infections or hazards to life from poor equipment cleaning or water quality. |
| Hospitals (non-Critical Access Hospitals)[1] | 56 percent | Wrong site surgery, medication errors, poor outcomes, failure to maintain an effective quality improvement system. |
| Home Health Agencies | 52 percent | Plan of Care, Medication Assessments, and Compliance with accepted Professional Standards and Principles. |
| Ambulatory Surgical Centers | 75 percent | Infection control deficiencies, improvement over the 50-59 percent range in prior years. |

[1] Non-Critical Access Hospitals (CAH) only

The examples above illustrate the profound importance of regular, comprehensive inspections of health care facilities, as well as timely and effective investigation of complaints.

In the past two fiscal years, the Government Accountability Office (GAO) and the Office of Inspector General (OIG) have issued 42 reports highlighting the need for Federal oversight to ensure quality of care. At various times, the GAO has placed areas of survey and certification oversight, particularly oversight of nursing homes and dialysis facilities, into a high-risk category, indicating a greater vulnerability to fraud, waste, abuse, and mismanagement. Recent reports from the OIG focused on hospital quality of care, health care worker qualifications, and ambulatory surgery centers oversight. CMS is implementing a variety of OIG recommendations to strengthen survey and certification oversight, such as improvements in infection control, adverse event reporting, and internal quality assessment and performance improvement. OIG and GAO reports continue to emphasize that maintaining survey and certification frequencies at or above the levels mandated by policy and statue is critical to ensuring Federal dollars support only quality care.

**Funding History**

| Fiscal Year | Budget Authority |
|---|---|
| FY 2014 | $375,330,000 |
| FY 2015 | $397,334,000 |
| FY 2016 | $397,334,000 |
| FY 2017 Annualized CR | $396,579,000 |
| FY 2018 | $406,135,000 |

**Budget Request: $406.1 million**

CMS' FY 2018 budget authority request for Medicare Survey and Certification is $406.1 million, an increase of $9.5 million above the FY 2017 Annualized CR level. CMS also assumes an additional $25.6 million in collections from a proposed revisit user fee program, for a total program level of $431.7 million. If enacted, the proposed collections associated with the revisit user fee, will increase CMS' current law Program Management appropriation. The requested increase in funds will allow CMS to continue surveys of healthcare facilities. In addition, this request will enable CMS to implement new regulations including revised Conditions of Participation for Long Term Care (LTC) facilities and Emergency and Planning. The table below provides the program level funding details from FY 2016 to FY 2018.

**Program Level Table**
(Dollars in Thousands)

| | FY 2016 Final | FY 2017 Annualized CR | FY 2018 President's Budget | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| Budget Authority (BA) | $397,334 | $396,579 | $406,135 | +$9,556 |
| Revisit/Complaint User Fee | $0 | $0 | $25,596 | +$25,596 |
| **Proposed Law Program Level Subtotal** | **$397,334** | **$396,579** | **$431,731** | **+$35,152** |
| IMPACT P.L. 113-185. Hospice Surveys/1 | $7,767 | $7,758 | $5,625 | -$2,133 |
| IMPACT Improve Nursing Home Staffing data | $5,556 | $3,641 | $589 | -$3,052 |
| **Program Level/2** | $410,656 | $407,978 | $437,945 | +$29,966 |

/1 Funding provided through the IMPACT P.L. 113-185 Section 3 for hospice surveys in FY 2016 and 2017 was subject to 6.8 and 6.9 percent sequester respectively

/2 Totals may not add due to rounding

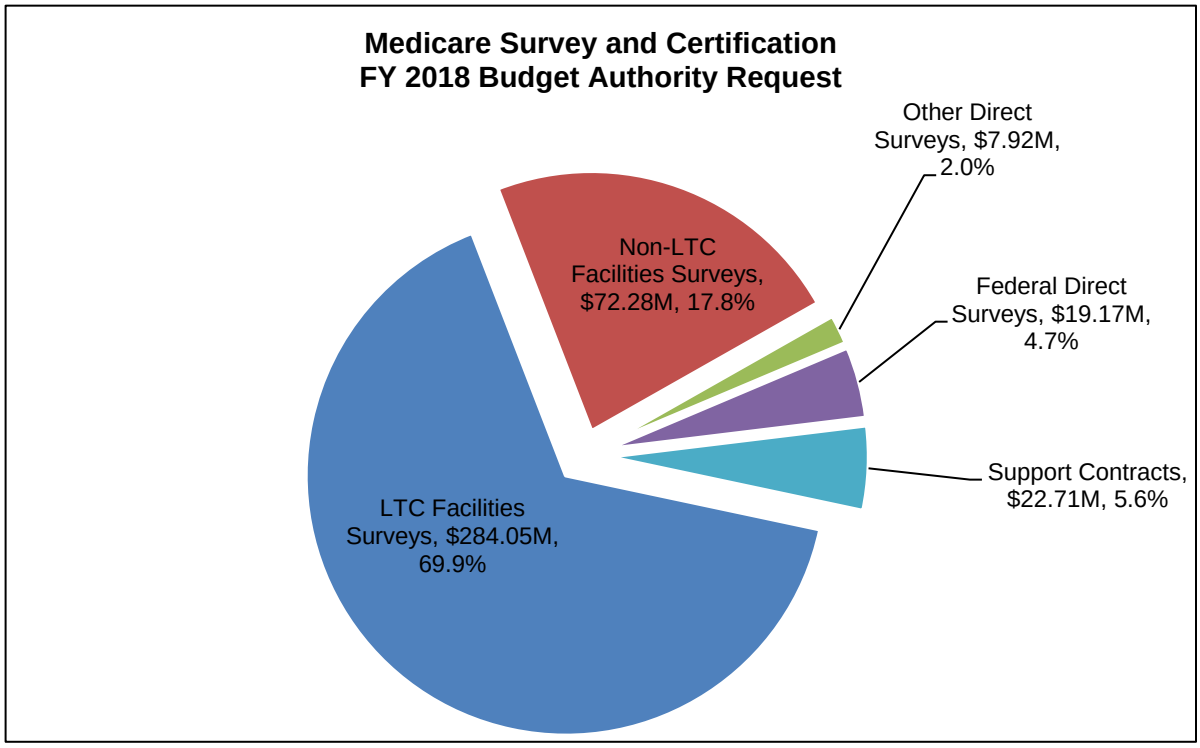
Further, funding is necessary to implement GAO and OIG recommendations for improvements to oversight and survey processes. CMS has seen a rise in costs associated with the expanded role that survey and certification plays in addressing issues of national importance such as reducing the use of anti-psychotics and improving dementia care in nursing homes, reducing infections, pressure ulcers and other healthcare-associated conditions in a variety of provider types, reducing hospital readmissions, and coordinating with the Department of Justice and other agencies to address fraud or poor quality of care.

Finally, the FY 2018 budget request also includes funding for continued program support contracts to strengthen quality improvement and national program consistency, promote gains in efficiency, make oversight of accrediting organizations more effective, and implement key recommendations made by the GAO and OIG.

The user fee proposal for FY 2018 provides CMS with the ability to charge providers for substantiated complaints that involve immediate jeopardy or actual harm and revisit surveys where they have been cited for deficiencies identified during initial certification or recertification surveys. The revisit is to confirm that they have restored their services to CMS requirements. Thus, the fee would only apply to providers or suppliers that have had serious quality of care or safety deficiencies giving facilities an incentive to prevent and correct problems in a timely manner. Prior experience with a revisit user fee in FY 2007 demonstrated its feasibility, and CMS estimates collecting $25.6 million in FY 2018.

The following pie chart illustrates various parts of Survey and Certification's FY 2018 budget request. The Long-Term Care and Non-Long Term Care (NLTC) portions make up the State Direct Survey Costs and represent 87.7 percent of the total FY 2018 budget request. The Other Direct Survey portion provides funding to support additional costs related to State Direct Survey Costs such as travel and equipment for surveyors' training,

validating surveys conducted by States and CMS approved accrediting organizations. The 4.7 percent of the budget that makes up Federal Direct Surveys will fund national contractors to perform specialized surveys in all organ transplant centers, psychiatric hospitals, and mitigate the delay experienced by prospective providers that newly seek Medicare participation. The Support Contracts section includes Information Technology (IT) making up 5.6 percent of the budget for training state or Federal-directed surveyors, implementing improved survey standards, identifying high risk areas, tracking progress, and IT systems maintenance and upgrades.




Direct Survey costs represent the funding provided to states to perform surveys and complaint investigations and to support associated program costs. Three facility types have statutorily mandated survey frequencies: each individual nursing home must be surveyed at least every 15 months and all nursing homes every 12 months on average; each home health agency (HHA) must be surveyed at least every 3 years; and hospice facilities must be surveyed at least once every 3 years.[2] Survey frequencies for all other facility types are determined by policy and funding levels. Direct survey costs are affected primarily by the number of Medicare-participating providers, facility survey time required, and inflation. The number of providers continues to increase, with hospice, End-Stage Renal Disease (ESRD) facilities, and home health agencies, growing the fastest in number, increasing by 26 percent, 20 percent, and 8 percent respectively from FY 2010 to FY 2016. These additional providers place increasing pressure on both the mandatory and discretionary budgets.

[2] Statutes that mandate survey frequency standards by facility: SSA Act 1819(g)(I) Nursing Home facilities; SSA Act 1891(a) Home Health Agencies; and SSA Act 1861(dd) and IMPACT Act Sec. 3 Hospice.

In addition to the cost of conducting surveys, Direct Survey costs also include Other Direct Survey costs, which support state program operations or responsibilities. These costs include support for validation surveys to assess the performance of CMS-approved accrediting organizations, which are necessary for effective program oversight and are in some cases required by law, state responsibilities for the Minimum Data Set (MDS), which helps hold nursing homes accountable for proper assessment of resident needs and conditions, as well as providing data to monitor and improve nursing home care and nursing home quality data for star ratings. Similarly, CMS includes support for the Outcome and Assessment Information Set (OASIS), which serves as the backbone of the home health prospective payment system. Further examples of Other Direct Survey costs include contractors that assist states to address performance issues, emergency preparedness and post-disaster recovery surveys.

In recent years, CMS improved standards and survey processes for many types of providers, especially dialysis facilities for ESRD, ambulatory surgical centers (ASC), hospices, home health, and nursing homes. Since 2008, dialysis facilities have been surveyed in accordance with the new ESRD regulations that have substantially improved infection control, water quality safety, and internal quality assurance. CMS has increasingly used statistical information to review outcomes and focus more attention on facilities whose performance data indicate a higher risk of poor patient outcomes. Beginning in 2011, CMS surveyed 25 percent of non-accredited ASCs each year using a more rigorous survey process that included a significantly increased focus on infection control. By the end of FY 2014, all participating non-accredited ASCs had been surveyed using the new process, and a consistently high level of infection control problems had been identified. CMS also conducts periodic surveys of a random sample of ASCs in order to assess whether previously surveyed ASCs have been able to sustain their improved practices.

In FY 2007, CMS began implementing onsite surveys of all solid organ transplant centers in the U.S., including enforcement of outcome standards if patient deaths or graft failure exceed 150 percent of the risk-adjusted expected number. Nationally, by the end of FY 2014, both patient and graft survival for all types of solid organ transplants had improved to the highest rates ever recorded, with the substantial improvements achieved in programs that entered into a System Improvement Agreement with CMS after being cited by CMS for substandard patient outcomes.

Individuals in nursing homes comprise a particularly vulnerable population. Consequently, CMS places a high priority on ensuring nursing home quality. The majority of funding for nursing homes is included in State Direct Survey costs, as these activities have become a standard part of nursing home survey procedures. These activities are intended to improve survey processes through targeted mechanisms such as investigating complaints which alleged 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 facilities with a history of persistent serious problems (i.e., the CMS Special Focus Facility (SFF) initiative).

Nursing home survey processes have been improved through clarified surveyor guidance (such as guidance on surveying for the use of unnecessary medications), further development of an improved survey process, and continued focus on the nursing homes judged to have the highest risk of poor quality of care through the CMS SFF initiative. A

2012 analysis of nursing homes identified for special attention from 2005-2011 through the SFF initiative found that such nursing homes came into compliance with CMS requirements 50 percent more quickly compared with facilities that were not surveyed with the same frequency. The FY 2018 budget would continue to support the SFF efforts.

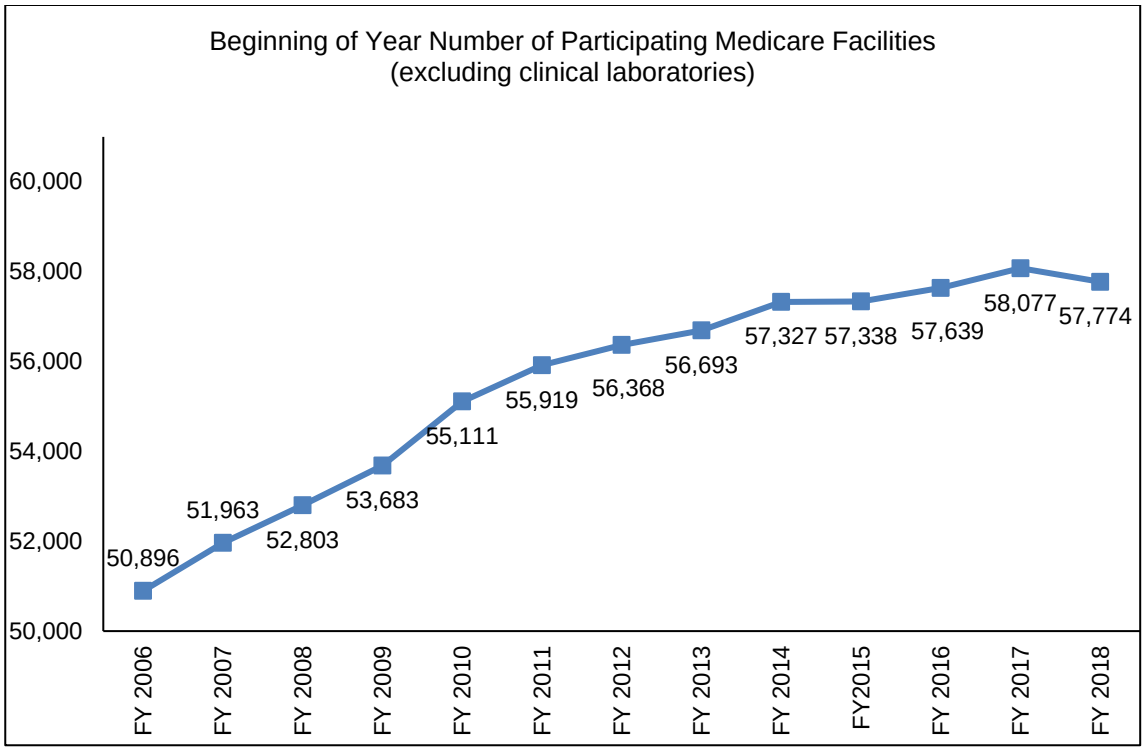
*State Direct Survey Costs:* $356.3 million. The FY 2018 request includes $356.3 million in discretionary budget authority for State Direct Survey costs. In addition, CMS proposes $25.6 million in estimated revisit fee collections from the proposed revisit user fee program for a total State Direct Survey program level of $381.9 million. This funding will enable CMS to continue to meet statutory survey frequencies for nursing homes, HHAs, and Hospice facilities, while approaching FY 2016 survey frequencies for non-statutory facilities. Hospice surveys are partially funded by the IMPACT Act to enable the statutorily mandated three-year rather than six-year survey frequency. Beginning in FY 2018, funding provided through the IMPACT Act for hospice surveys will be reduced by 27.5 percent.

CMS' FY 2018 request supports efforts to find efficiencies within existing survey processes. One example of this approach is the development and implementation of a revised nursing home survey process. This survey process is designed to blend the best features of the traditional and Quality Indicator Survey to maximize survey effectiveness while improving efficiency. Key features of the new survey process include tablet PC/Internet-based recording and transmission to expedite data handling and automate survey process.

The FY 2018 request supports the continued implementation of new regulations including LTC nursing home conditions of participation (COPs) and the Emergency preparedness regulation. The changes reflected in the COPs are substantial advances made in the theory and practice of service delivery and safety, and are an integral part of CMS' efforts to achieve broad-based improvements both in quality of healthcare furnished through federal programs, and in patient safety, while at the same time reducing procedural burdens on providers.

The Social Security Act authorizes CMS to use private health care accreditation organizations (AOs) to survey and certify providers in place of state agencies. Providers that use CMS approved AOs are consider deemed to have the same standards as providers surveyed and certified by state agencies. Deemed providers are subject to state or CMS validation surveys and complaint investigations. The FY 2018 request enables states to conduct validation surveys of CMS-approved AOs at a one percent sample size, the same as the FY 2016 level.

As shown in the pie chart above, the direct survey budget includes resources to survey most provider types, with the majority of the budget devoted to long-term care facility surveys (i.e., Skilled Nursing Facilities (SNFs) and dually-certified SNF/NFs). Between FY 2014 and the end of FY 2018, the number of Medicare-certified facilities to be surveyed is expected to have increased one percent, from 57,327 to 57,774 facilities in FY 2018, as shown in the following graph, excluding clinical laboratories.


Beginning of Year Number of Participating Medicare Facilities
(excluding clinical laboratories)
60,000
58,000
56,000
54,000
52,000
50,000
50,896
51,963
52,803
53,683
55,111
55,919
56,368
56,693
57,327
57,338
57,639
58,077
57,774
FY 2006
FY 2007
FY 2008
FY 2009
FY 2010
FY 2011
FY 2012
FY 2013
FY 2014
FY2015
FY 2016
FY 2017
FY 2018

**State Direct Survey Costs**
(Dollars in Millions)

| Provider Type | FY 2016 Final | FY 2017 Annualized CR | FY 2018 President's Budget | FY 2018 Proposed Law Program Level[/1] |
|---|---|---|---|---|
| **Statutory Facilities** | | | | |
| Skilled Nursing Home | $16.9 | $16.7 | $16.9 | $16.9 |
| SNF/NF (dually-certified) | $233.4 | $235.3 | $267.1 | $267.1 |
| Home Health Agencies | $17.4 | $17.2 | $25.4 | $25.4 |
| Hospices[/2] | $1.8 | $6.2 | $4.9 | $4.9 |
| **Non-Statutory Facilities** | | | | |
| Deemed Hospitals - Validations | $24.7 | $22.7 | $15.4 | $15.4 |
| Organ Transplant Facilities[/3] | $0.0 | $0.0 | $0.0 | $0.0 |
| Non-Deemed Hospitals | $13.2 | $12.9 | $8.1 | $14.8 |
| Outpatient Physical Therapy | $1.4 | $0.9 | $0.3 | $0.9 |
| Comprehensive Outpatient Rehabilitation Facility | $0.2 | $0.1 | $0.05 | $0.2 |
| Portable X-Rays | $0.3 | $0.2 | $0.07 | $0.3 |
| End-Stage Renal Disease (ESRD) | $25.9 | $22.3 | $12.4 | $22.5 |
| Rural Health Clinics | $2.3 | $1.5 | $.5 | $1.8 |
| Ambulatory Surgery Centers | $10.9 | $9.3 | $5.0 | $11.4 |
| Community Mental Health Centers | $0.4 | $0.5 | $0.08 | $0.3 |
| **Subtotal, Direct Survey Costs** | **$348.7** | **$345.6** | **$356.3** | **$381.9** |
| Other State Direct Survey Costs | $8.1 | $9.7 | $7.9 | $7.9 |
| **Total, State Direct Surveys [/4]** | **$356.8** | **$355.4** | **$364.2** | **$389.8** |

/1 This FY 2018 Proposed Law Program Level assumes additional funding from the proposed revisit user fee program.

/2 Hospice surveys are separately funded (in part) under the IMPACT Act PL 113-185 at $8.3 million beginning in FY 2015 and reduces to $7.8 million in FY 2016 & FY 2017 due to sequester, $5.6 million in FY 2018. This chart identifies funds needed in addition to the IMPACT Act funding to meet the statutory frequency. Funding provided by IMPACT in FY 2016, FY 2017, and FY 2018 is not entirely sufficient due to increasing survey costs based on current estimates.

/3 Excludes approximately $3 million for onsite surveys of organ transplant centers done by national contractor.

/4 Total may not add due to rounding.

CMS continues to advance efforts to address healthcare associated infections (HAI) across all providers. The request continues the enhanced survey process in ASCs to target infection control deficiencies. Individuals in hospices also remain a highly vulnerable population. Based on concerns regarding the quality of care in hospices (such as a 15 percent increase in complaints between FY 2010 and FY 2013), using $5.6 million of IMPACT Act funding, CMS will continue implementing the increased frequency of hospice surveys in FY 2018 from a prior average of once every 6 years to once every 3 years. Based off each fiscal year's budget presented in the State Direct Survey Cost table, below is a table with survey frequency rates for each facility type for FY 2016, FY 2017, and FY 2018.

**Survey Frequency Rates FY 2016 to FY 2018**

| Type of Facility | FY 2016 Final | FY 2017 Annualized CR | FY 2018 President's Budget[/1] |
|---|---|---|---|
| **Statutory Facilities** | | | |
| Long-Term Care Facilities | Every Year (100%)[/2] | Every Year (100%) | Every Year (100%) |
| Home Health Agencies | Every 3 Years (33.3%) | Every 3 Years (33.3%) | Every 3 Years (33.3%) |
| Hospices[/3] | Every 3 Years (33.3%) | Every 3 Years (33.3%) | Every 3 Years (33.3%) |
| **Non-Statutory Facilities** | | | |
| Deemed Hospitals - Validations | 1.0% Year Sample | 1.5% Year Sample | 1.0% Year Sample |
| Organ Transplant Facilities[/4] | *Every 5 Years (20%)* | *Every 5 Years (20%)* | *Every 5 Years (20%)* |
| Non-Deemed Hospitals | Every 3.5 Years (28.6%) | Every 3.9 Years (25.6%) | Every 4 Years (25.0%) |
| Outpatient Physical Therapy | Every 7 Years (14.3%) | Every 12 Years (8.3%) | Every 9 Years (12.0%) |
| Comprehensive Outpatient Rehabilitation Facility | Every 7 Years (14.3%) | Every 12 Years (8.3%) | Every 5 Years (20.0%) |
| Portable X-Rays | Every 7 Years (14.3%) | Every 12 Years (8.3%) | Every 6 Years (18.0%) |
| End-Stage Renal Disease (ESRD) Facilities | Every 3.5 Years (26.6%) | Every 3.8 Years (26.3%) | Every 4 Years (25.0%) |
| Rural Health Clinics | Every 6 Years (16.7%) | Every 12 Years (8.3%) | Every 9 Years (11.0%) |
| Ambulatory Surgery Centers | Every 4.0 Years (25.0%) | Every 4.7 Years (21.3%) | Every 4 Years (25.0%) |
| Community Mental Health Centers | Every 6 Years (16.7%) | Every 12 Years (8.3%) | Every 7 Years (15.0%) |

/1 The FY 2018 survey frequencies assume receipt of $25 million from the propose user fee collections.

/2 Numbers in parentheses indicate the approximate percent of each type of provider that would be surveyed in the FY.

/3 Hospice surveys are partially funded under the IMPACT Act PL 113-185.

/4 Organ Transplant Facilities surveys are contractor performed.

In FY 2018, CMS expects to complete approximately 23,900 initial and recertification inspections, as shown in the Surveys and Complaint Visits table below. In addition, CMS estimates 56,000 visits in response to complaints. As the Survey and Complaint Visit table shows, the majority of both surveys and complaint visits in FY 2018 are projected to be in nursing homes. These surveys will contribute to achieving CMS' nursing home quality goals to decrease the prevalence of pressure ulcers in nursing homes and to decrease the percentage of long-stay nursing home residents receiving an antipsychotic medication.

Survey and Complaint Visit Table

| FY 2017 Annualized CR | | | | | |
|---|---|---|---|---|---|
| **Facility** | **Projected Number of Facilities (Beginning of FY)** | **Total Recertification Surveys** | **Total Initial Surveys** | **Total Complaint Visits** | **Total** |
| Skilled Nursing Facility (SNF) | 795 | 795 | 82 | 975 | 1,852 |
| SNF/NF (dually-certified) | 14,425 | 14,525 | 115 | 48,275 | 62,915 |
| Home Health Agencies | 12,570 | 2,861 | 65 | 1,365 | 4,291 |
| Deemed Hospital | 4,675 | 70 | 0 | 2,624 | 2,694 |
| Organ Transplant Facilities/1 | 242 | 0 | 0 | 0 | 0 |
| Non-Deemed Hospitals | 1,585 | 406 | 12 | 405 | 823 |
| Hospices/2 | 4,160 | 845 | 37 | 625 | 1,507 |
| Outpatient Physical Therapy | 2,270 | 180 | 32 | 8 | 220 |
| Comprehensive Outpatient Rehabilitation Facility | 250 | 21 | 8 | 7 | 36 |
| Portable X-Rays | 565 | 47 | 25 | 5 | 77 |
| ESRD Facilities | 6,345 | 1,670 | 325 | 830 | 2,825 |
| Rural Health Clinics | 4,175 | 335 | 143 | 35 | 513 |
| Ambulatory Surgery Centers | 5,490 | 797 | 25 | 160 | 982 |
| Community Mental Health Centers | 530 | 44 | 5 | 10 | 59 |
| **Total** | **58,077** | **22,596** | **874** | **55,324** | **78,794** |

/1 Organ transplant centers surveys done by the CMS national contractors, do not appear in this chart.

/2 A portion of hospice surveys are separately funded under the IMPACT Act PL 113-185.

| FY 2018 President's Budget/1 | | | | | |
|---|---|---|---|---|---|
| **Facility** | **Projected Number of Facilities (Beginning of FY)** | **Total Recertification Surveys** | **Total Initial Surveys** | **Total Complaint Visits** | **Total** |
| Skilled Nursing Facility (SNF) | 785 | 785 | 32 | 1,020 | 1,837 |
| SNF/NF (dually-certified) | 14,405 | 14,985 | 118 | 50,575 | 65,678 |
| Home Health Agencies | 12,475 | 2,833 | 62 | 1,325 | 4,220 |
| Deemed Hospital | 4,670 | 47 | 0 | 1,341 | 1,388 |
| Organ Transplant Facilities/2 | 242 | 0 | 0 | 0 | 0 |
| Non-Deemed Hospitals | 1,495 | 374 | 11 | 385 | 770 |
| Hospices/3 | 4,262 | 847 | 165 | 475 | 1,487 |
| Outpatient Physical Therapy | 2,207 | 265 | 48 | 8 | 321 |
| Comprehensive Outpatient Rehabilitation Facility | 223 | 44 | 7 | 4 | 55 |
| Portable X-Rays | 525 | 95 | 18 | 2 | 115 |
| ESRD Facilities | 6,502 | 1,626 | 245 | 930 | 2,801 |
| Rural Health Clinics | 4,188 | 460 | 21 | 42 | 523 |
| Ambulatory Surgery Centers | 5,560 | 934 | 21 | 142 | 1,097 |
| Community Mental Health Centers | 235 | 35 | 5 | 5 | 45 |
| **Total** | **57,774** | **23,330** | **753** | **56,254** | **80,337** |

/1 This table assume receipt of $25.6 million from the propose user fee collections.

/2 Organ transplant centers surveys done by the CMS national contractors, do not appear in this chart.

/3 A portion of hospice surveys are separately funded under the IMPACT Act PL 113-185.

*Other State Direct Survey Costs*: $7.9 million. The FY 2018 Other State Direct Survey Cost estimate is $7.9 million, $1.8 million below the FY 2017 Annualized CR. While most of the funding for FY 2018 is flat with the FY 2017 Annualized CR and supports continuation of activities, a reduction of $1.8 million results from updates to state targeted surveys. Examples of continuing activities include:

- MDS state program costs, including system maintenance and ongoing collection and storage of data used in the development and testing of program improvement projects.
- OASIS state programs costs, including providing training to all home health agency providers on the OASIS, operating the system, running reports, and providing technical support.
- Validation surveys that assess the adequacy of surveys conducted by states and CMS approved accrediting organizations, particularly for accredited facilities such as hospitals, home health agencies, ASCs, and hospices.
- Manual, worksheets, and reference tools for surveyors, such as life safety code.

*Federal Direct Surveys*: $19.2 million. The FY 2018 budget request includes $19.2 million for Federal Direct Survey costs. This funding is flat with the FY 2017 Annualized CR. CMS will engage with a small number of national contractors (in lieu of or with States) to conduct certain surveys on behalf of CMS. These national contractors work in areas that are highly specialized or so small in number that states have difficulty maintaining infrequently-used expertise. For example, all organ transplant hospital surveys in FY 2018 will continue to be conducted by a national contractor, as will be the psychiatric hospital special conditions for active treatment, staffing and specialized training. National contractors also assist CMS Regional Offices in conducting comparative ("look-behind") surveys designed to check the accuracy and adequacy of surveys done by states, help states or federal surveyors in emergencies, addressing state performance lapses, or in responding to special challenges, and are used to provide special support to states for ESRD facility and for nursing home surveys.

In addition, prospective improvements in survey processes are often pre- tested with national contractors before enlisting state volunteers for pilot-testing. Use of national contractors also permits CMS and states to improve the quality of survey and complaint investigations in specialized areas and in U.S. territories.

The FY 2018 budget request continues the oversight of U.S. territories and islands health care facilities. This funding promotes improved health care and continued access to health care in both U.S. territories and among Indian tribes where there are often few providers. Providers and suppliers in such areas may face the prospect of Medicare and Medicaid termination due to unresolved safety or quality of care problems. Recent examples of providers CMS has been working with to improve care delivery include: an acute care hospital in the Commonwealth of the Northern Marianas, a hospital and nursing home on one of the Virgin Islands, a dialysis facility in one of the U.S. territories, and tribal and Indian Health Service hospitals.

*Support Contracts and Information Technology*: $22.7 million. Support contracts and information technology, managed by CMS, constitute $22.7 million of the FY 2018 budget request.

The FY 2018 budget request for support contracts totals $21.0 million. This funding is $0.8 million above the FY 2017 Annualized CR. This effort includes support to implement new laws and regulations, such as the previously mentioned COPs for home health agencies, and nursing homes; the statutory requirements for nursing home quality assurance, performance improvement, and ethics systems; and the CMS improved expectations for emergency preparedness on the part of most institutional providers. The funds also support data analysis of ESRD performance and follow-up actions based on ESRD performance metrics.

Surveyor training continues to be one of the largest categories in support contracts. These contracts enable CMS to fulfill statutorily required training mandates of Sections 1819, 1919, and 1891 of the Social Security Act. The requested funds will enable CMS to develop an increasing array of online course material and other innovative training methods to more efficiently train surveyors and maximize the value of training expenditures. Through web-based, in-person, and case-study training, surveyors gain the skills necessary to perform proficiently and promote quality care for beneficiaries. The training program is essential to ensure that Federal and state surveyors both understand Federal regulations and maintain accurate and consistent interpretation of Federal law and regulations, including the new Long-Term Care Conditions of Participation and Emergency Preparedness regulations. Training also helps promote efficient onsite survey processes, which is important for containing survey expenses. Other critical Survey and Certification support contracts include the Surveyor Minimum Qualifications Test and other efforts to ensure national program oversight and consistency.

As a consumer service and market-oriented incentive for nursing homes to improve quality, CMS also maintains and updates monthly the *Five Star Quality Rating System* on the *Nursing Home Compare* website, one of CMS' most-visited websites. Onsite surveys represent the primary source of verifiable information used for the *Five-Star Quality Rating System,* as the survey data come from direct observation of conditions in the nursing home by objective, trained surveyors. Support contracts also enable CMS to publish the reports of onsite surveys for nursing homes and for hospital complaint surveys in a searchable database accessible for public use. In addition to complaint investigations of acute care hospitals, complaint investigations for Critical Access Hospitals, Long Term Care Hospitals, and Psychiatric Hospitals are also now posted on the website. Support contracts also permit CMS to check on the accuracy of the data reported by nursing homes.

Nursing home contract activities include implementing an improved survey process; understanding and addressing survey variations across states; maintaining the Medicare and Medicaid Minimum Data Set; and publicly reporting nursing home staffing and other information on CMS' *Nursing Home Compare* website. The FY 2018 budget request continues to provide funds for operations and maintenance as well as enhancements of the CMS *Nursing Home Compare* website. CMS will continue to post, on the *Nursing Home Compare* website, information on deficiencies identified in each nursing home, as well as publishing the full survey reports in a searchable database on the web for all nursing home surveys and for hospital complaint investigations.

The IT funding request for FY 2018 is $1.7 million, which is the same as the FY 2017 Annualized CR level. This funding will support a revised version of the Providing Data Quickly (PDQ) application called the Quality and Certification Oversight Reporting System

(QCORS), a consolidated IT Learning Management System for surveyor training and the agency's automated budget system.

CMS maintains several information technology systems that are necessary for survey andcertification activities. The ASPEN suite of the Quality Improvement and Evaluation System (QIES) environment and the Federal Oversight/Support Survey System (FOSS) are, respectively, State and Federal workload database systems that are essential to the daily operation of the Survey and Certification program. The QIES system records and tracks information on the Survey and Certification process and quality of healthcare for over 316,500[3] Medicare, Medicaid, and Clinical Laboratory Improvement Amendments providers. The system also supports the program through the use of the Certification and Survey Provider Enhanced Reports (CASPER) database which includes all survey findings of surveyed providers and suppliers.

The FY 2018 budget request expands the use of evidence-based approaches, particularly through pilot tests of potentially improved survey processes. For example, a targeted survey will assess nursing home systems to investigate adverse events and make system improvements based on the results of the investigations. Similarly, CMS expects to test methods that may better calibrate the intensity of home health agency surveys with the degree to which evidence suggests the need for surveyor attention.

[3] This sum includes 182,700 CLIA Waived Labs which do not receive a survey because Waived Labs are not subject to routine surveys.

# Research, Demonstration and Evaluation
## (Dollars in thousands)

| | FY 2016 Final | FY 2017 Annualized CR | FY 2018 President's Budget | FY 2018 +/- FY 2017 Annualized CR |
|---|---|---|---|---|
| BA | $20,054 | $20,016 | $18,054 | ($1,962) |

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 2018 Authorization - One year

Allocation Method – Contracts, Competitive Grants/Cooperative Agreements

**Program Description and Accomplishments:**

The Research, Demonstration and Evaluation (RDE) program supports CMS' key role as a beneficiary centered purchaser of high-quality health care at reasonable costs. CMS develops, implements, and evaluates a variety of research and demonstration projects. These projects, in addition to data and information products, were created to support internal and external research, and continue to inform and guide CMS' efforts to improve the efficiency of payment, delivery, access and quality of our health care programs that will serve more than 143 million beneficiaries in FY 2018. CMS leverages other funding sources, such as Center for Medicare and Medicaid Innovation Center (Innovation Center) funding, to support RDE projects wherever possible.

| Fiscal Year | Budget Authority |
|---|---|
| FY 2014 | $20,054,000 |
| FY 2015 | $20,054,000 |
| FY 2016 | $20,054,000 |
| FY 2017 Annualized CR | $20,015,877 |
| FY 2018 | $18,054,000 |

**Budget Request: $18.1 Million**

The FY 2018 budget request for RDE is $18.1 million, a decrease of $1.9 million below the FY 2017 Annualized CR Level. CMS will continue funding ongoing research data analytic activities supporting CMS and split-funding the Medicare Current Beneficiary Survey with the Innovation Center.

*Medicare Current Beneficiary Survey (MCBS)*: $12.0 million. The budget request for MCBS is $12.0 million, the same as the FY 2017 Annualized CR Level. CMS requests funding to maintain the survey's content and utility, and support statutory requirements. In

FY 2018, CMS plans to continue an equal split of the MCBS' total operational cost of $24.0 million between RDE and the Innovation Center at $12.0 million each.

The MCBS is the most comprehensive and complete survey available on the Medicare population and is essential in capturing data not otherwise collected through CMS operations/administration. The MCBS is an in-person, nationally-representative, longitudinal survey of Medicare beneficiaries. The survey captures beneficiary information whether aged or disabled, living in the community or facility, or serviced by managed care or fee-for-service. Data produced as part of the MCBS are enhanced with CMS administrative data (e.g. fee-for-service claims, prescription drug event data, enrollment, etc.) to provide users with more accurate and complete estimates of total health care costs and utilization. The MCBS has been continuously fielded for more than 20 years (encompassing over 1 million interviews), and consists of three annual interviews per survey participant.

The primary goals of the MCBS are to:

- provide information on the Medicare beneficiary population that is not available in CMS administrative data and that is uniquely suited to evaluate or report on key outcomes and characteristics associated with beneficiaries treated in innovative payment and service delivery models;
- determine expenditures and sources of payment for all services (including services not covered by Medicare) used by Medicare beneficiaries, including copayments, deductibles, and non-covered services;
- ascertain all types of health insurance coverage among Medicare beneficiaries (e.g., Medigap coverage, retiree coverage) and relate this coverage to payment for specific services; and
- track changes in key beneficiary metrics over time, such as changes in health and functional status, spending down to Medicaid eligibility, access and satisfaction with Medicare programs and providers, and fluctuations in out-of-pocket spending.

*Other Research*: $6.1 million. The budget request for Other Research is $6.1 million, a decrease of $3.1 million below the FY 2017 Annualized CR Level. This funding supports efforts that build and improve CMS' health service research, data and analytical capacity, as well as program evaluations. These activities include, for example, the Chronic Condition Warehouse (CCW), Research Data Assistance Center (ResDAC) and CER Public Use Data Files and Medicaid Analytic Data and Historically Black Colleges University and Hispanic Serving Institutions Research Grant Programs.

Other research activities include various projects aimed at maintaining and building the necessary data and information products to support both internal and external research, and various types of evaluation research (i.e., program evaluations, prospective payment systems evaluation, refinement and monitoring).

CMS continues to develop, enhance and administer multiple initiatives aimed at providing important data products and information key to research efforts. One such tool is the chronic condition warehouse (CCW). The CCW houses CMS data that are easily linked, at the individual patient level, for all Medicare and Medicaid claims data, eligibility data, nursing home and home health assessments, and CMS beneficiary survey data. This data warehouse transforms and summarizes this administrative health insurance information into

research data files, thus providing researchers all the information they need to conduct studies focused on improving the quality and cost of care provided to chronically ill beneficiaries. To further facilitate research and assure the security of CMS' administrative data, the CMS Virtual Research Data Center (VRDC) was constructed within the current CCW infrastructure. The VRDC provides approved researchers with access to more timely CMS data in a secure and more cost effective manner. In addition, the CCW project supports the CCW Website (www.ccwdata.org) which includes documentation on the various data sets available via the CCW and provides a number of static data tables related to the Medicare and Medicaid population as well as an interactive Chronic Conditions Dashboard. Finally, the CCW project also includes help desk and training (both classroom and virtual) to better acclimate researchers to the complexity of working with Medicare and Medicaid data.

Another CMS tool that supports external and internal researchers is the Research Data Assistance Center (ResDAC), comprised of a help desk and website. The ResDAC provides technical assistance, workshops, and outreach to researchers on CMS data and data systems. The goal is to increase the number of researchers skilled in accessing and using CMS data for research studies, which may lead to improvements in the Medicare and Medicaid programs. The ResDAC receives approximately 6,800 data inquiries as well as close to 7,000 toll free calls a year.

Historically Black Colleges University and Hispanic Serving Institutions Research Grant Programs – CMS awards two-year grants to HBCU and HSI investigators to research topics of relevance to African American and Hispanic American Medicare, Medicaid, and CHIP beneficiaries. Through these grants, new pilot interventions to improve the health of minority populations are tested. These projects identify, implement, and evaluate solutions for addressing health disparities among its populations. These grants assist researchers in conducting health services research that supports the CMS mission and our diverse beneficiary population by presenting new paradigms, strategies, and tactics to reduce health care disparities and better the health of African American and Hispanic American populations.

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

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# Medicaid

Appropriation Language

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, [$262,003,967,000] *$284,798,384,000* to remain available until expended.

[For making,] *In addition, for carrying out such titles* after May 31, [2017 payments to States under title XIX or in the case of section 1928 on behalf of States under title XIX of the Social Security Act] *2018* for the last quarter of fiscal year [2017] *2018* for unanticipated costs incurred for the current fiscal year, such sums as may be necessary, *to remain available until expended.*

[For making payments to States or in the case of section 1928 on behalf of States under title XIX of the Social Security Act] *In addition, for carrying out such titles* for the first quarter of fiscal year [2018] *2019*, [$125,219,452,000] *$134,847,759,000,* 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, *[$262,003,967,000] $284,798,384,000*, to remain available until expended. | This section provides a no-year appropriation for Medicaid for FY 2018. This appropriation is in addition to the advance appropriation of $125.2 billion provided by P.L. 115-31 for the first quarter of FY 2018. Funds will be used under title XIX for medical assistance payments and administrative costs and under title XI for demonstrations and waivers. |
| [For making,] *In addition, for carrying out such titles after May 31, [2017 payments to States under title XIX or in the case of section 1928 on behalf of States under title XIX of the Social Security Act] 2018* for the last quarter of fiscal year *[2017] 2018*, for unanticipated costs incurred for the current fiscal year, such sums as may be necessary, *to remain available until expended.* | This section provides indefinite authority for payments to states in the last quarter of FY 2018 to meet unanticipated costs for carrying out titles XI and XIX, including the costs of the Vaccines for Children program. "For carrying out" is substituted for consistency throughout the appropriations language. "To remain available until expended" is included for alignment with other Medicaid appropriations provided in this language. |

# 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 of the Social Security Act] In addition, for carrying out such titles* for the first quarter of fiscal year [2018] *2019, [$125,219,452,000] $134,847,759,000,* to remain available until expended. | This section provides an advance appropriation for the first quarter of FY 2019 to ensure continuity of funding for activities authorized under titles XI and XIX. This allows the Medicaid program, including the Vaccines for Children program, to continue operating in the event a regular appropriation for FY 2019 is not enacted by October 1, 2018. "For carrying out" is substituted for consistency throughout the appropriations language. |
| *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)**

| | FY 2016 Actual | FY 2017 Current Law | FY 2018 Estimate | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| Appropriation Annual | $356,817,550 | $377,586,469 | $410,017,836 | $32,431,367 |
| Appropriation Indefinite | $9,854,707 | $1,462,720 | $0 | ($1,462,720) |
| Unobligated balance, start of year | $343,278 | $412,851 | $0 | ($412,851) |
| Unobligated balance, end of year | ($412,851) | $0 | $0 | $0 |
| Recoveries of Prior Year Obligations | $30,728,811 | $0 | $0 | $0 |
| Collections/Refunds | $885,802 | $944,100 | $1,029,300 | $85,200 |
| **Total Gross Obligations** | $398,217,297 | $380,406,140 | $411,047,136 | $30,640,996 |
| Offsetting Collections Medicare Part B QI Program | ($767,062) | ($941,000) | ($1,026,000) | ($85,200) |
| Offsetting Collections Other | ($13,802) | ($3,100) | ($3,300) | ($200) |
| Obligations Incurred but not Reported | $0 | ($1,007,000) | ($2,448,000) | ($1,441,000) |
| **Total Net Obligations** | $397,436,433 | $378,455,040 | $407,569,836 | $29,114,796 |

## Medicaid Program
## Appropriations History Table

| Fiscal Year | Budget Estimate to Congress | House Allowance | Senate Allowance | Appropriation | |
|---|---|---|---|---|---|
| 2009 | $216,627,700,000 | ------ | ------ | $254,890,065,000 | 1/ |
| 2010 | $292,662,503,000 | $292,662,511,000 | $292,662,511,000 | $292,662,511,000 | |
| 2011 | $259,933,181,000 | ------ | ------ | $258,365,747,000 | 2/ |
| 2012 | $270,724,399,000 | ------ | ------ | $270,724,399,000 | |
| 2013 | $269,405,279,000 | ------ | ------ | $269,405,279,000 | 3/ |
| 2014 | $284,208,616,000 | ------ | ------ | $305,843,467,000 | 4/ |
| 2015 | $338,081,239,000 | ------ | ------ | $368,405,940,000 | 5/ |
| 2016 | $356,817,550,000 | ------ | ------ | $366,672,257,000 | 6/ |
| 2017 | $377,586,469,000 | ------ | ------ | $377,586,469,000 | |
| 2018 | $410,017,836,000 | | | | |

1/ Includes $38.3 billion under indefinite funding authority obligated during FY 2009.
2/ Full-year continuing resolution appropriation provided indefinite funding authority of $171.6 billion for FY 2011.
3/ Full-year continuing resolution appropriation provided indefinite funding authority of $158.8 billion for FY 2013.
4/ Includes $21.6 billion under indefinite funding authority obligated during FY 2014.
5/ Includes $16.8 billion under indefinite funding authority obligated during FY 2015.
6/ Includes $9.9 billion under indefinite funding authority obligated during FY 2016.

**Medicaid**
**(Dollars in Thousands)**

| | FY 2016 Actual | FY 2017 Current Law | FY 2018 Estimate | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| Medical Assistance Payments (MAP) | $373,370,060 | $354,131,598 | $383,189,694 | $29,058,096 |
| Obligations Incurred by Providers But Not Yet Reported (IBNR) | $0 | $1,007,000 | $2,448,000 | $1,441,000 |
| Vaccines for Children | $4,395,924 | $4,436,935 | $4,598,358 | $161,423 |
| State & Local Administration (SLA), Survey and Certification, Fraud Control Units, and ARRA Health IT provider and admin | $20,451,313 | $20,830,607 | $20,811,084 | -$19,523 |
| Obligations (gross) | $398,217,297 | $380,406,140 | $411,047,136 | $30,640,996 |
| Unobligated Balance, Start of Year | -$343,278 | -$412,851 | $0 | $412,851 |
| Unobligated Balance, End of Year | $412,851 | $0 | $0 | $0 |
| Recoveries of Prior Year Obligations | -$30,728,811 | $0 | $0 | $0 |
| Appropriation Budget Authority (gross) | $367,558,059 | $379,993,289 | $411,047,136 | $31,053,847 |
| Collections | -$885,802 | -$944,100 | -$1,029,300 | -$85,200 |
| Total Budget Authority (net) | $366,672,257 | $379,049,189 | $410,017,836 | $30,968,647 |
| Indefinite Authority | $9,854,707 | $1,462,720 | $0 | -$1,462,720 |
| Advanced Appropriation | -$113,272,140 | -$115,582,502 | -$125,219,452 | -$9,636,950 |
| Annual Appropriation | $243,545,410 | $262,003,967 | $284,798,384 | $22,794,417 |

Authorizing Legislation - Social Security Act, title XIX, Section 1901 and Public Law 111-5, Public Law 111-148, Public Law 111-152

FY 2017 Authorization - Public Law 114-113, Public Law 114-254

Allocation Method - Formula Grants

**Medicaid Program**
**Summary of Changes**
**(Dollars in Thousands)**

| | |
|---|---|
| 2018 Estimated Budget Authority | $410,017,836 |
| 2017 Estimated Budget Authority from PB 2017 | $377,586,469 |
| Net Change | $32,431,367 |

## Program Description and Accomplishments

Authorized under title XIX of the Social Security Act, Medicaid provides health coverage for millions of America's most vulnerable populations, including low-income families with dependent children, pregnant women, children, aged, blind and disabled individuals, and other eligible adults. In addition, Medicaid provides home and community-based services and support to seniors and individuals with disabilities, as well as institutional long-term care services. Medicaid is administered by CMS in partnership with the states.

Medicaid covers a broad range of services to meet the health needs of beneficiaries. Some of the federally-mandated services for categorically-eligible Medicaid beneficiaries include hospital inpatient and outpatient services, home health care, laboratory and x-ray services, physician services, and nursing home care. Commonly offered optional services for both categorically- and medically-needy populations include prescription drugs, dental care, eyeglasses, prosthetic devices, hearing aids, services in intermediate care facilities for individuals with intellectual disabilities, and home and community-based long-term care services and supports, such as personal care services and attendant care services provided through the Community First Choice benefit. The Medicaid program's Early and Periodic Screening Diagnostic and Treatment benefit requires the provision of comprehensive health screenings and medically necessary services authorized under section 1905(a) of the Social Security Act to individuals from birth to age 21. In addition, states may elect to offer an array of home and community-based services to individuals with disabilities, individuals who are aging or individuals with chronic conditions through a variety of waivers and funding opportunities.

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 generally the payer of last resort. If other parties, including Medicare, are legally liable for services provided to a Medicaid beneficiary, that party generally must first meet its financial obligation before Medicaid payment is made.

Today, Medicaid provides critical health coverage that allows individuals to access health care services that may not be affordable otherwise and is the primary source of health care for almost 74 million beneficiaries, more than 22 percent of the U.S. population. Additionally, about 10 million people are dually eligible, that is, covered by both Medicare and Medicaid.

Medicaid Integrity Program

The Medicaid Integrity Program, though not funded from the Medicaid appropriation, supports the efforts of state Medicaid agencies through a combination of oversight and technical assistance. This program represents the most significant single, dedicated investment the federal government has made in ensuring the integrity of the Medicaid program. Further discussion of the Medicaid Integrity Program can be found in the Medicaid Integrity section located in the State Grants and Demonstrations chapter.

Vaccines for Children Program

The Vaccines for Children (VFC) program is 100 percent federally-funded by the Medicaid appropriation and operated by the Centers for Disease Control and Prevention. This program allows vulnerable children access to lifesaving vaccines as a part of routine preventive care, focusing on children without insurance, those eligible for Medicaid, and American Indian/Alaska Native children. Children with commercial insurance that lack an immunization benefit are also entitled to VFC vaccine, but only at Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs). To reach eligible children under the VFC program, federally-purchased vaccines are distributed to public health clinics and enrolled private providers. Through VFC, the Centers for Disease Control and Prevention provides funding to 61 state and local public health immunization programs that include all 50 states, six city/urban areas, and five U.S. territories and protectorates.

Medicaid Survey and Certification

The Medicaid survey and certification inspection program for nursing facilities, home health agencies and intermediate care facilities for individuals with intellectual disabilities ensures that Medicaid beneficiaries are receiving quality care in a safe environment. In order to secure quality care for the nation's most vulnerable populations, CMS requires that certain 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 other territories. Utilizing more than 7,500 surveyors across the country, state survey agencies inspect providers and determine their compliance with specific federal health, safety, and quality standards.

Medicaid Fraud Control Units (MFCUs)

Medicaid Fraud Control Units (MFCUs) are required by law to be established for all states operating a Medicaid program, unless the state receives a waiver from the Secretary. The MFCUs investigate state law violations of Medicaid fraud and review and prosecute cases involving neglect or abuse of patients in health care facilities, including nursing homes, and board and care facilities. The MFCU must be part of or coordinate with an office with statewide prosecutorial authority, such as the state Attorney General's office.

Managed Care

One of the most significant developments for the Medicaid program has been the shift in the delivery of services from fee-for-service to managed care. Prior to 1982, virtually all Medicaid beneficiaries received coverage through fee-for-service arrangements. The passage of the Omnibus Budget Reconciliation Act of 1981 and the Balanced Budget Act of 1997 made it easier for states to enroll populations into managed care delivery systems

thereby significantly increasing the number of Medicaid beneficiaries enrolled in managed care plans. As of September 2014, all but two states (Alaska and Connecticut) provide some form of managed care including primary care case management and pre-paid health plans. However, the primary form of managed care used in Medicaid today is comprehensive managed care organization (MCO) coverage. Thirty-nine of these states provide comprehensive MCO coverage to some or all Medicaid beneficiaries with nearly half (18) of these states covering 75 percent or more of their Medicaid populations under such contracts. States continue to experiment with various managed care approaches in their efforts to reduce unnecessary utilization of services, contain costs, improve access to services, and achieve greater continuity of care. Increasingly, states are using managed care to provide behavioral health services and long-term services and supports and are expanding managed care to include older individuals, individuals with disabilities, and individuals with chronic conditions in addition to more traditional primary care and acute care services.

Prior to the passage of the Balanced Budget Act of 1997, states primarily used section 1915(b) waivers or section 1115 demonstration authority to develop innovative managed care delivery systems. Section 1915(b) waivers can exempt states from state-wideness, comparability and freedom of choice requirements which are used to enroll beneficiaries in mandatory managed care programs. Under these waivers, states can also provide additional services via savings produced by managed care and/or create a “carve out” delivery system for specialty care (e.g. behavioral health, pre-paid inpatient health plans). Section 1115 demonstration authority provides additional flexibility from statutory and regulatory requirements not available under state plan amendments or 1915(b) waivers so long as they assist in promoting the objectives of the Medicaid and CHIP statute. Such waivers can, for instance, 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 added section 1932 of the Social Security Act and increased state flexibility to enroll certain Medicaid groups on a mandatory basis (with the exception of special needs children, dual eligible beneficiaries, and American Indians/Alaska Natives) into managed care through a state plan amendment. The Deficit Reduction Act of 2005 enabled states to mandate enrollment for certain non-exempt populations in benchmark and benchmark-equivalent benefit plans under section 1937 of the Social Security Act. If a state opts to implement the alternative benefit packages under section 1937, the state may also use a managed care delivery system to provide the services.

As Medicaid managed care programs continue to grow, CMS remains committed to ensuring that policies are in place to build a patient centered system of care that increases competition, quality and access. CMS’ efforts include evaluating and monitoring demonstration and waiver programs, enhancing information systems, and providing expedited review of state proposals. In 2016, CMS updated the Medicaid managed care regulations for the first time since 2002, and CMS will be conducting a full review of managed care regulations in order to prioritize beneficiary outcome and state priorities.

Section 1115 Demonstrations

Under section 1115 authority, many states have significantly restructured their Medicaid and/or CHIP programs in the areas of eligibility, benefits, service delivery systems, and financing. Most demonstrations are statewide and many include the majority of the

Medicaid population in the state. States use 1115 demonstrations to promote healthcare transformation in alignment with the objectives of Medicaid and CHIP.

For example, several states have used this authority to implement innovative new Medicaid financing arrangements, or to move their long-term services and supports into a managed care delivery system. To better monitor the program transformations that are being operationalized through these Medicaid demonstrations, CMS is building infrastructure to effectively monitor and evaluate waiver outcomes. The infrastructure will provide CMS with more robust data to assess the performance of these programs relative to their goals and assist in identifying best practices. The most current fiscal data available indicates the federal share of obligations for 1115 demonstrations in FY 2015 was $109.4 billion:

- Forty statewide health care reform demonstrations in 34 states (Alabama, Arizona, Arkansas, California, Colorado, Delaware, Florida, Hawaii, Idaho, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Montana, New Jersey, New Mexico, Nevada, New Hampshire, New York, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Utah, Vermont, Virginia and Wisconsin);

- One non-statewide health reform demonstrations (Missouri) and

- Ten demonstrations specifically targeted to family planning (Alabama, Florida, Georgia, Iowa, Mississippi, Missouri, Montana, Oregon, Washington, and Wyoming).

Recipients

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

Medicaid Enrollment (Person-Years in Millions) /1

| | FY 2016 Estimate | FY 2017 Estimate | FY 2018 Estimate | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| Aged | 5.7 | 5.8 | 6.0 | 0.2 |
| Disabled | 10.6 | 10.6 | 10.7 | 0.1 |
| Adults | 26.5 | 27.8 | 28.4 | 0.6 |
| Children | 28.1 | 28.2 | 30.0 | 1.8 |
| Territories | 1.4 | 1.4 | 1.4 | 0 |
| Total/1 | 72.2 | 73.8 | 76.5 | 2.7 |

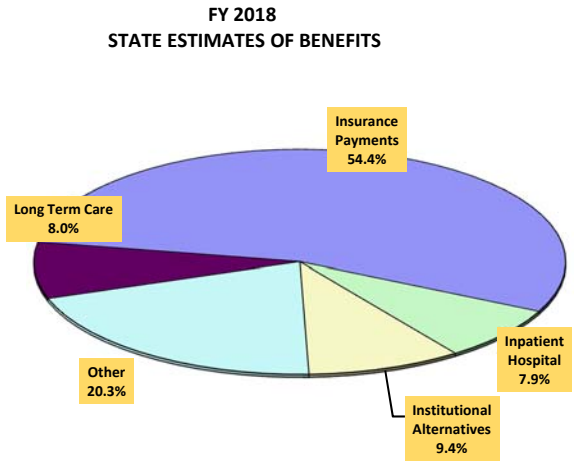
1/ Totals may not add due to rounding.

According to CMS projections of Medicaid enrollment in FY 2018, 76.5 million of the projected 329.2 million in the total U.S. population will be enrolled in Medicaid for the equivalent of a full year during FY 2018. In FY 2018, Medicaid is projected to provide coverage to more than one out of every five people in the nation.

CMS projects that in FY 2018, non-disabled children and adults under age 65 will represent almost 78 percent of the Medicaid population, but account for approximately 48 percent of the Medicaid benefit outlays, excluding Disproportionate Share Hospital (DSH) payments and Medicaid beneficiaries in the Territories. In contrast, older individuals and individuals with disabilities are estimated to make up over 22 percent of the Medicaid population, yet account for approximately 53 percent of the non-DSH benefit outlays on the U.S. mainland. Medicaid is the largest payer for long-term care for all Americans.

<u>Benefit Services</u>

As displayed in the table on the following page, the state estimates for medical assistance payments increased from $374.5 billion for FY 2017 to $377.8 billion for FY 2018.




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 $205.7 billion in funding for FY 2018 representing 54.4 percent of the state-submitted benefit estimates for FY 2018. The second largest FY 2018 Medicaid category of service is institutional alternatives. It is composed of personal care, home health, and home and community-based services. The states have submitted FY 2018 estimates totaling $35.4 billion or 9.4 percent of Medicaid benefits. The next largest category of Medicaid services for FY 2018 are for long-term care. It is composed of care provided in nursing facilities and intermediate care facilities for the intellectually disabled ($30.4 billion or 8.1 percent) followed by inpatient hospital services exclusive of disproportionate share hospital payment adjustments ($29.7 billion or 7.9 percent). Together these four benefit service categories for health insurance payments, institutional alternatives, long-term care, and inpatient hospital account for over 79.7 percent of the state-estimated cost of the Medicaid program for FY 2018. The rest of the benefit costs are represented in the Other Services category of service for targeted case management, hospice, and all other services. States have submitted estimates for a total of $76.6 billion or 20.3 percent of the total Medicaid benefits for these other services.

**Estimated Benefit Service Growth, FY 2017 to FY 2018**
**February 2017 State-Submitted Estimates and Actuarial Adjustments**
**(Dollars in thousands)**

| Major Service Category | Est. FY 2017 | Est. FY 2018 | 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) | $200,822,319 | $205,672,386 | $4,850,067 | 2.4% | 148.8% |
| **Institutional Alternatives** (Personal care, home health, and home and community-based care) | $35,172,865 | $35,449,827 | $276,962 | 0.8% | 8.5% |
| **Other** (Targeted case management, hospice, all other services, and collections) | $29,401,677 | $29,993,333 | $591,656 | 2.0% | 18.1% |
| **Long-Term Care** (Nursing facilities, intermediate care facilities for the mentally retarded) | $30,459,687 | $30,410,699 | -$48,988 | -0.2% | -1.5% |
| **Outpatient Hospital** | $9,475,470 | $8,380,798 | -$1,094,672 | -11.6% | -33.6% |
| **Prescribed Drugs** (Prescribed drugs and drug rebate offsets) | $4,854,200 | $5,108,420 | $254,220 | 5.2% | 7.8% |
| **Inpatient Hospital** (Regular payments –inpatient hospital and mental health facilities) | $31,432,408 | $29,704,025 | -$1,728,383 | -5.5% | -53.0% |
| **Physician/Practitioner/Dental** | $13,168,491 | $13,338,322 | $169,831 | 1.3% | 5.2% |
| **Other Acute Care** (Clinics, lab & x-ray, Federally-qualified health clinics and early periodic screening, and diagnostic treatment (EPSDT) | 9,094,292 | $9,069,679 | -$24,613 | -0.3% | -0.8% |
| **Disproportionate Share Hospital Payments** (Adjustment payments – inpatient hospital and mental health facilities) | $10,625,322 | $10,639,513 | $14,191 | 0.1% | 0.4% |
| **TOTAL STATE ESTIMATES** (Excludes Medicare Part B Transfer) | $374,506,731 | $377,767,002 | $3,260,271 | 0.9% | 100.0% |

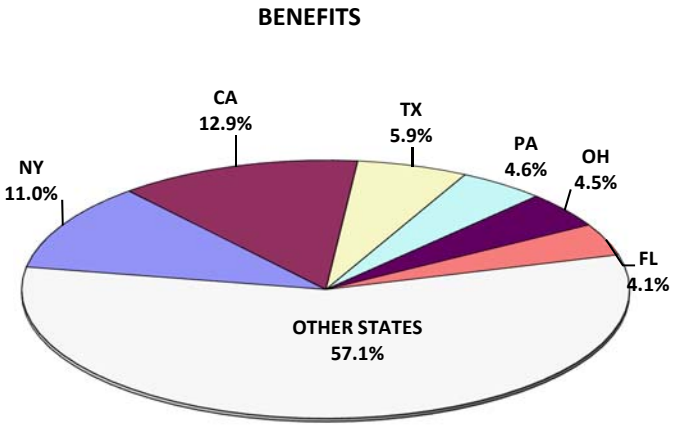
Note: This table reflects current law estimates.

Distribution of Medicaid Funding

The total FY 2018 state-submitted estimates for Medicaid are $396.5 billion, composed of $377.8 billion for Medicaid medical assistance payments and $18.7 billion for state and local administration.

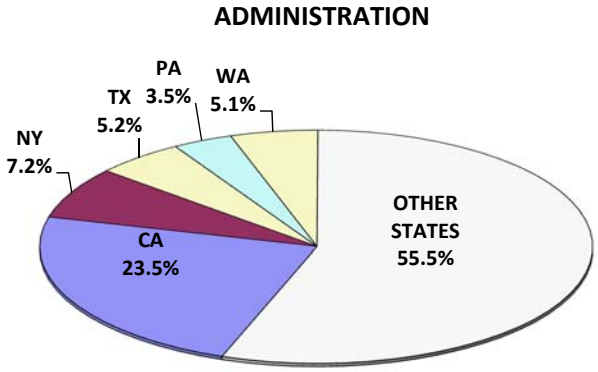
Distribution of Benefit Funding

As displayed, California, New York, Texas, Pennsylvania, Ohio and Florida account for $161.5 billion, or almost 43 percent, of the state-submitted estimates for benefits for FY 2018. Ten states represent over 54 percent of these estimates.




Distribution of State and Local Administration Funding

The state-submitted estimates for FY 2018 state and local administration represents less than 5 percent of the total state-submitted estimates for Medicaid costs for FY 2018. As displayed, California, New York, Texas, Washington, and Pennsylvania account for $8.3 billion or more than 44 percent of the FY 2018 estimates for state and local administration. Ten states represent over 58 percent of these estimates.




**Budget Request**

CMS's FY 2018 appropriation request for Grants to States for Medicaid is $410.0 billion, an increase of $32.4 billion relative to the FY 2017 request level of $377.6 billion. This appropriation is composed of $125.2 billion in authorized advance appropriation for FY 2018 and a remaining appropriation of $284.8 billion for FY 2018.

Resources will fund $411.0 billion in anticipated FY 2018 Medicaid gross obligations. These obligations are composed of:

- $383.2 billion in Medicaid medical assistance benefits;
- $2.4 billion for benefit obligations incurred but not yet reported;
- $20.8 billion for Medicaid administrative functions including funding for Medicaid state survey and certification and the state Medicaid fraud control units; and
- $4.6 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 CMS using Medicaid expenditure data as recent as the second quarter of FY 2017. The projections incorporate the economic and demographic assumptions promulgated by the Office of Management and Budget (OMB) for the FY 2018 President's Budget.

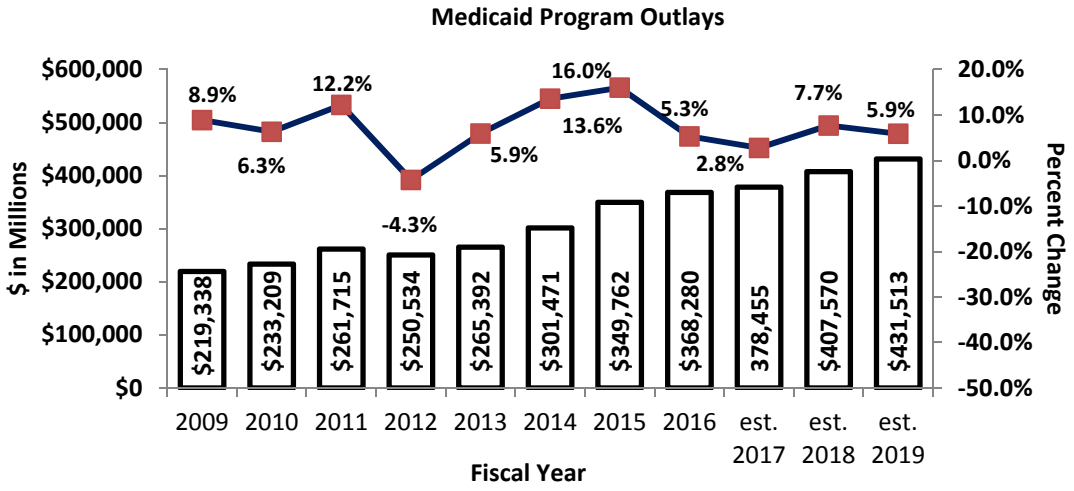
Under current law, the federal share of Medicaid outlays is estimated to be $407.6 billion in FY 2018. This represents an increase of 7.7 percent relative to the estimated net outlay level of $378.5 billion for FY 2017. Medicaid person-years of enrollment, which represent full-year equivalent Medicaid enrollment, are projected to increase approximately 4.1 percent during FY 2018.

Medical Assistance Payments (MAP)

In order to arrive at an accurate estimate of Medicaid expenditures, adjustments have been made to the February 2017 state estimates. These adjustments reflect actuarial estimates, legislative impacts, and CMS financial management reviews.

Actuarial Adjustments to the State Estimates for Medical Assistance Benefits

The November 2017 state estimates for MAP in FY 2018 are the first state-submitted estimates for FY 2018. Typically, state estimation error is most likely to occur early in the budget cycle because states are most focused on their current year budget and have not yet focused on their projections for the federal budget year. CMS' OACT developed the MAP estimate for FY 2018. Using the last three quarters of FY 2016 state-reported expenditures as a base, expenditures for FY 2017 and FY 2018 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 OMB and demographic trends in Medicaid enrollment. CMS' OACT also incorporated adjustments to the Medicaid benefit estimates based on their analysis of the February 2017 state-submitted estimates.




Adjustments to the Actuarial Estimates for Medical Assistance Payments for Recent Legislation

- 21st Century Cures Act (P.L. 114-255)
- Consolidated Appropriations Act, 2016 (P.L. 114-113)
- Bipartisan Budget Act of 2015 (P.L. 114-74)
- Protecting Access to Medicare Act of 2014 (P.L. 113-93)

In additional to the above-mentioned legislation, CMS' estimates were adjusted to reflect the finalization of the following regulations or sub-regulatory guidance:

- Medicaid and CHIP Managed Care Rule (CMS-2390-F)
- The Application of Mental Health Parity Requirements to Medicaid and CHIP (CMS-2333-F)
- SNAP (Supplemental Nutrition Assistance Program) to Medicaid State Official Letter (SHO #15-001)

Other Adjustments to the Actuarial Estimates for Medical Assistance Payments

Medicaid Financial Management Reviews
(Estimated FY 2018 savings are $71.0 million)

Financial management (FM) reviews conducted by CMS are expected to produce additional savings of $71.0 million in FY 2018. CMS is committed to a structured FM review process that will increase the level of FM oversight activities to ensure state compliance with federal

regulations governing Medicaid and state financing. Core activities of the FM process include the quarterly on-site reviews and processing of Medicaid budget and expenditure reports, performance of detailed FM reviews of specific high-risk areas, and other ongoing oversight and enforcement activities such as deferrals, disallowances, audit resolution, and financial data and information gathering.

Benefits Due and Payable (Incurred but not Reported)

The FY 2018 estimate of $2.4 billion represents the increase in the liability for Medicaid medical services incurred but not paid from October 1, 2017 to September 30, 2018. 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

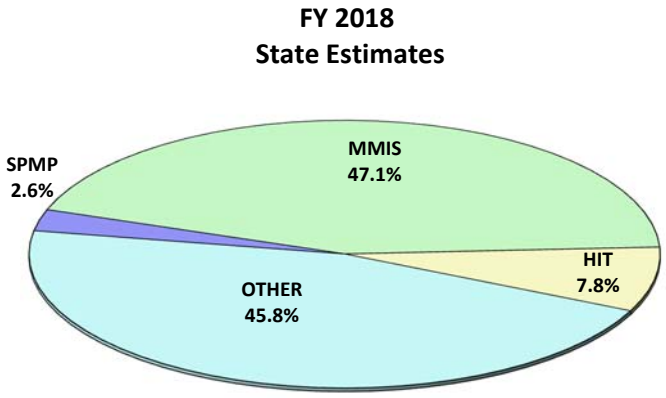
The nation's childhood immunization coverage rates are at high levels for most vaccines and vaccination series measures. As childhood immunization coverage rates increase, cases of vaccine-preventable diseases (VPDs) decline significantly. Vaccination against diphtheria, *haemophilus influenzae* type b, hepatitis A, hepatitis B, measles, mumps, pneumococcal, pertussis, polio, rotavirus, rubella, tetanus, and varicella is currently recommended. In addition to the health benefits of immunization, vaccines also provide significant economic value. Millions of children have benefited from vaccination since the Vaccines for Children Program began in 1994. Among children born during 1994–2013, vaccination will prevent an estimated 322.0 million illnesses, 21 million hospitalizations, and 732,000 early deaths over the course of their lifetimes, at a net savings of $295 billion in direct costs and $1.38 trillion in total societal costs.[1] CDC will be publishing a report reflecting data for this program through 2016 in the coming months.

The current FY 2018 estimate for the VFC program is $4.6 billion, which is $161.4 million above the FY 2017 estimate. This estimate includes an increase for vaccine-purchase contract costs and additional quality assurance and quality improvement site visits to VFC-enrolled providers. This budget will ensure sufficient quantities of pediatric vaccines are available to immunize VFC eligible children; approximately 96 percent of the VFC budget is used to purchase vaccines, including vaccine purchases for the VFC stockpile. The VFC stockpile is a strategic asset for the nation's immunization system that is used to fight outbreaks of VPDs and mitigate the impact of unanticipated shortages of routinely recommended vaccines. The remaining budget supports vaccine ordering and distribution, including costs of ordering vaccines on behalf of states, immunization coverage surveys, and program support and oversight.

State and Local Administration (ADM)

For FY 2018, based on recent actual data and the February 2017 state estimates, CMS estimated the federal share of state and local administration costs to be $20.8 billion. This estimate is composed of $20.3 billion for Medicaid state and local administration and $563.4 million in additional funding for Medicaid state survey and certification and state Medicaid fraud control units.

[1] https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6316a4.htm?s_cid=mm6316a4_w




In February 2017 the states estimated the federal share of state and local administration outlays to be $18.7 billion for FY 2018. State and Local Administration funding includes Medicaid management information systems (MMIS) design, development, and operation, immigration status verification systems; non-MMIS automated data processing activities; ARRA authorized Health Information Technology Incentive program; skilled professional medical personnel (SPMP); salaries, fringe benefits, and 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 2018 state-submitted estimates of $18.7 billion upward to reflect a growth rate more consistent with recent expenditure history and current economic conditions relative to the conditions when states submitted estimates. These estimates were adjusted to reflect the estimated costs of incentives to eligible providers and hospitals for the adoption and meaningful use of electronic health records (EHR), described further below.

Health Information Technology Meaningful Use Incentive Program

The current FY 2018 estimate for provider incentives payments is $1.6 billion. These incentives continue to encourage adoption and meaningful use of electronic health records (EHRs), The American Recovery and Reinvestment Act of 2009 (ARRA) authorizes Medicaid to provide incentive payments to doctors, hospitals, and other providers for the implementation and meaningful use of certified EHRs. The provision allows for enhanced federal financial participation (FFP) of 100 percent for incentive payments to providers for the purchase, maintenance, and meaningful use of certified EHRs, and 90 percent FFP for state and local administrative expenses associated with administering the incentive payments.

Medicaid State Survey and Certification

The purpose of survey and certification inspections for nursing facilities home health agencies and intermediate care facilities for individuals with intellectual disabilities in FY 2018 is to ensure that Medicaid beneficiaries are receiving quality care in a safe environment. The current FY 2018 estimate for Medicaid state survey and certification is $297.4 million. This represents an increase of over $6.4 million above the current FY 2017 estimate of $291 million. This increased funding level supports increasing workload

requirements (i.e., increases in the average hours per survey) and labor costs; costs associated with survey and certification activities covering over 33,500 Medicaid participating facilities with nearly 24,500 health and life safety code annual certifications, as well as over 55,800 complaint survey investigations; and direct state survey costs associated with nursing home and home health agency quality.

State Medicaid Fraud Control Units (MFCUs)

In FY 2018, state Medicaid fraud control unit operations are currently estimated to require $266.0 million in federal matching funds. This represents an increase of $11.0 million over the FY 2017 funding level of $255.0 million. Forty-nine states and the District of Columbia participate in the program. Estimated increases are due to increases in staff and related expenses as MFCUs invest resources into curtailing Medicaid fraud and patient abuse and neglect.

The MFCU's mission is to investigate and prosecute provider fraud in state Medicaid programs as well as patient abuse and neglect in health care facilities. In FY 2016, states reported $1.8 billion in expected recoveries for both civil and criminal cases handled by the 50 MFCUs.

**Medicaid Program**
**Budget Authority by Object**
**(Dollars in Thousands)**

| | 2017 Estimate | 2018 Estimate | Increase or Decrease |
|---|---|---|---|
| **CMS - Grants to States** | | | |
| Grants to States, Subsidies and Contributions | $374,612,254 | $405,419,478 | $30,807,224 |
| **CDC - Vaccines For Children** | | | |
| Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance | $4,436,935 | $4,598,358 | $161,423 |
| **Total Budget Authority** | $379,049,189 | $410,017,836 | $30,968,647 |

## FY 2018 MANDATORY STATE/FORMULA GRANTS[2]
## (Dollars in Thousands)
## CFDA No/Program Name: 93.778 Medical Assistance Program

| State/Territory | FY 2016 Actual | FY 2017 Estimate[3] | FY 2018 Estimate[3] | Difference +/- 2017 |
|---|---|---|---|---|
| Alabama | $3,964,085 | $4,319,980 | $4,826,423 | $506,443 |
| Alaska | $1,245,840 | $1,430,136 | $1,545,174 | $115,038 |
| Arizona | $8,552,731 | $9,290,268 | $9,710,002 | $419,734 |
| Arkansas | $4,919,318 | $5,374,510 | $5,529,078 | $154,568 |
| California | $55,457,936 | $60,223,130 | $52,726,804 | -$7,496,326 |
| Colorado | $5,125,368 | $5,243,127 | $5,399,168 | $156,041 |
| Connecticut | $4,612,597 | $4,619,061 | $4,741,438 | $122,377 |
| Delaware | $1,259,123 | $1,401,971 | $1,478,447 | $76,476 |
| District of Columbia | $2,172,898 | $2,284,498 | $2,300,948 | $16,450 |
| Florida | $13,647,918 | $15,239,202 | $15,663,728 | $424,526 |
| Georgia | $6,949,229 | $7,513,881 | $7,333,766 | -$180,115 |
| Hawaii | $1,496,967 | $1,430,594 | $1,380,897 | -$49,697 |
| Idaho | $1,275,769 | $1,458,086 | $1,517,463 | $59,377 |
| Illinois | $12,064,086 | $10,161,100 | $11,225,952 | $1,064,852 |
| Indiana | $7,799,745 | $8,149,687 | $8,171,562 | $21,875 |
| Iowa | $3,084,407 | $2,892,413 | $3,002,064 | $109,651 |
| Kansas | $1,942,405 | $1,973,106 | $1,889,440 | -$83,666 |
| Kentucky | $7,782,645 | $8,695,229 | $7,771,326 | -$923,903 |
| Louisiana | $5,627,369 | $7,513,295 | $9,436,234 | $1,922,939 |
| Maine | $1,667,812 | $1,750,052 | $1,783,586 | $33,534 |
| Maryland | $6,622,083 | $7,676,682 | $8,147,471 | $470,789 |
| Massachusetts | $9,731,280 | $10,479,318 | $10,091,307 | -$388,011 |
| Michigan | $12,738,084 | $13,582,901 | $13,524,085 | -$58,816 |
| Minnesota | $6,660,375 | $7,167,711 | $7,641,065 | $475,354 |
| Mississippi | $4,127,728 | $4,252,073 | $4,337,202 | $85,129 |
| Missouri | $6,474,410 | $7,089,312 | $7,401,505 | $312,193 |
| Montana | $973,077 | $1,274,290 | $1,318,750 | $44,460 |
| Nebraska | $1,093,989 | $1,224,467 | $1,274,154 | $49,687 |
| Nevada | $2,683,391 | $2,868,938 | $2,978,754 | $109,816 |
| New Hampshire | $1,265,965 | $1,315,409 | $1,335,061 | $19,652 |
| New Jersey | $9,182,098 | $9,417,407 | $9,998,376 | $403,889 |
| New Mexico | $4,370,292 | $4,068,962 | $4,653,063 | $584,101 |
| New York | $34,588,592 | $41,421,059 | $42,549,501 | $1,128,442 |
| North Carolina | $8,528,953 | $9,244,609 | $9,276,347 | $31,738 |
| North Dakota | $437,881 | $940,769 | $896,848 | -$43,921 |

| State/Territory | FY 2016 Actual | FY 2017 Estimate[3] | FY 2018 Estimate[3] | Difference +/- 2017 |
|---|---|---|---|---|
| Ohio | $15,506,012 | $16,826,923 | $17,675,357 | $848,434 |
| Oklahoma | $2,925,882 | $3,022,730 | $3,000,437 | -$22,293 |
| Oregon | $6,686,260 | $7,452,970 | $7,585,383 | $132,413 |
| Pennsylvania | $17,035,666 | $17,721,327 | $17,910,914 | $189,587 |
| Rhode Island | $1,533,540 | $1,703,278 | $1,741,945 | $38,667 |
| South Carolina | $4,453,291 | $4,514,379 | $4,480,758 | -$33,621 |
| South Dakota | $489,402 | $518,611 | $566,923 | $28,312 |
| Tennessee | $6,523,606 | $7,389,884 | $7,771,780 | $383,896 |
| Texas | $23,696,453 | $22,476,591 | $23,254,679 | $778,088 |
| Utah | $1,576,295 | $1,807,984 | $1,823,039 | $15,055 |
| Vermont | $1,072,721 | $1,044,291 | $1,059,758 | $15,467 |
| Virginia | $4,553,022 | $4,810,646 | $5,111,430 | $300,784 |
| Washington | $7,062,048 | $9,575,317 | $10,870,612 | $1,295,295 |
| West Virginia | $2,946,031 | $3,604,227 | $3,372,791 | -$231,436 |
| Wisconsin | $4,694,458 | $4,947,476 | $5,258,490 | $311,014 |
| Wyoming | $337,343 | $340,426 | $367,490 | $27,064 |
| **Subtotal** | **$361,218,477** | **$390,941,373** | **$394,712,775** | **$3,771,402** |
| American Samoa | $21,780 | $16,828 | $16,828 | $0 |
| Guam | $45,762 | $52,184 | $52,184 | $0 |
| Northern Mariana Islands | $20,603 | $19,527 | $19,527 | $0 |
| Puerto Rico | $1,630,447 | $1,631,834 | $1,592,694 | -$39,140 |
| Virgin Islands | $51,652 | $55,689 | $46,098 | -$9,591 |
| **Subtotal** | **$1,770,244** | **$1,776,062** | **$1,727,331** | **-$48,731** |
| **Total States/Territories** | **$362,988,721** | **$392,717,435** | **$396,440,106** | **$3,722,671** |
| Survey & Certification | $227,113 | $291,000 | $297,400 | $6,400 |
| Fraud Control Units | $228,841 | $255,000 | $266,000 | $11,000 |
| Vaccines For Children | $4,395,924 | $4,436,935 | $4,598,358 | $161,423 |
| Incurred But Not Reported | $0 | $1,007,000 | $2,448,000 | $1,441,000 |
| Medicare Part B | $767,062 | $941,000 | $1,026,000 | $85,000 |
| Undistributed | $29,609,636 | -$17,360,230 | $5,971,272 | $23,331,502 |
| **TOTAL RESOURCES** | **$398,217,297** | **$380,406,140** | **$411,047,136** | **$30,640,996** |

[2] Represents current law baseline projections of obligations.

[3] The obligation estimates reflect the State and Territory reported estimates submitted to CMS in February 2017.

# 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)(3) of Public Law 97-248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, [$299,187,700,000] $323,497,300,000.*

*In addition, for making matching payments under section 1844 and benefit payments under section 1860D-16 of the Social Security Act that were not anticipated in budget estimates, such sums as may be necessary.*

**Payments to the Health Care Trust Funds**
**Language Analysis**

| Language Provision | Explanation |
|---|---|
| *For payment to the Federal Hospital Insurance 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)(3) of Public Law 97-248, and for administrative expenses incurred pursuant to section 201(g) of the Social Security Act, $323,497,300,000.* | 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 that were 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 for general fund resources for Part D prescription drug benefit payments in the event that the annual appropriation is insufficient. |

# Payments to the Health Care Trust Funds

**Amounts Available for Obligation**

(Dollars in Thousands)

| | FY 2016 Final | FY 2017 Estimate | FY 2018 President's Budget | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| Appropriation: Annual | $283,171,800 | $299,187,700 | $323,497,300 | $24,309,600 |
| Indefinite Annual Appropriation, for SMI Premium Match | $21,224,344 | $14,838,000 | $0 | ($14,838,000) |
| Indefinite Annual Appropriation, for Part D Benefits | $5,547,000 | $0 | $0 | $0 |
| Lapse in Supplemental Medical Insurance | $0 | $0 | $0 | $0 |
| Lapse in General Revenue Part D: Benefits | $0 | $0 | $0 | $0 |
| Lapse in General Revenue Part D: Federal Administration | $0 | $0 | $0 | $0 |
| Lapse in Program Management | $0 | $0 | $0 | $0 |
| Lapse in Transfer for HCFAC Reimbursement | $0 | $0 | $0 | $0 |
| Lapse in State Low Income Determination | $0 | $0 | $0 | $0 |
| Total Obligations | $309,943,144 | $314,025,700 | $323,497,300 | $9,471,600 |

## Payments to the Health Care Trust Funds
## Summary of Changes

**FY 2017 Estimate**

Total Budget Authority - $314,025,700,000

**FY 2018 President's Budget**

Total Budget Authority - $323,497,300,000
Net Change, Total Appropriation - $9,471,600,000

| Changes | FY 2016 Final | FY 2017 Estimate | FY 2018 President's Budget | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| Federal Payment for Supplementary Medical Insurance (SMI) | $198,530,000,000 | $214,944,000,000 | $245,396,000,000 | $30,452,000,000 |
| Indefinite Annual Appropriation, SMI | $21,224,344,000 | $14,838,000,000 | $0 | ($14,838,000,000) |
| Hospital Insurance for Uninsured Federal Annuitants | $158,000,000 | $147,000,000 | $132,000,000 | ($15,000,000) |
| Program Management Administrative Expenses | $1,044,000,000 | $877,500,000 | $1,104,000,000 | $226,500,000 |
| General Revenue for Part D (Drug) Benefit | $82,453,000,000 | $82,512,000,000 | $76,133,000,000 | ($6,379,000,000) |
| Indefinite Annual Appropriation, Part D Benefits | $5,547,000,000 | $0 | $0 | $0 |
| General Revenue for Part D Federal Administration | $691,000,000 | $405,000,000 | $422,000,000 | $17,000,000 |
| Part D: State Low-Income Determination | $4,800,000 | $3,200,000 | $3,300,000 | $100,000 |
| Reimbursement for HCFAC | $291,000,000 | $299,000,000 | $307,000,000 | $8,000,000 |
| Net Change | $309,943,144,000 | $314,025,700,000 | $323,497,300,000 | $9,471,600,000 |

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

| | FY 2016 Final | FY 2017 Estimate | FY 2018 President's Budget | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| Supplementary Medical Insurance | $198,530,000 | $214,944,000 | $245,396,000 | $30,452,000 |
| Indefinite Annual Appropriation, SMI | 21,224,344 | $14,838,000 | $0 | ($14,838,000) |
| Hospital Insurance for Uninsured Federal Annuitants | $158,000 | $147,000 | $132,000 | ($15,000) |
| Program Management Administrative Expenses | $1,044,000 | $877,500 | $1,104,000 | $226,500 |
| General Revenue for Part D Benefit | $82,453,000 | $82,512,000 | $76,133,000 | ($6,379,000) |
| Indefinite Annual Appropriation, Part D Benefits | $5,547,000 | $0 | $0 | $0 |
| General Revenue for Part D Federal Administration | $691,000 | $405,000 | $422,000 | $17,000 |
| Part D: State Low-Income Determination | $4,800 | $3,200 | $3,300 | $100 |
| Reimbursement for HCFAC | $291,000 | $299,000 | $307,000 | $8,000 |
| Total Budget Authority | $309,943,144 | $314,025,700 | $323,497,300 | $9,471,600 |

**Payments to the Health Care Trust Funds**
**Authorizing Legislation**
(Dollars in Thousands)

| | FY 2016 Final | FY 2017 Estimate | FY 2018 President's Budget | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| 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) | $309,943,144 | $314,025,700 | $323,497,300 | $9,471,600 |
| Total Budget Authority | $309,943,144 | $314,025,700 | $323,497,300 | $9,471,600 |

**Annual Budget Authority by Activity**

(Dollars in Thousands)

| | FY 2016 Final | FY 2017 Estimate | FY 2018 President's Budget | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| Budget Authority | $309,943,144 | $314,025,700 | $323,497,300 | $9,471,600 |

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 to reimburse the Trust Funds for amounts to which they are entitled under law. 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 the General Fund under current law, including amounts due the SMI Trust Fund for the General Fund contribution for the cost of the Part B and Part D programs.
Through this appropriation, the Trust Funds are made whole for:

*Hospital Insurance for the Uninsured Federal Annuitants*:

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

The FY 2018 President's Budget of $132.0 million for Hospital Insurance for Uninsured Federal Annuitants is a net decrease of $15.0 million under the FY 2017 estimated amount of $147.0 million.

*Program Management Administrative Expenses*:

Program Management Administrative Expenses includes the portion of CMS' administrative costs, initially borne by the Hospital Insurance (HI) Trust Fund, which is properly chargeable to the general funds, e.g., federal administrative costs for the Medicaid program, and for Center for Consumer Information and Insurance Oversight (CCIIO) related activities.

The FY 2018 President's Budget amount of $1.1 billion to reimburse the HI Trust Fund for Program Management administrative expenses not attributable to Medicare trust fund activities, is a net increase of $226.5 million over the FY 2017 estimated amount of $877.5 million.

*Reimbursement for HCFAC*:

The Health Care Fraud and Abuse Control (HCFAC) account includes program integrity activities for Medicare, Medicare Advantage, Medicare Part D, Medicaid, and the Children's Health Insurance Program. The reimbursement includes that portion of HCFAC discretionary costs associated with program integrity activities that are initially borne by the Hospital Insurance and Supplementary Medical Insurance Trust Funds, which are properly chargeable to the general fund.

The FY 2018 President's Budget of $307.0 million for reimbursement of HCFAC is a net increase of $8.0 million above the FY2017 estimated amount of $299.0 million. This amount reflects an estimate of that portion of HCFAC discretionary costs associated with program integrity activities that are initially borne by the HI and SMI Trust Funds, but which are properly chargeable to the general fund. The FY 2018 request reflects the estimated Medicare non-trust fund burdens only. This is based on the current allocation of HCFAC spending data for the above mentioned non-trust fund program integrity activities.

*Federal Contribution for SMI*:

Federal Contribution for SMI consists of 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 generally set to cover 25 percent of the estimated incurred benefit costs for aged beneficiaries, including a sufficient contingency margin. The federal match, supplemented with interest payments to the SMI Trust Fund, covers the remaining benefit costs of both aged and disabled beneficiaries.

The FY 2018 President's Budget of $245.4 billion for the FY 2018 Federal Contribution for SMI is a net increase of $30.5 billion over the FY 2017 estimated amount of $214.9 billion. The cost of the federal match continues to rise from year to year because of beneficiary population and program cost growth.

*General Revenue for Part D (Benefits) and Federal Administration*:

The Medicare Prescription Drug Plan program was created as a result of the enactment of P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The reimbursements through the Payments to the Health Care Trust Funds account include General Revenue for Part D (Benefits) and General Revenue for Part D Federal Administration. General fund payments to the SMI Trust Fund offset these Medicare Prescription Drug Account costs. Most of these activities started in FY 2006.

The FY 2018 President's Budget of $76.1 billion for General Revenue for Part D (Benefits) is a net decrease of $6.4 billion under the FY 2017 estimated amount of $82.5 billion. The benefit contribution decreases when the Part D Prescription Drug program population and cost decrease.

The FY 2018 President's Budget of $422.0 million for General Revenue for Part D Federal Administration is a net increase of $17.0 million above the FY 2017 estimated amount of $405.0 million. These are annually revised estimates of the Part D share of

Program Management and Social Security Administration's Limitation on Administrative Expenses (LAE).

The FY 2018 President's Budget estimate for General Revenue for Part D State Eligibility Determinations is $3.3 million. This reflects a net increase of $100,000 over the FY 2017 estimate of $3.2 million.

**Funding History**

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

| Fiscal Year | Budget Authority |
|---|---|
| FY 2014 | $255,185,000,000 |
| FY 2015 | $268,212,000,000 |
| FY 2016 | $309,943,144,000 |
| FY 2017 | $314,025,700,000 |
| FY 2018 | $323,497,300,000 |

**Permanent Budget Authority**
**(Dollars in Thousands)**

| | FY 2016 Final | FY 2017 Estimate | FY 2018 President's Budget | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| Tax on OASDI Benefits | $23,022,000 | $24,210,000 | $27,425,000 | $3,215,000 |
| SECA Tax Credits | $9 | $0 | $0 | $0 |
| HCFAC, FBI | $130,303 | $131,335 | $144,454 | $13,119 |
| HCFAC, Asset Forfeitures | $53,999 | $30,000 | $31,000 | $1,000 |
| HCFAC, Criminal Fines | $24,055 | $590,000 | $630,000 | $40,000 |
| HCFAC, Civil Penalties and Damages: Administration | $23,650 | $32,000 | $32,500 | $500 |
| Total BA | $23,254,016 | $24,993,335 | $28,262,954 | $3,269,619 |

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 indefinite appropriations associated with the Health Care Fraud and Abuse Control (HCFAC) account activities will pass through the Payments to the Health Care Trust Funds account: FBI funding, asset forfeitures, criminal fines, and the administrative costs of activities associated with civil penalties and damages (CP&D). FBI and CP&D administrative funds address prosecution of health care matters, investigations, financial and performance audits, inspections, and other evaluations. Asset forfeitures and criminal fines are amounts collected from health care fraud activities, and again are permanent indefinite appropriations from the general fund, transferred to the HI Trust Fund.

**Payments to the Health Care Trust Funds**
**Budget Authority by Object**
**(Dollars in Thousands)**

| | FY 2016 Final | FY 2017 Estimated | FY 2018 President's Budget | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| Grants, subsidies and contributions: Non-Drug | $198,530,000 | $214,944,000 | $245,396,000 | $30,452,000 |
| Indefinite Annual Appropriation | $21,224,344 | $14,838,000 | $0 | ($14,838,000) |
| Grants, subsidies and contributions: Drug | $82,453,000 | $82,512,000 | $76,133,000 | ($6,379,000) |
| Indefinite Annual Appropriation, Part D Benefits | $5,547,000 | $0 | $0 | $0 |
| Insurance claims and indemnities | $158,000 | $147,000 | $132,000 | ($15,000) |
| Administrative costs-General Fund Share | $2,026,000 | $1,581,500 | $1,833,000 | $251,500 |
| General Revenue Part D: State Eligibility Determinations | $4,800 | $3,200 | $3,300 | $100 |
| Total Budget Authority | $309,943,144 | $314,025,700 | $323,497,300 | $9,471,600 |

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

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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, [$681,000,000] $751,000,000, to remain available through September 30, [2017] 2019, 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 [$486,120,000] $610,391,000 shall be for the [Medicare Integrity Program at the Centers for Medicare and Medicaid Services, including administrative costs, to conduct oversight activities for Medicare Advantage under Part C and the Medicare Prescription Drug Program under Part D of the Social Security Act and for activities described in Section 1893(b) of such Act,] Centers for Medicare and Medicaid Services program integrity activities, of which [$67,200,000] $74,246,000 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 $67,200,000 shall be for Medicaid and Children's Health Insurance Program ("CHIP") program integrity activities,]; and of which [$60,480,000] $66,363,000 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 [2016] 2018 shall include measures of the operational efficiency and impact on fraud, waste, and abuse in the Medicare, Medicaid, and CHIP programs for the funds provided by this appropriation: Provided further, That of the amount provided under this heading, $311,000,000 is provided to meet the terms of section 251(b)(2)(C)(ii) of the Balanced Budget and Emergency Deficit Control Act of 985, as amended, and [$370,000,000] $434,000,000 is additional new budget authority specified for purposes of section 251(b)(2)(C) of such Act. Provided*

*further, That the Secretary shall support the [full cost of the] Senior Medicare Patrol program to combat health care fraud and abuse from the funds provided to this account. (Note.- A full-year 2017 appropriation for this account was not enacted at the time this budget was prepared; therefore, the budget assumes this account is operating under the Further Continuing Appropriations Act, 2017 (P.L. 114-254). The amounts included for 2017 reflect the annualized level provided by the continuing resolution. Department of Health and Human Services Appropriations Act, 2016.)*

**Language Analysis**

| Language Provision | Explanation |
|---|---|
| *In addition to amounts otherwise available for program integrity and program management, [$681,000,000] $751,000,000, to remain available through September 30, [2017] 2019, 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 [$486,120,000] $610,391,000 shall be for Centers for Medicare and Medicaid Services program integrity activities,* | Provides funding for Centers for Medicare and Medicaid Services for program integrity activities. |
| *of which [$67,200,000] $74,246,000 shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act,* | Provides funding for the Office of Inspector General, and limits activities to those authorized under the original HIPAA statute. |
| *and of which [$60,480,000] $66,363,000 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 2018 shall include measures of the operational efficiency and impact on fraud, waste, and abuse in the Medicare, Medicaid, and CHIP programs for the funds provided by this appropriation:* | Specifies reporting requirement. |
| *Provided further, That the Secretary shall support the [full cost of the] Senior Medicare Patrol program to combat health care fraud and abuse from the funds provided to this account.* | Provides funding for the Administration for Community Living to conduct the Senior Medicare Patrol program to combat health care fraud and abuse. Striking the words “full cost” allows the HHS Secretary flexibility to fund SMP through either discretionary or mandatory HCFAC funds”. |

# Health Care Fraud and Abuse Control
## (Dollars in Thousands)

| | FY 2016 Final | FY 2017 Annualized CR | FY 2018 President's Budget | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| *Discretionary* | | | | |
| CMS Program Integrity | $553,320 | $553,320 | $610,391 | $57,071 |
| *Medicare Program Integrity* | *$486,120* | *$486,120* | *N/A* | *N/A* |
| *Medicaid Program Integrity* | *$67,200* | *$67,200* | *N/A* | *N/A* |
| OIG | $67,200 | $67,200 | $74,246 | $7,046 |
| DOJ | $60,480 | $60,480 | $66,363 | $5,883 |
| Subtotal, Discretionary | $681,000 | $681,000 | $751,000 | $70,000 |
| *Mandatory* | | | | |
| CMS Program Integrity | $866,475 | $859,239 | $899,866 | $40,627 |
| FBI | $130,303 | $131,335 | $144,454 | $13,119 |
| OIG | $187,617 | $185,906 | $204,436 | $18,530 |
| DOJ Wedge | $58,579 | $58,045 | $63,831 | $5,786 |
| HHS Wedge | $35,884 | $35,557 | $39,101 | $3,544 |
| Subtotal, Mandatory | $1,278,858 | $1,270,082 | $1,351,688 | $81,606 |
| Total Funding | $1,959,858 | $1,951,082 | $2,102,688 | $151,606 |

Authorizing Legislation – Social Security Act, Title XVIII, Section 1817(k)

FY 2016 Authorization – Public Law 104-191 and Public Law 114-113

Allocation Method – Other

OVERVIEW

Program Description and Accomplishments

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

Since its inception, HCFAC has been financed from the Federal Hospital Insurance Trust Fund, which provides a stable stream of mandatory funds. In FY 2009, discretionary funding was appropriated to increase program integrity efforts and the discretionary appropriation was authorized to be available for obligation over two fiscal years beginning in FY 2010.

In FY 2011, in a show of bipartisan support for combating health care fraud, waste, and abuse, and in recognition that program integrity efforts are paying off, the Budget Control Act of 2011 (BCA) created a discretionary allocation cap adjustment for HCFAC funding for 10 years, from FY 2012 through FY 2021. The passage of the Consolidated and Further Continuing Appropriations Act of FY 2015 was the first time the HCFAC cap adjustment was appropriated.

The budget proposes to continue funding discretionary cap adjustments aligned with the BCA for the Department of Health and Human Services (HHS) and the Department of Justice (DOJ). This level of funding will ensure HHS and the DOJ have the resources that they need to conduct necessary program integrity activities and make certain that the right people, receive the right payment, for the right reason, at the right time. Since its inception in 1997, HCFAC has grown steadily and has returned over $31.0 billion to the Medicare Trust funds. Billions of dollars in savings over the next ten years, from curtailing improper payments can be realized, if consistent, additional funding for program integrity is provided.

Fighting health care fraud is a top priority for the Administration. In particular, CMS has made it a priority to decrease program payment error rates and increase the program integrity return on investment (ROI). The HCFAC account is structured to ensure resources provided to OIG, DOJ, and CMS allow for these entities to coordinate oversight and law enforcement efforts to target bad actors efficiently and effectively. Through collaborations like the Medicare Strike Force teams, all three partners target areas with high incidence of fraud in order to carry out the coordinated effort to reduce fraud and recover taxpayer dollars. CMS's enhanced provider screening and fraud prevention endeavors, the OIG's investigative, audit, evaluation, and data analytic work, and DOJ's investigative and prosecutorial activities and tougher sentencing guidelines. Together, these efforts root out existing fraud and abuse and act as a deterrent for potential future bad actors. This collaboration continues to demonstrate positive results, yielding a $5 to $1 ROI for law enforcement and detection efforts in FY 2016.

The HCFAC cap adjustment provided in the Consolidated Appropriations Act of 2016 (P.L 114-113) allowed HHS and DOJ to enhance existing, successful healthcare fraud prevention and law enforcement efforts by investing more in proven anti-fraud and abuse strategies. These efforts will continue into FY 2018 to strengthen the integrity and sustainability of the Medicare and Medicaid programs by investing in activities to prevent fraud, waste, and abuse and promote high quality and efficient health care.

CMS' approach to program integrity is guided by four major principles:

- Prevention - Increase CMS' capability to stop fraudulent claims before they are paid by enhancing existing processes and increasing predictive analytic capabilities.

- Detection - Foster collaboration with HCFAC partners, including various components of HHS, DOJ, states, and other stakeholders with a shared interest in the integrity of the national health care system.

- Recovery - Identify and recover overpayments. CMS will continue to work with its contractors and partners, including the HHS/OIG, DOJ, state agencies for

survey and certification, and state Medicaid agencies to pursue appropriate corrective actions such as restitution, fines, penalties, damages, and program suspensions or exclusions.

- Transparency and Accountability - Develop and deploy a comprehensive program integrity communication plan to share key messages and information with internal and external stakeholders. Performance measures are also being developed to evaluate operations and outcomes against other CMS reporting activities.

Discretionary funding has allowed HCFAC to expand its activities to include; strengthened program integrity activities in Medicare Advantage (MA) and Medicare Part D, program integrity staffing and support, funding for program integrity initiatives, preventing excessive payments, and program integrity oversight efforts. Discretionary funds allow CMS to make traditional HCFAC actions such as Medical Review and Provider Audits more robust and all encompassing.

Additionally, CMS is committed to fighting fraud, waste, and abuse in the Medicaid program. HCFAC activities associated with Medicaid program integrity work in tandem with the activities of the Medicaid Integrity Program, which is detailed in the State Grants and Demonstrations chapter of this document, to protect Medicaid by improving both Federal oversight and support for program integrity efforts of state Medicaid programs. These activities enhance the Federal-State partnership.

CMS is committed to working with law enforcement partners who take a lead role in investigating and prosecuting alleged fraud. CMS has pursued this through participating in the Medicare Fraud Strike Force teams which investigate and track down individuals and entities that are defrauding Medicare and other government health care programs.

Strike Forces are located in nine areas: Miami, FL; Los Angeles, CA; Detroit, MI; Houston, TX; Brooklyn, NY; Southern Louisiana; Tampa, FL; Chicago, IL; and Dallas, TX. Since their inception in March 2007, Strike Force operations have charged more than 3,018 defendants who collectively falsely billed the Medicare program for more than $10.8 billion. CMS, working in conjunction with HHS/OIG, is taking steps to increase accountability and decrease the presence of fraudulent providers.

In addition, CMS has been working with its private and public partners to build better relationships and increase coordination. The Healthcare Fraud Prevention Partnership, launched in July 2012 by HHS and DOJ, is a collaboration of the Federal government, private health insurers, and other health care and anti-fraud groups and associations to combine the best health care fraud prevention and detection efforts in the public and private arena.

Additional funding for the Health Care Fraud and Abuse Control (HCFAC) program has allowed the Centers for Medicare and Medicaid Services in recent years to shift away from a “pay and chase” model toward identifying and preventing fraudulent or improper payments from being paid in the first place. Additional funding has also allowed CMS to develop and implement activities to prevent and find fraud such as the following:

- Enhanced Provider Screening – Risk-based screening of categories of providers for Parts A and B before enrolling in Medicare.

- National Site Visit Contractor– Focuses on conducting site visits (except for durable medical equipment suppliers) to increase efficiency and standardization of site visits performed in support of various program integrity initiatives.

- Enrollment Revalidation Project – CMS completed the initial revalidation of enrollment for all 1.6 million existing Medicare suppliers and providers, which will be required to revalidate every three to five years.

- Sharing of Information about Terminated Providers – CMS will continue the implementation of a standardized process to support the exchange of information between Medicare, State Medicaid programs, and Children's Health Insurance Program (CHIP) about providers and suppliers terminated for cause from those programs. CMS will also work with states to implement requirements in the 21st Century Cures Act (P.L. 114-255) that increase oversight, reporting, and information sharing regarding termination of Medicaid providers.

- Law Enforcement Access to Data – CMS continues to build the Integrated Data Repository (IDR) to provide a comprehensive view of Medicare and Medicaid data including claims, beneficiary data, provider data and drug information. The IDR is populated with historical Medicare Parts A, B, C and Durable Medical Equipment (DME) paid claims beginning with FY 2006, along with Part D drug events since Part D's inception. Additionally, Medicare Advantage claims processed are now available in the IDR as well as pre-payment claims data for Medicare Parts A, B and DME beginning with FY 2012. In FY 2018, CMS will continue evaluating with business owners the possibility of adding additional Medicaid claims, providers, and beneficiary data to the IDR. The IDR will continue to support its current user base, projects, programs, and any future needs that will be introduced, such as the Medicare Access and CHIP Reauthorization Act (MACRA) needs.

**Funding History**

| Fiscal Year | Budget Authority |
|---|---|
| FY 2014 | $1,557,367,000 |
| FY 2015 | $1,944,738,000 |
| FY 2016 | $1,959,858,000 |
| FY 2017 Annualized CR | $1,951,082,000 |
| FY 2018 President's Budget | $2,102,688,000 |

**Budget Request**

The FY 2018 budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The total FY 2018 request is $2.1 billion, $151.6 million above the FY 2017 Annualized CR Level. The FY 2018 discretionary request is $751.0 million, $70.0 million above the FY 2017 Annualized CR Level, and in line with the incremental increase included in the Budget Control Act (BCA).

MEDICARE INTEGRITY PROGRAM (MIP)

Program Description and Accomplishments

CMS conducts traditional Medicare Integrity Program (MIP) activities such as Medical Review (MR), Benefits Integrity, Medicare Secondary Payer (MSP), Audits, and Provider Education, as well as using innovative approaches to prevent fraud, such as predictive analytics in both claims processing and provider enrollment. These new approaches require the use of in-house personnel, contractors, law enforcement, and auditors to identify, investigate, and prosecute individuals committing fraud, waste, and abuse.

Specific steps CMS is taking with the current legislative authorities and financial resources available include: more stringent scrutiny of applicants seeking to bill the Medicare program, increased collaboration with law enforcement in the application of payment suspensions, enhanced oversight of MA and Part D Prescription Drug Plans (PDPs), and testing new methods to detect and deter potential fraudulent behaviors before and after providers and suppliers are enrolled in the Medicare program.

In FY 2018, the major initiatives CMS will fund under MIP include Provider Audit, Medicare Secondary Payer, Medical Review, Benefits Integrity, Data Matching, Provider Education and Outreach, and Error Rate Measurement. These activities will be discussed in more detail throughout this section.

**CMS Program Integrity Budget Request**

The FY 2018 CMS allocation of the discretionary HCFAC request is $610.3 million. The Budget proposes combining the CMS Medicare and Medicaid HCFAC discretionary amounts into a single program integrity allocation, allowing CMS to fund activities based on emerging needs across all health care programs under CMS' jurisdiction. A table showing this funding by activity can be found at the end of this chapter.

## I. Addressing the Full Spectrum of Waste, Abuse, and Fraud:

CMS uses a multifaceted approach to target all causes of fraud, waste, and abuse that result in improper payments, with a shifting emphasis towards prevention-oriented activities. CMS will broaden the scope of its program integrity activities by increasing its focus on initiatives that expand the prevention and detection of waste and improper payments. CMS has implemented powerful anti-fraud tools and large-scale, innovative improvements to the Medicare program integrity strategy to prevent fraud before it happens. CMS continues to improve its support of, and coordination with, law enforcement by working closely with the Office of Inspector General (OIG), the U.S. Department of Justice (DOJ), and the Federal Bureau of Investigation (FBI), to focus on prevention, early detection, and data sharing, moving beyond the paradigm of pay-and-chase, while continuing an aggressive and robust program of criminal investigation and prosecution.

Program Integrity Staffing and Support: This funding includes staffing for CMS' Central Office and field offices in areas of the country that are highly vulnerable to fraud, waste, and abuse in Medicare and Medicaid. The staff possess the required skills to perform detailed analytic and investigative work, fraud prevention and detection outreach, and policy development relating to all of CMS' program integrity activities. In addition, this funding provides support services for IT infrastructure, data communications, security, and administrative services. The FY 2018 request includes funding for staff to support expansion of existing programs and to develop new initiatives in order to support its mission, goals, and needs in combating fraud and abuse.

Integrity Continuum: The Integrity Continuum improvement activity is part of a CMS effort to define, coordinate, and consolidate activities for providers and suppliers in the Medicare fee-for-service program to improve operational efficiencies and payment accuracy. A key goal of the activity is to reduce provider burden by consolidating provider portal entry points and allowing for visibility into their current and historic billings and CMS audit activities. CMS is also working on a risk initiative and on a more effective use of its contractor resources to gain efficiencies to achieve better outcomes. In FY 2018, CMS will continue to leverage and enhance functionality in existing IT systems by updating additional MAC portals. As a component of the program, analytics will be used to produce public facing information related to market saturation for different service types and to help with provider compliance. Funding will also be used to facilitate CMS' efforts to define the strategic approach and analytic framework for individual provider and supplier risk scoring, develop and validate methodologies for individual provider and supplier types and services, and establish a concept of operations and roadmap to incorporate these methodologies into CMS operations.

Fraud Prevention System (FPS): CMS' sophisticated predictive analytics technology identifies investigative leads to further protect the Medicare and Medicaid programs from inappropriate billing practices. CMS is now working to develop next-generation predictive analytics with a new system design that even further improves the usability and efficiency of the FPS. The FPS 2.0 is being constructed to be even more flexible than before to allow for easy adaptability for the growing complexity to combat fraud, waste and abuse. In FY 2018, through the implementation of FPS 2.0, CMS will expand its current business intelligence capabilities, be able to provide real-time insight into the performance of models and edits, and implement edits that suspend claims for review by audit contractors. CMS also plans to enhance FPS edits, provide more functionality for FPS end users, increase the capacity to utilize advanced graphic capabilities, and expand its operations to bring in required additional data sources (i.e., Medicare Part C and Part D) that will allow the program to have a broader view on fraudulent, wasteful and abusive activities. The system enhancement work includes a web service integration with the Unified Case Management System (UCM) and bringing in much needed data to support edit and model development.

Program Integrity Modeling and Analytics: Program Integrity Modeling and Analytics continues to provide support for the FPS, the National Correct Coding Initiative (NCCI) and analytic investigations to detect and prevent fraud, waste, abuse, improper payments, and support administrative actions. Modeling and Analytic support utilizes rigorous statistical methodologies to identify vulnerabilities that are developed into sophisticated algorithms (models) and edits for deployment in the FPS. The output of the models and edits are used to generate leads to support CMS and its investigative

contractors' administrative actions (i.e., revocations, payment suspensions, deactivations, medical review) and return on investment activities for CMS program integrity efforts. In addition, the modeling and analytic contractor supports data analyses of ad hoc requests for Medicare, Medicaid, and managed care programs. The primary purpose of these efforts is to identify and stop illegitimate payments impacting improper payment rates. In FY 2018, this activity will continue to support the CMS program integrity strategic plan and CMS priorities for modeling and data analytics.

One PI Data Analysis: CMS has built the One PI portal to provide program integrity contractors, law enforcement, and OIG with centralized access to multiple analytical tools and data sources. Through this investment, CMS will continue to train and support a multitude of contractors and law enforcement on the use of these tools and the integrated data repository (IDR) to fight fraud, waste, and abuse. One PI provides access to current and historical Medicare and Medicaid data that is used to develop and refine predictive analytic models prior to integration into FPS.

In FY 2018, One PI will continue to add Medicaid data and enhance the data matching algorithms as needed, add additional data sources (e.g. HIGLAS, Open Payments); continue to enhance provider help desk, training, and data coaching support; develop and support the development of new and enhanced reports on various services; develop dashboards and associated reports for opioids, hospice, and others, and add system functionality to business intelligence tools. CMS is currently in the process of adding a business intelligence tool with geo-mapping capabilities, which is planned to continue into FY 2018. CMS also plans to support enhanced Medi-Medi data ingestion and data matching, development of Unified Case Management (UCM) web service connectivity, training to support the Unified Program Integrity Contractors implementation, and the ingestion of new data sources into the IDR.

Benefits Integrity (BI): Benefit Integrity activities deter and detect Medicare fraud through concerted efforts with CMS, HHS/OIG, DOJ, and other CMS partners. Nearly all of the BI funding is directed to the Zone Program Integrity Contractors (ZPICs) that operate throughout the United States.

In FY 2016, CMS began transitioning from the Zone Program Integrity Contractors (ZPICs) to the Unified Program Integrity Contractors (UPICs). Streamlining to the UPIC initiative will provide benefits that will ultimately enhance CMS' ability to aggressively combat fraud, waste and abuse by consolidating the separate funding sources into a single contract and will allow CMS to look at both Medicare and Medicaid. Benefits resulting from the UPIC strategy include reduced state and provider burden, increased contractor accountability, enhanced data and reporting capabilities, and improved program oversight. The UPIC initiative is the next logical step in the transition to an integrated program integrity strategy and is a key milestone supporting CMS' strategic goal of improving contractor accountability.

The continuum from detection to prosecution of fraudulent activity requires complete coordination among CMS, its contractors and law enforcement partners. CMS and our contractors will continue meeting on a regular basis with the HHS/OIG and DOJ staff to share information on active cases and new leads. CMS participates in fraud task forces, educational sessions and formal meetings to review the status of cases, and discuss identified fraud schemes.

The UPICs will continue to perform data analysis projects and to support immediate and real-time requests for information from the field offices' special projects. CMS has notably strengthened the revocation process by improving the manner in which substantiating documentation is obtained through our field office staff. Moving forward, there will be an increased need for rapid response activities to quickly investigate new leads to further identify and prevent potential fraud.

The UCM will continue to enhance its case management and analytical capabilities for health care fraud detection and prevention, as well as improve integration across the Medicare and Medicaid programs. The UCM went live in FY 2016 with both Medicare and Medicaid functionality, and the Mid-West UPIC was the first to receive training on the system. In FY 2018, system development, integration, and testing will continue, as well as beginning legacy data migration activities. This will allow CMS to provide more comprehensive, timely, and accurate health care fraud prevention modeling and reporting. Plans are still in place to replace the Fraud Investigation Database (FID) and Work Flow Management System (WFMS). Additionally, alerts sent to the ZPICs/UPICs will be linked to the Compromised Numbers Checklist (CNC), Provider Exclusion Databases, and several other useful tools. Emphasis will be placed on "boots on the ground" initiatives such as on-site visits and beneficiary and provider interviews which will help lead to accelerated administrative action.

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 appropriate conditions. Complex medical review is conducted on less than one percent of claims to confirm that services and items rendered are reasonable, necessary, and comply with all Medicare coding and documentation requirements. CMS conducts pre-payment medical reviews to prevent improper payments from being made and post-payment review to recover improper payments. Both types of medical reviews help reduce the Medicare fee-for-service error rate. CMS also conducts accuracy reviews, prior authorizations, and tasks performed by the Supplemental Medical Review Contractor (SMRC), which provides support for a variety of tasks and lowers the improper payment rate by enhancing medical review efficiencies. These tasks are national in scope and are often driven by recommendations from the Office of Inspector General.

HHS plans to continue the use of prior authorization in the Medicare FFS program for durable medical equipment prosthetics orthotics and supplies (DMEPOS) items and in other high improper payment rate areas through models and demonstrations as appropriate. In FY 2017, CMS plans to implement the program with one or two items while also maintaining the same level of prepayment review currently conducted for DMEPOS items. This is important because it will allow the MACs to stop prepayment review on areas requiring prior authorization and shift those efforts to other claim types that are contributing to the high DMEPOS error rate. During the past few years, CMS has increased its use of a probe and educate process aimed at completing a small sample of reviews and then offering individualized education as appropriate. CMS used a probe and educate process for all inpatient facilities for short stay inpatient claims and believes this process (along with the revised Two Midnight policy) helped see significant decreases to the error rate for short stay inpatient claims. CMS is also using this probe and educate process for home health claims and plans to continue this effort as appropriate.

In FY 2018, CMS plans to continue a series of activities aimed at decreasing appeals, reducing provider burden, and lowering the error rate. These include the creation of Provider Compliance Tips for providers to use so that they understand the Medicare requirements for payment of the claim, the creation of medical review guidelines so that Medicare contractors all have the same interpretation of CMS statutes, regulations, and manuals in an effort to separate documentation requirements from conditions of coverage and payment as appropriate. This last effort is commonly known as the Documentation Improvement project and is one that CMS is embarking on in an agency wide effort to reduce documentation requirements where possible, in an effort to decrease appeals and reduce provider burden. CMS also plans to continue its efforts to create electronic templates for areas with a high denial rate to better prompt the physician as to what documentation needs to be entered into an electronic health record during a patient visit.

Provider Audit: Auditing is one of CMS' primary instruments to safeguard payments made to institutional providers, such as hospitals, who are paid on an interim basis and whose costs are settled through the submission of an annual Medicare cost report. CMS plans to continue to enhance the cost report audit process and improve overall program integrity. In FY 2018, CMS plans to continue efforts to increase training at the MAC's, and has already initiated design sessions on cost report risk assessment strategies within CMS. This work will enable CMS and the MACs to reduce the number of appeals that are currently in process, and will increase the number of audits to be completed each year, thus increasing return on investment.

Medicare Secondary Payer (MSP): MSP efforts help to make sure that the appropriate primary payer makes payment for health care services for beneficiaries. The MSP program collects timely and accurate information on situations where Medicare is secondary to other payers to make sure that Medicare only pays for those claims where it has primary responsibility for payment of health care services. When mistaken Medicare primary payments are identified and when Medicare has made payments conditioned upon repayment, recovery actions are undertaken.

The Commercial Repayment Center (CRC) workload was recently expanded to include the recovery of certain conditional payments where either a liability insurer, no-fault insurer, or workers' compensation entity had or has primary payment responsibility. The CRC recovers directly from the applicable plan as the identified debtor when the applicable plan reports that it has ongoing responsibility for medicals, or otherwise notifies CMS of its primary payment responsibility. MSP also consolidated a substantial portion of Coordination of Benefits and Recovery (COB&R) systems to enhance customer service and will continue to expand self-service functions of the COB&R web portal.

Medicare-Medicaid Data Match Project (Medi-Medi): Authorized by the Deficit Reduction Act (DRA) of 2005, Medi-Medi is a voluntary partnership between CMS and participating states where data is collected, matched, and analyzed from both the Medicare and Medicaid programs with the intent of detecting potential fraud, waste and abuse. The Medicare and Medicaid programs share many common beneficiaries and providers. Matching claims from both programs help identify billing patterns that might be indicative of potential fraud, waste, and abuse and could otherwise go undetected if viewed in isolation. Accordingly, analysis performed in the Medi-Medi program can reveal trends that are not evident in claims data from each program alone, thereby, making the Medi-Medi program an important tool in identifying and preventing fraud. CMS is continuing the process of developing and operationalizing updated comprehensive strategies for the

Medi-Medi program with a focus on encouraging state participation. Currently, there are 18 states participating in the Medi-Medi program. Through these enhanced strategies, CMS plans to reduce provider and state audit burden, and establish enhanced collaboration between Medicare and Medicaid.

Appeals Initiatives: Appeals Initiatives are critical to the CMS' program integrity efforts. CMS's Qualified Independent Contractors (QICs) are responsible for performing second level appeals (reconsiderations) for Medicare fee-for-service (FFS) Parts A and B claims. In FY 2016, CMS increased the volume of Administrative Law Judge (ALJ) cases in which the QICs are able to participate as a party from approximately 800 per year to 2,500 per year. Participation as a party affords the QIC additional rights to successfully defend a claim denial (i.e., the ability to call witness, provide testimony and evidence, etc.) CMS anticipates that by invoking party status in more hearings, the QICs will reduce the ALJ reversal rate and lower Medicare Trust Fund expenditures. FY 2018 funds will support continued activities and efforts in QIC participations.

Administration for Community Living (ACL) Senior Medicare Patrols (SMPs): The mission of the SMP program is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education. In FY 2016, funding was used to provide 53 grants to states and territories to implement the Senior Medicare Patrol (SMP) program. The SMP program has saved the government over $124.6 million dollars since 1997 and annually meets with more than a million people through outreach and education. The Consolidated Appropriations Act of 2016 required the SMP program to by fully funded from the HCFAC discretionary account. In FY 2018, CMS plans to continue to support the SMP program and is requesting to change the appropriations language to provide the Secretary of HHS with greater flexibility in determining the funding amount and sources of funding (e.g. HCFAC mandatory or discretionary account) that this activity can be funded from.

## II. Proactively Manage Provider Screening

CMS proactively manages provider screening and enrollment so that only eligible providers are caring for beneficiaries and receiving payment from CMS programs. This objective focuses on the operations of conducting Medicare and Medicaid screening and enrollment in ways that are efficient and effective and that minimize provider burden. CMS will focus on initiatives related to eligibility for enrollment which requires Medicare and Medicaid providers and suppliers to undergo screening, including enhanced screening for certain high-risk providers and suppliers, and taking action to revoke or deny the enrollment of providers ineligible to participate.

Advanced Provider Screening (APS): The APS automatically screens all current and prospective providers against a number of data sources, including provider licensing and criminal records. APS also identifies and highlights potential program integrity issues that are investigated proactively by CMS. In FY 2018, the APS will continue to grow the number of reference data sources used to validate information, as well as increase connectivity and integration with state and other program integrity systems. In addition, APS will work to obtain the Medicaid provider information captured in the UPIC/ZPIC data warehouses.

Provider Enrollment, Chain and Ownership System (PECOS): PECOS is the national enrollment system for Medicare providers and suppliers. PECOS centralizes the enrollment data collected from enrollment forms into one system and is used by Medicare contractors to enter, update, and review data submitted online or via paper applications. Medicare providers and suppliers may also use PECOS to view and update their existing information. Increased funding in this category will be used to enhance the functionality to align with regulations and agency needs; and provide training to the Medicare contractors and the provider and supplier community. In addition, the consolidation and redesign of enrollment forms and PECOS enhancements will streamline the enrollment process, reduce the amount of paperwork processed, and provide clearer guidance to providers on what they need to submit.

Based on current trends, CMS is expecting an increase of initial online Medicare enrollment from the FY 2016 level of 38 percent to a level of 45 percent by the end of FY 2017. The PECOS provider enrollment interface will be dramatically improved to a more user centric platform focused on users that maintain the information, rather than just the providers. It will also be accompanied by reducing redundancy in data entry, and improving administrative processing of online applications to ensure online enrollment is significantly faster than submitting standard paper applications. In FY 2016, a new address validation tool was implemented in PECOS to flag Commercial Mail Receiving Agencies (CMRA), and invalid or vacant addresses. This enhanced address verification software in PECOS is used to better detect vacant or invalid addresses or CMRAs and to strengthen provider enrollment screening. As a result of this enhancement, CMS was able to prevent more than 900 CMRAs from entering the Medicare program. In FY 2017, CMS will continue its efforts to integrate PECOS with APS, modify the enrollment report for state users, enhance site visit logic and migrate site visit pictures into PECOS. Design, prototype, and development of the new version of PECOS will begin in FY 2017 and continue into FY 2018. Beyond the core needs around data accessibility, reduction to provider burden, and the need for increased operational efficiency, the new version of the enrollment system will support agency initiatives toward expansion of alternate payer models, increased alignment between Medicare and Medicaid, and enhanced Part C and D oversight – all of which is not possible without redesign. CMS will also provide technical assistance with individual states to assess provider screening and enrollment activities currently underway.

## III. Continue to Build States Capacity to Protect Medicaid

CMS assists states in building their internal capacity to conduct program integrity activities for Medicaid. CMS provides education, training, technical assistance, and forums to share best practices and lessons learned. Through reviews of state processes and procedures, CMS identifies areas of improvement and works with the states to make their program integrity activities robust.

State Medicaid Agency Access to Data and Support: Activities requested under this umbrella include the Medicaid Enterprise System (MES), Medicaid and CHIP Business Information Solutions (MACBIS) related to program integrity, and technical assistance to states initiatives.

In FY 2018, the MES will continue to support states with technical assistance to ensure that the design and implementation of changes associated with new eligibility and

enrollment requirements meet certain standards and conditions, as defined by CMS to achieve enterprise-wide efficiency and economy. This includes independent technical assistance for IT and policy requirements, including monitoring and oversight, in working with state-specific system requirements, IT system builds, and associated interfaces for all states and the territories. In FY 2016, all 50 states and territories received technical assistance with moving through the Enterprise Life Cycle (ELC) Gate Review Process, including any associated costs. Technical artifacts required by statute were analyzed and tracked to assess state progress. Gap analyses were done on a regular basis and risk registers studied to identify opportunities for improvement. In addition, numerous tasks as part of this effort are geared toward achieving reduction in fraud, waste, and abuse and reduction of cost of these Medicaid Management Information Systems. One such effort includes the development of an open source provider enrollment and screening module that will be able to be reused and shared by any state and integrated into its MMIS. This could potentially save CMS at least 75 percent of the average cost to procure enrollment and screening modules per state.

In FY 2018, MACBIS funding will be used to collect program data and tie it to operations data, improving visibility into potential fraud, waste, abuse, and trends analysis. In FY 2017, Medicaid program integrity resources contributed to system enhancements for two key Medicaid and CHIP systems – the Medicaid and CHIP Program (MACPro) Portal and the Transformed-Medicaid and Statistical Information (T-MSIS).

CMS continued work on the Medicaid and CHIP Program (MACPro) Portal, which allows CMS and states to collaborate online to process State Plan Amendments (SPA), waivers, Quality Measure reports, demonstrations, advance planning documents, and other initiatives. MACPro implemented two Medicaid and CHIP authorities covering functionality for state quality measure reporting and Home Health State Plan Amendments (SPAs). These authorities improve state reporting and federal review processes, program management, and transparency for adult and child quality measures and automated reporting for home health SPAs. Data from these home health SPAs and adult and child quality measures will be available to be associated with operational data for improving visibility into potential fraud, waste, and abuse and for performing trend analysis.

Second, CMS continued work on the Transformed-Medicaid and Statistical Information (T-MSIS), which modernizes and enhances the way states submit operational data about beneficiaries, providers, claims, and encounters for purposes of evaluation, research, and investigation. T-MSIS completed the system build to accept the submission of all Medicaid and CHIP agencies enrollment, eligibility, claims, and encounter data. Most states are actively working to submit new operational data (T-MSIS). As of April 2017, there were 33 states and 1 CHIP agency in production with T-MSIS. CMS is estimating that 41 states will be in production and current by September 30, 2017. CMS began using states' T-MSIS data for program integrity reviews in FY 2016. CMS is also working on system builds to make the data more readily accessible for use by various partners.

In addition to MACPro and TMSIS, CMS plans to increase control over the Medicaid Drug Rebate Program by enhancing the current redesign of the outdated drug systems, conducting a survey of wholesalers and manufacturers to verify Average Manufacturer Price and Best Price to provide analyses of the data generated against FDA data to

determine discrepancies, and resume an alternative dispute resolution process that provides facilitation and mediation assistance to manufacturers and states when Medicaid drug rebate amounts are in dispute.

In FY 2018, CMS also plans to conduct voluntary collaborative site visits to provide state technical assistance regarding legislative or regulatory requirements such as electronic visit verification (EVV), beneficiary eligibility, and managed care associated with the implementation of Section 12006 in the 21st Century Cures Act.

Monitoring and Oversight of State Actions and Outcomes Modernization:

In late FY 2015, CMS began a pilot effort to improve monitoring and oversight that included adding staff to better support federal and state monitoring and oversight of section 1115 demonstrations. Over the course of the last twenty years there has been a significant increase in the volume and scope of Medicaid section 1115 demonstrations to the point where three-quarters of states now operate at least one demonstration, and a growing number of states operate most or all of their Medicaid programs under section 1115 authority. The new staff allowed CMS to build program expertise in specific section 1115 demonstration areas such as service delivery reform and Medicaid expansion, and to focus more intensely on monitoring and oversight of finances under section 1115 demonstrations in order to address our fiduciary obligations and ensure that appropriate controls and beneficiary protections are being carried out. This better equips CMS to ensure that these demonstrations are in compliance with federal requirements and that outcomes align with the level of federal investment in these programs. In FY 2018, CMS will continue developing a targeted and risk-based assessment strategy and related protocols for the selection, conduct, and reporting of Medicaid Section 1115 demonstration site visits.

In FY 2018, CMS is proposing to expand on existing efforts and re-engineer its approach to monitoring and oversight of the Medicaid and CHIP programs generally, to include State Plan Amendments, 1915 waivers, and 1115 demonstrations. CMS plans to modernize monitoring and oversight activities, including enhanced reviews of compliance with program requirements, additional assessments of system performance, and improved financial oversight.

Medicaid Financial Management and Oversight Program: This program enhances the Medicaid financial management review processes and was designed in an effort to improve “up front” technical assistance to better ensure that states were making proper claims for federal dollars and to minimize post-payment recoveries. In FY 2018, CMS plans to conduct the following activities: identification and resolution of Medicaid financing issues, review of budget and expenditure reports, review of reimbursement proposals, and technical assistance in resolution of outside agency audit findings. Conducting this work will ensure that federal dollars are only used for allowable Medicaid services and activities. At the end of FY 2016, CMS assisted in the removal of an estimated $608 million (with approximately $230 million recovered and $378 million resolved) of approximately $8 billion identified in questionable Medicaid costs. Furthermore, an estimated $666 million in questionable reimbursement was actually averted due to this preventative work with states to promote proper state Medicaid financing methods. This activity is also currently supported from HCFAC Wedge funding discussed at the end of this chapter.

## IV. Extend Work in Medicare Parts C and D, and Medicaid Managed Care

CMS is committed to expanding its program integrity activities in capitated, managed care programs in Medicare and Medicaid. Medicaid spending for managed care increased 41 percent between FY 2011 and FY 2013 and enrollment in Medicaid managed care has grown at a rate of more than 8 percent per year, on average, since 2006. CMS expects Medicaid managed care enrollment to continue to grow. CMS is currently in the planning phase to offer states the option to introduce Risk Adjustment Data Validation (RADV) like audits to the Medicaid Recovery Audit Contractors (RACs). In addition, CMS has strengthened oversight of Medicaid expenditures by working with state partners to improve financial accountability for managed care and fee-for-service provider rate setting, accuracy of state claiming, beneficiary and provider eligibility processes, and has conducted oversight of Medicare Part D plan sponsors by conducting audits that detect whether plans are delivering the appropriate healthcare services and medications for which they are being paid. CMS provides oversight of Medicare Part C by engaging in Risk Adjustment Data Validation (RADV) activities that measure the extent to which inaccurate diagnosis codes impact payment for MA beneficiaries.

Medicare Drug Integrity Contractor (MEDICs): CMS has a fiduciary responsibility to safeguard the Medicare Part C and Part D programs and the Medicare Trust Fund from fraud, waste and abuse. In FY 2016, CMS recovered $78 million as a result of Part D data analysis projects and $6.2 million from Part D plan self-audits. Additionally, the MEDIC made referrals to law enforcement that resulted in court ordered restitution, forfeitures, fines or civil settlements totaling approximately $3.5 million related to Part C investigations and $100.1 million related to Part D investigations. In FY 2018, CMS will maintain the current state of audits and investigations.

Part C and D Contract/Plan Oversight: CMS will continue its comprehensive oversight efforts to assess whether an entity is qualified to contract with Medicare. CMS determines the qualifications of an entity through the Health Plan Management System (HPMS). HPMS is a web-enabled information system that supports the ongoing business operations of the Medicare Advantage (MA) and Part D programs. HPMS software modules collect data and manage a number of MA and Part D plan enrollment and compliance processes.

CMS will also continue its efforts to proactively monitor and oversee Part C and D contracts. Areas of assessment will include formulary and benefits, MA and Prescription Drug Plan (PDP) reasons for disenrollment, monitoring of plan websites for adherence to marketing guidelines, pharmacy network adequacy, and adherence to medication therapy management requirements. The MA and PDP reasons for disenrollment survey will help CMS identify possible issues that plans are facing, help inform CMS about beneficiary choice of plans, and help drive quality improvement among plans. In addition to continuing survey administration, CMS will continue to post these data on Medicare Plan Finder and produce plan-specific reports for quality improvement.

CMS will continue to enhance HPMS' support of Parts C and D contract plan compliance programs. CMS will move forward with additional releases of the Network Management Module (NMM) to support a wide array of network reviews, such as ongoing analysis of networks used by all renewing organizations and specialized analysis for networks supporting the financial alignment demonstrations, including Medicaid providers. CMS will also implement continued enhancements to the

redesigned audit functionality in HPMS, including expanding overall reporting and extracting capabilities, and supporting iterative corrective action plan (CAP) process. Other enhancements include integrating the review protocols for other types of plans, including the Program for All-Inclusive Care of the Elderly (PACE) and financial alignment demonstration programs.

Additionally, CMS plans to focus on improving the quality of supplemental file submissions for formularies. This focus ensures better coordination of the supplemental files with the main formulary file, enhancing quantity limit validations, and exploring changes to the tier structures. As for the Plan Management Dashboard, CMS will pursue the enhancement of improved key performance indicators and expansion of the new Audit Dashboard to include visual and graphic displays of data. CMS will continue to use a support contract to provide technical and analytic assistance with benefit review for about 3,600 plans and 18.5 million enrollees.

Monitoring, Performance Assessment, and Surveillance: Under this section, technical, clinical, compliance and enforcement audit support is provided to assist CMS in conducting MA and Part D audits. More specifically, experts conduct program audits to ensure a sponsor's readiness to participate in the MA and Part D programs, and conduct compliance program effectiveness audits for parent organizations.

In FY 2018, funding will continue to be used to monitor Parts C and D reporting requirement data submission, prepare and analyze submitted data, create Public Use Files (PUF), and conduct Disenrollment Reasons Survey. CMS uses this data and the analytical support to monitor and measure compliance of Medicare Advantage Organizations (MAOs) and Part D sponsors with federal regulations, to ensure that Medicare beneficiaries have access to information about their health and drug plans, and to ensure that beneficiaries are provided with timely, safe, high quality and effective care. This data is also used in the Star Ratings that impact Part C payments and participation in both the Part C and D programs.

Additionally, CMS conducts program audits that test a variety of core MA, Part D and PACE program functions to determine whether sponsors provided beneficiaries with the services and medication as required under their contract with CMS. The goal of CMS' audit program not only ensures that our beneficiaries are receiving the services and medications they need and are entitled to receive under the program, but also to drive the industry towards improvements in the delivery of health services in the MA, Part D and PACE programs.

In an effort to ensure accurate payment, CMS has enlisted the help of a reconciliation support contractor to analyze Part D reconciliation calculations, which helps CMS to understand plan impacts to Part D payments. Through the contractor, CMS will continue to review the direct and indirect remuneration (DIR) data submitted by the Part D sponsors. CMS will work with the Part D sponsors to help ensure that the DIR data factored into the final Part D payment reconciliation is accurate. CMS also receives, tracks, and analyzes issues raised by plans with respect to reconciliation after its completion, including appeals. This contractor supports our effort to collect Part D overpayments in accordance with section 1128J (d) of the Social Security Act entitled "Reporting and Returning of Overpayments", and also analyzes Prescription Drug Event (PDE) data and other relevant payment information to support correct Part D payment. CMS is anticipating an increase in the volume of data analysis, which requires

overpayment analysis and analyses associated with direct and indirect remuneration (DIR), a factor in the Part D reconciliations. CMS is also projecting increases in the number of PDE's, PDE's with coverage gap discount amounts, and PDE's that need to be identified to be withheld from the Medicare Coverage Gap Discount Program (CGDP) quarterly invoice process and additional validation and analysis. This translates into an increase in the number of correctable PDEs and more time assisting with upheld dispute tracking.

The agency launched the Encounter Data Processing System (EDPS) to collect encounter data that detail each item and service provided to enrollees of MA organizations. This information is comparable to the data collected on a Fee-For-Service (FFS) claim. With encounter data, CMS will have a much more detailed and comprehensive profile of the health care services provided to MA enrollees and CMS will be able to more accurately make risk adjusted capitated payments. CMS is now in the fifth year of data collection and is increasing efforts to analyze the data to ensure it is complete and accurate for program use. Specifically, the encounter data will enable CMS to pay more accurately because the MA risk adjustment model will be calibrated on MA diagnosis and cost data, and inform MA oversight, program integrity and compliance. This will allow CMS to analyze, compare and better manage the health care being provided to beneficiaries in both MA and FFS.

Recently, CMS began collecting Medical Loss Ratio (MLR) data for both Part C and Part D, which provides new information about MA organizations and their revenue profile. MLR supporting data are submitted annually by MA organizations and Part D sponsors. If the MA organization/Part D sponsor does not meet the MLR requirement, they will be subject to penalties such as: payment remittance, suspension from enrolling new beneficiaries, or termination of the plan. This data is validated by CMS to check for incorrect reporting, to verify whether or not the MLR percentage requirement is met by the MA organization/Part D sponsor, and for determining the appropriate penalty for failing to meet the requirements.

Program Audit: Sections 1857 (d)(1) and 1860D-12 (b)(3)(C) of the Social Security Act require the Secretary to provide for the annual audit of financial records (including data relating to Medicare utilization, costs, and computation of the bids) of at least one-third of the MAOs and PDPs offering plans. These audits enable CMS to review and assess previously submitted information to ensure compliance with program requirements.

Auditors review costs associated with the MA and PDPs, identify internal control deficiencies, and make recommendations for compliance with Medicare regulations and accurate reporting to CMS. Some of the specific areas of review include plans' solvency; related party transactions; administrative costs; direct medical costs; and Part D costs and payments, including direct and indirect remuneration and true out-of-pocket costs. To meet the one-third audit requirement, CMS conducts approximately 250 audits of MAOs and Part D sponsors per year.

CMS also engages in Risk Adjustment Data Validation (RADV) activities that measure the extent to which inaccurate diagnosis codes impact payment for MA beneficiaries. CMS reviews medical record documentation provided by each audited Medicare Advantage organization to substantiate conditions reported by the Medicare Advantage organizations for beneficiaries in each audit sample.

CMS conducts two major types of RADV projects, the National RADV activities and contract-level audits. The National RADV activities are used to compute an error estimate for the Medicare Part C Program to comply with program reporting requirements set forth in the Improper Payments Information Act of 2002 (IPIA), as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA). The contract-level audits are used to calculate an error estimate for specific MA contracts and to make payment adjustments to recover amounts paid to MA organizations for unsupported diagnosis data. These contract-level RADV audits are CMS' primary corrective action to recoup improper payments. CMS intends to conduct at least 60 audits in FY 2018, which is consistent with the number of audits planned in FY 2017. A sentinel effect on the quality of risk adjustment data submitted for payment has been observed as MA organizations recognize the potential financial impact of the audits.

Compliance and Enforcement: CMS provides compliance training, technical assistance, education, and outreach to the managed care industry, MAOs, PDPs, and audit assistance contractors. These training, education, and outreach models extend to internal and external stakeholders via webinars, compliance conferences, and on-line training sessions.

In addition, IT infrastructure plays a large role in supporting CMS' efforts of compliance and enforcement to safeguard the Trust Funds. For example, the Risk Adjustment System produces the risk adjustment scores to calculate beneficiary level payments. The Risk Adjustment System plays a key role in recovering overpayments owed by the plans and the recalculation of prior year risk scores allows CMS to take back funds returned by plans for prior years. CMS recalculates prior year risk scores each year.

The Medicare Advantage Prescription Drug (MARx) application is the enterprise system of record supporting daily nationwide operations of the Medicare MA and Part D programs. MARx primary system functions include processing transactions for enrollment/disenrollment of Medicare beneficiaries into/from MA and Part D health plans, and calculating monthly capitated payments to MA and Part D plans.

The implementation of the Managed Care Payment Validation Contractor is another measure CMS instituted to ensure the accuracy of payments to MAOs and PDPs. The contractor processes retroactive requests in accordance with CMS guidelines that reinforce the requirement for MAOs and Part D plans to adhere to CMS policies and procedures and improves payment accuracy. The data analysis conducted by the contractor allows CMS to take proactive measures to address vulnerabilities affecting payment accuracy and the implementation of other Parts C and D programmatic requirements. Furthermore, the information provided by the contractor assists the Regional Office Account Managers with their monitoring and oversight responsibilities.

The Marketing Material Accuracy, Review and Analysis - 42 CFR Section 422.111(b)(3) requires plans to disclose the number, mix and distribution of providers from whom enrollees may reasonably be expected to obtain services. MAOs are expected to update online provider directory information in real-time and provide complete information regarding providers who are accepting new patients/enrollees. Medicare beneficiaries rely on the accuracy of such information to select and access contracted providers, and often rely on this information to select a plan. This funding supports CMS' analyses of beneficiary marketing requirements against required documents like provider directories,

and may result in identifying areas of potential non-compliance, in which CMS may take compliance actions. These activities increase CMS' ability to: correlate inaccurate provider directories as an indicator of provider network inadequacy; better understand existing marketing practices of MA and Part D; and strengthen the empirical basis upon which we administer the MA and Part D programs.

## V. Provide Greater Transparency into Program Integrity Issues

CMS is dedicated to providing greater transparency to our stakeholders allowing them to better understand program integrity issues through education, outreach, partnership, measuring error rates, strategic communications, and data releases. CMS is well positioned to work with its partners and stakeholders to share best practices and lessons learned in program integrity. Linking financial, programmatic, and performance data helps provide an unprecedented level of transparency and accountability and upholds program efficiency and effectiveness. HHS regularly shares its findings with its partners, stakeholders, and the public.

Provider Outreach and Education (POE): POE funding is used by the Medicare FFS claims processing contractors (MACs, fiscal intermediaries and carriers) to educate Medicare providers and their staff about the fundamentals of the Medicare program, national and local policies and procedures, new Medicare initiatives, significant changes to the Medicare program, and issues identified through analyses of such mechanisms as provider inquiries, claim submission errors, medical review data, Comprehensive Error Rate Testing (CERT) data and Recovery Audit Contractor data. The primary goal of the POE program is to reduce the CERT error rate, while reducing provider burden, by giving Medicare providers timely and accurate information that enables correct billing of Medicare claims. Medicare contractors utilize a variety of strategies and methods to offer Medicare providers a broad spectrum of information about the Medicare program through a variety of communication channels and mechanisms such as educational events and webinars.

Outreach and education funding will also support the development and dissemination of educational information on policy and operations related to CMS' program integrity initiatives. These initiatives include CMS' efforts to curtail emerging fraud schemes and creating awareness and adherence to existing and new program integrity policies and regulations. Education and outreach to providers, beneficiaries, partners, and stakeholders are an essential element to the success of program integrity.

Healthcare Fraud Prevention Partnership (HFPP): The mission of the HFPP is to exchange data and information between partners to help improve capabilities to detect and combat fraud, waste and abuse. These exchanges of data and information take the form of targeted data exchange studies and include partnerships with HHS/OIG, DOJ, FBI, private health insurance companies, and anti-fraud groups and associations.

CMS employs a Trusted Third Party (TTP) contractor to perform duties associated with running joint public-private data analytics in a secure environment. The HFPP utilizes a secure portal, which provides partners enhanced security for HFPP study-data and additional collaboration capabilities. Products and communications materials will continue to be added to this portal throughout FY 2017 and FY 2018. Additionally, CMS will continue to invest in analytic capabilities specific to HFPP data, ensuring that CMS

both contributes effectively to the partnership and can act on HFPP data as a participating entity to realize cost savings. Funding represents the estimated cost of maintaining and expanding the partnership, maintaining systems in place to support the partnership, and continuing to expand fraud prevention and detection capabilities through public and private sector data exchanges.

Open Payments: Open Payments is a transparency program that is intended to help consumers make informed decisions about their treatment based on knowledge of the financial relationships that physicians or teaching hospitals have with manufacturers. The Open Payments website supports both manufacturers and physicians in registration, data submission, and with data review and dispute. Additionally, the Open Payments website supports public access of all reported payments or transfers of value made to physicians and teaching hospitals. CMS monitors and validates the data prior to public posting. This verifies the accuracy of the data and ensures that each payment is matched to the correct covered recipient (physician or teaching hospital).

The ongoing operations of the program will require funding for system operations, ongoing data validation, auditing and enforcement strategy and analytics support. Communications, outreach and education are also vital to this program as there are millions of potential users of the system who must be educated about the program and rules of participation. CMS may audit and impose civil monetary penalties for non-compliance with reporting requirements. This funding will be used to develop, implement, and support an Open Payments compliance strategy. Funds will also be used to make enhancements to the Open Payments data on the public display website to encourage use by the general public and stakeholders. As the data grows and awareness of the availability of the data increases, the Open Payments data will need to be more accessible and user-friendly.

Error Rate Measurement Activities: CMS is required to measure improper payments in order to comply with the *Improper Payment Information Act of 2002*, as amended by the *Improper Payments Elimination and Recovery Act of 2010* and the *Improper Payments Elimination and Recovery Improvement Act of 2012*. CMS measures Medicare, Medicaid, and Children Health Insurance Program (CHIP) improper payments through its improper payment measurement programs, which include the Comprehensive Error Rate Testing (CERT) program, Part C and Part D Error Rate measurement programs, and the Payment Error Rate Measurement (PERM) program. In FY 2018, the CERT and PERM programs will continue to produce improper payment rates for Medicare Fee-For-Service (FFS) and Medicaid/CHIP, respectively. CMS continues to evaluate the programs' measurements for accuracy and identify vulnerabilities in Medicare FFS and Medicaid/CHIP that require focused corrective actions. CMS will also continue to engage in program integrity activities by measuring and reporting annual payment error estimates for both Medicare Part C and Part D.

## 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 agencies such as HHS/OIG, the FDA, the DEA, the Defense Criminal

Investigative Service, the Office of Personnel Management-OIG, the Internal Revenue Service-CI, State Medicaid Fraud Control Units, and other state and local agencies. On the private side, the FBI is actively involved in the Healthcare Fraud Prevention Partnership, an effort to exchange facts and information between the public and private sectors in order to reduce the prevalence of health care fraud. These efforts will enable members to share successful anti-fraud practices and effective methodologies and strategies for detecting and preventing health care fraud. In addition, the FBI maintains significant liaison with private insurance national groups, such as the National Health Care Anti-Fraud Association, the National Insurance Crime Bureau, private insurance investigative units, and other professional associations.

In FY 2016, the FBI initiated 624 new health care fraud investigations and had 2,822 pending investigations. Investigative efforts produced 637 criminal health care fraud convictions and 892 indictments and informations. In addition, investigative efforts resulted in over 555 operational disruptions of criminal fraud organizations and the dismantlement of the criminal hierarchy of more than 128 health care fraud criminal enterprises.

**FBI Budget Request**

The FY 2018 FBI budget includes mandatory funding in the amount of $144.4 million, an increase of $13.1 million above the FY 2017 Annualized CR Level. The mandatory increase reflects an estimated inflationary adjustment based on Consumer Price Index-Urban (CPI-U) Annual Averages and Percent Change.

HHS OFFICE OF INSPECTOR GENERAL (OIG)

Program Description and Accomplishments

HHS/OIG uses HCFAC funding to conduct oversight of the Medicare and Medicaid programs. This includes holding individuals and corporations that engage in health-care-related offenses accountable through criminal and civil actions, while providing recommendations for improving the health care system to HHS policymakers, program officials, and Congress. In FY 2016, OIG's Medicare and Medicaid oversight efforts resulted in 765 criminal actions and 690 civil actions, which include false claims and unjust-enrichment lawsuits filed in Federal district court, civil monetary penalties (CMP) settlements and administrative recoveries related to provider self-disclosure matters. In addition, HHS/OIG excluded a total of 3,635 individuals and entities from participation in Federal health care programs. For FY 2016, potential savings from legislative and administrative actions that were supported by HHS/OIG recommendations were estimated by third parties, such as the Congressional Budget Office or actuaries within HHS, to be $21.0 billion in Medicare savings and $1.1 billion in savings to the Federal share of Medicaid.

**OIG Budget Request**

The FY 2018 OIG budget includes $204.4 million in mandatory funding. The FY 2018 discretionary request is $74.2 million, which represents an increase of $7.0 million above the FY 2017 Annualized CR Level.

DEPARTMENT OF JUSTICE (DOJ)

Program Description and Accomplishments

The DOJ's litigating components (United States Attorneys, Criminal Division, Civil Division, and Civil Rights Division) are allocated HCFAC program funds to support civil and criminal health care fraud and abuse investigation and litigation. These offices dedicate substantial resources to combating health care fraud and abuse. HCFAC funding supplements those resources by providing dedicated positions for attorneys, paralegals, auditors and investigators, as well as funds for litigation of resource-intensive health care fraud cases.

**DOJ Budget Request**

The FY 2018 DOJ budget estimate includes $63.8 million in mandatory funding, which is subject to agreement between the Secretary of HHS and the Attorney General. Decisions on how this money will be allocated will not be determined until after HHS and DOJ complete negotiations. The DOJ discretionary request for FY 2018 is $66.3 million, which represents an increase of $5.8 million above the FY 2017 Annualized CR Level.

HHS WEDGE FUNDING

Program Description and Accomplishments

In addition to MIP, CMS also uses resources from the wedge funds to carry out fraud and abuse activities. Decisions about wedge funding levels for DOJ and the HHS agencies are made by agreement between the Attorney General and the Secretary of HHS. For FY 2017, negotiated amounts were $35.6 million for distribution among HHS components and $58.0 million for DOJ. CMS anticipates the continued development of a number of Medicare and crosscutting fraud and abuse projects using HCFAC funding. The HHS portion of the wedge awards funded the following activities during FY 2017:

Medicaid Financial Management and Oversight Program: Described in greater detail above, funding specialists work in the field to review proposed Medicaid State Plan reimbursement amendments, develop financial management reviews, research state Medicaid financing policy and practices, and promote proper state Medicaid financing methods prior to implementation.

CMS Marketplace Program Integrity: The HCFAC Wedge supports a variety of pilot program integrity efforts in the Health Insurance Marketplaces. Specifically, it supports pilot efforts to apply targeted data analytics to agent and broker licensure requirements; to review Marketplace eligibility and enrollment requirements including during Special Enrollment Periods; and to assess consumer fraud complaints.

Office of the General Counsel (OGC): OGC primarily uses HCFAC funds in support of litigation and enforcement activities that assist in the recovery of program funds. In FY 2016, OGC participated in False Claims Act (FCA) and related matters that recovered over $2.0 billion for the Federal Government. The types of FCA cases that OGC participated included drug pricing manipulation; illegal marketing activity by

pharmaceutical manufacturers that resulted in Medicare and Medicaid paying for drugs for indications not covered; underpayment of rebates to state Medicaid programs; physician self-referral violations; and provider coding cases.

Food and Drug Administration (FDA) Pharmaceutical Fraud Program (PFP): The PFP is designed to detect, prosecute, and prevent pharmaceutical, biologic, and medical device fraud. In FY 2016, FDA initiated 31 criminal investigations, actively pursued several criminal prosecutions, and conducted a three-day training seminar for criminal investigators and supervisors covering PFP-related topics.

HHS Office of Inspector General (OIG): Wedge funds will allow OIG to fund new pilot programs and information technology investments that improve OIG's ability to conduct oversight of the Medicare and Medicaid programs. These new projects include: enhancing OIG's targeted predictive analytics effort to expand litigation and advisory work; developing a new portal to electronically accept and track exclusion considerations; and conducting a targeted outreach campaign to prevent medical identity theft.

**HHS Wedge Budget Request**

The FY 2018 HHS Wedge request includes mandatory funding of $39.1 million, which is an increase of $3.5 million above the FY 2017 Annualized CR Level. The HHS Wedge is subject to agreement between the Secretary of HHS and the Attorney General; therefore, decisions on how this funding will be allocated will not be determined until after HHS and DOJ complete negotiations.

# FY 2018 HCFAC Discretionary Table
## (Dollars in Thousands)

| Project or Activity | FY 2018 Discretionary President's Budget Request |
|---|---|
| **I. Address the Full Spectrum of Waste, Abuse, and Fraud** | |
| Program Integrity Staffing and Support | $87,878 |
| Integrity Continuum | $8,150 |
| Fraud Prevention System | $2,500 |
| Program Integrity Modeling and Analytics | $14,000 |
| One PI Data Analysis | $16,000 |
| Benefits Integrity | $51,685 |
| Medical Review | $38,867 |
| Appeals Initiatives | $9,540 |
| Administration for Community Living Senior Medicare Patrols | $18,000 |
| **Total** | **$246,620** |
| **II. Proactively Manage Provider Screening and Enrollment** | |
| Advanced Provider Screening | $21,090 |
| Provider Enrollment Chain Ownership System (PECOS) | $14,000 |
| **Total** | **$35,090** |
| **III. Continue to build States capacity to protect Medicaid** | |
| State Medicaid Agency Access to Data and Support | $32,500 |
| Monitoring and Oversight of State Actions and Outcomes Modernization | $10,535 |
| Medicaid Financial Management and Oversight | $25,000 |
| **Total** | **$68,035** |
| **IV. Extend Work in Medicare Parts C and D** | |
| Medicare Drug Integrity Contractor (MEDICs) | $25,000 |
| Part C&D Contract Plan and Oversight | $19,914 |
| Monitoring, Performance Assessment and Surveillance | $64,790 |
| Program Audit | $61,719 |
| Compliance and Enforcement | $17,600 |
| **Total** | **$189,023** |
| **V. Provide Greater Transparency into Program Integrity Issues** | |
| Provider Outreach and Education | $7,500 |
| Healthcare Fraud Prevention Partnership | $22,373 |
| Open Payments | $6,250 |
| Error Rate Measurement Activities | $35,500 |
| **Total** | **$71,623** |
| **HCFAC Summary** | |
| **Subtotal Medicare Program Integrity** | **$486,120** |
| **Subtotal Medicaid Program Integrity** | **$124,271** |
| **Total CMS Program Integrity** | **$610,391** |

# Children's Health Insurance Program

Current Law
(Dollars in Thousands)

| | FY 2016 Enacted | FY 2017 Estimate | FY 2018 Estimate | FY 2018 +/- FY2017 |
|---|---|---|---|---|
| State Allotments (ACA P.L. 111-148; P.L. 113-164; MACRA, P.L. 114-10) | $19,300,000 | $20,400,000 | $5,700,000 | ($14,700,000) |
| CHIP Performance Bonus Payments (P.L. 111-3, P.L. 113-235) | $45,153 | $6,319,615 | $6,896,284 | $576,669 |
| Child Health Quality Improvement (P.L. 111-3,114-10) | $47,947 | $32,385 | $15,013 | ($17,372) |
| **Total Budgetary Resources** /1 | **$19,393,100** | **$26,752,000** | **$12,611,297** | **($14,140,70)** |
| CHIP State Allotment Outlays | $14,181,878 | $16,600,000 | $12,000,000 | ($4,600,000) |
| Performance Bonus Payments Outlays | $28,607 | $38,500 | $0 | ($38,500) |
| Child Health Quality Improvement Outlays | $13,165 | $15,562 | $17,372 | $1,810 |
| Redistribution Payments | $81,485 | $0 | $0 | $0 |
| **Total Outlays** | **$14,305,135** | **$16,654,062** | **$12,017,372** | **($4,636,690)** |

1/ Funding levels reflect new appropriations and carry-forward balances from prior years net of enacted rescissions. These funding levels are subject to change due to adjustments throughout the year. The Child Health Quality funding excludes no less than $15 million in resources from the Adult Health Quality appropriation authorized pursuant to P.L. 113-93.

**Child Enrollment**
**Contingency Fund**
Current Law
(Dollars in Thousands)

| | FY 2016 Enacted | FY 2017 Estimate | FY 2018 Estimate | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| **Child Enrollment Contingency Fund, Budget Authority** /1 | **$5,908,337** | **$6,844,462** | **$576,669** | **($6,267,793)** |
| Temporary Rescission (P.L. 114-113) | ($2,048,337) | $0 | $0 | **$0** |
| Temporarily Unavailable (P.L. 114-223) | $0 | $570,000 | $0 | **($570,000)** |
| Transfer to Performance Bonus Fund | $0 | ($6,274,462) | ($576,669) | **$5,697,793** |
| Payments to Shortfall States | $224,341 | $0 | $0 | **$0** |
| Interest Estimate | $20,295 | $6,669 | $0 | **($6,669)** |
| Total Budgetary Resources, end of year | $3,656,125 | $576,669 | $0 | **($576,669)** |
| **Total Outlays** | **$52,586** | **$0** | **$0** | **$0** |

1/ Reflects both carryover resources and deposits into the Fund. The Consolidated Appropriations Act, 2016 (P.L. 114-113) makes the carryover balance temporarily unavailable for obligation during FY 2016.

Authorizing Legislation –
The Balanced Budget Act of 1997 (BBA) (P.L. 105-33),
The Balanced Budget Refinement Act of 1999 (BBRA) (P.L. 106-113),
The Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173),
The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 (P.L. 111-3),
The Patient Protection and Affordable Care Act (P.L. 111-148),
The Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10).

Allocation Method – Formula grants

**Program Description and Accomplishments**

The Balanced Budget Act of 1997 authorized 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 has improved access to health care and the 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, create separate CHIP programs, or have a combination of the two.

Since September 1999, all states, territories, commonwealths, and the District of Columbia have had approved CHIP plans. CMS continues to review states' CHIP plan amendments as they respond to the challenges of operating this program and take advantage of program flexibilities to make innovative changes. As of April 5, 2017, CMS has approved a total of 872 amendments to CHIP state plans.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) (P.L. 111-3) reauthorized CHIP from April 2009 through September 30, 2013 and increased funding by $44.0 billion through FY 2013 to maintain state programs and to cover more uninsured children. The Patient Protection and Affordable Care Act (P.L 111-148) extended funding for CHIP through FY 2015, providing an additional $28.8 billion in budget authority over the baseline. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) (P.L. 114-10) provided an additional $39.7 billion in budget authority for FYs 2016 and 2017. In FY 2018 there is a baseline funding level of $5.7 billion available to states. Funding for the CHIP program will expire on September 30, 2017.

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

- *CHIP Performance Bonus Payments* – Created as an incentive for states to enact policies promoting the enrollment and retention of eligible children, states received bonus payments for the enrollment increase on a per child basis equal to a portion of the state's annual per capita Medicaid expenditure on children. In order to receive a performance bonus payment, states had to implement 5 of 8 enrollment and retention provisions throughout the year and exceed a threshold enrollment level defined in statute. Performance bonus payments were initially funded with a $3.2 billion appropriation, and transfers of any unobligated national allotments and excess funds exceeding the aggregate cap from the Child Enrollment Contingency Fund. The authority for Performance Bonus payments expired at the end of FY 2013.

- *Child Enrollment Contingency Fund* – This fund is used to provide supplemental funding to states that exceed their allotment due to higher-than-expected child enrollment in CHIP. A state may qualify for a contingency fund payment if it projects a funding shortfall for the fiscal year and if its average monthly child enrollment exceeds the targeted average number of enrollees for the fiscal year. MACRA (P.L. 114-10) extended the Child Enrollment Contingency Fund authorization through FY 2017.

The fund received an initial appropriation equal to 20 percent of the FY 2009 national allotment ($2.1 billion). In FYs 2009-2017, Section 2104(n) of the Social Security Act appropriates amounts necessary to make payments to eligible states, not to exceed 20 percent of the total annual allotment appropriation for CHIP. Any amounts in excess of the aggregate cap are transferred to the CHIP Performance Bonus Fund. In addition, the Contingency Fund is invested in interest bearing securities of the United States; income derived from these investments constitutes a part of the fund. The fund accrued a total of $20.3 million in interest in FY 2016 and is estimated to accrue an additional $6.7 million in FY 2017. To date, three states (Iowa, Michigan, and Tennessee) have qualified for payments from the Contingency Fund.

*Child Health Quality Improvement in Medicaid and CHIP* – Section 1139A of the Social Security Act requires the Secretary to identify and publish a recommended core set of child health quality measures for use under Medicaid and CHIP. Other CHIPRA requirements include developing a standardized reporting format that encourages states to voluntarily report information regarding the quality of pediatric health care, encouraging the development and dissemination of a model electronic health record format for children enrolled in the state plan under Medicaid or CHIP, and authorizing several grants and contracts to develop and test these quality measures. A total of $225.0 million at $45.0 million per year for FYs 2009-2013 was appropriated and is available until expended. Section 210 of the Protecting Access to Medicare Act of 2014 (P.L. 113-93) ensured at least $15.0 million is transferred from Medicaid Adult Health Quality funding. The transfer occurred in FY 2015 and is available until expended. In addition, MACRA (P.L. 114-10) provided $20.0 million available for Child Health Quality activities beginning on October 1, 2015.

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

*CHIPRA Pediatric Quality Measures Program*:

- The Medicare Access and CHIP Reauthorization Act (MACRA) (P.L. 114-10) provides $20.0 million for additional Child Health Quality activities beginning on October 1, 2015. These funds will continue to support the CHIPRA Pediatric Quality Measures Program (PQMP) through FY 2019, which include a new CMS and the National Institute for Research on Safety and Quality collaboration for a next phase of pediatric measure testing under a new multi-year competitive cooperative agreement program aimed at establishing partnerships with state Medicaid/CHIP programs to support testing, use and implementation of new or enhanced pediatric quality measures (see https://grants.nih.gov/grants/guide/notice-files/NOT-HS-16-002.html). Currently this funding supports six new PQMP grantees focused on testing and implementing new pediatric quality measures previously developed by the PQMP Centers of Excellence (COE) across various Medicaid and CHIP delivery systems. They will collect data on measures and test quality improvement strategies at multiple levels of care, assessing the feasibility and usability of the new measures within the Medicaid/CHIP patient populations at the state, health plan, and provider levels to support performance monitoring and quality improvement.

*CHIPRA Electronic Health Record Program*:

- HHS jointly released development standards including data elements and standards for EHR developers to ensure relevant elements are captured in a consistent manner. The standards can be found at https://ushik.ahrq.gov/mdr/portals/cehrf?system=cehrf. Child-specific data elements and functionality recommendations are sorted into topic areas that include prenatal and newborn screening tests, immunizations, growth data, information for children with special health care needs and child abuse reporting. The format allows for the interoperable exchange of data, is

compatible with other EHR standards, and facilitates quality measurement and improvement through collection of clinical quality data.

- Two CHIPRA Quality Demonstration Grantees, Pennsylvania and North Carolina, completed testing the impact of the Children's EHR Format in 2014. An assessment of their experience can be found in Appendix A of the Children's EHR Format Enhancement: Final Recommendaiton Report (see https://healthit.ahrq.gov/sites/default/files/docs/page/children-ehr-format-enhancement-final-recommendation-report.pdf).

- In 2016 and 2017 to date, CMS has been assessing a number of options to test targeted items of the enhanced Format with State Medicaid and CHIP programs.

*CHIPRA Quality Demonstration Grants*:

- CMS partnered with the National Institute for Research on Safety and Quality and the National Evaluation team to complete 9 evaluations focused on how grantees are implementing medical home models and strategies to improve adolescent health care, and to support the use of care coordinators. In addition, the National Evaluation team produced two implementation guides titled: Engaging Stakeholders to Improve the Quality of Children's Health Care and Designing Care Management Entities for Youth with Complex Behavioral Health Needs. As the grant comes to a close, the National Evaluation team will work with National Institute for Research on Safety and Quality and CMS to develop updated grantee state profiles and a final evaluation report on lessons learned from the grantees.
- The National Evaluation team posted their final evaluation report: http://www.ahrq.gov/policymakers/chipra/demoeval/what-we-learned/final-report/index.html
- CMS received additional information from several states since the publication of the final report in November 2015. Therefore, CMS is continuing to partner with the National Institute for Research on Safety and Quality to issue supplemental findings and develop a knowledge transfer plan among states.

A Knowledge Transfer Plan has been developed by the CHIPRA National Evaluation Team through National Institute for Research on Safety and Quality with funding from CMS. This Knowledge Transfer plan began in February 2016 with an all states webinar to leverage the knowledge gained from this demonstration program and evaluation, and disseminate lessons learned from the states that participated in the demonstration program to other states, so that all states may benefit from this initial investment. This knowledge transfer will include an opportunity for technical assistance and peer-to-peer learning aimed at states that did not participate in the demonstration so that they may benefit from the experiences of the 18 states that did. This Knowledge Transfer plan is scheduled to continue through FY 2020.

## History of Funding for State Allotments

| Fiscal Year | Budget Authority |
|---|---|
| FY 2013 | $17,406,000,000 |
| FY 2014 | $19,147,000,000 |
| FY 2015 /1 | $16,512,000,000 |
| FY 2016 /2 | $14,621,500,000 |
| FY 2017 | $20,400,000,000 |
| FY 2018 | $5,700,000,000 |

1/ Reflects rescission of $4.5 billion in funding from section 108 of CHIPRA as amended by the ACA, pursuant to Continuing Appropriations Act, 2015 (P.L. 113-164).

2/ Reflects rescission of $4.7 billion in funding from section 108 of CHIPRA as amended by the ACA, Consolidated Appropriations Act, 2016 (P.L. 114-113).

**Mandatory State/Formula Grants**
**CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program**
**(dollars in millions)**

| State/Territory | FY 2016 Actual | FY 2017 Estimate | FY 2018 Estimate | FY2018 +/- FY2017 |
|---|---|---|---|---|
| Alabama | $457,271,965 | $319,667,364 | $305,946,691 | -13,720,673 |
| Alaska | $20,378,189 | $32,561,823 | $25,347,340 | -7,214,483 |
| Arizona | $123,657,687 | $206,434,239 | $259,834,771 | 53,400,532 |
| Arkansas | $174,523,842 | $194,356,170 | $144,542,485 | -49,813,685 |
| California | $1,995,221,518 | $2,668,626,138 | $2,605,865,703 | -62,760,435 |
| Colorado | $228,329,398 | $254,391,365 | $209,616,265 | -44,775,100 |
| Connecticut | $61,880,080 | $77,405,109 | $30,918,161 | -46,486,948 |
| Delaware | $38,530,635 | $35,252,059 | $26,468,804 | -8,783,255 |
| District of Columbia | $25,628,736 | $42,469,451 | $36,805,153 | -5,664,298 |
| Florida | $594,954,867 | $686,574,537 | $792,951,532 | 106,376,995 |
| Georgia | $418,167,985 | $404,760,462 | $329,946,627 | -74,813,835 |
| Hawaii | $46,342,953 | $52,297,015 | $52,657,078 | 360,063 |
| Idaho | $66,419,646 | $82,890,468 | $65,870,494 | -17,019,974 |
| Illinois | $406,233,653 | $547,395,047 | $298,379,627 | -249,015,420 |
| Indiana | $165,656,663 | $191,064,880 | $145,123,532 | -45,941,348 |
| Iowa | $147,611,275 | $145,720,122 | $98,040,556 | -47,679,566 |
| Kansas | $112,200,762 | $124,658,772 | $81,366,629 | -43,292,143 |
| Kentucky | $232,037,959 | $268,214,831 | $198,719,941 | -69,494,890 |
| Louisiana | $238,942,531 | $358,807,394 | $253,936,651 | -104,870,743 |
| Maine | $32,288,872 | $35,721,625 | $27,016,411 | -8,705,214 |
| Maryland | $290,764,875 | $295,918,657 | $236,463,485 | -59,455,172 |
| Massachusetts | $535,766,712 | $671,336,240 | $470,783,978 | -200,552,262 |
| Michigan | $592,608,875 | $264,781,729 | $242,977,418 | -21,804,311 |
| Minnesota | $98,575,110 | $115,190,260 | $19,215,578 | -95,974,682 |
| Mississippi | $246,725,634 | $316,824,536 | $249,117,259 | -67,707,277 |
| Missouri | $172,902,565 | $175,197,002 | $169,440,891 | -5,756,111 |
| Montana | $95,823,327 | $103,532,424 | $76,490,236 | -27,042,188 |
| Nebraska | $78,189,102 | $72,489,987 | $54,675,406 | -17,814,581 |
| Nevada | $63,304,187 | $69,978,264 | $58,197,515 | -11,780,749 |
| New Hampshire | $39,173,598 | $38,241,818 | $21,123,581 | -17,118,237 |
| New Jersey | $406,769,636 | $462,888,916 | $355,629,282 | -107,259,634 |
| New Mexico | $122,482,774 | $136,040,055 | $97,527,114 | -38,512,941 |
| New York | $1,074,559,391 | $1,233,546,153 | $799,439,872 | -434,106,281 |
| North Carolina | $448,150,621 | $479,488,834 | $596,373,187 | 116,884,353 |
| North Dakota | $21,240,226 | $21,886,855 | $15,757,482 | -6,129,373 |

| State/Territory | FY 2016 Actual | FY 2017 Estimate | FY 2018 Estimate | FY2018 +/- FY2017 |
|---|---|---|---|---|
| Ohio | $352,648,030 | $409,309,616 | $357,509,549 | -51,800,067 |
| Oklahoma | $189,238,252 | $248,979,624 | $176,228,293 | -72,751,331 |
| Oregon | $211,330,598 | $249,773,811 | $199,192,085 | -50,581,726 |
| Pennsylvania | $365,076,419 | $527,349,352 | $481,549,892 | -45,799,460 |
| Rhode Island | $65,427,018 | $72,827,787 | $51,174,457 | -21,653,330 |
| South Carolina | $162,036,814 | $154,192,358 | $126,292,289 | -27,900,069 |
| South Dakota | $23,572,173 | $26,938,963 | $22,234,649 | -4,704,314 |
| Tennessee | $213,273,226 | $464,950,817 | $211,903,271 | -253,047,546 |
| Texas | $1,345,137,792 | $1,382,119,845 | $1,203,545,525 | -178,574,320 |
| Utah | $148,910,798 | $131,562,934 | $117,982,704 | -13,580,230 |
| Vermont | $29,298,884 | $30,243,766 | $8,686,745 | -21,557,021 |
| Virginia | $265,184,717 | $291,081,830 | $230,788,835 | -60,292,995 |
| Washington | $215,289,431 | $242,500,772 | $162,744,578 | -79,756,194 |
| West Virginia | $65,438,595 | $61,048,494 | $56,067,944 | -4,980,550 |
| Wisconsin | $225,823,633 | $224,460,797 | $161,974,062 | -62,486,735 |
| Wyoming | $10,917,146 | $12,646,667 | $8,887,877 | -3,758,790 |
| **Subtotal** | **$13,761,919,375** | **$15,716,598,034** | **13,029,329,490** | **-2,687,268,544** |
| **Commonwealths and Territories** | | | | |
| American Samoa | $2,135,479 | $2,901,936 | $1,753,958 | -1,147,978 |
| Guam | $8,003,537 | $26,577,489 | $17,191,531 | -9,385,958 |
| Northern Mariana Islands | $1,042,711 | $6,706,039 | $4,376,697 | -2,329,342 |
| Puerto Rico | $179,847,155 | $192,487,039 | $138,464,716 | -54,022,323 |
| Virgin Islands | $5,323,221 | $6,877,695 | $4,915,984 | -1,961,711 |
| **Subtotal** | **$196,352,103** | **$235,550,198** | **166,702,886** | **-68,847,312** |
| **TOTAL RESOURCES** | **$13,958,271,478** | **$15,952,148,232** | **13,196,032,376** | **-2,756,115,856** |

Note: Allotments to states remain available for federal payments for two years.

# State Grants and Demonstrations

## State Grants and Demonstrations Budget Authority (Dollars in Thousands)[1]

| Program | FY 2016 Enacted | FY 2017 Estimate | FY 2018 Estimate | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| **Deficit Reduction Act (DRA)** | | | | |
| Money Follows the Person (MFP) Demonstration[2] | $418,375 | $0 | $0 | $0 |
| MFP Research & Evaluations[3] | $1,025 | $0 | $0 | $0 |
| Medicaid Integrity Program[4] | $77,403 | $78,016 | $85,809 | $7,793 |
| **Subtotal – DRA** | **$496,803** | **$78,016** | **$85,809** | **$7,793** |
| **Children's Health Insurance Program Reauthorization Act (CHIPRA)** | | | | |
| Grants to Improve Outreach and Enrollment[5] | $40,000 | $0 | $0 | $0 |
| **Subtotal – CHIPRA** | **$40,000** | **$0** | **$0** | **$0** |
| **Protecting Access to Medicare Act of 2014 (PAMA)** | | | | |
| Demonstration Programs to Improve Community Mental Health Services[6] | $23,300 | $0 | $0 | $0 |
| **Subtotal – PAMA** | **$23,300** | **$0** | **$0** | **$0** |
| **Appropriations/BA** | **$560,103** | **$78,016** | **$85,809** | **$7,793** |

Authorizing Legislation - Deficit Reduction Act of 2005, Public Law 109-171; Patient Protection and Affordable Care Act, Public Law 111-148 together with Public Law 111-152; Protecting Access to Medicare Act of 2014, Public Law 113-93, Medicare Access and CHIP Reauthorization Act of 2015, Public Law 114-10.
Allocation Method - Grants, Other

[1] This table does not include the following programs/laws: Ticket to Work, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, the Second Emergency Supplemental Appropriations Act to Meet Immediate Needs Arising From the Consequences of Hurricane Katrina, 2005, Katrina Relief - Additional Federal Payments Under Hurricane-related Multi-state Section 1115 Demonstrations, Application of Prospective Payment System for Services Provided by Federally-Qualified Health Centers and Rural Health Clinics, Medicaid Emergency Psychiatric Demonstration, Medicaid Incentives for the Prevention of Chronic Diseases Model, Psychiatric Residential Treatment Facilities, the National Clearinghouse for Long-Term Care Information, and Funding for the Territories since the Budget Authority is 0 or the money has been rescinded.
[2] P.L. 111-148 extended this funding through FY 2016 and added five years of new appropriations beginning FY 2012. The FY 2016 column reflects post-sequestration amounts.
[3] P.L. 111-148 extended this funding through FY 2016 and added five years of new appropriations beginning FY 2012. The FY 2016 column reflects post-sequestration amounts.
[4] P.L. 111-152 annually adjusts appropriations by the percentage increase in the CPI-U. The FY 2016 and FY 2017 columns reflect post-sequestration amounts.
[5] P.L. 114-10 provided new budget authority and extended the availability through FY 2017.
[6] The FY 2016 column reflects the post-sequestration amount.

## State Grants and Demonstrations Gross Outlays
## (Dollars in Thousands)

| Program | FY 2016 Enacted | FY 2017 Estimate | FY 2018 Estimate | FY 2018 +/- FY 2017 |
|---|---|---|---|---|
| **Ticket to Work and Work Incentives Improvement Act (TWWIIA)** | | | | |
| Sec. 203 – Medicaid Infrastructure Grants | $90 | $119 | $107 | -$12 |
| **Subtotal TWWIIA** | **$90** | **$119** | **$107** | **-$12** |
| **Medicare Modernization Act (MMA)** | | | | |
| Emergency Health Services for Undocumented Aliens | $1,848 | $700 | $0 | -$700 |
| **Subtotal – MMA** | **$1,848** | **$700** | **$0** | **-$700** |
| **Deficit Reduction Act (DRA)** | | | | |
| Psychiatric Residential Treatment Facilities (PRTF) | $5,690 | $0 | $0 | $0 |
| Money Follows the Person (MFP) Demonstration | $450,075 | $425,000 | $425,000 | $0 |
| MFP Research & Evaluation | $965 | $1,089 | $490 | -$599 |
| Medicaid Integrity Program | $73,339 | $79,960 | $86,420 | $6,460 |
| **Subtotal – DRA** | **$530,069** | **$506,049** | **$511,910** | **$5,861** |
| **Children's Health Insurance Program Reauthorization Act (CHIPRA)** | | | | |
| Grants to Improve Outreach and Enrollment | $6,259 | $14,214 | $12,596 | -$1,618 |
| **Subtotal – CHIPRA** | **$6,259** | **$14,214** | **$12,596** | **-$1,618** |
| **Patient Protection and Affordable Care Act (PPACA)** | | | | |
| Medicaid Emergency Psychiatric Demonstration Project | $1,364 | $197 | $0 | -$197 |
| Medicaid Incentives for Prevention of Chronic Diseases | $11,878 | $9,054 | $6,345 | -$2,709 |
| **Subtotal – PPACA** | **$13,242** | **$9,251** | **$6,345** | **-$2,906** |
| **Protecting Access to Medicare Act (PAMA)** | | | | |
| Demonstration Programs to Improve Community Mental Health Services | $8,281 | $7,210 | $4,133 | -$3,077 |
| **Subtotal – PAMA** | **$8,281** | **$7,210** | **$4,133** | **-$3,077** |
| **Total Outlays for State Grants and Demonstrations**[7] | **$559,789** | **$537,543** | **$535,091** | **-$2,452** |

[7] Amounts on this table include outlays from obligations made in previous fiscal years.

**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 activities empower states to drive innovation to improve quality and health outcomes and assist in providing state infrastructure support and services to targeted populations, including resources to combat fraud, waste and abuse, ensuring taxpayer dollars can focus on providing high quality care to beneficiaries.

**Funding History**

| Fiscal Year | Budget Authority |
|---|---|
| FY 2013 | $503,173,000 |
| FY 2014 | $1,423,230,000 |
| FY 2015 | $493,907,000 |
| FY 2016 | $560,103,000 |
| FY 2017 | $78,016,000 |

**Budget Overview**

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

**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. Authorized in Section 6071 of the DRA, as amended by Section 2403 of the Patient Protection and Affordable Care Act the MFP demonstration supports state efforts to empower patients to take ownership of their health and ensure that patients have flexibility and information to make choices as they seek care by:

- Rebalancing their long-term services and supports system so that individuals have a choice of where they live and receive services;
- Transitioning individuals from institutions who want to live in the community; and
- Implementing a system that provides the person-centered services and a quality management strategy that ensures provision and improvement of both home and community-based settings.

The demonstration provides for enhanced Federal Medical Assistance Percentage (FMAP) for 365 days of qualified home and community-based services (HCBS) for each person transitioned from an institution to the community during the demonstration period. To be

eligible for the demonstration, individuals must reside in a qualified institution for at least 90 days before they transition to the community, with the exception that any days an individual resides in an institution solely for the purpose of short-term rehabilitative services for which payment is limited under Medicare are excluded. In addition, states must continue to provide community-based services after the 365 day demonstration period for as long as the individual needs community services and is Medicaid eligible.

Section 2403 of the Patient Protection and Affordable Care Act amended the Deficit Reduction Act providing $450.0 million in each fiscal year from 2012-2016, totaling an additional $2.3 billion. In accordance with various sequestration reports, funding for the MFP demonstrations and evaluation was reduced by 5.1 percent in FY 2013, 7.2 percent in FY 2014, and 7.3 percent in FY 2015. The adjusted FY 2013 appropriation was $427.0 million; the adjusted FY 2014 appropriation was $418.0 million; and the adjusted FY 2015 appropriation was $417.0 million. The FY 2016 appropriation was $450.0 million. The FY 2016 appropriation was reduced by 6.8 percent due to sequestration, bringing the adjusted appropriation to $419.0 million.

The CMS Money Follows the Person (MFP) Tribal Initiative (TI), which received funding under the authority of Section 2403 of the Patient Protection and Affordable Care Act offers existing MFP state grantees and tribal partners the resources to build sustainable community-based long-term services and supports (CB-LTSS) specifically for Indian Tribes. The TI may be used to advance the development of an infrastructure required to implement CB-LTSS for American Indians and Alaska Natives (AI/AN) using a single or a variety of applicable Medicaid authorities. In April 2014, CMS awarded a total of $1.5 million to five MFP grantees for the first phase of the program development. The amounts in the chart on the following page are inclusive of these supplemental awards.

According to the December 2015 Report, *Money Follows the Person Demonstration: Overview of State Grantee Progress*, program transitions for the period from January 1, 2015 through December 31, 2015 numbered 11,440, which represents a 23 percent increase in cumulative transitions over the previous year. In total, grantees have transitioned over 63,337 individuals as of December 2015.

**Budget Overview**

Section 6071 of the DRA authorized and appropriated a total of $1.8 billion for the MFP Rebalancing Demonstration over the period January 1, 2007 through FY 2011. The provision appropriated $250.0 million for FY 2007, $300.0 million in FY 2008, $350.0 million in FY 2009, $400.0 million in FY 2010, and $450.0 million in FY 2011. Section 2403 of the Patient Protection and Affordable Care Act amended the Deficit Reduction Act providing $450.0 million in each fiscal year from 2012-2016, totaling an additional $2.3 billion. There is no appropriation beyond FY 2016 for this program. In addition, Section 6071 of the DRA allows funding from each fiscal year's award to be used that fiscal year and four additional fiscal years. CMS awarded multi-year grants in FY 2016 allowing the funds to be expended through FY 2020. CMS will continue to monitor each states' grant activities progress and expenditures thrFough the entire project period.

States participating in the MFP demonstration are provided reimbursement for approved home and community-based services at an enhanced FMAP rate. The enhanced FMAP increases the regular FMAP rate for HCBS by the number of percentage points equal to 50 percent of the state share, capped at 90 percent. The American Reinvestment and Recovery

Act of 2009 authorized an increased FMAP rate to preserve a significant differential between the MFP enhanced FMAP and the increased FMAP that states were receiving for most other Medicaid funded services under the Recovery Act in order for states to continue to have a financial incentive to meet the goals of the MFP program. This increase is reflected in the chart below.

Of the original DRA appropriation of $1.8 billion, a total of $2.4 million was made available in fiscal years 2007 and 2008 to carry out technical assistance for, and oversight of, states efforts to improve quality under HCBS waivers and $1.1 million per year for evaluation and reporting to Congress. In addition, Section 2403 of the Patient Protection and Affordable Care Act authorized $1.1 million from each year's appropriation in FY 2012 through FY 2016 that may be used to carry out evaluation and a required report to Congress.

As of September 30, 2016, CMS obligated $3.7 billion in grants to 44 states and the District of Columbia (DC). Grantees have transitioned over 63,337 individuals as of December 2015. The 42 participating states and DC have proposed to transition an additional 14,750 individuals out of institutional settings through 2017.

| ***State*** | ***Cumulative Award Total 2007-2016*** | ***Initial Award Date*** | ***Date of Last MFP Funded Transition*** |
|---|---|---|---|
| Alabama | $20,110,401 | September 27, 2012 | December 31, 2018 |
| Arkansas | $59,838,949 | January 1, 2007 | December 31, 2018 |
| California | $197,640,171 | January 1, 2007 | December 31, 2018 |
| Colorado | $21,878,138 | April 1, 2011 | December 31, 2018 |
| Connecticut | $234,576,991 | January 1, 2007 | December 31, 2018 |
| Delaware | $14,264,778 | May 1, 2007 | December 31, 2017 |
| District of Columbia | $34,658,883 | May 1, 2007 | December 31, 2017 |
| Georgia | $159,170,550 | May 1, 2007 | June 30, 2018 |
| Hawaii | $7,798,138 | May 1, 2007 | December 31, 2018 |
| Idaho | $21,859,299 | April 1, 2011 | December 31, 2018 |
| Illinois | $45,195,803 | May 1, 2007 | December 31, 2017 |
| Indiana | $92,059,136 | January 1, 2007 | December 31, 2018 |
| Iowa | $77,661,590 | January 1, 2007 | June 30, 2018 |
| Kansas | $65,487,431 | May 1, 2007 | June 30, 2017 |
| Kentucky | $74,068,555 | May 1, 2007 | December 31, 2018 |
| Louisiana | $83,884,594 | May 1, 2007 | December 31, 2018 |
| Maine | $10,371,462 | April 1, 2011 | December 31, 2018 |
| Maryland | $178,803,155 | January 1, 2007 | December 31, 2018 |
| Massachusetts | $95,060,502 | April 1, 2011 | December 31, 2016 |
| Michigan | $88,242,009 | January 1, 2007 | June 30, 2017 |
| Minnesota | $76,608,425 | April 1, 2011 | December 31, 2018 |
| Mississippi | $30,576,695 | April 1, 2011 | December 31, 2018 |
| Missouri | $82,353,917 | January 1, 2007 | December 31, 2018 |
| Montana | $9,306,595 | September 27, 2012 | December 31, 2018 |
| Nebraska | $22,184,278 | January 1, 2007 | December 31, 2018 |
| Nevada | $10,943,591 | April 1, 2011 | December 31, 2018 |
| New Hampshire | $13,972,772 | January 1, 2007 | March 31, 2016 |
| New Jersey | $120,250,213 | May 1, 2007 | December 31, 2018 |

| State | Cumulative Award Total 2007-2016 | Initial Award Date | Date of Last MFP Funded Transition |
|---|---|---|---|
| New York | $184,796,857 | January 1, 2007 | December 31, 2018 |
| North Carolina | $46,254,702 | May 1, 2007 | December 31, 2018 |
| North Dakota | $31,340,262 | May 1, 2007 | December 31, 2017 |
| Ohio | $380,488,044 | January 1, 2007 | December 31, 2018 |
| Oklahoma | $52,023,929 | January 1, 2007 | July 31, 2018 |
| Oregon | $22,655,153 | May 1, 2007 | September 30, 2011 |
| Pennsylvania | $153,143,765 | May 1, 2007 | December 31, 2018 |
| Rhode Island | $17,859,069 | April 1, 2011 | December 31, 2018 |
| South Carolina | $8,237,969 | April 1, 2011 | December 31, 2018 |
| South Dakota | $5,959,028 | September 27, 2012 | December 31, 2017 |
| Tennessee | $67,363,025 | April 1, 2011 | December 31, 2018 |
| Texas | $397,958,482 | January 1, 2007 | August 31, 2017 |
| Vermont | $15,862,913 | April 1, 2011 | December 31, 2017 |
| Virginia | $80,380,082 | May 1, 2007 | December 31, 2017 |
| Washington | $190,029,341 | January 1, 2007 | December 31, 2018 |
| West Virginia | $17,283,347 | April 1, 2011 | December 31, 2018 |
| Wisconsin | $64,386,314 | January 1, 2007 | December 31, 2018 |

NOTE: The table represents funding awarded to states. Funding for planning grants, quality initiatives, and reductions associated with sequestration are not reflected.

New Mexico and Florida had no transitions through the MFP program, rescinding grant awards in January 2012 and August 2013 respectively. Oregon inactivated their program in 2011 and officially closed out the grant in September 2016.

## MEDICAID INTEGRITY PROGRAM

### Program Description and Accomplishments

On February 8, 2006, Section 6034 of the Deficit Reduction Act of 2005 (DRA) (Public Law 109-171) established the Medicaid Integrity Program in Section 1936 of the Social Security Act. With the passage of this legislation, Congress provided the Centers for Medicare and Medicaid Services (CMS) with increased resources to prevent, detect, and reduce fraud, waste, and abuse in the Medicaid program, ensuring that taxpayer dollars can focus on providing high quality care to beneficiaries. While the Medicaid Integrity Program represents CMS' first national strategy to detect and prevent Medicaid fraud, waste, and abuse, other Medicaid program integrity activities are funded through the Health Care Fraud and Abuse Control (HCFAC) program and are discussed in the HCFAC chapter.

The Patient Access and Medicare Protection Act (Public Law 114-115) recently changed the authorities for the Medicaid Integrity Program to allow for greater flexibility in using a mix of contractors and Federal personnel for the activities described in Section 1936. CMS looks forward to using this new flexibility to more quickly adapt to changing Medicaid program integrity needs.

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 July 2006, and covered FY's 2006 through 2018. The most recent CMIP was released in July 2014 and covers FY's 2014 through 2018. The FY 2014-2018 CMIP is available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf

The Medicaid Integrity Program has achieved a number of clear successes since the start of the program in 2006.

The National Medicaid Audit Program (NMAP)

Congress originally mandated that CMS enter into contractual agreements with eligible entities to do the following:

- Review the actions of individuals or entities furnishing items or services to determine whether fraud, waste, or abuse has occurred, is likely to occur, or otherwise might result in expenditures not intended under Medicaid;
- Audit claims, including cost reports, consulting contracts, and risk contracts;
- Identify overpayments; and,
- Conduct education of state or local officers, employees, independent contractors, providers of services; managed care entities, beneficiaries, and other individuals.

The contractors that perform these functions have historically been known as Medicaid Integrity Contractors (MICs). In December 2007, CMS awarded umbrella contracts, and contractors began conducting provider reviews and audits in September 2008 as part of the NMAP.

CMS has redesigned the NMAP and significantly increased identified overpayments by focusing on collaborative audit projects with the states. This approach replaced an earlier type of federal audit, and instead uses more timely claims data residing with each state's Medicaid Management Information System (MMIS). Collaborative audits using state-level data have proven to be an effective way to coordinate federal and state audit efforts and resources to better meet states' needs, resulting in more timely and accurate audits. By the end of FY 2016, CMS had increased state participation in collaborative audits to a total of 45 states and territories, which represent an overwhelming majority of Medicaid program expenditures. As a result of continued improvements in the audit program, NMAP MICs identified $50.6 million in total computable overpayments in FY 2016.

CMS is reconfiguring its approach to the review and audit of Medicaid providers by implementing a Unified Program Integrity Contractor (UPIC) strategy that restructures and consolidates the current Medicare and Medicaid program integrity audit and investigation work. This reconfiguration focuses on efficient contractor structure and improved coordination between Medicare and Medicaid contractors and states. The UPIC concept consolidates the work of the MICs and the Medicare Zone Program Integrity Contractors (ZPICs), including their Medicare-Medicaid Data Match activities. The overarching goal of the UPIC is to integrate these program integrity functions by implementing a contracting strategy that rationalizes CMS's relationships with providers, leverages existing resources, and enhances cooperative efforts with partners, including states. CMS began awarding UPIC contracts in 2016; CMS plans to award all contracts by the end of 2017 and ultimately phase out the MICs.

Medicaid Integrity Institute (MII)

In collaboration with the United States Department of Justice (DOJ), CMS also established the MII to provide state employees with a comprehensive training of course work encompassing numerous aspects of Medicaid program integrity.

The MII has been cited repeatedly by states, the Government Accountability Office (GAO), the Medicaid and CHIP Payment and Access Commission (MACPAC), the National Association for Medicaid Program Integrity (NAMPI), and the National Association of Medicaid Directors (NAMD) as making a substantial contribution to state efforts to combat fraud and improper payments. From its inception in 2008 through March 15, 2017, the MII has trained state employees from all 50 states, the District of Columbia, and Puerto Rico through more than 7,400 enrollments in 160 courses and 11 workgroups. In FY 2016 alone, the MII conducted 16 courses and 1 workgroup meeting with 773 enrollments. The MII developed a distance learning program in addition to its classroom activities, and sponsored 40 webinars between FY 2012 and FY 2016 to extend its training capacity to even more state program integrity staff. The MII also began offering a credentialing program for state Medicaid program integrity employees to certify their professional qualifications. As of March 2017, 300 state employees in 47 states had received the credential of Certified Program Integrity Professional. In addition, the MII supports a secure, web-based information sharing system called the Regional Information Sharing System (RISS) that all states may use to exchange documents, questions and answers, tips, and best practices about Medicaid program integrity under the auspices of the Bureau of Justice Information Assistance within the DOJ. CMS plans to enhance the educational opportunities provided through the MII by expanding course offerings and other training opportunities. CMS made the following enhancements in FY 2017:

- In February 2017, the MII held a course entitled “Emerging Trends in Medicaid Home and Community Based Services/Personal Care Services,” which brought together CPI, CMCS, HHS-OIG, and state program, policy, operational, program integrity, and law enforcement subject matter experts to explore vulnerabilities, mitigation strategies, and challenges/barriers. This collaboration will result in a white paper detailing the group’s discussions and recommendations, continuing efforts to respond to a November 2012 HHS OIG recommendation that CMS should issue operational guidance for personal care services claims documentation, beneficiary assessments, plans of care, and supervision of attendants. .
- The July 2017 Program Integrity Partnership in Managed Care course will be designed to help state managed care actors understand each other’s’ roles and responsibilities in managed care. We will encourage a holistic discussion and collaboration about topics critical to the success of a state’s managed care program.
- The August 2017 Emerging Trends in Medicaid course, at the request of states and consistent with CMS priorities, will focus on opioid misuse. Opioids have been recognized as an epidemic public health issue, with opioid overdose now the leading cause of injury death in the United States. Like the personal care services course, this course will bring together a wide variety of state and federal stakeholders to explore vulnerabilities, mitigation strategies, and challenges/barriers.

State Program Integrity Reviews

Since 2007, CMS has conducted state program integrity reviews, which assess the operations of each state's Medicaid program integrity unit and report on vulnerabilities and best practices. By the end of FY 2013, CMS had completed 110 comprehensive program integrity reviews, including each state, Puerto Rico, and DC at least twice. During FY 2014 and FY 2015, CMS conducted focused reviews of high-risk program integrity areas rather than comprehensive state reviews. Focused reviews have examined areas such as managed care in Medicaid expansion states, enhanced provider screening and enrollment activities required by the Patient Protection and Affordable Care Act, non-emergency medical transportation, and personal care services. CMS has hosted conference calls with states to discuss program integrity issues and best practices, issued guidance on policy and regulatory issues, and published annual reports of program integrity best practices that have been of considerable value to states.

Technical Assistance to States

The Medicaid Integrity Program provides additional support to states through technical assistance from CMS staff and through contracted educational activities. For example, CMS has provided personnel and other resources to augment state Medicaid staff during field investigations designed to target identified and documented high-risk fraud and abuse situations with saturated enforcement actions. CMS has also worked with states to provide technical assistance regarding the procurement of predictive analytic technologies through the review of advance planning documents. CMS has identified criteria to evaluate and improve the states' procurement efforts. Moreover, CMS has also begun granting states' requests for Medicare data to be used in the states' program integrity efforts. CMS intends to continue working with these states while monitoring results in order to inform CMS and other states of positive opportunities for conducting analytics. Additionally, CMS is currently partnering with the Ohio Department of Medicaid (ODM) in a project to combine the state's Medicaid data with the federal Medicare data for proactive data analysis purposes.

CMS also assists in the education of Medicaid providers, beneficiaries, and Managed Care Organizations (MCOs) on program integrity efforts by developing materials, conducting training, providing educational resources to educate providers, beneficiaries, MCOs and stakeholders, promoting best practices and fraud and compliance awareness, and encouraging Medicaid beneficiaries to report fraud, waste, abuse, and suspected criminal activities. CMS currently maintains an online resource for Medicaid program integrity education (http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html). The website includes a wide array of resources on many relevent fraud, waste, and abuse topics using a variety of media including print and electronic formats, toolkits, train-the-trainer guides, webinars, YouTube videos, and other strategies. State staff has access to train-the-trainer resources to conduct ongoing education for their co-workers' providers, beneficiaries, and MCOs in their states.

CMS has continued to improve and expand support for provider enrollment and screening by state Medicaid programs. Section 1902 of the Social Security Act allows states to rely on Medicare Fee For Service provider enrollment screening and coordination between state programs for Medicaid terminated providers. CMS continues to facilitate the exchange of information between Medicare and all states about providers who have been terminated for cause – allowing Medicare and other state agencies to take action on those providers. To reduce provider burden and avoid duplication of efforts, CMS provides states access to the Medicare Enrollment System (PECOS) and to data files with key information about providers

to support state screening and enrollment efforts. The data sharing files are made available for all states to download. These files have been downloaded more than 1,000 times by participating states from February 2014 through January 2017, and, at the most recent PECOS training offered by CMS, 98 participants from states were in attendance. Additionally, CMS provides support and assistance to states through in-person outreach. Since May 2015, CMS has visited 20 states in an effort to support the Medicaid programs, and these visits have resulted in clarification of provider enrollment and screening policies. CMS is also continually providing states educational support via the monthly provider enrollment technical assistance group call, one-on-one webinar sessions and the MII.

**Budget Overview**

The DRA appropriated $5.0 million in FY 2006, $50.0 million in fiscal years 2007 and 2008 respectively, and $75.0 million in FY 2009 and each year thereafter for the Medicaid Integrity Program. Beginning in FY 2011, Section 1303(b)(3) of P.L. 111-152 adjusted this funding by the percentage increase in the CPI-U annually. The FY 2011 appropriation was $76.3 million, and the appropriation for FY 2012 was $78.3 million. In FY 2013 the appropriation for this program became subject to sequestration in addition to the CPI-U adjustments. The final budget authority for FY 2013 was $76.1 million; FY 2014 final budget authority was $75.6 million; and the final budget authority for FY 2015 was $76.8 million. The FY 2016 budget authority was $82.8 million with a CPI-U adjustment of 0.3 percent, bringing the adjusted budget authority to $83.1 million. The FY 2016 budget authority was reduced by 6.8 percent due to sequestration, bringing the final budget authority to $77.4 million. The FY 2017 budget authority is $83.1 million with a CPI-U adjustment of 0.9 percent, bringing the total budget authority to $83.8 million. The FY 2017 budget authority was reduced by 6.9 percent due to sequestration, bringing the final budget authority to $78.0 million. The FY 2018 budget authority is $83.8 million with an estimated CPI-U adjustment of 2.4 percent, bringing the adjusted budget authority to $85.8 million. The CPI-U adjustments are based on the current FY 2018 President's Budget economic assumptions. Funds appropriated remain available until expended.

## GRANTS TO IMPROVE OUTREACH AND ENROLLMENT

**Program Description and Accomplishments**

Section 201 of the Children's Health Insurance Program Reauthorization Act (CHIPRA) provided $100.0 million for Outreach and Enrollment Grants, a National Enrollment Campaign, and Outreach to Indian Children. Section 10203 of the Patient Protection and Affordable Care Act provided an additional $40.0 million. Section 303 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provided an additional $40.0 million in FY 2016 through FY 2017. These programs conduct outreach and enrollment efforts designed to increase the enrollment of children who are eligible for Medicaid or CHIP.

Outreach and Enrollment Grants

The grants provide outreach and application assistance to enroll eligible, uninsured children in CHIP and Medicaid, with a particular focus on children who are the most difficult to reach and enroll. Recognizing that traditional methods of outreach had not been effective with these children and families, CHIPRA funding was provided to develop specialized strategies to target these children by organizations that would have access to and credibility with families in the communities in which these eligible but uncovered children resided.

Of the $100.0 million provided by section 201 of CHIPRA, $80.0 million was appropriated for the Outreach and Enrollment Grants with an additional $10.0 million specifically dedicated to outreach and enrollment of American Indian/Alaska Native children (AI/AN). The first $40.0 million in grant funds was awarded on September 30, 2009. CMS awarded 69 grants distributing $40.0 million in federal funds across 41 states and the District of Columbia. On August 18, 2011, CMS awarded an additional $40.0 million in grant funds to 39 grantees across 23 states. These grants, entitled CHIPRA Outreach and Enrollment Grants (Cycle II), encouraged applicants to take a more systematic approach to outreach, enrollment, and retention. Grantees focused on five specific areas that had been identified as those most representing the opportunities and challenges for the enrollment and retention of children in health insurance coverage.

CMS awarded a third round of outreach and enrollment grants (a total of $32.0 million) entitled Connecting Kids to Coverage Outreach and Enrollment Grants (Cycle III) in July 2013 from funds provided as part of the Patient Protection and Affordable Care Act appropriation.

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

MACRA extended the Outreach and Enrollment Program through FY 2017. It provided an additional $40.0 million of funds, of which $32.0 million was dedicated to a fourth cycle of general outreach and enrollment grants. On June 13, 2016 CMS awarded 38 cooperative agreements in 27 states totaling just under the $32.0 million. Awards under these cooperative agreements fund activities aimed at educating families about the availability of free or low-cost health coverage under Medicaid and CHIP, identifying children likely to be eligible for these programs, and assisting families with the application and renewal process.

To date, a total of approximately $158.0 million in grant funding has been awarded to help reduce the number of children who are eligible for Medicaid and CHIP but are not enrolled.

Outreach to Indian Children

The authorizing statute for this program sets aside 10 percent of appropriations to award grants to Indian health care providers to reduce the number of uninsured, low-income children in the United States through the enrollment and retention of eligible AI/AN children in Medicaid and CHIP. On April 15, 2010, CMS awarded 41 grants for a total of $9.9 million. CMS awarded a second round of Outreach and Enrollment Grants, totaling $3.9 million, from the $4.0 million appropriated through the Patient Protection and Affordable Care Act, to organizations serving Indian children on November 12, 2014.

MACRA extended the Outreach and Enrollment Program through FY 2017. It provided an additional $40.0 million of funds, of which $4.0 million is dedicated to a third cycle of outreach and enrollment of children who are American Indian/Alaska Native. CMS expects to award up to 10 new AI/AN cooperative agreements in the spring of 2017. MACRA also provided $4.0 million for the National Enrollment Campaign efforts.

National Enrollment Campaign

The statute sets aside 10 percent of appropriations to develop and implement a national campaign to increase the enrollment of eligible, uninsured children. Through the Connecting Kids to Coverage National Campaign (National Campaign), CMS has developed materials, such as posters, palm cards, and public service announcements, which include a call to action to enroll and retain children in Medicaid and CHIP, as well as their parents in Medicaid. Campaign efforts have enhanced communications in target markets and with states, grantees, and other groups working on outreach and enrollment efforts through educational webinars and by distributing free tools that can be easily adapted to support these efforts.

With the funding appropriated under MACRA, CMS awarded a two-year contract in November 2015 to continue the National Campaign. Planning is in place to produce new public service announcements (PSAs), webinars, eNewsletters, and other materials to support outreach and enrollment efforts.

In FY 2015, CMS also developed PSAs for tribal communities and aired these on GoodHealth TV®, a health education program serving in tribal hospitals and clinic waiting rooms. CMS will continue to air PSA's and messaging via GoodHealth TV® in FY 2016 and FY 2017.

**Budget Overview**

CHIPRA appropriated a total of $100.0 million for fiscal years 2009 through 2013, and section 10203(d)(2)(E) of the Patient Protection and Affordable Care Act provided an additional $40.0 million in FY 2010 and extended the period of availability of all funds through fiscal year 2015. Of the total appropriated amount, 10 percent was set aside for the national enrollment campaign and another ten percent was for AI/AN outreach. CMS awarded $40.0 million in FY 2009 for outreach grants and approximately $10.0 million in FY 2010 for general outreach to AI/AN children. CMS awarded an additional $40.0 million of the remaining grants funds, under CHIPRA, on August 18, 2011. Under the Patient Protection and Affordable Care Act, in July 2013, CMS awarded a third round of outreach and enrollment grants (totaling $32.0 million) entitled "Connecting Kids to Coverage Outreach and Enrollment Grants (Cycle III)" and then in November 2014, awarded a second round of Outreach and Enrollment Grants, totaling $3.9 million to organizations serving AI/AN children.

The $10.0 million appropriated through CHIPRA in combination with the $4.0 million appropriated through the Patient Protection and Affordable Care Act have been used to fund National Enrollment Campaign efforts, as required under the statutes. Two National Enrollment Campaign contracts have been in place over the last six years. The first contract had a period of performance of June 2009 to July 2012 with a total contract value of approximately $6.6 million. A second contract was awarded in August 2012 and ended in August 2015 with a total contract value of $6.1 million.

MACRA appropriated an additional $40.0 million in FY 2016. Of this appropriated amount, $32.0 million is set aside for outreach grants, $4.0 million is set aside for Indian Health Service Grants, and $4.0 million is set aside for the National Enrollment Campaign. These additional funds are available for obligation through FY 2017.

## DEMONSTRATION PROGRAMS TO IMPROVE COMMUNITY MENTAL HEALTH SERVICES

Section 223 of the Protecting Access to Medicare Act of 2014 (P. L. 113-93) requires the Secretary to establish a two-year demonstration programs not later than January 1, 2016 that would increase the Federal Matching Percentages for participating states to improve access to behavioral health services.

Beginning one year after the first state has been selected for the Demonstration programs, the Secretary will submit an annual report to Congress in which the program is assessed on the basis of quality, scope, impact, and the use of funds.

### Budget Overview

Section 223 authorized and appropriated $2.0 million in FY 2014 and $25.0 million for the planning grants in FY 2016 to carry out this section. Amounts appropriated for this program shall remain available until expended. In FY 2016, $25.0 million in appropriated planning grant funding for this demonstration underwent a 6.8% sequestration cut which reduced the budget authority available for the planning grants to $23.3 million.

On May 20, 2015, SAMHSA, in conjunction with CMS released a Request for Applications (RFA) for Planning Grants to States that intend to participate in the section 223 Protecting Access to Medicare Act (PAMA) Demonstration Programs to Improve Community Mental Health Services. Planning Grant applications from states wishing to participate in the 2-year Certified Community Behavioral Health Clinic (CCBHC) Demonstration were due to SAMHSA on August 5, 2015, http://www.samhsa.gov/grants/grant-announcements/sm-16-001. On October 19, 2015, SAMHSA, in conjunction with CMS and ASPE, awarded approximately $22.9 million in planning grants to 24 states to support their efforts to improve behavioral health services under the Medicaid program by providing community-based mental health and substance use disorder treatment. SAMHSA, CMS, and ASPE provided robust technical assistance to grantee states throughout the FY 2016 one-year planning phase of the demonstration. When the planning grant phase ended in October 2016, eight states were selected to participate in the section 223 behavioral health demonstration to make services more widely available through certified community behavioral health clinics. The selected states will receive enhanced federal match for specific behavioral health services over a period of two years.

On October 31, 2016, 19 of 24 planning grant states submitted applications to participate in the 2-year Demonstration Programs to Improve Community Mental Health Services. Four of the planning grants states including Alaska, Connecticut, Virginia, and Maryland declined to submit applications while Illinois' application was deemed insufficient to score. In December 2016, HHS, based on an application review by SAMHSA, CMS, and ASPE announced the selection of the following eight states: Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon, and Pennsylvania. Demonstration programs in selected states will be launched between the months of January 1, 2017 to June 30, 2017.

## Information Technology

(Dollars in thousands)

| Information Technology Portfolio | FY 2016 Final | FY 2017 Annualized CR | FY 2018 President's Budget | FY 2018 PB +/- FY 2017 CR |
|---|---|---|---|---|
| Medicare Parts A & B | $ 434,310 | $ 387,409 | $ 387,262 | $ (147) |
| Other Medicare Operational Costs | 158,486 | 189,979 | 176,996 | (12,983) |
| Medicaid & CHIP | 61,435 | 65,988 | 70,396 | 4,408 |
| Health Care Planning & Oversight | 108,780 | 103,425 | 101,803 | (1,622) |
| Health Care Quality | 322,685 | 304,394 | 303,313 | (1,081) |
| Exchange IT | 400,066 | 366,127 | 342,175 | (23,452) |
| Outreach & Education | 26,578 | 27,000 | 23,244 | (3,756) |
| Enterprise Activities | 518,175 | 545,368 | 536,329 | (9,039) |
| **Total Information Technology Portfolio** | **$ 2,030,515** | **$ 1,989,690** | **$ 1,942,018** | **$ (47,672)** |

### Program Description and Accomplishments

CMS' information technology (IT) investments are funded from several budget sources, including the Program Management appropriation, user fees, Health Care Fraud and Abuse Control (HCFAC) program funding, and Quality Improvement Organizations (QIOs). IT activities support most programs that CMS oversees, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), the Exchanges, the Center for Medicare and Medicaid Innovation (CMMI), and associated quality-assurance and program safeguards. CMS' IT investments support a broad range of business operational needs, as well as implementation of provisions of enacted legislation. The CMS request supports Departmental enterprise IT initiatives identified through the HHS strategic planning process. Further information on specific IT projects can be found within the IT Portfolio Summary (formerly known as the Exhibit 53) and the Major IT Business Cases (formerly known as the Exhibit 300s), which can be viewed at the investment tab located at the following web address:
https://www.itdashboard.gov/drupal/summary/009

### Information Technology Portfolio:

### Budget Request

The FY 2018 President's Budget request for IT is $1.94 billion, $47.6 million below the FY 2017 Annualized CR. The decrease can be attributed to finding efficiencies within the Exchange IT operational strategy and the continuing effort to maximize contracting efficiencies. CMS continues to augment IT spending through frequent reassessments of its' overall IT investments strategies.

The FY 2018 request continues to support CMS' IT Shared Services strategy. The Shared Services strategy reduces costs associated with development and maintenance of enterprise functions. It increases reliability and promotes better government practices that are measured rigorously through performance and earned value management. CMS continues to use multiple funding sources to support the Shared Services environment. Using a cost allocation methodology, CMS utilizes funds from the Program Management, HCFAC, CMMI, and QIO accounts.

The chart below shows the IT portfolio by funding sources

**IT Funding Sources**
(Dollars in thousands)

| Information Technology Portfolio | FY 2016 Final | FY 2017 Annualized CR | FY 2018 Current Services | FY 2018 PB +/- FY 2017 CR |
|---|---|---|---|---|
| CLIA | $ 5,100 | $ 5,100 | $ 5,100 | $ - |
| ACA §3021 | 124,162 | 151,963 | 162,680 | 10,717 |
| Federal Admin | 39,919 | 37,632 | 37,632 | - |
| HITECH ARRA | 64,000 | 41,234 | 28,954 | (12,280) |
| Program Integrity (MIP/HCFAC) | 374,774 | 286,493 | 319,338 | 32,845 |
| Program Ops | 1,078,922 | 1,140,022 | 1,051,895 | (88,127) |
| Quality Improvement Organizations | 304,734 | 284,560 | 295,924 | 11,364 |
| RAC Collections | 18,251 | 18,561 | 18,418 | (143) |
| Survey and Certification | 2,050 | 1,713 | 1,713 | - |
| User Fee | 18,603 | 22,412 | 20,364 | (2,048) |
| **Total Information Technology Portfolio** | **$ 2,030,515** | **$ 1,140,022** | **$ 1,942,018** | **$ (47,672)** |

The chart below is a breakdown of IT funding within the eight investment categories by funding source.

## IT Investments Funding
(Dollars in thousands)

| Information Technology Portfolio | FY 2016 Final | FY 2017 Annualized CR | FY 2018 President's Budget | FY 2018 PB +/- FY 2017 CR |
|---|---|---|---|---|
| Program Operations | 141,794 | 169,012 | 172,254 | 3,242 |
| Program Integrity (MIP/HCFAC) | 221,914 | 170,182 | 179,266 | 9,084 |
| HITECH ARRA | 64,001 | 41,234 | 28,954 | (12,280) |
| User Fees | 3,900 | 3,900 | 3,850 | (50) |
| RAC Collections | 2,701 | 3,081 | 2,938 | (143) |
| ***Medicare Parts A&B, Subtotal*** | ***434,310*** | ***387,409*** | ***387,262*** | ***(147)*** |
| Program Operations | 112,095 | 133,908 | 111,259 | (22,649) |
| CMMI | 46,391 | 56,071 | 65,737 | 9,666 |
| ***Other Medicare Operational Costs, Subtotal*** | ***158,486*** | ***189,979*** | ***176,996*** | ***(12,983)*** |
| Program Operations | 19,985 | 26,230 | 26,230 | - |
| Program Integrity (MIP/HCFAC) | 34,000 | 24,250 | 28,500 | 4,250 |
| CMMI | 7,450 | 15,508 | 15,666 | 158 |
| ***Medicaid & CHIP*** | ***61,435*** | ***65,988*** | ***70,396*** | ***4,408*** |
| Program Operations | 39,125 | 39,792 | 39,792 | - |
| Program Integrity (MIP/HCFAC) | 54,656 | 44,843 | 44,768 | (75) |
| Quality Improvement Organizations | 1,000 | 1,000 | 1,000 | - |
| User Fees | 14,000 | 17,790 | 16,243 | (1,547) |
| ***Health Care Planning and Oversight, Subtotal*** | ***108,781*** | ***103,425*** | ***101,803*** | ***(1,622)*** |
| Program Operations | 19,052 | 20,248 | 7,584 | (12,664) |
| Quality Improvement Organizations | 297,308 | 278,158 | 289,741 | 11,583 |
| CLIA | 5,100 | 5,100 | 5,100 | - |
| Survey & Certification | 1,225 | 888 | 888 | - |
| ***Health Care Quality, Subtotal*** | ***322,685*** | ***304,394*** | ***303,313*** | ***(1,081)*** |
| Program Operations | 400,066 | 366,127 | 342,675 | (323,420) |
| ***Exchange IT, Subtotal*** | ***400,066*** | ***366,127*** | ***342,175*** | ***(23,952)*** |
| Program Operations | 26,578 | 27,000 | 23,244 | (3,756) |
| ***Outreach & Education, Subtotal*** | ***26,578*** | ***27,000*** | ***23,244*** | ***(3,756)*** |
| Program Operations | 320,227 | 357,705 | 328,856 | (28,849) |
| Program Integrity (MIP/HCFAC) | 64,205 | 47,218 | 66,804 | 19,586 |
| CMMI | 70,321 | 80,385 | 81,277 | 892 |
| User Fees | 701 | 720 | 271 | (449) |
| Survey & Certification | 825 | 825 | 825 | - |
| Federal Admin | 39,919 | 37,632 | 37,632 | - |
| RAC Collections | 15,550 | 15,480 | 15,480 | - |
| Quality Improvement Organizations | 6,426 | 5,403 | 5,184 | (219) |
| ***Enterprise Activities, Subtotal*** | ***518,174*** | ***545,368*** | ***536,329*** | ***(9,039)*** |
| **Total Information Technology Portfolio** | **$ 2,030,515** | **$ 1,989,690** | **$ 1,942,018** | **$ (47,672)** |

***Medicare Parts A & B Investments***

The FY 2018 President's Budget request for Medicare Parts A and B Investments is $387.3 million, $0.14 million below the FY 2017 Annualized CR.

Program Operations will continue to fund system upgrades and maintenance for the claims processing shared systems infrastructure, which includes the Common Working File (CWF), systems integration testing, and the ViPS Medicare System (VMS). This investment provides infrastructure and program management to all CMS Medicare Fee-For-Service (FFS) Part A, Part B, and Durable Medical Equipment (DME) operations. It also supports Web Hosting services for Medicare.gov, CMS.HHS.gov, CMSNet, and the Health Plan Management System (HPMS), and application hosting services for the 1-800 Medicare Next Generation Desktop Data Warehouse.

Medicare Parts A & B investments – This category reflects funding for the Medicare contractors' ongoing FFS workloads, which include 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). This funding also supports security related to privacy and fraud prevention. These activities support efforts to stabilize our claims processing systems, as well as strengthen and modernize CMS' IT infrastructure in anticipation of program growth. The Medicare Fee-for-Service program relies on improved IT infrastructure to operate successfully. Major systems within this category include:

- The Enterprise Data Centers (EDC) provide hosting and support for CMS systems and services.
- The Common Working File (CWF) is a single data source for Medicare Administrative Contractors (MACs), Fiscal Intermediaries (FIs) and Carriers to verify beneficiary eligibility and conduct prepayment review and approval of claims from a national perspective. It is the only place in the FFS claims processing system where full individual beneficiary information is housed.
- The Fiscal Intermediary Shared System (FISS) is a critical component of the FFS program, processing millions of Medicare claims a year. FISS is the shared system used to process Medicare Part A claims, including outpatient claims submitted under Part B. It interfaces directly with the CWF for verification, validation, and payment authorization. FISS must also implement changes needed to support the MAC authority for the Medicare FFS Program.
- The Multi Carrier System (MCS) is the shared system used to process Medicare Part B claims for physician care, DME, and other outpatient services nationwide. It also interfaces directly with the CWF.
- The Single Testing Contractor (STC) provides integration and regression testing for the Shared Systems functionality pertaining to claims adjudication, payments, remittance advices, and Medicare Summary Notices (MSN). It also provides testing for various system interfaces outside of the FISS, MCS, VMS, and CWF.
- ViPS Medicare System (VMS) is a shared system used to process DME claims for

physician services, diagnostic tests, ambulance services, and other services/supplies that are not covered by Part A. It interfaces directly with the CWF for verification, validation, and payment authorization.

- Health Information Technology for Economic and Clinical Health (HITECH) is Title IV of the American Recovery and Reinvestment Act of 2009 (Recovery Act), which was signed into law on February 17, 2009. HITECH provided for the use of incentive payments to promote the meaningful use of electronic health records (EHR) by eligible professionals and hospitals. The EHR Incentive program for Medicare eligible professionals sunsets at the end of 2018 and will transition to the Merit-based Incentive Payment Program (MIPS), established under the Medicare Access and Chip Reauthorization Act (MACRA). This investment includes all information technology required to implement the program for Medicare hospitals and Medicaid, including the maintenance of the National Level Repository (NLR). The NLR serves as the central system hub for the HITECH EHR Incentive Program. Funding supports the incentive payment program production operations and data quality initiatives including data validation, analysis, and investigation.

- CMS' Fraud Prevention Systems screen all national Medicare Part A, Part B, and DME claims during the adjudication process and consolidate alerts by provider. The systems provide risk scores and proposed actions to either deny or suspend payments, investigate claims or possibly revoke services. CMS applied predictive models and other algorithms to identify providers/suppliers exhibiting a pattern of behavior that is indicative of potential fraud, waste, and abuse.

***Other Medicare Operation Costs***

The FY 2018 President's Budget request is $177.0 million, $12.9 million below the FY 2017 Annualized CR Level. CMS will continue to fund the ACO Capitation Model, as well as the Oncology Care Model (OCM). This decrease reflects efficiencies within Healthcare Integrated General Ledger Accounting System (HIGLAS) operations and the completion of ICD-10.

Other Medicare Operation – IT investments within this category include the HIGLAS Operations, ICD-10, the Medicare-Medicaid Financial Alignment Models, and numerous CMMI activities including the new ACO capitation Model and the Medicare Appeals System (MAS). Projects in this category facilitate delivery system reform and will help provide stakeholders with the tools needed for effective medical decision-making.

- HIGLAS is a national standardized financial system that began operation in 2005. HIGLAS is a component of the Department of Health and Human Services' Unified Financial Management System (UFMS). HIGLAS is a single, integrated dual-entry accounting system that is compliant with the Federal Financial Management Improvement Act of 1996 (FFMIA) that processes the mission critical payment calculation for Medicare benefits to Part A and Part B, Medicaid Grants, and Children's Health Insurance Program (CHIP) for the entire nation. HIGLAS also incorporates internal CMS administrative program accounting transactions.

- IT funding for the Medicare-Medicaid Financial Alignment Models supports CMS' work to implement these integrated care models for Medicare-Medicaid

beneficiaries. CMS has enhanced its systems to support both the capitated and Fee-for-Service variations of the Financial Alignment Model. The capitated model tests new payment, enrollment, oversight, appeals, benefit, network adequacy, marketing, quality, and encounter data mechanisms. In the Fee-for-Service model, CMS has made changes to its IT systems to correctly align beneficiaries with the demonstration delivery model, as well as to track payments and shared savings.

- The Medicare Appeal Systems (MAS) continues to be an integral part of CMS' management and oversight of Medicare Administrative Contractor (MAC) and Qualified Independent Contractor (QIC) appeals. Access to real-time appeals data allows CMS to closely monitor workload trends and contractor performance.

***Medicaid and CHIP***

The FY 2018 President's Budget request is $70.4 million, $4.4 million above the FY 2017 Annualized CR Level. Funding in FY 2018 will support case management for Program Integrity and State Readiness, Enrollment, and Eligibility. CMS will continue to transform Medicaid and CHIP information and data gathering, submission, storage, and extraction processes by utilizing an electronic, automated process that provides CMS, its federal partners, the states, and other stakeholders the ability to monitor, evaluate, and analyze Medicaid and CHIP program performance.

*Medicaid and CHIP Investments* – CMS serves as the operational and policy center for the formulation, coordination, and evaluation of all national program policies and operations relating to Medicaid and the Children's Health Insurance Program (CHIP). Medicaid Data Investments establish an accurate, current, and comprehensive database containing standardized enrollment, eligibility, and paid claims for Medicaid beneficiaries. This data is used for the administration of Medicaid at the Federal level, to produce statistical reports, support Medicaid related research, and assist in the detection of fraud and abuse in the Medicaid and CHIP programs. Given the unprecedented levels of growth in the Medicaid program, Federal and state stakeholders need the ability to handle massive amounts of data, provide real-time eligibility determinations, and process thousands of enrollment applications. Activities funded under this category include:

- The Transformed Medicaid Statistical Information System (TMSIS), which supports efforts to combat fraud, waste, and abuse in Medicaid and CHIP, as well as much of the Medicaid research and analysis performed by the CMMI, the Congressional Budget Office, the Congressional Research Service, and many others. TMSIS captures claims and encounter data reported by the States, which allows for the audit of financial payments within the Medicaid and CHIP programs.

- The Medicaid Drug Rebate program systems used by CMS, states, and manufacturers to monitor and implement the collection of Medicaid rebates.

- Data storage (flat files, data warehouse, and data marts).

- The Medicaid and Child Health Budget and Expenditure (MBES) system, which enables CMS to support fiscal integrity for both state and Federal components of the Medicaid and CHIP programs by projecting anticipated budget

expenditures, managing and supporting tracking of financial operations and actual expenditures related to program operations.

- The Unified Case Management system, which serves as a central repository for tracking leads that contain all contractor workload reporting, dashboards to monitor progress, and outcome measure calculations.

***Health Care Planning and Oversight***

The FY 2018 President's Budget request is $101.8 million, $1.6 million below the FY 2017 Annualized CR Level. This decrease reflects operational efficiencies found within Part D Coordination of Benefits.

*Health Care Planning and Oversight Investments* - CMS maintains several major systems needed to run the Parts C and D programs. IT systems within this category support Beneficiary Enrollment and Plan Payment for Medicare Parts C and D along with Encounter Data processing. Key systems include:

- The Medicare Advantage Prescription Drug (MARx) and Premium Withhold Systems (PWS) deliver enrollment and health plan payment data for Medicare Part C and Medicare Part D benefits. These systems process transactions for approximately 40 million enrollees from more than 800 Part C and Part D plans.

- The Retiree Drug Subsidy (RDS) program creates a financial incentive for sponsors of retiree drug plans to continue offering high quality drug coverage to retirees. The RDS IT system gives plan sponsors the flexibility to leverage existing business arrangements with consulting companies to electronically submit required data to CMS. All transactions in the RDS program are performed electronically through the use of the Internet and electronic business technology.

- The Virtual Call Center supports the national system for handling beneficiary inquiries through the 1-800-MEDICARE toll-free lines.

- The Encounter Data System collects health care utilization (encounter) data for the purpose of editing, pricing, and storage of Medicare Advantage (MA) claims data for more than 16 million beneficiaries. This system supports CMS' ability to evaluate coverage, profile and analyze service utilization, and assess quality of care, with the goal of reducing fraud, waste and abuse and improving Medicare programs and healthcare in general.

- CMS Plan Enrollment - The Health Plan Management System (HPMS) is a secure web application that serves as the primary plan-based information system supporting the Medicare Advantage (MA) and Prescription Drug (Part D) programs. HPMS manages plan enrollment and compliance business processes for all private health and drug plans participating in the MA and Part D programs.

### *Health Care Quality*

The FY 2018 President's Budget request is $303.3 million, $1.1 million below the FY 2017 Annualized CR Level. This request will continue to fund systems that support performance and improvements to provide quality health care.

*Health Care Quality Investments* - CMS is committed to improving the quality and value of health care provided to beneficiaries and consumers through value based purchasing (VBP) programs and other CMS health care quality initiatives.

- IT investments for Accountable Care Organization (ACO) initiatives help CMS to share data, verify ACO eligibility, assign beneficiaries, calculate annual expenditures, calculate and apply performance and quality scores, calculate shared savings, and report program information. IT systems also support the activities associated with business intelligence development, database development, data dissemination, web portal application development and data analytics to support ACOs' current and future program needs. This investment is dependent on shared services data environments within the CMS framework including, the Integrated Data Repository (IDR), National Claims History (NCH), Master Data Management, Baltimore Data Center Hosting, and Business Intelligence Software.

- The Standard Data Processing System (SDPS) funds the hospital reporting system and is established for the user community to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries.

- The Health Care Quality Improvement System (QIES) is a national system that fully supports the Survey and Certification program, fulfills CMS' quality initiatives for select provider settings, aids in managing payment for services to beneficiaries, and assists in the battle against fraud and abuse. QIES supports major initiatives, such as Nursing Home Compare, Home Health Compare, and Hospital Compare. QIES supports over 111,000 users and is used by state survey agencies, Federal agencies, QIOs, beneficiaries, consumers, and researchers.

- Healthcare Quality End Stage Renal Disease (ESRD) Systems consist of the systems and network technology required to facilitate the collection and maintenance of information of the Medicare ESRD program, its beneficiaries, and the services provided to beneficiaries. It includes the network infrastructure needed to facilitate the collection, calculation, transmission, and maintenance of data to initiate performance-based payments for ESRD facilities.

### *Exchange IT*

The FY 2018 President's Budget request is $342.2 million, $24.0 million below the FY 2017 Annualized CR Level. This decrease is based on a steady state assumption within a largely operational environment. Corrective maintenance will still be supported. Please see the Exchanges narrative in the Program Operations chapter for more details.

### *Outreach and Education*

The FY 2018 President's Budget request is $23.2 million, which is a $3.8 million decrease from the FY 2017 Annualized CR Level. The Federal Coverage Payment Coordination system and portal for comparative information are no longer in a development and enhancement state, which attributes to the decrease in funding.

*Outreach and Education Investments* - IT systems within this category support the National Medicare Education Program (NMEP), Non-Exchange Healthcare.gov, and Exchange provider Outreach.

- Beneficiary e-Services create a virtual enterprise-wide, multi-contact channel for handling beneficiaries' inquiries that maximizes resources and service effectiveness. These systems support www.medicare.gov and www.cms.gov websites.

### *Enterprise Activities*

The FY 2018 President's Budget request is $536.3 million, $9.0 million below the FY 2017 Annualized CR Level. This funding will be used to support portal expansion and security for health care fraud systems. Enterprise activities also support the foundational infrastructure for data hosting. These funds also allow CMS to enhance the protection of information in the face of new cybersecurity threats by completing a transition to an enterprise approach for managing Information Security and Privacy (IS&P). CMS is in the process of automating Governance, Risk Management, and Compliance (GRC) processes, expanding security monitoring across the Agency through the Enterprise Security Operations Center (ESOC), implementing Information Security Continuous Monitoring (ISCM) solutions, and addressing Software Assurance (SwA) across the enterprise. CMS is working towards meeting the elevated requirements introduced by new federal mandates including the Federal Information Technology Acquisition Reform Act (FITARA) and OMB Memorandum M-14-03.

*Enterprise Activities Investments* - Enterprise IT activities encompass CMS' critical systems that support ongoing operations, primarily the Infrastructure Hosting and Centralized Communication Services (IHCCS), the VDC Infrastructure Enterprise Services (VIES), the CMS Enterprise Compute Services (CECS), and Large Scale Data Repository (LSDR). These VDC TOs support the day-to-day operations and maintenance activities of CMS' enterprise-wide infrastructure, including managing the mainframe, network, voice and data communications, as well as backing up CMS' mission critical applications and managing CMS' hardware and software. Enterprise Activities also address the protection of information in the face of new cybersecurity threats by completing a transition to an enterprise approach for managing Information Security and Privacy (IS&P). Additional IT systems within this category support Infrastructure Investments, General ACA IT, program administration and Enterprise Shared Services.

- Infrastructure Investments support the cost savings and operational efficiencies of data center consolidation, provide a reliable backup of data through enhanced disaster recovery, and maximize the value of software license costs by transitioning to usage-based enterprise license agreements. Major IT systems within this investment include:

  -Baltimore Data Center (BDC) Operations
  -Enterprise Software Licenses
  -Medicare DataComm Network (MDCN)
  -Integrated Data Repository
  -Enterprise Identity and Access Management Service

- IT systems that support voice and data telecommunication costs, web-hosting and satellite services, ongoing systems security activities and systems that support essential functions such as grants and contract administration, financial management, data management, and document management services.

- Infrastructure Hosting and Centralized Communication Services (IHCCS) includes all activities necessary to provide CMS an efficient, effective, and responsive Data Center and network infrastructure. The work performed under this includes all necessary aspects of planning, implementing, transitioning, operating, and maintaining CMS' IT Infrastructure and all related hardware and software in support of the BDC.

- VDC Infrastructure Enterprise Services (VIES) includes the delivery of Infrastructure Enterprise Services. The VIES Contractor is responsible for the development, administration, and management of all of the following enterprise services: Identity Management and Access Control, Enterprise File Transfer (EFT), Sweeps, Remedy, Enterprise Service Desk, and Enterprise Operation Center services.

- CMS Enterprise Compute Services (CECS) includes delivery of end-to-end services in support of the unified convergence of voice, video, and data technology to CMS end users in order to ensure a productive and mobile workforce. The CECS task order includes the engineering, implementation, maintenance, and operations of all Seat Management Services and end user specific Telecommunications and Network services including network printing, Microsoft Enterprise Lync, Voice over Internet Protocol (VOIP), Video Teleconferencing (VTC), Audio Conferencing Operational Support, and Moderator Services.

- The Large Scale Data Repository (LSDR) includes all activities necessary to provide a robust, stable, and effective data repository environment. The activities include all necessary aspects of planning, implementing, transitioning, operating, maintaining, and procuring all related hardware and software in support of services for the Teradata and Hadoop systems within the BDC.

Enterprise Shared Services include:

- *Enterprise Identity Management (EIDM)* **-** EIDM provides remote identity proofing by confirming persons are who they say they are and secure systems access via a single sign-on, while meeting federal security requirements.

- *Master Data Management (MDM)* **-** MDM comprises processes, policies, and tools that consistently define master data. MDM links and aggregates beneficiary, provider, program, and organization data from multiple disparate sources across the agency creating a trusted authoritative data source.

- *Enterprise Portal* **-** Provides a framework for integrating information and processes onto a single platform and entry point for beneficiaries, providers, organizations, and States to receive CMS information, products, and services.

- *Business Rules Enterprise Service (BRES)* **-** This business rules system enables policies and other operational decisions to be defined, tested, executed and maintained separately from application code, which facilitates enterprise consistency and efficiency.

The table below is the FY 2018 Program Operations IT funding request by investment category. This table crosswalks IT funding according to the breakout in the Program Operations Chapter.

**Program Operations – Information Technology**
(Dollars in Thousands)

| Activity | FY 2016 Final | FY 2017 Annualized CR | FY 2018 President's Budget |
|---|---|---|---|
| Ongoing Operations - MAC & Legacy | $ 76,078 | $ 84,451 | $ 96,478 |
| Claims Processing Investments | $ 57,256 | $ 75,775 | $ 75,776 |
| Contracting Reform | $ 8,460 | $ 8,786 | |
| **I. Medicare Parts A&B** | **$ 141,794** | **$ 169,012** | **$ 172,254** |
| HIGLAS Operations | $ 90,003 | $ 109,159 | $ 90,826 |
| QICs | $ 4,886 | $ 6,200 | $ 6,200 |
| HIPAA plus NPI | $ 15,926 | $ 18,549 | $ 14,233 |
| ICD-10 (and Version 5010) | $ 1,280 | $ - | $ - |
| HIGLAS Development | $ - | $ - | $ - |
| **II. Other Medicare Operational Costs** | **$ 112,095** | **$ 133,908** | **$ 111,259** |
| Medicaid & CHIP | $ 19,985 | $ 26,230 | $ 26,230 |
| **III. Medicaid & CHIP** | **$ 19,985** | **$ 26,230** | **$ 26,230** |
| Part C/D IT Systems Investments | $ 39,125 | $ 39,792 | $ 39,793 |
| **IV. Health Care Planning & Oversight** | **$ 39,125** | **$ 39,792** | **$ 39,793** |
| Health Care Quality IT | $ 16,799 | $ 17,333 | $ 7,584 |
| Physician Value | $ 2,253 | $ 2,915 | $ - |
| **V. Health Care Quality** | **$ 19,052** | **$ 20,248** | **$ 7,584** |
| National Medicare Education Program | $ 22,291 | $ 21,304 | $ 20,309 |
| Non-Exchange Healthcare.gov | $ 2,000 | $ 2,000 | $ - |
| Provider Outreach | $ 878 | $ 1,135 | $ 113 |
| Competitive Bidding | $ $1,410 | $ 2,561 | $ 2,822 |
| **VI. Outreach & Education** | **$ 26,579** | **$ 27,000** | **$ 23,244** |
| Enterprise Activities | $ 258,345 | $ 286,523 | $ 257,940 |
| Infrastructure Investments | $ 25,806 | $ 29,567 | $ 29,567 |
| Other MMA Mandates | $ 1,076 | $ 1,086 | $ 1,086 |
| General Other IT | $ 13,113 | $ 13,460 | $ 13,460 |
| Enterprise Shared Services | $ 21,887 | $ 27,069 | $ 26,803 |
| **VII. Enterprise IT** | **$ 320,227** | **$ 357,705** | **$ 328,856** |
| **VIII. Exchange IT** | **$ 400,065** | **$ 366,127** | **$ 342,175** |
| **Total** | **$ 1,078,922** | **$ 1,140,022** | **$ 1,051,895** |

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES
## Centers for Medicare & Medicaid Services
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# Department of Health and Human Services
# Centers for Medicare & Medicaid Services
# Office of National Drug Control Policy

## Resource Summary

| | FY 2016 Actual | FY 2017 Estimate | FY 2018 Estimate |
|---|---|---|---|
| Drug Resources by Budget Decision Unit and Function: | | | |
| Medicaid Treatment | $4,000 | $4,100 | $4,300 |
| Medicare Treatment | $1,390 | $1,450 | $1,540 |
| Total Funding | **$5,390** | **$5,550** | **$5,840** |
| Drug Resources Personnel Summary | | | |
| Total FTEs (direct only) | 0 | 0 | 0 |
| Drug Resources as a Percent of Budget | | | |
| Total Agency Budget (in Billions)[1] | $1,044.3 | $1,076.6 | $1,117.5 |
| Drug Resources Percentage | 0.5% | 0.5% | 0.5% |

### Program Summary

### Mission

As an effective steward of public funds, the Centers for Medicare and Medicaid Services (CMS) is committed to strengthening and modernizing the nation's health care system to provide access to high quality care and improved health at lower cost. Through its coverage of drug treatment services included within Medicare and Medicaid benefit payments, CMS helps support the goals of the Office of National Drug Control Policy (ONDCP) by continuing to meet the challenges of providing drug abuse treatment to eligible beneficiaries.

### Methodology

Medicaid

These projections were based on data from the Medicaid Analytic eXtract (MAX) for 2008 through 2011, based on expenditures for claims with substance abuse as a primary diagnosis. Managed care expenditures were estimated based on the ratio of substance abuse expenditures to all expenditures for fee-for-service by eligibility group. The estimates

[1] The total agency budget reflects only Medicare and Medicaid current law benefit costs as estimated by the CMS Office of the Actuary. The Medicaid total reflects the federal share of net benefit outlays and includes outlays from the Vaccines for Children Program, administered by the Centers for Disease Control and Prevention. The Medicare total reflects gross benefit outlays.

were trended forward to fiscal year 2015 using the growth rate of expenditures by state and eligibility category from the CMS-64, MAX data, and estimates consistent with the President's Budget. The annual growth rates were adjusted by comparing the rate of substance abuse expenditure growth from 2008-2011 to all service expenditure growth and adjusting the growth rate proportionately.

CMS notes that the estimates are lower than those for the FY 2017 President's Budget for several reasons. First, MAX data was used instead of the previous report from Mathematica Policy Research ("Medicaid Substance Abuse Treatment Spending: Findings Report"[2]) because this allowed CMS to use more current data through 2011 (as opposed to 2008 trended forward to 2011). Lower levels of expenditures in 2008 and slower growth in expenditures through 2011 accounted for much of the difference. In addition, adjustments were made to identify only those claims for which substance use disorder was a primary diagnosis, for consistency with the methodology for Medicare spending.

Medicare

The estimates of Medicare spending for the treatment of substance abuse are based on the FY 2018 President's Budget baseline. These projections reflect estimated Part A and Part B spending and are based on an analysis of historical fee-for-service claims through 2016, using the primary diagnosis code[3] included on the claims. The historical trend was used to make projections into the future.

These projections are higher than those for the 2017 President's Budget due to the incorporation of additional diagnosis codes for substance abuse. This methodological adjustment was made to be consistent with work done by the Office of National Drug Control Policy.

Another adjustment was made to reflect spending for beneficiaries who are enrolled in Medicare Advantage plans since their actual claims are not available. It was assumed that the proportion in costs related to substance abuse treatment was similar for beneficiaries enrolled in Medicare Advantage plans as for those enrolled in fee-for-service Medicare.

These estimates do not include spending under Part D of Medicare because there is not a straightforward way to get this information. There is no diagnosis code associated with prescription drug claims, and drugs used to treat substance abuse are often also used to treat other conditions.

**Budget Summary**

The total FY 2018 drug control outlay estimate for the CMS is $5,840.0 million. This estimate reflects Medicaid and Medicare, excluding Part D, benefit outlays for substance

[2] Bouchery E, Harwood R, Malsberger R, Caffery E, Nysenbaum J, and Hourihan K, "Medicaid Substance Abuse Treatment Spending: Findings Report," Mathematica Policy Research, September 28, 2012.

[3] Based on the International Classification of Diseases (ICD) coding system. The applicable ICD-9 codes for substance abuse include a subset of the 291, 292, 303, 304, and 305 category of codes, and also ICD-9 code 7903. The applicable ICD-10 codes for substance abuse include a subset of the F10, F11, F12, F13, F14, F15, F16, F17, F18, and F19, and R78 ICD-10 category of codes.

abuse treatment. Overall, year-to-year projected growth in substance abuse spending is a function of estimated overall growth in Medicare and Medicaid spending. The growth in Medicare is attributable to the incorporation of additional codes for substance abuse. The decrease in Medicaid projections is attributable to the use of more current data which had lower levels of expenditures and slower growth rates.

Medicaid
FY 2018 outlay estimate: $4,300.0 million
(Reflects $200.0 million increase from FY 2017)

Medicaid is a means-tested health care entitlement program financed by states and the federal government. Medicaid mandatory services include substance abuse services for detoxification and treatment for substance abuse needs identified as part of early and periodic screening, and diagnostic and treatment (EPSDT) services for individuals under age 21 years of age. Additional Medicaid substance abuse treatment services may be provided as optional services.

Medicare
FY 2018 outlay estimate: $1,540.0 million
(Reflects $90.0 million increase from FY 2017)

Medicare provides coverage of hospital, physician, skilled nursing facility, home health care, and other medical care services, as well as prescription drug coverage, to Americans age 65 and older and to disabled persons, including those with end-stage renal disease. Medicare benefits are permanently authorized. Medicare substance abuse treatment benefit payments are made by Medicare Part A and Medicare Part B. This benefit outlays total includes the estimated impact for services provided to beneficiaries enrolled in Medicare Advantage.

**Performance**

Both Medicaid and Medicare contain quality measurement programs that relate to substance abuse screening and treatment. However, none of the programs require reporting of specific measures, nor do they set specific performance targets for the measures.

In January 2017, CMS released its Opioid Misuse Strategy to combat opioid misuse and promote programs that support treatment and recovery support services.

Medicaid
In FY 2017, states will continue voluntary reporting on a core set of health care quality measures for adults enrolled in Medicaid. CMS released an updated core set of measures for 2017 in December 2016, including a new measure: "Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence." In addition, a measure related to initiation of and engagement in alcohol and other drug dependence treatment is maintained from the initial core set, and CMS is now reviewing data from voluntary state reporting for the first time on a new 2016 measure: "Use of Opioids from Multiple Providers at High Dosage in Persons without Cancer." CMS publicly reports data from the core set on Medicaid.gov at:https://www.medicaid.gov/medicaid/quality-of-care/index.html

Medicare

The Physician Quality Reporting System (PQRS) is a Medicare quality reporting program that encourages reporting of quality measures by eligible professionals by applying downward payment adjustments to those eligible professionals that do not meet satisfactory reporting criteria. Eligible professionals may select from a set of approximately 300 quality measures. The number of measures they are required to report in order to avoid a downward payment adjustment varies depending on the reporting method selected. The final reporting period for PQRS was calendar year 2016 with the respective program payment adjustments sun-setting at the end of 2018.

The new Quality Payment Program, which began in January 1, 2017, replaces PQRS and the Value Modifier program, as well as the separate payment adjustments under the Medicare Electronic Health Records Incentive program. There are two tracks to the Quality Payment Program: The Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs). Clinicians can choose how they want to participate based on their practice size, specialty, location, or patient population. There are four MIPS categories: Quality, Advancing Care Information, Improvement Activities, and Cost. In order to receive full credit under the Quality category, many clinicians must report on six quality measures. The current program portfolio includes two Improvement Activities and three quality measures that address opioid use.

CMS Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) are tasked to work across all states to reduce opioid related adverse drug events. QIN-QIOs are working with recruited providers, nursing homes, pharmacies, and other recruited stakeholders to improve medication management, care coordination, and education on opioids. Many QIN-QIOs are working with recruited stakeholders and local communities to implement interventions that are aimed to reduce opioid related adverse drug events, hospital admissions, and readmissions.

In November 2015, CMS made available a new interactive online Medicare Part D Opioid Drug Mapping Tool that allows the public to search Medicare Part D opioid prescription claims data at the state, county, and ZIP code levels. By openly sharing data in a secure, broad, and interactive way, CMS is supporting a better understanding of regional provider prescribing behavior variability and is adding insight to local health care delivery. For additional information: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-11-03.html

Clinical Quality Measure Reporting

CMS is working in partnership with the Office of the National Coordinator for Health Information Technology to incorporate clinical quality measures (CQMs) with relevant information into electronic health records (EHRs) to assist in implementing the health care delivery and payment reform provisions of the Affordable Care Act. The data collected will provide insight on a wide spectrum of health care quality issues, including screening and treatment for substance use.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES
## Centers for Medicare & Medicaid Services
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**CMS Program Management**
**Budget Authority by Object**

| | FY 2017 Annualized CR | FY 2018 President's Budget | FY 2018 +/- FY 2017 |
|---|---|---|---|
| Personnel compensation: | | | |
| Full-time permanent (11.1) | 464,079 | 463,779 | (300) |
| Other than full-time permanent (11.3) | 22,394 | 10,912 | (11,482) |
| Other personnel compensation (11.5) | 7,878 | 7,796 | (82) |
| Military personnel (11.7) | 13,573 | 13,787 | 214 |
| Special personnel services payments (11.8) | - | - | - |
| **Subtotal personnel compensation** | **507,924** | **496,274** | **(11,650)** |
| Civilian benefits (12.1) | 146,190 | 147,369 | 1,179 |
| Military benefits (12.2) | 6,992 | 7,102 | 110 |
| Benefits to former personnel (13.0) | - | - | - |
| **Total Pay Costs** | **661,106** | **650,745** | **(10,361)** |
| Travel and transportation of persons (21.0) | 2,800 | 5,300 | 2,500 |
| Transportation of things (22.0) | - | - | - |
| Rental payments to GSA (23.1) | 501 | 501 | - |
| Rental payments to Others (23.2) | - | - | - |
| Communication, utilities, and misc. charges (23.3) | - | - | - |
| Printing and reproduction (24.0) | 2,500 | 2,500 | - |
| Other Contractual Services: | | | |
| Advisory and assistance services (25.1) | - | - | - |
| Other services (25.2) | 2,040,380 | 1,607,991 | (432,389) |
| Purchase of goods and services from government accounts (25.3) | 3,100 | 3,100 | - |
| Operation and maintenance of facilities (25.4) | - | - | - |
| Research and Development Contracts (25.5) | 20,016 | 18,054 | (1,962) |
| Medical care (25.6) | 1,235,785 | 1,298,805 | 63,020 |
| Operation and maintenance of equipment (25.7) | - | - | - |
| Subsistence and support of persons (25.8) | - | - | - |
| **Subtotal Other Contractual Services** | **3,305,082** | **2,936,251** | **(368,831)** |
| Supplies and materials (26.0) | 1,000 | 1,000 | - |
| Equipment (31.0) | - | - | - |
| Land and Structures (32.0) | - | - | - |
| Investments and Loans (33.0) | - | - | - |
| Grants, subsidies, and contributions (41.0) | - | - | - |
| Interest and dividends (43.0) | - | - | - |
| Refunds (44.0) | - | - | - |
| **Total Non-Pay Costs** | **3,306,082** | **2,937,251** | **(368,831)** |
| **Total Budget Authority by Object Class** | **3,967,188** | **3,587,996** | **(379,192)** |

**CMS Program Management**
**Salaries and Expenses**

| | FY 2017 Annualized CR | FY 2018 President's Budget | FY 2018 +/- FY 2017 |
|---|---|---|---|
| Personnel compensation: | | | |
| Full-time permanent (11.1) | 464,079 | 463,779 | (300) |
| Other than full-time permanent (11.3) | 22,394 | 10,912 | (11,482) |
| Other personnel compensation (11.5) | 7,878 | 7,796 | (82) |
| Military personnel (11.7) | 13,573 | 13,787 | 214 |
| Special personnel services payments (11.8) | - | - | - |
| **Subtotal personnel compensation** | **507,924** | **496,274** | **(11,650)** |
| Civilian benefits (12.1) | 146,190 | 147,369 | 1,179 |
| Military benefits (12.2) | 6,992 | 7,102 | 110 |
| Benefits to former personnel (13.0) | - | - | - |
| **Total Pay Costs** | **661,106** | **650,745** | **(10,361)** |
| Travel and transportation of persons (21.0) | 2,800 | 5,300 | 2,500 |
| Transportation of things (22.0) | - | - | - |
| Rental payments to GSA (23.1) | 501 | 501 | - |
| Rental payments to Others (23.2) | - | - | - |
| Communication, utilities, and misc. charges (23.3) | - | - | - |
| Printing and reproduction (24.0) | 2,500 | 2,500 | - |
| Other Contractual Services: | | | |
| Advisory and assistance services (25.1) | - | - | - |
| Other services (25.2) | 2,040,380 | 1,607,991 | (432,389) |
| Purchase of goods and services from government accounts (25.3) | 3,100 | 3,100 | - |
| Operation and maintenance of facilities (25.4) | - | - | - |
| Research and Development Contracts (25.5) | 20,016 | 18,054 | (1,962) |
| Medical care (25.6) | 1,235,785 | 1,298,805 | 63,020 |
| Operation and maintenance of equipment (25.7) | - | - | - |
| Subsistence and support of persons (25.8) | - | - | - |
| **Subtotal Other Contractual Services** | **3,305,082** | **2,936,251** | **(368,831)** |
| Supplies and materials (26.0) | 1,000 | 1,000 | - |
| **Total Non-Pay Costs** | **3,306,082** | **2,937,251** | **(368,831)** |
| **Total Salary and Expense** | **3,967,188** | **3,587,996** | **(379,192)** |
| **Direct FTE** | 4,525 | 4,370 | (155) |

**CMS Program Management**
**Detail of Full Time Equivalents (FTE)**

| | 2016 Actual | 2017 Estimate | 2018 Estimate |
|---|---|---|---|
| **Office of the Administrator** | | | |
| Direct FTEs | 35 | 28 | 27 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 35 | 28 | 27 |
| **Center for Clinical Standards and Quality** | | | |
| Direct FTEs | 191 | 190 | 189 |
| Reimbursable FTEs | 32 | 40 | 44 |
| Subtotal | 223 | 230 | 233 |
| **Center for Consumer Information and Insurance Oversight** | | | |
| Direct FTEs | 195 | 211 | 188 |
| Reimbursable FTEs /2 | 73 | 138 | 138 |
| Subtotal | 268 | 349 | 326 |
| **Center for Medicaid and CHIP Services** | | | |
| Direct FTEs | 314 | 311 | 304 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 314 | 311 | 304 |
| **Center for Medicare** | | | |
| Direct FTEs | 664 | 658 | 642 |
| Reimbursable FTEs | 2 | 6 | 6 |
| Subtotal | 666 | 664 | 648 |
| **Center for Medicare and Medicaid Innovation** | | | |
| Direct FTEs | 0 | 0 | 0 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 0 | 0 | 0 |
| **Center for Program Integrity** | | | |
| Direct FTEs | 6 | 8 | 6 |
| Reimbursable FTEs | 25 | 29 | 29 |
| Subtotal | 31 | 37 | 35 |
| **Office of Acquisition & Grants Management** | | | |
| Direct FTEs | 160 | 164 | 155 |
| Reimbursable FTEs | 2 | 2 | 2 |
| Subtotal | 162 | 166 | 157 |
| **Office of the Actuary** | | | |
| Direct FTEs | 83 | 83 | 81 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 83 | 83 | 81 |
| **Office of Communications** | | | |
| Direct FTEs | 218 | 217 | 211 |
| Reimbursable FTEs /2 | 1 | 1 | 1 |
| Subtotal | 219 | 218 | 212 |
| **Office of Enterprise Information** | | | |
| Direct FTEs | 138 | 0 | 0 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 138 | 0 | 0 |
| **Office of Equal Opportunity and Civil Rights** | | | |
| Direct FTEs | 31 | 31 | 30 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 31 | 31 | 30 |

**CMS Program Management**
**Detail of Full Time Equivalents (FTE)**

| | 2016 Actual | 2017 Estimate | 2018 Estimate |
|---|---|---|---|
| **Office of Federal Coordinated Health Care** | | | |
| Direct FTEs | 26 | 28 | 25 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 26 | 28 | 25 |
| **Office of Financial Management** | | | |
| Direct FTEs | 232 | 244 | 225 |
| Reimbursable FTEs | 8 | 6 | 6 |
| Subtotal | 240 | 250 | 231 |
| **Office of Hearings and Inquiries** | | | |
| Direct FTEs | 123 | 124 | 119 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 123 | 124 | 119 |
| **Office of Technology Solutions** | | | |
| Direct FTEs | 367 | 0 | 0 |
| Reimbursable FTEs | 3 | 0 | 0 |
| Subtotal | 370 | 0 | 0 |
| **Office of Information Technology** | | | |
| Direct FTEs | 0 | 479 | 488 |
| Reimbursable FTEs | 3 | 2 | 2 |
| Subtotal | 3 | 481 | 490 |
| **Office of Legislation** | | | |
| Direct FTEs | 54 | 52 | 52 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 54 | 52 | 52 |
| **Office of Minority Health** | | | |
| Direct FTEs | 21 | 21 | 20 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 21 | 21 | 20 |
| **Office of Human Capital** | | | |
| Direct FTEs | 172 | 172 | 167 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 172 | 172 | 167 |
| **Office of Support Services and Operations** | | | |
| Direct FTEs | 96 | 97 | 93 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 96 | 97 | 93 |
| **Office of Strategic Operations and Regulatory Affairs** | | | |
| Direct FTEs | 152 | 152 | 147 |
| Reimbursable FTEs | | 0 | 0 |
| Subtotal | 152 | 152 | 147 |
| **Office of Enterprise Data and Analytics (OEDA)** | | | |
| Direct FTEs | 75 | 77 | 72 |
| Reimbursable FTEs | 0 | 0 | 0 |
| Subtotal | 75 | 77 | 72 |
| **Consortia** | | | |
| Direct FTEs | 1,174 | 1,188 | 1,135 |
| Reimbursable FTEs | 33 | 34 | 34 |
| Subtotal | 1,207 | 1,222 | 1,169 |
| **Total, CMS Program Management FTE 1/** | **4,706** | **4,792** | **4,637** |
| *Total, CMS Military Staffing (Non-Add) 1/* | *189* | *138* | *138* |

**American Recovery and Reinvestment Act (ARRA):**

**CMS Program Management**
**Detail of Full Time Equivalents (FTE)**

| | 2016 Actual | 2017 Estimate | 2018 Estimate |
|---|---|---|---|
| **Total, CMS Program Management FTE 1/** | **78** | **73** | **73** |

1/ FY 2016 reflects actual FTE consumption. Excludes directly-appropriated provisions.
2/ CMS estimates at least 139 FTEs will be funded through Exchange user fees in FY 2017 and FY 2018. This number is expected to change as CMS works to transition staff to this funding source while working to reduce the overall number of Exchange FTE through attrition.

**Average GS Grade**

| | |
|---|---|
| FY 2013 | **13/4** |
| FY 2014 | **13/4** |
| FY 2015 | **13/4** |
| FY 2016 | **13/4** |
| FY 2017 | **13/4** |
| FY 2018 | **13/4** |

**CMS Program Management**
**Detail of Positions**
(Dollars in Thousands)

| | 2016 Actual | 2017 Annualized CR | 2018 President's Budget |
|---|---|---|---|
| Subtotal, EX | 0 | 0 | 0 |
| Total - Exec. Level Salary | $0 | $0 | $0 |
| Subtotal | 76 | 76 | 76 |
| Total - ES Salaries | $13,654 | $13,838 | $14,055 |
| GS-15 | 585 | 566 | 545 |
| GS-14 | 578 | 559 | 539 |
| GS-13 | 2,061 | 1,994 | 1,922 |
| GS-12 | 617 | 597 | 576 |
| GS-11 | 194 | 187 | 181 |
| GS-10 | 1 | 1 | 1 |
| GS-9 | 176 | 170 | 164 |
| GS-8 | 4 | 4 | 4 |
| GS-7 | 74 | 72 | 69 |
| GS-6 | 37 | 35 | 34 |
| GS-5 | 69 | 67 | 64 |
| GS-4 | 49 | 48 | 46 |
| GS-3 | 11 | 11 | 10 |
| GS-2 | 0 | 0 | 0 |
| GS-1 | 0 | 0 | 0 |
| Subtotal 1/ | 4,456 | 4,311 | 4,156 |
| Total - GS Salary 1/ | $459,464 | $472,635 | $460,636 |
| Average GS grade 1/ | 13/4 | 13/4 | 13/4 |
| Average GS salary 1/ | $103,111 | $109,635 | $110,836 |

1/ Reflects direct discretionary staffing within the Program Management account.

## FTEs Funded by the Affordable Care Act
## Centers for Medicare & Medicaid
(Dollars in Thousands)

| Program | Section | FY 2010 | | | FY 2011 | | | FY 2012 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Total | FTEs | CEs | Total | FTEs | CEs | Total | FTEs | CEs |
| **ACA Direct Appropriated** | | | | | | | | | | |
| Health Insurance Consumer Information | 1002 | $30,000 | 0 | | | 2 | | | 0 | |
| Rate Review Grants | 1003 | | 0 | | | 0 | | | 0 | |
| Pre-existing Condition Insurance Plan Program | 1101 | $5,000,000 | 0 | | | 13 | | | 18 | |
| Reinsurance for Early Retirees | 1102 | $5,000,000 | 0 | | | 2 | | | 4 | |
| Affordable Choices of Health Benefit Plans | 1311 | $49,322 | 0 | | $478,374 | 28 | | $1,654,596 | 44 | |
| Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers (CO-OP) | 1322 | $ 6,000,000 | 0 | | $ (2,200,000) | 1 | | $ (400,000) | 6 | |
| CO-OP Contingency Fund | 1322/644 | | 0 | | | 0 | | | 0 | |
| Adult Health Quality Measures 2/ | 2701 | $ 60,000 | 0 | | $ 60,000 | 2 | | $ 60,000 | 5 | |
| Medicaid Emergency Psychiatric Demonstration | 2707 | | 0 | | $ 75,000 | 0 | | | | |
| Quality Measurement 2/ | 3014 | $ 20,000 | 0 | | $ 20,000 | 2 | | $ 20,000 | 4 | |
| Establishment of Center for Medicare/Medicaid Innovation within CMS | 3021 | $ 5,000 | 4 | | $ 10,000,000 | 68 | | | 163 | |
| Independence At Home Demonstration 2/ | 3024 | $ 5,000 | 0 | | $ 5,000 | 0 | | $ 5,000 | 3 | |
| Community Based Care Transitions | 3026 | | 0 | | $ 500,000 | 0 | | | 2 | |
| Treatment of Certain Complex Diagnostic Lab Tests | 3113 | $ 5,000 | 0 | | | 0 | | | 2 | |
| Medicaid Incentives for Prevention of Chronic Disease | 4108 | | 0 | | $ 100,000 | 0 | | | 1 | |
| Community Prevention and Wellness | 4202 | $ 50,000 | 0 | | | 0 | | | 1 | |
| Graduate Nurse Education 2/ | 5509 | | 0 | | | 0 | | $ 50,000 | 1 | |
| Sunshine Act | 6002 | | 0 | | | 0 | | | 0 | |
| LTC National Background Checks | 6201 | $ 160,000 | 3 | | | 2 | | | 3 | |
| Provider Screening & Other Enrollment Requirements 1/ | 6401 | | 0 | | | 5 | | | 8 | |
| Enhanced Medicare/Medicaid Program Integrity Provisions 1/ | 6402 | | 0 | | $ 10,000 | 2 | | $ 10,000 | 2 | |
| Expansion of the Recovery Audit Contractor Program 1/ | 6411 | | 0 | | | 2 | | | 2 | |
| Termination of Provider Participation under Medicaid 1/ | 6501 | | 0 | | | 0 | | | 0 | |
| Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/ | 10323 | Such Sums | 0 | | Such Sums | 0 | | $302,000 | 2 | |
| **Total ACA Direct Appropriated FTEs** | | | **7** | | | **129** | | | **271** | |

1/ From FY 2014 through FY 2018, the Health Care and Education Reconciliation Act of 2010 (HCERA) section 1303 [(FY 2011, $95,000,000), (FY 2012, $55,000,000), (FY 2013, $30,000,000), (FY 2014, $30,000,000), (FY 2015, $20,000,000), (FY 2016, $20,000,000)] may allocate funds which may be used for Health Care Fraud and Abuse (HCFAC) activities in addition to funds provided by ACA section 6402.

2/ Net sequester reductions in FY 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), and FY 2017 (-6.9%).

## FTEs Funded by the Affordable Care Act
## Centers for Medicare & Medicaid
(Dollars in Thousands)

| Program | Section | FY 2013 | | | FY 2014 | | | FY 2015 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Total | FTEs | CEs | Total | FTEs | CEs | Total | FTEs | CEs |
| **ACA Direct Appropriated** | | | | | | | | | | |
| Health Insurance Consumer Information | 1002 | | 0 | | | 0 | | | 0 | |
| Rate Review Grants | 1003 | | 0 | | | 0 | | | 0 | |
| Pre-existing Condition Insurance Plan Program | 1101 | | 12 | | | 7 | | | 5 | |
| Reinsurance for Early Retirees | 1102 | | 11 | | | 4 | | | 4 | |
| Affordable Choices of Health Benefit Plans | 1311 | $2,147,000 | 56 | | $784,000 | 51 | | $469,624 | 49 | |
| Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers (CO-OP) | 1322 | $ (2,278,544) | 18 | | | 15 | | | 0 | |
| CO-OP Contingency Fund | 1322/644 | $ 240,259 | | | | | | | 15 | |
| Adult Health Quality Measures 2/ | 2701 | $ 56,940 | 10 | | $ 55,680 | 9 | | | 11 | |
| Medicaid Emergency Psychiatric Demonstration | 2707 | | | | | 0 | | | 1 | |
| Quality Measurement 2/ | 3014 | $ 18,980 | 6 | | $ 18,560 | 9 | | | 9 | |
| Establishment of Center for Medicare/Medicaid Innovation within CMS | 3021 | | 258 | | | 355 | | | 479 | |
| Independence At Home Demonstration 2/ | 3024 | $ 4,745 | 2 | | $ 4,640 | 1 | | $ 4,635 | 1 | |
| Community Based Care Transitions | 3026 | | 1 | | | 0 | | | 0 | |
| Treatment of Certain Complex Diagnostic Lab Tests | 3113 | | 1 | | | 0 | | | 0 | |
| Medicaid Incentives for Prevention of Chronic Disease | 4108 | | 1 | | | 1 | | | 1 | |
| Community Prevention and Wellness | 4202 | | 1 | | | 0 | | | 0 | |
| Graduate Nurse Education 2/ | 5509 | $ 47,450 | 0 | | $ 46,400 | 0 | | $ 46,350 | 1 | |
| Sunshine Act | 6002 | $ 16,050 | 11 | | $ 1,024 | 14 | | $ 21,399 | 16 | |
| LTC National Background Checks | 6201 | | 4 | | | 5 | | | 5 | |
| Provider Screening & Other Enrollment Requirements 1/ | 6401 | $ 5,000 | 10 | | | 12 | | $ 18,035 | 13 | |
| Enhanced Medicare/Medicaid Program Integrity Provisions 1/ | 6402 | $ 13,000 | 1 | | $ 3,000 | 1 | | $ 27,377 | 2 | |
| Expansion of the Recovery Audit Contractor Program 1/ | 6411 | $ 3,300 | 1 | | $ 3,783 | 2 | | $ 3,975 | 2 | |
| Termination of Provider Participation under Medicaid 1/ | 6501 | | 0 | | | 0 | | | 0 | |
| Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/ | 10323 | $418 | 1 | | $316 | 1 | | $ 549 | 1 | |
| **Total ACA Direct Appropriated FTEs** | | | **405** | | | **487** | | | **615** | |

1/ From FY 2014 through FY 2018, the Health Care and Education Reconciliation Act of 2010 (HCERA) section 1303 [(FY 2011, $95,000,000), (FY 2012, $55,000,000), (FY 2013, $30,000,000), (FY 2014, $30,000,000), (FY 2015, $20,000,000), (FY 2016, $20,000,000)] may allocate funds which may be used for Health Care Fraud and Abuse (HCFAC) activities in addition to funds provided by ACA section 6402.

2/ Net sequester reductions in FY 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), and FY 2017 (-6.9%).

## FTEs Funded by the Affordable Care Act
## Centers for Medicare & Medicaid
(Dollars in Thousands)

| Program | Section | FY 2016 | | | FY 2017 | | | FY 2018 | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Total | FTEs | CEs | Total | FTEs | CEs | Total | FTEs | CEs |
| **ACA Direct Appropriated** | | | | | | | | | | |
| Health Insurance Consumer Information | 1002 | | 0 | | | 0 | | | 0 | |
| Rate Review Grants | 1003 | | | | | | | | 0 | |
| Pre-existing Condition Insurance Plan Program | 1101 | | 0 | | | 0 | | | 0 | |
| Reinsurance for Early Retirees | 1102 | | 0 | | | 0 | | | 0 | |
| Affordable Choices of Health Benefit Plans | 1311 | $20,163 | 34 | | $24,297 | 34 | | $17,277 | 34 | |
| Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers (CO-OP) | 1322 | | 0 | | | 0 | | | 0 | |
| CO-OP Contingency Fund | 1322/644 | | 18 | | | 0 | | | 0 | |
| Adult Health Quality Measures 2/ | 2701 | | 11 | | | 10 | | | 10 | |
| Medicaid Emergency Psychiatric Demonstration | 2707 | | 0 | | | 0 | | | 0 | |
| Quality Measurement 2/ | 3014 | | 0 | | | 0 | | | 0 | |
| Establishment of Center for Medicare/Medicaid Innovation within CMS | 3021 | | 521 | | | 615 | | | 617 | |
| Independence At Home Demonstration 2/ | 3024 | | 1 | | | 1 | | | 0 | |
| Community Based Care Transitions | 3026 | | 1 | | | 1 | | | 0 | |
| Treatment of Certain Complex Diagnostic Lab Tests | 3113 | | 0 | | | 0 | | | 0 | |
| Medicaid Incentives for Prevention of Chronic Disease | 4108 | | 0 | | | 0 | | | 0 | |
| Community Prevention and Wellness | 4202 | | 0 | | | 0 | | | 0 | |
| Graduate Nurse Education 2/ | 5509 | | 1 | | | 1 | | | 1 | |
| Sunshine Act | 6002 | $ 4,211 | 17 | | $ 5,615 | 24 | | $ 5,615 | 24 | |
| LTC National Background Checks | 6201 | | 6 | | | 6 | | | 6 | |
| Provider Screening & Other Enrollment Requirements 1/ | 6401 | $ 3,509 | 14 | | $ 3,509 | 14 | | $ 3,509 | 14 | |
| Enhanced Medicare/Medicaid Program Integrity Provisions 1/ | 6402 | $ 468 | 2 | | $ 468 | 2 | | $ 468 | 2 | |
| Expansion of the Recovery Audit Contractor Program 1/ | 6411 | $ 468 | 2 | | $ 468 | 2 | | $ 468 | 2 | |
| Termination of Provider Participation under Medicaid 1/ | 6501 | | 0 | | | 0 | | | 0 | |
| Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/ | 10323 | $329 | 1 | | | 0 | | | 0 | |
| **Total ACA Direct Appropriated FTEs** | | | **629** | | | **710** | | | **710** | |

1/ From FY 2014 through FY 2018, the Health Care and Education Reconciliation Act of 2010 (HCERA) section 1303 [(FY 2011, $95,000,000), (FY 2012, $55,000,000), (FY 2013, $30,000,000), (FY 2014, $30,000,000), (FY 2015, $20,000,000), (FY 2016, $20,000,000)] may allocate funds which may be used for Health Care Fraud and Abuse (HCFAC) activities in addition to funds provided by ACA section 6402.

2/ Net sequester reductions in FY 2014 (-7.2%), FY 2015 (-7.3%), FY 2016 (-6.8%), and FY 2017 (-6.9%).

# CMS Program Management
# Programs Proposed for Elimination

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

Physicians' Comparability Allowance (PCA) Worksheet

DHHS: Centers for Medicare and Medicaid Services

Table 1

| | | FY 2016 | FY 2017 enacted* | FY 2018 |
|---|---|---|---|---|
| 1) Number of Physicians Receiving PCAs | | 51 | 63 | 79 |
| 2) Number of Physicians with One-Year PCA Agreements | | 1 | 2 | 2 |
| 3) Number of Physicians with Multi-Year PCA Agreements | | 49 | 61 | 77 |
| 4) Average Annual PCA Physician Pay (without PCA payment) | | $137,281 | $158,836 | $158,836 |
| 5) Average Annual PCA Payment | | $24,725 | $28,009 | $28,009 |
| 6) Number of Physicians Receiving PCAs by Category (non-add) | Category I Clinical Position | | | |
| | Category II Research Position | | | |
| | Category III Occupational Health | | | |
| | Category IV-A Disability Evaluation | | | |
| | Category IV-B Health and Medical Admin. | 51 | 63 | 79 |

*FY 2017 data will be approved during the FY 2018 Budget cycle

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than I through IV-B). Provide the number of PCA agreements per additional category for the PY, CY and BY.

Additional physician categories have not been designated by CMS.

8) Provide the maximum annual PCA amount paid to each category of physician in your agency and explain the reasoning for these amounts by category.

The maximum amount of a PCA varies depending on the GS level; the number of years as a government physician; if the service agreement is for one year or multiple years, if they are board certified; and mission-specific which is a factor based on the physician's duties that are directly related to the strategic mission and goals of CMS. CMS completed new policy guidance which provides a consistent yet flexible framework for determining recommended amounts for the two discretionary factors in PCA service agreements. The maximum yearly PCA amount for less than 24 months as a government physician is $14,000 and for more than 24 months as a government physician is $30,000.

9) Explain the recruitment and retention problem(s) for each category of physician in your agency (this should demonstrate that a current need continues to persist).

In order to attract and retain highly skilled and qualified Medical Officers, CMS uses two special pay systems, Physician's Comparability Allowance (PCA) and the Physician's and Dental Pay (PDP). Details of the PDP are not included in this report. The majority of CMS Medical Officers receive PCA. CMS Medical Officers are recruited nationwide for the Central Office and Regional Offices to support the work of Medicare and Medicaid Programs. CMS has a continual need to access highly skilled physicians to carry out the unique mission of the agency. Within the last year, CMS has hired nine new medical officers from the private sector,one medical officer transferred from another agency, and one medical officer was promoted. Also within the last year, CMS had two medical officers transfer to another OPDIV, two retired, four resigned, one died, and three moved to another component within CMS to broaden their scope of responsibilities. Of the four that resigned, they separated for employment in the private sector. Five (5) selectees declined the job offer after the PCA had been approved. Some of the declinations have been circumstances where components went through great efforts to fill a Medical Officer position, announcing the position twice and making several selections before a candidate is hired. The biggest challenge is that even with the PCA, CMS is unable to match physician salary in the private sector. Generally speaking, physicians tend to accept more private sector opportunities due to the restrictions of the GS pay scale.

10) Explain the degree to which recruitment and retention problems were alleviated in your agency through the use of PCAs in the prior fiscal year.

Recent legislation over the past several years required CMS to implement new programs. Some of these mandates require establishing additional new Medical Officer positions or quickly filling vacated Medical Officer position to fill very specific needs. Many of these positions were also supervisory positions. Even though CMS has experienced many hurtles trying to recruit medical officers, the PCA is still necessary because the candidates with quality experience make significantly more money in the private sector compared to what CMS would be able to offer them without PCA. PCA has made the salary offers at least more comparable to give us the opportunity to attract and hire exceptional physicians. Without this recruitment and retention allowance CMS would not be able to attract and retain highly qualified physicians.

11) Provide any additional information that may be useful in planning PCA staffing levels and amounts in your agency.

Several of CMS medical officers have already or plan to retire within the next year or two. So backfilling these positions will be critical as those positions are generally medical officers that have been with CMS for many years and take a wealth of knowledge with them.

CMS projects at least 23 Medical Officer positions that need to be filled in FY17/FY18 based upon information received from the components listed below. However, this projection does not include responses from all components and regions so the number may be higher than the projected response.

CMMI
One of CMMI's main objective is to identify, validate and disseminate information about new care models and payment approaches to serve Medicare and Medicaid beneficiaries seeking to enhance the quality of health and health care and reducing cost through improvement. As such, CMMI has a continual need to access highly skilled physicians to carry out the unique mission of the component's mission and objectives. In FY 2016, CMMI lost three Medical Officers (MOs), two of which occupied supervisory positions. CMS anticipates the loss of two nonsupervisory MOs to reassign to other components/OPDIVs in the very near future.

CCSQ
CCSQ has been asked to be involved in broad Agency projects that require clinical expertise and experience with systematic evidence reviews including comparative effectiveness analyses and technology assessments. CMS is also partnering more with the FDA, NIH and CDC on clinical trials. We will need at least two MOs with a background in clinical research (e.g., biostats or epidemiology). We need at least one additional MO to assist with all of the Local Coverage Determination work. In addition, we anticipate at least three Medical Officers leaving CCSQ which will require the need to backfill those positions. CCSQ has four vacancies but hopes three of them will be filled within the next couple of months.

CM
CM Fee For Service anticipates needing to fill one Medical Office position and potentially up to two additional Supervisory Medical Officers over the next two years.

CMCS
CMCS currently has all their medical officer positions filled.

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

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## SIGNIFICANT ITEMS AND REPORTS TO CONGRESS FOR INCLUSION IN THE FY 2018 CONGRESSIONAL JUSTIFICATION

**Senate Report**

*ACA Notifications-The* Committee continues bill language requiring the administration to provide detailed enrollment figures to the Committees on Appropriations of the House of Representatives and the Senate not less than two full business days before any public release of the information.

Action Taken or To Be Taken
The Department is committed to providing the Committees detailed enrollment figures from the Exchanges pertaining to enrollments during the open enrollment period. The Department will continue to notify the Committees two business days in advance of any upcoming release of detailed enrollment figures.

*Access to Mental Health* Care- The Committee continues to prioritize mental health treatment and services and provides an increase within the bill for these programs. The Committee provides an increase of $30,000,000 for the Mental Health Block Grant at SAMHSA as well as $50,000,000 to expand mental health services in Community Health Centers around the Nation. While these programs remain fundamental components of the mental and behavioral health system, the Committee notes that without access to these services, many Americans suffering from mental or behavioral health issues will continue to go untreated. The Committee strongly urges CMS to pursue initiatives that expand access to quality care and increase parity for mental health services.

Action Taken or To Be Taken
CMS recognizes the importance of mental and behavioral health services. In 2016 CMS participated with other federal agencies in the President's Mental Health and Substance Use Disorder Parity Task Force. The Task Force's final report highlights the progress made on parity implementation, summarizes comments from stakeholders and actions taken, and offers recommendations on how to support consumers, improve parity implementation, and enhance parity compliance and enforcement. The report is available here: https://www.hhs.gov/sites/default/files/mental-health-substance-use-disorder-parity-task-force-final-report.pdf

Additional federal guidance and consumer tools to improve parity implementation and compliance can be found here: https://www.hhs.gov/about/agencies/advisory-committees/parity/

In addition, HHS released the beta version of the new Mental Health and Addiction Insurance Help Consumer Portal. The Portal is a web site designed to help consumers find the appropriate Federal or State agency to assist with their parity complaints, appeals, or other actions.

As part of Medicare' ongoing efforts to improve payment for primary care and patient-centered care management services under the Physician Fee Schedule, beginning in CY 2017, we established new codes to pay separately for behavioral health integration (BHI) services furnished under the psychiatric Collaborative Care Model, a specific model for BHI that typically is provided by a primary care team consisting of a primary care provider and a care manager who works in collaboration with a psychiatric consultant, and other BHI models. For purposes of payment under the Medicare Physician Fee Schedule for the new codes, BHI services may be

furnished when a beneficiary has a psychiatric or behavioral health condition(s) that in the treating physician or other qualified health care professional's clinical judgment, requires a behavioral health care assessment, behavioral health care planning, and provision of interventions. CMS hopes the coding and separate payment for BHI services will lead to greater access to BHI services for Medicare beneficiaries with psychiatric or behavioral health conditions.

In addition, BHI is also a core component of the Comprehensive Primary Care Plus Model (CPC+), an advanced primary care medical home model being tested by the Center for Medicare and Medicaid Innovation. CPC+ aims to enable primary care practices to care for their patients the way they think will deliver the best outcomes and to pay them for achieving results and improving care. CPC+ is an advanced primary care medical home model that rewards value and quality by offering an innovative payment structure to support delivery of comprehensive primary care. This 5-year model began in 2017. Many of the physician practices participating in the model must choose and implement at least one option from a menu of options for integrating behavioral health into care.

To improve mental health parity for Medicaid and Children's Health Insurance Program (CHIP) beneficiaries, CMS published a final rule on March 29, 2016 to align mental health and substance use disorder benefits for low-income Americans with benefits required of private health plans and insurance. The final rule applies certain provisions of the Mental Health Parity and Addiction Equity Act of 2008 to Medicaid and Children's Health Insurance Program (CHIP). The Act requires that financial requirements or treatment limitations on mental health and substance use disorder benefits be no more restrictive than they are for medical and surgical services. This final rule helps to prevent inequity between beneficiaries who have mental health or substance use disorder conditions in the commercial market and Medicaid and CHIP, and helps to promote greater consistency for these beneficiaries. The final rule is accessible here: https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of

Medicaid is also playing an increasingly important role as a payer for services provided to individuals with substance use disorder (SUD) in the United States. Since 2014, CMS has been working with states through our Medicaid Innovation Accelerator Program (IAP) to provide opportunities within Medicaid to enhance existing efforts or take up new efforts to design, deliver, and pay for services that improve health outcomes for individuals with substance use disorder (SUD). The IAP provides states with expert resources, coaching opportunities and technical support to accelerate policy, program, and payment reforms appropriate for a robust SUD treatment system and the needs of individuals with opioid use disorder. CMS has also provided states with information and options to manage the prescribing of opioid pain medications, including an informational bulletin regarding best practices for addressing prescription opioid overdoses, misuse, and addiction. CMS is committed to building on this work and continuing to disseminate materials and lessons learned, so all states can benefit from the experiences of the participating states. Information on the Medicaid IAP may be found at: http://www.medicaid.gov/state-resource-center/innovation-accelerator-program/innovation-accelerator-program.html.

In 2015, CMS announced new opportunities for states to design service delivery systems for individuals with SUD, including a new opportunity to allow states to pursue 1115 demonstrations to improve the care and outcomes for individuals with SUD. The specific goals of this initiative include promoting strategies to identify individuals with substance use issues or disorders, enhancing clinical practices and promote clinical guidelines and decision-making tools for serving youth and adults with SUD, build aftercare and recovery support services, coordinate SUD treatment with primary care and long-term care, encourage increased use of quality and outcome measures to inform benefit design and payment models, and coordinate with other sources of local, state and federal funds for an efficient use of resources consistent with program objectives. To date, several states have submitted 1115 SUD demonstration waivers applications under this new opportunity.

Finally, on April 19, 2017, Secretary Price sent a letter to state Governors regarding the opioid epidemic. In the letter, Secretary Price announced that he will be releasing $485 million in grants to help states and territories combat opioid addiction. The funding, which is the first of two rounds provided for in the 21st Century Cures Act, will be provided through the State Targeted Response to the Opioid Crisis Grants administered by our Federal partners at the Substance Abuse and Mental Health Services Administration. This funding will support a comprehensive array of prevention, treatment, and recovery services depending on the needs of recipients. States and territories were awarded funds based on rates of overdose deaths and unmet need for opioid addiction treatment. At this time, HHS has prioritized five specific strategies to combat the opioid epidemic: strengthening public health surveillance, advancing the practice of pain management, improving access to treatment and recovery services, targeting availability and distribution of overdose-reversing drugs, and supporting cutting-edge research. Secretary Price's letter may be found here: https://www.hhs.gov/about/news/2017/04/19/trump-administration-awards-grants-states-combat-opioid-crisis.html

*Cancer Screening Technologies*- The Committee believes it is critical for Medicare beneficiaries to have access to high-quality preventive services, including innovative cancer screening tests. To help maintain robust access to quality preventive cancer care, the Committee requests that CMS, when considering Medicare quality measurements, work with stakeholders, as appropriate, to ensure that cancer screening technologies are reviewed in a timely manner.

Action Taken or To Be Taken

CMS uses quality measures in its various quality initiatives to promote high quality care for Medicare beneficiaries. For example, the Medicare Physician Quality Reporting System has included a quality measure for a reminder system for screening mammograms, which is also considered a high-priority Communication and Care Coordination measure in the Merit-Based Incentive Payment System (MIPS). The measure captures the percentage of patients undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram. Medicare also covers several cancer screenings. For example, Medicare Part B covers a screening mammogram once every 12 months and a diagnostic mammogram when medically necessary.

*Caregiver Counseling and Supportive* Services.- The Committee is aware of a body of evidence that suggests defined counseling and supportive services delivered to family (non-paid) caregivers of Medicare beneficiaries with Alzheimer's disease and dementia can substantially delay beneficiary placement in an institutional care setting and reduce Federal expenditures

associated with such care. The Committee is concerned about the current and anticipated Medicare and Medicaid costs associated with Alzheimer's disease and recommends that CMS, in consultation with ACL, consider a pilot or demonstration program to evaluate the impact of such evidence-based Alzheimer's caregiver support models could have on the Medicare and Medicaid programs.

Action Taken or To Be Taken
CMS agrees that caregivers have an important role in the lives of individuals with Alzheimer's disease and dementia as they face the challenges of these diseases. As part of CMS' ongoing efforts to improve payment for primary care and patient-centered care management services under the Medicare Physician Fee Schedule, beginning in CY 2017, we established a new code to pay separately for comprehensive assessment and care planning for patients with cognitive impairment, such as from Alzheimer's disease or dementia. The service includes central elements that must be performed, with some of the elements requiring engagement with caregivers. For example, the physician (or other appropriate practitioner) must identify caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver(s) to take on caregiving tasks. In addition, a care plan must be created and shared with the patient and/or caregiver with initial education and support. We also included a Communication and Care Coordination quality measure in the Merit-Based Incentive Payment System (MIPS) that measures the percentage of patients, regardless of age, with a diagnosis of dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes and referred to additional resources for support within a 12 month period.

We appreciate the recommendation to consider a model to evaluate the impact of Alzheimer's caregiver support models on the Medicare and Medicaid programs. As we consider payment and service delivery models to test under the Center for Medicare and Medicaid Innovation, we draw upon many suggestions and proposals to inform our priorities and help us develop specific models to test.

*Electrodiagnostic Tests*- The Committee requests an update from CMS submitted to the Committees on Appropriations of the House of Representatives and the Senate on the three recommendations proposed by the 2014 OIG Report: "Questionable Billing for Medicare Electrodiagnostic Tests".

Action Taken or To Be Taken
As you are aware, in 2014, the Department of Health and Human Services' Office of Inspector General (OIG) released a report titled, *Questionable Billing for Medicare Electrodiagnostic Tests* and found that, in 2011, physicians had questionable Medicare billing for EDX tests totaling $139 million. The OIG made three recommendations: that the Centers for Medicare & Medicaid Services (CMS) increase monitoring of EDX billing; provide additional guidance and education to physicians on EDX testing; and take appropriate action regarding physicians identified by the OIG as having inappropriate or questionable billing. Since receipt of that report, CMS has taken several steps to implement OIG's recommendations.

First, OIG recommended that CMS increase its monitoring of billing for EDX testing. CMS has implemented a Fraud Prevention System (FPS) nerve conduction model related to unusually high billing for EDX tests. The FPS models create alerts as the models identify claims and other data that suggest aberrant billing. Leads are then prioritized by potential fraud risk in the system, and Zone Program Integrity Contractors investigate those within the highest risk tier for fraud.

In addition, CMS tasked a medical review contractor, the Supplemental Medical Review Contractor (SMRC), to review samples of EDX claims from the top 100 physicians, ranked by questionable amounts billed, as identified in the OIG report. CMS instructed the SMRC to determine which, if any, of the categories of questionable billing in the review are the best predictors of improper payments. CMS will issue the SMRC findings to the Medicare Administrative Contractors (MACs) and encourage them to include predictors of improper payments in EDX claims when developing their 2017 annual Improper Payment Reduction Strategy.

Second, OIG recommended that CMS provide additional guidance and education to physicians regarding EDX tests. CMS has conducted a webinar to provide additional guidance and education to providers regarding EDX testing. CMS has also issued two Comparative Billing Reports (CBRs), which are educational tools, to physicians on EDX testing. The first was released in June 2014 and the second in January 2016. When appropriate, CBRs are sent to the top 5,000 billing providers and contain information and explanations that compare a provider's billing and payment patterns to those of their peers in their state and across the nation.

In February 2016, CMS also conducted a webinar on the CBRs that discussed Medicare coverage policy, the CBR's results and methodology, and provider references and resources. CMS believes this information helps educate providers on Medicare payment for EDX tests. OIG has agreed that this recommendation has been implemented.

Finally, OIG recommended that CMS take appropriate action regarding physicians identified as having inappropriate or questionable billing. As mentioned, CMS tasked the SMRC with reviewing samples of EDX claims. The SMRC found errors related to overutilization of services, services not being medically-necessary, and lack of orders for the requested tests. However, the claims referral from OIG was for claims for 2011, which are now past the statutory four year look-back timeframe. CMS is considering options for examining more recent claims data and sharing claims requiring adjustment with the applicable Medicare Administrative Contractors (MACs). CMS believes these actions will implement the recommendation.

In addition to the work described above to address OIG's recommendations, it is important to note that as OIG was doing its work on nerve conduction and EMG, CMS was reforming coding and payment to reflect appropriate payment policies. As part of our continuing misvalued code initiative, both nerve conduction tests and electromyography tests were identified for review because they were performed together more than 75 percent of the time. This resulted in the American Medical Association's (AMA) Current Procedural Terminology (CPT) Editorial Panel creating new bundled payment codes for nerve conduction for calendar year (CY) 2013 and new codes for electromyography testing when performed with nerve conduction testing for CY 2012. CMS established revised values for these new bundled codes that reflected the efficiencies of tests being performed together in the same session. Not only did these changes result in significant reductions in the payments made for these services in total, but simplified

the coding which significantly reduced the incentive to provide services that were not medically necessary. Total combined payment for nerve conduction tests and electromyography tests declined by 32 percent from 2011 to 2013. The 2014 OIG report was based upon claims data from 2011 and thus does not reflect these changes.

*Evaluation and Management Research.*- The Committee recognizes that both traditional and innovative payment models rely on traditional fee-for-service as a foundation for physician payment. The existing outpatient evaluation and management service codes do not adequately capture the range of outpatient evaluation and management work performed by cognitive physicians. The Committee encourages CMS to commission the research necessary to understand, on the basis of newly collected data, what occurs during and following an outpatient evaluation and management service. Once complete, CMS should use these findings to develop new outpatient service codes and the associated documentation requirements. This research model can then be used to revise the other evaluation and management code families. The Committee expects a report submitted to the Committees on Appropriations of the House of Representatives and the Senate on the status of this research in the fiscal year 2018 CJ.

Action Taken or To Be Taken
In recent years, CMS has been engaged in an ongoing effort to update and improve the relative value of primary care, care management/coordination, and cognitive services within the Medicare Physician Fee Schedule (PFS) by identifying gaps in appropriate payment and coding. These efforts include changes in payment and coding for a broad range of PFS services.

In calendar year (CY) 2013, CMS began by focusing on post-discharge care management and transition of Medicare beneficiaries back into the community, establishing new codes under the PFS to pay separately for transitional care management services. Next, we finalized new coding and separate payment beginning in CY 2015 for chronic care management services provided by clinical staff. We subsequently established new codes and separate payments beginning in CY 2017 for comprehensive assessment and care planning for patients with cognitive impairment, and for behavioral health integration services furnished under the psychiatric Collaborative Care Model and other models. Starting in CY 2017, we also finalized separate payments for existing CPT codes describing non-face-to-face prolonged E&M services and separate payments for chronic care management for patients with greater complexity.

Through these efforts, CMS has undertaken ongoing work to improve valuation and payment accuracy, as well as address coding and payment gaps, for primary care, cognitive services, and patient-centered care management to meet the changing needs of the Medicare population.

*Pre·Dispute Arbitration* SNF- The Committee is aware that CMS has proposed regulations that would restrict or prohibit predispute arbitration agreements in skilled nursing facilities. The Committee urges CMS to more thoroughly study the impact of restricting pre-dispute arbitration agreements before taking further action.

Action Taken or To Be Taken
On September 28, 2016, the Federal Register posted the notice of the CMS final rule *Reform of Requirements for Long-Term Care Facilities*. The rule was published in the Federal Register on October 4, 2016, and became effective on November 28, 2016. The published final rule revises

the requirements that LTC facilities must meet to participate in the Medicare and Medicaid programs. One of the new requirements at 42 C.F.R. §483.70(n)(1) prohibits nursing homes receiving Medicare or Medicaid funds from entering into pre-dispute binding arbitration agreements with any resident or resident's representative nor require that a resident sign an arbitration agreement as a condition of admission to the nursing home.

On November 7, 2016, the United States District Court for the Northern District of Mississippi, Oxford Division (Civil Action No. 3:16-CV-00233), issued an order preliminarily enjoining CMS from enforcing section 483.70(n)(1). At this time, CMS is not enforcing the new rule prohibiting skilled nursing facilities, nursing facilities and dually-certified facilities from using pre-dispute binding arbitration agreements while there is a court-ordered injunction in place prohibiting enforcement of this provision.

*Health Insurance Exchange Transparency*- The Committee continues bill language that requires CMS to provide cost information for the following categories: Federal Payroll and Other Administrative Costs; Exchange related Information Technology [IT]; Non-IT Program Costs, including Health Plan Benefit and Rate Review, Exchange Oversight, Payment and Financial Management, Eligibility and Enrollment; Consumer Information and Outreach, including the Call Center, Navigator Grants and Consumer Education and Outreach; Exchange Quality Review; Small Business Health Options Program [SHOP] and Employer Activities; and Other Exchange Activities. Cost Information should be provided for each fiscal year since the enactment of the Patient Protection and Affordable Care Act (Public Law 111-148). CMS is also required to include the estimated costs for fiscal year 2018.

Action Taken or To Be Taken

**Health Insurance Exchanges Transparency Table**

Dollars in Thousands

| Activity | FY 2010 Actual | FY 2011 Actual | FY 2012 Actual | FY 2013 Actual | FY 2014 Actual | FY 2015 Actual | FY 2016 Actual | FY 2017 Annualized CR /2 | FY 2018 President's Budget |
|---|---|---|---|---|---|---|---|---|---|
| **Health Plan Bid Review, Management and Oversight** | $ - | $ 300 | $ 21,936 | $ 40,595 | $ 33,497 | $ 43,960 | $ 40,520 | $ 37,654 | $ 31,058 |
| **Payment and Financial Management** | $ - | $ 1,698 | $ 24,998 | $ 25,832 | $ 49,615 | $ 43,733 | $ 51,325 | $ 44,442 | $ 32,942 |
| **Eligibility and Enrollment** | $ - | $ 2,218 | $ 3,433 | $ 275,501 | $ 339,754 | $ 363,768 | $ 445,249 | $ 380,300 | $ 321,638 |
| **Consumer Information and Outreach** | $ - | $ 2,427 | $ 32,610 | $ 701,075 | $ 704,136 | $ 753,238 | $ 805,833 | $ 712,935 | $ 573,500 |
| *Call Center (non-add)* | $ | $ - | $ 22,000 | $ 505,446 | $ 545,600 | $ 566,178 | $ 563,638 | $ 541,000 | $ 510,000 |
| *Navigators Grants & Enrollment Assisters (non-add)* | $ - | $ - | $ - | $ 107,513 | $ 97,152 | $ 102,438 | $ 99,677 | $ 97,115 | $ 13,500 |
| *Consumer Education and Outreach (non-add)* | $ | $ - | $ 7,043 | $ 77,436 | $ 49,334 | $ 54,897 | $ 101,048 | $ 44,350 | $ 20,000 |
| **Information Technology** | $ 2,346 | $ 92,672 | $ 166,455 | $ 402,553 | $ 770,957 | $ 798,648 | $ 664,083 | $ 680,520 | $ 636,000 |
| **Quality** | $ | $ - | $ - | $ - | $ 17,189 | $ 15,634 | $ 11,736 | $ 14,000 | $ 4,000 |
| **SHOP and Employer Activities** | $ | $ 366 | $ 18,479 | $ 25,076 | $ 30,541 | $ 42,717 | $ 34,520 | $ 21,000 | $ 11,500 |
| **Other Marketplace** | $ 1,879 | $ 14,906 | $ 13,738 | $ 4,400 | $ 6,728 | $ 3,614 | $ 12,032 | $ 27,500 | $ 9,250 |
| **Federal Payroll and Other Administrative Activities** | $ 429 | $ 10,805 | $ 43,493 | $ 68,429 | $ 80,000 | $ 80,000 | $ 85,000 | $ 85,000 | $ 73,750 |
| **Total** | $ 4,654 | $ 125,392 | $ 325,142 | $ 1,543,461 | $ 2,032,418 | $ 2,145,312 | $ 2,150,297 | $ 2,003,350 | $ 1,693,638 |

1/ Fiscal years 2010 through 2016 include obligations as of September 30 of each year.

2/ FY 2017 Annualized Continuing Resolution (CR) is an estimate and subject to change.

NOTE: Before the Exchanges were transferred to CMS, $4.7 million and $66.3 million in obligations were incurred in FY 2010 and FY 2011, respectively.

*Recovery Audit Contractors* [RAC]- The Committee directs the Medicare appeals intra-agency working group to provide quarterly updates to the Committees on Appropriations of the House of Representatives and the Senate reflecting the total number of appeals filed, appeals pending, and appeals disposed of for all four levels of the appeals process. The quarterly updates should include a breakout of RAC and non-RAC claims, an update on RAC contracting and how new RAC requirements have affected the rate of appeals.

Action Taken or To Be Taken
The intra-agency appeals working group will provide quarterly updates to the Committees on Appropriations of the House of Representatives and the Senate reflecting the total number of appeals filed, appeals pending, and appeals disposed of for all four levels of the appeals process.

*Risk Corridor Program*- The agreement continues bill language to prevent the CMS Program Management appropriation account from being used to support risk corridor payments. The agreement directs CMS to provide a report starting with plan year 2014 and continuing through the duration of the program to the Committees on Appropriations of the House of Representatives and the Senate detailing the receipts and transfer of payments for the Risk Corridor Program.

Action Taken or To Be Taken
On November 18, 2016, CMS announced issuer-level risk corridors payments and charges for the 2015 benefit year, including risk corridors payments and charges calculated for the 2015 benefit year, by State and issuer, and the additional amount based on anticipated 2015 risk corridors collections that HHS expects to pay towards the calculated 2014 benefit year payments. This information is currently available on the CMS website by following the link below.
https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf

*Rural Health*- While nearly a quarter of the U.S. population lives in rural areas, access to CAHs continues to be a challenge for many residents as these hospitals face significant financial challenges. The majority of rural residents are older, poorer, and less likely to have employer sponsored health plans. As a result, if a rural hospital closes, many patients end up driving long distances to see a doctor, forgo seeking medical care, or even worse, wait until it is too late to seek proper medical attention. These patients spend more money out of pocket to travel and miss out on routine preventative care which will end up increasing healthcare costs in the long run. The Committee continues to direct CMS to work with HRSA's Office of Rural Health and provide an update in the fiscal year 2018 CJ on actions taken to alleviate the disproportionate impact of regulations, reimbursement cuts, and workforce issues on rural hospitals.

Action Taken or To Be Taken
Rural issues are an important focus of the CMS Administrator. CMS has rural health coordinators at each of our Regional Offices, who meet monthly with participation from CMS central office staff and the Health Resources and Services Administration (HRSA) to discuss emerging issues. In addition, staff from the Federal Office of Rural Health Policy (FORHP) take part in the review of all proposed regulations with a specific charge to analyze the impact on small rural hospitals and other providers. CMS and FORHP staff also meet regularly through the year to discuss the impact of current regulations and seek opportunities to reduce the regulatory

and administrative burden on small, rural providers. In 2016, CMS also established the CMS Rural Health Council. Made up of experts from across the agency, the Rural Health Council has been thinking about three strategic areas – first, ways to improve access to care for all Americans in rural settings; second, ways to support the unique economics of providing health care in rural America; and third, making sure the health care innovation agenda appropriately fits rural health care markets. In addition, in October 2016, the Rural Health Council hosted the CMS Rural Health Solutions Summit, which brought together national, state, and local leaders to discuss innovative strategies for improving rural care, access, and cost. The Rural Health Council continues to work with CMS program experts to bring attention to rural issues.

*Use of Social Security Numbers on Medicare Beneficiaries' Cards- Under* Public Law 114-10, Congress prohibits the use of Social Security numbers on Medicare beneficiary cards. The Committee urges CMS to work expeditiously to remove Social Security numbers from Medicare cards as directed in Public Law 114-10. The Committee directs CMS to provide an update on the progress of this initiative in their fiscal year 2018 CJ.

Action Taken or To Be Taken
Beginning in April 2018, CMS will start sending new Medicare cards with the Medicare Beneficiary Identifier (MBI) to Medicare beneficiaries. By October 2018, CMS will complete distribution of new Medicare cards with an MBI to all people with Medicare. We plan to have a transition period where either the SSN-based Health Insurance Claim Number (HICN) or the MBI can be used to exchange data with us. The transition period will begin no earlier than April 1, 2018 and run through December 31, 2019. CMS is updating our systems and will reach out soon to help stakeholders get ready for the new Medicare cards.

**House report**

*Access to Home Health Care*—The Committee is aware that the current requirement that home health plans be solely certified by a physician has resulted in problems with access to home health care. The Committee urges CMS to ensure access to home health care by considering methods to waive the requirement that home health plans be solely certified by a physician. The Committee also requests CMS consider the entire record of documentation and not require a subjective component regarding an individual in determining whether home health services meet the requirements for coverage. The Committee requests CMS take authorized steps to address the backlog of face-to-face appeals like allowing comparable documentation to satisfy the face-to-face requirements, such as those recently referred from the hospital setting, to be exempt from the face-to-face requirement. The Committee requests an update in the fiscal year 2018 budget request on these efforts.

Action Taken or To Be Taken
As a condition for payment of home health services under Medicare, the statute requires that only a physician can certify a patient's eligibility for the Medicare home health benefit. As part of the certification of patient eligibility, the statute also requires that the certifying physician must document that a face-to-face encounter with the patient was performed. The face-to-face encounter can be performed by the certifying physician, a physician that cared for the patient in an acute or post-acute care facility (from which the patient was directly admitted to home health), or an allowed non-physician practitioner (working in collaboration with/under the supervision of the certifying physician or the acute/post-acute-care physician).

Whereas a certifying physician previously had to include a narrative explaining the clinical findings of the face-to-face encounter, in the CY 2015 Home Health Prospective Payment System final rule, CMS eliminated the face-to-face narrative requirement effective for home health episodes beginning on or after January 1, 2015. Documentation of the face-to-face encounter, as part of the certification of home health benefit eligibility, now consists of the certifying physician documenting the date of the face-to-face encounter and attesting that the face-to-face encounter occurred within a certain timeframe, was related to the primary reason the patient requires home health services, and was performed by one of the allowed clinicians.

For medical review purposes, CMS separately requires documentation in the certifying physician's medical records and/or the acute/post-acute care facility's medical records (if the patient was directly admitted to home health) to be used as the basis for certification of patient eligibility. Information from the home health agency, such as the initial and/or comprehensive assessment of the patient required by the home health conditions of participation, can be incorporated into the certifying physician's and/or the acute/post-acute care facility's medical record for the patient and used to support the certification. However, the information from the home health agency must be corroborated by other medical record entries in the certifying physician's and/or the acute/post-acute care facility's medical record for the patient. In addition, the certifying physician must review and sign off on anything incorporated into the patient's medical record that is used to support the certification.

CMS is developing voluntary electronic and paper clinical templates for documenting patient eligibility for the Medicare home health benefit. For the electronic clinical template, CMS is developing a list of clinical elements that would allow electronic health record vendors to create prompts to assist physicians when documenting patient eligibility for the home health benefit. Once a physician has completed the relevant template, the resulting progress note or clinic note would be part of the medical record.

*Adult Immunization Quality Measures*— The Committee recognizes the importance of quality measurement tools to ensuring accountability and improvements in care delivery and patient outcomes, including reducing racial and ethnic health disparities. The Committee requests a report is the fiscal year 2018 budget request on steps the agency has taken to improve outcome quality measures applicable to adult immunization under the Medicare and Medicaid programs.

Action Taken or To Be Taken

CMS recognizes the importance of adult immunization, and believe that quality measurement is one of the efforts that can assist in the goal of improved immunization rates. CMS now has a number of Medicare quality reporting programs with measures that can both assist in evaluating the quality of care, and that can provide valuable information to clinicians and facilities about clinical outcomes and processes. Quality measures related to influenza immunization and pneumococcal vaccine immunization for adults are currently included in some of these programs.

For example, the new Merit-Based Incentive Payment System for clinicians, which is part of the Quality Payment Program, is in its first reporting period in 2017. Under this program, clinicians choose measures to report; among the measures are two immunization measures: the Influenza Immunization measure and the Pneumococcal Vaccination Status for Older Adults measure. Clinicians can choose to report these measures through registries or, in some cases, on their claims. Alternatively, if a group of 25 or more clinicians chooses to report quality data under this program through an option called the CMS Web Interface, there are 15 required measures that must be reported, and the two immunization measures are among them.

The influenza and pneumococcal vaccine measure are also part of the Home Health Quality Reporting Program. Home health agencies report this data through an assessment instrument (the Outcome and Assessment Information Set), and the results are reported on the Home Health Compare website. In addition, for inpatient hospitals, the Immunization for Influenza measure is included in the Hospital Inpatient Quality Reporting Program, and the measure is displayed on the Hospital Compare website.

Through collection and reporting of quality measure data on immunization, CMS hopes that this will lead to improved preventive care, higher immunization rates, reduced morbidity, and overall better health for adults.

*Colorectal Cancer Screening*— The Committee understands that regardless of the fact that colorectal cancer screening by colonoscopy has an A grade from the U.S. Preventive Services Task Force, CMS has determined that it does not have authority to waive Medicare beneficiary coinsurance for a colorectal cancer screening colonoscopy when a polyp or other tissue is removed during the preventive screening. The Committee requests an update in the fiscal year 2018 budget request outlining the rationale for this determination, to include why CMS believes it does not have the waiver authority.

Action Taken or To Be Taken
Colorectal cancer screening identifies premalignant polyps that can be removed and early-stage tumors that can be treated effectively. Under current law, Medicare beneficiaries are not subject to the Part B deductible and coinsurance or copayments for most preventive and screening services, including screening colonoscopies. However, if a screening colonoscopy results in removal of a polyp, ablation or other procedure, section 1834(d)(3)(D) of the Social Security Act (1) directs the Secretary to treat it like a diagnostic/treatment procedure for payment purposes, and (2) waives the Part B deductible but does not waive applicable coinsurance or copayments.

Under a National Coverage Determination (NCD) issued in 2009, CMS carefully reviewed the available evidence on Screening Computed Tomography (CT) Colonography for Colorectal Cancer (also known as “virtual colonoscopy”) and concluded the evidence did not support coverage of this procedure. Thus virtual colonoscopy is not covered by Medicare at this time. Any party may request reconsideration of an NCD along with submission of appropriate new evidence.

*CMS Test Environment for Testing Industry Solutions*— The Committee requests an update in the fiscal year 2018 budget request on the how it is using this initiative to test IT solutions.

Action Taken or To Be Taken
CMS continues to test and implement new and innovative IT solutions. CMS recently tested and implemented a SAS Grid within the Virtual Research Data Center (VRDC), which has created a faster and more readily-available processing environment with a central point of control for administering policies, programs, and job prioritization across all users. CMS now has over 600 programmers using the VRDC environment.

*Durable Medical Equipment, Prosthetics, Orthotics and Suppliers (DMEPOS)*—The Committee encourages speedy implementation of the DMEPOS bid surety bonds requirement to take effect on January 1, 2017. The Committee requests an update in the fiscal 2018 budget request on the expected impact of this requirement in the 2017 competitions.

Action Taken or To Be Taken
In the CY 2017 ESRD PPS final rule (81 FR 77834) published November 4, 2016, CMS finalized the requirement for bidding entities to obtain and provide proof of a bid surety bond for each competitive bidding area (CBA) in which the entity submits its bid(s). The final rule requires bidding entities to obtain a bid surety bond, from an authorized surety on the Department of the Treasury's Listing of Certified Companies, for each CBA associated with their bid. The bid surety bond amount was finalized at $50,000. The final rule included an impact statement (81 FR 77961), which estimated the aggregate total out of pocket cost for bidding entities to bid in this next competition to be $13,000,000.

*Evaluation and Management (E&M) Codes*—The Committee requests CMS provide an update in the fiscal year 2018 budget request on planned or on-going research related to E&M codes.

Action Taken or To Be Taken
In recent years, CMS has been engaged in an ongoing effort to update and improve the relative value of primary care, care management/coordination, and cognitive services within the Medicare Physician Fee Schedule (PFS) by identifying gaps in appropriate payment and coding. These efforts include changes in payment and coding for a broad range of PFS services.

In calendar year (CY) 2013, CMS began by focusing on post-discharge care management and transition of Medicare beneficiaries back into the community, establishing new codes under the PFS to pay separately for transitional care management services. Next, we finalized new coding and separate payment beginning in CY 2015 for chronic care management services provided by clinical staff. We subsequently established new codes and separate payments beginning in CY 2017 for comprehensive assessment and care planning for patients with cognitive impairment, and for behavioral health integration services furnished under the psychiatric Collaborative Care Model and other models. Starting in CY 2017, we also finalized separate payments for existing CPT codes describing non-face-to-face prolonged E&M services and separate payments for chronic care management for patients with greater complexity.

Through these efforts, CMS has undertaken ongoing work to improve valuation and payment accuracy, as well as address coding and payment gaps, for primary care, cognitive services, and patient-centered care management to meet the changing needs of the Medicare population.

*Fraud, Waste, and Abuse*— The Committee requests an update in the fiscal year 2018 request on the CMS process, across all operations, to ensure CMS maintains a focus on preventing improper payments and paying claims right the first time. The Committee requests the update include the metric to measure prevention in lieu of the ''pay and chase'' measures typically reported by CMS.

Action Taken or To Be Taken
Starting in FY 2013, CMS improved its ability to measure program success, grounding the revised savings methodology in the Fraud Prevention System methodology, which was certified by the HHS Office of Inspector General (OIG). CMS revised many of its savings measures to be more precise in determining the impact to the Medicare Trust Funds. Notably, CMS started estimating the impact of revoking providers' billing privileges in FY 2013. By taking swift administrative action to remove providers and suppliers from the program who were no longer qualified to bill Medicare, CMS can estimate avoided payments to these revoked providers over the three-year period following their revocation. CMS calculates a return on investment by dividing the total Medicare savings from program integrity activities for a Fiscal Year (FY) by the

total Medicare costs of conducting those program integrity activities for the same FY. The FPS helped identify or prevent $654.8 million in inappropriate payments during calendar year 2015 through actions taken due to the FPS or through investigations expedited, augmented, or corroborated by the FPS. These identified savings were about 44% higher than the identified savings from the previous year, with a nearly $11.5 to $1 ROI.

*Genetic Testing.*— To help eliminate the abuse of opioids, the FDA recently implemented stricter black box advisories requiring pharmacogenetics testing prior to prescribing many opioid based pain medications. The Committee is concerned the Medicare Administrative Contractors (MACs) changed their coverage policy and are denying reimbursements for these pharmacogenetics tests despite its requirement by the FDA. As a result, providers cannot order these tests and patients are at risk of serious adverse reactions. The Committee urges CMS to review this coverage determination and allow patients to access pharmacogenetics testing for opioid-based pain medications. The Committee requests an update in the fiscal year 2018 budget request on the justification for this new coverage decision including the impact on patient safety, cost, and provider compliance with FDA regulations.

Action Taken or To Be Taken
There is nothing in opioid labels that includes a requirement for pharmacogenetic testing before prescribing**.** Certain codes for drug testing were added to the Medicare Clinical Laboratory Fee Schedule effective January 1, 2016. These tests were crosswalked from a similar existing test code that was on the Medicare Clinical Laboratory Fee Schedule for many years. Under the Medicare Clinical Laboratory Fee Schedule policy, Medicare pays the lesser of the laboratory's charges, the local rate established by the Medicare Administrative Contractor, or the national limitation amount.

*Indian Health Care*—The Committee supports the CMS plan to establish a Tribal Resources Center and requests a timeline in the fiscal year 2018 budget request on the opening and expected goals and objectives for fiscal years 2017 and 2018.

Action Taken or To Be Taken
Although CMS appreciates the Committee's interest, CMS has not requested funding for this initiative in FY 2018.

*Medicare 1115 Waivers*— The Committee is concerned about extended deliberations regarding the home and community-based waiver application. For example, the Wisconsin Department of Health Services in December 2014 submitted a waiver application and a resolution still has not been provided. The Committee encourages CMS to engage more fully the State and tribal stakeholders in an effort to resolve the issue prior to the end of the fiscal year. The Committee requests an update in the fiscal year 2018 budget request on the process and the number days it takes on average, along with the longest and shortest time to make a determination on such a waiver. Further, it should describe steps CMS is taking to reduce the final decision timeframe.

Action Taken or To Be Taken
§1915(c) of the Social Security Act authorizes the Secretary of HHS to waive certain specific Medicaid statutory requirements so that a state may offer home and community-based services to state-specified target group(s) of Medicaid beneficiaries who need a level of institutional care that is provided under the Medicaid State plan. Thus, the Wisconsin waiver referenced is actually a 1915(c) Home and Community-Based (HCBS) Waiver, not an 1115 waiver.

In order to launch a HCBS waiver, a state must submit an initial waiver application to CMS. The application describes the proposed waiver's design and must include sufficient information to permit CMS to determine that the waiver meets applicable statutory and regulatory requirements, especially the assurances specified in 42 CFR §441.302. In accordance with 42 CFR §430.25(f)(3), CMS has no more than 90 calendar days within which to approve or deny an initial waiver application, a waiver renewal or an amendment request or alternatively issue a written request for additional information (RAI). As a general matter, CMS attempts to resolve problems with a waiver application through informal dialogue with the state. CMS attempts to identify any serious problems in an application within 45-days of its receipt.

In regards to Wisconsin's 1915(c) waiver application proposed for tribal entities only, CMS found significant issues with the original application as it targeted a specific group based on national origin and race in violation of federal law. CMS has been in contact with both the state and the tribes to identify other waiver options that the state could pursue to meet their stated goals. At this time, the state has not made a decision as to which path it wants to pursue.

*National Diabetes Prevention Program (NDPP)*— The Committee understands the CMS Office of the Actuary certified expansion of the NDPP would reduce net Medicare spending and improve the quality of care without limiting coverage or benefits. The Committee requests CMS provide an update in the fiscal year 2018 budget request on the feasibility of establishing a certification process for NDPP providers within CMS. Further, the update should discuss the feasibility of establishing a new provider class of practitioners for the NDPP to allow for the lowest cost and effective delivery method.

Action Taken or To Be Taken

The Medicare Diabetes Prevention Program (MDPP) expanded model is a Center for Medicare and Medicaid Innovation model that is being expanded in duration and scope under section 1115A(c) of the Act and will be covered as an additional preventive service under Medicare. CMS is requiring all Diabetes Prevention Program (DPP) organizations, regardless of any existing enrollment in Medicare, to enroll in Medicare as MDPP suppliers in order to furnish and bill for MDPP services.

For the MDPP expanded model, CMS is not, at this time, requiring additional training, certification, or clinician oversight or affiliation beyond the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures, particularly given that the initial DPP model test met the criteria for expansion without these requirements. We will further consider whether we will require coach certification, the impact credentials may have on coaches, and the possibility of clinician affiliation or oversight as we implement, monitor, and evaluate the expanded model.

MDPP supplier enrollment in Medicare is expected to begin following rulemaking in 2017, and ahead of implementation of the MDPP expanded model on January 1, 2018. Additional rulemaking is required to finalize enforcement activities related to supplier enrollment.

*Out of Network Emergency Care*— The Committee is concerned the Center for Consumer Information and Insurance Oversight (CCIIO) has not provided sufficient clarity on how to determine the ‘‘Usual, Customary & Reasonable’’ (UCR) amount in its final rule for patient protections (80 Fed. Reg. 72191). Therefore, the Committee requests CCIIO publish guidance, which may come in the form of Frequently Asked Questions, clarifying what constitutes the UCR

amount using a transparent and fair standard, such as an independent unbiased charge database.

Action Taken or To Be Taken
On April 20, 2016, the Departments of Health and Human Services, Labor and the Treasury published Affordable Care Act Frequently Asked Questions (FAQs) Implementation Part 31. One of the FAQs in that set (#4) provided additional clarity on plan and issuer obligations regarding disclosure of the manner in which they determine the minimum payment required for out-of network emergency services under PHSA section 2719A and its implementing regulations. The FAQ is accessible here (and pasted below): https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-31_Final-4-20-16.pdf

**Q4: Is a plan or issuer required to disclose how it calculated the amount under the minimum payment standards, including the method the plan or issuer generally uses to determine payments for out-of-network services (e.g., the UCR amount)?**

Yes. For plans subject to the Employee Retirement Income Security Act (ERISA), documentation and data used to calculate each of the minimum payment standards, including the UCR amount, for out-of-network emergency services are considered to be instruments under which the plan is established or operated and would be subject to the disclosure provisions under ERISA section 104(b) and 29 CFR 2520.104b-1, which generally require such information be furnished to plan participants (or their authorized representatives) within 30 days of request.

In addition, the DOL claims procedure regulations, as well as the internal claims and appeals and external review requirement under PHS Act section 2719, which apply to non-grandfathered group health plans and issuers of non-grandfathered group or individual coverage, set forth rules regarding claims and appeals, including the right of a claimant (or the claimant's authorized representative) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. A failure to provide or make payment in whole or in part is an adverse benefit determination.

*Quality Improvement.*—The Committee is concerned about the inconsistency of how health care practices and facilities focus on quality improvement. The Committee requests the Secretary conduct a cross-agency review of the programs, agencies, and offices that are conducted in conjunction with public and private organizations to evaluate the effectiveness of these approaches to promote quality metrics that drive continuous quality improvement within hospitals, health care facilities, and health care systems. The review should include all CMS and Innovation Center programs, as well as those conducted throughout other HHS agencies. Further, the review should examine how these efforts address pediatric neurodevelopmental disabilities, including autism. The review should include recommendations and a public report posted on an HHS website. The Committee requests a time line and approach for the review to be included in the fiscal year 2018 budget request.

Action Taken or To Be Taken
The Department acknowledges the Committee's concern and shares its commitment to ensuring high quality health care. In May of 2016, CMS published the CMS Quality Measure Development Plan (MDP) and the Blueprint for the CMS Measures Management System

(MMS), which discuss the need to align measures and fill in vital gaps in quality measurement. The MDP and MMS build on the Department's National Quality Strategy and the CMS Quality Strategy. At this time, the Department is in the process of developing a timeline and approach to conduct an agency-wide review of our quality metrics and programs. We look forward to sharing with the Committee a timeline and approach as soon as they are available.

*Pediatric End-Stage Renal Disease*— The Committee encourages CMS to examine the pediatric case-mix adjuster for the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS). Specifically, the Committee requests CMS examine Medicare claims and cost data along with data from CROWNWeb to determine the cost of dialysis treatment for Medicare ESRD pediatric patients compared to non-pediatrics Medicare patients to ensure the appropriate reimbursement mix-adjustment formula is being utilized in the PPS for pediatrics. The Committee requests an update on this issue with the analysis in the fiscal year 2018 budget request.

Action Taken or To Be Taken
CMS agrees it is important that the ESRD PPS payment adjustments are updated and refined so that the system reflects current clinical practice. Although we do not reevaluate and update the payment multipliers each year, we assess the impact of the changes we make to the ESRD PPS by simulating payments using the most recent year of ESRD facility claims and estimating the impact on facilities. For ESRD facilities that treat pediatric patients, we estimate the impact separately for facilities that treat less than 2 percent, between 2 and 19 percent, between 20 and 49 percent, and over 50 percent and publish the impacts in the annual ESRD PPS proposed and final rules.

*Pharmacy Benefit Managers (PBMs)*— The Committee understands CMS fails to conduct oversight on the updating of the PBMs Maximum Allowable Cost (MAC) lists and that when not updated correctly, errors in the PBM MAC lists can lead to increased costs for the government, taxpayers, and most importantly seniors. The Committee requests an update in the fiscal year 2018 budget request on the process CMS uses to oversee that the PBM MAC lists are updated as required.

Action Taken or To Be Taken
CMS requires that Part D sponsors disclose MAC price updates to network pharmacies in a manner that pharmacies can use to validate the prices. Specifically, regulations require that Part D plan sponsors agree to: update any prescription drug pricing standard (including MAC) based on the cost of the drug used for reimbursement of network pharmacies by the Part D sponsor on January 1 of each contract year and not less frequently than once every 7 days thereafter; indicate the source used for making any such updates; and disclose all individual drug prices to be updated to the applicable pharmacies in advance of their use for reimbursement of claims, if the source for any prescription drug pricing standard is not publicly available (42 CFR §423.505(b)(21)). CMS is actively engaged in oversight of MAC pricing requirements. We review contracts between Part D applicants and their pharmacy benefit managers for required language. We will continue to monitor Part D sponsors' implementation of and compliance with these provisions and enforce the regulatory requirements consistent with our oversight authority.

*Recovery Audit Contractors (RACs)*— The Committee understands that although the RACs significantly reduced the number of audits recently, the number of audits is expected to increase. The Committee agrees that true fraud, waste, and abuse must be addressed;

however, the existing audit process continues to result in unintended consequences of reduced patient access to care. A reasonable balance must be found to eliminate true fraud and abuse while not slowing payment to providers so significantly. The bill language redirects all offsetting collections derived from the RACs to tackle this challenge with additional resources to educate health care providers on how to reduce errors and on the program integrity and compliance audits; for the Office of Medicare Hearings and Appeals (OMHA) to reduce its backlog; and to establish a process to provide feedback between OMHA, CMS, and CMS' contractors to reduce unintended claims, speed appeals, and reduce the number of claims elevated to OMHA. Further, the Committee reiterates its request for CMS to publish in the fiscal year 2018 budget request, and future budget requests, a CMS actuarial report that estimates the dollar level of improper payments by year and the actual and estimated recovery of each year's improper payments, and the percentage of each year's recovered level compared to the estimate of improper payments.

Action Taken or To Be Taken
The Medicare Fee-For-Service gross improper payment estimate for FY 2016 is 11.0 percent or $41.08 billion. OMB Circular A-136 requires agencies to provide detailed information on their recovery auditing programs, as well as other efforts related to the recapture of improper payments. Some of our programs have results to report in this area and those results are included in Table 4 on page 240 of the Department of Health and Human Services FY 2016 Agency Financial Report, available here: https://www.hhs.gov/sites/default/files/fy-2016-hhs-agency-financial-report.pdf

*Robotic Stereotactic Radiosurgery*—The Committee was encouraged by CMS' decision to reverse the National Correct Coding Initiative procedure edit regarding CPT codes 77295 and 77300 used in the provision of robotic radiosurgery (retroactive to January 1, 2016). The Committee remains concerned that the cuts CMS continues to make to robotic stereotactic radiosurgery threatens its viability. The Committee continues to urge CMS to make no further changes to these services (G0339 and G0340) in the freestanding center setting for three years as noted in House Report (114-195).

Action Taken or To Be Taken
CMS did not finalize its proposal from the CY 2015 Medicare Physician Fee Schedule proposed rule that would have recognized only CPT codes 77372 and 77373 for payment of stereotactic radiosurgery services (SRS) and deleted G0339 and G0340, the codes used to report robotic delivery of SRS. After consideration of public comments regarding the appropriate inputs to use in pricing SRS, we concluded that we lacked sufficient information to make a determination about the appropriateness of deleting codes G0339 and G0340 and paying for all SRS/stereotactic body radiation therapy services using the CPT codes. Codes G0339 and G0340 remain in place and continue to be contractor-priced under the Medicare Physician Fee Schedule as of CY 2017.

*Standard Plan Design and Plan Limitation*—The Committee is concerned about recent proposals and considerations from CMS on Federally Facilitated Exchanges, which could further destabilize the individual market and limit beneficiary choice. In the proposed 2017 notice of benefit and payment parameters, CMS proposes to introduce standard plan designs and is considering making these standard plan designs a requirement for future years. Additionally, CMS appears to be considering limiting the number of offerings from plans on the Exchanges for future years. The Committee requests CMS provide justification in the fiscal year 2018 budget request analyzing the impact from the proposals on plan participation, premiums, and formulary and network design for 2017 and the impact each would have on consumers.

Action Taken or To Be Taken

Issuers selling plans on the Federally-facilitated Exchanges are not required to offer standardized plan designs to consumers. As indicated in the HHS Notice of Benefit and Payment Parameters for 2018 Final Rule, published in the Federal Register on December 22, 2016, however, standardized options can simplify the consumer shopping experience in many markets and encourage the availability of plan designs with beneficial features (such as pre-deductible services) that may not otherwise exist in certain markets. The rule identifies one standardized option at each metal level and one at each cost-sharing reduction plan variation level for use in each State for health insurance issuers that choose to offer such options. CMS recognizes that the cost-sharing structures in the standardized options may not be appropriate for all issuers or all markets, and issuers are not required to offer standardized options, nor is their ability to offer other qualified health plans limited, subject to other applicable law.

*Program Integrity Activities*— For several years now, the Committee has requested CMS improve consistency, transparency, and processing of appeals. The Committee has and continues to request CMS use offsetting collections from the RAC program to further educate health care providers on how to reduce errors to reduce the backlog of appeals and resolve audits in a timely manner. The Committee reiterates these requests and further directs CMS to provide a quarterly report on how the overall process of appeals, including all entities involved in the appeals process are making the necessary changes to improve the system. CMS should detail in the report all the actions the agency has specifically taken to improve the process of audits and appeals. The Committee also requests a description in the fiscal year 2018 budget request on the adoption of a policy similar to Social Security appeals that would require Medicare's Administrative Law Judges (ALJs) to follow Medicare payment policies. Further, the Committee requests the Secretary consider ways to sample and consolidate similar claims for administrative efficiency, expedite procedures for claims with no material fact in dispute, rules to require ALJs to rule according to Medicare policy if they do not violate the law, the impact of sending claims back to the first level of appeal when new evidence is introduced, and the impact of creating Medicare Magistrates to streamline the appeal resolution process.

Action Taken or To Be Taken

Administrative Law Judges (ALJs) are bound by the same requirements as the Qualified Independent Contractors and the Departmental Appeals Board and we continue to engage in ALJ education to ensure all adjudicators share an understanding of the CMS regulations, statute, rules, and coverage determinations. HHS intends to submit to Congress a comprehensive legislative reform package for Medicare appeals that addresses the Committee's requests in the near future.

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**Program Management Appropriation Summary**
**Proposed Law**
**(Dollars in Thousands)**

| Activity | FY 2016 Final | FY 2017 Annualized CR | FY 2018 Budget Request |
|---|---|---|---|
| **Program Operations** | $2,824,823 | $2,819,453 | $2,441,274 |
| Mandatory Appropriation, Proposed Law | $0 | $0 | $0 |
| Appropriation, Net, Proposed Law | $2,824,823 | $2,819,453 | $2,441,274 |
| **Federal Administration** | $732,533 | $731,140 | $722,533 |
| Mandatory Appropriation, Proposed Law | $0 | $0 | $0 |
| Appropriation, Net, Proposed Law | $732,533 | $731,140 | $722,533 |
| **State Survey & Certification** | $397,334 | $396,579 | $406,135 |
| Discretionary Appropriation, Proposed Law 1/ | $0 | $0 | $25,596 |
| Appropriation, Net, Proposed Law | $397,334 | $396,579 | $431,731 |
| **Research, Demonstration & Evaluation** | $20,054 | $20,016 | $18,054 |
| Mandatory Appropriation, Proposed Law | $0 | $0 | $0 |
| Appropriation, Net, Proposed Law | $20,054 | $20,016 | $18,054 |
| **Discretionary Appropriation, Net** | **$3,974,744** | **$3,967,188** | **$3,587,996** |
| **Discretionary Appropriation, Proposed Law** | **$0** | **$0** | **$25,596** |
| **Total Appropriation, Proposed Law** | **$3,974,744** | **$3,967,188** | **$3,613,592** |

1/ Includes estimated offsetting user fee collections to implement the Survey and Certification Revisit Fee proposal contained in the President's Budget.

# Program Management Proposed Law Summary (Discretionary)

CMS' FY 2018 request includes a discretionary proposal for offsetting collections. The authority to implement the new collections will be requested through appropriations language. The proposal is described in more detail below:

- **Survey and Certification Re-Visit and Complaint Investigation Fee**

  CMS proposes a discretionary fee for revisits that occur as a result of deficiencies found during initial certification, recertification, or substantiated complaints surveys. In addition, CMS will also charge facilities a fee for substantiated compliant surveys resulting in findings cited at the level of immediate jeopardy or actual harm. The collections would supplement the Program Management funding for the Survey and Certification program. Collections are estimated at $25.6 million in FY 2018.

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This performance section documents CMS progress towards the goals and objectives of the previous Administration. The current Administration's priorities will be reflected in the upcoming FY 2019 CMS Performance Budget and in the HHS Strategic Plan FY 2018-2022 and FY 2019 Annual Performance Plan and Report, all due to be released in FY 2018.

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# CMS FY 2018 PERFORMANCE APPENDIX

# PROGRAM OPERATIONS

## MCR9: Ensure Beneficiary Telephone Customer Service

| Measure | FY | Target | Result |
|---|---|---|---|
| MCR9.1a: Quality Standards: Minimum of 90 percent pass rate for Adherence to Privacy Act | 2018 | 90% | Oct 31, 2018 |
| | 2017 | 90% | Oct 31, 2017 |
| | 2016 | 90% | 98% (Target Exceeded) |
| | 2015 | 90% | 97% (Target Exceeded) |
| | 2014 | 90% | 97% (Target Exceeded) |
| | 2013 | 90% | 98% (Target Exceeded) |
| | 2012 | 90% | 98% (Target Exceeded) |
| | 2011 | 90% | 97% (Target Exceeded) |
| | 2010 | 90% | 98% (Target Exceeded) |
| | 2009 | 90% | 97% (Target Exceeded) |
| | 2008 | 90% | 97% (Target Exceeded) |

| | | | |
|---|---|---|---|
| MCR9.1b: Quality Standards: Minimum of 90 percent meets expectations for Customer Skills Assessment | 2018 | 90% | Oct 31, 2018 |
| | 2017 | 90% | Oct 31, 2017 |
| | 2016 | 90% | 96%<br>(Target Exceeded) |
| | 2015 | 90% | 94%<br>(Target Exceeded) |
| | 2014 | 90% | 98%<br>(Target Exceeded) |
| | 2013 | 90% | 98%<br>(Target Exceeded) |
| | 2012 | 90% | 98%<br>(Target Exceeded) |
| | 2011 | 90% | 98%<br>(Target Exceeded) |
| | 2010 | 90% | 99%<br>(Target Exceeded) |
| | 2009 | 90% | 96%<br>(Target Exceeded) |
| | 2008 | 90% | 94%<br>(Target Exceeded) |

| | | | |
|---|---|---|---|
| MCR9.1c: Quality Standards: Minimum of 90 percent meets expectations for Knowledge Skills Assessment | 2018 | 90% | Oct 31, 2018 |
| | 2017 | 90% | Oct 31, 2017 |
| | 2016 | 90% | 95% (Target Exceeded) |
| | 2015 | 90% | 94% (Target Exceeded) |
| | 2014 | 90% | 95% (Target Exceeded) |
| | 2013 | 90% | 93% (Target Exceeded) |
| | 2012 | 90% | 97% (Target Exceeded) |
| | 2011 | 90% | 92% (Target Exceeded) |
| | 2010 | 90% | 98% (Target Exceeded) |
| | 2009 | 90% | 93% (Target Exceeded) |
| | 2008 | 90% | 94% (Target Exceeded) |

| | | | |
|---|---|---|---|
| MCR9.3: Minimum of 90 percent pass rate for the Customer Satisfaction Survey | 2018 | 90% | Oct 31, 2018 |
| | 2017 | 90% | Oct 31, 2017 |
| | 2016 | 90% | 92% (Target Exceeded) |
| | 2015 | 90% | 88% (Target Not Met) |
| | 2014 | 90% | 90% (Target Met) |
| | 2013 | 90% | 93% (Target Exceeded) |
| | 2012 | 90% | 93% (Target Exceeded) |
| | 2011 | 90% | 92% (Target Exceeded) |
| | 2010 | 90% | 90% (Target Met) |

The Beneficiary Contact Center (BCC) has expanded to handle calls and inquiries related to the new Health Insurance Exchanges. As a result, the contact center is now named Contact Center Operations (CCO) to reflect the handling of both beneficiary (Medicare) and consumer (Exchange) inquiries. A CMS Quality Call Monitoring process is used by the Contact Center Operations (CCO) to evaluate each Customer Service Representative's (CSR's) performance in responding to telephone inquiries. The CCO is responsible for evaluating and scoring each CSR's performance each month in handling telephone inquiries using the quality standards of privacy act, knowledge skills, and customer skills. The CCO has met or exceeded the FY 2014 target of 90 percent for each standard. Despite exceeding targets in previous reporting years, we will continue to maintain the quality standards target levels at 90 percent. In order to increase contact center quality standards, contact centers would need to increase the amount of quality assurance staff responsible for monitoring and coaching staff. This would be additional costs for the contractors supporting the contact center. The resources required to ensure a higher quality metric would be better allocated to taking the increased amount of contacts associated with the incoming baby-boomer population as well as the inclusion of Health Insurance Exchange inquiries.

Beginning in FY 2009, the CCO (formerly, BCC) has been assessed by an independent quality assurance (IQA) contractor. The intent of this change is to gather more detail on where improvements can be made in handling telephone inquiries to better serve the calling population. There is currently a parallel effort between the CCO and the IQA contractor to assess quality through quality monitoring tools – but for separate purposes. The CCO

contractor uses Quality Call Monitoring for coaching individual CSRs. Alternatively, CMS' IQA contractor uses Quality Call Monitoring to assess quality from a global perspective as well as to identify processes and areas needing attention and make specific recommendations regarding quality improvements. Part of the IQA Plan addresses quality oversight of English and Spanish inbound and outbound telephone and written correspondence, as well as e-mail, web chat, and faxed inquiries. CMS will use the results of the IQA audits for root cause analysis and identifying areas of improvement to training and content materials as well as any other tools currently available to CSRs.

CMS began collecting data for a new customer satisfaction measure in FY 2009. This measure is based on survey methods designed by CMS with questions approved by the Office of Management and Budget. The survey measures a variety of customer service dimensions, including overall satisfaction, program knowledge, clarity, rapport, customer effort, and First Call Resolution, and captures an aggregated score of these dimensions.

## MCR12: Maintain CMS' Improved Rating on Financial Statements

| Measure | FY | Target | Result |
|---|---|---|---|
| MCR12: Maintain an unmodified opinion | 2018 | Maintain an unmodified opinion | November 30, 2018 |
| | 2017 | Maintain an unmodified opinion | November 30, 2017 |
| | 2016 | Maintain an unmodified opinion | Target Met |
| | 2015 | Maintain an unqualified opinion | Target Met |
| | 2014 | Maintain an unqualified opinion | Target Met |
| | 2013 | Maintain an unqualified opinion | Target Met |
| | 2012 | Maintain an unqualified opinion | Target Met |
| | 2011 | Maintain an unqualified opinion | Target Met |
| | 2010 | Maintain an unqualified opinion | Target Met |
| | 2009 | Maintain an unqualified opinion | Target Met |
| | 2008 | Maintain an unqualified opinion | Target Met |
| | 2007 | Maintain an unqualified opinion | Target Met |

The Chief Financial Officers (CFO) Act of 1990 creates a framework for the Federal Government to focus on the integration of accounting, budget, and other financial activities under one umbrella. This is meant to reduce waste and to provide complete, reliable, timely, and consistent information to Congress on the financial status of the Federal Government.

Our annual goal is to maintain an unmodified opinion, which indicates that our financial statements fairly present, in all material respects, the financial position, net costs, changes in net position, and budgetary resources of CMS. An independent audit firm reviews the financial operations, internal controls, and compliance with laws and regulations at CMS and its contractors.

CMS met its FY 2016 target of maintaining an unmodified opinion on four out of the six principal financial statements. During FY 2016 the auditors could not express an opinion on the CMS Statement of Social Insurance (SOSI) as of January 1, 2016 or the CMS Statement of Changes in Social Insurance Amounts (SCSIA).

CMS has been substantially compliant with the Federal Financial Management Improvement Act (FFMIA) since FY 2010. CMS considers our financial systems to be integrated in accordance with OMB Circular A-127, *Financial Management Systems.* HIGLAS is CMS' official financial system of record used to produce our financial statements. Overall, CMS continued to improve its financial management performance in many areas as evidenced by no material weaknesses being reported as a result of the agency's CFO audit and OMB Circular A-123 review. In addition, we provided a FY 2016 Federal Managers' Financial Integrity Act (FMFIA) statement of reasonable assurance regarding the Agency's internal controls over financial reporting for June 30 and September 30.

During the close-out of the FY 2016 CFO audit, OMB requested that CMS change the term used to describe a clean audit opinion from "unqualified" to "unmodified". We have confirmed with our external CFO auditors (Ernst and Young, LLP) that the terms "unqualified" and "unmodified" have similar meaning and are used interchangeably. The change is in terminology only and does not reflect a change in the auditors' opinion that CMS's FY 2016 financial statements are fairly presented. To comply with OMB's request, going forward CMS will use the term "unmodified" vs "unqualified" to describe a clean opinion.

## MCR21: Effectively Manage Information Technology (IT) Systems and Investments to Minimize Risks and Maximize Return

| Measure | FY | Target | Result |
|---|---|---|---|
| MCR21.1: Percent of CMS Federal Information Security Management Act (FISMA) systems authorized for operation based on defining the number of CMS FISMA systems.<br><br>CMS is reporting (219 out of 224 systems) having an Authorization to Operate (ATO) which aligns to the annual FISMA Report metric (1.1.3) for 2016. | 2018 | 98% | Dec 31, 2018 |
| | 2017 | 95% | Dec 31, 2017 |
| | 2016 | 95% | 97.7%<br>(Target Exceeded) |
| | 2015 | 90% | 92%<br>(Target Exceeded) |
| | 2014 | 90% | 93%<br>(Target Exceeded) |
| | 2013 | 90% | 85%<br>(Target Not Met) |
| | 2012 | 90% | 78%<br>(Target Not Met) |
| | 2011 | 80% | 88%<br>(Target Exceeded) |
| | 2010 | New in 2011 | 78%<br>(Trend) |
| MCR21.2: Percentage of CMS FISMA systems scanned and monitored by a vulnerability management solution<br><br>Baseline: 0% FY 2009 | 2018 | 100% | Oct 31, 2018 |
| | 2017 | 100% | Oct 31,2017 |
| | 2016 | 85% | 100%<br>(Target Exceeded) |
| | 2015 | 85%[1] | 87%<br>(Target Exceeded) |
| | 2014 | 100% | 100%<br>(Target Met) |
| | 2013 | 100% | 100%<br>(Target Met) |
| | 2012 | 100% | 100%<br>(Target Met) |
| | 2011 | 75% | 100%<br>(Target Exceeded) |
| | 2010 | New in 2011 | 63%<br>(Trend) |

[1] Value dropped to 85% as CMS moved FISMA systems to the cloud and to data centers not connected to the CMS network backbone, thus the oversight of those systems were reduced. It is anticipated that those systems will once again be under the oversight of CMS in FY2018.

| | | | |
|---|---|---|---|
| MCR21.3: Percent of information technology (IT) projects that have adapted to the Expedited Life Cycle (XLC) framework<br><br>Baseline: 10% FY 2009 | 2018 | 100% | Dec 31, 2018 |
| | 2017 | 100% | Dec 31, 2017 |
| | 2016 | 100% | 100%<br>(Target Met) |
| | 2015 | 95% | 100%<br>(Target Exceeded) |
| | 2014 | 95% | 100%<br>(Target Exceeded) |
| | 2013 | 95% | 100%<br>(Target Exceeded) |
| | 2012 | 90% | 100%<br>(Target Exceeded) |
| | 2011 | 75% | 100%<br>(Target Exceeded) |
| | 2010 | New in 2011 | N/A |
| MCR21.4: Determine success of new IT implementation projects by completing post-implementation reviews (PIR)<br><br>Baseline: 0 PIR FY2009 | 2018 | 75% (TBD PIRs) | Dec 31, 2018 |
| | 2017 | 75% (or 5 PIRs) | Dec 31, 2017 |
| | 2016 | 75% (or 4 PIRs) | 0%(or 0 PIRs)<br>(Target Not Met) |
| | 2015 | 70% (or 5 PIRs) | 0% (or 0 PIRs)<br>(Target Not Met) |
| | 2014 | 70% (or 2 PIRs) | 100% (or 2 PIRS)<br>(Target Exceeded) |
| | 2013 | 60% (or 24 PIRs) | 31% (or 5 PIRs)<br>(Target Not Met) |
| | 2012 | (40% (or 12 PIRs) | 53% (or 16 PIRs)<br>(Target Exceeded) |
| | 2011 | 12% (or 2 PIRs) | 47% (or 8 PIRs)<br>(Target Exceeded) |
| | 2010 | New in 2011 | N/A |

CMS has four performance measures representing effective management of CMS IT systems and investments to minimize risks and maximize returns. CMS ensures that IT investments are managed effectively by adhering to the Expedited Life Cycle (XLC) framework, by conducting post-implementation reviews, and by making sure that CMS IT systems have a formal Authority to Operate (ATO) and are included in a vulnerability management program.

CMS did not meet its targets for metric 21.4 for FY2015 and FY2016. The process requires the Business Owners to schedule a Post Implementation Review (PIR) following implementation with the Technical Review Board (TRB). There were no PIRs scheduled by the business owners for the projects identified during that fiscal year. As a result, CMS has been at 0% for this goal. To address this, the TRB will revise its TRB Recommendation

Letter to emphasize and mention the importance of a PIR and will reach out to the Business Owners for a status.

## MCR26: Reduce All-Cause Hospital Readmission Rates for Medicare Beneficiaries by One Percent over the Previous Year's Actual Rate

| Measure | CY | Target | Result |
|---|---|---|---|
| MCR26: Reduce all-cause hospital readmission rate by 1% per year from the prior year's actual rate[2] | 2018 | 17.8%[3] | March 1, 2018 (based on CY 2016 data) |
| | 2017 | 17.4% | 18.0% (Target Not Met) (based on CY 2015 data) |
| | 2016 | 17.4% | 17.6 % (Target Not Met) (based on CY 2014 data) |
| | 2015 | 17.9% | 17.6% (Target Exceeded) (based on CY 2013 data) |
| | 2014 | 18.3% | 18.1% (Target Exceeded) (based on CY 2012 data) |
| | 2013 | 18.5% | 18.6% based on CY 2011 data (Target Not Met) |
| | 2012 | Baseline | 18.7% (Baseline – based on CY 2010 data) |

CMS is measuring preventable Medicare inpatient hospital readmissions. CMS established the Hospital Readmissions Reduction Program in FY 2013, which would reduce a portion of Medicare's payment amounts for certain potentially preventable Medicare inpatient hospital readmissions covering three conditions: Acute Myocardial Infarction, Pneumonia, and Congestive Heart Failure. For FY 2015 and future years two additional readmissions measures were added to the program: Chronic Obstructive Pulmonary Disease, and Total Hip Arthroplasty and Total Knee Arthroplasty. For FY 2017 and future years, we established an additional measure for patients readmitted following coronary artery bypass graft (CABG) surgery and we refined the pneumonia readmission measure cohort.

[2] CMS targets reduction of all-cause Medicare hospital readmissions by one percent (not to be confused with one percentage point) per year from the prior year's actual rate (if available) or the prior year's target for the time period when the prior year's actual rate is not yet known. To meet or exceed the Target, the Result must be less than or equal to the calculated Target.

[3] The CY 2018 target may be adjusted based on CY 2017 actual results.

In addition to the Hospital Readmissions Reduction Program, CMS leverages efforts of other programs to reduce hospital readmissions. Among these are the Hospital Improvement Innovation Networks that work to reduce preventable complications during a transition from one care setting to another which includes partnership with the Community-Based Care Transitions Program and Quality Improvement Organizations. CMS' efforts to reduce readmissions also extend to Accountable Care Organizations (ACOs), which must report on and meet targets for quality measures if they wish to receive incentives under the Medicare Fee-for-Service Shared Savings Program.

CMS did not meet its targets for FY2017 because the reduction in the readmission rates appears to have slowed from its recent historical pattern. It is unclear if this is the beginning of a longer term trend or a short term anomaly. CMS will continue to monitor the data. We have set the 2018 target at 17.8 percent. The 2018 target was adjusted based on 2017 actuals. The readmission rate will be monitored annually.

## MCR29: Protect the Health of Medicare Beneficiaries by Implementing the First Value-Based Purchasing Program: End-Stage Renal Disease Quality Incentive Program

| Measure | FY | Target | Result |
|---|---|---|---|
| MCR29.1: Develop drafts and final rules for each payment year (PY) | 2018 | Publish PY 2021 final rule | November, 10 2017 |
| | 2017 | Publish PY 2020 final rule | November, 10 2016 (Target Met) |
| | 2016 | Publish PY 2019 final rule | November 10, 2015 (Target Met) |
| | 2015 | Publish PY 2017/PY 2018 final rule | Final Rule Published November 6, 2014 (Target Met) |
| | 2014 | Publish PY 2016 final rule | Final Rule Published December 2, 2013 (Target Met) |
| | 2013 | Publish PY 2015 final rule | Final Rule published November 9, 2012 (Target Met) |
| | 2012 | Publish PY 2014 final rule | Final rule published November 10, 2011 (Target Met) |
| | 2011 | Publish PY 2013 final rule | Final rule published November 10, 2011 (Target Met) |
| MCR29.2: Implement payment reductions (to meet statutory requirement) | 2018 | Adjust payments for facilities not meeting performance standards (based on 2016 data) | Jan 1, 2018 |
| | 2017 | Adjust payments for facilities not meeting performance standards (based on 2015 data) | Jan 1, 2017 ( Target Met) |
| | 2016 | Adjust payments for facilities not meeting performance standards (based on 2014 data) | Jan 1, 2016 (Target Met) |
| | 2015 | Adjust payments for facilities not meeting performance standards (based on 2013 data) | Jan 1, 2015 (Target Met) |
| | 2014 | Adjust payments for facilities not meeting performance standards (based on 2012 data) | Jan 1, 2014 (Target Met) |
| | 2013 | Adjust payments for facilities not meeting performance standards (based on 2011 claims data) | Jan 1, 2013 (Target Met) |
| | 2012 | Adjust payments for facilities not meeting performance standards | Procedures have been completed and payment reductions began Jan 1, |

| Measure | FY | Target | Result |
|---|---|---|---|
| | | (based on 2010 claims data) | 2012 (Target Met) |
| MCR29.3: Obtain monitoring and evaluation (M&E) contractor and implement monitoring strategy | 2018 | Develop and complete ESRD QIP Final Monitoring Report for PY 2017 | July 31, 2018 |
| | 2017 | Develop and complete ESRD QIP Final Monitoring Report for PY 2016 | July 31, 2017 |
| | 2016 | Develop and complete ESRD QIP Final Monitoring Report for PY 2015 | July 31, 2016 (Target Met) |
| | 2015 | Develop and complete ESRD QIP Final Monitoring Report for PY 2014 | July 31, 2015 (Target Met) |
| | 2014 | Develop and complete ESRD QIP Final Monitoring Report for PY 2013 | July 31, 2014 (Target Met) |
| | 2013 | Develop and complete ESRD QIP Final Monitoring Report for PY 2012 | April 30, 2013 (Target Met) |
| | 2011 | Procure contractor | Acumen awarded M&E contract on Sep 29, 2011 (Target Met) |

Section 153(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) requires the Secretary to implement an End Stage Renal Disease (ESRD) Quality Incentive Program (QIP) that will result in payment reductions to dialysis facilities that do not meet or exceed a total performance score with respect to performance standards established for specified measures. Payment reductions, which will be up to 2 percent, will only apply to payments for renal dialysis services furnished on or after January 1, 2012. Payment reductions are specific to the payment year (PY), and will not factor in future payment years.

Measures adopted in the ESRD QIP directly address four of the six goals in the 2016 CMS Quality Strategy: 1) making care safer; 2) strengthening person and family engagement; 3) promoting effective prevention and treatment of chronic disease; and 4) promoting effective communication and coordination of care. CMS has also obtained a Monitoring and Evaluation contractor to facilitate the monitoring of quality and access to care for beneficiaries under the ESRD Prospective Payment System (PPS) and the ESRD QIP.

The PY 2015 ESRD QIP was finalized in the Federal Register on November 9, 2012. It added new measures for anemia management, and it replaced the dialysis adequacy measure with one that includes adult hemodialysis patients, adult peritoneal dialysis patients, and pediatric in-center hemodialysis patients. The PY 2017 ESRD QIP was finalized in the Federal Register on November 6, 2014. This rule added a new measure risk-standardized hospital readmission ratio and expanded the patient experience of care

measure to a clinical measure using this measure's performance to base facility payments. An outcome measures on transfusions and reporting measures on pain and depression were added to the ESRD QIP measure set for PY 2018, and the PY 2019 ESRD QIP introduced a consolidated composite measure for dialysis adequacy. CMS met its targets for all goals in FY2016 and so far for MCR 29.2 for FY2017. CMS is on target to meet the remaining targets in FY2017.

The 2016 CMS' Quality Strategy goals are being addressed in part by the ESRD QIP monitoring and evaluation (M&E) efforts. With the support of contractor Arbor Research Collaborative for Health, CMS uses qualitative and quantitative approaches to analyze and a stratify findings by beneficiary and facility sub population characteristics. The areas of analysis include an emphasis on beneficiary quality of care, health outcomes, beneficiary access to care and program changes in Medicare expenditures.

Several ESRD QIP monitoring and evaluation analyses are ongoing and investigate beneficiary data in the following areas: Erythropoietin Stimulating Agents (ESA) usage and transfusion rates, vascular access, infection, transplant, and mortality and morbidity rates. These analyses are conducted to identify unintended consequences of the ESRD QIP on beneficiaries and have determined that the ESRD QIP has not had any negative consequences across the monitoring period. For example, beneficiary analyses conducted in previous years examining ESA use have revealed changes in reported ESA use that corresponds with the FDA labeling changes and hemoglobin recommendations. Also, the national facility performance average for standardized readmission rate decreased by 2 percent from 2014 to 2015. As the program develops additional outcome and patient experience measures, we will provide further results in the future.

For future years of the program, CMS aims to strengthen the ESRD QIP by evaluating facilities on a wider range of measures covering more topic areas. CMS is currently developing measures, including those that assess patient engagement, prevention, quality of life, and critical patient outcomes (such as hospitalizations and mortality). In addition, CMS is interested developing further measures on bone mineral metabolism and adopting measures that pertain to transplantations, and chronic disease management.

## MCR30 – Shift Medicare Health Care Payments from Volume to Value

| Measures | CY | Target | Result Available |
|---|---|---|---|
| MCR30 **Alternative payment models**<br><br>Increase the percentage of Medicare Fee-for-Service (FFS) Payments Tied to Alternative Payment Models | 2018 | 50% | Nov 2019 |
| | 2017 | 40% | Nov 2018 |
| | 2016 | 30% | Nov 2017 |
| **Baseline**: Calendar Year (*CY)* 2014 22% | 2015 | 26% | 26%<br><br>(Target Met) |

Health care costs consume a significant amount of our nation's resources. In the United States, one source of inefficiency is a payment system that rewards medical inputs rather than outcomes, has high administrative costs, and lacks focus on disease prevention. HHS, through the Innovation Center at CMS, identifies tests, evaluates, and expands, as appropriate, innovative payment and service delivery models that can reduce program expenditures for Medicare, Medicaid, and Children's Health Insurance Program, while improving or preserving beneficiary health and quality of care. Under this authority, CMS is testing a variety of alternative payment models that create new incentives for clinicians to deliver better care at lower cost. In addition, CMS is implementing payment reforms that increasingly reward quality and efficiency of care (such as the readmissions/hospital acquired condition reduction program).

These alternative payment models and payment reforms that increasingly tie Fee-for-Service (FFS) payments to value are currently moving the health care system in the right direction, but increased alignment across payers would be beneficial. To encourage alignment, Medicare is leading the way by publicly tracking and reporting payments tied to alternative payment models. Moving payments to more advanced payment models in an aligned fashion and on an aligned timeframe increases the overall likelihood that new payment models will succeed.

To monitor the movement of payments to more advanced payment models, HHS developed the following payment taxonomy to describe health care payment through the stages of transition from pure fee-for-service to alternative payment models and, ultimately, population based payments. CMS is using this framework to measure Medicare payments tied to alternative payment models. This framework classifies payment models into four categories according to how clinicians and organizations are paid.

- category 1—fee-for-service with no link of payment to quality;
- category 2—fee-for-service with a link of payment to quality;
- category 3—alternative payment models built on fee-for-service architecture; and
- category 4—population-based payment.

To encourage alignment between public and private payers and to help move payment reform along the continuum described above, HHS has set a target for Medicare: to have 30 percent, 40 percent, and 50 percent of Medicare FFS payments tied to alternative

payment models by the end of CY 2016, CY 2017, and CY 2018, respectively. Data for this measure will be collected and aggregated across CMS alternative payment models. CMS is currently accounting for beneficiaries who are participating in multiple alternative payment models, however, CMS may explore additional methodologies to account for these overlapping beneficiaries across alternative payment models in future reporting years. CMS has established a baseline of 22 percent of Medicare FFS payments tied to alternative payment models in CY 2014. Due to the growing size of CMS alternative payment models, CMS set target of 26 percent of Medicare FFS payments tied to alternative payment models in CY 2015, and has met that target. Through the launch of new and reopened models, CMS expects to continue to increase the percentage of Medicare FFS payments tied to quality and value through alternative payment models.

## MCR31: Improve Patient and Family Engagement by Improving Shared Decision-Making

| Measure | CY | Target | Result |
|---|---|---|---|
| MCR31: Improve Clinician and Group-Consumer Assessment of Healthcare Providers and Systems (CAHPS) Shared Decision Making Survey Score | 2018 | TBD | July 2019 |
| | 2017 | 76% | July 2018 |
| | 2016 | Historical Actual | July 2017 |
| Baseline:<br>CY 2014: MSSP ACO CAHPS: 74.6%<br><br>*ACOs Mean Score | 2015 | Historical Actual | 75.17* |

Ensuring that all patients and their family members are engaged in their care is a core priority of the National Quality Strategy (NQS).

Despite recent efforts to shift our healthcare system to one in which patients are passive recipients of care to one in which they are empowered to actively participate in their care decisions, there is still much work to make this a reality. The purpose of this performance goal is to help assess an important component of patient experience of care with their provider. Specifically, shared decision making between patient, caregiver and provider is considered to be a fundamental component of a patient-centered healthcare system that leads to improved health outcomes for patients. The Shared Decision Making section of the Summary Survey Measures (SSM) asks beneficiaries questions such as whether they spoke to their provider about the reasons they may want to take a medicine or why they may not want to take a medicine. It also asks beneficiaries whether the provider had asked them what they thought was best for them regarding potential surgeries or procedures and whether their provider respected their wishes in regards to how much of their personal information could be shared with family or friends. As beneficiaries become more empowered to actively participate in their care, we would expect better performance in the Shared Decision Making section of the SSM, as this section of the CAHPS survey focuses on beneficiary engagement related to their care. And as more beneficiaries actively participate in their care decisions, we should also see improved health outcomes for beneficiaries.

The Shared Decision Making section of the SSM is collected and reported through the CAHPS survey for Physician Quality Reporting programs and the CAHPS for ACOs Survey administered by ACOs participating in the Medicare Shared Savings Program (Shared Savings Program). Congress created the Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals,

and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO).

The performance target set for this measure was established using Shared Savings Program's quality measure performance benchmark distribution. Prior to the start of a performance year, CMS publishes quality measure performance benchmarks that are set using all available Medicare fee-for-service quality data. These data-driven benchmarks are used to assess quality attainment (and more recently, quality improvement) and ultimately translated into points used in the program's financial performance calculations. The 76 percent target set for the Shared Decision Making measure in 2017 (available for reporting in 2018) was set using the 2015 Shared Savings Program quality measure benchmarks, assuming continued improvement in measure performance over the next two years. Specifically, the performance target focuses on measuring continued improvement of the scores related to beneficiary responses to the Shared Decision Making section of the SSM. Results from the CY 2016 survey administration period are not yet available; however, they should be received by late Spring 2017. After the CY 2016 scores are available and analyzed, CMS will determine the performance target for 2018.

To ensure ACOs attain high measure performance, and improve measure performance, CMS provides training webinars, dedicated resource webpages and materials including a CAHPS toolkit to support ACOs and group practices to improve their CAHPS scores. In an effort to streamline the CAHPS for ACO survey, CMS is currently reviewing potential survey revisions. Revisions to the survey will likely shorten the survey, but maintain or strengthen the reliability and validity of the survey. While the potential survey revisions being considered could impact the ability to compare data from the old survey to the new survey, over time we will again be able to calculate trend data on the revised survey. Additionally, we believe that the revised survey will be less burdensome to complete for beneficiaries and may increase response rates.

## MCR32: Improve Patient outcomes by expanding participation in the Advancing Care Information category of Merit Based Incentive Payment System (MIPS)

| Measure | CY | Target | Result |
|---|---|---|---|
| MCR32.1: Increase the number of eligible clinicians participating in the Advancing Care Information Category of Merit Based Incentive Payment System (MIPS).<br><br>Baseline: 2017 Baseline Available March 31, 2018 | 2019 | Target Set when 2017 Baseline is Set | March 31, 2020 |
| | 2018 | Target Set When 2017 Baseline is set | March 31, 2019 |
| | 2017 | Set Baseline | March 31, 2018 |
| MCR32.2: Increase the number of eligible clinicians who report all the measures under the Health Information Exchange (HIE) objective in the Advancing Care Information Category of MIPS<br><br>Baseline: 2017 Baseline Available March 31, 2018 | 2019 | Target Set when 2017 Baseline is Set | March 31, 2020 |
| | 2018 | Target Set When 2017 Baseline is set | March 31, 2019 |
| | 2017 | Set Baseline | March 31, 2018 |

The Centers for Medicare & Medicaid Services (CMS) wants to increase the number of eligible clinicians who are participating in the advancing care information (formerly known as meaningful use) category of the Merit-Based Incentive Payment System (MIPS) in

CY 2018[4]. MCR32.1 ensures that with the implementation of MIPS, clinicians will continue to embrace and work to improve the lives of patients through the use of information technology. CMS' objective for increasing the number of eligible clinicians participating in the advancing care information category is to ensure that the coordination of care is streamlined and is improved as a result of interoperability and information exchange[5].

The goal of MCR32.2 is to increase the number of eligible clinicians who report all the measures under the Health Information Exchange (HIE) objective in the Advancing Care Information category. CMS is aligning this measure with another HHS goal of safely transmitting patient information. CMS wants to ensure eligible clinicians in MIPS are safely handling Personally Identifiable Information (PII) and Protected Health Information (PHI). The baseline results for this measure will be available in March 2018. The HIE objective encourages interoperability among providers and therefore will help improve care coordination.

[4] https://www.healthit.gov/buzz-blog/from-the-onc-desk/moving-improved-care-information/
[5] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf

CMS is currently working on accomplishing the goals of the measure through the development of an education and outreach strategy and plans to receive public comments from the eligible clinicians who are affected by the new program.

The long term outcome of these goals is to achieve improving patient safety, patient and family engagement, care coordination, and supporting continuous quality improvement for beneficiaries, it is critically important to increase the number of eligible clinicians participating in the advancing care information category of MIPS. In addition, the HIE objective is to improve care coordination, support interoperability, and ensure the privacy of electronic PHI by increasing the number of eligible clinicians who report measures under the HIE objective in the Advancing Care Information category of MIPS.

## MCR34: Improve Care Coordination, support interoperability, and ensure the privacy of electronic Protected Health Information (PHI) by increasing the number of eligible hospitals and Critical Access Hospitals (CAHs) who report all the measures under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program

| Measure | CY | Target | Result |
|---|---|---|---|
| MCR34: Increase the number of eligible hospitals and CAHs who report all the measures under the Medicare and Medicaid Electronic (EHR) Incentive Program | 2019 | Target Set when 2017 Baseline is Available | March 31, 2020 |
| | 2018 | Target Set when 2017 Baseline is Available | March 31, 2019 |
| | 2017 | Set Baseline | March 31, 2018 |

CMS goal is to increase the number of eligible hospitals and CAHs who report all the measures under the Health Information Exchange (HIE) objective in the EHR Incentive Program. CMS is striving to ensure eligible hospitals and CAHs under the EHR Incentive Program are safely handling Personally Identifiable Information (PII) and Protected Health Information (PHI) for 2017, through the health information exchange objective. This measure supports the HHS objective to improve health care and population health through meaningful use of health information technology." The baseline results for this measure will be available in March 2018.

The long term outcome of this goal is to improve care coordination, support interoperability, and ensure the privacy of electronic PHI. It is critically important to increase the number of eligible hospitals and critical access hospitals who report measures under the HIE objective in the Medicare and Medicaid EHR Incentive Programs.

## MMB1: Reduce all-cause hospital readmission rate for Medicare-Medicaid Enrollees

| Measure | CY | Target | Result |
|---|---|---|---|
| MMB1: Reduce all-cause hospital readmission rate for Medicare-Medicaid Enrollees<br><br>Baseline 2012: 91.48 readmissions per 1000 beneficiaries | 2018 | TBD | January 31, 2020 |
| | 2017 | +2 percent reduction over prior year result | January 31, 2019 |
| | 2016 | +2 percent reduction over prior year result | January 31, 2018 |
| | 2015 | Historical Actual | June 30, 2017 |
| | 2014 | Historical Actual | +2.84% below CY 2013 baseline 82.21 per 1000 |
| | 2013 | Historical Actual | +7.5% below CY 2012 baseline 84.61 per 1000 |

A “hospital readmission" occurs when a patient, who has recently been discharged from a hospital (such as, within 30 days), is once again readmitted to a hospital. A thirty-day period for readmission data has been standard across the quality measure industry for several years. Discharge from a hospital is a critical transition point in a patient’s care; incomplete handoffs at discharge can lead to adverse events for patients and avoidable readmissions. Hospital readmissions may indicate poor care, missed opportunities to better coordinate care, and result in unnecessary costs.

While many studies have pointed to opportunities for improving hospital readmission rates, the rate of readmissions for individuals who are dually eligible for both Medicare and Medicaid (Medicare-Medicaid Enrollees) is often higher than for Medicare beneficiaries overall. In 2015, an estimated 11.4 million beneficiaries were dually eligible for Medicare and Medicaid.

Compared to non-dually eligible Medicare beneficiaries, Medicare-Medicaid enrollees have higher rates of chronic and co-morbid conditions[6] and higher rates of institutionalization[7], as well as challenges posed by socioeconomic issues. As a result, we seek to assess the impact of interventions on this sub-population.

In calendar year (CY) 2013, CMS implemented two demonstrations focused on improving care for Medicare-Medicaid enrollees. The first and larger demonstration is the Financial Alignment Initiative, in which CMS partners with State Medicaid Agencies to test models for integrated, coordinated care for this population. The second demonstration is the Initiative to *Reduce Avoidable Hospitalizations among Nursing Home Residents*.

This measure will be calculated using the number of readmissions per 1000 eligible beneficiaries. This will be a more sensitive measure for dual eligible beneficiaries than the

[6] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Condition_Prevalence_Comorbidity_2014.pdf
[7] http://cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/2008NationalSummary.pdf

rate of readmissions (numerator) divided by admissions (denominator) used in other hospital readmissions measures. There has been concern that such a ratio does not accurately capture quality improvement outcomes of decreased readmissions and admissions at any given hospital. For example, such a ratio can remain unchanged if admissions decline at the same rate as readmissions due to hospital quality improvement efforts to reduce both.[8] [9]

The CY 2012 baseline was 91.48 readmissions per 1000 eligible beneficiaries. Our CY 2013 result was 84.61 readmissions per 1000 beneficiaries, a reduction of 7.5% from the previous year; Our CY 2014 result was 82.21 readmissions per 1000 beneficiaries, a reduction of 2.84% from the previous year. For CY 2016 and CY 2017, we have chosen a target rate reduction of 2 percent of the previous year's readmissions per 1000 beneficiaries per year.

Due to the transition from ICD-9 to ICD-10 diagnostic codes on October 1, 2015, there was a need to re-program this measure's data extraction for CY 2015. We anticipate this will cause a delay of at least two months in reporting 2015 results. We, therefore, expect to report the CY 2015 results by no later than June 30, 2017.

CMS has identified a path forward that will allow us to add psychiatric diagnoses and psychiatric facilities to our current methodology. However more research into technical specifications and requirements are necessary before this can be implemented.

[8] Brock, J., Mitchell, J., et al., Association Between Quality Improvement for Care Transitions in Communities and Rehospitalizations Among Medicare Beneficiaries, *JAMA,* January 23/30, 2013, Vol. 309, No. 4

[9] Jencks, S., Protecting Hospitals That Improve Population Health, http://altarum.org/health-policy-blog/protecting-hospitals-that-improve-population-health, Dec. 16, 2014

## PHI2: Increase the number of young adults ages 19 to 25 who are covered as a dependent on their parent's employer-sponsored insurance policy[10]

| Measure | CY | Target | Result |
|---|---|---|---|
| PHI2: Increase the number of young adults ages 19 to 25 who are covered, as a dependent on their parent's employer-sponsored insurance policy | 2018 | Report as contextual indicator | Nov 30, 2019 |
| | 2017 | Report as contextual indicator | Nov 30, 2018 |
| | 2016 | Report as contextual indicator | Nov 30, 2017 |
| | 2015 | Report as contextual indicator | 11.0 million |
| | 2014 | 9.7 million | 10.8 million (Target Exceeded) |
| | 2013 | 9.7 million | 10.5 million (Target Exceeded) |
| | 2012 | 8.7 million | 10.2 million (Target Exceeded) |
| | 2011 | 8.4 million | 9.5 million (Target Exceeded) |
| | 2010 | Historical Actual | 8.3 million |
| | 2009 | Baseline | 7.3 million |

In order to extend coverage for a segment of the American population that is disproportionately uninsured, CMS is monitoring the implementation of a regulation that allows adult children to remain on their parents' health insurance plans through age 26. CMS, along with the Departments of Labor and Treasury, is responsible for monitoring compliance with the new guideline and implementing the regulation. Current law requires group health plans and private health insurance issuers offering group or individual health insurance coverage that provides dependent coverage of children to continue to cover an adult child until the age of 26 effective for plan years beginning September 23, 2010.

The estimated number of adult children covered as dependents on a parent's insurance policy increased from 10.7 million in FY 2014 to 11.0 million in FY 2015.

[10] http://www.hhs.gov/budget/fy2015/online-performance-appendix.pdf, p. 14.

The underlying data on the number of potentially-affected individuals were derived from the Current Population Survey Annual Social and Economic Supplement (CPS ASEC). CMS continues to monitor compliance with the requirement that issuers offer coverage for young adults ages 19 to 25. After 2014, we no longer set targets for this measure but report the trend annually as a contextual indicator.

Changes in the CPS ASEC health insurance methodology, beginning with the data for CY 2013, allow more accurate estimates of whether coverage from outside the household is sponsored by an employer (included in PHI2) or directly purchased from an insurance company (excluded from PHI2). The newly available variables suggest a somewhat lower number of young adults are on parents' plans, but this would likely also be true for the PHI2 baseline year of 2009, for which the new variables are not available.

The Data Validation source, the National Health Interview Survey (NHIS), also suggests an increase in private health insurance coverage among 19 to 25-year-olds between 2014 and 2015 (see https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201611.pdf, Table 3). The NHIS measure, unlike PHI2, is on a Calendar Year basis, and includes young adults enrolling in Exchange coverage.

## PHI5: Track the Number of Individuals who have Confirmed Enrollment through the Health Insurance Exchanges

| Measure | CY | Target | Result |
|---|---|---|---|
| PHI5: Track the number of individuals who have confirmed enrollment through the Affordable Insurance Exchanges | 2018 | TBD | Spring 2019 |
| | 2017 | 11.4 million | Spring 2018 |
| | 2016 | 10 million[11] | Spring 2017 |
| | 2015 | 9.0 million[12] | 8,780,545[13] |
| | 2014 | Baseline | 6,337,860[14] |

While Congress works to pass legislation to repeal and replace Obamacare, the Administration remains committed to provide needed flexibility to issuers to help attract healthy consumers to enroll in health insurance coverage, improve the risk pool and bring stability and certainty to the individual and small group markets, while increasing the options for patients and providers. The Administration also supports state flexibility and control to create a free and open health care market and will continue to empower states to make decisions that work best for their markets. The Budget funds necessary activities to continue to operate the Health Insurance Exchanges. The Administration will continue to work with Congress to provide for a stable transition from the burdensome requirements of Obamacare and transition to a health care system focused on increasing choices for patients and providers and promoting state flexibility and control. During this transition, CMS will continue to measure and report on number of individuals covered through Exchange plans.

Baseline enrollment data for CY 2014 is 6,337,860 and results for CY 2015 are that 8,780,545 individuals were enrolled in Exchanges as of December 31, 2015. The CY 2016 target is 10 million individuals enrolled and the CY 2017 target is 11.4 million enrollees.

[11] http://aspe.hhs.gov/basic-report/how-many-individuals-might-have-marketplace-coverage-at-the-end-of-2016
[12] http://aspe.hhs.gov/health/reports/2014/Targets/ib_Targets.pdf
[13] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-11.html
[14] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html

## PHI6: Protect Individual and Small Businesses from Potentially Unreasonable Health Insurance Premium Increases through the Effective Rate Review Program

| Measure | FY | Target | Result |
|---|---|---|---|
| PHI6: Decrease or maintain the percentage of submissions for rate increases equal to or greater than 10%.<br><br>Baseline: FY 2014 – 12% | 2018 | 10% | November 2018 |
| | 2017 | 10% | November 2017 |
| | 2016 | 10% | 54%<br>(Target Not Met) |
| | 2015 | 11% | 28%<br>(Target Not Met) |
| | 2014 | Baseline | 12% |

Current law requires that in every State, proposed rate increases of 10 percent or more are now evaluated by independent experts to assess whether the increases are based on reasonable cost assumptions and solid evidence. The review and scrutiny is expected to prevent unjustified premium hikes by insurance companies, cutting costs for individuals, families, and small business owners. Since September 1, 2011, health insurers have been required to justify any rate increase of 10 percent or more before the increase takes effect. Although CMS does not have the authority to compel issuers to reduce rates, the requirement that issuers justify rate increases of 10 percent or more may exert pressure on issuers to reduce rate increases.

Additionally, all rate increases are required to be monitored by the Secretary and the States after January 1, 2014, when the new federal rating rules also took effect. This added scrutiny is conducted by requiring issuers to submit all single risk pool rate submissions (using the Unified Rate Review template and Actuarial Memorandum) to States and CMS.

This measure tracks submissions both on and off the Exchanges, and the number of those submissions that are subject to review, if the rate increase is 10 percent or more. Initially, the submissions that were considered to be “subject to review” were measured at the product level (i.e. HMO, PPO), but after further consideration, that measurement was adjusted for the 2017 plan year to apply to any plan within a product. This change enabled CMS to gain a more detailed picture of the marketplaces.

In 2016 CMS received 2,843 product submissions from issuers. Of those 2,843 products, 1,536 products were subject to review. A number of factors resulted in the requests for what are considered high rate increases to be larger than the 10 percent target for FY 2016. Issuers may submit rate increases of 10 percent or more that are not unreasonable due to factors beyond the influence of the Rate Review Program such as increases to medical

costs, physician or laboratory services, new technologies and/or their financial situation since premiums must be high enough to cover issuers' projected claims and administrative costs. Additionally, continuation of the transitional plan program has slowed the entrance of healthier members into the single risk pool.

CMS has diligently worked to assist States to enhance their capabilities to effectively monitor and review rate increases, make reasonableness determinations, and review for compliance with federal rating rules. This combination of review and monitoring can lead to lower implemented rate increases. CMS and State efforts have been supported through both regulation and the Rate Review Grants program, which provided States with a total of $250 million to improve their rate review capabilities.

CMS has set standards for States by defining what makes a rate review effective; most States have met those standards. We continue to monitor and assess the effectiveness of State rate review programs. Most States have also utilized grant money to help implement these new national standards to help assure consistency and enhanced competency throughout the country.

Although CMS has no direct control over premium rate increases, we believe that through continued enhancement, States and CMS will have the tools, staff, and capabilities necessary to effectively evaluate and monitor rate increases in their markets. This should help limit unjustified rate increases and increase transparency for consumers.

## PHI7: Maintain or reduce percent of population who are uninsured by providing increased access to health care through Private Insurance, Medicaid and CHIP

| Measure | CY | Target | Result |
|---|---|---|---|
| PHI7: Percentage of the Nonelderly United States Population Who are Uninsured (Civilian, Noninstitutionalized)<br><br>Baseline: CY 2010: 18.2% | 2018 | Contextual Indicator | May 2019 |
| | 2017 | Contextual Indicator | May 2018 |
| | 2016 | Contextual Indicator | May 2017 |
| | 2015 | Contextual Indicator | 10.5% |
| | 2014 | Contextual Indicator | 13.3% |
| | 2013 | Contextual Indicator | 16.6% |
| | 2012 | Contextual Indicator | 16.9% |
| | 2011 | Contextual Indicator | 17.3% |

This contextual indicator tracks the Percentage of the United States Civilian Nonelderly Noninstitutionalized Population who are Uninsured. The indicator has tracked the impact of various legislative and administrative policies on health insurance coverage and serves as a baseline while the Administration considers additional health care reforms to expand choice, increase access, and lower premiums. While Congress works to pass legislation to repeal and replace Obamacare, the Administration remains committed to provide needed flexibility to issuers to help attract healthy consumers to enroll in health insurance coverage, improve the risk pool and bring stability and certainty to the individual and small group markets, while increasing the options for patients and providers.

# MEDICARE SURVEY & CERTIFICATION PROGRAM

## MSC1: Decrease the Prevalence of Pressure Ulcers in Nursing Homes

| Measure | FY | Target | Result |
|---|---|---|---|
| MSC1: Decrease the prevalence of pressure ulcers in nursing homes | 2018 | 5.4% | January 2019 |
| | 2017 | 5.5% | January 2018 |
| | 2016 | 5.5%[15] | 5.7% (Target Not Met) |
| | 2015 | 5.7% | 5.8% (Target Not Met) |
| | 2014 | 6.7%[16] | 5.9% (Target Met) |
| | 2013 | 6.9% | 6.1% (Target Exceeded) |
| | 2012 | 6.9% | 6.5% (Target Exceeded) |
| | 2011 | N/A | 7.1% (New baseline) |
| | 2010 | 8.1% | 7.4% (Target Exceeded) |
| | 2009 | 8.2% | 7.6% (Target Exceeded) |
| | 2008 | 8.5% | 8% (Target Exceeded) |
| | 2007 | 8.6% | 8.1% (Target Exceeded) |

[15] The FY 2015 target was reduced from 5.6% to 5.5%.
[16] For internal purposes, the FY 2014 target was reduced from 6.7% to 5.9%, but the target could not be reduced for external reporting due to GPRA requirements.

Beginning with the FY 2012 reporting period, we are reporting the prevalence of pressure ulcers, stage 2 and greater, in high-risk long stay residents. The previous measure included pressure ulcers, stage 1-4, for all long stay nursing home residents.

The purpose of this measure is to decrease the prevalence of pressure ulcers in nursing homes. The prevalence of pressure ulcers in nursing homes is an indicator of quality of care and may be considered a quality of life measure for nursing home residents. We exceeded our FY 2013 target of 6.9 percent with an actual prevalence of 6.1 percent, and we met our goal in FY 2014 with an actual prevalence of 5.9 percent. The target for 2015 was relatively ambitious with a full percentage point drop between 2014 and 2015. We did not meet the 2015 goal, but there was a continued decline from 2014 to 2015. We note that we do not have the ability to distinguish between preventable and non-preventable pressure ulcers. Given the vulnerability of this population, we expect some level of pressure ulcers, and do not expect the prevalence to be eliminated. Therefore, we believe we need to analyze the target over the next year to determine if the target, or measure, should be changed due to lack of opportunity for significant gains. Regardless, efforts will continue to reduce the prevalence of pressure ulcers.

## MSC2: Percentage of States that Survey All Nursing Homes at Least Every 15 Months

| Measure | FY | Target | Result |
|---|---|---|---|
| MSC2: Percentage of States that survey nursing homes at least every 15 months | 2018 | 97% | April 30, 2019 |
| | 2017 | 97% | April 30, 2018 |
| | 2016 | 97% | 86% (Target Not Met) |
| | 2015 | 97% | 94% (Target Not Met) |
| | 2014 | 97% | 84% (Target Not Met) |
| | 2013 | 97% | 87% (Target Not Met) |
| | 2012 | 97% | 83% (Target Not Met) |
| | 2011 | 97% | 86% (Target Not Met) |
| | 2010 | 95% | 87% (Target Not Met) |
| | 2009 | 85% | 96% (Target Exceeded) |
| | 2008 | 80% | 96% (Target Exceeded) |

Federal statute requires that every nursing home be surveyed at least every 15 months. This measure evaluates CMS and survey partners' success in meeting core statutory obligations for carrying out surveys with routine frequency to assure quality of care to residents of our nation's nursing homes. CMS removes the dollar value of “non-delivered surveys” from States’ subsequent allocation.

CMS failed to meet the FY 2015 target. However, we note that there has been a significant improvement from 2014 (from 84 percent to 94 percent). CMS believes that weaknesses in hiring practices continue to impede the ability of State Survey Agencies (SSAs) to conduct surveys in a timely manner. Although CMS provides the funding for staff, many SSAs are required to follow state hiring practices. In addition the salaries that nurse surveyors are

paid are frequently well below other nursing salaries. The major internal factor affecting this measure is the requirement that CMS ensure that proper operational controls, such as training and regulations, are in place. CMS issues directions to states outlining the agency's policies and the statutory survey frequency requirements. These communications also prioritize the requirements for conducting recertification surveys for the non-statutorily mandated provider/supplier type to assure that the statutory survey timeframes are completed. CMS also conducts a formal assessment of whether the SSAs fulfill their outlined responsibilities through the State Performance Standards System. CMS uses this set of standards to determine whether the SSAs are meeting the requirements for the survey and certification program and to identify areas for improvement in management.

CMS and SSAs face significant challenges as they seek to ensure quality in the provision of Medicare and Medicaid services. One challenge is to sustain the improvements made in the survey system in recent years. Other challenges include: increases in the number of providers requiring onsite surveys, new responsibilities (such as surveys of transplant programs) and other uncertainties (e.g., budget shortfalls, hiring freezes, and furloughs) at both the federal and state levels. In light of these challenges, CMS has sought to promote the highest possible state survey performance by redirecting resources, as needed, to increase program efficiency and effectiveness.

CMS has not met the target result for several years. We are engaged in several efforts to try and improve the results in this area including 1) CMS has contracted for technical assistance with states to try and plan workload and address other challenges; 2) CMS is revising the survey process to both incorporate new regulatory requirements, but also try to streamline the survey process; 3) CMS is reviewing the State Performance Standards System to review the manner in which we measure state performance and proactively identify issues; and 4) CMS is looking to provide additional guidance and clarity to states on the complaint triage process as many states are struggling to manage a large volume of complaints while maintaining their 15 month statutory mandate.

## MSC3: Percentage of States That Survey All Home Health Agencies at Least Every 36 Months

| Measure | FY | Target | Result |
|---|---|---|---|
| MSC3: Percentage of States that survey Home Health Agencies at least every 36 months | 2018 | 96% | April 30, 2019 |
| | 2017 | 96% | April 30, 2018 |
| | 2016 | 96% | June 30, 2017 |
| | 2015 | 96% | 96% (Target Met) |
| | 2014 | 96% | 86% (Target Not Met) |
| | 2013 | 96% | 90.4% (Target Not Met) |
| | 2012 | 96% | 83% (Target Not Met) |
| | 2011 | 95% | 85% (Target Not Met) |
| | 2010 | 90% | 81% (Target Not Met) |
| | 2009 | 75% | 94% (Target Exceeded) |
| | 2008 | 70% | 94% (Target Exceeded) |

Federal statute requires that every home health agency be surveyed at least once every 36 months. States that do not complete all required surveys have the dollar value of “non-delivered surveys” deducted from their subsequent budget allocation. This measure quantifies CMS and its survey partners' success in meeting core statutory obligations for carrying out surveys with routine frequency. Routine surveys are used to assure quality care to beneficiaries who receive care from the nation's home health agencies.

CMS met its FY 2015 target. The major internal factor affecting this goal is the states' and regions' ability to provide adequately trained personnel and follow proper survey protocols outlined in the regulations and State Operations Manual for the survey of Home Health Agencies. To meet these targets, CMS issues directions to states outlining the agency's policies and the statutory survey frequency requirements. These communications also

prioritize the requirements for conducting recertification surveys for the non-statutorily mandated provider/supplier type to assure that the statutory survey timeframes are completed. CMS also conducts a formal assessment of whether the State survey agencies fulfill their outlined responsibilities through the State Performance Standards System. CMS uses this set of standards to determine whether the state survey agencies are meeting the requirements for the survey and certification program and to identify areas for management improvement.

## MSC5: Decrease the Percentage of Long-stay Nursing Home Residents Receiving an Antipsychotic Medication

| Measure | CY | Target | Result |
|---|---|---|---|
| MSC5: Decrease the percentage of long-stay nursing home residents receiving an antipsychotic medication. | 2018 | 16.0% | January 2019 |
| | 2017 | 16.0%. | January 2018 |
| | 2016 | 16.7% | 16.7%<br>(Target Met) |
| | 2015 | 17.9%[17] | 17.1%<br>(Target Exceeded) |
| | 2014 | 19.1%[18] | 19.1%<br>(Target Met) |
| | 2013 | 20.3%[19] | 20.3%<br>(Target Met) |
| | 2012 | Historical Actual | 19.8% |
| | 2011 | Baseline – 23.87% (4th Q) | Last Quarter of Pre-Intervention Period |

The purpose of including this measure as a CMS performance measure is to decrease the use of antipsychotic medications in nursing homes with emphasis on improving dementia care. These medications have common and dangerous side effects when used for the behavioral and psychological symptoms of dementia.

In 2012, CMS began a nationwide initiative - the *Partnership to Improve Dementia Care in Nursing Homes* – to improve dementia care and reduce the use of antipsychotic medications. CMS staff has been working with partners, including state coalitions, provider associations, nursing home resident advocates, and stakeholders to decrease the use of these drugs. Some of this work includes developing and conducting trainings for nursing home providers, surveyors, and consumers; conducting research; raising public awareness; using regulatory oversight; improving surveyor guidance; conducting focused dementia care surveys in selected states; and by public reporting to increase transparency. We hope to enhance person-centered care for all nursing home residents, particularly those with dementia-related behaviors.

A number of evidence-based non-pharmacological interventions and approaches have been reviewed by national scientists and thought leaders through the National Partnership to Improve Dementia Care. These have been incorporated into clinical practice guidelines

[17] FY 2015 target was reduced from 19% to 17.9%
[18] FY 2014 target was reduced from 20.3% to 19.1%
[19] FY 2013 target was reduced from 21.5% to 20.3%

and various tools and resources and are now posted on the Advancing Excellence website (in the public domain) at www.nhqualitycampaign.org. State Coalitions are reaching out to providers in every state and encouraging the use of these resources, as well as Hand in Hand, the training for nursing home staff developed by CMS. A number of meta-analyses have reviewed the use of non-pharmacological approaches to behaviors in people with dementia. Studies have shown that these interventions may be effective in reducing behaviors associated with dementia that may be distressing to residents or families.[20]

Person-centered care is an approach to care that focuses on residents as individuals and supports caregivers working most closely with them. It involves a continual process of listening, testing new approaches, and changing routines and organizational approaches in an effort to individualize and de-institutionalize the care environment. Person-centered care is the central theme of the Hand in Hand training.

In July 2012 CMS began posting on the Nursing Home Compare website quality measures of antipsychotic use in long-stay and short-stay nursing home residents, excluding residents with schizophrenia, Tourette's syndrome, or Huntington's disease. In 2015, we added the quality measures to the Five-Star Quality Rating System on the website.

For this GPRA goal, we report the prevalence of antipsychotic use in the last three months of the fiscal year. The numerator consists of long-stay residents receiving an antipsychotic medication on the most recent assessment. The denominator is all long-stay nursing home residents, excluding residents with schizophrenia, Tourette's syndrome, or Huntington's disease. Residents are considered to be long-stay residents if they have resided in the nursing home for 101 or more days. The baseline number reflects the prevalence of use in the last quarter of CY 2011. It was selected because it was the last quarter in the pre-intervention period.

The CY 2012-2013 goal represented approximately a 15 percent reduction in prevalence from the baseline. The goals for succeeding years represent an additional 5 percent reduction each year. The resulting CY 2016 goal represents a 30 percent reduction from the baseline, for a prevalence rate of 16.7 percent or lower by the end of the CY. Prior to the CMS and National Partnership intervention in CY 2012, the prevalence rates had consistently risen each quarter. In January 2015 the Government Accountability Office (GAO) affirmed that CMS had made clear progress in reducing antipsychotic use in nursing homes, and recommended that HHS undertake similar efforts in settings beyond nursing homes (such as assisted living and home and community-based environments). CMS met its CY 2016 goal.

CMS continues to have quarterly national calls with the public on aspects of good dementia care and the use of non-pharmacological approaches. CMS is conducting focused dementia care surveys on those facilities that continue to have high rates of antipsychotic use, and has modified the regulations limiting the use of antipsychotic medications on an as needed basis.

[20] Gitlin LN, Kales HC, Lyketsos CG. Nonpharmacologic Management of Behavioral Symptoms in Dementia. JAMA, November 21, 2012; 308(19): 2020-2029.

## MSC6: Percentage of States that Survey All Hospice Facilities within 36 Months

| Measure | FY | Target | Result |
|---|---|---|---|
| MSC6: Percentage of States that complete required hospice surveys within 36 months.<br><br>Baseline: N/A | 2018 | 100% of States will complete 100% of required hospice surveys | April 30, 2019 |
| | 2017 | 95% of States complete 98% of required hospice surveys | April 30, 2018 |
| | 2016 | 90% of States complete 95% of required hospice surveys | 71%<br>(Target Not Met) |

A hospice is a public agency or private organization that is primarily engaged in providing care to terminally ill individuals. Hospice care is an approach to caring for terminally ill individuals that stresses palliative care (relief of pain and uncomfortable symptoms), as opposed to curative care. In addition to meeting the patient's medical needs, hospice care addresses the physical, psychosocial, and spiritual needs of the patient, as well as the psychosocial needs of the patient's family/caregiver. The emphasis of the hospice program is on keeping the hospice patient at home with family and friends as long as possible. Although some hospices are located as a part of a hospital, nursing home, or home health agency, all hospices must meet specific federal requirements and be separately certified and approved for Medicare participation. There are approximately 4,000 Medicare certified hospice agencies in the U.S providing care to over 1 million Medicare beneficiaries annually. We are working on including the data for nursing homes and home health agencies.

The Social Security Act mandates the establishment of minimum health and safety standards for all participating hospice providers. These standards are further defined in the Medicare Conditions of Participation (COPs) which establish the minimum requirements which a hospice agency must meet in order to participate in Medicare. State Survey Agencies (SSAs), under agreements between the state and CMS, evaluate hospice compliance through the survey and certification process.

The *Improving Medicare Post-Acute Care Transformation Act of 2014* (the IMPACT Act) mandates the frequency of hospice recertification surveys to be not less frequently than once every 36 months. Prior to the IMPACT Act, CMS did not have a legislative or regulatory standard for the frequency of hospice recertification surveys. Annual targets for these surveys were established by agency policy based on available resources each year and had been every 72 months. In additional to mandating a 36 month frequency of hospice recertification surveys, the IMPACT Act provides funding to support CMS in meeting this requirement. The shorter duration for hospice recertification surveys mandated by the IMPACT Act will ensure hospice providers are more frequently assessed against the minimum requirements for quality of care, providing greater oversight of these providers by CMS.

The purpose of this measure is to ensure that the new statutory requirements for hospice survey intervals are met by all SSAs in order to ensure quality of care. Although the CMS target is 100 percent compliance with the statutory requirement, the stated measure represents a realistic expectation considering the resources required to achieve the new survey interval. The data to confirm compliance with the requirements of the Act will not be

available until September 30, 2018. This data delay is a result of necessary follow up survey activity and data entry into the Automated Survey Processing Environment (ASPEN) system. SSAs that do not comply with the survey interval instructions contained within the Mission and Priority Document, which is issued annually by CMS, are subject to a deduction, from their annual budget projection, of the amount of the costs that would have been incurred had the surveys been completed as required. Starting in April 2018 this deduction will apply for those state agencies that fail to maintain a 36 month survey interval for hospice agencies.

Nationwide we have gone from an average of 17 percent per year (rather than 33 percent on a 3 year survey cycle) to 39 percent in 2015 (rather than 33 percent on a 3 year cycle.)

a) Prior to the implementation of the IMPACT Act, our Mission and Priority Document required a survey interval of 6.5 to 7.0 years for hospice agencies. Accordingly, in 2014 there were 564 surveys conducted out of 2603 non-deemed providers. This was consistent with the instructions in the MPD. In 2015, with full implementation of the IMPACT Act, there were 1007 hospice surveys conducted nationwide out of a total of 2545 non-deemed hospice agencies. Under the MPD the expected number of surveys would have been around 424. However, under the IMPACT Act an additional 583 were completed.

b) CMS is monitoring all the SSAs on an ongoing basis through periodic data reports and findings from State Performance Standards reviews. All agencies are on target to be in compliance with the IMPACT Act by 2018. In addition CMS is utilizing a federal survey contractor to assist any states needing additional assistance to bring all surveys into compliance.

c) Our analysis to date shows that the average number of deficiencies for hospice agencies actually decreased in 2015 from 2014. However, this may be a factor of the increased number of surveys overall. The percentage of hospice surveys with Condition level (more serious) survey findings actually decreased between 2014-2015 from 30 percent to 21 percent.

CMS is working through the CMS Regional Offices to identify all hospice providers that require survey before April 6, 2018 in order to comply with the IMPACT Act and to ensure that states have plans in place to maintain compliance going forward. CMS does have additional survey support for the states through FY 2017 and is working to ensure that the most critical needs are addressed. CMS anticipates compliance by April, 2018.

# MEDICAID

**Please refer to the Childrens' Health Insurance Program (CHIP section of the Performance Appendix for other related performance goal(s):**

- **CHIP3 – Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid.**

**MCD6: Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program (CHIP) through Implementation of Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality Initiatives**

| Measure | FY | Target | Result |
|---|---|---|---|
| MCD6: Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program (CHIP) through Implementation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality Initiatives | 2018 | Work with States to ensure that 90 percent of States report on at least eleven quality measures in the CHIPRA children's core set of quality measures | March 2019 |
| | 2017 | Work with States to ensure that 90 percent of States report on at least eleven quality measures in the CHIPRA children's core set of quality measures | March 2018 |
| | 2016 | Work with States to ensure that 90 percent of States report on at least ten quality measures in the CHIPRA children's core set of quality measures | 86% of States reported at least ten quality measures (Target Not Met) |
| | 2015 | Work with States to ensure that 90 percent of States report on at least nine quality measures in the CHIPRA children's core set of quality measures | 88% of States reported at least nine quality measures (Target Not Met) |
| | 2014 | Work with States to ensure that 90 percent of States report on at least eight quality measures in the CHIPRA children's core set of quality measures | 88% of States reported on at least eight quality measures (Target Not Met) |

| Measure | FY | Target | Result |
|---|---|---|---|
| | 2013 | Work with States to ensure that 85 percent of States report on at least seven quality measures in the CHIPRA children's core set of quality measures. | 88% of States reported on at least seven quality measures<br>(Target Exceeded) |
| | 2012 | Work with States to ensure that 80 percent of States report on at least five quality measures in the CHIPRA children's core set of quality measures. | 92% of States reported on at least five quality measures<br>(Target Exceeded) |
| | 2011 | Work with States[21] to ensure that 70 percent of States report on at least one quality measure in the CHIPRA children's core set of quality measures. | 84% of States reported on at least one quality measure<br>(Target Exceeded) |

The purpose of this measure is to improve children's health care quality across Medicaid and CHIP. Section 1139A of the Social Security Act establishes a national pediatric quality measures program. The first step in the development of this program was the publication of an initial core set (Child Core Set) of 24 children's quality measures. While the use of the Child Core Set is voluntary for States, CMS encourages all States to use and report on the Child Core Set to collect data that will lead to improved health outcomes and to enhance the accuracy and applicability of the pediatric quality measures program specific to the Medicaid and CHIP programs. CMS has just concluded a multi-year, $100 million CHIPRA Quality Demonstration initiative that included support for state activities related to core measure data collection and reporting[22].

CMS annually releases an updated Child Core Set Technical Specifications and Guidance for Reporting Manual,[23] which contains the technical instructions for collecting and calculating the core set measures for Medicaid and CHIP programs. A State Health Official Letter (SHO) (#11-001)[24] was released on February 14, 2011 to provide additional guidance on the Child Core Set and the process for voluntary reporting to CMS. The SHO also describes the CMS and AHRQ Pediatric Quality Measures Program[25] (PQMP) designed to develop measures that can be used to improve the Child Core Set. Thus far, the PQMP Centers of Excellence (COE) have developed 15 measures that have received National

[21] For the purposes of reporting, "States" refers to the 50 States and the District of Columbia.
[22] http://www.ahrq.gov/policymakers/chipra/demoeval/childhealth/index.html
[23] https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html
[24] http://www.cms.gov/smdl/downloads/SHO11001.pdf
[25] http://www.ahrq.gov/policymakers/chipra/pubs/pqmpfact.html

Quality Forum (NQF) measure endorsement. In the current NQF pediatric measures endorsement committee, there are six measures developed by the PQMP COEs under consideration.

In March 2011, CMS launched a multi-year national Technical Assistance and Analytic Support (TA/AS) program for States collecting, reporting, and analyzing the core measures to target improvements in the quality of care for children. CMS will continue to work with our TA/AS contracting team to provide States with specific clarifications on measurement collection questions; hold all-State webinars as well as one-on-one calls with states around specific measurement challenges; and publish technical assistance briefs designed to provide States with guidance on measurement collection and reporting. By using a multi-pronged approach to providing technical assistance (TA), CMS targets States that are already reporting multiple measures as well as those that are just beginning to understand how to collect and report the measures. Further, as the TA/AS program continues to mature, CMS is also expanding the scope of the TA to help States understand how to use the data they collect to drive quality improvement and State and programmatic levels. As part of the TA/AS program, CMS held a CMS Medicaid/CHIP Quality Conference in 2011 and 2012, and hosted a Medicaid and CHIP track at annual CMS Quality Conferences during the last three years (2014-2016). The conference agendas included in-person interactive sessions on the core measures related to data collection, reporting, and quality improvement.

The CHIPRA Quality Demonstration initiative has now concluded and funding to improve state efforts in core measure data collection and reporting under that grant is no longer available. Additionally, as measures are retired from the CMS child core set (which states have become accustomed to reporting), and new measures are added requiring new data collection and reporting efforts, we recognize states may choose to report on a lower number of measures without continued grant funding.

We also anticipate that states may want to prioritize certain voluntary core measures for collection and reporting in order to target improvement strategies, rather than reporting on a large volume of measures. With this in mind, we anticipate a leveling and probable decline in the number of quality measures that states will report in future years.

Therefore, the target for FY 2018 will remain at the same level as the FY 2017 target to work with States to ensure that 90 percent of States report on at least eleven quality measures in the Child Core Set.

Findings from state reporting on the Child Core Set are published annually and available on the Children's Health Care Quality Measures webpage of Medicaid.gov. [26]

Section 1139A(b)(5) of the Social Security Act provides that, beginning January 1, 2013 and annually thereafter, the Secretary shall publish recommended changes to the Children's Core Set. CMS currently partners with the National Quality Forum Measure Applications Process to strengthen its Child and Adult Core Sets. In January 2013, CMS added the three measures (HPV vaccinations for female adolescents; medication management for people with asthma, and behavioral risk assessment for pregnant women)

[26] https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html

and retired one measure (otitis media with effusion).[27] In January 2014, CMS retired three measures: appropriate testing for children with pharyngitis (two to 18 years); annual pediatric hemoglobin A1C testing (five to 17 years); and annual percentage of asthma patients who are two to 20 years old with one or more asthma-related emergency department visits.[28] In December 2014, CMS retired one measure, percentage of eligibles that received dental treatment services, and added two measures: dental sealants for 6-9 year old children at elevated caries risk; and child and adolescent major depressive disorder: suicide risk assessment.[29] In December 2015, CMS added two measures: Use of Multiple Concurrent Antipsychotics in Children and Adolescents; and Audiological Evaluation no later than 3 months of age.[30] CMS released the 2016 annual update for child core measures in January 2016. In December 2016, CMS added two measures to the Child Core Set; use of first-line psychosocial care for children and adolescents on antipsychotics, and Postpartum contraceptive care, which was also added to the Adult Core Set. CMS retired the standalone Human Papilloma Virus (HPV) since the Immunization for Adolescents (IMA) has been updated to include HPV measure[31].

This initiative continues to align with the Medicare & Medicaid Electronic Health Record (EHR) Incentive Program. Providers in Medicaid can qualify to receive incentive payments for adopting, implementing and upgrading EHRs in the first year, and meaningful use of certified electronic health record technology in future years. As part of meaningful use, providers are required to report data on clinical quality measures. Five of the 2016 CMS Child Core set measures meet the meaningful use criteria for quality measures under the EHR Medicaid Incentive Program. CMS continues to partner with the Office of the National Coordinator to electronically specify quality measures for potential inclusion in future child core measure annual updates and collected through EHRs.

[27] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-002.pdf
[28] http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-19-13.pdf
[29] http://www.medicaid.gov/federal-policy-guidance/downloads/cib-12-30-2014.pdf
[30] https://www.medicaid.gov/federal-policy-guidance/downloads/cib-12-11-15.pdf
[31] https://www.medicaid.gov/federal-policy-guidance/downloads/cib120516.pdf

## MCD7: Improve Access to and Utilization of Oral Health Care Services for Children Covered by Medicaid and Medicaid Expansion CHIP Programs

| Measure | FY | Target | Result |
|---|---|---|---|
| MCD7: Increase the national rate of low income children and adolescents, who are enrolled in Medicaid and Medicaid expansion Children's Health Insurance Programs (CHIP), who receive any preventive dental service. | *2018* | +5 percentage points over 2011 baseline | October 15, 2019 |
| | *2017* | +4 percentage points over 2011 baseline | October 15, 2018 |
| | *2016* | +3 percentage points over 2011 baseline | October 15, 2017 |
| | *2015* | +5 percentage points over 2011 baseline | 47% (Target Not Met) |
| | *2014* | +6 percentage points over 2011 baseline | 45% (Target Not Met) |
| | *2013* | +4 percentage points over 2011 baseline | 44% (Target Not Met) |
| | *2012* | +2 percentage points over 2011 baseline | 44%** (Target Not Met) |
| | *2011* | National baseline | 43%* |

*The FY 2011 national Medicaid baseline was reduced from 44 percent to 43 percent because, in early 2013, several states submitted corrected FY 2011 data. The corrected state data, when rolled up into the national statistic, reduced that percentage by one point. We want the baseline for the GPRA goal to reflect the most accurate data.

**As final FY 2012 data from CT were not available at the time of publication, CMS substituted FY 2011 data for CT in calculating this result. FY 2012 data were used for all other states.

States' efforts over the past decade have resulted in improved access to dental care for children covered by Medicaid and Medicaid expansion CHIP programs. From FFY 2000 to (FFY) 2012, the number of Medicaid-enrolled children, ages 1-20, accessing preventive or treatment dental services nationally increased 166% from 6.3 million to 16.9 million.[32] Between FFY 2007 and FFY 2014, thirty (30) states achieved at least a ten percentage point increase in the proportion of enrolled children, ages 1-20, who received a preventive dental service during the reporting year[33,34] Between FFY 2007 and FFY 2015, thirty-six

[32] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/downloads/dental-trends-2000-to-2012.pdf
[33] . http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-04-18-13.pdf.
[34] The definition of "preventive dental service" differs in this cited analysis from that used in the GPRA goal. The cited analysis includes only preventive dental services performed by, or under the supervision of, a dentist. The GPRA goal includes all preventive dental and oral health services, including those performed by dental professionals not under the supervision of a dentist as well as primary care medical professionals.

(36) states achieved at least a ten percentage point increase in the proportion of enrolled children, ages 1-20, who received a preventive dental service during the reporting year. Despite this improvement, only half of all enrolled children nationally are receiving any dental service in a year, and fewer than half are receiving at least one preventive dental service in a year. There remains a wide variation across states.[35]

The purpose of this performance measure is to increase the number of children and adolescents enrolled in Medicaid and Medicaid expansion CHIP programs who receive preventive dental services. In FY 2015, 47% of children enrolled in Medicaid and CHIP received a preventive dental service. This is one percentage point short of our FY 2015 target to increase children's receipt of preventive dental services by 5 percentage points (48%) over the FY 2011 baseline of 43%. Our future goals are to increase the percentage of children receiving a preventive dental service by 4 percentage points over the FFY 2011 baseline in FFY 2017 and 5 percentage points over the FFY 2011 baseline by FFY 2018.

To help improve performance, CMS spent five years working with its federal and state partners, the dental and medical provider communities, children's advocates and other stakeholders to expand the number of dental professionals participating in Medicaid and to increase the awareness of the need for dental care among beneficiaries in order to continue to improve children's access to dental care, with an emphasis on prevention. What follow are some highlights of that work.

In April 2013, CMS released an Informational Bulletin announcing the setting of state-specific FFY 2011 baselines, as well as goals for FFY 2015, for preventive dental services. In May, 2013, CMS sent letters to each state Medicaid director communicating the state's FFY 2011 baseline and FFY 2015 goal for preventive dental services. In July, 2014, CMS released an Informational Bulletin providing an update on progress on the Oral Health Initiative, explaining that 15 states had met their first-year interim goal of a 2 percentage point or greater increase and an additional 18 states achieved a 1 percentage point increase.[36]

CMS invited all state Medicaid agencies to develop Oral Health Action Plans as a roadmap to achieving these goals. Twenty-six states have submitted Action Plans. CMS contracted with Mathematica (6/2014-7/2016) to support the oral health performance improvement work. As part of that contract, in November 2014 CMS launched a "learning collaborative" geared toward supporting five states to develop Oral Health Action Plans and to begin implementing them. Participation was competitive by application. The five states with the strongest applications were invited to join: the District of Columbia, Florida, Kansas, Michigan and Utah. That learning collaborative has begun to yield results. The five state teams developed multi-faceted action plans, moved into implementation, and are now seeing improvements in their preventive dental service utilization. For example, Florida achieved 12 points of improvement between FFY 2011 and FFY 2015, 4 of those points during the life of the learning collaborative. With the help of Mathematica, CMS launched another learning collaborative in 2015 with a focus on developing impactful oral health Performance Improvement Projects in managed care. Kentucky participated along with its six contracted managed care plans.

[35] https://www.medicaid.gov/medicaid/benefits/downloads/ohi-baselines-progress-goals.pdf
[36] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-10-2014.pdf.

As data quality is an important aspect of setting and meeting performance goals, CMS also developed a set of web-based training modules to help states learn how to improve the quality of their dental data reporting on the Form CMS-416.[37] States can also request direct technical assistance from CMS to aid in their reporting.

In September 2013 CMS released *Keep Kids Smiling: Improving Oral Health Through the Medicaid Benefit for Children and Adolescents* to bring states' attention to proven strategies for increasing use of dental care by children enrolled in Medicaid.[38]

In February 2014, CMS released *Improving Oral Health Care Delivery in Medicaid and CHIP: A Toolkit for States*. The Toolkit offers states a data-centric quality improvement approach to achieving their oral health improvement goals.[39]

In May 2015, CMS released three issue briefs aimed at helping state leaders understand the disease of early childhood caries, new and effective approaches to prevention and management, and what state Medicaid policies could support clinicians and families to be more successful delivering, and receiving, effective oral health care. The issues briefs are available in the Tools to Help States Improve the Delivery of Dental and Oral Health Services section of this page on Medicaid.gov.[40]

One aspect of the challenge of low utilization of dental care by children enrolled in Medicaid and CHIP is low oral health literacy. To help address this gap, in 2013 CMS developed and released three consumer-directed oral health education materials, branded "Think Teeth," which are available free to states and other stakeholders.[41]

Another aspect of the challenge is connecting Medicaid and CHIP families to a dental home. The Insure Kids Now dental provider locator tool is intended to help families locate a participating local dentist. In March 2014, CMS released an upgraded consumer interface for the tool as well as a "widget" which can be placed on any website to help families learn about and use the tool.[42]

[37] http://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/416-dental-reporting-training.html.
[38] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Keep-Kids-Smiling.pdf
[39] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/Oral-Health-Quality-Improvement-Toolkit-for-States.pdf
[40] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Dental-Care.html
[41] http://www.insurekidsnow.gov/professionals/dental/index.html.
[42] http://datawarehouse.hrsa.gov/tools/widgets.aspx#InsureKidsNow

## MCD8: Improve Adult Health Care Quality across Medicaid

| Measure | FY | Target | Result |
|---|---|---|---|
| MCD8: Improve Adult Health Care Quality Across Medicaid | 2018 | Work with States to ensure that 75 percent of States report on at least eleven quality measures in the Adult Medicaid core set of quality measures | March 2019 |
| | 2017 | Work with States to ensure that 75 percent of States report on at least eleven quality measures in the Adult Medicaid core set of quality measures | March 2018 |
| | 2016 | Work with States to ensure that 70 percent of States report on at least nine quality measures in the Adult Medicaid core set of quality measures | 70 percent<br>Target met |
| | 2015 | Work with States to ensure that 70 percent of States report on at least seven quality measures in the Adult Medicaid core set of quality measures | 73 percent<br>(Target Exceeded) |
| | 2014 | Work with States to ensure that 65 percent of States report on at least five quality measures in the Adult Medicaid core set of quality measures | 67 percent<br>(Target Exceeded) |
| | 2013 | Work with States[43] to ensure that 60 percent of States report on at least three quality measures in the Adult Medicaid core set of quality measures | 59 percent<br>(Target Not Met) |
| | 2012 | Publish core set of adult quality measures in the Federal Register | Target Met |
| | 2011 | Publish recommended core set of adult quality measures in the Federal Register | Target Met |

The purpose of this measure is to improve health care quality for adults across Medicaid. Similar to the children's quality goal (MCD6), which measures development of a core set of children's quality measures, this goal focuses on creating a core set of adult quality measures for voluntary use by states to assess the care received by adults in the Medicaid program. By encouraging states to report the core measures in a standardized manner, CMS is creating a foundation for a national system of quality measurement, reporting, and improvement for adults in Medicaid.

[43] For the purposes of reporting, "States" refers to the 50 states and the District of Columbia.

Section 2701 of the Affordable Care Act, which added section 1139B(a) to the Social Security Act (the Act), requires the Secretary of the Department of Health and Human Services to develop and publish, for public comment by January 1, 2011, an initial recommended core set of quality measures for Medicaid-eligible adults (Medicaid Adult Core Set). CMS published the recommended measures in the Federal Register on December 30, 2010 and Medicaid Adult Core Set in December 2011.

In December 2012, CMS awarded two-year grants to 26 States to collect and test up to 15 measures the Medicaid Adult Core Set measures and to conduct quality improvement projects focused in these areas.[44] Participating grantees submitted data on the measures in early 2014. Since the grant program ended before FY14 reporting, grantees were not required to submit data on the measures in the current reporting period. However, as part of a Technical Assistance/Analytic Support program, CMS has discussed with grantee states how to sustain quality measurement and improvement efforts currently underway.

Findings from state reporting on the Adult Core Set are published annually on the Adult Health Care Quality Measures webpage of Medicaid.gov [45]

Section 1139B of the Social Security Act, as amended by Section 2701 of the Affordable Care Act, provides that the Secretary shall issue updates to the Adult Core Set beginning in January 2014 and annually thereafter. CMS worked with the National Quality Forum's (NQF) Measures Application Partnership (MAP) to review the Adult Core Set and to identify ways to improve it. In December 2014, CMS retired the Comprehensive Diabetes Care: LDL-C Screening measure; and added the Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%) measure.[46] In December 2015, CMS added two measures: Use of Opioids from Multiple Providers at High Dosage in Persons Without Cancer: Opioid High Dosage; and Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications.[47] In December 2016, CMS added three measures: Diabetes Care for People with Serious Mental Illness: Hemoglobin (HbA1c) Poor Control (>9.0%), Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence, Contraceptive Care –Postpartum. CMS also retired one measure in 2016, Timely Transmission of Transition Record [48].

This initiative aligns with the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program under the Recovery Act of 2009. Providers in Medicaid can qualify to receive incentive payments for adopting, implementing, and demonstrating meaningful use of certified electronic health record technology. To comply with meaningful use requirements, providers report data on clinical quality measures. Eight of the measures in the 2017 Medicaid Adult Core Set are identified as meeting the meaningful use criteria for quality measures under the EHR Medicaid Incentive Program.

It is important to highlight that the Adult Quality Measure Grant initiative has now concluded and funding toward state efforts in core measure data collection and reporting under that grant is no longer available. Additionally, as measures are retired from the CMS adult core set (which states have become familiar with reporting), and new measures are added

[44] http://medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/adult-medicaid-quality-grants.html
[45] https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html
[46] http://www.medicaid.gov/federal-policy-guidance/downloads/cib-12-30-2014.pdf
[47] https://www.medicaid.gov/federal-policy-guidance/downloads/cib-12-11-15.pdf
[48] https://www.medicaid.gov/federal-policy-guidance/downloads/cib120516.pdf

requiring new data collection and reporting efforts, we recognize states may choose to report a limited number of measures without continued grant funding.

We also anticipate that states may want to prioritize certain voluntary core measures for collection and reporting in order to target improvement strategies, rather than reporting on a large volume of measures. With this in mind, we anticipate a leveling in the number of quality measures that states will report in future years.

Therefore, the target for FY 2018 will remain at the same level as the FY 2017 target to work with States to ensure that 75 percent of States report on at least eleven quality measures in the Adult Medicaid core set of quality measures.

## MCD9: Improve capacity to collect programmatic quality data and related performance metrics for evaluating performance of payment and service delivery reform 1115 demonstration programs.

| Measure | FY | Target | Result |
|---|---|---|---|
| MCD9: Improve capacity to collect programmatic quality data and related performance metrics for evaluating payment and service delivery reform 1115 demonstration programs. | 2018 | Submission of data in the reporting platform from a minimum of 5 states. | September 2018 |
| | 2017 | Testing 1 core metric data set with a minimum of 5 states. | September 2017 |
| | 2016 | Release of an automated collection and reporting platform for 1115 performance metrics & related requirements for State data submission. | Goal Met |

Section 1115 of the Social Security Act (the Act) provides broad authority to the HHS Secretary to grant waivers of the Act to states to test innovative reforms in Medicaid and the Children's Health Insurance Program (CHIP). This measure will track the development of an automated infrastructure to support current section 1115 Medicaid demonstrations, testing innovations focusing on payment and/or service delivery reform.

States are using 1115 demonstration authority to achieve Medicaid reform through alternative models of service delivery and/or financing aimed at improving the quality of their Medicaid programs and their capacity to serve more people. CMS is making significant investments in these types of demonstrations in order to study results on State based and national levels. However, there is no automated system for data collection of performance metrics, analytics, or reporting to assess quality performance of demonstrations. Additionally, demonstration information provided by states is not captured in a manner that easily permits data collection or manipulation to support program management, oversight, monitoring or evaluation. CMS is focused on improving the quality and structure of data and other information under section 1115 demonstrations through a more automated process that will improve federal monitoring of section 1115 demonstration progress and performance. This initiative aligns with the Agency's Medicaid and CHIP Program System (MACPro) initiative to receive more complete and timely Medicaid and CHIP related data from States in support of better program oversight, administration, and program integrity; and will be designed for eventual incorporation into MACPro.

We have modified our 2017 and 2018 targets to assure adequate state engagement through the new state Technical Advisory Group (TAG). We experienced a four month delay in standing up the TAG to get all the necessary input from National Association of Medical Doctors (NAMD) and others to ensure the TAG was structured in a way that would maximize state participation and input. As we moved through the work of establishing this

TAG, and in a parallel activity encouraged several states to consider standardized core metric sets under new demonstrations, it became apparent to us that the adoption of more standardized submission of core metrics will take more time and testing then we initially expected.

We met our 2016 target to release an automated collection and reporting platform for 1115 performance metrics and related requirements for state data submission. The system went through the Security Controls Assessment process to receive an authorization to operate. Performance Metrics Database and Analytics was released in April 2016. In late FY 2016, CMS organized an initiative to stand up a State TAG to get state input on improvements we want to make in 1115 demonstrations generally, and including the use of standardized core metric sets for selected high priority 1115 demonstrations. In early FY 2017 we worked closely with NAMD and State Medicaid Offices to identify members with the appropriate skill set and experience to be members of the State TAG, and in the second quarter of FY2017 we had our first meeting with the State TAG. CMS will also work with states to begin phasing in submission of demonstration program data via this collection and reporting platform for active demonstrations and develop standardized reports and an executive dashboard for this data. Later in FY 2017, we expect to set up a test with at least 5 states on the capacity of the PMDA system and states' ability to submit core metrics on at least one demonstration type.

Our 2018 target is to continue work with the State TAG to develop standardized core metric data sets for a few high priority demonstration types that states will report on in a specified format; as well as a standardized report template for all states to use in submitting the required quarterly reports. By late 2018, CMS expects to begin utilizing at least one of the standardized core metrics for a specific demonstration type.

**MCD10 - Improve access for people with disabilities and older adults, by increasing the proportion of public funding directed to home and community-based services (HCBS) as a portion of long term services and supports (LTSS) expenditures.**

| Measure | FY | Target | Result |
|---|---|---|---|
| MCD10.1: Increase the percentage of Medicaid spending on long-term services and supports for home and community based services (HCBS) to 65 percent by 2020. | 2020 | 65% | April 2022 |
| | 2019 | 63% | April 2021 |
| | 2018 | 61% | April 2020 |
| | 2017 | 59% | April 2019 |
| | 2016 | 57% | April 2018 |
| | 2015 | 55% | 55% (Target Met) |
| | 2014 | 53% | 53% (Target Met) |
| | 2013 | 51% | 51% (Target met) |
| | 2012 | Actual-Baseline | 49.5% |
| MCD10.2: Increase the number of States that utilize at least 50 percent of Medicaid spending on long-term services and supports for home and community based services (HCBS) by 2020. | 2020 | 38 States and District of Columbia (74.5%) | April 2022 |
| | 2019 | 37 States and District of Columbia (72.5%) | April 2021 |
| | 2018 | 36 States and District of Columbia (70.6 %) | April 2020 |
| | 2017 | 35 States and District of Columbia (68.6%) | April 2019 |
| | 2016 | 38 States and District of Columbia (74.5%) | April 2018 |
| | 2015 | 35 States and District of Columbia (68.6%) | 27 States and District of Columbia (55%) (Target Not Met) |

| Measure | FY | Target | Result |
|---|---|---|---|
| | 2014 | 31 States and District of Columbia (60.8%) | 25 States and District of Columbia (49%) (Target Not Met) |
| | 2013 | 27 States and District of Columbia (52.9%) | 25 States and District of Columbia (49%) |
| | 2012 | Actual-Baseline | 23 States and District of Columbia (45.1%) |

There is evidence that home and community-based services (HCBS) are more cost-effective than institutional care for many beneficiaries. While services can be provided under many different authorities, most are provided under §1915(c) waivers which are required to limit aggregate HCBS costs to less than or equal to the average institutional service cost the individual would otherwise receive.

Several newer statutory programs and funding improvements to help ensure that people can receive long-term services and supports in the community have been enacted including a new Community First Choice state plan option; improvements to an existing HCBS state plan option; additional financial incentives for states to rebalance the provision of long-term care to include HCBS; an extension of and improvements to the "Money Follows the Person Rebalancing Demonstration"; and an extension of the "spousal impoverishment" protections to people who receive HCBS. We believe that the new opportunities have further enhanced state offerings in HCBS. In federal fiscal year (FFY) 2015, Medicaid spent $158 billion on LTSS, which represented a nearly four percent increase in overall LTSS attributable to HCBS expenditures. The LTSS spending now only represents 30 percent of all Medicaid spending as other Medicaid spending has expanded at a faster pace than LTSS spending.[49]

CMS is facilitating state efforts to increase expenditures for beneficiaries receiving HCBS instead of institutional care through the following: the Balancing Incentive Program that provided enhanced funding through September 30, 2015, for structural changes to improve the delivery of HCBS; a revised application process for §1915(c) HCBS waivers, including a web-based application and published, consistent, review criteria; education and technical assistance outreach to help states implement §1915(i) HCBS; enhanced funding and technical assistance under MFP to reinforce and increase state efforts to serve beneficiaries with quality HCBS rather than institutional care; enhanced federal funding for individuals receiving services under the 1915(k) Community First Choice option and,

Mathematica Policy Research, Inc. and the Centers for Medicare & Medicaid Services (CMS), Preliminary Information - Medicaid Expenditures for Long-Term Services and Supports in FFY 2015.

technical assistance and education for states concerning other authorities for HCBS.

The HCBS expenditures in FY 2015 represented all of the 3.8 percent growth in LTSS spending. In recent years, expenditures slowed due in large part to the presence of state budget deficits that reduced the capacity of state governments to appropriate additional funds to serve new waiver participants; however, this trend appears to be changing. These changes are reported in the Medicaid Budget and Expenditure System (MBES). The MBES is used by CMS to capture state expenditures as reported on a quarterly basis. Due to the timing of available information on Medicaid expenditures; this goal is only updated annually with data that is available 15 to 18 months after the end of the fiscal year. The FY 2017 targets project increasing expenditure growth in total to 59 percent.

The expenditure growth reflects the percentage of state and federal funds that will be targeted to beneficiaries who received home and community-based services in the out years. MLTSS expenditures continue to be estimated in total based on state reporting through a CMS contractor since expenditures for the HCBS portion of MLTSS expenditures were not available through MBES in FY 2015. CMS expects to meet or exceed targets by supporting the development of the previously mentioned programs and activities. The 65 percent 2020 expenditure target represents a basic outcome measure, which will be further refined over the coming years to ensure that the growth represents quality outcomes for individuals receiving HCBS. Last year CMS continued efforts to expand HCBS quality initiatives by introducing the Consumer Assessment of Health Care Providers and System (CAPHS) Home and Community-Based Services (HCBS) survey. This CAPHS trademarked tool allows states to determine the beneficiaries' experience of care in HCBS programs. Additionally, through the use of National Quality Forum (NQF) approved measures from the tool, states will also be able to improve the HCBS system by adopting valid and reliable performance indicators. Finally, new discrete individual level claims data collected through the Transformed Medicaid Statistical Information System (T-MSIS) will provide promising opportunities to expand the development of quality metrics in the future.

Building off the information and reporting in MCD10.1, CMS believes that it is important to create a balance of expenditures on a state by state basis. The opportunity for increased expenditures and the benefits provided within the HCBS system should be available nationally to all beneficiaries regardless of where he/she resides. States recognize the opportunity to reduce cost associated with institutional expenditures through HCBS provision, but the entitlement of institutional services often takes precedence over HCBS during difficult economic times.

There are currently twenty-seven states, including the District of Columbia, that have reached the balancing benchmark with 50 percent or more of the LTSS expenditures supporting home and community based service options as reported under measure MCD10.2. This represents a better than 10% increase over the base year of this measure. The improvement is significant but the goal remains unmet for the third consecutive year. The HCBS settings regulations, Money Follows the Person program, other federal authorities and changes under current statute have been used by states to expedite efforts to become a more balanced system; however, some of these programs will end or have ended making future progress uncertain. CMS will continue to provide technical assistance to assist states to sustain efforts as the MFP demonstration program phases down. Specifically, during the next period we have focused efforts on assisting states through the Innovation Accelerator Program (IAP) Community Integration track. Further, CMS issued a

Request for Information in late 2016 that solicited public input on how CMS could improve access to HCBS. We received input from states and other stakeholders on topics ranging from addressing the home care worker shortage, ensuring program integrity and quality of service provision, and establishing potential demonstration initiatives to reform HCBS delivery. Comments were received in January 2017, and their analysis will inform next steps and recommendations to leadership.

**Supplemental Information**

By including two additional data points (in addition to the CMS contractor-reported information), the table below furnishes updates to help CMS and interested parties to understand how efforts to balance the system are progressing.

In Table 1 below, the "Report Total" that will be provided annually in the tables above will be augmented by annual preliminary estimates. MBES Totals and MBES Projected Totals will allow CMS and other parties to see projected estimates based on CMS unadjusted state submissions to MBES. The MBES Total expenditures row represents an entire Federal Fiscal Year total for the year following Report Total. The MBES Projected Total expenditures row will provide the most current FFY projected forward. These totals will be adjusted annually to help CMS and others anticipate changes to the program.

**Table 1 – Reported and Projected Expenditures**

| | Federal Fiscal Year | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** |
| **MCD 10.1** | **Percentage of HCBS Expenditures** | | | | | | | | |
| Report Total | 49.50% | 51% | 53% | 55% | | | | | |
| Projected Total 1yr Out | | | 52% | 56% | 57% | | | | |
| Projected Total 2yr Out | | | | 53% | 57% | 59% | | | |
| **MCD 10.2** | **Number of States above 50% HCBS Expenditures** | | | | | | | | |
| Report Total | 23 | 26 | 26 | 28 | | | | | |
| Projected Total 1yr Out | | | 28 | 34 | 36 | | | | |
| Projected Total 2yr Out | | | | 31 | 33 | 42 | | | |

Source: MBES unadjusted data.

# HEALTH CARE FRAUD AND ABUSE CONTROL (HCFAC)

## MIP1: Reduce the Percentage of Improper Payments Made under the Medicare Fee-for- Service (FFS) Program

| Measure | FY | Target | Result |
|---|---|---|---|
| MIP1: Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service (FFS) Program | 2019 | 9.30% | Nov 15, 2019 |
| | 2018 | 9.40% | Nov 15, 2018 |
| | 2017 | 10.40% | Nov 15, 2017 |
| | 2016 | 11.50 % | 11.00% (Target Exceeded) |
| | 2015 | 12.5% | 12.09% (Target Exceeded) |
| | 2014 | 9.9% | 12.7% (Target Not Met) |
| | 2013 | 8.3% | 10.1% (Target Not Met) |
| | 2012 | 5.4% | 8.5%[50] (Target Not Met) |
| | 2011 | 8.5% | 8.6% [51] (Target Not Met) |
| | 2010 | 9.5% | 9.1% (Target Not Met) |
| | 2009 | 3.5% | 10.8%[52] (Measure Method Changed) |
| | 2008 | 3.8% | 3.6% (Target Exceeded) |

The purpose of this measure is to continue to reduce the percentage of improper payments made under the Fee-for-Service (FFS) program as reported in the Department of Health and Human Services (HHS) Agency Financial Report (AFR). One of CMS' key goals is to pay claims properly the first time. This means paying the right amount, to legitimate

[50] Beginning with the 2012 report period, CMS modified the report period by moving it back six months. As a result, the FY 2012 reporting period considers claims from July 1, 2010 through June 30, 2011. In addition, CMS refined the improper payment methodology to account for the impact of rebilling of denied Part A inpatient claims for allowable Part B services.
[51] In the FY 2012 Agency Financial Report (AFR), CMS refined its error rate estimation methodology to reflect activity related to the receipt of additional documentation and the outcome of appeals decisions that routinely occur after the cut–off date for the published AFR. The error rate and target for FY 2011 has been adjusted to reflect this revised methodology.
[52] The HHS 2009 AFR reported the Medicare FFS error rate as 7.8 percent, or $24.1 billion in improper payments. This rate reflected a combination of two different review methodologies to determine errors: 1) the old review process, accounting for the majority of the FY 2009 reviews and 2) the new review process that implemented a more stringent review methodology. Since the new review process was to be used going forward, CMS estimated an adjustment to the FY 2009 error rate for comparison purposes. The adjusted FY 2009 rate was 12.4 percent. Based on the refined estimation methodology outlined in FY 2011 AFR, CMS further calculated and adjusted the 2009 error rate from 12.4% to 10.8% and 2010 error rate from 10.5% to 9.1%.

providers, for covered, reasonable and necessary services provided to eligible beneficiaries.

The Medicare FFS improper payment estimate is calculated under the Comprehensive Error Rate Testing (CERT) program. The CERT program was initiated in Fiscal Year (FY) 2003 and has produced a national Medicare FFS improper payment rate for each year since its inception. Information on the Medicare FFS statistical sampling process and review period can be found in the 2016 HHS AFR.

In FY 2016, the Medicare FFS improper payment rate decreased due to the successes of the corrective actions to address improper payments for inpatient hospital services, which include: policy revisions and medical review. CMS did meet the 2016 AFR target for this measure. The FY 2016 Medicare FFS program improper payment rate is 11.00 percent, compared to the FY 2015 improper payment rate of 12.09 percent. This decrease was driven by a reduction in improper payments for inpatient hospital claims. CMS's "Two Midnight" rule and corresponding educational efforts led to a reduction in improper inpatient hospitals claims, reducing the improper payment rate from 6.18 percent in FY 2015 to 3.85 percent in FY 2016.

Improper payments for home health and Inpatient Rehabilitation Facility (IRF) claims were the major contributing factors to the FY 2016 Medicare FFS improper payment rate. The primary causes of improper payments in FY 2016 continue to be insufficient documentation and medical necessity errors. Insufficient documentation to support medical necessity for home health claims continues to be prevalent, despite the decrease from 58.95 percent in FY 2015 to 42.01 percent in FY 2016. Medical necessity (i.e., the services billed were not medically necessary) was the major error reason for IRF claims. The improper payment rate for IRF claims increased from 45.50 percent in FY 2015 to 62.39 percent in FY 2016.

The factors contributing to improper payments are complex and vary from year to year. CMS is committed to reducing improper payments in the Medicare FFS program. CMS uses data from the CERT program and other sources to reduce or eliminate improper payments through various corrective actions. Each year, CMS outlines actions the agency will implement to prevent and reduce improper payments for all error categories. While some corrective actions have been implemented, others are in the early stages of implementation. CMS believes these focused corrective actions will have a larger impact over time as they become integrated into business operations.

Detailed information on corrective actions can be found in the 2016 HHS AFR. Future targets are 10.40 percent for FY2017, 9.40 percent for FY2018, and 9.30 percent for 2019.

## MIP5: Reduce the Percentage of Improper Payments Made under the Part C Medicare Advantage (MA) Program

| Measure | FY | Target | Result |
|---|---|---|---|
| MIP5: Reduce the Percentage of Improper Payments Made Under the Part C Medicare Advantage (MA) Program. | 2018 | 9.1% (target in FY 2016 AFR) | Nov 15, 2018 |
| | 2017 | 9.5% (target in FY 2016 AFR) | Nov 15, 2017 |
| | 2016 | 9.14% (target in FY 2013 AFR) | 9.99% (Target Not Met) |
| | 2015 | 8.5 % (target in FY 2013 AFR) | 9.5% (Target Not Met) |
| | 2014 | 9.0 (target in FY 2013 AFR) | 9.0% (Target Met) |
| | 2013 | 10.9 % (target in FY 2012 AFR) | 9.5% (Target Exceeded) |
| | 2012 | 10.4% (target in FY 2011 AFR) | 11.4% (Target Not Met) |
| | 2011 | 13.7% (target in FY 2010 AFR) | 11.0% (Target Exceeded) |
| | 2010 | 14.3% (target in FY 2009 AFR) | 14.1% (Target Exceeded) |
| | 2009 | Baseline error rate | 15.4% |

In FY 2016, CMS fell short of its Part C Medicare Advantage (MA) error rate target of 9.14 percent, reporting an actual improper payment rate of 9.99 percent or $16.18 billion. The FY 2016 error rate increased from the prior year's reported error estimate was due to volatility in underlying payment methodology and to lack of improvement in validity of plan-reported diagnoses.

The FY 2017 target is 9.6 percent and the FY 2018 target is to reduce the Part C error rate to 9.1 percent.

The Part C program payment error estimate reflects the extent to which plan-submitted diagnoses for a national sample of enrollees are substantiated by medical records. Validation of diagnoses in medical records for sampled beneficiaries is performed during CMS' annual Medical Record Review process, where medical records are reviewed by two separate coding entities in the process of confirming discrepancies for sampled beneficiaries. To calculate the Part C program's error rate, the dollars in error are divided by the overall Part C payments for the year being measured.

CMS has implemented two key initiatives, described below, to improve payment accuracy in the Part C program: contract-level audits and new regulatory provisions.

**Contract-Level Audits:** HHS is proceeding with the Risk Adjustment Data Validation (RADV) contract-level audits to recover overpayments. Contract-level RADV audits verify, through medical record review, the accuracy of enrollee diagnoses submitted by MAOs for risk adjusted payment.

**Regulatory Provisions:** In CMS-4159-F, *Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit P*rogram (79 FR 100), CMS codified the Affordable Care Act requirement that MA organizations must report and return overpayments that they identify. In CMS-1613-FC, *The Calendar Year 2015 OPPS/ASC* Final Rule (79 FR 67032), CMS also established a payment recovery and appeal mechanism to be applied when CMS identifies erroneous payment data submitted by a Medicare Advantage Organization. Accordingly, in FY 2016, MAOs have reported and returned approximately $317 million in overpayments, which appears to be the result of the sentinel effect of the RADV audits as well as the “report and return” regulatory requirement.

## MIP6: Reduce the Percentage of Improper Payments Made under the Part D Prescription Drug Program

| Measure | FY | Target | Result |
|---|---|---|---|
| MIP6: Reduce the Percentage of Improper Payments Made Under the Part D Prescription Drug Program | 2018 | 3.2% (target in FY 2016 AFR) | Nov 15, 2018 |
| | 2017 | 3.3% (target in FY 2016 AFR) | Nov 15, 2017 |
| | 2016 | 3.4% (target in FY 2013 AFR) | 3.41%[53] (Target Met) |
| | 2015 | 3.5% (target in FY 2013 AFR) | 3.6% (Target Not Met) |
| | 2014 | 3.6% (target in 2013 AFR) | 3.3% (Target Exceeded) |
| | 2013 | 3.1% (target in FY 2011 AFR) | 3.7% (Target Not Met) |
| | 2012 | 3.2% (target in FY 2011 AFR) | 3.1% (Target Exceeded) |
| | 2011 | Report Baseline Composite Error Rate for the Part D Program | 3.2% (Target Met) |
| | 2010 | Further develop component measures of payment error for the Part D program | Additional component measure reported (Target Met) |

The purpose of this measure is to reduce the percentage of improper payments in the Part D Prescription Drug program. Measuring Part D payment errors protects the integrity of the Part D program by ensuring that CMS has made correct payments to contracting private health plans for coverage of Medicare-covered prescription drug benefits.

The Part D composite payment error rate reported in FY 2016 represents payment error related to Prescription Drug Event (PDE) data.

The Medicare Part D gross improper payment estimate for FY 2016 is 3.41 percent or $2.39 billion. The FY 2015 net improper payment estimate is 1.32 percent or $927.75 million. The primary factor that drove the program's decrease from the prior year's reported error estimate was a change in the program's methodology.

CMS will continue its national training sessions for Part D sponsors on Part D payment and data submission. CMS will also conduct outreach to Part D sponsors regarding invalid/incomplete documentation, including Plan Sponsor Summary Reports to all plans participating in the PDE (Prescription Drug Event) validation process.

CMS continues to pursue enhancement of program integrity through national training sessions for Part D plan sponsors on Part D sponsors to update beneficiary Low Income

[53] Per OMB guidance, target is met if the estimate is within 0.01% of the target.

Subsidy statuses prior to reconciliation, and continue formal outreach to plans on invalid/incomplete PDE data submission for Prescription Drug Event Data Validation (PEPV). Lastly, in CMS-4159-F, *Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program* (79 FR 100), HHS codified the Affordable Care Act requirement that Part D sponsors must report and return overpayments that they identify. In *The Calendar Year 2015 OPPS/ASC* Final Rule (79 FR 67032), HHS also established a payment recovery and appeal mechanism to be applied when HHS identifies erroneous payment data submitted by a Part D sponsor. Accordingly, in FY 2015, approximately $11.6 million in overpayments have been reported and returned. This recovery of Part D risk adjustment related overpayments appears to be the result of the "report and return" requirement.

## MIP8: Prevent Medicare Fraud and Abuse by Strengthening CMS' Provider Enrollment and Payment Safeguard Actions

| Measure | FY | Target | Result |
|---|---|---|---|
| MIP8: Prevent Medicare Fraud and Abuse by Strengthening CMS' Fraud Prevention Actions. Increase the percentage of Medicare providers and suppliers identified as high risk that receive an administrative action.<br><br>FY 2012 Baseline: 27% | 2018 | TBD | November 2018 |
| | 2017 | 45% | November 2017<br>Pending |
| | 2016 | 45% | 38.31%<br>(Below Target) |
| | 2015 | 42% | 43.63%<br>(Target Exceeded) |
| | 2014 | 36% | 41.15%<br>(Target Exceeded) |
| | 2013 | 31% | 31.8%<br>(Target Exceeded) |
| | 2012 | 27%* | Baseline |
| *27% is the FY 2012 baseline for this goal calculated based on the result of the leads at the end of the first year of the Fraud Prevention System (FPS) (July 2012). The targets for FY 2013, FY 2014 and FY 2015 are calculated by increasing the previous year's target by 15%. The target for FY 2016 is calculated by increasing the FY 2015 target by 7.5% (One-half the previous increase). The FY 2017 target is held constant at the FY 2016 level. | | | |

In order to protect the integrity of the Medicare Trust Fund, CMS must ensure that correct Medicare payments are made to legitimate providers for covered, appropriate and reasonable services for eligible beneficiaries. This goal is aimed at measuring CMS' ability to target high risk fraud providers and suppliers effectively. The most recent adjustments to this goal, described above, closely align with the program integrity work being conducted at CMS.

The FPS uses sophisticated algorithms and computer modeling to identify providers whose behavior is aberrant and potentially fraudulent. The FPS screens Medicare claims on a pre-payment basis for indications of fraud, waste and abuse. The powerful modeling tools used in this work will identify providers and suppliers that have exhibited high risk, suspect behaviors. The analytic results are shared with our program integrity contractors as high priority Alert Summary Reports (ASRs) for review and possible administrative actions. Any ASR that is or ever was in the highest risk ASRs is included in the contractors' workload. CMS will track the number of ASRs in our contractors' workload and the number and type of subsequent administrative actions taken for the providers and suppliers identified by the models and algorithms.

Goal Implementation: Our predictive analytics work, using FPS, will focus on activities in the areas where incidence or opportunity for improper payments and/or fraud are greatest. While this risk-based approach increases contractors' efficiency, it also reduces the burden on legitimate providers by focusing the majority of fraud detection and prevention resources on those posing higher risk of fraud.

For goal implementation, we intend to measure whether the providers and suppliers identified as high risk actually pose the highest risk of fraud, waste and abuse, and are

appropriately identified as high risk by reviewing data on the number and type of administrative actions required post identification.

This goal currently measures the number and percent of identified high risk providers and suppliers, as identified through predictive analytics, and the number and percent of high risk providers and suppliers subject to one or more of the specified administrative actions. More than one administrative action may be implemented for an individual provider; however, our metrics will measure instances where a high risk provider had at least one administrative action (numerator) as compared to the universe of high risk providers and suppliers (denominator).

It is important to note that this goal does not measure all high risk providers identified to CMS. CMS relies upon the Fraud Prevention System to best demonstrate how we strengthen our fraud prevention activities because the data contained therein and the associated alerts reflect an audited set of information that is connected to a variety of activities that span across CMS' program integrity activities.

CMS is partnering with HHS' Office of General Counsel and the Office of Inspector General, the Department of Justice, and the Federal Bureau of Investigation to implement the full spectrum of administrative actions, including those that result from referrals to law enforcement. Instances of potential fraud identified through predictive analytics are referred to law enforcement for additional civil and criminal remedies such as: prosecution; settlements, restitution and fines; asset forfeiture, civil monetary penalties and exclusion. These law enforcement actions are powerful tools to assist CMS to protect the integrity of the Medicare Trust Fund.

For purposes of this initiative, we have defined the range of administrative actions to be measured to include the following:

Any post-enrollment site visit, whether announced or unannounced.

Pre-payment review of all or some of their claims prior to payment (provider-specific edits) and/or review of claims for particular services most likely to be non-covered, incorrectly coded and/or not medically necessary (service-specific edits).

Post-payment claim reviews, and overpayment determinations.

Revocation, deactivation, or denial of the provider's or supplier's Medicare billing privileges, end-dating locations which are no longer operational.

Suspension of Medicare payments to providers or suppliers.

In addition, we have linked the measurement of performance more directly to the goal in a way that is a more meaningful measure of success.

Due to a desire to reflect statutorily mandated changes in CMS fraud prevention work and due to difficulties and anomalies in the reporting systems and data collection used to measure goal performance, the design of this goal has changed four times since its initial development and approval. Initially, the goal focused on individual providers and suppliers that were termed "high risk" because they had elevated fraud level indicators. The original goal changed to align with new provisions in the ACA on how to track and target high risk providers through a risk based supplier and provider screening process. The goal changed

again with the enactment of the Small Business Jobs Act (SBJA) which added new requirements to use advanced predictive analytics to identify high risk providers. With funding authorized in the SBJA CMS developed the Fraud Prevention System (FPS) which also allows for a better tracking of administrative actions against high risk providers and suppliers. It is the provisions in the SBJA and the improved tracking system using FPS that forms this current goal and the basis for the projected development of baseline information and the goal targets for 2012—2016.

By limiting the administrative actions to those that are most relevant to the FPS, CMS will produce a more accurate, focused measure of success.

Fiscal Year 2011 and Fiscal Year 2012 Difficulties in Reporting and Measurement: In 2011, CMS encountered a number of difficulties in collecting complete information from all CMS contractors about administrative actions taken for the High Risk Providers identified via the regulatory requirements published in February 2011. There were several inconsistencies in data that were reported. With regard to the High Risk Providers identified via predictive analytics, there were a number of definitional changes in the early stages of implementation of the FPS and the reporting system used to capture information about actions taken was inconsistent. As a result, it was not possible to aggregate the data measuring actions taken post identification of High Risk Providers. Although, CMS has partial data for both types of High Risk Providers, it would be inappropriate to suggest a baseline using incomplete data that cannot be aggregated. CMS was unable to develop the 2011 baseline as anticipated, and was therefore unable to meet the FY 2012 target for the percentage of administrative actions taken for Medicare providers and suppliers identified as high risk of 15 percent.

Fiscal Year 2012 and Fiscal Year 2013 Modifications of the Goal: CMS has redesigned this goal to reflect the preponderance of our direct fraud identification and prevention work—the National Fraud Prevention Program (NFPP). The FPS predictive analytics develop leads in the form of ASRs that are investigated by Medicare program integrity contractors.

Since the second year of the FPS, which began July 2012, it has been possible to link actions taken based on ASRs as contemplated in the description of this goal. For example, the FPS data collection is automatic and enables identification of the numbers of high risk ASRs and the subsequent actions taken, including all of those included in the goal description. In its first year, the FPS was extremely successful, but due to the changes in definitions and operational improvements in a complex, developmental system, it would be more meaningful to measure performance based on the second year of operation. Our FY 2012 baseline is from the first year of the FPS (FY 2012) at a rate of 27 percent of Medicare providers and suppliers (identified through predictive analytics) identified as a high risk that received an administrative action. In FY 2014, the 36 percent target rate was again exceeded by an actual rate of 41.15 percent. We set our FY 2015 target at a rate of 42 percent. The FY 2015 actual rate was 43.63 percent, again exceeding the target established for the period. The FY 2016 actual rate was 38.31 percent, which was below the target of 45 percent. The decline in the rate during FY 2016 was due to the number of providers and suppliers identified as high risk (denominator) growing at a disproportionately higher rate than the number of providers and suppliers that had at least one administrative action taken against them (numerator). The FY 2017 target has been set at 45 percent and the FY 2018 target will be determined.

## MIP9.1: Estimate the Improper Payment Rate in the Medicaid Program and MIP9.2: Estimate the Improper Payment Rate in the Children's Health Insurance (CHIP)

| Measure | FY | Target | Result |
|---|---|---|---|
| *MIP9.1: Estimate the Improper Payment Rate in the Medicaid Program | 2018 | 6.68% | Nov 15, 2018 |
| | 2017 | 9.57% | Nov 15, 2017 |
| | 2016 | 11.53% | 10.48% (Target Exceeded) |
| | 2015 | 6.7% | 9.78% (Target Not Met) |
| | 2014 | 5.6% | 6.7% (Target Not Met) |
| | 2013 | 6.4% | 5.8%[54] (Target Exceeded) |
| | 2012 | 7.4% | 7.1% (Target Exceeded) |
| | 2011 | Report rolling average improper payment rate in the 2011 AFR based on states reported in 2009-2011. Meet or exceed the target of 8.4%. | 8.1% (Target Met) |
| | 2010 | Report baseline rolling average improper payment rate in the 2010 AFR based on states measured in 2008 – 2010. Develop baseline and future targets. | 9.4% (Target Met) |
| *MIP9.2: Estimate the Improper Payment Rate in the Children's Health Insurance Program (CHIP) | 2018 | 7.06% | Nov 15, 2018 |
| | 2017 | 7.38% | Nov 15, 2017 |
| | 2016 | 6.81% | 7.99% (Target Not Met) |
| | 2015 | 6.5% | 6.80% (Target Not Met) |
| | 2014 | Report rolling improper payment rate in the 2014 AFR. | 6.5% (Target Met) |
| | 2013 | Report rolling improper payment rate in the 2013 AFR. | 7.1%[55] (Target Met) |

[54] In FY 2013, CMS made two improper payment rate calculation methodology enhancements to improve the accuracy of the Medicaid improper payment rate estimate. These two enhancements include: (1) replacing the three-year weighted average national Medicaid improper payment rate with a single-year rolling national Medicaid improper payment rate and (2) incorporating prior year state-level improper payment rate recalculations.

[55] The two Medicaid improper payment rate calculation methodology enhancements described above in footnote 1 also apply to the CHIP improper payment rate estimate.

| Measure | FY | Target | Result |
|---|---|---|---|
| | 2012 | Report national improper payment rates in the 2012 AFR. | 8.2% (Target Met) |

*In FY 2013 budget/performance documents, these goals were numbered MCD1.1 and MCD1.2. They were renamed MIP9.1 and 9.2 in order to reflect the reporting schedule to be consistent with the year of the latest HHS Agency Financial Report.

The Payment Error Rate Measurement (PERM) program measures improper payments in the fee-for-service, managed care, and eligibility components of both Medicaid (MIP9.1) and CHIP (MIP9.2). CMS measures improper payments in 17 states each year as a means to contain cost, reduce the burden on states, and make measurement manageable. In this way, states can plan for the reviews and CMS can complete the measurement on time for the HHS AFR reporting. At the end of a three-year period, each state will have been measured once and will rotate in that cycle in future years, (e.g., the states measured in the 2013 AFR were also measured again in the 2016 AFR). Information on the Medicaid and CHIP statistical sampling process and review period can be found in the FY 2016 HHS AFR.

The national Medicaid improper payment rate (MIP9.1) reported in the 2016 AFR is based on measurements that were conducted in FYs 2014, 2015, and 2016.

The current national Medicaid improper payment rate is 10.48 percent. The national Medicaid error component rates are: Medicaid FFS: 12.42 percent and Medicaid managed care: 0.25 percent. The Medicaid eligibility component is held constant at the FY 2014 reported rate of 3.11 percent.

For FYs 2015 through 2018, CMS is not conducting the eligibility measurement component of PERM. During this time, the FY 2014 national eligibility improper payment rate is used as a proxy in the overall improper payment rate calculation while CMS develops a new eligibility review methodology

In place of the FYs 2015 through 2018 PERM eligibility reviews, all states are required to conduct eligibility review pilots. The eligibility review pilots provide more targeted, detailed information on the accuracy of eligibility determinations. The pilots use targeted measurements to: provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility, identify strengths and weaknesses in operations and systems leading to errors, and test the effectiveness of corrections and improvements in reducing or eliminating those errors.

This improper payment rate increased from prior years due to an increase in the FFS component, driven primarily by state systems having difficulty complying with new requirements.

As described above, although all states are included in the improper payment rates, CMS only reviews 17 states each year. In FY 2014, HHS reported a rate reflecting the first 17 states measured under new the requirements. The FY 2015 improper payment rates reflected the second group of 17 states subject to new requirements for a total of 34 states. The FY 2016 rate reflects the measurement of the final group of 17 states subject to new requirements. CMS expects to see a decrease in improper payment rates in following years due to corrective actions as states are measured again.

The national CHIP improper payment rate (MIP 9.2) reported in the 2016 AFR is based on measurements conducted in FYs 2014, 2015, and 2016. The current national CHIP improper payment rate is 7.99 percent. The national CHIP error component rates are: CHIP FFS: 10.15 percent and CHIP managed care: 1.01 percent. The CHIP eligibility component is held constant at the FY 2014 reported rate of 4.22 percent. Additional detail about Medicaid and CHIP error rates and underlying components is available in the FY 2016 HHS AFR.

Trend analysis results indicate that errors related to state difficulties coming into compliance with new requirements contribute significantly to the improper payment rate. These new state requirements include: all referring or ordering providers must be enrolled in Medicaid/CHIP and their National Provider Identifier (NPI) must be on the claim, states must screen providers under a risk-based screening process prior to enrollment, and attending providers must include their NPI on all electronically filed institutional claims.

While these requirements will ultimately strengthen program integrity, they require systems changes that many states have not fully implemented. CMS is working to help state come into compliance with these new requirements.

In order to reduce the national Medicaid and CHIP improper payment rates, states are required to develop and submit Corrective Action Plans (CAPs) to CMS. Since the Medicaid and CHIP improper payment rates were driven by state difficulties becoming compliant with new requirements, state CAPs focus on systems changes to reduce these errors (e.g. claims edits, new provider enrollment processes). State CAPs have also focused on provider education, training, communication, and outreach efforts to reduce errors related to missing or insufficient documentation.

In addition to the development, execution, and evaluation of the State-specific CAPs, CMS has implemented additional efforts to lower improper payments rates including provider outreach, mini-PERM audits, best practice calls, and various other methods of state outreach. For more information on corrective actions see the FY 2016 HHS AFR.

## MIP11: Improve Efficiency in the Medicare Enrollment Process by Increasing the Proportion of Providers Initially Enrolling in the Medicare Program Online

| Measure | CY | Target* | Result |
|---|---|---|---|
| MIP11 Increase the proportion of providers performing initial enrollment **in the** Medicare Program online.<br><br>Calendar Year (CY) 2015 Baseline: 30.1%<br><br>This is a CY goal. | 2018 | 38.7% | April 2019 |
| | 2017 | 36.7% | April 2018 |
| | 2016 | 34% | 34.7%<br>(Target Exceeded) |
| | 2015 | Baseline | 30.1% |

*The baseline was established in calendar year 2015 when the result was measured at 30.1%. The calendar year 2016 target was established at 34%, based on the expectation of a modest increase over the baseline result. Consistent with this concept the calendar year 2017 target is based on an increase of 2% above the calendar year 2016 result, a target of 36.7%.

The Provider Enrollment, Chain and Ownership System (PECOS) is the CMS national repository and system of record for all enrollment information on Medicare providers and suppliers. Providers and suppliers are required to enroll in the Medicare program in order to bill for services rendered to program beneficiaries and to be paid for those services. As an online, electronic application system, PECOS helps to improve operational efficiency in CMS' enrollment process, reduce the cost associated with processing paper enrollment applications, and improve beneficiary access to care by reducing the time needed to issue provider certifications. This measure identifies annual improvement (increases) in electronic applications for initial enrollments that provide savings.

The purpose of the measure is to increase PECOS online submission of enrollment applications and reduce the number of paper applications, therefore increasing operational efficiency. An estimated 50 percent – 70 percent of all provider paper initial enrollment applications must be returned to the provider for further information or explanation. This process unnecessarily lengthens the provider enrollment timeframe and increases the CMS enrollment contractors' time and effort when processing enrollment applications. This added time and expense negatively impacts CMS' operational efficiency and can affect program beneficiaries' access to services. The average time to process an electronic enrollment application is 45 days This compares favorably to the 60 days of average time to process a paper enrollment application. This difference is further amplified by the annual average of more than a million enrollment applications processed by CMS.

This measure will improve operational efficiency by reducing the number of hours needed to process enrollment applications by Medicare Contractors through PECOS, thereby resulting in reduced operating costs and improving access to care through timelier provider certification. Increased usability of online enrollment submissions by providers will also result in more complete applications and faster screening results through real time data verification to the Medicare contractors, thereby reducing overall processing time. Online enrollment submission will result in faster submission of applications by the provider community, as the application is tailored to supply information for their needs and provides quick and easy access to update their information for accuracy. The electronic enrollment process will also enhance CMS' capabilities to perform its responsibilities under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Faster processing and timely updates of enrollment information in PECOS will facilitate data sharing and identifying and determining the program eligibility of the providers and groups in MACRA programs like the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs), thus benefiting multiple CMS programs.

**Goal Implementation:** We propose to measure the increase in the proportion of providers enrolling online by taking a baseline measurement in the year 2015 and measuring the increase/decrease of these target measures in future years. Goal implementation occurred in CY 2016.

The CY 2016 result was 34.7 percent, which exceeded the target of 34 percent. The CY 2017 result will be available by the end of April 2018, and subsequent measurements will be available by April of each year follow

# CLINICAL LABORATORY IMPROVEMENTS AMENDMENTS of 1988 (CLIA)

## CLIA3: Provider Performed Microscopy Laboratories: Improve Compliance and Quality Performance Measure

| | FY | Target | Result |
|---|---|---|---|
| CLIA3 Provider Performed Microscopy Laboratories: Improve Compliance and Quality Performance<br><br>Developmental | 2018 | TBD | TBD |
| | 2017 | Developmental | TBD |
| | | | |

Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 to ensure the quality of laboratory testing. CLIA requires all laboratories that examine materials derived from the human body for diagnosis, prevention, or treatment purposes to be certified by the Secretary of Health and Human Services (HHS) and meet the CLIA provisions.

This new performance goal will measure the compliance in Provider Performed Microscopy (PPM) laboratories.

PPM laboratory tests are performed by healthcare practitioners during the course of the patient office visit. Typically, these tests are considered labile, and any delay in performing the test could compromise the accuracy of the test result. In addition, the personnel conducting these tests must have the technical knowledge to perform the test correctly and interpret results accurately. Thus laboratories with a PPM certificate are subject to CLIA safety and quality regulations. Currently there are 34,808 certified PPM laboratories, an increase of approximately 47% since 1993.

In conjunction with the Centers for Disease Control and Prevention (CDC), CMS has recently published a new educational resource, Provider Performed Microscopy Procedures: A Focus on Quality Practices. The booklet explains the CLIA regulatory requirements for PPM laboratories and provides safety tips for laboratory testing. We intend to distribute this booklet to all PPM laboratories.

We also plan to conduct educational surveys of PPM laboratories which will allow CMS surveyors to assess compliance with federal regulations. Surveyors will also assess whether the laboratories are performing tests that are within the scope of the PPM certificate. If quality problems are found, the surveyor will provide education and assistance to the laboratory to achieve accurate and reliable results.

We envision that the combination of educational surveys of PPM laboratories and distribution of the booklet will result in a number of measureable outcomes. The type of survey letter issued will identify the level of laboratory compliance and document areas for

improvement. The State Surveyor Information System (SSIS) will be utilized to identify the number of laboratories that use the information and tools in the PPM booklet to meet compliance. During the first year of implementation, we would expect to gather baseline information from the results of surveys and responses to questions about the utility of the booklet. In subsequent years we would expect to observe small increments of improvement as providers learn and utilize the information and templates offered in the booklet.

FY2017 will be a developmental year, as we need to work with the CDC to make updates to the SSIS, develop the educational survey protocol for PPM laboratories, distribute the survey protocol and train surveyors, develop a new questionnaire for laboratories to provide feedback on the booklet, distribute the PPM booklet and inform stakeholders of our intention to survey.

# QUALITY IMPROVEMENT ORGANIZATIONS (QIO)

## QIO7: Make Nursing Home Care Safer via the National Nursing Home Quality Care Collaborative (NNHQCC)

| Measure ID | FY | Target | Result |
|---|---|---|---|
| QIO7.1: **Making Care Safer** Improve nursing home safety by recruiting under-performing (one star) nursing homes via collaboratives to provide peer-to-peer improvement of Medicare beneficiary health care by end of FY. Baseline: Zero (0) | 2018 | Discontinued | N/A |
| | 2017 | 75% | July 1, 2017 |
| | 2016 | N/A* | N/A* |
| | 2015 | 50% | 72%<br>Target Exceeded |
| QIO7.2 Demonstrate Improvement in Health Care Quality of Participating One-Star Homes. *Developmental* | 2018 | TBD by October 2017 | TBD |
| | 2017 | TBD by October 2017 | TBD |

*There are two collaborative time periods. 2016 is a recruitment period with targets in 2017.

More than 3 million Americans rely on services provided by nursing homes each year. There are 1.4 million Americans who reside in the nation's 15,600 nursing homes on any given day. Those individuals, and an even larger number of their family members, friends, and relatives, must be able to count on nursing homes to provide reliable, high quality care. Current law requires CMS to develop a strategy that will guide local, state and national efforts to improve the quality of care in nursing homes. The most effective approach to ensure quality is one that mobilizes and integrates all available tools and resources – aligning them in a comprehensive, actionable strategy.

In December 2008, CMS added a star rating system to the Nursing Home Compare website. This rating system serves three purposes: 1) to provide residents and their families with an assessment of nursing home quality, 2) to make a distinction between high and low performing nursing homes, and 3) to provide incentives for nursing homes to improve their performance. The one-star hospital rating is the lowest rating and the five star rating is the highest. The Quality Innovation Network-Quality Improvement Organization (QIN-QIO), via recruitment of Nursing Homes and other activities, shall support the creation of a National Nursing Home Quality Care Collaborative (NNHQCC).

The purpose of the NNHQCC is to ensure, along with its partners, that every nursing home resident receives the highest quality of care. Specifically, the QIN-QIO shall support the Collaboratives objective to "instill quality and performance improvement practices, eliminate healthcare acquired conditions, and improve resident satisfaction." Although the QIN-QIO will recruit nursing homes with an existing star status, all nursing homes or facilities providing long-term care services to Medicare beneficiaries are eligible and encouraged to participate in the Collaborative.

One-star nursing homes face specific challenges, including lack of understanding of quality improvement processes; lack of resources to implement the processes; poor understanding of the data for use in improvement; lack of consistent leadership; and perhaps lower resident and family engagement. Participation in the NNHQCC will entail peer-to-peer learning activities in an "all teach/all learn" environment involving virtual, face-to-face

meetings, and quality improvement activities which help guide the nursing home to engage in the use of facility- specific data for rapid-cycle quality improvement activities, such as Plan-Do-Study Act cycles, to instill systems-level improvement in the individual nursing home. There are two collaborative time periods, and recruitment goals are measured at the start of each collaborative. Continued engagement in collaborative activities is monitored throughout the life of each collaborative via the facilities' individual Composite Scores and outcome measures, such as the decreased use of antipsychotic medication in residents with dementia.

The one-star recruitment measure will assess the ability of the QIN-QIO to gain participation in peer-to-peer quality improvement activities, measured by the percentage increase of one-star nursing homes participating in the NNHQCCs through 2018. Participation would therefore ensure safer care received by Medicare beneficiaries residing in the lowest performing nursing homes. While we plan to begin with measuring *participation* in the early years of the project, the goal is to move toward measuring *improvement* utilizing the NNHQCC Quality Measure Composite Score of each participating nursing home as the project matures.

As of March 31, 2015, in the Collaborative I time period, QIN-QIOs exceeded the GPRA recruitment goal of 50 percent by recruiting 72 percent of the total One-Star Category Target Number (SCTN) for the 11th SOW. However with the re-balancing of the Medicare.gov 5-Star Rating system effective February 20, 2015, one star homes will continue to be recruited by QIN-QIOs as part of Collaborative II in the NNHQCC.

The Quality Measure Composite Score (C.7.2) also referred to as the Composite Score, is used to monitor NNHQCC progress at the national, QIN-QIO, and nursing homes levels. Nursing homes participating in the NNHQCC focus on processes that improve their systems and measure individual tests of change. Specifically, nursing homes look at their Plan-Do-Study-Act (PDSA) improvement cycle results, clinical outcomes measures, and composite scores. The Composite Score is comprised of 13 National Quality Forum (NQF)-endorsed*, publically reported, long-stay quality measures that represent processes and inter-related systems of care within the long term care setting. The accelerated pace and short- term nature of the NNHQC Collaboratives benefit from data that can be monitored on a monthly or quarterly basis. The Composite Score is calculated and updated more frequently than other data or rating systems, such as the five-star rating system. This frequency helps QIN-QIOs and CMS determine if the quality of care of nursing home is improving on a timely basis, and to identify best practice interventions or areas of need.

While there are benefits to the Composite Score (C.7.2) for assessing nursing home health care quality and quality improvement, there needs to be further research on the national aggregation of this score before finalizing this measure as a GPRA goal. Additional analyses and testing is needed to confirm factors such as scaling of the measures that comprise the composite, and risk adjustment. Further research on the composite is needed to validate its use as a national measure, and therefore, this is a developmental GPRA goal. The baseline and targets will be set after additional research is completed, by October 2017.

*Some of the measures that make up the composite score, are pending NQF endorsement.

## QIO8: Strengthening Person and Family Engagement in Beneficiary Health Care Quality by Increasing Satisfaction of Quality of Care Complaint Resolution

| Measure ID | FY | Target | Result |
|---|---|---|---|
| QIO8: Increase beneficiary satisfaction with the resolution of all beneficiary initiated quality of care complaints. | 2018 | 75% QIO Satisfaction | December 31, 2018 |
| | 2017 | 70% QIO satisfaction | December 31, 2017 |
| | 2016 | 62% - Baseline | September 30, 2016 |

The primary focus of the Beneficiary and Family Centered Care (BFCC) is to improve healthcare services for Medicare beneficiaries, through the Quality Improvement Organization (QIO) performance of statutory review functions. This includes, but is not limited to, quality of care reviews, beneficiary complaint reviews, discharge and termination of service appeals in various provider settings, medical necessity reviews, and the Emergency Medical Treatment & Labor Act (EMTALA) reviews. Beneficiary satisfaction with the review process has been mixed over the course of the past several years with concerns raised by patients and families regarding the quality of the reviews and the impartiality of the reviewers.

The BFCC QIOs develop activities that engage patients and families, with the goal of increasing patient knowledge, skill, and confidence in taking an active role in managing patient health and health care. Engagement in these activities are captured on the Beneficiary Satisfaction surveys. The current survey measures satisfaction for Quality of Care reviews and Appeals Reviews. The BFCC- Oversight and Review Center (ORC) began administering the satisfaction survey in April 2016, beginning with cases closed in November 2015 and continuing to the present. CMS began receiving QIO performance data for satisfaction beginning in July 2016.

The survey is mailed to Medicare beneficiaries who file a Quality of Care Complaint or Appeal and have agreed to participate in the survey. The survey is mailed monthly to beneficiaries who are randomly chosen to share their views about their experience with the BFCC-QIO and the Medicare Complaint or Appeal process. The survey assesses beneficiary satisfaction in three domains which include:

- Effectiveness of the QIO review process
- Courtesy & Respect of BFCC-QIO staff in handling a beneficiary's complaint; and -
- Responsiveness of BFCC QIO staff-

The 11th SOW survey scoring method was used to develop the 2017 target.

## QIO9: Improve Health Outcomes for Medicare, Beneficiaries by Providing Technical Assistance (TA) Support Related to Value-Based Payment and Quality Improvement Programs to the Eligible Clinician Population Working in Ambulatory Care Settings

| Measure ID | FY | Target | Result |
|---|---|---|---|
| QIO9: Increase Clinician Practice Technical Support | 2018 | 540,000<br>(90% of 600,000 eligible clinicians) | January 2019 |
| | 2017 | 510,000<br>(85% of 600,000 eligible clinicians) | January 2018 |

The purpose of this measure is to ensure broad reaching national access to TA for clinicians in clinical practices in order to support successful participation in value-based payment and quality improvement programs. Programs will provide TA through Learning and Action Network (LAN) events and/or direct TA. These LAN events will include topics related to improving health outcomes for beneficiaries, improving care coordination and costs related to care. Measuring the reach of TA provided across programs will ensure these programs achieve successful outcomes. For 2017 and 2018, reach of TA will include clinicians who have committed to quality improvement targets of the program and participate in program sponsored webinars, complete learning via program modules, LANs, receive direct technical assistance, and/or report quality improvement measure trend data back to the program. In subsequent years, the measure will include only those clinicians that submit longitudinal outcome data. Furthermore, through the TA provided by the Quality Insights Quality Improvement Organizations (QIN-QIOs), related to quality payment and quality reporting programs, and Transforming Clinical Practice Initiative (TCPI), eligible clinicians will be supported in their endeavors to improve practice and enter into Alternative Payment Models (APMs). The increase in clinicians in APMs changes the healthcare environment payment structure from that of a fee-for-service system to a structure that emphasizes payment based on the quality of care provided, ultimately leading to improved patient outcomes.

The Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) legislation was signed into law on April 16, 2015 and repeals the 1997 Sustainable Growth Rate Formula that linked to Medicare annual payment. This legislation provides Health and Human Services with $20 million each fiscal year starting in 2016 through 2020 to provide direct technical assistance (TA) to Merit-Based Incentive Payment System (MIPS) eligible clinicians in practices of 15 or fewer professionals and offers that priority will be given to rural areas, health professional shortage areas, and those areas that are medically underserved. The Quality Payment Program Small, Underserved, and Rural Support Contractors will be performing education, outreach, technical assistance, and LAN activity in order to support eligible clinicians for MACRA.

This support will assist approximately 200,000 + clinicians.

Covered areas of technical assistance and educational offerings that will be included are the following:

- Merit-Based Incentive Payment System (MIPS) performance categories
- Stages of clinical practice transformation
- Clinical quality measurement strategies

The QIN-QIO 11th SOW has broad reaching support for clinicians to improve the quality of care with focus areas specific to the following:

- Cardiac health;
- Reducing disparities in diabetes care;
- Improving prevention coordination through meaningful use of Health Information Technology (HIT);
- Improving care coordination;
- Supporting improvement through the value based payment model, the Quality Payment Program (QPP), and quality reporting. This support will also include reaching non-rural providers to help them comply with their QPP requirements via customized, direct technical assistance as requested as well as through LAN activity, QPP – aligned modules, and education/outreach. Efforts related to MIPS eligible clinicians (not specific to rural providers) will reach at least 25,000 eligible clinicians.

The Transforming Clinical Practice Initiative (TCPI) is designed to help clinicians achieve large-scale health transformation. The initiative is designed to support more than 140,000 clinician practices over the next four years in sharing, adapting and further developing their comprehensive quality improvement strategies. The aims to strengthen the quality of patient care and spend health care dollars more efficiently.

## QIO10: Reduce the Risk of Vascular Access-Related Infections By Reducing the Rate of Long-Term Central Venous Catheter (CVC) Use Among Prevalent Patients Nationally with the Placement of an Arteriofistula (AVF) or Graft

| Measure | FY | Target | Result |
|---|---|---|---|
| QIO10: Decrease the rate of long-term central venous catheter (CVC) use among prevalent patients<br><br>Baseline: FY 2015: 10.8% | 2018 | 1% Relative Improvement over 2017 baseline | September 2019 |
| | 2017 | 1% Relative Improvement over 2016 baseline | September 2018 |
| | 2016 | 1% Relative Improvement over 2015 baseline | September 2017 |

Individuals are diagnosed with End-Stage Renal Disease (ESRD) when their kidneys are no longer able to remove excess fluids and toxins from their blood. ESRD can be cured only with a kidney transplant. ESRD patients who have not received a transplant rely on dialysis to perform the life-saving filtering function. The estimated number of prevalent Medicare ESRD patients grew by 3.2 percent to 661,648 with a total of $30.9 billion of Medicare claims paid in 2015. Hemodialysis requires repeated vascular access to large blood vessels capable of effectively removing wastes from the blood. The three forms of vascular access are arteriovenous fistula (AVF), arteriovenous graft (AVG), and central venous catheter (CVC). A patient's vasculature and other medical and physical conditions are used to determine access type.

Hemodialysis access-related complications, infection being the most common, remain one of the most important sources of morbidity and cost, with total annual costs exceeding $1 billion annually[56]. While CVCs have the advantage of immediate use for dialysis after placement, they are associated with a host of complications particularly when used long term. Long term CVC use refers to having a tunneled hemodialysis catheter in place for 90 days or longer. Compared with patients who receive an AVF, patients with a CVC may experience poorer clearance of blood toxins secondary to unreliable blood flow, central vein scarring with subsequent vein occlusion and antibiotic resistance. Patients with a CVC may have higher rates of anemia, and require greater doses of intravenous iron and recombinant human erythropoietin compared with patients with AVFs or AVGs. In addition, CVC use is associated with greater rates of infection, including bacteremia, endocarditis, septic shock, septic arthritis, and epidural abscess. Undoubtedly, the CVC is associated with the greatest risk of infection-related and all-cause mortality compared with the AVF and AVG[57]. Because of the risks associated with catheter use, CVCs should be viewed as a bridge to an AVF or AVG while a permanent access is maturing or healing or as a permanent access in patients who have exhausted other options or whose clinical condition precludes the placement of an AVF or AVG. It is unclear why high rates of CVC use persist

[56] Ramanathan V, Chiu E J, Thomas J T, Khan A, Dolson G M, Darouiche R O. Healthcare costs associated with hemodialysis catheter-related infections: a single-center experience. Infect Control Hospital Epidemiology):606–609.[PubMed]

[57] USRDS, 2014

among hemodialysis patients in the United States in view of the clear disadvantages and evidence-based practice guidelines to the contrary.

In 2013, the Fistula First Catheter Last Workgroup Coalition (FFCL) was established to build on the success of the Fistula First Breakthrough Initiative but with a specific focus on hemodialysis catheter reduction and increasing the number and percentage of AVFs in use. The FFCL is comprised of representatives from the ESRD Network Program, subject matter experts, access experts, dialysis providers, patients and other stakeholders. The four workgroups included: (1) FFCL Data Committee, (2) Access Monitoring, (3) Access Planning and Coordination, and (4) Access Infection Prevention.

CMS established bold goals for vascular access with the 2013 ESRD Network Redesigned Statement of Work. Specifically, CMS set a target maximum goal of 10 percent for the percentage of patients with tunneled hemodialysis catheters in place for 90 days or longer. The ESRD Network Statement of Work calls for ESRD Networks to increase their efforts to encourage and support the use of AVFs and decrease the use of catheters.

Currently, the ESRD Networks maintain a national level of AVF placement of approximately 63-68 percent within their network service areas.

## QIO11: Improve Hospital Patient Safety by Reducing Preventable Patient Harms

| Measure | CY | Target | Result |
|---|---|---|---|
| QIO11: Hospital Patient Safety Harm Reduction<br><br>Baseline: CY 2014: 121 harms per 1,000 discharges | 2019 | 20% decrease from 2014 baseline<br>(97 harms per 1,000 discharges) | December 2020 |
| | 2018 | 101 harms per 1,000 discharges | December 2019 |
| | 2017 | 106 harms per 1,000 discharges | December 2018 |
| | 2016 | N/A | December 2017 |
| | 2015 | N/A | 115* |

*Data are preliminary based on partial data from this calendar year combined with data from prior years to fill gaps. The estimates are subject to change after all data from this calendar year are available and all quality control procedures have been completed.

The purpose of this measure is to determine the national impact of patient safety efforts by counting the number of preventable patient harms that take place per 1,000 inpatient discharges. Examples of some of the preventable patient harms included in this measure are:

- Adverse Drug Events (ADEs);
- Catheter-Associated Urinary Tract Infections (CAUTI);
- Central Line-Associated Bloodstream Infections (CLABSI);
- Falls;
- Pressure Ulcers (PrUl);
- Surgical Site Infections (SSI);
- Ventilator-Associated Pneumonia/Events (VAP/VAE);
- Venous Thromboembolism (VTE);
- And more[58].

These preventable harms can cause additional pain, stress, and costs to the patient and their family during intended treatment, as well as increased spending on the part of payers. This measure utilizes the *Agency for Healthcare Research and Quality (*AHRQ) National Scorecard, which includes abstraction from a nationally representative sample of approximately 30,000 hospital charts per year that yields clinical relevant yet highly standardized national hospital safety metrics. This system is in active operation, and was originally put into place to measure the impact of the Partnership for Patients (PfP) Center for Medicare & Medicaid Innovation (CMMI) model test. By itself however, it represents an enormous contribution to the government's ability to measure, monitor, and improve patient

[58] Hackbarth A., Munier B., Eldridge N., et. al. (2014). "An Overview of Measurement Activities in the Partnership for Patients." *Journal of Patient Safety*. Sept. 2014. Vol. 10, Issue 3.

safety at a national scale. As a composite of many different harms, the AHRQ National Score Card also includes data from the Centers for Disease Control (CDC's) National Healthcare Safety Network (NHSN) and AHRQ's Healthcare Cost and Utilization Project (HCUP) databases.

The results of this dataset thus far demonstrate a reduction in harm from 145 harms per 1,000 discharges in the baseline year of 2010 (defined prior to the PfP model test), to 115 harms per 1,000 discharges in CY2015, the latest year for which preliminary data are available at this time. These data demonstrate a reduction in harm to patients of approximately 21 percent over five years.

| Calendar Year | # Harms per 1,000 Discharges | Percent decrease from baseline |
|---|---|---|
| 2015 | 115 | 21% |
| 2014 | 121 | 17% |
| 2013 | 121 | 17% |
| 2012 | 132 | 9% |
| 2011 | 142 | 2% |
| 2010 -- Baseline | 145 | Baseline |

The proposed 2019 target is a 20 percent reduction in patient harms, compared to the 2014 baseline (annualized reduction [-4.4%] applied for 5 years). Given the progress to date, the active interventions of Hospital Innovation and Improvement Networks (HIINs) currently in the field under Partnership for Patients (PfP) 3.0, CMS and AHRQ believe that this is a challenging, yet achievable goal.

CMS will leverage the momentum and lessons learned from the model test in aligning PfP with the Quality Innovation Networks-Quality Improvement Organizations (QIN-QIO) improvement efforts. The Center for Clinical Standards and Quality (CCSQ) has made patient safety an essential component of both the QIN-QIOs and PfP, the alignment of these programs will permit the systematic use of innovative patient safety practices at a national scale. Integration presents unique opportunities to leverage scope and scale in achieving the goals of the 11th SOW (e.g., Hospital Acquired Condition (HAC) reduction in hospitals).The goal of the integrated PfP and QIN-QIO patient safety effort is to directly work with recruited hospitals to implement evidence based interventions and best practices, track improvement using a data driven approach (e.g. using CDC's NHSN system), and establish a culture of safety and quality improvement to make care safer for Medicare beneficiaries. This work does not directly involve payment incentives or penalties as participation with HIINs and/or QIOs is completely voluntary on the part of the hospital. The quality programs that CMS operates through the Inpatient Prospective Payment System (IPPS) also contribute to the aims of this goal, to increase patient safety and reduce harms.

It is important to note that the data obtained from the AHRQ National Scorecard experiences a lag of approximately one year between service delivery and the collection, analysis, and delivery of preliminary results and a second year between delivery of preliminary and final results. The preliminary data that will be used to obtain confirmation of CMS's achievement of this 2019 target is expected to be available in the December CY 2020 and final data in CY 2021.

# Medicare Benefits

## MCR1 Ensure Satisfaction of Medicare Beneficiaries with the Health Care Services They Receive

| Measure | FY | Target | Result |
|---|---|---|---|
| MCR1.1a: Maintain or exceed percent of beneficiaries in Medicare Fee-for-Service (MFFS) who report access to care.<br><br>Baseline: 91% (FY 2007) | 2018 | Contextual Indicator | December 31, 2018 |
| | 2017 | Contextual Indicator | December 31, 2017 |
| | 2016 | Contextual Indicator | 90% |
| | 2015 | 90% | 91% (Target Met) |
| | 2014 | 90% | 91% (Target Exceeded) |
| | 2013 | 90% | 91% (Target Exceeded) |
| | 2012 | 90% | 90% (Target Met) |
| | 2011 | 90% | 92% (Target Exceeded) |
| | 2010 | 90% | 90% (Target Met) |
| | 2009 | 90% | 90% (Target met) |
| | 2008 | 90% | 90% (Target Met) |
| MCR1.1b: Maintain or exceed percent of beneficiaries in Medicare Advantage (MA) who report access to care<br><br>Baseline: 90% (FY 2007) | 2018 | Contextual Indicator | December 31, 2018 |
| | 2017 | Contextual Indicator | December 31, 2017 |
| | 2016 | Contextual Indicator | 90% |
| | 2015 | 90% | 90% (Target met) |
| | 2014 | 90% | 90% (Target met) |
| | 2013 | 90% | 91% (Target Exceeded) |
| | 2012 | 90% | 91% (Target Exceeded) |
| | 2011 | 90% | 92% (Target Exceeded) |
| | 2010 | 90% | 91% (Target Exceeded) |
| | 2009 | 90% | 90% (Target Met) |
| | 2008 | 90% | 90% (Target Met) |

CMS has monitored Medicare Fee-for-Service (FFS) and Medicare Advantage (MA) access to care as measures of beneficiary satisfaction since the enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003. As the ACA is implemented, we will continue to monitor FFS and MA access to care in order to maintain the same high rates for our beneficiaries. To measure these rates, beneficiaries respond to the following question in the Medicare Consumer Assessment of Healthcare Providers and Systems survey: “Percent of persons with FFS (or MA Plans) report they usually or always get needed care right away as soon as they thought they needed it.” CMS met or exceeded our FY 2015 targets reflecting beneficiary experience in FFS and MA access to care in 2014. For FY 2015, at least 90 percent of beneficiaries surveyed reported that they have access to care in the MFFS and MA programs.

After FY 2015, we no longer set targets for this measure, but will report the data trend annually as a contextual measure.

## MCR23: Reduce the average out-of-pocket share of prescription drug costs while in the Medicare Part D Prescription Drug Benefit coverage gap for non-LIS Medicare beneficiaries who reach the gap and have no supplemental coverage in the gap

| Measure | FY | Target | Result |
|---|---|---|---|
| MCR23: Reduce the average out-of-pocket share of prescription drug costs while in the Medicare Part D Prescription Drug Benefit coverage gap for non-Low Income Subsidy (LIS) Medicare beneficiaries who reach the gap and have no supplemental coverage in the gap | 2018 | 37% | February 2020 |
| | 2017 | 43% | February 2019 |
| | 2016 | 48% | February 2018 |
| | 2015 | 50% | 49% (Target Exceeded) |
| | 2014 | 53% | 53% (Target Met) |
| | 2013 | 55% | 52% (Target Exceeded) |
| | 2012 | 58% | 57% (Target Exceeded) |
| | 2011 | 60% | 57% (Historical Actual) |
| | 2010 | N/A | Baseline = 100% |

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) amends Title XVIII (Medicare) of the Social Security Act by adding a Voluntary Prescription Drug Benefit Program (Medicare Part D). Since its inception, Medicare Part D has significantly increased the number of beneficiaries with comprehensive drug coverage, and enhanced access to medicines.

While Medicare Part D offers substantial insurance coverage for prescription drugs, it does not offer complete coverage. Prior to 2010, a beneficiary was responsible for paying 100 percent of the prescription costs between the initial coverage limit and the out-of-pocket threshold (or catastrophic limit). Only once the beneficiary reached the catastrophic limit, did Medicare coverage recommence. This is known as the coverage gap (or “donut hole”). For 2015, this “gap” in coverage is above $2,960 in total drug costs until one spends$4,700 out-of-pocket.

Since 2011, brand-name manufacturers have been required to provide a 50 percent discount of the negotiated price of drugs while a beneficiary is in the coverage gap. The discount is applied at the point of sale, and 100 percent of the negotiated price would count

toward the annual out-of-pocket threshold (True Out-of-Pocket Costs; TrOOP). Since 2013, Part D Plans have been required to cover a portion of the costs of brand drugs in the coverage gap as well, with this coverage increasing over time from 2.5 percent in 2013 to 25 percent for 2020 and beyond. Since 2011, Part D Plans have also been required to cover a portion of the costs for generic drugs in the coverage gap, starting with 7 percent in 2011 and increasing to 75 percent for 2020 and beyond.

The purpose of this performance measure is to reflect this effort to reduce the average out-of-pocket costs paid by non-LIS Medicare beneficiaries while in the coverage gap and to ensure that the coverage gap is closed completely by 2020 as required by law. For 2020 and beyond, the beneficiary, on average, will only be responsible for 25 percent of the costs of both generic and brand name drugs while in the coverage gap.

The target numbers were adjusted to reflect current analysis using base-line data and applying the discounts that will be available to beneficiaries in 2011 through 2020.

## MCR25 Increase the Number of Medicare Beneficiaries Who Receive an Annual Wellness Visit

| Measure | FY | Target | Result |
|---|---|---|---|
| MCR25: Increase the number of Medicare Part B beneficiaries who receive an annual wellness visit<br><br>Baseline: (CY2011 – 2.3 million) | 2018 | Contextual Indicator | June 30, 2019 |
| | 2017 | Contextual Indicator | June 30, 2018. |
| | 2016 | Contextual Indicator | June 30, 2017 |
| | 2015 | Contextual Indicator | 6.02 million |
| | 2014 | 3.2 million | 4.9 million (Target Exceeded) |
| | 2013 | 2.8 million | 4.1 million (Target Exceeded) |
| | 2012 | Baseline set with CY 2011 data | 3.2 million (Target met) |
| | 2011 | N/A | N/A |

CMS measures the number of Medicare Annual Wellness Visits (AWVs) to demonstrate success in increasing beneficiary awareness and utilization of this important benefit, which was first available January 2011. Under the current law, this benefit is available to Medicare beneficiaries with no copayments or other cost-sharing if the doctor or other health care provider accepts assignment. The AWV includes elements that focus on assessing health risks, furnishing personalized health advice and referrals, as appropriate to health education and preventive counseling services, and creating a screening schedule for the next five to ten years. The elements also include a list of risk factors and conditions, as well as ongoing and/or recommended interventions. The CY 2014 target was set at 3.2 million and 4.9 million beneficiaries received an AWV, exceeding that target.

After FY 2014, we no longer set targets for this measure, but report the trend annually as a contextual indicator. In CY 2015 there were 6.02 million beneficiaries who received the AWV. Additional information about preventive services provided to Medicare beneficiaries is available at Medicare.gov.

# CHILDRENS HEALTH INSURANCE PROGRAM (CHIP)

**Please refer to the Medicaid program section of the Performance Appendix for other related performance goal(s):**

- MCD6: Improve Children's Health Care Quality Across Medicaid and the Children's Health Insurance Program (CHIP) through Implementation of Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality Initiatives

**CHIP3: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid**

| Measure | FY | Target | Result |
|---|---|---|---|
| CHIP3: Improve availability and accessibility of health insurance coverage by increasing enrollment of eligible children in CHIP and Medicaid | *2018* | 46,440,401 children (Medicaid – 37,152,321/CHIP – 9,288,080) | March 31, 2019 |
| | *2017* | 46,062,581 children (Medicaid – 36,850,065/CHIP – 9,212,516 | March 31, 2018 |
| | *2016* | 45,271,662 children (Medicaid – 36,217,330/CHIP – 9,054,332) | 45,980,595 children (Medicaid - 37,080,521/ CHIP- 8,900,074) (Target met) |
| | *2015* | 47,642,385 children (Medicaid – 38,920,959/CHIP – 8,721,426) | 45,201,455 children (Medicaid – 36,834,253/CHIP – 8,367,202) (Target Not Met) |
| | *2014* | 46,617,385 children (Medicaid – 38,083,596/CHIP – 8,533,789) | 43,689,824[59] children (Target Not Met) |

[59] The results for this measure reflect enrollment at a "point in time," but states may subsequently revise their current and/or historical data at any time. For example, the FY 2014 enrollment total reported as of March 2015 was 43,689,824. As of January 2017, the enrollment total for FY 2014 is 44,125,521. The change is due primarily to improvements in data quality.

| Measure | FY | Target | Result |
|---|---|---|---|
| | *2013* | 45,592,385 children<br>(Medicaid – 37,246,233/CHIP – 8,346,152) | 45,292,410 children<br>(Medicaid – 37,198,483/CHIP – 8,093,927)<br>(Target Not Met) |
| | *2012* | Historical actual | 44,453,639 children<br>(Medicaid – 36,305,242/CHIP – 8,148,397) |
| | *2011* | Historical actual | 43,542,385 children |
| | *2008* | Baseline | 37,311,641 children |

The purpose of this measure is to increase enrollment in CHIP and Medicaid from 43,542,385 children in FY 2011 to 46,440,401 children by the end of FY 2018. Under the CHIP and Medicaid programs, States[60] submit quarterly and annual statistical forms, which report the number of children who are enrolled in Medicaid, separate CHIP programs, and Medicaid expansion CHIP programs. The enrollment counts reflect an unduplicated number of children ever enrolled during each year.

This measure should be considered in the context of 2014 data that show that in 32 States at least 90 percent of children eligible for Medicaid and CHIP are enrolled in these programs.[61] In contrast, in 2008, only five States had rates at or above 90 percent.[62] With such gains in increasing children's participation in Medicaid and CHIP, it is important to note that the remaining eligible uninsured children will be the hardest to reach. CMS' strategy to increase the availability and accessibility of health insurance coverage for children includes collaborating with our State and Federal partners, continuing to implement CHIPRA and other statutory provisions that encourage program simplification, supporting CHIP outreach grantees, and bolstering our data collection activities.

Many factors affect enrollment figures in CHIP and Medicaid, including States' economic situations, programmatic changes, efficiency of state eligibility and enrollment processes, and the accuracy and timeliness of State reporting. There have also been key legislative changes in recent years with policy changes directed at eligibility and enrollment. The Children's Health Insurance Program Reauthorization Act (CHIPRA), which reauthorized CHIP through September 30, 2013, provided options for States to expand their title XXI program in several ways. CHIPRA increased funding by $44 billion through 2013 to maintain State programs and to cover more uninsured children.

[60] The term "states" includes the 50 states and DC.
[61] https://www.insurekidsnow.gov/about/participation-rates/index.html.
[62] http://www.urban.org/uploadedpdf/412901-%20Medicaid-CHIP-Participation-Rates-Among-Children-An-Update.pdf
[5] http://ccf.georgetown.edu/all/welcome-mat-effect-oregon-data-demonstrates-parent-child-coverage-follow-pattern/

Considerable investments have been made to modernize eligibility verification procedures to rely primarily on electronic data sources while providing states flexibility to determine the usefulness of available data before requesting additional information from applicants, and simplifying verification procedures for states through the operation of a federal data services “Hub” that links states with federal data sources. Retention in Medicaid and CHIP is strengthened by the new renewal policies which require that eligibility is renewed by first evaluating the information available through existing data sources and limits renewals for the beneficiaries to once every 12 months unless a beneficiary reports a change or the agency has information to prompt a reassessment of eligibility. The Affordable Care Act extended federal CHIP funding for an additional two years through September 30, 2015, authorized the program through 2019, and required maintenance of eligibility standards for children in Medicaid and CHIP through 2019.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended CHIP funding for an additional two years, through September 30, 2017. MACRA also provided $40 million for activities aimed at reducing the number of children who are eligible for Medicaid and CHIP, but are not enrolled and improving retention of eligible children who are currently enrolled. Of the total $40 million, $4 million was dedicated to national outreach and enrollment campaign efforts. Of this $4 million, $3.3 million was dedicated to the “Connecting Kids to Coverage National Campaign” and $700,000 was dedicated to the American Indian/ Alaska Native enrollment campaign. Of the remaining $36 million, $32 million was made available in grant funding to states, local government, schools, or health care providers with the goal to reduce the number of children who are eligible for Medicaid and CHIP, but are not enrolled, and to improve the retention of eligible children who are currently enrolled.On June 13, 2016, CMS awarded 38 cooperative agreements in 27 states totaling just under the $32 million. Awards under these cooperative agreements fund activities aimed at educating families about the availability of free or low-cost health coverage under Medicaid and CHIP, identifying children likely to be eligible for these programs, and assisting families with the application and renewal process. In addition, under MACRA, CMS awarded a single source emergency cooperative agreement to the Greater Flint Health Coalition. The funds are aimed at educating and providing outreach and enrollment to families of children impacted by lead exposure in Flint, Michigan. To date, a total of approximately $158 million in grant funding has been awarded to help reduce the number of children who are eligible for Medicaid and CHIP but are not enrolled. The additional $4 million, under MACRA, will be dedicated to another cycle of grants specifically targeting the outreach and enrollment of American Indian/Alaska Native (AI/AN) children. CMS released a funding opportunity announcement for these grants on November 15, 2016 and proposals were due on January 17, 2017. CMS expects to award up to 10 new AI/AN cooperative agreements in the spring of 2017.

The $3.3 million provided by MACRA for the “Connecting Kids to Coverage National Campaign” and other target campaign efforts builds upon an effort established in 2009 to find and enroll an estimated five million uninsured children who are eligible but not enrolled in Medicaid and CHIP, a number which has dropped to 3.7 million in 2013. The “Connecting Kids to Coverage National Campaign” continues to provide outreach training and support for grantees and partners who are working hard to help enroll all eligible

children in Medicaid and CHIP. The Campaign continues to focus on informing families that their eligible children can enroll in Medicaid and CHIP any time of the year, messaging that initially launched in 2014. In 2016, the Campaign continued conducting training webinars and worked with partners on outreach, refreshed existing print materials, and produced new social media graphics. Additionally, research was conducted to better understand grantee needs to enroll the remaining uninsured, as well as messaging which resonates with parents of uninsured children. Planning for 2017 is currently underway, but the Campaign plans to use learnings from the 2016 research to create new television and radio public service announcements, fact sheets and other resources, as well as continued partnership and training efforts. The Campaign continues to publish a regular electronic newsletter to a list that has grown to over 30,000 subscribers. The e-newsletter promotes Campaign resources and training opportunities, as well as grantee and partner outreach and enrollment activities. These and other materials – including training webinars and a growing outreach video library – can be found on the Campaign website, www.InsureKidsNow.gov.

With 91 percent of eligible children enrolled in Medicaid and CHIP, effective and targeted strategies are needed to enroll the remaining 9 percent of eligible uninsured children.[6] As noted above, the remaining eligible but uninsured children are the hardest to reach. MACRA's provision of $40 million in funding for grants and the "Connecting Kids to Coverage National Campaign" is critical to addressing this need for greater awareness among eligible uninsured families.

# CENTER OF MEDICARE AND MEDICAID INNOVATION (CMMI)

## ACO1[63]: Reduce the growth of health care costs while promoting better health and health care quality through delivery system reform

| Measure | CY | Target | Result |
|---|---|---|---|
| ACO1.1 Increase the number of Medicare beneficiaries who have been aligned with Accountable Care Organizations Baseline – 4,002,532 | 2018 | Total Estimate= 11,245,000 | Sept 2019 |
| | 2017 | Total Estimate= 9,920,000, | Sept 2018 |
| | 2016 | Total Estimate= 8,710,000 | Sept 2017 |
| | 2015 | Total Estimate= 7,090,000 | Total Actual = 7,731,655 (Target Exceeded) |
| | 2014 | Total Estimate= 5,425,000 | Total Actual= 5,954,342 (Target Exceeded) |
| | 2013 | Baseline | Total Actual= 4,002,532 |
| ACO1.2 Increase the number of physicians participating in an Accountable Care Organization Baseline – 102,717 | 2018 | Total Estimate= 331,200 | Sept 2019 |
| | 2017 | Total Estimate= 275,200 | Sept 2018 |

[63] In FY 2014 budget/performance documents, these goals were numbered CMMI1.1, CMMI1.2, and CMMI1.3. They were renamed ACO1.1, ACO1.2, and ACO1.3

| Measure | CY | Target | Result |
|---|---|---|---|
| | 2016 | Total Estimate= 266,600 | Sept 2017 |
| | 2015 | Total Estimate= 178,000 | Total Actual= 195,212 (Target Exceeded) |
| | 2014 | Total Estimate= 150,000 | Total Actual= 132,148 (Target Not Met) |
| | 2013 | Baseline | Total Actual= 102,717 |
| ACO1.3 Increase the percentage of Accountable Care Organizations that share in savings Baseline – 34% | 2018 | CMS Estimate = TBD | Sept 2019 |
| | 2017 | CMS Estimate = 37% | Sept 2018 |
| | 2016 | CMS Estimate = 36% | Sept 2017 |
| | 2015 | CMS Estimate = 37% | CMS Result= 34% (Target Not Met) |
| | 2014 | CMS Estimate = 35% | CMS Result= 34% (Target Not Met) |
| | 2013 | Baseline | CMS Baseline Result = 34% |

Delivery system reform will potentially include a very broad array of interventions, but this measure focuses on Accountable Care Organizations (ACOs), which are groups of physicians, providers and suppliers that work together to coordinate care for beneficiaries with original Medicare fee-for-service health coverage. These ACOs enter into agreements with CMS, taking responsibility for the quality of care they provide to Medicare beneficiaries in return for the opportunity to share in savings realized through care improvement. Data for this measure will be collected and aggregated across the following initiatives: Medicare Shared Savings Program (SSP). The ACO Investment Model, the Comprehensive End-

Stage Renal Disease (ESRD) Care Initiative, the Next Generation ACO model, and the ACO Track 1+Model. This measure represents efforts across CMS, not just CMMI, to promote better health and health care quality through delivery system reform.

We aim to increase the number of Medicare beneficiaries who have been aligned with ACOs, the number of physicians participating in ACOs, and the percentage of ACOs that share in savings (ACO measures 1.1-1.3). We have seen an increasing number of beneficiaries aligned to ACOs, with more than 4 million in 2013 (3,394,587 in Medicare SSP and 607,945 in Pioneer), nearly 6 million in 2014 (5,329,831 in Medicare SSP and 624,511 in Pioneer), 7,731,655 in 2015 (7,270,233 in Medicare SSP and 461,442 in Pioneer), and the expectation of increasing alignment to more than 8 million beneficiaries during the 2016 performance year. Additionally, just over 100,000 physicians participated in an ACO in 2013 (83,877 Medicare SSP and 18,840 Pioneer), just over 132,000 physicians participated in an ACO in 2014 (111,608 in Medicare SSP and 20,540 Pioneer), and 195,212 physicians participated in an ACO in 2015 (181,552 in Medicare SSP and 13,660 Pioneer).

The Medicare Shared Savings Program has an annual application process and the size of new ACOs varies each year. We are encouraged by the number of new entrants 2017. On January 8, 2017, CMS announced 99 new ACOs and 79 reviewing ACOs that agreed to join or continue their participation in the SSP. Even with the Pioneer ACO model ending in December of 2016, the launch of the Next Generation ACO model in January of 2016 and the Comprehensive ESRD Care Initiative in the October of 2015, will drive increases in physician participation in ACOs in performance years 2016 and 2017. Furthermore, we hope the announcement of the ACO Track 1+ model will spur participation in 2018.

CMS also established a baseline for the percentage of ACOs that generated shared savings after more than 1 year of participation of 34 percent in 2013. We anticipated modest growth in the percentage of ACOs that will share in savings in subsequent performance years, and found that 34 percent of Medicare SSP ACOs generated shared savings after more than 1 year of participation in 2015, but note that the overall number of Medicare SSP ACOs that had participated in more than 1 year that generated shared increased by 32 ACOs in 2015 (69 ACOs in 2014 to 101 ACOs in 2015). The Medicare Shared Savings Program was implemented in 2012. Our participants are continually learning, developing, and implementing best practices that lead to improved quality and savings for Medicare. We continue to be encouraged by the continued interest in the Program as seen by the number of annual applicant ACOs and renewing ACOs, as well as the number of providers participating and beneficiaries assigned to ACOs. We anticipate as ACOs gain more experience with the program, more ACOs will share in savings. As we reconcile additional performance years we expect for our targets to become more refined, as well. Given the fact that the program is growing rapidly and the number of ACOs beyond their first performance year is increasing, we anticipate minimal growth in the percentage of ACOs that share in savings in 2016 and 2017, but note that we expect an increase in the number of ACOs that share in savings each year. Therefore, in the 2016 performance year, CMS targets that approximately 36 percent of ACOs to share in savings.

A summary of the measure breakouts contributing to the measure trends for this goal are highlighted below:

| ACO1.1 | | |
|---|---|---|
| **CY** | **Model Estimates** | **Model Actuals** |
| 2018 | SSP Estimate= 9,800,000<br>NG ACO Estimate= 1,400,000<br>CEC Estimate= 45,000 | Sept 2019 |
| 2017 | SSP Estimate= 8,800,000<br>NG ACO Estimate= 1,075,000<br>CEC Estimate= 45,000 | Sept 2018 |
| 2016 | SSP Estimate= 7,800,000<br>Pioneer Estimate= 400,000<br>NG ACO Estimate= 490,000<br>CEC Estimate= 20,000 | Sept 2017 |
| 2015 | SSP Estimate= 6,480,000<br>Pioneer Estimate= 610,000 | SSP Actual= 7,270,233<br>Pioneer Actual= 461,442 |
| 2014 | SSP Estimate= 4,800,000<br>Pioneer Estimate= 625,000 | SSP Actual= 5,329,831<br>Pioneer Actual= 624,511 |
| *2013* | **Baseline** | SSP Actual= 3,394,587<br>Pioneer Actual= 607,945 |

| ACO1.2 | | |
|---|---|---|
| **CY** | **Model Estimates** | **Model Actuals** |
| 2018 | SSP Estimate= 285,000<br>NG ACO Estimate= 45,000<br>CEC Estimate= 1200 | Sept 2019 |
| 2017 | SSP Estimate= 240,000<br>NG ACO= 34,000<br>CEC Estimate= 1200 | Sept 2018 |
| 2016 | SSP Estimate= 200,000<br>Pioneer Estimate= 16,000<br>NG ACO Estimate= 50,000<br>CEC Estimate= 600 | Sept 2017 |
| 2015 | SSP Estimate= 160,000<br>Pioneer Estimate= 18,000 | SSP Actual= 181,552<br>Pioneer Actual= 13,660 |
| 2014 | SSP Estimate= 130,000<br>Pioneer Estimate= 20,000 | SSP Actual= 111,608<br>Pioneer Actual= 20,540 |

| ACO 1.3 Measure | | |
|---|---|---|
| **CY** | **Model Estimates** | **Model Actuals** |
| 2018 | SSP Estimate= 35%<br>NG ACO Estimate= 45%<br>CEC Estimate= TBD | Sept 2019 |
| 2017 | SSP Estimate= 35%<br>NG ACO Estimate = 41%<br>CEC Estimate = 57% | Sept 2018 |
| 2016 | SSP Estimate = 35%<br>Pioneer Estimate = 67% | Sept 2017 |
| 2015 | SSP Estimate = 36%<br>Pioneer Estimate = 65% | SSP= 33%<br>Pioneer= 50% |
| 2014 | SSP Estimate = 34%<br>Pioneer Estimate = 55% | SSP= 32%<br>Pioneer= 55% |
| 2013 | **Baseline** | SSP= 32%<br>Pioneer=48% |

## CMMI2: Identify, test, and improve payment and service delivery models

| Measure | FY | Target | Result |
|---|---|---|---|
| CMMI2.1: Increase the number of model tests that currently indicate 1) cost savings while maintaining or improving quality, and/or 2) improving quality while maintaining or reducing cost.<br>Baseline: 1.0 FY 2014 | *2018* | 6.0 | Nov 2018 |
| | *2017* | 5.0 | Nov 2017 |
| | *2016* | 4.0 | 4.0<br>(Target Met) |
| | *2015* | 3.0 | 3.0<br>(Target Met) |

The CMS Innovation Center routinely and rigorously assesses the impact of each model on quality and cost. To formally evaluate models, evaluators employ advanced statistical methods and carefully define and select comparison groups, as appropriate, to ensure that models deemed to be successful represent high-value investments of taxpayer dollars. Similarly, model teams often employ implementation contractors to apply rigorous self-monitoring methodologies to assess the performance of models and generate value-based payments.

The purpose of measure CMMI2.1 is to identify those models, based on available data that indicate cost savings and/or quality improvements. This measure reflects the documented progress that the Innovation Center is making toward sustainable success of its models. As of September 30, 2016, four Section 1115A model tests (Pioneer Accountable Care Organization (ACO_, the YMCA of the USA Diabetes Prevention Program [Y-USA DPP]) the Initiative to Prevent Avoidable Hospitalizations among Nursing Facilities Residents (NFI), and lower-extremity joint replacement (LEJR) under the Bundled Payments for Care Improvement Initiative [BPCI]), have met this goal according to data received to date. The Pioneer ACO model has been certified by the CMS Office of the Actuary (OACT) to reduce net program spending in an expanded model under Section 1115A of the Social Security Act, and in addition, quality results have been favorable. The Y-USA DPP model also has been certified by OACT to reduce net program spending in an expanded model under Section 1115A of the Social Security Act, and in addition, quality results have been favorable. The third annual NFI report shows that total average Medicare expenditures for all Enhanced Care and Coordination Providers (ECCPs) declined by $9,711,398, and the count of both all-cause and potentially avoidable hospitalizations declined for all ECCPs. Evaluation results for BPCI Model 2 during the first 21 months (10/01/2013 – 06/30/2015) show that the total Medicare standardized allowed payments for lower extremity joint replacement decreased by $1,166 per episode while demonstrating improved patient mobility and pain management as indicated by beneficiary surveys and no change in other measures of quality of care.

For other 1115A models, we continue to assemble and assess the evidence as it becomes available. The Innovation Center's targets are to increase the number of models indicating positive results to five in FY 2017 and six in FY 2018, consistent with the evidence available under early model tests.

## CMMI3: Accelerate the Spread of Successful Practices and Models

| Measure | FY | Target | Result |
|---|---|---|---|
| CMMI3.1: Percentage of Medicare beneficiaries participating in Innovation Center models<br><br>Baseline: 2014: 5% | 2018 | Contextual Indicator | Nov 2018 |
| | 2017 | Contextual Indicator | Nov 2017 |
| | 2016 | Contextual Indicator | 9% |
| | 2015 | Contextual Indicator | 9% |
| CMMI3.2: Number of states developing and implementing a health system transformation and payment reform plan<br><br>Baseline: 2014: 25 | 2018 | 12 | Nov 2018 |
| | 2017 | 17 | Nov 2017 |
| | 2016 | 38 | 38<br>(Target Met) |
| | 2015 | 38 | 38<br>(Target Met) |
| CMMI3.3: Number of providers participating in Innovation Center models<br><br>Baseline: 2014: < 60,000 | 2018 | Contextual Indicator | Nov 2018 |
| | 2017 | Contextual Indicator | Nov 2017 |
| | 2016 | Contextual Indicator | 103,291 |
| | 2015 | Contextual Indicator | 61,000 |
| CMMI3.4: Increase the percentage of active model participants who are highly engaged in Innovation Center or related learning activities<br><br>Baseline: 2014: 56% | 2018 | 60% | Nov 2018 |
| | 2017 | 59.7% | Nov 2017 |
| | 2016 | 64.5% | 56.9%<br>(Target Not Met) |
| | 2015 | 61% | 58.6%<br>(Target Not Met) |

Established by ACA Section 3021[64], CMMI's mission is to "test innovative payment and service delivery models to reduce program expenditures…while preserving or enhancing the quality of care furnished" to Medicare, Medicaid and CHIP beneficiaries. Every Innovation Center test of a new service delivery or payment model also includes a plan of action to ensure that the lessons learned and best practices identified during the test can be spread as widely and effectively as possible to support improvement for both CMS and the health care system at large. The CMS Innovation Center also strives to understand the level of participation from beneficiaries, providers, States, payers, and other stakeholders in order to effectively design, test, and evaluate its portfolio of models. Information about data sources, data validation and numerators/denominators is available at the end of this section.

To date, the Innovation Center has introduced a wide range of Medicare initiatives – involving a broad array of Medicare Fee-for-Service beneficiaries, health care providers, States, payers and other stakeholders. In FY 2014, nearly 2.7 million Medicare Fee-for-Service (FFS) beneficiaries were aligned to Innovation Center models. In FY 2015, the number of Medicare FFS beneficiaries who participated in Innovation Center 3021 models increased to over 3 million, representing approximately 9 percent of Medicare FFS beneficiaries. In FY 2016, over 3.6 million Medicare FFS beneficiaries participated in Innovation Center 3021 models, representing approximately 9 percent of Medicare FFS beneficiaries. As a contextual indicator, this measure provides a snapshot of Medicare beneficiary model participation at a given point in time (not cumulative participation) in 3021 models that have been operational for more than 6 months.[65] This denominator reflects total Medicare Part A beneficiaries excluding Medicare Advantage beneficiaries. The rationale behind this approach for the denominator is that Part A is mandatory and therefore using that as the initial total and removing MA beneficiaries provides a more accurate Medicare FFS beneficiary population.

States play a critical role in determining the effectiveness of the health care system and the health of their population. In addition to being health care payers for the Medicaid, the Children's Health Insurance Program (CHIP) and state employee populations, states impact the delivery of care through several different levers including legislation, policy development and implementation, public payer, educational institutions, public health activities, convening ability and many others. The Innovation Center is providing funding and technical assistance to states to design or to test new payment and service delivery models that have the potential to reduce health care costs in Medicare, Medicaid, and CHIP. In FY 2014, 25 participating states were designing or implementing a health system transformation and multi-payer payment reform strategy. In FY 2015, an additional 9 states, 3 territories, and the District of Columbia (38 in total) were committed to designing or testing new payment and service delivery models in exchange for financial and technical support. In FY 2016, these 38 states have continued designing and testing new payment and service delivery models. In FY 2017, we expect 17 states to continue testing and improving their health system transformation and payment reform plans; the reduction in number of State Innovation Models (SIM) states is due to the design award project period ending as intended by the program. No decisions have been made about future rounds of

[64] The Center for Medicare & Medicaid Innovation (Innovation Center, or CMMI) is authorized by Section 1115A of the Social Security Act, as established by Section 3021 of the Affordable Care Act of 2010 (ACA).
[65] Individual beneficiaries may be counted in more than one model.

SIM grants. In FY 2018, the number of states testing their delivery system and payment transformation plans is targeted to be 12. The number of test states in FY 2017 has decreased by 5 in accordance with the specified project period for the SIM Round 1 states.

To accelerate the development and testing of new payment and service delivery models, the Innovation Center recognizes that many of the best ideas will come from a broad array of health care providers, states, payers, and other stakeholders in communities across the country. This contextual indicator seeks to understand the level of interest and participation among providers in the Innovation Center's model portfolio. In FY 2014, we estimated that more than 60,000 providers would participate in Innovation Center payment and service delivery models. In 2015, we estimated that approximately 61,000 providers would participate in Innovation Center payment and service delivery models. In FY 2016, we estimate that 103,291 providers would participate in Innovation Center payment and service delivery models. As the Innovation Center begins new models, this number is expected to increase.

The Innovation Center has created learning collaboratives for providers and other model participants in its models to promote broad and rapid dissemination of lessons learned and best practices that have the potential to deliver higher quality and lower cost of care for Medicare, Medicaid and CHIP beneficiaries. Every Innovation Center test of a new service delivery or payment model includes a plan of action to ensure that the lessons learned and best practices identified during the test can be spread as widely and effectively as possible. In FY 2014, 56 percent of 609 participating organizations in three mature models (Pioneer Accountable Care Organizations (ACOs), the Comprehensive Primary Care initiative, and Health Care Innovation Awards Round 1) engaged in learning activities intended to disseminate best practices. In FY 2015, 58.6 percent of 599 participating organizations in these same three mature models were engaged in learning activities intended to disseminate best practices. Although the target of 61 percent was not attained for the overall participant rate, the data from 2015 showed improvement in participation in learning events across the models. When the data are stratified by specific model, the Pioneer ACOs demonstrated an increased participation rate; the 2014 rate was 62.7 percent and the 2015 rate was 84.5 percent. The participation percentages also increased for CPC from 50.6 percent to 52.3 percent and for HCIA from 77.6 percent to 81.8 percent. We are exploring new ways to enhance engagement to meet or exceed our future targets. As these models mature, they have added other types of learning events that may improve engagement. For future reporting, we will include data on some of these additional activities, such as regional webinars, action groups and in-person learning events. For FY 2016, as in the baseline year, the term "participant" refers to the number of organizations or awardees for each model. The approach in calculating the 2016 results was based on using the average percentage of invited participants who attended the learning events. An average percentage was calculated for each model and the overall percentage was calculated by adding the average percentage of each model and divided by the number of the models reported. In FY 2016 report, data were obtained for 9 models including the ACO Investment Model, the Comprehensive ESRD Care Initiative, the Next Generation ACO Model, the Pioneer ACO Model, the Bundled Payments for Care Improvement (BPCI) Models, the Comprehensive Primary Care (CPC) Initiative, the Health Care Innovation Awards (HCIA) Round 2, the OCM and the Strong Start Model. They were chosen because these models had been operational for more than 6 months as of 9/30/2015; and CMS has obtained learning system event data from them. Furthermore, the type of learning events

has expanded in the current reporting period. Previously, learning events reported only included the all-awardee events. Now, all types of learning events, including: all-awardees events, regional webinars, action groups, and in-person learning events are included. The results for 2016 showed a slightly decrease in overall participation to 56.9 percent from 58.6 percent. Although the overall goal of 64.5 percent target was not attained for the overall participation rate, when data are stratified by each model, the majority of the models included in FY 2016 reporting performed higher than the set target of 64.5 percent (79.6 percent for CEC, 81.7 percent for Next Gen ACO, 70.7 percent for Pioneer ACO and 85.4 percent for OCM). Based on the FY 2016 result, CPC, BPCI, HCIA and Strong Start underperformed the set target, and as a result brought down the overall percentage rate across 9 models reported. A target of 59.7 percent has been set for FY 2017 and 60 percent for FY 2018.

# CMS DISCONTINUED PERFORMANCE MEASURES

## Program Operations Discontinued Measures

**MCR20: Implement ICD-10:** This measure was discontinued because CMS successfully implemented the ICD-10 program on October 1, 2015. This measure was implemented to track the pre-implementation objectives and milestones.

| Measure | FY | Target | Result |
|---|---|---|---|
| MCR20: Implement the International Classification of Diseases (ICD)-10 | 2017 | Discontinued | N/A |
| | 2016 | 1. Continue external ICD-10 outreach and communications for post-implementation.<br>2. Review and monitor ICD-10 industry compliance level and State Medicaid program baselines;<br>3. Continue post implementation monitoring and assessment;<br>4. Monitor and remediate ICD-10 claims payment, policy, and systems issues. | 1. October 1, 2015 and Ongoing (Target Met)<br>2. December 1, 2015 (Target Met) and May 4, 2016 |
| | 2015 | 1. Continue external ICD-10 outreach and communications for pre-implementation.<br>2. Review and monitor ICD-10 industry compliance levels and State Medicaid program baselines<br>3. Continue pre-implementation monitoring and assessment.<br>4. Monitor, test, and remediate ICD-9 claims payment, policy, and systems issues. | 1. October 1, 2014 and Ongoing (Target Met)<br>2. December 1, 2014 and May 4, 2015 (Target Met)<br>3. December 1, 2014 and Ongoing (Target Met)<br>4. August 1, 2015 (Target Met) |
| | 2014 | 1. Continue external ICD-10 outreach and communications<br>2. Update ICD-10 industry compliance Level and State Medicaid program Readiness baselines.<br>3. Complete transition back to ICD-9. Review and monitor ICD-10 industry compliance levels for ICD-9. | 1. October 1, 2013 and Ongoing (Target Met)<br>2. December 2, 2013 and May 1, 2014 (Target Met)<br>3. September 30, 2014 (new target for ICD-9 due to PAMA Bill) (Target Met) |
| | 2013 | 1. Continue external ICD-10 outreach and communications<br>2. Update ICD-10 industry compliance Level and State Medicaid program readiness baselines | 1. October 1, 2012 and Ongoing (Target Met)<br>2. December 2, 2012 and May 1, 2013 (Target Met) |

| Measure | FY | Target | Result |
|---|---|---|---|
| | 2012 | 1. Continue external ICD-10 outreach and communications<br>2. Update ICD-10 industry compliance level and State Medicaid program readiness baselines | 1. October 1, 2011 and ongoing (Target Met)<br>2. December 1, 2011 (Target Met) and May 1, 2012 and ongoing |
| | 2011 | 1. Finalize ICD-10 Implementation Planning Recommendations<br>2. Update ICD-10 industry compliance level and State Medicaid program readiness baselines<br>3. Continue external outreach and communications | 1. October 1, 2010 (Target Met)<br>2. December 1, 2010, (Target Met) and May 1, 2011 (Target Met)<br>3. October 1, 2010 (Target Met) and ongoing |
| | 2010 | 1. Complete CMS ICD-10 Implementation Plan<br>2. Initiate External ICD-10 outreach and communications plan<br>3. Develop ICD-10 industry compliance level baselines<br>4. Update State Medicaid program readiness baseline | 1. March 1, 2010 (Target Met)<br>2. March 1, 2010 (Target Met)<br>3. Industry compliance level baselines developed (Target Met)<br>4. May 1, 2010 (Target Met) |
| | 2009 | New in FY 2010 | 1. Phase II ICD-10 Impact analysis completed<br>2. Final ICD-10 rule published<br>3. State Medicaid program ICD-10 readiness baseline established |

**MCR27: Promote the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program among eligible professionals (EP) and hospitals:** This EHR goal measures the number of health care providers who receive EHR Incentive payments under the Medicare or Medicaid EHR Incentive Programs. The last year for Medicare eligible professionals to initiate participation and receive an incentive payment was program year 2014. The last year for Medicare eligible hospitals to initiate participation and receive an incentive payment is program year 2015. The last year for Medicaid providers to initiate participation and receive an incentive payment is program year 2016. As providers are only counted in the first year that they receive an incentive payment, the Medicare numbers will stagnate as payments will cease. This goal has been discontinued after FY 2016 because it will not capture providers who begin to demonstrate meaningful but are unable to earn an incentive payment due to the initiation year.

| Measure | CY/FY | Target | Result |
|---|---|---|---|
| **Number of Eligible Professionals Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use** | | | |
| MCR27.1: Medicare | FY2017 | Discontinued | N/A |
| | FY2016 | 290,000 | 324,778 (Target Exceeded) |
| | FY2015 | 290,000 | 305,731 (Target Exceeded) |
| | FY 2014 | 240,000 | 279,000 (Target Exceeded) |
| | FY 2013 | 138,000*** | 217,007 (Target Exceeded) |
| | FY 2012 | 34,350 | 93,652 (Target Exceeded) |
| | FY 2011 | **Baseline: 3,700 | Baseline set |
| MCR27.2: Medicaid | FY2017 | Discontinued | N/A |
| | FY2016 | 75,000 | 179,762 (Target Exceeded) |
| | FY2015 | 65,000 | 105,009 (Target Exceeded) |
| | FY 2014 | 28,000 | 63,650 (Target Exceeded) |
| | FY 2013 | 8,000 | 23,012 (Target Exceeded) |
| | FY 2012 | 5,600 | 1874 (Target Not Met) |
| | FY 2011 | Baseline: 0 | Baseline set |
| ***Number of Eligible Hospitals and Critical Access Hospitals (CAHs) Receiving EHR Incentive Payments for the Successful Demonstration of Meaningful Use** | | | |
| MCR27.3: Medicare | FY2017 | Discontinued | N/A |
| | FY2016 | 4,550 | 4,782 (Target Exceeded) |
| | FY2015 | 4,500 | 4,698 (Target Exceeded) |
| | FY 2014 | 4,000 | 4538 |

| Measure | CY/FY | Target | Result |
|---|---|---|---|
| | | | (Target Exceeded) |
| | FY 2013 | 2,205 | 3,812 (Target Exceeded) |
| | FY 2012 | 650 | 1,474 (Target Exceeded) |
| | FY 2011 | **Baseline:150 | Baseline set |
| MCR27.4: Medicaid | FY2017 | Discontinued | N/A |
| | FY2016 | 4,350 | 4,706 (Target Exceeded) |
| | FY2015 | 4,300 | 4,616 (Target Exceeded) |
| | FY 2014 | 2,800 | 4,307 (Target Exceeded) |
| | FY 2013 | 1,000 | 1,835 (Target Exceeded) |
| | FY 2012 | 815 | 316 (Target Not Met) |
| | FY 2011 | *Baseline: 150 | Baseline set |
| **Measure** | **CY/FY** | **Target** | **Result** |
| **Number of Providers receiving EHR incentive payments for Adopt/Implement/Upgrade (AIU) under the Medicaid incentive program** | | | |
| MCR27.5: Eligible Professionals | FY2017 | Discontinued | N/A |
| | FY2016 | 175,000 | 175,594 (Target Exceeded) |
| | FY2015 | 150,000 | 153,055 (Target Exceeded) |
| | FY 2014 | 110,000 | 128,451 (Target Exceeded) |
| | FY 2013 | 77,295 | 104,324 (Target Exceeded) |
| | FY 2012 | 38,135 | 58,334 (Target Exceeded) |
| | FY 2011 | **Baseline:6,300 | Baseline set |
| **Measure** | **CY/FY** | **Target** | **Result** |
| *MCR27.6: Eligible Hospitals | FY2017 | Discontinued | N/A |
| | FY2016 | 3,725 | 3,667 (Target Not Met) |
| | FY2015 | 3,700 | 3,630 (Target Not Met) |
| | FY 2014 | 3,550 | 3,334**** (Target Not Met) |
| | FY 2013 | 3,500 | 3,281 (Target Not Met) |
| | FY 2012 | 450 | 2,484 (Target Exceeded) |
| | FY 2011 | **Establish:400 | Baseline set |

*Eligible hospitals may receive incentive payments from both the Medicare and Medicaid incentive programs; therefore the total number of hospitals may contain duplicates.

**The Medicare and Medicaid annual results will always reflect partial year data due to a compressed timeline (does not include the attestation tail period for hospitals or the remaining 3 months of the CY and the attestation tail for the eligible professionals; and for Medicaid the 2011 baselines are not representative of all 50 states, only those that were making payments as of the end of FY 2011
*** Due to issues with double counting, the supporting measures do not sum to the key indicators because we do not want to count Eligible professionals twice for AIU and MU.
****This result has been revised due to an accounting error. The original amount of 3,679 was publicly reported in the FY 2016 Congressional Justification.

**MCR28: Reduce Healthcare-Associated Infections:** CMS has been successful in its intra-Agency partnership goal to reduce Cather-Associated Urinary Tract Infections (CAUTI) in hospitals. CMS introduced a new goal to improve Hospital Safety by Reducing Preventable Patient Harms (QIO11and this composite goal is to reduce overall hospital harms using a constellation of measures, including CAUTI. As a result, the CAUTI goal is being discontinued as of FY2018.

| Measure ID | FY | Target | Result |
|---|---|---|---|
| MCR28.2: Reduce by 10[1] percent hospital-acquired catheter-associated urinary tract infections (CAUTI) by the end of FY 2017. | 2018 | Discontinued | N/A |
| | 2017 | 10% | Mar 31, 2018 |
| | 2016 | 5% | 5% decrease (Target Met) |
| | 2015 | 10%[2] | 10% decrease (Target Met) |
| | 2014 | 5% | 4.9 decrease (Target Not Met) |
| | 2013 | 20% | +12% increase (Target Not Met) |
| | 2012 | 10% | +17% increase (Target Not Met) |

[1] The FY2017 target is a 10% reduction equating to a national CAUTI SIR of 0.90 (from 1.0 to 0.90). CDC rest the national CAUTI SIR baseline to 1.0 in FY2015.

[2]The final CAUTI target will be 10% reduction in the national CAUTI SIR from baseline or a target SIR 0.93. (Note: the October 31, 2014 report noted an end CAUTI SIR of 1.02.)

## Medicaid Discontinued Measures

**MCD5: Percentage of Section 1115 Demonstration Budget Neutrality Reviews Completed Out of Total Number of Operational Demonstrations for Which Targeted Budget Reviews are Scheduled:** The original purpose of this goal was to ensure State compliance with the Administration's policy of budget neutrality; i.e., that any state demonstration should not cost the Federal government more than what it would cost absent the demonstration. CMS conducted budget neutrality reviews on a 3-year cycle and exceeded the Agency target by achieving 100 percent. CMS discontinued this performance goal after FY 2015, is changing the focus of this goal to measure development of an automated infrastructure to support current section 1115 Medicaid demonstrations testing innovations focusing on payment and/or service delivery reform. This new measure is MCD9, Improve Capacity to Evaluate 1115 Demonstration Programs.

For FY 2015, 19 demonstrations were subject to a third-year review and CMS exceeded this target by completing 20 budget neutrality reviews. All were found to be budget neutral.

| Measure | FY | Target | Result |
|---|---|---|---|
| MCD5: Percentage of Section 1115 demonstration budget neutrality reviews completed | 2016 | Discontinued | N/A |
| | 2015 | 100% | 100%<br>Target met |
| | 2014 | 100% | 100%<br>(Target Met) |
| | 2013 | 98% | 100%<br>(Target Exceeded) |
| | 2012 | 98% | 100%<br>(Target exceeded) |
| | 2011 | 98% | 100%<br>(Target exceeded) |
| | 2010 | 96% | 100%<br>(Target exceeded) |
| | 2009 | 94% | 100%<br>(Target exceeded) |
| | 2008 | 92% | 100%<br>(Target exceeded) |
| | 2006 | N/A | 100%<br>(Baseline) |

## Clinical Laboratory Improvement Amendments of 1988 (CLIA)

## Discontinued Measures

**CLIA2: Improve Laboratory Safety for Certificate of Waiver Laboratories:**
The CLIA law allows an exemption or waiver from the CLIA quality provisions for laboratories that perform only simple tests that meet the statutory criteria for a waiver. Laboratories that demonstrate full CLIA compliance, as measured by the number of Letters of Congratulations, are considered to be providing safe, quality care for patients.

Additional background on this goal can be seen here.

CMS continues to make good progress in this goal and will focus its performance improvement efforts in developing a measure to improve the quality and compliance of Provider-Performed Microscopy Laboratories (CLIA3).

| Measure | FY | Target | Result |
|---|---|---|---|
| CLIA2.1: Increase the percentage of certificate of waiver labs that are in full compliance with CLIA regulations. | 2017 | Discontinued | N/A |
| | 2016 | +2% over 2015<br>% of certificate of waiver laboratories qualifying for a Letter of Congratulations | 47%<br>(Target Exceeded |
| | 2015 | +2% over 2014<br>% of certificate of waiver laboratories qualifying for a Letter of Congratulations | 45%<br>(Target not met) |
| | 2014 | +2% over 2013<br>% of certificate of waiver laboratories qualifying for a Letter of Congratulations | 48%<br>(Target Exceeded) |
| | 2013 | +2% over 2012<br>% of certificate of waiver laboratories qualifying for a Letter of Congratulations | 45%<br>(Target Exceeded) |
| | 2012 | +2 % over 2011<br>% of certificate of waiver laboratories qualifying for a Letter of Congratulations | 41%<br>(Target Exceeded) |
| | 2011 | Actual(Historical data)<br>% of certificate of waiver laboratories qualifying for a Letter of Congratulations | 32%<br>(Baseline) |
| | 2010 | Baseline(Historical data) | 18% |

| Measure | FY | Target | Result |
| --- | --- | --- | --- |
| CLIA2.2: The percentage of certificate of waiver labs that are in full compliance with CLIA regulations. | 2017 | Discontinued | N/A |
| | 2016 | Percentage of certificate of waiver laboratories qualifying for a Letter of Congratulations<br>Contextual indicator | 57% |
| | 2015 | Percentage of certificate of waiver laboratories qualifying for a Letter of Congratulations<br>Contextual indicator | 50% |
| | 2014 | Baseline (Historical Data)<br>Contextual indicator | 47% |

## Quality Improvement Organizations Discontinued Measures

**QIO1: Protect the Health of Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of Those who Receive an Annual Vaccination for Influenza:** We discontinued this measure after 2015.

| Measure | FY† | Target | Result |
|---|---|---|---|
| QIO1: Increase influenza immunization (long term care facility or "institutional" subpopulation)[3] | 2016 | Discontinued | N/A |
| | 2015 | 85.4% | September 2017 |
| | 2014 | 85% | 82.1% (Target Not Met But Improved) |
| | 2013 | 84.8% | 81.3 % (Target Not Met) |
| | 2012 | 84% | 83.6% (Target Not Met But Improved) |
| | 2011 | 86% | 82.5% (Target Not Met But Improved) |
| | 2010 | 81.8% | 76.5% (Target Not Met) |
| | 2009 | 80% | 84.2% (Target Exceeded) |
| | 2008 | 79% | 81.7% (Target Exceeded) |

Notes: † There is a 95% confidence interval: ± 0.06) in the reported preliminary influenza vaccination coverage estimate. ††Fiscal year is equivalent to flu year. For example, FY 2008 (10/07 – 9/08) is equivalent to the flu season starting in October '07 through Winter '08. Data reflect 65 and older population.

[3] Long-term care facility residents are Medicare ¬beneficiaries who lived solely in a long-term care facility during the calendar year (see long-term care facility), and who received facility interviews only. A facility interview was conducted whenever a sample person was residing in a facility: 1) that contains three or more beds; 2) that is classified by the administrator as providing long-term care, and 3) whose physical structure allows long-term care residents of the facility to be separately identified from those of the institution as a whole. This broad definition allows analysis beyond traditional views of long-term care, that is, nursing home and related care homes having three or more beds and providing either skilled nursing, or rehabilitative or personal care (other than supervision).
[2] In CDC's *Recent Influenza Vaccination Trends across Influenza Seasons*: http://www.cdc.gov/flu/professionals/vaccination/trends/adults-over65.htm