DEPARTMENT OF HEALTH AND HUMAN SERVICES

FISCAL YEAR 2019

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) 2019 performance budget. In FY 2019, nearly 140 million Americans will rely on the programs CMS administers including Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Exchanges.

This is a critical time in healthcare, and our agency has a responsibility to move toward a healthcare system that is sustainable, while driving down costs and providing Americans more high quality healthcare choices. To achieve this, we are committed to fulfilling one overarching goal across all of our programs to "Put Patients First". CMS will focus its resources on efforts that reduce regulatory burden on health care providers in an effort to improve patient care, which seeks to empower patients and doctors to make decisions about their healthcare; usher in a new era of state flexibility and local leadership; support innovative approaches to improve quality, accessibility, and affordability; and improve the CMS customer experience.

This performance budget reflects greater programmatic efficiency by using data to drive decision making and leveraging our experience and existing systems to avoid duplication. We will modernize our programs to address the changing needs of the beneficiaries we serve, while leveraging innovation and technology to drive better care. This budget supports continued investments in high priority activities with a focus on high quality service for our customers. It will allow us to improve the experience providers, patients, caregivers, and the states have with CMS in a way that we can anticipate their needs and better serve them. To allow providers to spend more time with their patients, we will continue to evaluate and streamline regulations to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience. To support better health outcomes, we will allow the states to drive reforms based on the unique needs of their populations. With this performance budget, CMS will modernize our programs and strengthen the integrity and sustainability of Medicare and Medicaid by investing in activities to prevent fraud, waste, and abuse.

We take our role seriously in leading national efforts to improve healthcare quality, accessibility, and outcomes in the most cost-effective manner. The investments proposed in FY 2019 will enable CMS to promote the high quality and efficient healthcare that all Americans deserve.

On behalf of all those we serve, I thank you for your continued support of CMS and its FY 2019 performance budget.

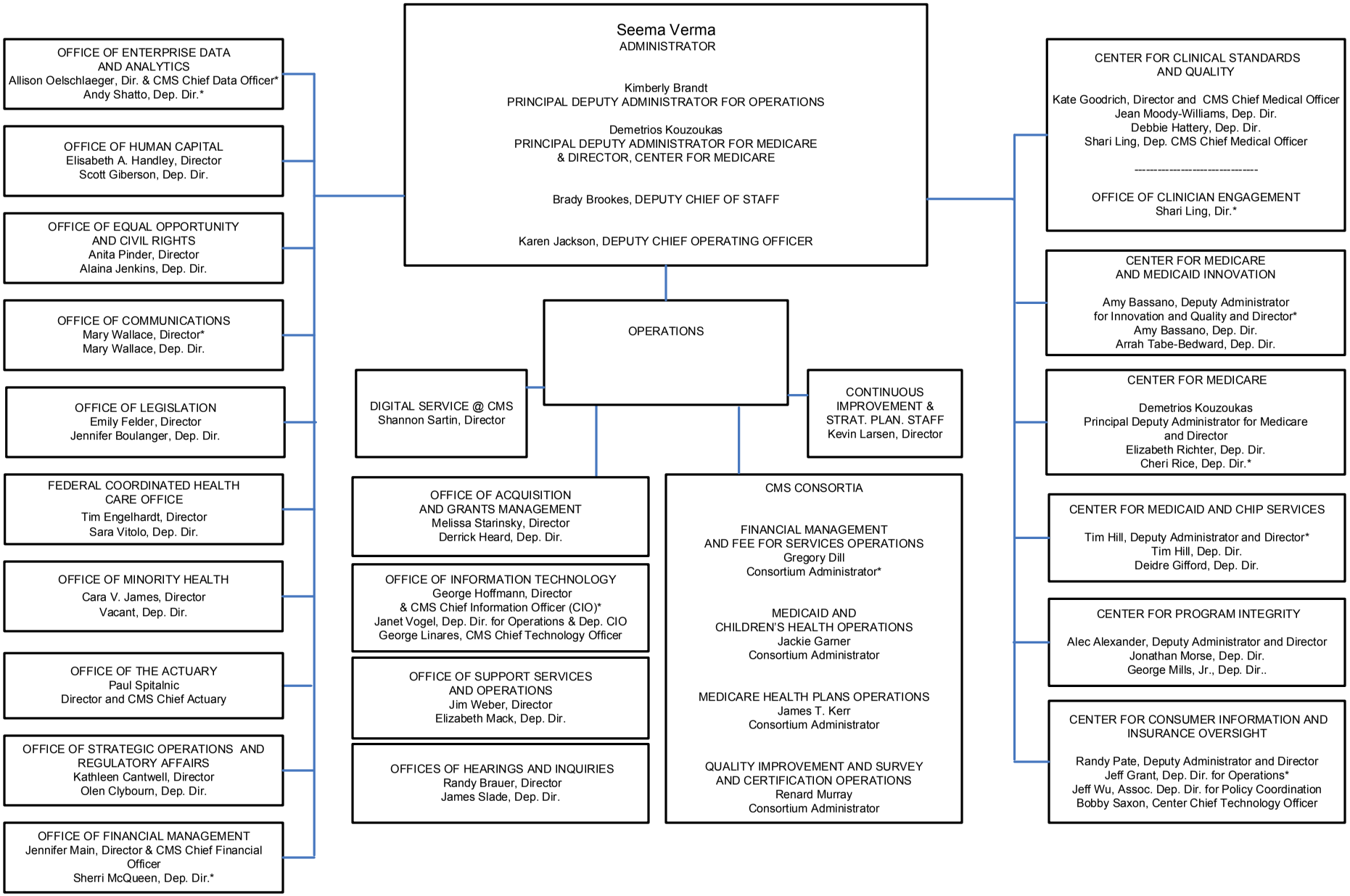
Seema Verma, MPH

Central Office Org Chart Text Version

Consortia Org Chart Text Version

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

APPROVED as of March 1, 2018
* Acting



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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 the two largest Federal health care programs - Medicare and Medicaid - as well as the Children's Health Insurance Program (CHIP) and the Exchanges. CMS' programs will touch the lives of nearly 140 million beneficiaries and consumers in FY 2019. 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, CMS 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 its customers and other stakeholders 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, strengthening program integrity by reducing fraud, waste, and abuse, and promoting innovation. CMS supports innovative approaches to improve quality, accessibility and affordability.

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 2017 Final, FY 2018 Annualized CR, and FY 2019 Request levels 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 2019 budget request reflects a level of funding that will allow CMS to focus on base operations and improve its traditional activities in Medicare, Medicaid, and CHIP.

CMS Annually-Appropriated Accounts
(Dollars in Millions)

Accounts	FY 2017 Final	FY 2018 Annualized CR	FY 2019 Request	FY 2019 +/- FY 2018
Program Management	$3,966.3	$3,947.8	$3,543.9	($403.9)
HCFAC – Discretionary	$725.0	$725.0	$770.0	$45.0
Grants to States for Medicaid 1/	$377,586.5	$410,017.8	$411,084.0	$1,066.2
Payments to Health Care Trust Funds 1/	$328,187.7	$352,597.3	$378,343.8	$25,746.5
Grand Total	**$710,465.5**	**$767,287.9**	**$793,741.7**	**$26,453.8**

1/ Totals may not add due to rounding. The FY 2018 amounts are the estimates included in the FY 2018 President's Budget and exclude indefinite authority.

Key Initiatives

Empowering Patients and Providers

The FY 2019 Budget seeks to reduce burdensome regulations so that providers can focus on providing high-quality health care to their patients. To achieve this, CMS seeks to implement policies that build on a patient-centered system of care that increases competition, quality, and access to care. The goal is to empower patients to take ownership of their health and ensure that they have the flexibility and information to make choices as they seek care. For example, CMS is launching the "digital seniors" initiative, which aims to empower seniors with health data. This initiative will allow patients to request and obtain their data more quickly and in a format that can easily be shared with others to analyze and make recommendations.

Medicaid State Flexibilities

The FY 2019 Budget provides states and local communities with additional flexibility so they can design innovative programs based on the unique needs of their populations. However, states will also be held accountable for achieving better health outcomes and results.

Invest in Program Integrity

The FY 2019 Budget proposes a $45.0 million increase over the FY 2018 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 recent years, additional funding for the HCFAC program has allowed 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.

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 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 $14.1 million in FY 2019 - exact amounts would be dependent on rule making.

National Medicare & You Education Program (NMEP) User Fee [Mandatory Proposal]

CMS seeks a legislative change to Section 1857 (e)(2)(D)(ii)(V) of the Social Security Act to rebase the user fees from Medicare Advantage and Prescription Drug plans for the NMEP. This change is proposed to more equitably allocate the projected costs of the NMEP program based on the higher share of enrollees in Medicare Advantage and Part D than when the current cap was instituted. Current estimated collections are $82.6 million. With this change, collections are estimated at $112.6 million in FY 2019.

FY 2019 Budget Request

Program Management

In FY 2019, CMS requests $3.5 billion in discretionary funding. CMS' request reflects funding needed to process Medicare claims and service the continued growth in CMS' traditional programs. CMS' budget request supports CMS' 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 2019 budget request for Program Operations is $2.4 billion, a decrease of $403.6 million below the FY 2018 Annualized CR Level. This request will allow CMS to continue operating Medicare, Medicaid, CHIP, and basic CMS support programs. The FY 2019 Budget proposes to wind down the Federal Exchanges for plan year 2020, as states transition to new Market-based health care grants. Additionally, the budget requests funding to reinvent CMS Medicaid and CHIP operations through improving data systems and creating scorecards that will give States an opportunity to demonstrate how they are using new and existing flexibilities to serve the interests of their citizens with appropriate Federal oversight. The request also funds core outreach and education activities that positively impact the beneficiary experience and CMS' customer service goals. CMS will continue to invest in high priority activities with a focus on high quality service for our beneficiaries and participating providers. CMS is evaluating areas for contract efficiencies to maximize our annual appropriation.

- Federal Administration:

  CMS' FY 2019 budget request for Federal Administration is $702.6 million, a decrease of $25.0 million below the FY 2018 Annualized CR Level. Of this request, $639.1 million supports 4,237 direct FTEs. This is 266 lower than the FY 2018 Annualized CR Level of 4,503. 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:

  CMS' FY 2019 CMS budget request for Survey and Certification is $421.1 million, an increase of $26.5 million above the FY 2018 Annualized CR Level. In addition, CMS proposes $14.1 million in estimated revisit fee collections for a total survey and certification program level of $435.3 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 request also supports 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 Government Accountability Office (GAO).

- Research:

  CMS' FY 2019 budget request for Research is $18.1 million, a decrease of $1.9 million below the FY 2018 Annualized CR Level. This request supports the Medicare Current Beneficiary Survey (MCBS) as well as the Chronic Condition Warehouse (CCW) and several other research related activities.

Health Care Fraud and Abuse Control

CMS requests $770.0 million in discretionary HCFAC funding in FY 2019, an increase of $45.0 million above the FY 2018 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 as well as enhance IT systems and other capacities to support data collection, analytics, and efficient oversight.

Grants to States for Medicaid

The FY 2019 Medicaid request is $411.1 billion, an increase of $1.1 billion above the FY 2018 President's Budget. Continued increases in grants to states are required as more individuals enroll in Medicaid. This appropriation consists of $276.3 billion for FY 2019 and $134.8 billion in an advance appropriation from FY 2018. These funds will help finance $460.4 billion in estimated gross obligations in FY 2019. These obligations consist of:

- $434.2 billion in Medicaid medical assistance benefits;
- $21.5 billion for Medicaid administrative functions including Medicaid survey and certification and State fraud control units; and
- $4.7 billion for the Centers for Disease Control and Prevention's Vaccines for Children program.

Payments to the Health Care Trust Funds

The FY 2019 request for Payments to the Health Care Trust Funds account totals $378.3 billion, an increase of $25.7 billion above the FY 2018 President's Budget. 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 2019 is largely driven by increases for the General Fund contributions for the SMI Trust Fund.

Conclusion

CMS' FY 2019 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 $793.7 billion in FY 2019, an increase of $26.5 billion above the FY 2018 Annualized CR level.

CMS' FY 2019 total discretionary appropriated request for Program Management is $3.5 billion. This funding will allow CMS to continue its traditional activities in the Medicare, Medicaid, and CHIP programs.

CMS requests $770.0 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, safeguarding its programs, and 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. This performance budget makes recommendations that are consistent with the Administration's work to advance patient-centered health care and putting people first. We continue to work on aligning our performance commitments to the CMS and HHS strategic goals. While CMS tracks many of its established performance measures, we also introduce new measures that reflect the Administration's priorities.

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.

The CMS FY 2019 Performance section is designed to create a more complete presentation of performance commitments, accomplishments, and trends which reflects the vision of this Administration.

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

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 President's Budget +/- FY 2018 Annualized CR
Program Operations	$ 2,816,393	$ 2,805,640	$ 2,402,089	$ (403,551)
Federal Administration	$ 732,533	$ 727,558	$ 702,601	$ (24,957)
State Survey & Certification	$ 397,334	$ 394,636	$ 421,135	$ 26,499
Research	$ 20,054	$ 19,918	$ 18,054	$ (1,864)
Subtotal, Appropriation/BA Current Law (Discretionary; 0511)	**$ 3,966,314**	**$ 3,947,752**	**$ 3,543,879**	**$ (403,873)**
MIPPA (Mandatory; P.L. 110-275)	$ 2,793	$ 2,802	$ 3,000	$ 198
PAMA (P.L. 113-93)	$ 5,586	$ 5,604	$ 10,000	$ 4,396
IMPACT (P.L. 113-185)	$ 19,861	$ 17,396	$ 18,625	$ 1,229
MACRA (P.L. 114-10)	$ 196,441	$ 152,242	$ 115,000	$ (37,242)
CURES (P.L. 114-255)	$ 18,000	$ -	$ -	$ -
Total, Mandatory Appropriation/BA C.L. (Mandatory; 0511)	**$ 242,681**	**$ 178,044**	**$ 146,625**	**$ (31,419)**
Total, Appropriation/BA Current Law (0511)	**$ 4,208,995**	**$ 4,125,796**	**$ 3,690,504**	**$ (435,292)**
Proposed Law Appropriation (Mandatory) 1/	$ -	$ -	$ 230,000	$ 230,000
Total, Appropriation/BA Proposed Law (0511)	**$ 4,208,995**	**$ 4,125,796**	**$ 3,920,504**	**$ (205,292)**
Est. Offsetting Collections from Non-Federal Sources:				
User Fees and Reimbursements, C.L.	$ 230,593	$ 214,200	$ 222,183	$ 7,983
Exchange User Fees, C.L.	$ 1,141,029	$ 1,232,399	$ 1,000,000	$ (232,399)
Risk Corridors, C.L.	$ 97,724	$ 25,000	$ -	$ (25,000)
Recovery Audit Contracts, C.L.	$ 348,605	$ 284,870	$ 572,000	$ 287,130
Subtotal, New BA, Current Law 2/	**$ 6,026,946**	**$ 5,882,265**	**$ 5,484,687**	**$ (397,578)**
No/Multi-Year Carryforward 3/	$ 892,937	$ -	$ -	$ -
Program Level, Current Law (0511)	**$ 6,919,883**	**$ 5,882,265**	**$ 5,484,687**	**$ (397,578)**
Proposed Law Discretionary 4/	$ -	$ -	$ 14,120	$ 14,120
Program Level, Proposed Law (0511)	**$ 6,919,883**	**$ 5,882,265**	**$ 5,728,807**	**$ (153,458)**
HCFAC Discretionary	**$ 725,000**	**$ 725,000**	**$ 770,000**	**$ 45,000**
Non-CMS Administration 5/	**$ 1,893,000**	**$ 1,837,947**	**$ 2,344,852**	**$ 506,905**
CMS FTEs:				
Direct (Federal Administration)	4,514	4,503	4,237	-266
Reimbursable (CLIA, CoB, RAC, Exchange)	240	249	249	0
Subtotal, Program Management FTEs	**4,754**	**4,752**	**4,486**	**-266**
Affordable Care Act (Mandatory)	17	17	17	0
ARRA Implementation (Mandatory)	75	69	69	0
Other Direct (PAMA, IMPACT, MACRA) (Mandatory)	67	71	71	0
Total, Program Management FTEs, Current Law	**4,913**	**4,909**	**4,643**	**-266**
Program Management, Proposed Law	0	0	0	0
Total, Program Management FTEs	**4,913**	**4,909**	**4,643**	**-266**
Affordable Care Act (Mandatory)	608	626	600	-26
HCFAC Mandatory	196	403	403	0
HCFAC Discretionary	253	0	0	0
Medicaid Integrity (State Grants; Mandatory)	91	207	207	0
Demonstrations	10	15	15	0
QIO	229	232	232	0
Total, CMS FTEs 6/	**6,300**	**6,392**	**6,100**	**-292**

1/ Includes proposal for increased MA/PDP user fee collection of $30 million and $200 million in administrative funding to implement the CMS proposals in the President's Budget.

2/ Includes user fees and reimbursables supporting CMS program management. FY 2017 and FY 2018 are net of sequester and pop up. FY 2019 includes gross collections.

3/ Reflects remaining no-year and multi-year funding within the traditional Program Management account (75-0511), excluding user fees.

4/ CMS' FY 2019 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**]** *$3,543,879,000*, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act*;* together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary 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, 2022**]** *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] 2019 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**]** *$3,543,879,000*, 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, 2022**]** *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**]** *2019* 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. 220. Notwithstanding section of 1864(e) of the Social Security Act (42 U.S.C. 1395aa(e)), the Secretary shall charge health care facilities or entities fees 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 in addition to any other funds available for conducting 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 for such purpose. No such fees shall be charged to an Indian Health Program (as that term is defined in section 4 of the Indian Health Care Improvement Act)."	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 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Trust Fund Discretionary Appropriation:			
Appropriation (L/HHS)	$3,966,314,000	$3,947,751,513	$3,543,879,000
Trust Fund Mandatory Appropriation:			
PAMA/SGR (PL 113-93)	$5,586,000	$5,604,000	$10,000,000
IMPACT Act (PL 113-185)	$19,861,000	$17,395,750	$18,625,000
MACRA (PL 114-10)	$196,441,000	$152,242,000	$115,000,000
21st Century Cures (PL 114-255)	$18,000,000	$0	$0
Subtotal, trust fund mand. Appropriation 1/	$239,888,000	$175,241,750	$143,625,000
Mandatory Appropriation:			
MIPPA (PL 110-275)	$2,793,000	$2,802,000	$3,000,000
ACA (PL 111-148/152)	$0	$0	$0
Subtotal, trust fund mand. Appropriation 1/	$2,793,000	$2,802,000	$3,000,000
Offsetting Collections from Non-Federal Sources:			
CLIA user fees	$50,470,000	$46,700,000	$50,000,000
Coordination of benefits user fees	$41,344,000	$28,020,000	$30,000,000
MA/PDP user fees 3/	$84,484,000	$80,831,000	$82,600,000
Sale of data user fees	$23,203,000	$20,000,000	$20,000,000
Provider enrollment user fees	$30,972,000	$24,094,000	$24,000,000
Exchange user fees	$1,118,804,000	$1,210,200,000	$962,000,000
Risk adjustment administration	$22,225,000	$22,199,000	$38,000,000
Recovery audit contracts	$348,605,000	$284,870,000	$572,000,000
Risk corridors	$97,724,000	$25,000,000	$0
Nursing home CMPs/Other	$120,000	$14,555,000	$15,583,000
Subtotal, offsetting collections 2/	$1,817,951,000	$1,756,469,000	$1,794,183,000
Total Budget Authority	**$6,026,946,000**	**$5,882,264,263**	**$5,484,687,000**

1/ Current law display. Net of sequester.
2/ FY 2017 and FY 2018 are net of sequester and pop-up authority. FY 2019 shows gross collections.
3/ FY 2019 Collections reflect current law. An additional $30 million in collections are included in proposed law.

Summary of Changes

2018	
Total estimated budget authority 1/	$3,947,751,513
(Obligations) 1/	($3,947,751,513)
2019	
Total estimated budget authority 1/	$3,543,879,000
(Obligations) 1/	($3,543,879,000)
Net Change	**($403,872,513)**

	FTE	2018 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		$2,805,639,627		$71,143,000
2. Federal Administration		$727,558,368		$11,880,632
3. State Survey & Certification		$394,635,705		$26,499,295
4. Research		$19,917,813		$0
Subtotal, Program Increases 1/				**$109,522,927**
Total Increases 1/				**$109,522,927**
Decreases:				
A. Built-in:				($36,646,000)
1. One Day Less Pay				$0
Subtotal, Built-in Decreases 1/				**($36,646,000)**
B. Program:				
1. Program Operations		$2,805,639,627		($474,693,627)
2. Federal Administration	4,503	$727,558,368	(266)	($192,000)
3. State Survey & Certification		$394,635,705		$0
4. Research		$19,917,813		($1,863,813)
Subtotal, Program Decreases 1/				**($476,749,440)**
Total Decreases 1/				**($513,395,440)**
Net Change 1/				**($403,872,513)**

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 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
1. Program Operations	$2,511,393	$2,805,640	$2,402,089
Additional Medicare Operations Funding	$305,000	$0	$0
MIPPA (PL 110-275)	$3,000	$3,000	$3,000
PAMA/SGR (PL 113-93)	$6,000	$6,000	$10,000
IMPACT Act (PL 113-185)	$13,000	$13,000	$13,000
MACRA (PL 114-10)	$211,000	$163,000	$115,000
21st Century Cures (114-255)	$18,000	$0	$0
Sequester	($16,077)	($12,210)	$0
Subtotal, Program Operations	**$3,051,316**	**$2,978,430**	**$2,543,089**
(Obligations)	($3,094,000)	($3,172,000)	($2,422,000)
2. Federal Administration	$732,533	$727,558	$702,601
Sequester	$0	$0	$0
Subtotal, Federal Administration	**$732,533**	**$727,558**	**$702,601**
(Obligations) 2/	($762,000)	($727,558)	($702,601)
3. State Survey & Certification	$397,334	$394,636	$421,135
IMPACT Act (PL 113-185)	$8,333	$5,625	$5,625
Sequester	($575)	($371)	$0
Subtotal, State Survey & Certification	**$405,092**	**$399,890**	**$426,760**
(Obligations)	($409,000)	($425,000)	($444,000)
4. Research, Demonstration & Evaluation	$20,054	$19,918	$18,054
Sequester	$0	$0	$0
Subtotal, Research, Demonstration & Evaluation	**$20,054**	**$19,918**	**$18,054**
(Obligations) 2/	($58,000)	($85,000)	($29,000)
5. User Fees	$1,396,753	$1,454,168	$1,222,183
Sequester	($109,682)	($110,446)	$0
Sequester Pop-Up	$84,551	$102,877	$0
Subtotal, User Fees	**$1,371,622**	**$1,446,599**	**$1,222,183**
(Obligations) 2/	($1,729,000)	($1,446,599)	($1,222,183)
6. Recovery Audit Contracts	$374,441	$305,000	$572,000
Sequester	($25,836)	($20,130)	$0
Subtotal, Recovery Audit Contracts	**$348,605**	**$284,870**	**$572,000**
(Obligations)	($89,000)	($285,000)	($572,000)
7. Risk Corridors	$97,724	$25,000	$0
Sequester	$0	$0	$0
Subtotal, Risk Corridors	**$97,724**	**$25,000**	**$0**
(Obligations) /3	($3,978,221)	$0	$0
Total, Budget Authority 1/	**$6,026,946**	**$5,882,265**	**$5,484,687**
(Obligations) 1/	**($10,119,221)**	**($6,141,157)**	**($5,391,784)**
FTE 1/	**4,913**	**4,909**	**4,643**

1/ Reflects CMS' current law request.

2/ Where obligations exceed budget authority, mandatory carryforward of BA not reflected on the table is the source of BA.

3/ Total obligations exclude FY 2018 deobligations made due to the end of the three-year program period for collecting funds in the Risk Corridor program.

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 **3/**	$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 **3/**	$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 **3/**	$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 **3/**	$4,109,549,000	$0	$0	$3,974,744,000
IMPACT Act (PL 113-185)	$0	$0	$0	$21,333,000
PAMA/SGR (PL 113-93)	$0	$0	$0	$6,000,000
MACRA (PL 114-10)	$0	$0	$0	$211,000,000
21st Century Cures (PL 114-255)	$0	$0	$0	$18,000,000
Sequestration	$0	$0	$0	($16,444,977)
Subtotal	$4,109,549,000	$0	$0	$4,214,632,023
2018				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	($198,000)
Trust Fund Appropriation:				
Base **1/ 3/**	$3,587,996,000	$3,451,141,000	$3,974,744,000	$3,947,751,513
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
Sequestration	$0	$0	$0	($12,383,250)
Subtotal	$3,587,996,000	$3,451,141,000	$3,974,744,000	$4,135,376,513
2019				
General Fund Appropriation:				
MIPPA (PL 110-275)	$0	$0	$0	$3,000,000
Sequestration	$0	$0	$0	$0
Trust Fund Appropriation:				
Base **2/**	$3,543,879,000	$0	$0	$0
PAMA/SGR (PL 113-93)	$0	$0	$0	$10,000,000
MACRA (PL 114-10)	$0	$0	$0	$115,000,000
IMPACT Act (PL 113-185)	$0	$0	$0	$18,625,000
Sequestration	$0	$0	$0	$0
Subtotal	$3,543,879,000	$0	$0	$143,625,000

1/ Based on Annualized CR

2/ Based on Current Law Request

3/ Base appropriation includes an additional $305 million in the FY 2018 Senate allowance to support Program Management activity related to the Medicare Program.

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 2018

CMS Program Management has no appropriations not authorized by law.

Program Operations
(Dollars in Thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$2,816,393	$2,805,640	$2,402,089	($403,551)

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 Authorizing 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 2019 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; the Children's Health Insurance Program (CHIP), established in 1997, for low-income children in families with incomes above the Medicaid eligibility levels; and the consumer Health Insurance Exchanges.

Program Operations primarily funds the processing of Medicare Fee-For-Service (FFS) claims, as well as information technology (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 health care, reforming the health care delivery system, decreasing medical costs and payment error rates, reducing new Medicare 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 ESRD. 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 61 million beneficiaries expected in FY 2019. 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 processes providers' claims, funds beneficiary outreach and education, maintains the IT infrastructure needed to support various claims processing systems, and make 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, operational support for programs such as Medicare claim appeals, oversight and monitoring functions, and audits of 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, aged, blind and disabled individuals, and other adults. Medicaid also provides community based long-term care services and supports 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 younger than 19 years of age.

Private Health Insurance Protections and Programs

CMS conducts market oversight of PPACA-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 operate State-Based Exchanges, CMS operates Federal Exchanges on their behalf.

Funding History

Fiscal Year	Budget Authority
FY 2015	$2,824,823,000
FY 2016	$2,824,823,000
FY 2017 Final	$2,816,393,000
FY 2018 Annualized CR	$2,805,640,000
FY 2019 President's Budget	$2,402,089,000

Budget Request: $2,402.1 Million

CMS' FY 2019 budget request for Program Operations is $2,402.1 million, a decrease of $403.6 million below the FY 2018 Annualized CR level. This request will allow CMS to efficiently operate Medicare, Medicaid, CHIP, and other CMS support programs while allowing Federal Exchange operations to wind down in an orderly fashion under the proposal to repeal and replace Obamacare. Additionally, the request allows CMS to reinvent Medicaid operations by improving data systems and increasing transparency about program administration and outcomes through the Medicaid and CHIP Scorecard initiative. The request also funds core outreach and education activities that positively impact the beneficiary experience and CMS' customer service goals. CMS will continue to invest in high priority activities with a focus on high quality service for beneficiaries and participating providers and will continue evaluating areas for contract efficiencies to maximize resources.

Program Operations
(Dollars in Millions)

Activity	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Program Operations				
I. Medicare Parts A&B				
Ongoing Operations	$926.299	$942.104	$935.640	($6.464)
FFS Operations Support	$118.169	$83.518	$77.400	($6.118)
Claims Processing Systems	$54.533	$75.776	$75.776	--
DME/Part B Competitive Bidding	$26.566	$10.958	$52.066	$41.108
II. Other Medicare Operational Costs				
Accounting & Audits	$120.726	$100.726	$100.726	--
QIC Appeals (BIPA 521/522)	$86.273	$86.505	$91.000	$4.495
HIPAA Administrative Simplification	$28.851	$24.389	$23.083	($1.306)
III. Medicaid & CHIP				
Medicaid & CHIP Operations	$44.809	$82.528	$99.668	$17.140
IV. Health Care Planning & Oversight				
Part C&D IT Systems Investments	$39.721	$44.423	$39.792	($4.631)
Oversight & Management	$59.652	$51.225	$56.000	$4.775
Federal Exchange	$690.493	$500.000	$122.700	($377.300)
Other Exchange Sources (non-add)	*$1,385.221*	*$1,296.913*	*$1,027.500*	*($269.413)*
Total Exchange Program Level (non-add)	*$2,075.714*	*$1,796.913*	*$1,150.200*	*($646.713)*
V. Health Care Quality				
Health Care Improvement Initiatives	$47.568	$34.376	$38.000	$3.624
VI. Outreach & Education				
Beneficiary Outreach/NMEP	$186.723	$291.555	$281.161	($10.394)
Provider Outreach	$22.611	$20.767	$9.168	($11.599)
Consumer Outreach	$4.251	$3.627	$2.500	($1.127)
VII. Information Technology				
Systems and Support	$359.149	$453.163	$397.409	($55.754)
TOTAL[1]	**$2,816.393**	**$2,805.640**	**$2,402.089**	**($403.551)**

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

I. MEDICARE - PARTS A AND B

Program Description and Accomplishments

Ongoing Operations

CMS processes beneficiary claims through Medicare Administrative Contractors (MACs). 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 Original Medicare. 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 physician/supplier program (PARDOC). These are the primary contracts for managing Medicare and are mission critical for the success of CMS.

The following table displays claims volumes for the period FY 2016 to FY 2019.

FFS Claims Volume
(Claim Count in Millions)

	FY 2016 Actual	FY 2017 Actual	FY 2018 Estimate	FY 2019 Estimate
Part A	252.9	255.4	258.0	260.6
Part B	1,045.6	1,056.1	1,066.6	1,077.3
Total	**1,298.5**	**1,311.5**	**1,324.6**	**1,337.9**

Budget Request: $935.6 Million

The FY 2019 budget request for Ongoing Operations is $935.6 million, a decrease of $6.5 million below the FY 2018 Annualized CR level. This request allows the MACs to continue processing Medicare claims accurately, in a timely manner, and in accordance with CMS' program requirements. The funding accounts for a one percent increase in the MAC workload and assumes that CMS will find contract efficiencies to maintain operations. The Ongoing Operations funding request will also support various provider service operations and first level redetermination initiatives to aid in lowering the appeal backlog.

In FY 2019, MACs are expected to:

- Process over 1.3 billion claims;
- Handle 2.5 million Medicare appeal redeterminations;
- 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 approximately 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, durable medical equipment suppliers, clinical laboratories, and other providers and suppliers. 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, indirect medical education, disproportionate share hospital, and bad debt payments. The MACs provider reimbursement areas perform many other payment review activities, maintain claims information systems, and are responsible for making determinations of status.

Medicare Appeals – The 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, and determine if the original determination should be changed, and handle any reprocessing activities. The statute contemplates that MACs issue a decision within 60 calendar days of receipt of an appeal request.

In FY 2017 and FY 2018, the MACs are expected to process 2.6 million and 2.4 million redeterminations respectively. CMS estimates the MACs will process over 2.5 million redeterminations in FY 2019 reflecting minimal growth in the number of redeterminations as seen in prior fiscal years.

Medicare Appeals Initiatives – As part of the Department's effort to improve the Medicare appeals process and address the pending backlog of appeals at Administrative Law Judge and Departmental Appeals Board levels, CMS continues to explore settlement initiatives to resolve large groups of appeals. To effectively manage these initiatives, CMS will require external support to administer the settlements and additional funding for its Medicare Administrative Contractors for effectuation.

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 Inquiries and Toll-Free Service – 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.

Costs for the Provider Contact Center are primarily driven by the number of minutes of telephone service, which are projected to remain flat through FY 2019. Other costs include toll-free lines, support contracts, answering inquiries and customer service representatives.

In FY 2019, 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 utilize 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 2016 through FY 2019 (estimated):

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

	FY 2016 Actual	FY 2017 Actual	FY 2018 Estimate	FY 2019 Estimate
Completed Calls	34.2	34.2	34.4	34.4

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 data, and the Recovery Audit Program data.

Fee-for-Service Operations and System 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: $77.4 Million

The FY 2019 budget request for FFS operations support is $77.4 million, a decrease of $6.1 million below the FY 2018 Annualized CR level. The decrease reflects the annual cost fluctuation of cyclical contract actions necessary to maintain ongoing operations.

This request funds several additional critical services supporting the Medicare FFS program. These include:

- *Contracting Reform*: $17.9 million. Medicare contracting reform changed the face of the traditional Medicare program by integrating Parts A and B FFS claims contracting under a single contract authority, known as a MAC, using competitive acquisition procedures under the Federal Acquisition Regulation (FAR). CMS must support the transition, termination, and implementation costs associated with transitioning from incumbent MACs to their successor MACs. In FY 2019 CMS has scheduled the re-procurements of the A/B MAC Jurisdiction 8, Jurisdiction H, Jurisdiction 5, and Jurisdiction 6 contracts.

- *Printing and Postage*: $12.7 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 premiums for beneficiaries who may not receive a monthly Social Security Administration, Office of Personnel Management, or Railroad Retirement Board 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.

- *IT Systems*: $9.1 million. CMS hosts many systems to aid in managing contracts for FFS, to automate the change management process, and other electronic data interchanges. This budget request continues funding operations and maintenance for Contractor Management Information System (CMIS), eChimp system, and Common Electronic Interchange System (CEDI).

- *Relative Value Units (RVU) Implementation*: $5.0 million. This proposal targets CMS's approach to valuing Relative Value Units in the Physician Fee Schedule. The Budget includes $5 million in discretionary Program Management funding to initiate efforts to develop independent assessments of service costs that would improve accuracy of payments to physicians and other health care professionals.

- *Bundled ESRD PPS*: $3.9 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 to expand and update these claims surveillance programs as well as develop a broader monitoring framework to address spending variation across the Medicare program.

- *Office of Minority Health Contract Support:* $3.3 million. From Coverage to Care (C2C) is a health literacy initiative designed to assist consumers with any type of insurance (Medicare, Medicaid, Marketplace, private insurance) to understand their health insurance and how to use it for primary care and preventive services. C2C depends on

collaboration with community groups, consumers, and providers to focus on prevention, regular primary care, and proper utilization of emergency care to encourage reduced costs and better health outcomes. C2C empowers stakeholders by providing digital and print resources and messages to enable a patient-centered approach for accessibility and affordability.

- *Home Health PPS Refinement*: $2.3 million. Section 5012 of the 21st Century CURES Act introduces a new Medicare home infusion therapy benefit set to begin in 2021. Medicare will make a single payment for professional and nursing services, training and education, remote monitoring, and monitoring services for providing home infusion therapy and drugs. This funding will provide for contractor support to analyze data of the home infusion industry to evaluate the scope of the benefit and identify the best and most efficient way to develop the regulation.

- *A-123 Internal Controls Assessment*: $2.0 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 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 Cures Act Support:* $1.8 million. The 21st Century Cures Act requires expanded use of tele-health technology and home infusion therapy for our Medicare beneficiaries. CMS requires support to oversee the national implementation of new regulations promulgated under the Cures Act and contract support to aid in education and training, technical assistance, and an evaluation of the findings.

- *Cost Contract Audits*: $1.7 million. CMS has 179 contract awards with firms who have cost reimbursable contracts requiring necessary steady state audit efforts to comply with the FAR and Departmental Supplemental Regulations (HHSAR). The GAO and HHS 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.

- *Medicare Beneficiary Ombudsman*: $1.7 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.

- *Medicare Healthcare Effectiveness Data and Information Set (HEDIS) Quality of Care Performance Measures*: $1.4 million. This contract provides for the proper oversight and management of Medicare Advantage 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.

CMS will work on developing and testing new quantifiable outcome measures that will provide more specific information about Medicare Advantage 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.

- *Actuarial Services*: $1.2 million. This contract provides additional actuarial services, including modeling, for the numerous requests that the Office of the Actuary is unable to handle due to time constraints and staff shortages. This contract also assists CMS in providing actuarial cost estimates for various demonstrations and other statutorily required issues.

- *Other Operational Costs:* $13.4 million. This request supports activities involving program monitoring, provider validation, satisfaction surveys, and many other FFS administrative functions.

Claims Processing Systems

CMS' claims processing systems process nearly 1.3 billion Part A and Part B claims each yea, and are a major component of CMS 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 2019 budget request for claims processing systems is $75.8 million, the same as the FY 2018 Annualized CR. Maintaining claims processing systems 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 Original Medicare 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 Medicare fee-for-service claims processing systems in a fully-integrated, production-like approach that includes data exchanges with all key systems. This program 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 the Original Medicare program, processing millions of Medicare claims each year. This shared system processes Medicare Part A claims, including outpatient claims submitted under Part B. It interfaces directly with the CWF System for verification, validation, and payment authorization. FISS must also implement changes needed to support the MAC authority for the Original Medicare 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 Obamacare legislation subsequently amended and expanded the program to cover 100 MSAs. Obamacare also mandated that all areas of the country be subject to either DMEPOS competitive bidding or payment rate adjustments using competitively bid rates by 2016. The program sets 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: $52.1 Million

The FY 2019 budget request for DME competitive bidding is $52.1 million, an increase of $41.1 million above the FY 2018 Annualized CR level. The increase supports performing a consolidated re-compete for rounds 1 and 2 of the program into one round. CMS believes this will lower our operational costs and administrative burden for the life of this program if both rounds are consolidated.

- *Competitive Bidding Implementation Contractor (CBIC):* $49.0 million. The budget request will fund operations and maintenance for the Round 2 Re-Compete MSAs. Funding for FY 2019 will also cover the oversight and monitoring for the consolidated Round 2019 and the preparation for a consolidated Round 2022. Round 2019 will consolidate all rounds and areas included in the Medicare DMEPOS Competitive Bidding Program into a single round of competition.

- *DME Bidding Systems (DBidS)*: $3.1 million. This system collects bids from DMEPOS for competitive bidding of equipment. The data collected by the DBidS application will be used by the CBIC who will make recommendations to CMS on the selection of

certain suppliers by DME product and Competitive Bidding Area. 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

Program Description and Accomplishments

Accounting and Audits

The Healthcare Integrated General Ledger Accounting System (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 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 2019 budget request for HIGLAS and the CFO audit is $100.7 million, the same as the FY 2018 Annualized CR. In FY 2019, CMS will support the production and application maintenance of HIGLAS. There is no request for funding in FY 2019 for additional development, modernization, or enhancements to HIGLAS. During FY 2019 CMS will transition the DME MACs to HIGLAS, which culminates a 2 year initiative.

- *HIGLAS*: $90.8 million. This request supports operations and maintenance costs for HIGLAS.

  HIGLAS implementation strengthened the Federal government's fiscal management and program operations of the Medicare program. HIGLAS was a critical success factor in CMS and HHS achieving compliance with the Federal Financial Management Improvement Act (FFMIA) of 1996. In addition, HIGLAS contributes towards HHS' ability to retain a "clean" audit opinion as required by the Chief Financial Officer's (CFO) Act.

  HIGLAS is a critical application enabling CMS to manage its business operations. All of CMS' core program dollars are accounted for in HIGLAS. It is the largest Oracle Federal Financials System based on the 4.5 million daily average number of payments equating to over $1.4 trillion in gross outlays in FY 2017. 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.

The HIGLAS effort has improved significantly the ability of CMS/HHS to perform Medicare accounting transactions. Some of these improvements 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 overpayments. Moreover, CMS now has better internal financial controls across Medicare contractor operations. Maintaining a state-of-the-art financial system like HIGLAS has a significant and positive impact on the amount of additional interest earned (saved) in the Medicare Trust Funds. Internal CMS analysis has shown that Medicare contractors transitioned to HIGLAS are collecting monies quicker than 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. In addition, HIGLAS supports the Federal Payment Levy Program (FPLP) operated by Treasury by offsetting payments. Through December 29, 2017 CMS has recouped $555.37 million in Federal Tax debts and $250.34 million in Non-Tax debts from Medicare Provider Payments under the FPLP.

- *CFO/Financial Statement Audits:* $9.9 million. This funding is necessary to pay for the statutorily required CFO audit which ensures CMS financial statements are reasonable, internal controls are adequate, and CMS complies 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 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. CMS' goal is to maintain an unmodified 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 redetermination of a claim by a MAC during the first level of appeal. BIPA contemplates that QICs 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 60 day 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 at the Office of Medicare Hearings and Appeals (OMHA). This program ensures that Medicare 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: $91.0 Million

The FY 2019 budget request for QIC appeals (BIPA section 521) is $91.0 million, an increase of $4.5 million above the FY 2018 Annualized CR level. The increase funds a minimal growth in workloads and maintains steady state operations.

- *QIC Operations*: $84.8 million. This request includes annual operational costs and activities to advance the Departmental priority of continuing to timely adjudicate Medicare appeals at the second level in the appeals process.

The table below includes a breakout of the reconsiderations workload for FYs 2016 – 2019 (estimated). The FY 2018 and 2019 projections were formulated based upon a review and extrapolation of early FY 2018 data with consideration to the projected Medicare beneficiary growth rates in the out years. As in previous years, CMS will continue to review and analyze workload trends and adjust as necessary.

QIC Appeals Workload
(Volume in Appeals)

	FY 2016 Actual	FY 2017 Actual	FY 2018 Estimate	FY 2019 Estimate
QIC Appeals	511,996	424,615	384,884	392,986
% Increase from Previous Year	--	(20.5%)	(10.3%)	2.0%

In furtherance of the Departmental priority to improve the Medicare appeals process and address the pending backlog of appeals at Levels 3 and 4, CMS initiated several administrative actions that may have contributed to the decrease in claims following several years of substantial growth. These initiatives include, but are not limited to, the following:

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

- Settlement Facilitation Conferences: OMHA staff who have been trained in mediation techniques are facilitating settlement conferences between CMS and appellants. These conferences bring appellants and CMS together to discuss administratively settling pending appeals at Levels 3 and 4. Beginning in April 2018, OMHA will be expanding the current Settlement Conference Facilitation program to reach additional appellants. Appellants not eligible for the Low Volume Appeals Settlement can be eligible to participate in this alternative dispute resolution process for their pending 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.

- Low Volume Appeal Initiative: Appellants with fewer than 500 appeals pending at OMHA and the Medicare Appeals Council at the Departmental Appeals Board, combined, as of November 3, 2017 are eligible to settle the portion of their pending appeals that have total billed amounts of $9,000 or less per appeal in exchange for timely partial payment of 62% of the net Medicare approved amount. This settlement opportunity is available as of February 5, 2018.

The following chart details the percentage of appeals completed timely by type from FY 2014 through FY 2018 to date:

FY	Reconsiderations (2nd Level of Appeal)	
	Part A	**Part B**
2014	92.44%	99.89%
2015	97.89%	98.46%
2016	96.73%	99.72%
2017	92.74%	99.68%
2018	99.71%	99.61%

- *Medicare Appeals System (MAS)*: $6.2 million. An 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.

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 2019 budget request for HIPAA Administrative Simplification is $23.1 million, a decrease of $1.3 million below the FY 2018 Annualized CR Level. Funding is requested for the following activities:

- *HIPAA Claims-Based Transactions and Electronic Data Interchange (EDI)*: $10.4 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 which provides eligibility information to FFS 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.

- *NPI & NPPES*: $7.2 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 Administrative Simplification Enumeration and Audit of Health Plans*: $3.2 million. CMS is responsible for driving the enumeration of Health Plans as required by 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.

- *HIPAA Enforcement*: $2.3 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 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 submissions, and providing technical assistance in analyzing complex complaints, HIPAA transactions, and potential violations.

III. MEDICAID AND CHIP

Program Description and Accomplishments

Medicaid and CHIP 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, and CHIP. 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 program, while the Supplemental Security Income 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, 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 80 million in FY 2019 with more than 1 in 5 Americans enrolled in Medicaid or CHIP.

Budget Request: $99.7 Million

The FY 2019 budget request for Medicaid and CHIP operations is $99.7 million, an increase of $17.1 million above the FY 2018 Annualized CR level. Funding in this section includes support for administrative activities necessary to effectively operate and improve oversight of Medicaid and CHIP. The funding increase will allow CMS to reinvent Medicaid operations through improving data systems, and continuing support for the Medicaid and CHIP (MAC) scorecard that will increase transparency and accountability to allow states to better serve the interests of their citizens.

- *Medicaid and CHIP Business Information Solution (MACBIS):* $40.8 million. MACBIS is a CMS enterprise-wide initiative to improve the data infrastructure and information technologies that support Medicaid and CHIP. 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. With the contributions from those other accounts, this request fully funds ongoing operations and

maintenance of the Transformed Medicaid Statistical Information System (TMSIS), building out of public use files and release of TMSIS data to states and other stakeholders, completion of the Medicaid drug rebate system build, as well as rollout of additional authorities in the Medicaid and CHIP Program (MACPRO) system.

- *MAC Scorecard Initiative:* $31.9 million. FY 2019 will be the first year of full-scale rollout and operations of a searchable, web-based reporting platform on Medicaid health outcomes, quality of care, access and federal and state administrative performance/efficiency. The request will support all data collection and systems operations needed to support the Initiative. Additionally, FY 2019 funding will support continued business process redesign at CMS to support a new accountability framework for Medicaid. The following activities are core components to this effort:

    - *Project Management*: This initiative will continue to support state demonstration development. In addition to working with states to develop demonstrations, CMS also supports the implementation and monitoring of Medicaid Section 1115 demonstrations that account for approximately $100 billion annually in federal spending. CMS will award a contract to provide evaluation and technical support that will provide new perspective into how demonstrations operate and what process improvements can be implemented. More importantly, CMS will use the project to implement recommended process improvements.

    - *Business Re-engineering:* This project will fund re-engineering efforts across CMS as part of a new initiative to improve state and federal accountability across the entire Medicaid portfolio. This project will include business process redesign efforts, development of new policies and procedures, tools, aids to support state transition, learning collaboration and project management.

    - *Quality Measurement:* CMS must determine and develop Quality Measures needed for the State Scorecard. Contractor support will provide data quality assurance to states.

- *State Demonstration Evaluations:* $7.3 million. Contractor support is required to provide an evaluation of the impacts of the Section 1115 demonstration waivers. This includes a survey of beneficiary experience with these specific waivers. The contractor will review federal national survey data and state claims and encounter data to compare, among other things, beneficiary participation, continuity of coverage, access to care, and health outcomes.

- *Section 1115 Demonstration Management, Transitioning, and Waiver Transparency*: $6.2 million. Section 1115 of the Social Security Act provides broad authority to CMS and states under Medicaid and 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.

- *Survey of Retail Prices*: $4.6 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.

- *The National Home and Community-Based Services (HCBS) Quality Enterprise*: $3.0 million. The Home and Community-Based (HCB) Settings Project assists CMS in reviewing and monitoring Statewide Transition Plans (Plans) designed to bring states into compliance with the HCB settings requirements, to ensure HCB settings are integrated, and individuals receiving Medicaid HCBS have equal access to community support. The HCB Settings Project will assist CMS in the development of necessary tools, protocols and guidance materials to ensure consistent national implementation of new requirements. The Administration has given states additional time to come into compliance with the 2014 HCBS final rule; states must now be in compliance by March 2022.

- *Managed Care Review and Oversight*: $2.0 million. Managed care is the dominant delivery system for Medicaid benefits. As of 2015, over $200 billion dollars were spent annually on Medicaid managed care. Currently, there are 48 states and the District of Columbia operating over 170 programs covering roughly 62 million individuals. CMS implemented this project to increase our oversight and technical assistance to states to address the needs created by the growth of managed care and GAO concerns. Under this project, CMS created guidance for Managed Long Term Services and Supports (MLTSS) and encounter data. CMS also produced the 2013 - 2016 Medicaid Managed Care Enrollment Report which provides managed care enrollment information. Each of these deliverables has contributed much needed assistance to states as they work on improving beneficiary health outcomes and generating managed care related savings.

- *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 legislation. 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 health care system.

- *Medicaid Cures Act Support:* $1.6 million. Section 12006(a) of the 21st Century Cures Act requires an ongoing electronic visit verification system (EVS) to monitor states, and an ongoing, graduated, Federal Medical Assistance Percentage (FMAP) reduction for

states that are not fully compliant. Section 12006(b) requires the collection and dissemination of best practices to state Medicaid directors. EVS tasks include surveying states, tracking/analyzing EVS findings, and conducting training for CMS and States related to EVS in order to share promising practices and promote compliance with guidance/policy for the January 2018 dissemination of promising practices.

- *Other Medicaid, CHIP, and Basic Health Program Activities*: $0.7 million. CMS has a variety of 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.

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

Part C and D Information Technology (IT) Systems Investments

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

- *Medicare Advantage Prescription Drug Payment System (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.

- *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 Medicare Advantage and Part D plans.

Budget Request: $39.8 Million

The FY 2019 budget request for Parts C and D IT Systems Investments is $39.8 million, a decrease of $4.6 million below the FY 2018 Annualized CR level. 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 Medicare Advantage 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 vital to ensuring that beneficiaries are receiving the health care services that they expect from our programs.

Budget Request: $56.0 Million

The FY 2019 budget request for Oversight and Management is $56.0 million, an increase of $4.8 million above the FY 2018 Annualized CR level.

- *Medicare Parts C and D*: $48.3 million. This funding supports audits, actuarial reviews, estimates of Medicare Advantage and Prescription Drug Plans, the Retiree Drug Subsidy Program, and the on-going Medicare Part C and Part D reconsideration contracts. This also funds ongoing initiatives such as closing the Medicare Part D coverage gap, reforming Medicare Advantage 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

Medicare Advantage plan determinations, late enrollment penalties (LEP), and coverage denials made by Medicare Advantage and Part D 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 and projection is presented below:

QIC Appeals Workload for Parts C/D
(Volume in Appeals)

	FY 2016 Actual	FY 2017 Actual	FY 2018 Estimate	FY 2019 Estimate
Part C Appeals	55,048	63,486	66,000	69,300
Part D Benefit Appeals	34,387	41,616	42,000	43,000
Part D LEP appeals	45,989	41,303	43,000	45,000

- *Insurance Market Reforms:* $4.5 million. CMS on behalf of HHS is required to enforce market wide protections under Obamacare. To ensure compliance, CMS collects and reviews plan documents from health insurance issuers and conducts investigations and market conduct examinations of non-federal government plans based on complaints received.

  Funds will be used to continue compliance with market wide requirements, to assist with research to investigate complaints, and to perform market conduct examinations.

- *Medical Loss Ratio (MLR):* $3.2 million. Section 2718 of Obamacare requires an issuer to report annually how it used its premium revenue for the prior calendar year to ensure that consumers will receive value by using their premium dollars on medical care, quality improvement activities, or to pay a rebate to policyholders. This data analysis ensures consumers receive the rebates to which they are entitled if their health insurance issuer fails to meet the 80% (in the individual and small group market) or 85% (in the large group market) MLR standard. CMS is responsible for directly enforcing the regulations with respect to MLR for all issuers in the private health insurance market. The funding will be used to continue contractor support to conduct MLR examinations.

Federal Exchanges

The Federal Exchanges allow individuals to compare health plan options, see if financial assistance with premiums and cost-sharing is available, and purchase coverage. The FY 2019 Budget assumes passage of legislation to repeal and replace Obamacare, which would phase down the Federal Exchanges as the new Market-Based Health Care grants become available in plan year 2020.

States currently have the option to operate a State-Based Exchange (SBE) or elect to use the Federally-facilitated Exchange (FFE). SBEs can partner with CMS to use portions of the federal platform, such as enrollment, and are referred to as State-Based Exchanges on the federal platform (SBE-FP).

CMS will continue to conduct the following core responsibilities on behalf of all individual market Exchanges:

- Verify consumers' eligibility data for financial assistance through the Exchange or other health insurance programs, including Medicaid and CHIP;
- Ensure proper payment of financial assistance in the form of advanced payment of the premium tax credit (APTC) and cost-sharing reduction to issuers where a consumer is determined eligible;
- Operate a quality rating system for display on Exchange websites; and
- Conduct 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, 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.

Beginning in January 2018, CMS will no longer facilitate enrollment in the Federally-facilitated Small Business Health Options Program (FF-SHOP). Small employers will continue to use FF-SHOP to obtain eligibility determinations, but will enroll directly through participating issuers or work with a SHOP-registered agent or broker to complete the enrollment process. CMS will continue to support policyholders who purchased plans in 2017 through the end of their plan year. States will continue to have the option of operating a State-Based SHOP Exchange. CMS will continue to conduct oversight and provide technical assistance and analytic support to states.

In FY 2019, CMS proposes to further empower stakeholders by providing greater flexibility and recognizing the traditional regulatory role of States. States will be able to assume more control of their markets and expand enrollment options to include private partners to promote innovation and provide a better consumer experience. This includes a proposal to repeal and replace Obamacare, which would phase down Federal Exchange operations in plan year 2020.

Budget Request: $1,150.2 million of which $135.2 million is funded through discretionary appropriations

The FY 2019 Budget request for Federal Exchange activities is $1,150.2 million at the program level, of which $135.2 million is discretionary appropriations, including $122.7 million within Program Operations and $12.5 million within Federal Administration, along with $1,000.0 million in anticipated user fee collections, and $15.0 million in other resources.

- *Health Plan Bid Review, Management, and Oversight:* $10.0 million, of which none 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 Federal Exchange.

  The Budget assumes that in FY 2019 CMS will reduce issuer oversight efforts and wind down Federal Exchanges for plan year 2020 as states transition to their new Market-based health care grants.

- *Payment and Financial Management:* $40.8 million, of which $27.8 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 the Health Insurance Oversight System (HIOS). Exchange-related payments leverage the HIGLAS and financial management processes such as reporting and debt management.

  Each month, CMS receives enrollment information from the issuers or Exchanges, calculates the amount of aggregate APTC owed to issuers, and distributes payments. APTC is reconciled by the IRS when the consumer files a tax return.

  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 accesses issuers' dedicated data environments to check program integrity and perform calculations for program implementation. The risk adjustment data validation (RADV) program conducts reviews and audits of data that was used to calculate risk adjustment transfers.

  In FY 2019, CMS will continue to administer financial assistance payments on behalf of all States and operate the risk adjustment program. CMS is working to strengthen financial oversight through increased external audits of issuers including claims based reviews. Funding supports strengthening the RADV program through a stronger audit process by incorporating a second audit to ensure that prior reviews were correctly done.

- *Eligibility and Enrollment:* $233.8 million, of which $36.3 million is funded through discretionary appropriations. This activity allows consumers to submit applications for coverage during the open enrollment period or special enrollment periods (SEPs). Electronic applications are processed through HealthCare.gov where eligibility for financial assistance, Medicaid, and CHIP are verified through the Data Services Hub.

When consumer-provided information does not match electronic data sources, data match inconsistencies will be generated. CMS reviews consumer-submitted supporting documentation to resolve the issue. Consumers have the opportunity to appeal determinations for financial assistance, and SEP eligibility. Appeal activities include processing incoming documents, reviewing appeal requests and supporting documentation, requesting information and documents from appellants, and general case management.

CMS works with issuers to reconcile enrollment, resolving discrepancies identified through analytics or by issuers themselves. 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.

The Budget assumes that CMS will continue to operate these activities for the plan year 2019 and will support States and FFE enrollees as they transition to other forms of coverage and Market-Based Health care grants for plan year 2020. CMS will continue to operate eligibility verification services for all States and conduct State-delegated and original jurisdiction appeals.

- *Consumer Information and Outreach:* $341.2 million, of which none 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 event 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, CMS prints and mails pertinent consumer notices including application status, data matching issues, and appeals.

  CMS provides educational publications on a wide variety of topics. Year-round on the ground community-based support is available through Navigators that supply impartial information to consumers on eligibility applications and selecting a plan.

  The Budget assumes that in FY 2019, CMS will support FFE enrollees as they transition to other forms of coverage for plan year 2020.

- *Information Technology (IT):* $457.9 million of which $44.5 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

Exchanges also leverage existing CMS Enterprise Shared Services. Major applications that support Exchanges include:

- *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.

- *HealthCare.gov Web Portal* – 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.

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

- *Small Business Health Option Program (SHOP):* $2.4 million, of which none is funded through discretionary appropriations. SHOPs provide small businesses, defined as those with fewer 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 2019, as CMS ends support for existing Federally-facilitated SHOP participants, but will continue to conduct oversight and provide technical assistance and analytic support to states.

- *Other Activities:* $10.2 million funded through discretionary appropriations. CMS will continue implementing an improper payment risk assessment for APTC and Basic Health Program payment accuracy in accordance with existing statutes. In FY 2019, CMS will also focus on oversight of State operations.

- *Administration:* $50.0 million, of which $12.5 million is funded through discretionary appropriations. This funding supports administrative activities for the Federal Exchange.

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 health care quality initiatives, such as the Medicare Shared Savings Program. Value-based programs such as this one not only help our beneficiaries receive high quality of care, but also create a more efficient and better healthcare service experience.

Budget Request: $38.0 Million

The FY 2019 budget request for health care quality improvements is $38.0 million, an increase of $3.6 million above the FY 2018 Annualized CR level. The increase in funding will be used to re-compete contracts supporting the Medicare Shared Savings Program.

- *Medicare Shared Savings Program*: $27.4 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 561 ACOs serving 10.5 million beneficiaries. More physicians continue to join existing ACOs each year, demonstrating that clinicians are recognizing the value and opportunity of coordinated care, quality improvement, and shared savings.

  In FY 2019, additional funding is needed to re-compete the Compliance and Communications Support and Applications and Coordination Support competitive/delivery contracts.

  FY 2019 funds will also be used to fund the Consumer Assessment of Healthcare Providers & Systems (CAHPS) contractor and to continue supporting a payment contractor to assist with shared savings payments made to ACOs and the recoupment of shared losses. Finally, FY 2019 funds will be used to for the program analysis contract. This program analysis contractor supports beneficiary assignment, financial benchmarking, financial reconciliation and payments, and quality measurement and reporting, as they have done in years past.

- *Medicare Data for Performance Measurement:* $6.0 million. Under current law, the Secretary is required to establish a process to certify qualified entities 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 for program management, data preparation and distribution, and technical assistance.

- *Hospital Value-Based Purchasing (VBP):* $2.9 million. The Hospital Value-Based Purchasing Program, which provides value-based incentive payments to hospitals based on their performance on quality and cost measures, is mandated by the PPACA. FY 2019 funding is required in order to re-compete the task order on payment standardization in order to continue payment standardization of Medicare Part A and B

claims on a monthly basis, and working toward greater automation of this process through integration into the shared systems to support the calculation of resource use measures for VBP programs and for other agency and external users who leverage this data for their work

- *Value Based Payment Modifier Close-Out:* $0.9 million. The Value-Based Payment Modifier sunsets at the end of 2018. Funding for FY 2019 is needed in order to continue close-out and unforeseen expenses associated with the decommissioning of the Value-Based Payment Modifier and Quality Resource Use Reports through early 2019.

- *Hospital Readmission Reduction Program*: $0.3 million. This provision requires the Secretary to make readmission rates for hospitals publicly available and directs the Secretary to establish a program for eligible hospitals to improve their readmission rates through the use of patient safety organizations. Funding is needed for ongoing operations so CMS can 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) of 2014 established a new program to promote the use of appropriate use criteria for advanced imaging services. In order to implement this program to have the greatest impact, CMS will focus appropriate use criteria on clinical areas and imaging modalities of high volume to the Medicare population. In addition to focusing on areas of high volume, CMS will further review the applicable appropriate use criteria in these areas for their evidence-base and variability among competing appropriate use criteria. Funding is required for ongoing operations to continue implementing the 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 MMA of 2003. 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. This is CMS' primary vehicle to educate Medicare beneficiaries and their caregivers so they can make informed health care decisions. 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. Additionally, CMS in coordination with the Administration for Community Living and State Health Insurance Assistance Programs (SHIPS), will work to ensure that NMEP activities continue to provide accurate, comprehensive, understandable information to individuals.

National Medicare Education Program Budget Summary
(Dollars in Millions)

NMEP Category	Funding Source	FY 2017 Final	FY 2018 CR	FY 2019 Request	Description of Activity in FY 2019
Beneficiary Materials	**Total**	**$61.7**	**$57.1**	**$60.5**	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 funding the Handbook.
	PM	$31.7	$27.1	$30.5	
	Postage	$30.0	$30.0	$30.0	
Beneficiary Contact Center/1-800-MEDICARE	**Total**	**$197.6**	**$279.8**	**$307.7**	Call center and print fulfillment services available with 24 hours a day, 7 days a week access to customer service representatives.
	PM	$113.1	$199.0	$195.1	
	User Fees	$84.5	$80.8	$112.6	
Internet	**Total**	**$23.8**	**$26.3**	**$27.3**	Maintenance and updates to existing interactive websites to support the CMS initiatives for health and quality of care information; software licenses; enhancements to the on-line capabilities of MyMedicare.gov.
	PM	$20.2	$22.5	$27.3	
	QIO	$3.6	$3.8	(TBD)	
Community-Based Outreach	**Total**	**$1.8**	**$2.4**	**$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	$1.8	$2.4	$2.1	
Program Support Services	**Total**	**$19.8**	**$40.6**	**$26.2**	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	$19.9	$40.6	$26.2	
	Total	**$304.8**	**$406.2**	**$423.8**	
	PM	**$186.7**	**$291.6**	**$281.2**	
	User Fees	**$84.5**	**$80.8**	**$112.6**	
	Postage	**$30.0**	**$30.0**	**$30.0**	
	QIO	**$3.6**	**$3.8**	**(TBD)**	

Budget Request: $281.2 Million

The FY 2019 budget authority request for NMEP is $281.2 million, a decrease of $10.4 million below the FY 2018 Annualized CR level. The following activities are funded within the request:

- *Beneficiary Materials*: The total FY 2019 request is $60.5 million, $30.5 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. The handbook is updated annually and mailed to all current beneficiary households every October. Beneficiaries, currently, have the option to opt out of receiving a hard copy of the handbook by signing up at Medicare.gov/gopaperless for an electronic copy that gets emailed to them each the fall. 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 FYs 2013 through 2017 and the estimated distribution for FYs 2018 and 2019. 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 2016 Actual	FY 2017 Actual	FY 2018 Estimate	FY 2019 Estimate
Number of Handbooks Distributed	44.9	45.5	47.2	48.6

- *1-800-MEDICARE/Beneficiary Contact Center (BCC):* The total FY 2019 request is $307.7 million, of which $195.1 million is 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 2013 through 2017 and the number of calls we expect to receive in FYs 2018 and 2019. In FY 2019, CMS expects to receive 26.3 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. At the FY 2019 funding request, CMS anticipates an average speed to answer of 5-7 minutes.

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

	FY 2016 Actual	FY 2017 Actual	FY 2018 Estimate	FY 2019 Estimate
Number of Calls	25.0	22.4	27.1	26.3

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

- *Internet*: $27.3 million. The Internet budget funds operations and maintenance for three websites. Increased funding in FY 2019 will provide additional software and hardware upgrades, while providing improvements to the web services offered online.

The http://www.cms.gov website is CMS'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 CMS'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 2019, CMS estimates 365 million page views to http://www.medicare.gov, approximately a one percent increase in traffic from the page views anticipated in FY 2018. 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 2016 Actual	**FY 2017 Actual**	**FY 2018 Estimate**	**FY 2019 Estimate**
Number of http://www.medicare.gov Page Views	316.5	353.2	360.0	365.0

- *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 2019 funding is requested 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:* $26.2 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, 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 $112.6 million in user fees and $30.0 million is postage funding bringing the total FY 2019 budget request for NMEP to $423.8 million, an increase of $17.6 million above the total FY 2018 Annualized CR level.

Provider Outreach

Provider outreach activities allow CMS 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. These functions make up one part of our core communication strategy by providing healthcare practitioners with up-to-date information so they may deliver the best possible care to our beneficiaries.

Budget Request: $9.2 Million

The FY 2019 budget request for Provider Outreach is $9.2 million, a decrease of $11.6 million below the FY 2018 Annualized CR level. In FY 2019, CMS intends to shift additional provider services to the MAC Provider Contact Center.

- *National Provider Education, Outreach, and Training*: $5.0 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 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.

- *Federal Coverage and Payment Coordination:* $4.2 million. This activity supports necessary activities and resources to implement the Medicare-Medicaid Coordination Office's (MMCO's) statutory obligations, as well as the HHS and CMS strategic goals.

Each activity is pivotal in CMS' success in improving quality, cost, and care coordination for dual eligible beneficiaries. This work includes navigating a number of very complex operational issues, merging often conflicting systems, policies, financing, monitoring and oversight protocols, and data requirements across Medicare and Medicaid, and then adapting that work to the unique environment of each state.

Consumer Outreach

CMS is responsible for performing outreach to all eligible persons who can obtain health insurance through the private market. Our outreach activities for consumers are based on proven strategies utilized by our NMEP program to support CMS' Medicare and Medicaid beneficiaries. Each year CMS incorporates best practices from last open enrollment (OE) to make our media more efficient and effective. Previous OEs have taught us lessons about effective messages and tactics to reach the uninsured Americans who need information and assistance the most. This request provides support to maintain and update general consumer information for private insurance on www.Healthcare.gov and allows us to tailor outreach programs to the disenfranchised and minority groups. Ongoing funding will make our outreach more effective, helping more people get coverage, stay healthy, and ensure that our consumers are receiving up-to-date information regarding their healthcare coverage.

Budget Request: $2.5 Million

The FY 2019 budget request for Consumer Information and Outreach is $2.5 million, a decrease of $1.1 million below the FY 2018 Annualized CR level.

- *General Consumer Information on Private Insurance:* $2.0 million. The funding request supports a multitude of activities to ensure the public has access to timely and accurate resources to assist with private insurance plan comparisons, understanding insurance and rate changes, comparing coverage providers, and learning how various parts of Obamacare may impact their health care insurance benefits and coverage. This information is made publicly available at of www.Healthcare.gov.

- *Indian Health Care*: $0.5 million. The goal of this activity is to expand the reach of CMS programs for American Indian and Alaska Natives (AI/AN). Federal delivery of health services and funding of programs to maintain and improve the health of AI/AN's are consonant with and required by the Federal Government's historical and unique legal relationship with Indian Tribes. Ongoing AI/AN outreach contracts will support the continued implementation of a well-developed, flexible and successful quality outreach strategy that provides critically needed and culturally appropriate resource materials to increase the enrollment of AI/AN beneficiaries in CMS programs including private insurance, Medicaid, Medicare, and an increased focus on Dual Eligible populations.

VII. INFORMATION TECHNOLOGY

Program Description and Accomplishments

Systems and Support

Enterprise IT activities provide infrastructure and support for applications and operations that are used across the agency. These activities provide CMS the capability to quickly expand to address future system needs, adopt new and more efficient technologies, and support new programs. CMS must continue to invest in expansions of software, licensing and processing capacity to manage system growth, and consolidation and replacement of end of life and/or less efficient equipment in its efforts to modernize its information technology. Enterprise IT activities include security and governance within CMS, which provides the standards and guidelines for compliance and response capabilities. CMS protects our networks and information systems against the continual attacks of malicious cyber actions through a comprehensive 24/7 cyber threat monitoring program.

Specifically, CMS will continue to invest in the transition to the Virtual Data Center which supports Medicare Part C & D operations and enterprise shared services. CMS continues to invest in infrastructure for the HPMS, which is integral to the management of nearly 800 MA and Part D organizations to ensure they are fulfilling the various statutory, regulatory, and administrative requirements of these programs.

Budget Request: $397.4 Million

The FY 2019 budget request for Enterprise activities is $397.4 million, a decrease of $55.7 million below the FY 2018 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 operations. These activities provide the operational support to manage CMS's data environment for mission-critical and enterprise-wide CMS IT strategies.

The decrease in funding in FY 2019 can be attributed to continuous work on the part of CMS to find efficiencies within its contracts. For example, in FY 2018 CMS will invest funding in terminating legacy costs that support old and outdated systems, consistent with its IT modernization efforts. Once these systems have been fully transitioned to newer more efficient ones, they have potential to achieve substantial out-year savings.

In FY 2019 CMS will continue to make substantial investments in security in order to increase the protection of CMS data and processing activities through additional cybersecurity and privacy program actions. In support of this effort, CMS completed the initial review of its high value assets (HVA) and is continuing with HVA security testing. CMS is also working towards the full implementation of continuous diagnostics and mitigation (CDM). To date, CMS has developed a configuration of log aggregation (activate equipment) for connecting CDM tools provided by Department of Homeland Security vendors, and the Data Center has incorporated CDM tools into their daily operational life-cycle.

In addition, CMS' current data platform does not adhere to the medical industries' utilization of Application Programming Interface as a standard format. Therefore, CMS launched a new initiative called "Digital Seniors" in FY 2018 to update its existing claims processing infrastructure and other systems to better interface with the rest of the medical industry. This will allow patients to request and obtain their data more quickly and in a format that can easily be shared with others, including plans, providers, and family members, to analyze and make recommendations. CMS will continue to invest $17 million in FY 2019 in the Digital Seniors initiative.

While "Information Technology Systems and Support" describes CMS' investment in Enterprise-wide IT, Program Operations funding also supports IT across all of CMS' programs. These amounts are included within the total budget requests for each program, making it potentially difficult to get a sense of how much money CMS spends on IT across them all. Please see the Program Operations IT spending table in the supplementary items to show IT funding requested for each of the categories within Program Operations. For a more complete picture of CMS IT spending from all sources and across all programs, please see the "Information Technology" Chapter of the CJ.

Federal Administration
(Dollars in Thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$732,533	$727,558	$702,601	($24,957)
FTE[/1]	4,514	4,503	4,237	(266)

1/Excludes staffing funded from indirect cost allocations.

Authorizing Legislation – Reorganization Act of 1953
Authorization Status – Permanent
FY 2019 Authorization – One Year
Allocation Method – Direct, Contracts, Other

Program Description and Accomplishments

Federal Administration funds the majority of routine operating expenses in support of agency activities for a variety of health care financing programs. Funding covers employee compensation, rent, utilities, information technology, contracts, supplies, equipment, training, and travel. Many of these costs are determined by policies and agencies beyond CMS, but are essential for carrying out our mission.

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.

Personnel and associated costs for programs and activities where specific funding sources are available are not included in the Federal Administration request. In order to ensure indirect costs are appropriately applied to these funding sources, CMS utilizes a cost allocation methodology to offset some costs that would otherwise be funded out of the Federal Administration account. In FY 2019, we estimate that $147.0 million will be available from indirect cost allocations, which is not included in our discretionary funding level.

Funding History

Fiscal Year	Budget Authority
FY 2015	$732,533,000
FY 2016	$732,533,000
FY 2017	$732,533,000
FY 2018 Annualized CR	$727,558,000
FY 2019 President's Budget	$702,601,000

Budget Request: $702.6 million

CMS requests $702.6 million, a decrease of $25.0 million below the FY 2018 Annualized CR level. The requested amount excludes the portion of the total costs that is being covered by CMS' other fund sources through indirect costs allocations. This request fully funds changes to employee benefits and accounts for other inflationary increases. CMS' FY 2019 request has been prepared in accordance with Executive Order 13771, Reducing Regulation and Controlling Regulatory Costs. In FY 2019, this funding provides resources for contracts that support our daily operations and associated expenses. In addition, CMS will focus efforts on achieving Homeland Security Presidential Directive 12 (HSPD-12) compliance.

Federal Administration Discretionary Summary Table
(Dollars in Thousands)

Objects of Expense	**FY 2017 Final**	**FY 2018 Annualized CR**	**FY 2019 President's Budget**	**FY 2019 PB +/- FY 2018 Annualized CR**
Personnel Compensation and Benefits	$668,380	$675,700	$639,054	($36,646)
Travel	$1,900	$1,048	$1,048	$0
Rent, Communications and Utilities	$5,100	$5,100	$5,100	$0
Printing and Postage	$2,101	$1,671	$2,223	$552
Contractual Services	$52,487	$41,969	$52,798	$10,829
Supplies	$1,000	$1,003	$811	($192)
Training	$1,565	$1,067	$1,567	$500
Total, Federal Administration	**$732,533**	**$727,558**	**$702,601**	**($24,957)**

- *Personnel Compensation and Benefits:* $639.1 million. The requested funding supports 4,237 direct FTEs, a decrease of 266 FTEs as compared to the FY 2018 Annualized CR level. The reduction in workforce will occur through natural attrition across the Agency. This category covers the full range of civilian and Commissioned Corps pay, awards, and overtime as well as fringe benefits. Commissioned Corps are entitled to additional benefits including housing and other allowances. CMS' staffing level and related compensation and benefits expense is largely workload-driven. Staffing funded from the Federal Administration line will enable us to execute Secretarial priorities. These priorities include maintaining and improving the

performance of our traditional programs, Medicare, Medicaid, and CHIP, to ensure they are successfully delivered with the highest quality. Additional CMS staffing costs are funded through other line items and accounts, including Health Care Fraud and Abuse Control (HCFAC), various user fees, and direct appropriations from recent legislation.

- *Travel:* $1.0 million. 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.

- *Rent, Communications, & Utilities*: $5.1 million. 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. 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.

- *Printing and Postage:* $2.2 million. The largest expense in this category is for printing notices in the Federal Register and Congressional Record. CMS is required 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.

- *Contractual Services:* $52.8 million. This category funds daily operations and information technology support services, contracts, and agreements with other agencies. This category includes information technology infrastructure to support voice and data telecommunications, web-hosting, and IT security. This category also provides funds for the CMS share of the Department of Health and Human Services (DHHS) Program Support Center (PSC) and other shared expenses including payroll, financial management, and e-mail systems.

- *Supplies:* $0.8 million. 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.

- *Training:* $1.6 million. This category supports continuous learning of technical, professional, and general business skills with special emphasis on leadership and management development. This category covers certifications for staff, such as actuaries, contract specialists, financial managers, nurses, and other health professional specialists. The funding also supports mandatory agency wide trainings such as Reasonable Accommodation and Alternative Dispute Resolution.

Medicare Survey and Certification

(Dollars in Thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$397,334	$394,636	$421,135	+$26,499

Authorizing Legislation - Social Security Act (SSA), title XVIII, Section 1864

FY 2019 Authorization - One Year

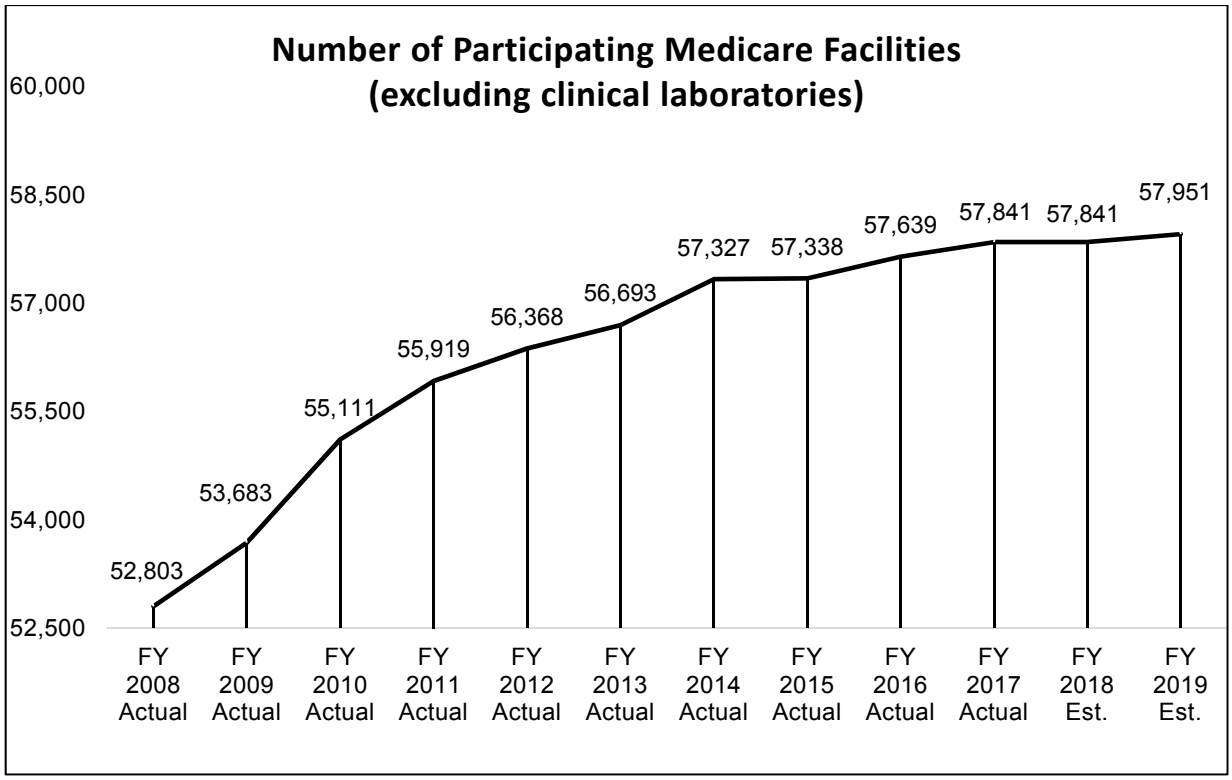
Allocation Method – Contract Agreements

Program Description and Accomplishments

The mission of CMS' Survey and Certification program is to ensure basic levels of quality and safety for all patients, residents and clients receiving care at Medicare and Medicaid certified health care facilities. In order to participate in and receive reimbursements from Medicare and Medicaid, health care facilities are required to be certified as meeting applicable requirements. The certification of facilities is conducted through an initial survey, or inspection, and on a regular basis thereafter to ensure that the facility continues meeting health, safety, and quality standards as required by the Conditions of Participation (COP) established by CMS.

CMS works in partnership with State Survey Agencies (SA) or directly through national contractors to ensure that facilities in each of the 50 States, the District of Columbia, and U.S. territories can be certified and recertified for Medicare participation. In addition, CMS allows some provider types to use private accreditation organizations (AO) in place of SAs; providers that are certified by approved AOs are deemed to be in compliance with Medicare COPs but are still subject to State or CMS validation surveys. For all facility types, CMS conducts investigations to substantiate reported complaints and takes appropriate actions when facilities are found to have health care deficiencies as a result of complaints. Collectively, the certification, recertification, and complaint surveys are referred to as the certification process.

The total number of Medicare-participating facilities, excluding clinical laboratories, has grown by 9.5 percent from FY 2008 to FY 2017 and has been driven by hospice, end-stage renal disease (ESRD) providers, and home health agencies (HHAs). Between FY 2010 and FY 2016, these facilities have grown by 26 percent, 20 percent, and 8 percent, respectively.


Number of Participating Medicare Facilities
(excluding clinical laboratories)
60,000
58,500
57,000
55,500
54,000
52,500
52,803
53,683
55,111
55,919
56,368
56,693
57,327
57,338
57,639
57,841
57,841
57,951
FY 2008 Actual
FY 2009 Actual
FY 2010 Actual
FY 2011 Actual
FY 2012 Actual
FY 2013 Actual
FY 2014 Actual
FY 2015 Actual
FY 2016 Actual
FY 2017 Actual
FY 2018 Est.
FY 2019 Est.

The majority of CMS' survey and certification funding is provided directly to States to survey, certify, and recertify health care facilities. States prioritize surveys based on statutory requirements, CMS priorities, and funding levels. The chart below demonstrates which facilities have survey frequencies that are mandated by statute, and, for those without a statutorily mandated frequency, what CMS views as an ideal survey frequency under its administrative policy.

Statutory and CMS Policy Level Survey Frequencies

Type of Facility	Statutory Status/CMS Priority	Survey Frequency/1
Long-Term Care Facilities		
Skilled Nursing Home (SNF)	Statutory SSA Sec. 1819 (g)(l)	Max 15.9 months for individual nursing home. Min 12.9 months for Statewide average interval between surveys.
Skilled nursing facilities (SNFs) and Nursing Facilities (NFs)	Statutory SSA Sec. 1819 (g)(l) and 1919 (g)	
Special Focus Facility Nursing Homes (SFF)	Statutory SSA Sec. 1819 (g)(l)/2	
Non-Long Term Care Facilities		
Home Health Agencies (HHA)	Statutory SSA Sec. 1891 (a)	No more than 36.9 months interval between surveys for HHA facility.
Hospices	Statutory SSA Sec. 1861 (dd)	No more than 36.9 months interval between surveys for Hospices facilities.
Deemed Hospitals - Validations	CMS Administrative Priority Policy	5% Year Sample
Organ Transplant Facilities/3	CMS Administrative Priority Policy	5 Years
Non-Deemed Hospitals	CMS Administrative Priority Policy	Every 3 Years
End-Stage Renal Disease (ESRD)/4	CMS Administrative Priority Policy	Every 3 Years
Ambulatory Surgical Centers (ASC)/4	CMS Administrative Priority Policy	Every 3 Years
Outpatient Physical Therapy/4	CMS Administrative Priority Policy	Every 6 Years
Comprehensive Outpatient Rehabilitation Facility (CORF)	CMS Administrative Priority Policy	Every 6 Years
Portable X-Rays	CMS Administrative Priority Policy	Every 6 Years
End-Stage Renal Disease (ESRD)	CMS Administrative Priority Policy	Every 3 Years
Rural Health Clinics (RHC)	CMS Administrative Priority Policy	Every 6 Years
Ambulatory Surgical Centers (ASC)	CMS Administrative Priority Policy	Every 3 Years
Community Mental Health Centers (CMHC)	CMS Administrative Priority Policy	Every 6 Years

/1 This display reflects statutory and policy survey frequencies.
/2 CMS directs State Agencies to validate survey and certification of facilities conducted by Accreditation Organizations.
/3 Survey and certification of Organ Transplant facilities are conducted by national contractors.
/4 Facilities identified by Government Accountability Office (GAO) and the Office of Inspector General (OIG) that pose a high risk to patients requiring CMS to administer stronger survey and certification oversight.

CMS has accomplished improvements in oversight of facilities through enhanced survey processes and standards that use statistical information to review outcomes and prioritize facilities whose performance data indicate higher risk of poor patient outcomes. A few of these accomplishments are highlighted below:

- CMS places a high priority on ensuring nursing home quality. To safeguard patients, CMS introduced targeted survey methods, such as investigating complaints alleging actual harm within 10 days of reporting, imposing immediate sanctions for facilities found to have care deficiencies that involve actual harm, and staggering inspection times to ensure that a specific amount to begin on weekends and evenings.

- CMS continues its Special Focus Facility (SFF) initiative for nursing homes judged to be at highest risk of poor quality. Historically, nursing homes with the SFF designation, and which are surveyed twice as frequently, have come into compliance with CMS requirements more quickly than facilities that were surveyed at the normal frequency. The FY 2019 budget would continue to support the SFF efforts.

- As a result of clearer guidance implementation of State performance standards, and other improvements, the percentage of nursing homes surveyed at least every 15.9 months has remained above 99 percent in FY 2016.

- CMS has made similar improvements in the area of home health, with the percent of HHAs surveyed at least every three years, as required by statute, increasing from 97 percent in 2004 to 99.6 percent in FY 2016.

- Surveys in accordance with the new ESRD regulations have substantially improved infection control, water quality safety, and internal quality assurance at dialysis facilities.

- The implementation of onsite surveys for all organ transplant centers has improved graft survival for all types of organ transplants, with substantial improvements achieved in programs that entered into a System Improvement Agreement with CMS after being cited for substandard patient outcomes.

- After a more rigorous survey process introduced in FY 2011 and revised in FY 2015 for ASC facilities, a high level of infection control problems were identified in particular ASC facilities. CMS implemented additional oversight, including periodic surveys of a random sample of previously deficient ASCs, to ensure that they improved practices and sustained any gains.

Nationally, while the average number of deficiencies has decreased in recent years for ESRD facilities, hospitals, and ASCs, these facilities continue to highlight the importance of regular, comprehensive inspections as well as timely and effective investigation of complaints.

Facilities of Concern and Deficiencies

Facility Type	National Average Number of Deficiencies per Facility			Examples of Deficiencies
	FY 2014	FY 2015	FY 2016	
Dialysis Facilities	5.6	5.8	5.3	Hygiene and Infections or hazards to life from poor equipment cleaning or water quality.
Hospitals	5.7	4.9	4.2	Supervision, patient rights, and infection control.
Ambulatory Surgical Centers	4.8	4.2	4.0	Sanitary environment, infection control deficiencies, and drug administration.

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 health care. At various times, the GAO has placed areas of survey and certification oversight, particularly oversight of nursing homes and ESRD facilities, into a high-risk category, indicating a greater vulnerability to fraud, waste, abuse, and mismanagement of care. Recent reports from the OIG focused on hospital quality of care, health care worker qualifications, and ASC oversight. CMS is attempting to implement 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 are critical to ensure Federal dollars support quality care.

Funding History

Fiscal Year	Budget Authority
FY 2015	$397,334,000
FY 2016	$397,334,000
FY 2017	$397,334,000
FY 2018 Annualized CR	$394,636,000
FY 2019 President's Budget	$421,135,000

Budget Request: $421.1 million

The FY 2019 budget request is $421.1 million, $26.5 million above the FY 2018 Annualized CR level. CMS assumes additional funding from collections as a result of the proposed revisit user fee. The enactment of the revisit user fee will provide CMS the authority to charge providers a fee for revisits as a result of deficiencies found during initial certification, recertification, or substantiated complaints. In addition, CMS will also charge facilities a fee for substantiated complaints surveys resulting in findings cited at the level of immediate

jeopardy or actual harm. The fee will incentivize facilities to restore and maintain compliance with Medicare COPs.

CMS levied a revisit user fee for one year FY 2007, exhibiting the feasibility of such a fee. If enacted in FY 2019, CMS estimates $14.1 million in collections (actual collection amounts would be dependent on rule making) for a total proposed law discretionary program level of $435.3 million. This request will allow CMS to continue to survey and certify health care facilities, employ a Regional Strike Force who will respond to facilities where patient's health and well-being are in jeopardy, and improve data used by SAs and CMS Regional Offices (ROs) for survey and enforcement activities. The table below provides the program level funding details from FY 2017 to FY 2019.

Program Level Table
(Dollars in Thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Budget Authority (BA)	$397,334	$394,636	$421,135	+$26,499
Revisit/Complaint User Fee	$0	$0	$14,120	+$14,120
Proposed Law Discretionary Program Level Subtotal	**$397,334**	**$394,636**	**$435,255**	**+$40,619**
IMPACT P.L. 113-185. Hospice Surveys/1	$7,758	$5,254	$5,625	+$371
IMPACT Improve Nursing Home Staffing Data	$3,700	$529	$0	-$529
Program Level	$408,792	$400,419	$440,880	+$40,461

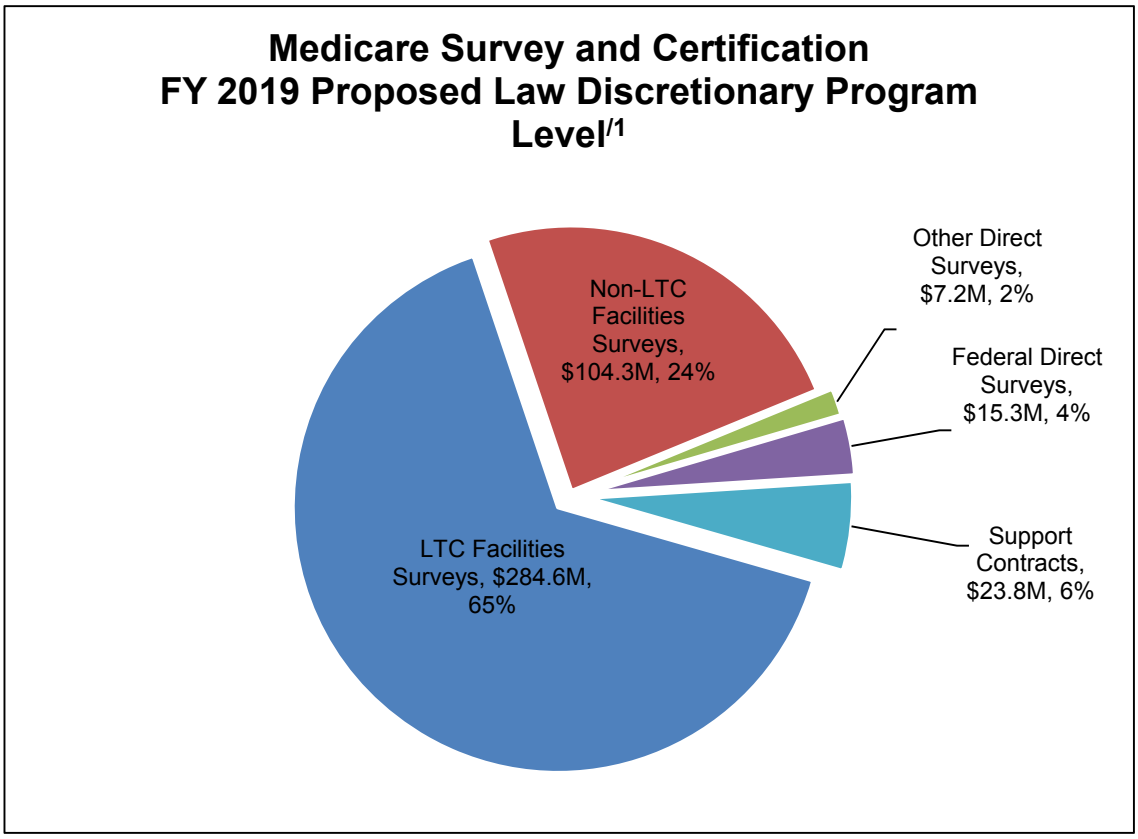
/1 Funding provided through the IMPACT P.L. 113-185 Section 3 for hospice surveys in FY 2017 and FY 2018 was subject to 6.9 percent and 6.6 percent sequester respectively.

The FY 2019 CMS 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 AOs more effective, and implement key recommendations made by the GAO and OIG.

As costs to conduct survey and certification increase, CMS' Survey and Certification program prioritizes funding to maintain survey and certification standards set in statute for nursing homes, HHAs, and hospices. Growth in the number of beneficiaries and facilities, inflation, changes in laws, and improvements in quality standards are all factors that increase program costs.

If funding levels do not account for increased program costs in alignment with the FY 2019 budget request, CMS would have to reduce funding for lower risk non-statutory facilities delay implementation of projects, and reallocate that funding to maintain survey and certification standards of statutory facilities and non-statutory facilities with higher priority like non-deemed hospitals, ESRDs, and ASCs.

The pie chart below illustrates the Survey and Certification's FY 2019 budget request allocation.



/1 Totals may not add due to rounding.

- The State Direct Survey category accounts for nearly 90 percent of the total CMS' Survey and Certification FY 2019 budget request, which is subdivided into Long-Term Care (LTC) facilities like nursing homes, and non-LTC facilities. This funding is provided directly to States to assist in implementing the survey and certification program.
- The Support Contractors request comprises nearly 6 percent of the total FY 2019 Survey and Certification budget for training national contractors, implementing improved survey standards, identifying high risk areas, tracking facility progress, and IT systems maintenance and upgrades.
- The Federal Direct Survey is 4 percent of the total FY 2019 Survey and Certification budget. These funds are used to hire national contractors who survey and certify psychiatric hospitals and transplant centers since these facilities are small in number and require highly specialized methods and survey expertise to ensure quality of care. They also help mitigate the delay experienced by prospective providers that newly seek Medicare participation.
- The Other Direct Survey category makes up about 2 percent of the total FY 2019 Survey and Certification budget to fund administrative costs related to State Direct Surveys such as training, travel, and AO validation surveys conducted by SAs to ensure CMS COPs are being upheld.

Each funding category is discussed in further detail below.

- *State Direct Survey:* $389.0 million. The FY 2019 request includes $389.0 million in discretionary budget authority for State Direct Survey costs, which is $36.8 million above the FY 2018 Annualized CR Level. This funding amount will enable CMS to continue to meet statutory survey frequencies for nursing homes, HHAs, and hospice facilities, while improving upon the survey frequencies rates for non-statutory facilities as estimated for FY 2018. The requested increase is needed in part because the mandatory IMPACT Act funding to implement the three year frequency for Hospice facilities is reduced in statute by close to 30 percent starting in FY 2018 and continuing into FY 2019. In addition, the aforementioned drivers of facility and beneficiary growth and increasing quality measures continue to drive program costs upward.

  The FY 2019 budget request supports efforts to find improvements 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. The enhancements will include:

  - Strengthening the focus on residents and their experiences of quality of life and quality of care, in part, by moving away from memorization questions to more conversational style, within the context of a structured interview guide to ensure important topics are discussed. This approach is meant to emphasize the "human element" by sparking more natural conversation and building on surveyor interview skills.

  - Clarifying how to consistently and thoroughly investigate care concerns, primarily by using updated Critical Element (CE) Pathways to look at processes and care concerns to guide surveyors more consistently through the investigation.

  - Using data to guide surveyors through the process of inspecting and certifying facilities. This will allow surveyors to be more flexible, understand residents' characteristics, and identify facility concerns.

  The table below presents survey frequency rates for each facility type and associated costs in FY 2017, FY 2018, and FY 2019. In FY 2018, under the Continuing Resolution, CMS estimates that most non-statutory facilities will not be surveyed at the rates reported in previous years.

FY 2017 to FY 2019 Survey Frequency Rates and Cost by Facility Type

(Dollars in Millions)

Type of Facility	FY 2017 Final	FY 2018 Annualized CR	FY 2019 Proposed Law Discretionary Program Level/1
Statutory Facilities			
Skilled Nursing Home	Annually $16.7	Annually $16.3	Annually $16.0
SNF/NF (dually-certified)	Annually $235.3	Annually $268.9	Annually $268.7
Total Long-Term Care Facilities	**$252.0**	**$285.2**	**$284.7**
Home Health Agencies	3 Years $17.2	3 Years $24.5	3 Years $29.3
Hospices/2	3 Years $6.2	3 Years $7.2	3 Years $7.0
Non-Statutory Facilities			
Deemed Hospitals - Validations	1.5% Year Sample $22.7	0.4% Year Sample $22.8	1.0% Year Sample $25.5
Organ Transplant Facilities/3	5 Years	5 Years	5 Years
Non-Deemed Hospitals	4 Years $12.9	/4 $4.1	5 Years $12.0
Outpatient Physical Therapy	12 Years $0.9	/4 $0.2	12 Years $0.8
Comprehensive Outpatient Rehabilitation Facility	12 Years $0.1	/4 $0.1	12 Years $0.1
Portable X-Rays	12 Years $0.2	/4 $0.1	12 Years $0.2
End-Stage Renal Disease (ESRD)	3.8 Years $22.3	/4 $6.4	5 Years $19.4
Rural Health Clinics	12 Years $1.5	/4 $0.3	12 Years $1.3
Ambulatory Surgery Centers	5 Years $9.3	/4 $1.2	5 Years $8.6
Community Mental Health Centers	12 Years $0.5	/4 $0.1	12 Years $0.1
State Direct Survey Costs	**$345.8**	**$352.2**	**$389.0**
Other State Direct Survey Costs	**$9.7**	**$5.8**	**$7.2**
Total, State Direct Survey	**$355.5**	**$358.0**	**$396.2**

/1 FY 2019 Level assumes additional funding from the proposed Revisit User Fee Program.
/2 Hospice surveys are partially funded under the IMPACT ACT PL 113-185.
/3 Organ Transplant Facilities surveys are contractor performed.
/4 Local jurisdictions will continue to respond to complaints, and based on availability of resources, certify new facilities.

In FY 2019, CMS expects to complete approximately 23,000 initial and recertification inspections. In addition, CMS estimates 59,000 visits in response to complaints. The Survey and Complaint Visit Table below show that the majority of both surveys and complaint visits in FY 2018 and FY 2019 are projected to be in nursing homes. These surveys will contribute to achieving one of CMS' nursing home quality goals to decrease the percentage of long-stay nursing home residents receive antipsychotic medications.

Survey and Complaint Visit Table

FY 2018 Annualized CR					
Facility	**Projected Number of Facilities (Beginning of FY)**	**Total Recertification Surveys**	**Total Initial Surveys**	**Total Complaint Visits**	**Total**
Skilled Nursing Facility (SNF)	747	750	32	1,020	1,802
SNF/NF (dually-certified)	14,550	15,132	118	50,575	65,825
Home Health Agencies	11,904	2,724	62	1,325	4,111
Deemed Hospital	4,738	19	0	2,565	2,584
Organ Transplant Facilities/1	242	0	0	0	0
Non-Deemed Hospitals	1,412	14	11	385	410
Hospices/2	4,564	826	165	475	1,466
Outpatient Physical Therapy	2,052	17	48	8	73
CORF	188	2	7	4	13
Portable X-Rays	489	4	18	2	24
ESRD Facilities	6,998	70	245	930	1,245
Rural Health Clinics	4,209	34	21	42	97
Ambulatory Surgery Centers	5,597	37	21	142	200
CMHC	151	1	5	5	11
Total	**57,841**	**19,630**	**753**	**57,478**	**77,861**

/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.

Survey and Complaint Visit Table

FY 2019 Proposed Law Discretionary Program Level/1					
Facility	**Projected Number of Facilities (Beginning of FY)**	**Total Recertification Surveys**	**Total Initial Surveys**	**Total Complaint Visits**	**Total**
Skilled Nursing Facility (SNF)	783	783	33	1,065	1,881
SNF/NF (dually-certified)	14,515	14,603	112	51,935	66,650
Home Health Agencies	12,284	2,805	40	1,182	4,027
Deemed Hospital	4,712	28	0	2,865	2,893
Organ Transplant Facilities/2	242	0	0	0	0
Non-Deemed Hospitals	1,488	298	12	345	655
Hospices/3	4,406	828	28	442	1,298
Outpatient Physical Therapy	2,128	159	39	6	204
CORF	205	17	3	1	21
Portable X-Rays	515	43	18	3	64
ESRD Facilities	6,719	1,344	305	942	2,591
Rural Health Clinics	4,249	324	68	33	425
Ambulatory Surgery Centers	5,517	730	21	93	844
CMHC	188	16	5	4	25
Total	**57,951**	**21,978**	**684**	**58,916**	**81,578**

/1 The FY 2019 Proposed Law Discretionary Program Level assumes additional funding from the revisit user fee proposal.
/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*: $7.2 million. The FY 2019 Other State Direct Survey request is $7.2 million, $1.4 million above the FY 2018 Annualized CR level. The increase in funding will support State targeted survey efforts and expand oversight, which reduce risks to patients.

  In addition, this funding will support States' program operations or responsibilities that include:

  - Support for validation surveys to assess the performance of CMS-approved accrediting organizations, as required by law.

  - State responsibilities to collect and report survey data 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.

  - Support for the Outcome and Assessment Information Set (OASIS), which serves as the backbone of the home health prospective payment system. This will fund contractors that assist States to address performance issues, emergency preparedness and post-disaster recovery surveys.

- *Federal Direct Surveys*: $15.3 million. The FY 2019 budget request for Federal Direct Survey is $15.3 million. This funding is $1.6 million above the FY 2018 Annualized CR Level, and will allow CMS to engage with national contractors to conduct specialized surveys. The FY 2019 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. Facilities 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*: $23.8 million. Support contracts and information technology constitute $23.8 million of the FY 2019 budget request.

  The FY 2019 budget request for support contracts is $22.7 million. This funding is $0.7 million above the FY 2018 Annualized CR Level. The increase in funding supports:

  - The improvement of State Performance Standards data, allowing State Agencies and CMS Regional Offices to monitor survey and enforcement activities, identify problems, and quickly deploy corrective actions.

  Surveyor training continues to be one of the largest categories in support contracts. These contracts enable CMS to fulfill statutorily required facility staff training mandates of Sections 1819, 1919, and 1891 of the Social Security Act. The requested funds also 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 ensure national program oversight and consistency such as the Surveyor Minimum Qualifications Test, and supervision of accrediting organizations' adherence to established criteria when they recommend CMS approved waivers for facilities deemed to be in compliance with COPs.

  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. 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 homes 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 MDS; and publicly reporting nursing home staffing and other information on CMS' Nursing Home Compare website. The FY 2019 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 2019 is $1.0 million, which is $0.1 million above the FY 2018 Annualized CR Level. IT funds will continue to support maintenance for Providing Data Quickly (PDQ) application, Survey & Certification / Clinical Laboratory Improvement Amendments Budget and Expenditure (SC&CLIA) system, and fund enhancement of PDQ through the Quality and Certification Oversight Reporting System (QCORS).

Research, Demonstration and Evaluation

(Dollars in Thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
BA	$20,054	$19,918	$18,054	($1,864)

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 2019 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 nearly 140 million beneficiaries in FY 2019. 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 2015	$20,054,000
FY 2016	$20,054,000
FY 2017 Final	$20,054,000
FY 2018 Annualized CR	$19,917,813
FY 2019 President's Budget	$18,054,000

Budget Request: $18.1 Million

The FY 2019 budget request for RDE is $18.1 million, a decrease of $1.9 million below the FY 2018 Annualized CR. CMS will continue funding ongoing research data analytic activities supporting CMS and split-funding the Medicare Current Beneficiary Survey with the Innovation Center. This request funds ongoing operations.

- *Medicare Current Beneficiary Survey (MCBS)*: $12.0 million. CMS requests funding to maintain the survey's content and utility, and support statutory requirements. In

FY 2019, 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. 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.

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

Appropriation Language

For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, [$284,798,384,000] *$276,236,212,000,* to remain available until expended.

[For making,] *In addition, for carrying out such titles* after May 31, [2018 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] *2019* for the last quarter of fiscal year [2018] *2019* 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 [2019] *2020*, [$134,847,759,000] *$137,931,797,000,* 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.

Grants to States for Medicaid

Language Analysis

Language Provision	Explanation
For carrying out, except as otherwise provided, titles XI and XIX of the Social Security Act, *[$284,798,384,000] $276,236,212,000*, to remain available until expended.	This section provides a no-year appropriation for Medicaid for FY 2019. This appropriation is in addition to the advance appropriation of $134.8 billion for the first quarter of FY 2019. 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, [2018 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] 2019* for the last quarter of fiscal year *[2018] 2019*, 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 2019 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.

Grants to States for 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 [2019] *2020, [$134,847,759,000] $137,931,797,000,* to remain available until expended.	This section provides an advance appropriation for the first quarter of FY 2020 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 2020 is not enacted by October 1, 2019. "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.

Grants to States for Medicaid
Amounts Available for Obligation
(Dollars in Thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Mandatory Appropriation:				
Advanced Appropriation.....	$115,582,502	$125,219,452	$134,847,759	$9,628,307
Annual Appropriation.....	$262,003,967	$284,798,384	$276,236,212	($8,562,172)
Indefinite Annual Appropriation.....	$11,763,291	$0	$0	$0
Subtotal, Mandatory Appropriation	$389,349,760	$410,017,836	$411,083,971	$1,066,135
Offsetting Collections from Federal Sources:				
Collection Authority: Medicare Part D…	$0	$3,000	$4,000	$1,000
Collection Authority: Medicare Part B…	$941,000	$1,000,000	$1,054,000	$54,000
Subtotal, Collections Authority	$941,000	$1,003,000	$1,058,000	$55,000
Total New Budget Authority	**$390,290,760**	**$411,020,836**	**$412,141,971**	**$1,121,135**
Unobligated Balances:				
Unobligated balance, Start of year…….	$412,851	$309,808	$11,546,424	$11,236,616
Unobligated balance, Recoveries of Prior Year Obligations……..	$31,650,863	$33,869,000	$36,673,844	$2,804,844
Subtotal, Unobligated Balances.....	$32,063,714	$34,178,808	$48,220,268	$14,041,460
Total Amounts Available for Obligations	**$422,354,474**	**$445,199,644**	**$460,362,238**	**$15,162,594**
Gross Obligations.....	($422,044,666)	($433,653,220)	($460,362,238)	($26,709,019)
Unobligated balance, end of year……..	$309,808	$11,546,424	$0	($11,546,424)
Net Obligations:				
Gross Obligations.....	$422,044,666	$433,653,220	$460,362,238	$26,709,019
Actual Collections: Medicare Part D…..	$0	($3,000)	($4,000)	($1,000)
Actual Collections: Medicare Part B…..	($652,493)	($1,000,000)	($1,054,000)	($54,000)
Unobligated balance, Start of year.....	($412,851)	($309,808)	($11,546,424)	($11,236,616)
Unobligated balance, Recoveries of Unpaid Obligations.....	($34,566,891)	($33,869,000)	($36,673,844)	($2,804,844)
Total Net Obligations	**$386,412,431**	**$398,471,412**	**$411,083,971**	**$12,612,559**

Grants to States for Medicaid
Appropriations History Table

Fiscal Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation	
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	1/
2012	$270,724,399,000	------	------	$270,724,399,000	
2013	$269,405,279,000	------	------	$269,405,279,000	2/
2014	$284,208,616,000	------	------	$305,843,467,000	3/
2015	$338,081,239,000	------	------	$368,405,940,000	4/
2016	$356,817,550,000	------	------	$366,672,257,000	5/
2017	$377,586,469,000	------	------	$389,349,760,000	6/
2018	$410,017,836,000	------	------	------	
2019	$411,083,971,000	------	------	------	

1/ Full-year continuing resolution appropriation provided indefinite funding authority of $171.6 billion for FY 2011.
2/ Full-year continuing resolution appropriation provided indefinite funding authority of $158.8 billion for FY 2013.
3/ Includes $21.6 billion under indefinite funding authority obligated during FY 2014.
4/ Includes $16.8 billion under indefinite funding authority obligated during FY 2015.
5/ Includes $9.9 billion under indefinite funding authority obligated during FY 2016.
6/ Includes $11.8 billion in indefinite funding authority estimated to be obligated during FY 2017.

Grants to States for Medicaid
Budget Authority by Object
(Dollars in Thousands)

	2018 Estimate	2019 Estimate	Increase or Decrease
CMS - Grants to States			
Grants to States, Subsidies and Contributions	$406,619,928	$407,415,510	$795,582
CDC - Vaccines For Children			
Grants/Cooperative Agreements and Research Contracts, Utilities, Rent, and Program Support Activities, Intramural Research and Program Assistance	$4,400,908	$4,726,461	$325,553
Total Budget Authority	**$411,020,836**	**$412,141,971**	**$1,121,135**

Grants to States for Medicaid
Budget Authority by Activity
(Dollars in Thousands)

	2017 Final	2018 Annualized CR	2019 President's Budget	FY 2019 +/- FY 2018
1. Benefits				
Medical Assistance Payments.....	$362,327,399	$347,983,280	$345,819,788	($2,163,492)
Benefits Due and Payable (IBNR)……..	$0	$36,673,844	$39,062,837	$2,388,994
Qualified Individuals	$941,000	$1,000,000	$1,054,000	$54,000
Vaccines for Children.....	$4,427,184	$4,400,908	$4,726,461	$325,553
Subtotal, Benefits	**$367,695,583**	**$390,058,031**	**$390,663,086**	**$605,055**
2. State Administration				
State and Local Administration.....	$19,940,361	$19,298,238	$19,818,400	$520,162
State Low Income Determinations……..	$0	$3,000	$4,000	$1,000
HIT- Incentives.....	$1,703,603	$457,596	$272,199	($85,397)
HIT- Administration.....	$429,148	$636,571	$795,971	$159,400
State Survey and Certification.....	$268,037	$297,400	$308,315	$10,915
State Fraud Control Units.....	$254,028	$270,000	$280,000	$10,000
Subtotal, State Administration	**$22,595,177**	**$20,962,805**	**$21,478,885**	**$516,080**
Total Mandatory Appropriation	$389,349,760	$410,017,836	$411,083,971	$1,066,135
Total Offsetting Collections Authority	$941,000	$1,003,000	$1,058,000	$55,000
Total, Budget Authority	**$390,290,760**	**$411,020,836**	**$412,141,971**	**$1,121,135**

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

FY 2018 Authorization - Public Laws 115-31, 115-56, 115-90, 115-96

Allocation Method - Formula Grants

Grants to States for Medicaid
Summary of Changes
(Dollars in Thousands)

2019 Mandatory Appropriation Request	$411,083,971
2018 Mandatory Appropriation Request	$410,017,836
Net Change	$1,066,135

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.

In FY 2019, Medicaid will provide critical health coverage that allows individuals to access health care services that may not be affordable otherwise and is estimated to be the primary source of health care for almost 79 million beneficiaries, more than 23 percent of the U.S. population. Additionally, about 10.5 million people are dually eligible, that is, covered by both Medicare and Medicaid.

<u>Vaccines for Children Program</u>

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 (CDC) 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 State 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.

State 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. 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.

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 flexibility.

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 2016 was $108 billion:

- Forty-one statewide health care reform demonstrations in 35 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, Washington and Wisconsin);

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

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

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.

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 50 states in the program.

Medicaid Enrollment

(Person-Years in Millions, excludes U.S. Territories) /1

	FY 2017 Estimate	FY 2018 Estimate	FY 2019 Estimate	FY 2019 +/- FY 2018
Aged	5.8	6.0	6.2	0.2
Disabled	10.6	10.7	10.9	0.2
Adults	27.7	28.2	28.5	0.3
Children	28.2	29.7	32.0	2.3
Total/1	72.4	74.6	77.7	3.1

1/ Totals may not add due to rounding.

Benefit Services

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 $220.2 billion in funding for FY 2019 representing 55.7 percent of the state-submitted benefit estimates for FY 2019. The second largest FY 2019 Medicaid category of service is inpatient hospital services exclusive of disproportionate share hospital payment adjustments. The states have submitted estimates totaling $39 billion for this category in FY 2019. The next largest category of Medicaid services for FY 2019 is institutional alternatives. It is composed of personal care, home health, and home and community-based services. The states have submitted FY 2019 estimates totaling $35.0 billion or 8.9 percent of Medicaid benefits. The next largest category is long term care. It is composed of care provided in nursing facilities and intermediate care facilities for the intellectually disabled ($28.1 billion or 7.1 percent). Together these four benefit service categories for health insurance payments, institutional alternatives, long-term care, and inpatient hospital account for over 81 percent of the state-estimated cost of the Medicaid program for FY 2019. 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 $73 billion or 18.4 percent of the total Medicaid benefits for these other services. For more information regarding spending on Medicaid benefit services, please see the most recent Medicaid actuarial report which can be found at https://www.medicaid.gov/medicaid/financing-and-reimbursement/actuarial-report/index.html.

Budget Request

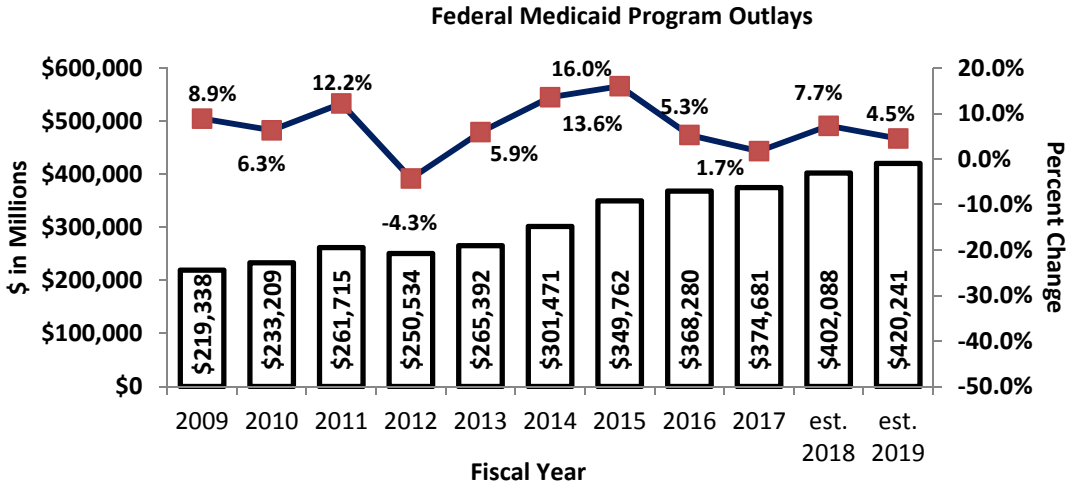
CMS estimates its FY 2019 appropriation request for Grants to States for Medicaid is $411.1 billion, an increase of $1.1 billion relative to the FY 2018 level of $410.0 billion. This appropriation is composed of $134.8 billion in authorized advance appropriation for FY 2019 and a remaining appropriation of $276.2 billion for FY 2019.

Medical Assistance Payments (MAP)

For FY 2019, the Federal share of medical assistance payments was estimated by the CMS' Office of the Actuary and adjusted for recent legislation, financial management reviews and expenditures Incurred but not Reported (IBNR). After these adjustments, the FY 2019 Federal share of medical assistance payment obligations are estimated to be $434.2 billion.

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 2019. 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' Office of the Actuary (OACT) developed the MAP estimate for FY 2019. Using the last three quarters of FY 2017 state-reported expenditures as a base, expenditures for FY 2018 and FY 2019 were projected by applying factors to account for assumed growth rates in Medicaid caseloads, utilization of services, and payment rates. These growth rates were derived mainly from economic assumptions promulgated by the Office of Management and Budget and demographic trends in Medicaid enrollment. CMS' OACT also incorporated adjustments to the Medicaid benefit estimates based on their analysis of the state-submitted estimates.



Legislative and Regulatory Impacts to the MAP Actuarial Estimates

In addition to adjusting the state estimates, CMS' OACT also estimates the impact of recent legislative and regulatory actions. Below is a list of recent legislation that made an impact to the current actuarial baseline estimate.
Recent Legislative Actions

- Equity in Government Compensation Act of 2015 (P.L. 114-113)
- 21st Century Cures Act (P.L. 114-255)
- National Defense Authorization Act for Fiscal Year 2018 (P.L. 115-91)

Recent Regulatory and Sub-Regulatory Actions

- Medicaid and CHIP Managed Care Rule (CMS-2390-F)
- SMD# 17-003: Strategies to address the opioid epidemic
- SMD# 17-005: Phase-out of expenditure authority for Designated State Health Programs (DSHP) in Section 1115 demonstrations
- SMD# 18-002: Opportunities to promote work and community engagement among Medicaid beneficiaries

Administrative Proposals

- Require minimum standards in Medicaid state drug utilization review programs
- Establish unique identifiers for personal care service attendants
- Improve data collection on supplemental payments
- Make Medicaid Non-Emergency Medical Transportation optional

Benefits Due and Payable (Incurred but not Reported)

The FY 2019 estimate of $39.0 billion represents the entire liability for Medicaid medical services incurred but not paid from October 1, 2018 to September 30, 2019. The Medicaid liability is developed from estimates received from the states. The Medicaid estimate represents the net of unreported expenses incurred by the state 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.

Other Adjustments to the Actuarial Estimates for Medical Assistance Payments

Medicaid Financial Management Reviews
(Estimated FY 2019 savings are $40.0 million)

Financial management (FM) reviews conducted by CMS are expected to produce additional savings of $40.0 million in FY 2019. 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.

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 influenza* 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. CDC estimates that among children born during 1994–2016, vaccination will prevent an estimated 381 million illnesses, 24.5 million hospitalizations, and 855,000 early deaths over the course of their lifetimes, at a net savings of $360 billion in direct costs and $1.65 trillion in total societal costs.[1]

The current FY 2019 estimate for the VFC program is $4.7 billion, which is $325.6 million above the FY 2018 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 2019, based on recent actual data and the November 2017 state estimates, CMS estimated the federal share of state and local administration costs to be $21.5 billion. This estimate is composed of $19.8 billion for Medicaid state and local administration and $1.1 billion for the costs of the health information technology provisions in section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA). The estimate also includes $588.3 million in additional funding for Medicaid state survey and certification and state Medicaid fraud control units.

In November 2017, the states estimated the federal share of state and local administration outlays to be $18.8 billion for FY 2019. 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 2019 state-submitted estimates of $18.8 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).

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

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 2019 is to ensure that Medicaid beneficiaries are receiving quality care in a safe environment. The current FY 2019 estimate for Medicaid state survey and certification is $308.3 million. This represents an increase of over $10.9 million above the current FY 2018 estimate of $297.4 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 2019, state Medicaid fraud control unit operations are currently estimated to require $280.0 million in federal matching funds. This represents an increase of $10.0 million over the estimated FY 2018 funding level of $270.0 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 2017, states reported $1.8 billion in expected recoveries for both civil and criminal cases handled by the 50 MFCUs.

FY 2019 MANDATORY STATE/FORMULA GRANTS[1,2]

(Dollars in Thousands)

CFDA No/Program Name: 93.778 Medical Assistance Program

State/Territory	FY 2017 Obligations	FY 2018 Estimate	FY 2019 Estimate	Difference +/- 2019
Alabama	$4,068,128	$4,391,003	$4,599,057	$208,054
Alaska	$1,437,360	$1,660,904	$1,704,574	$43,670
Arizona	$9,168,872	$9,936,912	$10,417,087	$480,175
Arkansas	$3,994,695	$5,537,079	$5,592,450	$55,371
California[3]	$60,223,130	$67,138,967	$64,719,285	-$2,419,682
Colorado[3]	$5,243,127	$5,481,265	$5,562,128	$80,863
Connecticut	$4,581,203	$5,143,255	$5,154,927	$11,672
Delaware	$1,400,746	$1,498,157	$1,552,379	$54,222
Dist. Of Col.	$2,175,606	$2,334,974	$2,434,888	$99,914
Florida	$14,628,664	$16,082,299	$15,397,518	-$684,781
Georgia	$7,251,905	$7,984,219	$8,294,427	$310,208
Hawaii	$1,609,715	$1,591,533	$1,514,318	-$77,215
Idaho	$1,372,954	$1,546,165	$1,657,080	$110,915
Illinois	$9,950,384	$12,651,389	$10,980,454	-$1,670,935
Indiana	$8,370,623	$9,638,767	$9,592,409	-$46,358
Iowa	$2,673,861	$2,972,410	$3,061,275	$88,865
Kansas	$1,955,720	$2,037,617	$2,269,341	$231,724
Kentucky	$7,584,554	$7,909,569	$5,560,974	-$2,348,595
Louisiana	$7,939,911	$8,984,463	$9,336,121	$351,658
Maine	$1,777,811	$1,811,222	$1,787,753	-$23,469
Maryland	$7,065,053	$7,280,782	$7,295,261	$14,479
Massachusetts	$9,978,555	$10,941,833	$10,017,259	-$924,574
Michigan	$12,568,266	$13,312,472	$13,871,596	$559,124
Minnesota	$6,930,018	$7,955,963	$8,369,470	$413,507
Mississippi	$4,227,454	$4,403,344	$4,643,092	$239,748
Missouri	$6,678,010	$7,766,641	$7,847,240	$80,599
Montana	$1,482,546	$1,569,406	$1,629,704	$60,298
Nebraska	$1,145,760	$1,263,492	$1,272,138	$8,646
Nevada[3]	$2,868,938	$2,908,779	$3,052,796	$144,017
New Hampshire	$1,297,338	$1,323,354	$1,391,204	$67,850
New Jersey	$9,399,266	$9,999,183	$10,711,468	$712,285
New Mexico	$3,858,468	$4,313,744	$4,440,315	$126,571
New York	$38,531,701	$45,163,703	$46,524,750	$1,361,047
North Carolina	$9,411,458	$9,800,796	$9,560,745	-$240,051
North Dakota[3]	$940,769	$941,778	$876,301	-$65,477
Ohio	$16,478,815	$16,764,297	$17,637,034	$872,737
Oklahoma	$2,983,507	$3,013,817	$3,222,874	$209,057
Oregon	$6,514,146	$7,681,487	$7,770,054	$88,567
Pennsylvania	$17,742,316	$19,499,035	$21,194,279	$1,695,244
Rhode Island	$1,664,801	$1,807,675	$1,853,704	$46,029
South Carolina	$4,466,748	$4,595,111	$4,556,651	-$38,460
South Dakota	$531,828	$583,350	$640,309	$56,959
Tennessee	$6,298,350	$7,027,764	$7,365,781	$338,017

State/Territory	FY 2017 Obligations	FY 2018 Estimate	FY 2019 Estimate	Difference +/- 2019
Texas	$21,078,511	$22,678,795	$20,809,152	-$1,869,643
Utah	$1,809,543	$1,863,444	$1,856,317	-$7,127
Vermont	$1,040,439	$1,121,635	$999,434	-$122,201
Virginia	$4,811,942	$5,378,931	$5,427,984	$49,053
Washington	$7,997,273	$8,169,896	$8,414,997	$245,101
West Virginia	$3,277,360	$3,408,420	$3,507,449	$99,029
Wisconsin	$5,033,472	$5,295,825	$5,657,814	$361,989
Wyoming	$343,345	$362,027	$371,141	$9,114
Subtotal	**$375,864,968**	**$414,528,948**	**$413,976,758**	**-$552,190**
Amer. Samoa	$19,402	$18,812	$18,812	$0
Guam	$53,786	$54,038	$54,037	-$1
N. Mariana Islands[4]	$17,018	$19,967	$13,813	-$6,154
Puerto Rico[4]	$1,631,538	$824,100	$359,200	-$464,900
Virgin Islands	$46,751	$108,668	$83,396	-$25,272
Subtotal	**$1,768,495**	**$1,025,585**	**$529,258**	**-$496,327**
Total States and Territories	**$377,633,463**	**$415,554,533**	**$414,506,016**	**-$1,048,517**
Survey & Certification	$268,037	$297,400	$308,315	$10,915
Fraud Control Units	$254,028	$270,000	$280,000	$10,000
Vaccines For Children	$4,427,184	$4,400,908	$4,726,461	$325,553
Medicare Part B	$941,000	$1,000,000	$1,054,000	$54,000
Incurred But Not Reported	$0	$36,673,844	$39,062,837	$2,388,994
Undistributed	$38,520,953	-$26,243,465	-$7,784,391	$18,459,074
Total Resources	**$422,044,666**	**$431,953,220**	**$452,153,238**	**$20,200,019**

[1]The obligation estimates reflect the state and territory reported estimates of Medicaid needs available to CMS in November 2017.

[2]Represents proposed law baseline projections of obligations

[3]The FY 2017 actuals for CA, CO, NV, and ND have not been certified by their respective states. The amounts displayed for these states are the FY 2017 estimates provided in the FY 2018 President's Budget.

[4]The FY 2018 and FY 2019 estimates for Puerto Rico and the Commonwealth of the Northern Mariana Islands have been adjusted to account for the limitation on total Medicaid payments to each territory as defined by 42 U.S.C. 1308 as well as the additional funding for the Territories provided under 42 U.S.C. 18043. [Note: The limitation on Medicaid payments to territories under 42 U.S.C. 1308 is not yet available for FY 2019, so the FY 2019 column assumes the FY 2018 limitation applies.]

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, [$323,497,300,000] $378,343,800,000.

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.	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 2017 Final	FY 2018 Estimate	FY 2019 President's Budget	FY 2019 +/- FY 2018
Appropriation: Annual	$299,187,700	$323,497,300	$378,343,800	$54,846,500
Indefinite Annual Appropriation, for SMI Premium Match	$22,000,000	$17,100,000	$0	($17,100,000)
Indefinite Annual Appropriation, for Part D Benefits	$7,000,000	$12,000,000	$0	($12,000,000)
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	$328,187,700	$352,597,300	$378,343,800	$25,746,500

Payments to the Health Care Trust Funds
Summary of Changes

FY 2018 Estimate

Total Budget Authority - $352,597,300,000

FY 2019 President's Budget

Total Budget Authority - $378,343,800,000

Net Change, Total Appropriation - $25,746,500,000

Changes	FY 2017 Final	FY 2018 Estimate	FY 2019 President's Budget	FY 2019 +/- FY 2018
Federal Payment for Supplementary Medical Insurance (SMI)	$214,944,000,000	$245,396,000,000	$284,288,300,000	$38,892,300,000
Indefinite Annual Appropriation, SMI	$22,000,000,000	$17,100,000,000	$0	($17,100,000,000)
Hospital Insurance for Uninsured Federal Annuitants	$147,000,000	$132,000,000	$127,000,000	($5,000,000)
Program Management Administrative Expenses	$877,500,000	$1,104,000,000	$898,000,000	($206,000,000)
General Revenue for Part D (Drug) Benefit	$82,512,000,000	$76,133,000,000	$92,070,000,000	$15,937,000,000
Indefinite Annual Appropriation, Part D Benefits	$7,000,000,000	$12,000,000,000	$0	($12,000,000,000)
General Revenue for Part D Federal Administration	$405,000,000	$422,000,000	$642,000,000	$220,000,000
Part D: State Low-Income Determination	$3,200,000	$3,300,000	$3,500,000	$200,000
Reimbursement for HCFAC	$299,000,000	$307,000,000	$315,000,000	$8,000,000
Net Change	$328,187,700,000	$352,597,300,000	$378,343,800,000	$25,746,500,000

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

	FY 2017 Final	FY 2018 Estimate	FY 2019 President's Budget	FY 2019 +/- FY 2018
Supplementary Medical Insurance	$214,944,000	$245,396,000	$284,288,300	$38,892,300
Indefinite Annual Appropriation, SMI	$22,000,000	$17,100,000	$0	($17,100,000)
Hospital Insurance for Uninsured Federal Annuitants	$147,000	$132,000	$127,000	($5,000)
Program Management Administrative Expenses	$877,500	$1,104,000	$898,000	($206,000)
General Revenue for Part D Benefit	$82,512,000	$76,133,000	$92,070,000	$15,937,000
Indefinite Annual Appropriation, Part D Benefits	$7,000,000	$12,000,000	$0	($12,000,000)
General Revenue for Part D Federal Administration	$405,000	$422,000	$642,000	$220,000
Part D: State Low-Income Determination	$3,200	$3,300	$3,500	$200
Reimbursement for HCFAC	$299,000	$307,000	$315,000	$8,000
Total Budget Authority	$328,187,700	$352,597,300	$378,343,800	$25,746,500

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

	FY 2017 Final	FY 2018 Estimate	FY 2019 President's Budget	FY 2019 +/- FY 2018
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)	$328,187,700	$352,597,300	$378,343,800	$25,746,500
Total Budget Authority	$328,187,700	$352,597,300	$378,343,800	$25,746,500

Annual Budget Authority by Activity

(Dollars in Thousands)

	FY 2017 Final	FY 2018 Estimate	FY 2019 President's Budget	FY 2019 +/- FY 2018
Budget Authority	$328,187,700	$352,597,300	$378,343,800	$25,746,500

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 to 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:

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 2019 President's Budget request of $284.3 billion, is a net increase of $38.9 billion over the FY 2018 estimated amount of $245.4 billion. The cost of the federal match continues to rise from year to year because of beneficiary population and program cost growth.

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 2019 President's Budget request of $127.0 million for Hospital Insurance for Uninsured Federal Annuitants is a net decrease of $5.0 million from the FY 2018 estimated amount of $132.0 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 2019 President's Budget request of $898.0 million to reimburse the HI Trust Fund for Program Management administrative expenses not attributable to Medicare trust fund activities is a net decrease of $206.0 million from the FY 2018 estimated amount of $1.1 billion.

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. Beginning in FY 2006, 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.

The FY 2019 President's Budget request of $92.1 billion for General Revenue for Part D (Benefits) is a net increase of $15.9 billion over the FY 2018 estimated amount of $76.1 billion. The benefit contribution increases when the Part D Prescription Drug program population and cost increase.

The FY 2019 President's Budget request of $642.0 million for General Revenue for Part D Federal Administration is a net increase of $220.0 million above the FY 2018 estimated amount of $422.0 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 2019 President's Budget request for General Revenue for Part D State Eligibility Determinations is $3.5 million. This reflects a net increase of $200,000 over the FY 2018 estimated amount of $3.3 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 2019 President's Budget request of $315.0 million for reimbursement of HCFAC is a net increase of $8.0 million above the FY 2018 estimated amount of $307.0 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 2019 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.

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	$328,187,700,000
FY 2018	$352,597,300,000

Permanent Budget Authority
(Dollars in Thousands)

	FY 2017 Final	FY 2018 Estimate	FY 2019 President's Budget	FY 2019 +/- FY 2018
Tax on OASDI Benefits	$24,210,000	$27,425,000	$30,239,000	$2,814,000
SECA Tax Credits	$0	$0	$0	$0
HCFAC, FBI	$131,335	$134,920	$147,777	$12,857
HCFAC, Asset Forfeitures	$30,000	$31,000	$31,000	$0
HCFAC, Criminal Fines	$590,000	$630,000	$670,000	$40,000
HCFAC, Civil Penalties and Damages: Administration	$32,000	$32,500	$33,000	$500
Total Budget Authority	$24,993,335	$28,253,420	$31,120,777	$2,867,357

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 2017 Final	FY 2018 Estimate	FY 2019 President's Budget	FY 2019 +/- FY 2018
Grants, subsidies and contributions: Non-Drug	$214,944,000	$245,396,000	$284,288,300	$38,892,300
Indefinite Annual Appropriation	$22,000,000	$17,100,000	$0	($17,100,000)
Grants, subsidies and contributions: Drug	$82,512,000	$76,133,000	$92,070,000	$15,937,000
Indefinite Annual Appropriation, Part D Benefits	$7,000,000	$12,000,000	$0	($12,000,000)
Insurance claims and indemnities	$147,000	$132,000	$127,000	($5,000)
Administrative costs-General Fund Share	$1,581,500	$1,833,000	$1,855,000	$22,000
General Revenue Part D: State Eligibility Determinations	$3,200	$3,300	$3,500	$200
Total Budget Authority	$328,187,700	$352,597,300	$378,343,800	$25,746,500

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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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, [$751,000,000] $770,000,000 to remain available through September 30, [2019] 2020, 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 [$610,391,000] $604,389,000 shall be for the Centers for Medicare and Medicaid Services program integrity activities, of which [$74,246,000] $87,230,000 shall be for the Department of Health and Human Services Office of Inspector General to carry out fraud and abuse activities authorized by section 1817(k)(3) of such Act, and of which [$66,363,000] $78,381,000 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 [2018]2019 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 1985, as amended, and [$434,000,000] $454,000,000 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 Senior Medicare Patrol program to combat health care fraud and abuse from the funds provided to this account.

Note.—A full-year 2018 appropriation for this account was not enacted at the time the budget was prepared; therefore, the budget assumes this account is operating under the Continuing Appropriations Act, 2018 (Division D of P.L. 115-56). The amounts included for 2018 reflect the annualized level provided by the continuing resolution.

Language Analysis

Language Provision	Explanation
In addition to amounts otherwise available for program integrity and program management, [$751,000,000] $770,000,000 to remain available through September 30, [2019] 2020, 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 [$610,391,000] $604,389,000 shall be for the Centers for Medicare and Medicaid Services program integrity activities,	Provides funding for Centers for Medicare and Medicaid Services for program integrity activities.
of which [$74,246,000] $87,230,000 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 [$66,363,000] $78,381,000 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]2019 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 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 through either discretionary or mandatory HCFAC funds.

Health Care Fraud and Abuse Control
(Dollars in Thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Discretionary				
CMS Program Integrity	$569,068	$569,068	$604,389	$35,321
HHS/OIG	$82,132	$82,132	$87,230	$5,098
DOJ	$73,800	$73,800	$78,381	$4,581
Subtotal, Discretionary	$725,000	$725,000	$770,000	$45,000
Mandatory				
CMS Program Integrity	$859,239	$877,244	$916,827	$39,583
FBI	$131,335	$134,525	$147,200	$12,675
HHS/OIG	$185,906	$190,389	$208,290	$17,901
DOJ Wedge	$58,045	$59,445	$65,033	$5,588
HHS Wedge	$35,557	$36,414	$39,838	$3,424
Subtotal, Mandatory	$1,270,082	$1,298,017	$1,377,188	$79,171
Total Funding	$1,995,082	$2,023,017	$2,147,188	$124,171

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

FY 2017 Authorization – Public Law 104-191 and Public Law 115-31

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 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. If consistent, additional funding for program integrity is provided, billions of dollars in savings over the next ten years, from curtailing improper payments can be realized.

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 HHS/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. Together, CMS' enhanced provider screening and fraud prevention endeavors, the HHS/OIG's investigative, audit, evaluation, and data analytic work, and DOJ's investigative and prosecutorial activities and tougher sentencing guidelines, 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 2017 (P.L. 115-31) allow HHS and DOJ to enhance existing, successful health care fraud prevention and law enforcement efforts by investing more in proven anti-fraud and abuse strategies. These efforts will continue into FY 2019 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 CMS to focus on the priorities set forth by the agency to address improper payment rates, manage provider screening and enrollment, empower states to build an internal capacity to conduct Medicaid program integrity activities, as well as assists in reducing provider burden to allow providers to focus on providing high quality healthcare.

CMS is committed to fighting fraud, waste, and abuse in the Medicaid program by improving both federal oversight and support for program integrity activities for the state Medicaid programs. These activities enhance the federal-state partnership and can be found outlined in the State Grants and Demonstrations chapter of this document.

CMS is also 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.

CMS has been working with its private and public partners to build better relationships and increase coordination. The Healthcare Fraud Prevention Partnership (HFPP), 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 arenas. HFPP partners have voluntarily reported nearly $329 million in savings resulting from their participation in the HFPP to date.

Additional funding in recent years has also allowed CMS to develop and implement activities to prevent and fight fraud such as the following:

- Sharing of Information about Terminated Providers – CMS continues to support the exchange of information between Medicare and State Medicaid and Children's Health Insurance Program (CHIP) programs regarding providers and suppliers terminated for cause from those programs. CMS is also working 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 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 2019, 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 2015	$1,944,738,000
FY 2016	$1,959,858,000
FY 2017	$1,995,082,000
FY 2018 Annualized CR	$2,023,017,000
FY 2019 President's Budget	$2,147,188,000

Budget Request

The FY 2019 budget proposes to continue funding the HCFAC program through both mandatory and discretionary funding streams. The total FY 2019 request is $2.1 billion, $124.2 million above the FY 2018 Annualized CR Level. The FY 2019 discretionary request is $770.0 million, $45.0 million above the FY 2018 Annualized CR Level, and in line with the incremental increase included in the 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 2019, 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 2019 CMS allocation of the discretionary HCFAC request is $604.4 million. The request 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.

In FY 2019, CMS will focus its program integrity efforts through several initiatives, which are discussed in further detail throughout this chapter. Through these initiatives, CMS will balance program integrity activities aimed to protect beneficiaries and the Trust Funds while minimizing provider burden; integrate, analyze, and share data to inform decision making and reduce stakeholder burden; share best practices with states and allow flexibility in program integrity approaches while improving accountability in Medicaid programs. Furthermore, CMS will continue work in Medicare Part C and Part D, while clarifying and simplifying program requirements through collaboration, transparency, outreach and education.

I. Balance Program Integrity Initiatives Aimed to Protect Beneficiaries and the Trust Funds while Minimizing Provider Burden

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 HHS/OIG, DOJ, and the 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 Administration and Support: This funding provides support services for IT infrastructure, data communications, security, and administrative services. The FY 2019 request includes funding 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 to identify high, medium and low provider and supplier risk; to define the strategic approach and analytic framework for individual provider and supplier risk scoring; develop and validate methodologies for individual risk scoring for different provider and supplier types and services; establish a concept of operations and roadmap to incorporate these methodologies into CMS operations; and streamline more effective use of its contractor resources to gain efficiencies and achieve better outcomes. In FY 2019, 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 increase provider compliance while decreasing provider burden. 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 program 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 even more flexible than before to allow adaptability for the growing complexity to combat fraud, waste and abuse. In FY 2019, 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.

During FY 2016, HHS took administrative action against 1,044 providers and suppliers, resulting in an estimated $527.06 million in identified savings. These FY 2016 savings represent a $6.34 to $1 return on investment. This return on investment calculation includes costs associated with both FPS 1.0 and the development of FPS 2.0, which became operational in FY 2017. If the FPS 2.0 costs are excluded from the calculation, the ROI would be $8.20 to $1. Simultaneously, the FPS also generated leads for 476 new investigations and augmented information for 212 ongoing investigations. HHS will report FY 2017 savings from the FPS in the FY 2018 Agency Financial Report.

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. In FY 2019, CMS aims to expand its capacity to perform program integrity (PI) initiatives to identify fraud, waste, and abuse in the Medicaid program through the use of T-MSIS data. The primary purpose of these efforts is to identify and stop illegitimate payments impacting improper payment rates. In FY 2018 and FY 2019, 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 HHS/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 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 2019, One PI will continue to add Medicaid data, enhance 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. 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: Benefit Integrity activities deter and detect Medicare and Medicaid fraud through concerted efforts with CMS, HHS/OIG, DOJ, and other CMS partners. The Benefit Integrity funding is directed to the Unified Program Integrity Contractors (UPICs) that operate in various geographic jurisdictions throughout the United States. The UPICs consolidated the work of the Zone Program Integrity Contractors (ZPICs), including the Medicare-Medicaid Data Match (Medi-Medi) program, and the audit Medicaid Integrity Contractors (MICs). Streamlining to the UPIC initiative provides benefits that enhance CMS' ability to aggressively combat fraud, waste and abuse by consolidating the separate funding sources into a single contract and allows 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 is an integrated program integrity strategy and is a key to CMS' strategic goal of improving contractor accountability.

The end-to-end process from detection to prosecution of fraudulent activity requires complete coordination between CMS and its contractors and law enforcement partners. CMS and its 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 Midwest UPIC was the first to receive training on the system. In FY 2018 and FY 2019, 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 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 expand the use of prior authorization in the Medicare FFS program for durable medical equipment prosthetics orthotics and supplies (DMEPOS) items and to explore its use in other high improper payment rate areas through models and demonstrations as appropriate. The use of prior authorization 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 a high 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 contributed to the significant decreases to the error rate for these inpatient claims. CMS is also using this probe and educate process for home health claims and plans to continue this effort as appropriate. CMS has expanded its probe and educate process nationwide to allow MACs to perform targeted probe and educate on a wide variety of services. Whereas probe and educate included reviews and education of all providers, targeted probe and educate improves the process by only including providers who may need additional review and education.

In FY 2019, 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 and 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 Requirements Simplification project and is one that CMS will continue in FY 2019 in an agency wide effort to reduce documentation requirements, appeals, and provider burden where possible. 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 final Medicare Part A reimbursement 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 2019, CMS plans to continue efforts to increase training at the MACs and has already initiated design sessions on cost report risk assessment strategies within CMS. A risk assessment process would entail an independent body to analyze the cost reports and to determine the dollars at risk. This assessment is based on CMS' priorities to focus efforts and resources to the areas that pose the highest risk to the trust fund.

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. CMS plans to continue improvements to the Coordination of Benefits and Recovery (COB&R) systems in FY 2019 to enhance customer service through a consolidated database, expanded repayment capabilities and additional 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 helps identify billing patterns that might be indicative of potential fraud, waste, and abuse that 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. Currently, there are 18 states participating in the Medi-Medi program.

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) Part A and Part B claims. QICs were able to participate as a party in approximately 2,500 Administrative Law Judge (ALJ) cases in FY 2016 and approximately 2,800 in FY 2017. 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.). Based on experience, CMS anticipates that by invoking party status in hearings, the QICs will reduce the ALJ reversal rate and lower Medicare Trust Fund expenditures. FY 2019 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 2017 required the SMP program to by fully funded from the HCFAC discretionary account. The FY 2019 Budget continues to support ACL's SMP program through HCFAC and requests 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).

II. Integrate, Analyze, and Share Data to Inform Decision Making and Reduce Stakeholder Burden

CMS will expand the ability to use data analytics to protect Medicare and Medicaid from inappropriate billing. CMS will also 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 system 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 2019, the APS system will 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.

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 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 online Medicare enrollment from the estimated FY 2018 level of 43 percent to approximately 47 percent by the end of FY 2019. In FY 2019, development of the new version of PECOS will continue and 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 2019, CMS will continue its efforts to integrate PECOS with APS. 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 alternative payment 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. Share Best Practices with States and Allow Flexibility in Program Integrity Approaches while Improving Accountability in Medicaid Programs

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 2019, 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. As a result of modular certification authority granted in the final rule CMS-2392-F, CMS is receiving a significantly increased amount of certification requests from states for various modules, as well as technical assistance requests during the certification lifecycle, which require support under MES. This includes independent technical assistance for IT and policy requirements, including monitoring and oversight, working with state-specific system requirements, and IT system builds and associated interfaces for all states and the territories. In FY 2017, 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 (MMIS). One such effort includes the development of an open source provider enrollment and screening module that can 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 2017 and FY 2018, 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). In FY 2019, MACBIS funding will again be used for these activities, supporting CMS efforts to collect program data and link it to operations data and improving CMS's ability to conduct program integrity oversight and monitoring.

For the first system enhancement, in FY 2017 CMS continued work on the Medicaid and CHIP Program (MACPro) Portal. The MACPro system allows CMS and states to collaborate online to process State Plan Amendments (SPA), waivers, Quality Measure reports, 1115 waivers and demonstrations, advance planning documents, and other initiatives. Through MACPro, CMS implemented Quality Measures for Adults, Children, Maternal Infants, Health Homes and the annual reporting for two Medicaid authorities, including Health Home, Medicaid Eligibility and Administration 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 health home SPAs and adult and child quality measures will be able to be linked with operational data that will strengthen CMS's Medicaid and CHIP data analytic capabilities for improved program monitoring and program integrity oversight.

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 program integrity oversight, program monitoring, research, evaluation, and investigation. CMS completed the portion of the T-MSIS system build necessary to accept the submission of all Medicaid and CHIP agencies enrollment, eligibility, claims, and encounter data. The vast majority of states are now "live" and submitting T-MSIS data. As of January 2018, there are 50 states and 1 CHIP agency in production with T-MSIS. CMS expects the remaining states will be submitting in T-MSIS production file format starting in early 2018. 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. CMS is coding T-MSIS Analytic Files (TAF) that will be research-ready files for use by CMS, states and researchers to conduct more timely analysis and oversight of the Medicaid and CHIP programs. Additionally, with nearly all states now submitting T-MSIS data, the focus has shifted to monitoring the quality of state submissions. As part of this monitoring effort, CMS is providing one-on-one technical assistance with each post-production state. CMS has also prioritized 12 top priority data quality areas for initial improvement with all states. Through this one-on-one state technical assistance effort, CMS reviews a state's data quality issues in these 12 areas, then works with the state on addressing them. CMS plans to expand its data quality monitoring review to be more comprehensive in the spring of 2018.

In addition to MACPro and T-MSIS, CMS plans to strengthen oversight of the Medicaid Drug Programs by enhancing the current redesign of the outdated drug rebate and the Federal Upper Limit (FUL) system, as well as automating the Branded Prescription Drug program (BPD) that CMS Medicaid uses to calculate sales fees and receive

disputes on those fees, and automating the Medicaid Drug Rebate program's Dispute Resolution Program (DRP). This redesign will combine three individual systems (i.e., the existing Medicaid Drug Rebate and Drug Data Reporting for Medicaid system and the obsolete FUL system) into one, and will also incorporate other parts of the Medicaid Drug Programs, including dispute resolution and Drug Utilization Review. The redesign project is currently underway and is in early development stages with a targeted implementation of late 2018.

In FY 2019, 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.

Medicaid Section 1115 Demonstrations Financial and Performance Monitoring, Oversight, 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. CMS has been able 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 and FY 2019, CMS will use the business requirements developed in FY 2017 to create IT capacity for tracking site visits and generating reports to inform more robust monitoring and oversight of section 1115 demonstrations.

The FY 2019 request will allow CMS to target our program and fiscal monitoring priorities to develop a more meaningful and efficient approach to the conduct of that monitoring and oversight to improve program integrity, and use the findings to support corrective action and improvement in states' demonstrations.

CMS will continue to develop additional business requirements and build the IT capacity to support a more robust, integrated monitoring of section 1115 demonstrations. This work will derive from business re-engineering work that CMS is currently undertaking to create standard operating procedures and integrated workflows related to oversight and monitoring of section 1115 demonstrations. The business requirements, tools, training, and IT capacity will all support the robust approach to oversight and monitoring to ensure program integrity of the demonstrations. In FY 2019, this project will provide a phased in approach to design, develop, implement, and update a more targeted and risk-based federal assessment of program and financial performance under the 1115 waiver demonstrations including:

- Develop, update and maintain monitoring for key priorities such as fiscal integrity, access to and quality of care, and grievances and appeals
- Develop and update state training materials on protocols, which will cover measurement and approach to oversight, roles and responsibilities, and documentation
- Transition states to standardized metric sets for reporting purposes to improve the data analysis that CMS can perform, as well as to implement a standardized budget neutrality tool that will support analyses of the financial integrity of section 1115 demonstrations

CMS is developing the Medicaid and CHIP (MAC) Scorecard Initiative to provide greater public transparency about Medicaid and CHIP program administration and outcomes. The MAC Scorecard Initiative focuses on publicly reporting data in three areas: state health system performance, state administrative accountability, and federal administrative accountability. Over time, additional data collection, improved measures, and the monitoring of performance measures in the MAC Scorecard Initiative will help state and federal officials drive improvements and increase accountability in health outcomes, program administration, and financial oversight. As part of a long-term effort to re-engineer activities that support the MAC Scorecard Initiative, CMS plans to leverage HCFAC funding to embark on efforts to build an accountability infrastructure, including Section 1115 Demonstrations modernizing monitoring and oversight activities, such as enhanced reviews of compliance with program requirements, additional assessments of system performance, and improved financial oversight. HCFAC funding will be used to support the program integrity aspects of this work.

The Upper Payment Limit-Disproportionate Share Hospital (UPL/DSH) initiative provides oversight as it relates to state Medicaid financing methods, oversight of Medicaid payment methodologies, and analysis of Medicaid UPL demonstrations and supplemental provider payments, to include Medicaid DSH. In FY 2019, CMS plans to provide technical assistance to states with regard to the collection and analysis of state-reported UPL/DSH data in a standardized format. These activities will benefit the work of the MAC Scorecard Initiative by contributing to an accountability infrastructure that may result in the identification of improper payments and by enhancing CMS's efforts to gauge the efficiency and effectiveness of state plan and DSH supplemental payments at the provider-level.

The Rate Review initiative improves the efficiency and effectiveness of rate setting oversight and financial reporting in the Programs of All-inclusive Care for the Elderly (PACE), and Home & Community Based Services (HCBS) waiver and state plan programs. To support the MAC Scorecard Initiative and improved oversight of state health and welfare assurance activities, CMS will establish suggested HCBS health and welfare performance indicators and develop trend analysis methods to assess fidelity with Scorecard criteria. In FY 2019, CMS plans to conduct site visits with states that have been identified as having promising incident management systems in order to build appropriate performance indicators specific to health and welfare in HCBS that can be included in the Scorecard initiative. CMS also plans to align Survey and Certification health and welfare standards with current HCBS requirements to enhance oversight of state health system performance where appropriate.

IV. Medicare Part C and Part D

CMS is committed to expanding its program integrity activities in capitated, managed care programs in Medicare. CMS and the MEDIC conduct data analyses, audits, and quarterly outlier prescriber reports to help identify the overprescribing of opioids. CMS shares the findings with plan sponsors, and based on the findings, CMS provides education and outreach to plan sponsors. CMS proactively fights fraud and strengthens the Medicare Parts C and D programs by utilizing the Medicare Drug Integrity Contractors, performing plan audits, enhancing data analysis, conducting risk adjustment data validation (RADV), and conducting compliance and enforcement efforts. These efforts aid in the reduction of the error rate.

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 2019, 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 through use of 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. Over 60 HPMS software modules have been developed to collect data and manage a number of MA and Part D plan enrollment and compliance processes, including a training module plan sponsors can access and system support in the submission of data on providers and pharmacies regarding suspected fraud, waste, or abuse activity.

CMS will also 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 fulfillment time frames for beneficiaries' requests for plan materials in alternative formats. 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 the Medicare Plan Finder and produce plan-specific reports for quality improvement.

CMS will 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 Medicare-Medicaid Plan (MMP) demonstrations, including Medicaid providers. CMS will also implement continued enhancements to the redesigned audit functionality in HPMS, including expanding overall reporting and extracting capabilities, further integration of the review protocols for Program for All-

Inclusive Care of the Elderly (PACE) and MMP demonstration programs, and examining how the deeming program fits into the Audit module.

Additionally, CMS plans to focus on improving the quality of supplemental file submissions for formularies. This focus will aim to streamline submission and review processes and reduce burden, where applicable, and to ensure better coordination of supplemental files with the main formulary file. Efforts are also being made to improve the efficiency and speed of critical formulary reports. 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 4,000 plans and 18.9 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 beneficiaries have appropriate access to health and drug services. This includes evaluating their compliance program effectiveness. Program audits are conducted at the parent organization level, as opposed to the contract level. CMS also conducts readiness audits to determine a sponsor's readiness to participate in the MA and Part D programs.

In FY 2019, funding will also 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 analytical support to monitor and measure compliance of Medicare Advantage Organizations (MAOs) and Part D sponsors with federal regulations. This ensures that Medicare beneficiaries have access to information about their health and drug plans, and 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. The goal of CMS' audit program is to ensure that our beneficiaries are receiving the services and medications they need and are authorized to receive under the program. These audits 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 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 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 sixth 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 MA and FFS.

Recently, CMS began collecting Medical Loss Ratio (MLR) data for Part C and Part D, which provides new information about MA organizations and their revenue profile. MLR 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 is refining the methodology for the RADV audits to focus on diagnoses at the highest risk of payment error. CMS intends to implement the new methodology and conduct at least 60 audits using this methodology in FY 2018. For FY 2019, CMS will continue to conduct at least 60 audits and will evaluate the refined methodology to determine whether any additional improvements are required. 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 online 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. Clarify and Simplify Program Requirements through Collaboration, Transparency, Outreach, and Education

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) 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, 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 in 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. In FY 2019, CMS plans to expand the membership, maintain systems, and 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 system infrastructure supports manufacturers, physicians, and teaching hospitals in registration, data submission, and with data review and dispute. The website provides public access of all reported payments or transfers of value made to physicians and teaching hospitals. CMS ensures that each payment is associated with a valid covered recipient (physician or teaching hospital) prior to publication. 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 support a comprehensive, long-term Open Payments strategy to educate stakeholders and users, create program awareness, and improve data integrity and accuracy. This includes educating entities that have failed to report payments and other transfers of value completely, timely, and accurately to the Open Payments program and to implement interventions to ensure the completeness and accuracy of the Open Payments data. CMS also plans to make enhancements to the presentation of the Open Payments data on the public 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.

Improper Payment 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's Health Insurance Program (CHIP) improper payments through its improper payment measurement programs, which include the CERT program, Part C and Part D Error Rate measurement programs, and the Payment Error Rate Measurement (PERM) program. In FY 2019, the CERT and PERM programs will 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 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 2019 FBI budget includes mandatory funding in the amount of $147.2 million, an increase of $12.7 million above the FY 2018 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 healthcare-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 2017, HHS/OIG's Medicare and Medicaid oversight efforts resulted in 881 criminal actions and 826 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 3,244 individuals and entities from participation in Federal health care programs. For FY 2017, 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 nearly $24.4 billion.

HHS/OIG Budget Request

The FY 2019 HHS/OIG budget includes $208.3 million in mandatory funding. The FY 2019 discretionary request is $87.2 million, which represents an increase of $5.1 million above the FY 2018 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 2019 DOJ budget includes $65.0 million in mandatory funding, which is subject to agreement between the Secretary of HHS and the Attorney General. The DOJ discretionary request for FY 2019 is $78.4 million, which represents an increase of $4.6 million above the FY 2018 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:

CMS Exchange Program Integrity: The HCFAC Wedge supports a variety of pilot program integrity efforts in the Health Insurance Exchanges. Specifically, it supports pilot efforts to apply targeted data analytics to agent and broker licensure requirements; to review Exchange 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 HHS/OIG to fund new pilot programs and information technology investments that improve HHS/OIG's ability to conduct oversight of the Medicare and Medicaid programs. These new projects include: enhancing HHS/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 2019 HHS Wedge request includes mandatory funding of $39.8 million, which is an increase of $3.4 million above the FY 2018 Annualized CR level. The HHS Wedge is subject to agreement between the Secretary of HHS and the Attorney General. Funding allocations are determined after HHS and DOJ complete negotiations.

FY 2019 CMS HCFAC Discretionary Table
(Dollars in Thousands)

Project or Activity	FY 2019 CMS Discretionary Request
I. Balance Program Integrity Initiatives Aimed to Protect Beneficiaries and the Trust Fund while Minimizing Provider Burden	
Program Integrity Administration and Support	$14,157
Integrity Continuum	$8,150
Fraud Prevention System	$1,000
Program Integrity Modeling and Analytics	$22,101
One PI Data Analysis	$16,000
Benefits Integrity	$117,217
Medical Review	$33,769
Appeals Initiatives	$4,000
Administration for Community Living Senior Medicare Patrols	$18,000
Total	**$234,394**
II. Integrate, Analyze, and Share Data to Inform Decision Making and Reduce Stakeholder Burden	
Advanced Provider Screening	$28,399
Provider Enrollment Chain Ownership System (PECOS)	$16,000
Total	**$44,399**
III. Share Best Practices with States and Allow Flexibility in Program Integrity Approaches while Improving Accountability in Medicaid Programs	
State Medicaid Agency Access to Data and Support	$32,500
Section 1115 Demonstrations Financial and Performance Monitoring, Oversight, and Outcomes Modernization	$17,278
Total	**$49,778**
IV. Medicare Part C and Part D	
Medicare Drug Integrity Contractor (MEDICs)	$25,000
Part C and D Contract Plan and Oversight	$20,383
Monitoring, Performance Assessment and Surveillance	$69,979
Program Audit	$67,038
Compliance and Enforcement	$16,727
Total	**$199,127**
V. Clarify and Simplify Program Requirements through Collaboration, Transparency, Outreach, and Education	
Provider Outreach and Education	$7,000
Healthcare Fraud Prevention Partnership	$18,691
Open Payments	$6,250
Improper Payment Rate Measurement Activities	$44,750
Total	**$76,691**
HCFAC Summary	
Subtotal Medicare Program Integrity	**$490,743**
Subtotal Medicaid Program Integrity	**$113,646**
Total CMS Program Integrity	**$604,389**

Children's Health Insurance Program

Current Law
(Dollars in Thousands)

	FY 2017 Enacted	FY 2018 Estimate	FY 2019 Estimate	FY 2019 +/- FY2018
State Allotments (ACA P.L. 111-148; P.L. 113-164; MACRA, P.L. 114-10; P.L. 115-96)	$20,400,000	$5,700,000	$5,700,000	$0
CHIP Performance Bonus Payments (P.L. 111-3, P.L. 113-235)	$88,611	$88,611	$0	($88,611)
Child Health Quality Improvement (P.L. 111-3,114-10)	$49,455	$43,562	$23,898	($19,664)
Total Budgetary Resources /1 /2	**$20,538,066**	**$5,832,173**	**$5,723,898**	**($108,275)**
CHIP State Allotment Outlays	$16,206,463	$9,547,876	$5,700,000	($3,847,876)
Performance Bonus Payments Outlays	$7,648	$0	$0	$0
Child Health Quality Improvement Outlays	$5,923	$19,664	$23,898	$4,234
Redistribution Payments /2	$3,884	$3,052,124	$0	$3,052,124
Total Outlays	**$16,223,918**	**$12,619,664**	**$5,723,898**	**($6,895,766)**

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.

2/ Does not reflect the Children's Health Insurance Program (CHIP) funding extension through FY 2027, as the Budget was finalized prior to the enactment of P.L. 115-120 and P.L. 115-123.

Child Enrollment
Contingency Fund
Current Law
(Dollars in Thousands)

	FY 2017 Enacted	FY 2018 Estimate	FY 2019 Estimate	FY 2019 +/- FY 2018
Child Enrollment Contingency Fund, Budget Authority/1 /2	**$6,844,462**	**$1,142,656**	**$1,160,024**	**$17,368**
Temporarily Unavailable /3	($570,000)	($1,160,024)	$0	**$1,160,024**
Transfer to Performance Bonus Fund	($5,705,684)	$0	$0	**$0**
Payments to Shortfall States	$2,382	$0	$0	**$0**
Interest Estimate	$6,259	$17,368	$26,923	**$9,555**
Total Budgetary Resources, end of year	**$572,656**	**$1,160,024**	**$1,186,947**	**$26,923**
Total Outlays	**$27,122**	**$198,000**	**$0**	**($198,000)**

1/ Reflects both carryover resources and deposits into the Fund.

2/ Does not reflect the Children's Health Insurance Program (CHIP) funding extension through FY 2027, as the Budget was finalized prior to the enactment of P.L. 115-120 and P.L. 115-123.

3/ The Consolidated Appropriations Act, 2017 (P.L. 114-223) makes the $570 million temporarily unavailable for obligation in FY 2017 and the Continuing Appropriations Act, 2018 (P.L. 115-56) makes $1.160 billion temporarily unavailable for obligation in FY 2018.

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),
The Continuing Appropriations Act, 2018 (P.L. 115-96),
The HEALTHY KIDS Act, 2018 (P.L. 115-120),
The Bipartisan Budget Act, 2018 (P.L. 115-123).

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.

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 $68.9 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 $40.2 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. On January 22, 2018, Congress passed and the President signed P.L. 115-120, which provides $144.4 billion to extend CHIP funding for six years through FY 2023. On February 9, 2018, the Bipartisan Budget Act (P.L. 115-123) further extended CHIP through FY 2027.

CHIPRA also 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. 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. The Fund receives an appropriation equal to 20 percent of the Sec. 2104(a) CHIP national allotment appropriation under the Social Security Act. Any amounts in excess of the appropriation 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 $6.3 million in interest in FY 2017. To date, three states (Iowa, Michigan, and Tennessee) have qualified for payments from the Contingency Fund.

MACRA (P.L. 114-10) extended the Child Enrollment Contingency Fund authorization through FY 2017. Most recently, P.L. 115-120 extended the Contingency Fund through FY 2023. Then, P.L. 115-123 further extended the Contingency Fund through FY 2027.

Child Health Quality Improvement in Medicaid and CHIP. CHIPRA created section 1139A of the Social Security Act to require 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 in CHIPRA 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. Most recently, P.L. 115-120 provided an additional $90 million for child health quality activities through FY 2023. The Bipartisan Budget Act of 2018 (P.L. 115-123) provided an additional $60 million for these activities through FY 2027.

Medicaid and CHIP quality funding supports the Pediatric Quality Measures Program (PQMP), the CHIPRA Electronic Health Record Program, and CHIPRA Quality Demonstration grants.

CHIPRA Pediatric Quality Measures Program - The CHIPRA Pediatric Quality Measures Program (PQMP) activities include a new CMS and the Agency for Healthcare Research and Quality (AHRQ) 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, and use and implementation of new or enhanced pediatric quality measures (see https://grants.nih.gov/grants/guide/notice-files/NOT-HS-16-002.html). This program, that started in 2016 (see https://www.ahrq.gov/pqmp/grants/current-grantees.html), supports a four-year cooperative grant to six PQMP grantees focused on testing and implementing new pediatric quality measures previously developed by the PQMP Centers of Excellence (COEs) across various Medicaid and CHIP delivery systems. In 2017, CMS and AHRQ initiated the PQMP Learning Collaborative to bring together multi-disciplinary partnership teams to foster and accelerate the work of the PQMP grantees in the testing, dissemination and implementation of key quality measures. (See https://www.ahrq.gov/pqmp/about/learning-collaborative.html). They 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. Additional information on the PQMP grants: https://www.ahrq.gov/pqmp/index.html.

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 first phase of the impact of the Children's EHR Format in 2014. These two states provided significant findings and information led to recommended Format improvements that continue to be a foundation for the next phase of format testing on targeted items of the Format. An assessment of their experience can be found in Appendix A of the Children's EHR Format Enhancement: Final Recommendation Report (see https://healthit.ahrq.gov/sites/default/files/docs/page/children-ehr-format-enhancement-final-recommendation-report.pdf).

In 2016, 2017, and 2018 to date, CMS has been assessing a number of options to test targeted items of the enhanced Format with State Medicaid and CHIP programs. CMS conducted extensive outreach to federal partners in 2017 following the enactment of new legislation that could impact the certification standards for pediatric electronic health records (e.g.; the 21st Century Cures Act). In collaboration with Office of the National Coordinator, Centers for Disease Control and Prevention, and Agency for Healthcare Research and Quality, CMS is currently reviewing revised options identified in late 2017 to finalize planning for the next phase of testing.

CHIPRA Quality Demonstration Grants - In 2010, CMS awarded ten grants for demonstrations in 18 states to improve health care quality and delivery systems for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). Focus areas for the grants included using quality measures, applying health information technology, implementing provider-based service delivery models, investigating electronic health records, and trying other innovative approaches to improve children's health.

CMS partnered with the Agency of Healthcare Research and Quality (AHRQ) to evaluate the demonstration. The evaluation produced several resources for future use, including Spotlights for each state's work, 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, and a report. The final evaluation report, with links to other resources, can be found at: 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 updating the State Spotlights, creating searchable web postings as a resource for states and other stakeholders to learn from the experiences of the grantees, and developing a knowledge transfer plan among states.

The Spotlights are currently being formatted for publication on the AHRQ website and will be available in early 2018. The searchable resource web postings for states to be posted on Medicaid.gov are early in development with contractor support.

The knowledge transfer plan began in February 2016 with an all-states webinar to leverage the knowledge gained from this demonstration and disseminate lessons learned. To that end, CMS is offering an affinity group to state Medicaid agencies on Medicaid and school-based health services delivery, which began in September 2017. Eight states (Arkansas, Colorado, Idaho, Michigan, Nebraska, New Jersey, North Carolina, and Ohio) are exploring ways to partner with schools to improve health outcomes, using the Child Quality Measures Core Set to evaluate progress. CMS facilitates monthly one-on-one technical assistance calls with each state to help support their work on action plans the states created during the first months of the affinity group. Technical assistance is based on the individual needs of participating states and includes one-on-one consultation and peer-to-peer learning. In addition, CMS provides monthly all-state webinars which are led by national subject matter experts and highlight the successful work of state Medicaid agencies. These webinars cover a broad range of topics, including coverage and benefits, care delivery models, telemedicine, managed care, data sharing, and behavioral health supports. The affinity group will run through October 2018.

History of Funding for State Allotments

Fiscal	Budget Authority
FY 2014	$19,147,000,000
FY 2015/1	$15,840,600,000
FY 2016	$19,300,000,000
FY 2017/2	$16,446,000,000
FY 2018/3	$5,700,000,000
FY 2019/3	$5,700,000,000

1/ Reflects rescission of $5.2 billion in funding from section 108 of CHIPRA as amended by P.L. 111-148 pursuant to the Consolidated Appropriations Act, 2016 (P.L. 114-113) and the Consolidated Appropriations Act, 2017 (P.L. 115-31).

2/ Reflects rescission of $3.8 billion in funding from section 301(b) of MACRA, pursuant to the Consolidated Appropriations Act, 2017 (P.L. 115-31) and the Continuing Appropriations Act, 2018 (P.L. 115-56).

3/ Does not reflect the Children's Health Insurance Program (CHIP) funding extension through FY 2027, as the Budget was finalized prior to the enactment of P.L. 115-120 and of P.L. 115-123.

Mandatory State/Formula Grants[1]
CFDA NUMBER/PROGRAM NAME: 93.767 State Children's Health Insurance Program
(dollars in thousands)

State/Territory	FY 2017 Actual	FY 2018 Estimate	FY 2019 Estimate	FY2019 +/- FY2018
Alabama	$319,667	$342,669	$228,446	-$114,223
Alaska	$32,562	$34,905	$23,270	-$11,635
Arizona	$206,434	$221,288	$147,525	-$73,763
Arkansas	$194,356	$208,341	$138,894	-$69,447
California	$2,668,626	$2,860,650	$1,907,099	-$953,551
Colorado	$254,391	$272,696	$181,797	-$90,899
Connecticut	$77,405	$82,975	$55,316	-$27,659
Delaware	$35,252	$37,789	$25,192	-$12,597
District of Columbia	$42,469	$45,525	$30,350	-$15,175
Florida	$686,575	$735,978	$490,652	-$245,326
Georgia	$404,760	$433,885	$289,257	-$144,628
Hawaii	$52,297	$56,060	$37,373	-$18,687
Idaho	$82,890	$88,854	$59,236	-$29,618
Illinois	$547,395	$586,783	$391,189	-$195,594
Indiana	$191,065	$204,813	$136,542	-$68,271
Iowa	$145,720	$156,206	$104,137	-$52,069
Kansas	$124,659	$133,629	$89,086	-$44,543
Kentucky	$268,215	$287,515	$191,676	-$95,839
Louisiana	$358,807	$384,626	$256,417	-$128,209
Maine	$35,722	$38,293	$25,528	-$12,765
Maryland	$295,919	$317,212	$211,475	-105,737
Massachusetts	$671,336	$719,643	$479,762	-$239,881
Michigan	$264,782	$283,835	$189,223	-$94,612
Minnesota	$115,190	$123,478	$82,319	-$41,159
Mississippi	$316,825	$339,622	$226,415	-$113,207
Missouri	$175,197	$187,803	$125,202	-$62,601
Montana	$103,532	$110,982	$73,988	-$36,994
Nebraska	$72,490	$77,707	$51,804	-$25,903
Nevada	$69,978	$75,013	$50,009	-$25,004
New Hampshire	$38,242	$40,994	$27,329	-$13,665
New Jersey	$462,889	$496,197	$330,798	-$165,399
New Mexico	$136,040	$145,829	$97,219	-$48,610
New York	$1,233,546	$1,322,307	$881,538	-$440,769
North Carolina	$479,489	$513,992	$342,661	-$171,331
North Dakota	$21,887	$23,462	$15,641	-$7,821

State/Territory	FY 2017 Actual	FY 2018 Estimate	FY 2019 Estimate	FY2019 +/- FY2018
Ohio	$409,310	$438,762	$292,508	-$146,254
Oklahoma	$248,980	$266,895	$177,930	-$88,965
Oregon	$249,774	$267,746	$178,498	-$89,248
Pennsylvania	$527,349	$565,295	$376,863	-$188,432
Rhode Island	$72,828	$78,068	$52,046	-$26,022
South Carolina	$154,192	$165,287	$110,191	-$55,096
South Dakota	$26,939	$28,877	$19,252	-$9,625
Tennessee	$464,951	$498,407	$332,271	-$166,136
Texas	$1,382,120	$1,481,572	$987,714	-$493,858
Utah	$131,563	$141,030	$94,020	-$47,010
Vermont	$30,244	$32,421	$21,613	-$10,808
Virginia	$291,082	$312,027	$208,018	-$104,009
Washington	$242,501	$259,951	$173,300	-$86,651
West Virginia	$61,048	$65,440	$43,627	-$21,813
Wisconsin	$224,461	$240,612	$160,408	-$80,204
Wyoming	$12,647	$13,557	$9,038	-$4,519
Subtotal	**15,716,598**	**16,847,503**	**11,231,662**	**-$5,615,841**
Commonwealths and Territories				
American Samoa	$2,902	$3,111	$2,074	-$1,037
Guam	$26,577	$28,489	$18,993	-$9,496
Northern Mariana Islands	$6,706	$7,188	$4,792	-$2,396
Puerto Rico	$192,487	$206,338	$137,558	-$68,780
Virgin Islands	$6,878	$7,373	$4,915	-$2,458
Subtotal	**235,550**	**252,499**	**168,332**	**-$84,167**
TOTAL RESOURCES	**15,952,148**	**17,100,002**	**11,399,994**	**-$5,700,008**

[1] Represents proposed law baseline projections of obligations.

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][2]

Program	FY 2017 Final	FY 2018 Estimate	FY 2019 Estimate	FY 2019 +/- FY 2018
Medicaid Integrity Program[3]	$78,016	$79,911	$87,440	$7,529

Authorizing Legislation - Deficit Reduction Act of 2005, Public Law 109-171;
Patient Protection and Affordable Care Act, Public Law 111-148 together with the Health Care and Education Reconciliation Act of 2010, Public Law 111-152.

[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, Money Follows the Person Rebalancing Demonstration, Grants to Improve Outreach and Enrollment, and Funding for the Territories since the Budget Authority is $0 or the money has been rescinded.
[2] The Budget does not incorporate the effects of Public Law 115-120.
[3] P.L. 111-152 annually adjusts appropriations by the percentage increase in the CPI-U. The FY 2017 and FY 2018 columns reflect post-sequestration amounts.

State Grants and Demonstrations Gross Outlays[4]
(Dollars in Thousands)

Program	FY 2017 Actual	FY 2018 Estimate	FY 2019 Estimate	FY 2019 +/- FY 2018
Ticket to Work and Work Incentives Improvement Act (TWWIIA)				
Ticket to Work	$13	$48	$0	-$48
Subtotal – TWWIIA	**$13**	**$48**	**$0**	**-$48**
Deficit Reduction Act (DRA)				
Money Follows the Person (MFP) Demonstration	$392,848	$487,325	$483,000	-$4,325
MFP Research & Evaluation	$841	$627	$308	-$319
Medicaid Integrity Program	$81,767	$80,735	$85,775	$5,040
Subtotal – DRA	**$475,456**	**$568,687**	**$569,083**	**$396**
Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA)				
Grants to Improve Outreach and Enrollment	$16,110	$9,548	$5,871	-$3,677
Subtotal – MACRA	**$16,110**	**$9,548**	**$5,871**	**-$3,677**
Patient Protection and Affordable Care Act (PPACA)				
Medicaid Emergency Psychiatric Demonstration Project	$68	$19	$23	$4
Medicaid Incentives for Prevention of Chronic Diseases	$2,245	$609	$567	-$42
Subtotal – PPACA	**$2,313**	**$628**	**$590**	**-$38**
Protecting Access to Medicare Act (PAMA)				
Demonstration Programs to Improve Community Mental Health Services	$9,258	$3,018	$1,682	-$1,336
Subtotal – PAMA	**$9,258**	**$3,018**	**$1,682**	**-$1,336**
Total Outlays for State Grants and Demonstrations[5]	**$503,150**	**$581,929**	**$577,226**	**-$4,703**

[4] The Budget does not incorporate the effects of Public Law 115-120

[5] Amounts on this table include outlays from obligations made in previous fiscal years. These outlay estimates are based on FY 2017 actual activity and PB 2019 baseline estimates.

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, and ensuring taxpayer dollars can focus on providing high quality care to beneficiaries.

Funding History

Fiscal Year	Budget Authority
FY 2015	$493,907,000
FY 2016	$560,103,000
FY 2017	$78,016,000
FY 2018	$79,911,000
FY 2019	$87,440,000

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

Authorized in Section 6071 of the Deficit Reduction Act of 2005 (DRA), as amended by Section 2403 of Patient Protection and Affordable Care Act, the MFP demonstration supports state efforts to empower individuals 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 an 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.

The CMS Money Follows the Person (MFP) Tribal Initiative (TI), which received funding under the authority of Section 2403 of 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 table on the following page are inclusive of these supplemental awards.

According to the December 2016 Report, *Money Follows the Person Demonstration: Overview of State Grantee Progress*, (https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/2016-cross-state-report.pdf), program transitions for the period from January 1, 2016 through December 31, 2016 numbered 11,217, which represents a 19 percent increase in cumulative transitions over the previous year. In total, grantees have transitioned over 75,151 individuals as of December 2016.

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 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 for 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 through 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 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 (https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-rtc.pdf).

As of September 30, 2016, CMS obligated $3.7 billion in grants to 44 grantee states and the District of Columbia (DC). Grantees have transitioned over 75,151 individuals as of December 2016.

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, 2018
Georgia	$159,170,550	May 1, 2007	December 31, 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	December, 31, 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	September 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
New Mexico	$595,839	April,1 2011	N/A
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, 2018
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	June 30, 2018

State	Cumulative Award Total 2007-2016	Initial Award Date	Date of Last MFP Funded Transition
Tennessee	$67,363,025	April 1, 2011	December 31, 2018
Texas	$397,958,482	January 1, 2007	December 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 deactivated 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 & 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. The Medicaid Integrity Program represents CMS' first national strategy to detect and prevent Medicaid fraud, waste, and abuse, in coordination with the Health Care Fraud and Abuse Control (HCFAC) program and funding, which are discussed in the HCFAC chapter.

CMS established 5-year Comprehensive Medicaid Integrity Plans (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, and CMS is now working on the next CMIP. The FY 2014-2018 CMIP is available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf

The Patient Access and Medicare Protection Act (Public Law 114-115) 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 is using this new flexibility to more quickly adapt to changing Medicaid program integrity needs.

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.

CMS is still meeting these aims by implementing a Unified Program Integrity Contractor (UPIC) strategy that restructures and consolidates 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 previously used Medicaid Integrity Contractors (MICs) and the Medicare Zone Program Integrity Contractors (ZPICs), including their Medicare-Medicaid Data match activities. The overarching goal of the UPICs 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.

Medicaid/CHIP Financial Management Project

Previously funded under HCFAC, this project involves funding specialists, including accountants and financial analysts, who work to improve CMS' financial oversight of the Medicaid and CHIP Programs. In FY 2017 through the continued efforts of these specialists, CMS removed an estimated $2.7 billion (with approximately $647 million recovered and $2.1 billion resolved) of approximately $9.5 billion identified in questionable Medicaid costs.

Furthermore, an estimated $457 million in questionable reimbursement was actually averted due to the funding specialists' preventive work with states to promote proper state Medicaid financing. The funding specialists' activities included reviews of proposed Medicaid state plan amendments that related to reimbursement; development of financial management reviews; research regarding state Medicaid financing policy and practices; collaboration with states to resolve the Medicaid and CHIP portions of the A-133 "Single State" audits; and identification of sources of the non-Federal share.

Medicaid Integrity Institute (MII)

In collaboration with the United States Department of Justice (DOJ), CMS also established the MII to provide state employees with comprehensive training courses 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 September 30, 2017, the

MII has trained state employees from all 50 states, the District of Columbia, and Puerto Rico through more than 8,000 enrollments in 170 courses and 14 workgroups. In FY 2017, the MII conducted 18 courses and 4 workgroup meetings with 986 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 September 2017, 359 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 CMS, HHS-OIG, and state program, policy, operational, program integrity, and law enforcement subject matter experts to explore vulnerabilities, mitigation strategies, and challenges/barriers.

- In December 2017, CMS released the resulting white paper, "Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services," which is an account of program integrity professionals' consensus recommendations to help states more effectively protect vulnerable beneficiaries, fight fraud, and reduce improper payments in personal care services (PCS). The purpose of this paper is to provide and disseminate a compendium of the program integrity vulnerabilities and mitigation strategies in PCS developed by MII participants to inform Medicaid programs nationwide.

- In FY 2018, three "Emerging Trends" series courses are scheduled to take place: the "Emerging Trends in Medicaid – Opioids" course which occurred in October 2017, the "Emerging Trends in Medicaid – Third Party Liability (TPL)" course scheduled for February 2018, and the "Emerging Trends in Medicaid – Beneficiary Eligibility and Fraud" course which will occur in March 2018. Additional "Emerging Trends" series courses will be added to the MII curriculum in FY 2019 and FY 2020.

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. CMS has completed focused program integrity reviews on specific target areas in 31 states since FY 2014. These reviews have focused on a number of issues, including the enhanced provider screening and enrollment provisions resulting from Patient Protection and Affordable Care Act, the extent of states' program integrity oversight of the managed care program, the extent of selected managed care organizations' oversight of their own programs, and issues in PCS. CMS also conducted additional reviews that encompassed a broader assessment of program vulnerabilities and risk of Medicaid improper payments. Known as desk reviews, these reviews allowed CMS to increase the number of states that received customized program integrity oversight. During FY 2016,

CMS awarded a contract to support Program Integrity reviews. The contract included a base period of 12 months and two 12-month option periods. CMS has hosted conference calls with states to discuss program integrity issues and best practices, and issued guidance on policy and regulatory issues 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 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 began 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 plans to expand general technical assistance at states' requests on topics such as managed care, electronic visit verification, opioids, and beneficiary fraud.

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 relevant 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. In FY 2017, CMS began the development of the Data Exchange (DEX) system that will support states automated submissions of terminations. To reduce provider burden and avoid duplication of efforts, CMS provides states access to the Medicare Provider Enrollment Chain and Ownership 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 5,000 times by participating states from February 2014 through July 2017. In FY 2017, CMS launched a states' PECOS page that allows states to easily and efficiently rely upon Medicare's screening. Through the PECOS page, states may search for providers'

Medicare enrollments, site visit information, fingerprinting results, and more. Furthermore in FY 2017, CMS conducted seven PECOS training sessions to states. Additionally, CMS provides support and assistance to states through in-person outreach. Since May 2015, CMS has visited 23 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 funds yearly beginning in FY 2006, and beginning in FY 2011, Section 1303(b) (3) of Public Law (P.L). 111-152 adjusted this funding by the percentage increase in the CPI-U annually. The FY 2015 the final budget authority was $76.8 million, and the final FY 2016 budget authority was $77.4 million. The FY 2017 budget authority was $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 a CPI-U adjustment of 2.1 percent, bringing the adjusted budget authority to $85.6 million. The FY 2018 budget authority was reduced by 6.6 percent due to sequestration, bringing the final budget authority to $79.9 million. The FY 2019 budget authority is $85.6 million with an estimated CPI-U adjustment of 2.2 percent, bringing the adjusted budget authority to $87.4 million. The CPI-U adjustments are based on the current FY 2019 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) (P.L. 111-3) provided $100.0 million for Outreach and Enrollment Grants, a National Enrollment Campaign, and Outreach to Indian Children. Section 10203 of 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. The HEALTHY KIDS Act of 2018 (P.L. 115-120) and the Bipartisan Budget Act of 2018 (P.L. 115-123) provided a total of $168 million for outreach and enrollment activities for FY 2018 through FY 2027. These programs conduct outreach and enrollment efforts designed to increase the enrollment of children who are eligible for Medicaid or CHIP.

<u>Outreach and Enrollment Grants</u>

The grants provide outreach and application assistance to enroll eligible, uninsured children in Medicaid and CHIP, 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) and $10.0 million for a national outreach campaign. 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.

MACRA extended the Outreach and Enrollment Program through FY 2017. It provided an additional $40.0 million, 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. MACRA also provided $4.0 million for outreach and enrollment of American Indian/Alaska Native children (AI/AN) and $4.0 million for a national outreach campaign. On June 14, 2017, CMS awarded eight cooperative agreements in six states totaling just under $4.0 million. To date, a total of approximately $162.0 million in total grant funding has been awarded. This total comprises $144.0 million dedicated to the Outreach and Enrollment Grants and $18.0 million dedicated to outreach and enrollment of American Indian/Alaska Native (AI/AN) children. All of the outreach and enrollment grants share the common goal to help reduce the number of children who are eligible for Medicaid and CHIP but are not enrolled.

Outreach to Indian Children

Section 2113(b)(2) of the Social Security Act sets aside 10 percent of any amounts appropriated under that section 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 $10.0 million. On November 12, 2014, CMS awarded a second round of Outreach and Enrollment Grants, from a $4.0 million Patient Protection and Affordable Care Act appropriation, to organizations serving Indian children. On June 15, 2017, CMS awarded eight new AI/AN cooperative agreements with $4.0 million in funds from MACRA. This set-aside also applies to appropriations provided in the HEALTHY KIDS Act and the Bipartisan Budget Act of 2018.

National Enrollment Campaign

The statute sets aside ten percent of appropriations (CHIPRA, ACA, MACRA, the HEALTHY KIDS Act, and the Bipartisan Budget Act) 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; the National Campaign will conclude in March 2018. New TV and radio public service announcements (PSAs) were produced in 2017 in English and Spanish and distributed nationally for two years. The National Campaign also continues to coordinate webinars, distribute newsletters, liaise with partners, and develop other materials to support outreach and enrollment efforts.

In FY 2015, CMS also developed PSAs for tribal communities and aired these on Good Health TV®, a health education program serving in tribal hospitals and clinic waiting rooms.

Budget Overview

CHIPRA appropriated a total of $100.0 million for fiscal years 2009 through 2013. Section 10203(d)(2)(E) of 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, ten 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 million of the remaining grant funds under CHIPRA, on August 18, 2011. Under 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 $4.0 million to organizations serving AI/AN children.

The $10.0 million appropriated through CHIPRA in combination with the $4.0 million appropriated through Patient Protection and Affordable Care Act have been used to fund National Enrollment Campaign efforts, as required under the statutes.

MACRA appropriated an additional $40.0 million in FY 2016. Of this appropriated amount, $32.0 million was set aside for outreach grants, $4.0 million was set aside for outreach and enrollment grants specifically dedicated to the outreach and enrollment of AI/AN children, and $4.0 million was set aside for the National Enrollment Campaign. These additional funds were available for obligation through FY 2017. For the National Enrollment Campaign, over $3.0 million was obligated in FY 2016. In FY 2017, the remaining funds were obligated.

The HEALTHY KIDS Act of 2018 (P.L. 115-120) appropriated $120 million over FY 2018 through FY 2023 to continue support for outreach grants, including grants dedicated to the outreach and enrollment of AI/AN children and the National Enrollment Campaign. The Bipartisan Budget Act of 2018 (P.L. 115-123) appropriated an additional $48 million from FY 2024 through FY 2027 and established an additional 10 percent set-aside for evaluation and technical assistance to grantees.

DEMONSTRATION PROGRAMS TO IMPROVE COMMUNITY MENTAL HEALTH SERVICES

Section 223 of the Protecting Access to Medicare Act of 2014 (P. L. 113-93) required the Secretary to establish a two-year demonstration program 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 program, 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 percent 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 two 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.

On October 31, 2016, 19 of 24 planning grant states submitted applications to participate in the two 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 to receive enhanced federal match for specific behavioral health services over a period of two years. Demonstration programs in selected states were launched between the months of April 1, 2017 to July 1, 2017. HHS will report to Congress annually with an assessment of the quality, scope, and impact, and use of funds by demonstration programs, with a final report submitted no later than December 2021 that provides recommendations for continuation, expansion, modification, or termination of demonstration projects under Section 223.

Information Technology

(Dollars in thousands)

Information Technology Portfolio	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Program Management	***$1,654,638***	***$1,701,330***	***$1,465,107***	***($236,223)***
Discretionary Appropriation	*$1,264,431*	*$1,180,173*	*$883,229*	*($296,944)*
Federal Administration	$27,628	$28,990	$28,990	$0
Program Operations	$1,233,512	$1,145,206	$850,414	($294,792)
Research	$2,500	$5,161	$3,000	($2,161)
Survey & Certification	$816	$816	$825	$9
Mandatory Appropriation	*$115,827*	*$137,941*	*$136,858*	*($1,083)*
ACA Section 2701	*$5,028*	*$4,832*	*$9,913*	*$5,081*
IMPACT Section 2 & 2a	*$31,725*	*$26,370*	*$23,356*	*($3,014)*
MACRA Section 101	$37,395	$50,430	$45,903	($4,527)
MACRA Section 501	$18,249	$37,097	$38,281	$1,184
Medicaid (4201)	$2,577	$3,306	$3,315	$9
Medicare (4101, 4102)	$17,404	$12,481	$12,812	$331
PAMA Section 210 & 216	$3,446	$3,422	$3,275	($147)
Offsetting Collections	*$274,380*	*$383,216*	*$445,020*	*$61,804*
CLIA	$3,125	$4,050	$4,050	$0
COB User Fees	$20,885	$22,795	$21,453	($1,342)
Exchange Risk Adjustment User Fees	$7,991	$6,859	$4,537	($2,322)
Exchange User Fees	$236,940	$344,073	$409,541	$65,468
RAC MSP & Parts A/B	$5,438	$5,438	$5,438	$0
Quality Improvement Organizations	***$377,638***	***$370,154***	***$345,659***	***($24,495)***
QIO - Programmatic Contracts	$228,500	$230,592	$203,287	($27,305)
QIO - Support Contracts	$149,138	$139,561	$142,372	$2,811
Innovation Center	***$187,740***	***$250,296***	***$198,266***	***($52,030)***
Health Care Fraud & Abuse	**$350,291**	**$440,763**	**$418,788**	**($21,975)**
Mandatory	$151,564	$195,087	$172,517	($22,570)
Discretionary	$198,726	$245,675	$246,271	$596
Total Information Technology Portfolio	**$2,570,337**	**$2,762,543**	**$2,427,820**	**($334,723)**

Program Description and Accomplishments

Information technology (IT) allows CMS to achieve mission critical operations, from running one of the largest claims processing networks under Medicare, to protecting beneficiaries

information from cybers threats. CMS IT investments are designed to support programs, such as Quality Improvement Organizations (QIOs), and to support internal functions across the agency. CMS relies heavily on IT infrastructure and applications to sustain our range of business needs, including eligibility verification, coverage determinations, beneficiary claims processing, provider and issuer reimbursement, fraud prevention, and quality measurement. The infrastructure includes a variety of data center configurations to host applications, a robust networking infrastructure to link resources across the country, and storage for claims and related data across programs. CMS houses one of the largest health care data repositories in the world and administers cybersecurity programs to ensure the protection of provider and beneficiary information in compliance with statutory requirements. CMS IT investments not only handle current demands, but must adapt to future requirements.

Program Accomplishments include:

- IT Security – CMS protects its networks and information systems against the continuous risk posed by malicious cyber actions through a comprehensive, 24/7, cyber-threat monitoring program.

- Health Insurance Portability and Accountability Act (HIPAA) Eligibility Transaction System (HETS) Improvements – HETS completed the migration from a legacy system to a modern processing environment. The HETS system processes nearly 2.5 million Medicare eligibility inquiries daily.

- New Medicare Card Project – CMS is making considerable progress in the effort to replace current Social Security Number-based Medicare numbers with new randomly generated numbers, known as Medicare Beneficiary Identifiers (MBIs). Thus far, CMS has completed the development and implementation of the new MBIs, implemented a translation service, and is nearly finished with the necessary system updates across the agency to adapt to these new numbers.

This chapter covers Agency-wide IT spending across all funding sources and programs. The intention is to provide a portfolio view of major CMS IT investments to show how these investments relate to specific activities. While this chapter focuses on major investments, multiple non-major investments support each of the activities as well. Additional information on specific IT investments can be viewed at the IT Portfolio Dashboard located at the following web address:
https://www.itdashboard.gov/drupal/summary/009

Funding History

Fiscal Year	Budget Authority
FY 2015	$1,939,569,857
FY 2016	$2,030,515,000
FY 2017	$2,581,419,000
FY 2018 Annualized CR	$2,700,027,000
FY 2019 President's Budget	$2,427,820,000

FY 2019 IT Funding Level: $2,427.8 million

The FY 2019 funding level for CMS-wide IT is $2,427.8 million, a decrease of $334.7 million below the FY 2018 Annualized CR. This funding supports all CMS essential IT investments. Below are several of CMS' top priorities within the IT portfolio.

- Physician Transparency ($13.0 million): The Physician Transparency program is a national disclosure program that promotes accountability by making information about the financial relationships between the healthcare industry and healthcare providers available to the public. This investment requires increased infrastructure, system maintenance, and storage to grow with the additional volume and complexity of this data. Collecting and publicly reporting this information continues CMS' effort to prevent health care fraud and abuse.

- Case Management ($31.8 million): The Unified Case Management system improves and enhances the management of program integrity related to fraud and abuse. This investment provides direct and transparent access to the program integrity workflow, promoting efficiencies through the case lifecycle.

- IT Security ($66.4 million): This funding will continue to ensure an enterprise cyber-risk management program that protects the entirety of CMS's systems on a 24/7 basis. Sustaining an enterprise cyber security strategy enables CMS to proactively protect and defend critical assets against malicious attacks.

- IT Modernization ($30.0 million): This funding will 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 & Privacy. CMS will automate Governance, Risk Management, and Compliance processes, expand security monitoring across the agency through the Enterprise Security Operations Center, implement Information Security Continuous Monitoring solutions, and address Software Assurance across the enterprise. These changes will allow CMS to be in compliance with the elevated requirements introduced by new federal mandates including Federal Information Technology Acquisition Reform Act and OMB Memorandum M-14-03.

- Digital Seniors ($17.0 million): Because CMS' current data platforms are using outdated technologies that do not conform to the medical industry standards for Application Programming Interfaces (APIs), beneficiaries receive their health care data on an 18-month delay. APIs allow for standardized data exchanges, allowing third parties to more easily integrate data into beneficiary-facing applications. In FY 2018, CMS launched a new initiative to update the existing systems and infrastructure to better interface with the medical industry through the use of APIs. This will allow beneficiaries to request and obtain their healthcare data more quickly and in a format that can easily be shared with others, including plans, providers, and family members, to analyze and make recommendations.

Medicare Parts A & B

Medicare Parts A & B investments support the fee-for-service (FFS) and durable medical equipment (DME) claims processing operations. For these activities, CMS acts as a

traditional insurance company by verifying beneficiary eligibility, enrolling providers and suppliers, and processing and paying out claims. CMS administers a number of payment incentive programs that reward eligible providers for improving quality, reducing unnecessarily resource utilization, and adopting new technologies.

Funding Level: $661.2 million

The FY 2019 funding level for Medicare Parts A and B investments is $661.2 million, a decrease of $38.3 million below the FY 2018 Annualized CR. This decrease is primarily due to the Medicare Administrative Contractors' (MACs) contracting cycle, which included a set of system security updates in FY 2018 that required a higher level of dedicated funding in that year.

Beneficiary Enrollment: CMS processes Medicare beneficiary enrollment and defines eligibility status. CMS works in coordination with the Social Security Administration (SSA) to verify eligibility, effectuate enrollment, and ensure that premiums are collected. CMS also works with the Railroad Retirement Board (RRB) to manage beneficiaries who receive assistance. These operations ensure consistent information on enrollment status, including whether premium payments are up-to-date, and that CMS makes appropriate claims payments.

- *Medicare Beneficiary Enrollment Data Management Systems* – These systems provide the authoritative source for Medicare beneficiary eligibility and enrollment status, ensuring that only claims for valid beneficiaries are paid. CMS manages the billing and collection of premiums for both beneficiaries and third party payers. In coordination with investments in *Beneficiary Enrollment and Plan Payment for Part C & D,* CMS ensures beneficiaries are appropriately enrolled in the various types of insurance coverage offered by the agency.

- *New Medicare Card Project* – This investment supports the replacement of Social Security Number-based health insurance claim numbers (HICNs) with new Medicare Beneficiary Identifiers (MBIs). This includes creation of a real-time translation service, modifications to existing systems to minimize disruption, and continuation of critical data exchanges with Federal and other business partners.

Provider Enrollment: These investments allow providers and suppliers to enroll in Medicare and verifies their eligibility to participate. They also support collecting required information, establishing billing relationships, and screening providers to flag potential fraudulent actors.

- *Interoperability & Standardization: Provider Enrollment* – Provides the authoritative national repository of all enrolled Medicare and Medicaid providers and suppliers. Entities providing payment under Medicare are required to verify provider participation before issuing payment. This investment includes collecting and maintaining data on initial enrollment, changes of information, reassignments, and mandated revalidations or reenrollments. CMS collects information about ownership, authorized officials, delegated officials, managing employees, practice locations, practice types, and affiliated provider information.

- *Advanced Provider Screening* – Aggregates data from multiple sources to conduct pre- and post-enrollment provider screening. This investment provides the ability to

proactively and retrospectively assess program eligibility criteria, as well as provide additional data to further assess eligibility, such as criminal background checks. By flagging potentially ineligible providers, CMS can take appropriate action to eliminate a potential source of fraud, waste, and abuse.

Claims Processing: Medicare FFS relies on multiple IT investments running on an integrated infrastructure to successfully process and pay claims. Claims processing includes investments that support processing appeals and ensure that Medicare is the most appropriate payer. CMS conducts extensive testing to ensure this suite of investments operates efficiently and effectively.

- *Medicare Shared Systems (MSS)* – Supports a common environment for operating legacy claims processing systems for inpatient hospital services, outpatient services, and DME. A single data source with full individual beneficiary information allows contractors to verify beneficiary eligibility, conduct prepayment review, and approve claims. These investments support the receipt of claims, editing, pricing, adjudication, correspondence, on-line inquiry, file maintenance, financial processing, and reporting. This investment captures the Certificate of Medical Necessity and supplier interfaces specific to DME claims. Claims are screened through the Fraud Prevention System, to identify potential waste, fraud, or abuse.

- *Shared Systems Integrated Testing (STC)* – Provides integration and regression testing for MSS functionalities including claims adjudication, payments, remittance advices, Medicare Summary Notices (MSNs), and various system interfaces within and between investments.

- *HIPAA Eligibility Transaction System (HETS)* – Allows providers to check beneficiary eligibility for Medicare Part A and B services using HIPAA-compliant Accredited Standards Committee (ASC) X12 transactions. HETS processes close to 1 billion transactions per year.

- *Medicare Appeals System (MAS)* – Provides a unified appeals case-tracking system that facilitates maintenance and transfer of case-specific data with regard to FFS and managed care appeals. MAS is capable of docketing hearings, scheduling expert witnesses for testimony, compiling case notes, and facilitating adjudication. In addition, MAS provides the capability to report on appeals data, enabling more accurate and expedient reporting and allowing for more precise assessments and policy-setting.

- *Medicare Secondary Payer System (MSPS)* – Ensures proper benefits coordination and payment recovery when Medicare is not the primary payer. MSPS collects and processes data from other insurers and employers, allowing CMS to make more accurate primary and secondary payment decisions.

- *Fraud Prevention System (FPS)* – Provides state-of-the-art analytical tools to help predict and prevent potentially wasteful, abusive, or fraudulent payments before they occur. Before Medicare fee-for-service claims are approved for payment, they are processed through FPS to identify high-risk claims for further review. Proven predictive models are used in risk scoring to generate alerts and triangulate the results to identify high-risk claims and providers.

Incentive Payment Programs: Providers and some suppliers can be eligible for payment adjustments based on participation in a variety of incentive programs. The most significant change to these programs in recent years is the Quality Payment Program (QPP), which replaced the previous physician incentive programs with a two-track system designed to modernize provider quality reporting and encourage participation in Alternative Payment Models (APMs).

- *Quality Payment Program (QPP)* – Includes two tracks for clinicians under Medicare, one through the Merit-based Incentive Payment System, which adjusts clinicians' payment based on performance on cost, quality, improvement activities, and advancing care information, and one through participation in Advanced APMs. Clinicians who reach a certain level of participation in Advanced APMs are eligible for a 5 percent incentive payment from 2019 through 2024 and a higher payment update under the Medicare physician fee schedule starting in 2026. Implementing the QPP involves a significant investment to develop a single reporting portal that will allow participating clinicians to better understand the program, submit data, and review their information.

- *Hospital Quality Reporting (HQR) System* – Supports the collection and analysis of quality measures from participating hospitals in order to make appropriate payment adjustments based on performance.

- *Accountable Care Organizations (ACOs)* – Support the Medicare Shared Savings Program by providing ACO eligibility verification and beneficiary assignment, and by calculating annual expenditures, performance and quality scores, and shared savings.

- *End Stage Renal Disease (ESRD) Quality Reporting System* – Provides a comprehensive ESRD patient registry that tracks services provided to ESRD beneficiaries for calculating performance-based payments.

Medicare Parts C & D

Medicare beneficiaries have the option of purchasing prescription drug coverage or combining some or all of their coverage options through private issuers. Prescription drug coverage (Part D) and Medicare Advantage (Part C) have a different operational profiles and present different challenges than Parts A & B. Instead of interacting with and paying providers through the claims process, CMS interacts and pays private issuers through specifically designed IT systems. Business processes and IT systems are designed to manage beneficiary enrollment, ensure issuer compliance with benefit design parameters, manage special benefits, and balance risk across issuers.

Funding Level: $153.5 Million

The FY 2019 funding level for Medicare Part C & D IT investments is $153.5 million, a decrease of $7.4 million below the FY 2018 Annualized CR. This funding continues to support the Agency's mission of serving beneficiaries through the investments listed below:

Beneficiary and Plan Management: Ensures that beneficiaries are able to enroll in Part C & D coverage. CMS works extensively with private issuers to review their plans, collect data, and ensure proper payment.

- *Beneficiary Enrollment and Plan Payment for Parts C & D* – Delivers enrollment and health plan payment for approximately 40 million Parts C & D enrollees. This investment is dependent upon certain beneficiary demographic and entitlement data in the *Medicare Beneficiary Enrollment Data Management* systems. CMS maintains, updates, tests, and monitors system operations for enrollment and payment functions, and provides technical assistance and customer service associated with audits and compliance.

- *Health Plan Management System (HPMS)* – Manages the day-to-day interactions with private plan issuers who are offering more than 700 plans to beneficiaries. Participating issuers can submit applications, bids, formulary submissions, marketing material reviews, and plan oversight documents, as well as manage complaints, review enrollment and payment data feeds, and maintain data for the Medicare & You handbook and Medicare Plan Finder. This system also supports the annual plan bidding process, ensuring that issuers comply with regulatory requirements such as no-cost preventive services.

Drug Subsidies: Many beneficiaries are entitled to discounts and rebates through various programs. These investments ensure that beneficiaries receive the correct discounts, as well as support Part D enrollees in managing out-of-pocket expenses.

- *Drug Claims Processing System (DCPS)* – Collects, processes, and stores data from Part D claims to ensure the appropriate payment of covered drugs. Records are submitted electronically on a monthly basis and validated through automatic and manual edits. The claims are used during the payment reconciliation process in order to compare actual expenditures, including discounts for applicable drugs provided at the point-of-sale, to prospective payments made during the year. CMS coordinates the collection of discount payments from manufacturers and participating issuers.

- *Coordination of Benefits/True Out-of-Pocket (TrOOP)* – Provides real-time primary and secondary coverage information to pharmacies and Part D plans via pharmacy industry telecommunications systems. This investment provides eligibility and coverage information to pharmacies to enable real-time billing, and routes information on payments made by secondary payers back to the Part D plans.

Risk Adjustment: Ensures that each Medicare private plan issuer's risk is adjusted based on the medical experiences of individuals enrolled in their plans. Risk adjustment ensures that participating plans are not incentivized to select for healthier enrollees by transferring premiums from low to high-risk issuers.

- *Risk Adjustment Data Collection* – Calculates the risk scores for over 18 million beneficiaries. Multiple risk adjustment factors are created by analyzing the diagnosis history for each beneficiary and using statistical models to adjust the risk experienced by each Part C & D plan. The risk factors are provided to HPMS for initial, mid-year, and final reconciliation payments, as well as reruns of prior years

to process overpayments.

- *Encounter Data* – Collects beneficiary level, per-visit health care encounter data from participating issuers to enable calculation of risk coefficients that accurately reflect the demographics, patterns of care, and the predicted costs of diseases for Part C enrollees.

- *Central Data Abstraction Tool (CDAT)* – Collects diagnosis information from participating issuers to support the risk adjustment data validation (RADV) audits. CMS uses the results of these audits to estimate and recover overpayments.

Medicare Outreach & Education

Medicare Outreach and Education IT systems support the National Medicare Education Program (NMEP). Beneficiary e-Services creates a virtual, enterprise-wide, multi-contact channel for handling beneficiaries' inquiries that maximizes resources and service effectiveness. These systems support the medicare.gov and cms.gov websites.

Funding Level: $70.4 Million

The FY 2019 funding level for Medicare Outreach and Education is $70.4 million, an increase of $9.2 million above the FY 2018 Annualized CR. The increase in funding will support upgrades and maintenance to the medicare.gov and cms.gov websites to continue system improvements that provide beneficiaries the highest quality information possible.

- *Beneficiary e-Services* – Provides a virtual, enterprise-wide, one-stop service for handling Medicare beneficiary inquiries from multiple channels to meet the unique needs of our beneficiary population. Beneficiaries can contact CMS through beneficiary websites and portals, such as medicare.gov, and the Beneficiary Contact Center that handles phone, written, and email communications. Using the Next Generation Desktop application, these processes can access CMS data systems to answer Medicare inquiries on enrollment, claims, health care options, preventive services, and prescription drug benefits. The websites offer beneficiaries interactive tools like Medicare Plan Finder and Nursing Home Compare, as well as personalized information such as enrollment, preventive services, claims, and prescription drugs. The Beneficiary Contact Center uses an interactive voice response system to provide beneficiaries with automated self-service information and options. Based on selections made, if the automated system cannot solve the caller's request, they are routed to the next available and best qualified agent to resolve their inquiry.

- *Medicare and Medicaid Financial Alignment* – Supports the implementation of State programs to integrate care for individuals enrolled in both Medicare and Medicaid. This investment focuses on technical assistance to the States who are engaged in this effort by creating and providing necessary Medicare data files, as well as guidance on the request process and the use of Medicare data.

Medicaid and the Children's Health Insurance Program (CHIP)

CMS serves as the operational and policy center for the formulation, coordination, and evaluation of national policies and operations for Medicaid and CHIP. Investments in data

infrastructure and systems ensure an accurate, current, and comprehensive database containing standardized enrollment, eligibility, and paid claims. This data is used to produce statistical reports, support research, and assist in the detection of fraud and abuse.

Funding Level: $81.5 million

The FY 2019 funding level for Medicaid and CHIP IT is $81.5 million, a $20.6 million decrease from the FY 2018 Annualized CR. At this funding level, CMS will continue to support the development of public use files and increased data sharing amongst the States within Medicaid and CHIP Business Information Solutions (MACBIS), as well as new tools that allow CMS and States to collaborate online to process State Plan Amendments, waivers, quality measure reports, demonstrations, advance planning documents, and other initiatives. CMS is also deploying a Medicaid and CHIP (MAC) Scorecard Initiative that will consolidate and display State-level performance data in an easy-to-use format allowing for meaningful comparisons.

- *Medicaid and CHIP Business Information Solutions (MACBIS)* – Provides the data infrastructure and environment to facilitate collection of State-level programmatic claims data, including managed care options, beneficiary, and provider data. ·MACBIS automates the State plan approval process by collecting programmatic data on State Medicaid and CHIP operations. State plans support evaluation activities and ensure States remain in compliance with policies or waivers. Further, the investment supports a data analytics infrastructure for operational data about recipients, providers, claims, and encounters. This allows the States and CMS to better identify fraudulent activities and to integrate data across programs.

- *Medicaid Data Information System* – Provides comprehensive data warehouse services with standardized enrollment, eligibility, and paid claims of dual-eligible, Medicare-Medicaid beneficiaries.

- *MAC Scorecard Initiative* – Will eventually display state-by-state performance and quality data, providing increased transparency and accountability.

Federal Exchanges

The Federal Exchanges enable consumers to compare and purchase private health insurance and determine if financial assistance with premiums and cost-sharing is available.

Funding Level: $270.7 million

The FY 2019 funding level for Federal Exchange IT is $270.7 million, a decrease of $113.6 million below the FY 2018 Annualized CR. The funding supports:

- *Health Insurance & Oversight System (HIOS)* – Provides participating issuers with a common portal to submit a range of information regarding health plans offered on the Exchanges. Issuers can submit health plan rates, benefits, and supporting information for display on healthcare.gov. Issuers also submit Medical Loss Ratio calculations, rate review justifications, quality information, and state regulatory data.

- *Federally-Facilitated Exchange (FFE)* – Provides a common platform for consumers and issuers to join together to provide coverage. Consumers can shop and enroll in coverage using easy plan compare tools based on price, benefits, services, and quality. The FFE provides comprehensive services to issuers for managing qualified health plan information, reconciling enrollment, and ensuring accurate payments. This investment also provides automated eligibility verification services facilitating access to multiple Federal, Medicaid, and private data sources.

- *Multidimensional Insurance Data Analytics System (MIDAS)* – Provides an integrated data repository for capturing, aggregating, and analyzing information on health insurance coverage. The data is used to monitor, forecast, trend, analyze, and report on the individual and small group health insurance markets.

- *Health Care Web Support* – Supports the individual portal for consumers to access the Health Insurance Exchanges. The systems, tools, and applications included in the investment help users review, enroll in, and change their healthcare plans.

- *Eligibility Appeals Case Management System (EACMS)* – Ensures CMS is able to receive, process, and monitor appeals submitted by individuals, employers, and States who have delegated authority to CMS. EACMS provides a centralized point for the collection and review of appeals requests and supporting documentation including the secure transfer of case data between coordinating entities.

Health Care Quality

CMS is committed to improving the quality and value of health care provided to beneficiaries and consumers through a variety of health care quality initiatives.

Funding Level: $220.8 million

The FY 2019 funding level for Health Care Quality IT is $220.8 million, a decrease of $89.3 million below the FY 2018 Annualized CR. This funding continues the development, testing, integration, and maintenance of the physician value requirements. This funding also supports upgrades to the Medicare physician resource reporting system.

- *Health Care Quality Improvement System (QIES)* – QIES is the key source of CMS quality data, aggregating data from State Survey Agencies, Federal contractors, and QIOs to support research, analysis, and beneficiary information such as the Nursing Home, Home Health, and Hospital Compare websites.

- *Quality Enterprise Services* – Provides a common architecture and system for the submission, parsing, staging, and processing of data from multiple quality programs to allow for streamlined measure reporting and calculation.

- *QIO Information Systems* – Supports collaboration within the QIO community, coordination between CMS and the QIOs, and data collection to support operational analytics.

- *Innovation Core Systems* – Provides core IT systems that support models and demonstrations to manage their specific needs. Investments support a variety of

activities, including beneficiary and provider enrollment, managing data collection, conducting analysis, and assisting in model evaluations.

Enterprise Information Technology

Enterprise IT encompasses investments which span multiple program areas or provide CMS-wide services. Examples of enterprise-wide investments are those associated with dual-eligible, Medicare-Medicaid beneficiaries, as well as program integrity activities that integrate data from across CMS to identify bad actors. Other investments focus on providing CMS-wide support and solutions to ensure operating and security standards are applied across CMS. These activities achieve economies of scale and allow for business owners to reuse existing processes to reduce cost.

Funding Level: $969.5 Million

The FY 2019 funding level for Enterprise IT is $969.5 million, a decrease of $74.6 million below the FY 2018 Annualized CR. This funding supports necessary investments in existing systems, such as upgrades at key data centers and enterprise-wide software licenses. CMS will continue making these functional enhancements designed to optimize user interfaces, while facilitating improved compliance.

- *Healthcare Integrated General Ledger Accounting System (HIGLAS)* – Provides a centralized and integrated dual-entry accounting system that standardizes financial accounting functions for all CMS programs.

Infrastructure and Data Management: Supports core IT infrastructure and data management for use across CMS.

- *IT Infrastructure Ongoing* – Provides vital infrastructure and services to CMS employees, researchers, contractors, and beneficiaries, including unified voice, video, and data technologies. This category of investments also supports overall management of data center resources by providing single, virtual entry for accessing hosting and technology offerings, such as private cloud technologies, standardization of architecture, and service management. Other activities in this category include supporting day-to-day operations of the mainframe, network, voice, and data communications, as well as backup and disaster recovery of mission critical applications. The investment provides an enterprise approach for managing information security and privacy, and supports the Large Scale Data Repository (LSDR), allowing for a robust, stable, and effective data repository environment.

- *Information Management and Analysis* – Supports data lifecycle management by providing guidance and technical assistance in the development, maintenance, administration, and enforcement of data asset reuse and metadata standards for over 820 databases. This investment also assures system performance, data availability, communication, and disaster recovery capabilities. Additionally, it supports coding changes and technical support for ongoing operations of legacy Cobol-based systems.

- *Systems Security* – Ensures that IT systems and data are adequately protected and meet IT security requirements. This investment includes required security control assessments and necessary employee security trainings, and also ensures that the MACs meet security requirements. Systems security investments also provide a full-time, enterprise cyber risk management program to maintain situational awareness of cyber threats and enable leadership to make informed decisions.

- *Integrated Data Repository (IDR)* – Provides a multi-view data warehouse orientation that is capable of integrating data on beneficiaries, providers, health plans, claims, and prescriptions, without relying on voluminous raw data extracts. The IDR provides a scalable system to meet current and expanding data volumes.

- *Chronic Condition Warehouse (CCW)* – Provides a research database that makes Medicare, Medicaid, and Part D Prescription Drug Event data for individuals with chronic conditions readily available to support research activities. The CCW contains data dating back to 1999 for Medicare FFS, eligibility and enrollment, and assessments. The data is linked by a unique, unidentifiable beneficiary key, which allows researchers to analyze information across the continuum of care.

Shared Services: Provides CMS with cost-effective solutions that eliminate duplication by providing services that can be accessed across the various investments. These solutions provide standardized interfaces and reusable processes.

- *Enterprise Identity Management (EIDM)* – Ensures individuals have secure, authorized access to CMS business applications by providing a single point of entry and conducting remote identity proofing to confirm individual identities.

- *Master Data Management (MDM)* – This master directory provides a common identifier, which allows CMS to link and aggregate beneficiary, provider, program, and organization data from contrasting sources to create a trusted and authoritative data source. MDM is available to other investments, business processes, and applications, ensuring consistent display across CMS.

- *Enterprise Portal* – Provides a common portal for beneficiaries, providers, organizations, and States to access information and applications based on their roles and permissions. The portal combines and displays content and forms from multiple applications, and supports users with easy navigation, cross-enterprise search tools, simplified sign-on, and personalized, role-based access.

Program Integrity: Supports CMS-wide efforts to combat waste, fraud, and abuse by linking data across CMS programs via comprehensive and integrated investments that allow for better analysis and identification of bad actors.

- *Electronic Submission of Medical Documentation* (ESMD) – Allows providers to electronically submit medical documentation in support of medical review and audit efforts.

- *Open Payments* – Collects information on payments from drug and device companies to physicians and teaching hospitals for things like travel, research, gifts, speaking fees, and meals. This includes ownership interests of physicians or their immediate family members in these companies. Providers who participate in CMS programs are required to report an annual basis. The data is publically available in an easy to use, searchable, and downloadable format.

- *Healthcare Fraud Prevention Partnership (HFPP)* – Provides a space for private and public payers to collaborate on fraud identification and prevention activities.

- *One Program Integrity (One PI)* – Provides an integrated data warehouse, which enables state Medicaid data to be combined with claims data from Medicare Parts A, B, and D. This allows for improved analytics to detect fraud, waste, and abuse activities across multiple Medicare programs.

- *The Unified Case Management System* – Serves as a central repository for contractor workload reporting, dashboards to monitor progress, and outcome measure calculations. This investment strategically positions CMS for a coordinated approach to Medicare and Medicaid audits and investigations.

Information Technology Portfolio Budget
by Investment Category
(Dollars in thousands)

IT Funding by Category	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
Medicare Parts A & B	$565,703	$699,559	$661,211	*($38,348)*
Medicare Parts C & D	$149,928	$160,886	$153,454	*($7,432)*
Medicare Outreach & Education	$65,038	$61,152	$70,449	*$9,297*
Medicaid and the Children's Health Insurance Program	$92,922	$102,259	$81,587	*($20,672)*
Federal Exchanges	$435,811	$384,368	$270,742	*($113,626)*
Health Care Quality	$295,127	$310,156	$220,844	*($89,312)*
Enterprise IT	$965,782	$1,044,167	$969,533	*($74,634)*
Total IT Portfolio	**$2,570,311**	**$2,762,547**	**$2,427,820**	***($334,727)***

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 2017 Actual (millions)	FY 2018 Estimate (millions)	FY 2019 Estimate (millions)
Drug Resources by Budget Decision Unit and Function:			
Medicaid Treatment	$4,980	$5,230	$5,440
Medicare Treatment	$2,070	$2,170	$2,250
Total Funding	**$7,050**	**$7,400**	**$7,690**
Drug Resources Personnel Summary			
Total FTEs (direct only)	0	0	0
Drug Resources as a Percent of Budget			
Total Agency Budget (in Billions)[1]	$1,054.0	$1,083.7	$1,172.5
Drug Resources Percentage	0.7%	0.7%	0.7%

Program Summary

Mission

As an effective steward of public funds, the Centers for Medicare & 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 a 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 providing substance use disorder treatment to eligible beneficiaries.

Methodology

Medicaid

These projections were based on data from the Medicaid Analytic eXtract (MAX) for 2007 through 2012, based on expenditures for claims with substance use disorders as a primary diagnosis. Managed care expenditures were estimated based on the ratio of substance use disorder expenditures to all expenditures for fee-for-service by eligibility group. The estimates were trended forward to FY 2016 using the growth rate of expenditures by state and eligibility category from the CMS-64, MAX data, and estimates consistent with the

[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.

President's Budget. The annual growth rates were adjusted by comparing the rate of substance use disorder expenditure growth from 2007-2011 to all service expenditure growth and adjusting the growth rate proportionately.

CMS notes that the estimates are higher than those for the FY 2018 President's Budget for several reasons. First, CMS expanded the methodology to include more claims codes than had previously been used. Second, updated prior year expenditure data was higher than previous estimates, which increased the overall projection.

Medicare

The estimates of Medicare spending for the treatment of substance use disorder 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[2] included on the claims. The historical trend was used to make projections into the future.

Like in FY 2018, the FY 2019 projections are higher than those for the FY 2017 President's Budget due to the incorporation of additional diagnosis codes for substance use disorder. This methodological adjustment was made to be consistent with work done by the ONDCP.

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 of costs related to substance use disorder 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 use disorder are often also used to treat other conditions.

Budget Summary

The total FY 2019 drug control outlay estimate for the CMS is $7,690.0 million. This estimate reflects Medicaid and Medicare (excluding Part D) benefit outlays for substance use disorder treatment. Overall, year-to-year projected growth in substance use disorder spending is a function of estimated overall growth in Medicare and Medicaid spending. The growth in Medicare and Medicaid substance use disorder spending is attributable to the use of actual data, which was higher than anticipated, and the incorporation of additional diagnosis codes for substance use disorder.

Medicaid

FY 2019 outlay estimate: $5,440.0 million
(Reflects $210.0 million increase from FY 2018)

Medicaid is a means-tested health care entitlement program financed by states and the

[2] 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.

federal government. Medicaid mandatory services include substance use disorder services for detoxification and treatment for substance use disorder needs identified as part of early and periodic screening, and diagnostic and treatment services for individuals under age 21 years of age. Additional Medicaid substance use disorder treatment services may be provided as optional services.

Medicare
FY 2019 outlay estimate: $2,250.0 million
(Reflects $80.0 million increase from FY 2018)

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 use disorder 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. As noted above, Medicare Part D prescription drug spending is not counted in these estimates.

Performance

CMS uses quality measures in its various programs that include quality improvement, pay for reporting, and public reporting. However, none of the programs require reporting of specific measures, nor do they set specific performance targets for measures. In May 2017, the National Quality Forum, a Consensus-Based Entity, which has multiple duties in improving performance measurement, endorsed three new measures to help identify use of opioids at high doses or from multiple providers to persons without cancer.

The Department of Health and Human Services established a FY 2018-19 HHS-wide Agency Priority Goal to *Reduce Opioid Misuse*, and CMS is a supporting partner in that effort. Additional information can be seen on Performance.gov.

Medicaid
In FY 2018, states will continue voluntary reporting on a core set of health care quality measures for adults and children enrolled in Medicaid and CHIP. The 2018 Adult Core Set includes several measures focused on behavioral health; these along with similar measures from the Child Core Set have been identified as a Behavioral Health Core Set. CMS released an updated Adult Core Set of measures for 2018 in November 2017, including a new measure: “Concurrent Use of Opioids and Benzodiazepines.” Additional related measures include: “Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence,” “Initiation and Engagement of Alcohol and Other Drug Dependence Treatment,” and “Use of Opioids at High Dosage in Persons without Cancer.” CMS publicly reports data from the core sets on Medicaid.gov under Annual Reporting at: Adult Health Care Quality Measures.

Medicare
In 2017, the Physician Quality Reporting System transitioned to the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program (QPP). The program encourages reporting of quality measures by “eligible professionals” by tying payment adjustments to reporting criteria. The QPP has two tracks: the MIPS and Advanced Alternative Payment Models (APMs). Clinicians can choose how they want to participate

based on their practice size, specialty, location, or Medicare 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, most clinicians must report on six quality measures. The current program portfolio includes two Improvement Activities, and four quality measures that address opioid use.

The CMS Quality Innovation Network- Quality Improvement Organization program (QIN-QIO) is working with over 5,000 outpatient settings including pharmacies, nursing homes, and clinical practices and with community coalitions and state based efforts across the nation to improve management and safety of opioid medication while addressing appropriate treatment of pain. The program is currently working toward 2018 goals to achieve a hospital utilization reduction of over 58,000 opioid admissions, observation stays, and emergency department visits for the high-risk opioid-utilizing Medicare population and a reduction in over 4,800 readmissions for the high risk opioid Medicare population. To reach these goals, QIN-QIOs implement interventions in partnership with clinicians, use data analytics to support local innovation and change, and support local efforts such as improving communication across settings and communities. CMS QIN-QIOs have established a methodology using CMS data to identify adverse events for high-risk Medicare beneficiaries who have taken an opioid medication. QIN-QIOs provide aggregated reports to recruited providers and community coalitions to support local and national efforts to address the opioid epidemic and increase surveillance of adverse events. QIN-QIOs also use advance analytics to support clinicians in prescribing and understanding how they compare to their state or community. Additional information about these initiatives can be found at the following links:
http://qioprogram.org/campaign-meds-management
http://qioprogram.org/qionews/topics/adverse-drug-events.

CMS recently updated its 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. The tool allows the user to see both the number and percentage of opioid claims at the local level and allows a better understanding of variability in provider prescribing behaviors within and across region and how this critical issue impacts communities nationwide. The updated tool includes the addition of extended-release opioid prescribing rates and county-level hot spots and outliers, which may identify areas that warrant attention.

Medicare Part D Drug Management Program
CMS currently uses the Part D Opioid Drug Utilization Review (DUR) Policy and Overutilization Monitoring System based on retrospective DUR to reduce opioid utilization in Part D, Medicare's prescription drug benefit. In conjunction with Part D opioid overutilization policies that address prospective opioid use, this policy has played a key role in reducing high-risk opioid overutilization. The Comprehensive Addiction and Recovery Act of 2016 (CARA), effective January 2019, requires CMS to establish through rulemaking a framework under which Part D plan sponsors may establish a drug management program for "at-risk beneficiaries." Under such a program, sponsors may restrict at-risk beneficiaries' access to controlled substances that CMS determines are "frequently abused drugs" to a selected prescriber(s) and/or network pharmacy(ies) through "lock-in". Lock-in programs are common in Medicaid programs, and CARA provides statutory authority to allow Part D plan sponsors to lock in beneficiaries to a certain pharmacy or prescriber in the Medicare Part D program. In November 2016 CMS convened stakeholders to provide input on specific topics in promulgating regulations governing Part D drug management

programs. In November 2017, CMS published a proposed regulation with suggested parameters for implementing the lock-in program in plan year 2019.

Clinical Quality Measure Reporting

CMS has included opioid use disorders as a key meaningful measure area in the Meaningful Measures framework, and also incorporated opioids-related measures and clinical improvement activities for clinicians to select as they participate in Medicare's QPP. CMS is also working in partnership with the Office of the National Coordinator for Health Information Technology to incorporate clinical quality measures with information into electronic health records to assist in implementing healthcare delivery and payment. Finally, CMS includes opioid-related quality measures in the "Measures Under Consideration (MUC) List" published each year to inform the public about measures being considered for use in Medicare. The 2017 MUC list included "Continuity of Pharmacotherapy for Opioid Use Disorder for the Merit-based Incentive Program, and "Opioid Related Adverse Respiratory Events for the Inpatient Quality Reporting Program."

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Object Classification - Direct Budget Authority
CMS Program Management
(Dollars in Thousands)

Object Class	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Direct Budget Authority			
Personnel compensation:			
Full-time permanent (11.1)	$ 470,276	$ 482,590	$ 450,408
Other than full-time permanent (11.3)	$ 22,416	$ 10,935	$ 10,996
Other personnel compensation (11.5)	$ 7,800	$ 7,897	$ 7,655
Military personnel (11.7)	$ 13,868	$ 14,077	$ 14,077
Special personnel services payments (11.8)	$ -	$ -	$ -
Subtotal personnel compensation	**$ 514,360**	**$ 515,499**	**$ 483,136**
Civilian benefits (12.1)	$ 146,875	$ 145,949	$ 148,667
Military benefits (12.2)	$ 7,145	$ 7,252	$ 7,251
Benefits to former personnel (13.0)	$ -	$ -	$ -
Subtotal Pay Costs	**$ 668,380**	**$ 668,700**	**$ 639,054**
Travel and transportation of persons (21.0)	$ 1,900	$ 1,048	$ 1,048
Transportation of things (22.0)	$ -	$ -	$ -
Rental payments to GSA (23.1)	$ 5,100	$ 5,100	$ 5,100
Communication, utilities, and misc. charges (23.3)	$ -	$ -	$ -
Printing and reproduction (24.0)	$ 2,101	$ 1,671	$ 2,223
Other Contractual Services:			
Advisory and assistance services (25.1)	$ -	$ -	$ -
Other services (25.2)	$ 1,963,760	$ 1,934,269	$ 1,541,533
Purchase of goods and services from government accounts (25.3)	$ 3,100	$ 2,192	$ 3,187
Operation and maintenance of facilities (25.4)	$ -	$ -	$ -
Research and Development Contracts (25.5)	$ 20,054	$ 19,918	$ 18,054
Medical care (25.6)	$ 1,300,919	$ 1,313,851	$ 1,332,869
Operation and maintenance of equipment (25.7)	$ -	$ -	$ -
Subsistence and support of persons (25.8)	$ -	$ -	$ -
Subtotal Other Contractual Services	**$ 3,287,833**	**$ 3,270,230**	**$ 2,895,643**
Supplies and materials (26.0)	$ 1,000	$ 1,003	$ 811
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)	$ -	$ -	$ -
Subtotal Non-Pay Costs	**$ 3,297,934**	**$ 3,279,052**	**$ 2,904,825**
Total Direct Budget Authority	**$ 3,966,314**	**$ 3,947,752**	**$ 3,543,879**
Average Cost per FTE			
Civilian FTEs	4,376	4,365	4,099
Civilian Average Salary	$ 148	$ 148	$ 151
Percent change	0%	0%	2%
Military FTEs	138	138	138
Military Average Salary	$ 152	$ 155	$ 155
Percent change	0%	2%	0%
Total OPDIV FTEs	4,514	4,503	4,237
Total OPDIV Average Salary	$ 148	$ 149	$ 151
Percent change	0%	0%	2%

CMS Program Management
Salaries and Expenses
(Dollars in Thousands)

	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Personnel compensation:			
Full-time permanent (11.1)	$ 470,276	$ 482,590	$ 450,408
Other than full-time permanent (11.3)	$ 22,416	$ 10,935	$ 10,996
Other personnel compensation (11.5)	$ 7,800	$ 7,897	$ 7,655
Military personnel (11.7)	$ 13,868	$ 14,077	$ 14,077
Special personnel services payments (11.8)	$ -	$ -	$ -
Subtotal personnel compensation	**$ 514,360**	**$ 515,499**	**$ 483,136**
Civilian benefits (12.1)	$ 146,875	$ 145,949	$ 148,667
Military benefits (12.2)	$ 7,145	$ 7,252	$ 7,251
Benefits to former personnel (13.0)	$ -	$ -	$ -
Total Pay Costs	**$ 668,380**	**$ 668,700**	**$ 639,054**
Travel and transportation of persons (21.0)	$ 1,900	$ 1,048	$ 1,048
Transportation of things (22.0)	$ -	$ -	$ -
Rental payments to GSA (23.1)	$ 5,100	$ 5,100	$ 5,100
Rental payments to Others (23.2)	$ -	$ -	$ -
Communication, utilities, and misc. charges (23.3)	$ -	$ -	$ -
Printing and reproduction (24.0)	$ 2,101	$ 1,671	$ 2,223
Other Contractual Services:			
Advisory and assistance services (25.1)	$ -	$ -	$ -
Other services (25.2)	$ 1,963,760	$ 1,934,269	$ 1,541,533
Purchase of goods and services from government accounts (25.3)	$ 3,100	$ 2,192	$ 3,187
Operation and maintenance of facilities (25.4)	$ -	$ -	$ -
Research and Development Contracts (25.5)	$ 20,054	$ 19,918	$ 18,054
Medical care (25.6)	$ 1,300,919	$ 1,313,851	$ 1,332,869
Operation and maintenance of equipment (25.7)	$ -	$ -	$ -
Subsistence and support of persons (25.8)	$ -	$ -	$ -
Subtotal Other Contractual Services	**$ 3,296,934**	**$ 3,278,049**	**$ 2,904,014**
Supplies and materials (26.0)	$ 1,000	$ 1,003	$ 811
Total Non-Pay Costs	**$ 3,297,934**	**$ 3,279,052**	**$ 2,904,825**
Total Salary and Expense	**$ 3,966,314**	**$ 3,947,752**	**$ 3,543,879**
Direct FTE	4,514	4,503	4,237

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2017 Actual	2018 Estimate	2019 Estimate
Office of the Administrator			
Direct FTEs	22	44	24
Reimbursable FTEs	0	0	0
Subtotal	22	44	24
Center for Clinical Standards and Quality			
Direct FTEs	198	192	189
Reimbursable FTEs	40	40	40
Subtotal	238	232	229
Center for Consumer Information and Insurance Oversight			
Direct FTEs	226	222	211
Reimbursable FTEs	130	126	126
Subtotal	356	348	337
Center for Medicaid and CHIP Services			
Direct FTEs	312	315	293
Reimbursable FTEs	0	0	0
Subtotal	312	315	293
Center for Medicare			
Direct FTEs	664	655	622
Reimbursable FTEs	4	6	6
Subtotal	668	661	628
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	8	8	7
Reimbursable FTEs	30	29	29
Subtotal	38	37	36
Office of Acquisition & Grants Management			
Direct FTEs	164	163	154
Reimbursable FTEs	2	2	2
Subtotal	166	165	156
Office of the Actuary			
Direct FTEs	83	82	78
Reimbursable FTEs	0	0	0
Subtotal	83	82	78
Office of Communications			
Direct FTEs	226	222	211
Reimbursable FTEs	1	1	1
Subtotal	227	223	212
Office of Information Technology			
Direct FTEs	438	421	411
Reimbursable FTEs	1	2	2
Subtotal	439	423	413
Office of Equal Opportunity and Civil Rights			
Direct FTEs	34	34	32
Reimbursable FTEs	0	0	0
Subtotal	34	34	32

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2017 Actual	2018 Estimate	2019 Estimate
Federal Coordinated Health Care Office			
Direct FTEs	28	28	26
Reimbursable FTEs	0	0	0
Subtotal	28	28	26
Office of Financial Management			
Direct FTEs	246	246	231
Reimbursable FTEs	4	6	6
Subtotal	250	252	237
Office of Hearings and Inquiries			
Direct FTEs	126	125	118
Reimbursable FTEs	0	0	0
Subtotal	126	125	118
Office of Legislation			
Direct FTEs	61	57	57
Reimbursable FTEs	0	0	0
Subtotal	61	57	57
Continuous Improvement and Strategic Planning			
Direct FTEs	10	10	9
Reimbursable FTEs	0	0	0
Subtotal	10	10	9
Digital Service at CMS			
Direct FTEs	0	0	0
Reimbursable FTEs	0	0	0
Subtotal	0	0	0
Office of Minority Health			
Direct FTEs	21	20	19
Reimbursable FTEs	0	0	0
Subtotal	21	20	19
Office of Human Capital			
Direct FTEs	174	178	163
Reimbursable FTEs	0	0	0
Subtotal	174	178	163
Office of Support Services and Operations			
Direct FTEs	98	95	91
Reimbursable FTEs	1	1	1
Subtotal	99	96	92
Office of Strategic Operations and Regulatory Affairs			
Direct FTEs	152	151	142
Reimbursable FTEs	0	0	0
Subtotal	152	151	142
Office of Enterprise Data and Analytics			
Direct FTEs	80	71	75
Reimbursable FTEs	0	0	0
Subtotal	80	71	75
Consortia			
Direct FTEs	1,145	1,164	1,072
Reimbursable FTEs	27	36	36
Subtotal	1,172	1,200	1,108
Total, CMS Program Management FTE 1/	**4,754**	**4,752**	**4,486**
Total, CMS Military Staffing (Non-Add) 1/	*138*	*138*	*138*

CMS Program Management
Detail of Full Time Equivalents (FTE)

	2017 Actual	2018 Estimate	2019 Estimate
American Recovery and Reinvestment Act (ARRA):			
Total, CMS Program Management ARRA FTE 1/	**75**	**69**	**69**

1/ FY 2017 reflects actual FTE consumption. Excludes directly-appropriated ACA provisions.
2/ Exchange User Fee FTEs are projected to remain consistent in FY 2019 and the decrease will occur amongst Direct FTEs.

Average GS Grade

FY 2015	**13.4**
FY 2016	**13.4**
FY 2017	**13.4**
FY 2018	**13.4**
FY 2019	**13.4**

CMS Program Management
Detail of Positions
(Dollars in Thousands)

	2017 Final	2018 Annualized CR	2019 President's Request
Subtotal, EX	1	1	1
Total - Exec. Level Salary	$165	$165	$165
Subtotal	76	76	76
Total - ES Salaries	$13,444	$13,645	$13,838
GS-15	567	564	529
GS-14	574	571	536
GS-13	2,077	2,066	1,938
GS-12	733	729	684
GS-11	138	137	129
GS-10	1	1	1
GS-9	158	157	148
GS-8	2	2	2
GS-7	40	40	37
GS-6	4	4	4
GS-5	9	9	8
GS-4	7	7	6
GS-3	0	0	0
GS-2	0	0	0
GS-1	0	0	0
Subtotal 1/	4,310	4,288	4,022
Total - GS Salary 1/	$479,083	$479,615	$447,340
Average GS grade 1/	13.4	13.4	13.4
Average GS salary 1/	$111.156	$111.851	$111.223

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	$250,000	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%), FY 2017 (-6.9%) and FY 2018 (-6.6%)

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%), FY 2017 (-6.9%) and FY 2018 (-6.6%).

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		$18,221	25		$12,655	26	
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			8			8	
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			551			600	
Independence At Home Demonstration 2/	3024		1			1			1	
Community Based Care Transitions	3026		1			0			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			2			2	
Sunshine Act	6002	$ 4,211	17		$ 5,615	22			0	
LTC National Background Checks	6201		6			6			6	
Provider Screening & Other Enrollment Requirements 1/	6401	$ 3,509	14		$ 3,509	9			0	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402	$ 468	2		$ 468	1			0	
Expansion of the Recovery Audit Contractor Program 1/	6411	$ 468	2			0			0	
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**			**625**			**643**	

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%), FY 2017 (-6.9%), and FY 2018 (-6.6%).

FTEs Funded by the Affordable Care Act
Centers for Medicare & Medicaid
(Dollars in Thousands)

Program	Section	FY 2019		
		Total	FTEs	CEs
ACA Direct Appropriated				
Health Insurance Consumer Information	1002		0	
Rate Review Grants	1003		0	
Pre-existing Condition Insurance Plan Program	1101		0	
Reinsurance for Early Retirees	1102		0	
Affordable Choices of Health Benefit Plans	1311		0	
Assist Establishment & Operation of Nonprofit, Member-Run Health Insurance Issuers (CO-OP)	1322		0	
CO-OP Contingency Fund	1322/644		0	
Adult Health Quality Measures 2/	2701		8	
Medicaid Emergency Psychiatric Demonstration	2707		0	
Quality Measurement 2/	3014		0	
Establishment of Center for Medicare/Medicaid Innovation within CMS	3021		600	
Independence At Home Demonstration 2/	3024		1	
Community Based Care Transitions	3026		0	
Treatment of Certain Complex Diagnostic Lab Tests	3113		0	
Medicaid Incentives for Prevention of Chronic Disease	4108		0	
Community Prevention and Wellness	4202		0	
Graduate Nurse Education 2/	5509		2	
Sunshine Act	6002		0	
LTC National Background Checks	6201		6	
Provider Screening & Other Enrollment Requirements 1/	6401		0	
Enhanced Medicare/Medicaid Program Integrity Provisions 1/	6402		0	
Expansion of the Recovery Audit Contractor Program 1/	6411		0	
Termination of Provider Participation under Medicaid 1/	6501		0	
Medicare Coverage for Individuals Exposed to Environmental Health Hazards 2/	10323		0	
Total ACA Direct Appropriated FTEs			**617**	

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%), FY 2017 (-6.9%), and FY 2018 (-6.6%).

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 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
1) Number of Physicians Receiving PCAs		48	62	66
2) Number of Physicians with One-Year PCA Agreements		1	3	3
3) Number of Physicians with Multi-Year PCA Agreements		47	59	63
4) Average Annual PCA Physician Pay (without PCA payment)		$157,035	$157,035	$158,836
5) Average Annual PCA Payment		$24,615	$25,100	$28,009
6) Number of Physicians Receiving PCAs by Category (non-add)	Category I Clinical Position	0	0	0
	Category II Research Position	0	0	0
	Category III Occupational Health	0	0	0
	Category IV-A Disability Evaluation	0	0	0
	Category IV-B Health and Medical Admin.	48	62	66

*FY 2018 data will be approved during the FY 2019 Budget cycle

7) If applicable, list and explain the necessity of any additional physician categories designated by your agency (for categories other than me 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. 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 hurdles 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.

The average annual PCA Physician Pay (without PCA payment) will increase in FY 2018/FY 2019 as there will be 17 Medical Officers eligible for step increases during that timeframe. The average annual PCA amounts will increase in FY 2018/FY 2019 as four Medical Officers will have completed their 24 months as a government physician. Once they have more than 24 months, the maximum PCA limit is $30,000. Currently of the 48 Medical Officers, CMS has 15 at the maximum PCA amount of $30,000.

CMS projects 18 Medical Officer positions that need to be filled in FY 2018/FY 2019 based upon information received from the components listed below. Several of CMS medical officers have already or plan to retire within the next year or two; therefore, 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. Since FY 2018 has begun, three Medical Officers have resigned from CMS and those positions will need to be backfilled.

<u>CMMI</u>
CMMI anticipates a request to fill three Medical Officer positions in FY 2018 and three additional Medical Officers in FY 2019. CMMI has a strong need to hire Medical Officers that will provide

strategic and clinical support for new model development in multiple areas such as competitive pricing, prescriptions drugs, and physician specialty models.

CCSQ
CCSQ anticipates a request to fill four Medical Officer positions in FY 2018. 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. CCSQ will need at least two Medical Officers with a background in clinical research (e.g., biostats or epidemiology) and one Medical Officer to assist with all of the Local Coverage Determination work. In addition, CCSQ anticipates at least three Medical Officers leaving CCSQ which will require the need to backfill those positions.

CM
CM currently has one request to hire a Medical Officer in FY 2018. They also anticipate backfilling one Medical Officer position based on a resignation in FY 2017.

CPI
CPI anticipates a request to fill two Medical Officer positions in FY 2018. CPI is implementing a new program that is related to the opioids initiative across the Agency. Also, a Medical Officer who is currently on a detail with CDC will be returning to CPI in FY 2019.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
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SIGNIFICANT ITEMS
Significant Items in Appropriation Committee Reports 193

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SIGNIFICANT ITEMS AND REPORTS TO CONGRESS FOR INCLUSION IN THE FY 2019 CONGRESSIONAL JUSTIFICATION

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 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.

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 2019.

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 Actual	FY 2018 Annualized CR /1	FY 2019 President's Budget
Health Plan Bid Review, Management and Oversight	$ -	$ 300	$ 21,936	$ 40,595	$ 33,497	$ 43,960	$ 40,520	$ 39,846	$ 38,023	$ 10,000
Payment and Financial Management	$ -	$ 1,698	$ 24,998	$ 25,832	$ 49,615	$ 43,733	$ 51,325	$ 47,640	$ 45,663	$ 40,770
Eligibility and Enrollment	$ -	$ 2,218	$ 3,433	$ 275,501	$ 339,754	$ 363,768	$ 445,249	$ 484,144	$ 403,843	$ 233,764
Consumer Information and Outreach	$ -	$ 2,427	$ 32,610	$ 701,075	$ 704,136	$ 753,238	$ 805,833	$ 640,232	$ 578,080	$ 341,230
Call Center (non-add)	$	$ -	$ 22,000	$ 505,446	$ 545,600	$ 566,178	$ 563,638	$ 540,197	$ 514,000	$ 281,350
Navigators Grants & Enrollment Assisters (non-add) /2	$ -	$ -	$ -	$ 107,513	$ 97,152	$ 75,996	$ 99,677	$ 51,166	$ 13,730	$ 13,530
Consumer Education and Outreach (non-add)	$	$ -	$ 7,043	$ 77,436	$ 49,334	$ 54,897	$ 101,048	$ 16,599	$ 11,350	$ 16,350
Information Technology	$ 2,346	$ 92,672	$ 166,455	$ 402,553	$ 770,957	$ 798,648	$ 664,083	$ 710,867	$ 612,853	$ 457,875
Quality	$	$ -	$ -	$ -	$ 17,189	$ 15,634	$ 11,736	$ 7,301	$ 8,000	$ 4,000
SHOP and Employer Activities	$	$ 366	$ 18,479	$ 25,076	$ 30,541	$ 42,717	$ 34,520	$ 16,500	$ 10,500	$ 2,375
Other Marketplace	$ 1,879	$ 14,906	$ 13,738	$ 4,400	$ 6,728	$ 3,614	$ 12,032	$ 49,584	$ 26,201	$ 10,186
Federal Payroll and Other Administrative Activities	$ 429	$ 10,805	$ 43,493	$ 68,429	$ 80,000	$ 80,000	$ 85,000	$ 79,602	$ 73,750	$ 50,000
Total	$ 4,654	$ 125,392	$ 325,142	$ 1,543,461	$ 2,032,418	$ 2,145,312	$ 2,150,297	$ 2,075,714	$ 1,796,913	$ 1,150,200

1/ FY 2018 Annualized Continuing Resolution (CR) is an estimate and subject to change.

2/ Funding for Enrollment Assisters ended in FY 2017.

NOTE: Fiscal years 2010 through 2017 include obligations as of September 30 of each year.

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.

Medicare Prescription Drug Plan (PDP) Standardized Reporting - The Committee requests CMS to provide an update in the 2019 CJ on how they plan to require standardized reporting by PDP sponsors of all price concessions received from, and incentive payments made to, network pharmacies, except those contingent price concessions or incentive payments that cannot reasonably be determined at the point of sale.

Action Taken or To Be Taken

Under current law, when not explicitly required to do so for certain types of pharmacy price concessions, Part D sponsors can choose whether to reflect various price concessions, including manufacturer rebates, they or their intermediaries receive in the negotiated price. Specifically, section 1860D-2(d)(1)(B) of the Act merely requires that negotiated prices "shall take into account negotiated price concessions, such as discounts, direct or indirect subsidies, rebates, and direct or indirect remunerations, for covered part D drugs . . .." In other words, Part D sponsors are allowed, but not currently required, to apply rebates and other price concessions at the point-of-sale to lower the price upon which beneficiary cost-sharing is calculated. To date, sponsors have only very rarely elected to include rebates and other price concessions in the negotiated price at the point-of-sale. All rebates and other price concessions that are not included in the negotiated price must be reported to CMS as direct and indirect remuneration (DIR) at the end of the coverage year and are used in our calculation of final plan payments, which, under the statute, are required to be based on costs actually incurred by Part D sponsors, net of all applicable DIR.

On November 16, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule with comment period that proposes to update Medicare Advantage (MA) and the prescription drug benefit program (Part D) by promoting innovation and empowering MA and Part D sponsors with new tools to improve quality of care and provide more plan choices for MA and Part D enrollees. The proposed rule includes a Request for Information soliciting comment on potential policy approaches for applying some manufacturer rebates and all pharmacy price concessions to the price of a drug at the point of sale. We would use ideas and comments provided in response to the Request for Information to evaluate and consider proposals for rulemaking.

Plan Finder - The Committee encourages CMS to enhance the Medicare Plan Finder web site to strengthen beneficiaries' ability to shop for and choose plans that best meet their needs. CMS should consider improvements such as improving navigation on mobile devices, providing information on the estimated out-of-pocket costs for Medicare beneficiaries for common services, and providing searchable up-to-date provider network directories. The Committee encourages CMS to solicit input from relevant stakeholders to help inform and facilitate such changes. The Committee requests that an update of these efforts be provided in the fiscal year 2019 CJ.

Action Taken or To Be Taken

The Medicare Plan Finder at Medicare.gov/find-a-plan features a star rating system for Medicare health and drug plans. The Overall Star Rating gives an overall rating of the plan's quality and performance for the types of services each plan offers. Users of the Medicare Plan Finder are able to compare plans' quality summary rating from the previous year, identify which drugs may or may not be restricted or on a plan's formulary, and compare the cost ranges for plans available in their area. CMS continues to make it easier for people with Medicare to find and choose high quality plans. In addition to the star ratings, users will find a low performer icon that shows those plans that had a low Part C and/or Part D summary rating for at least the past

three years. There is also a gold star icon that identifies those plans that have a five star rating for 2018.

As described in the 2019 Advance Notice and Draft Call Letter, starting with the 2019 Annual Election Period (AEP), CMS intends to display an icon or other type of notice on Plan Finder for sponsoring organizations that have received a Civil Money Penalty (CMP). CMS expects that the icon or notice would provide current enrollees and prospective enrollees with general information about a CMP, and may link to the CMP letter on the CMS website for that particular sponsoring organization.

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 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 15, 2017 CMS released a report detailing Risk Corridor payments and charges for the 2016 benefit year. That report can be found here:

https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-Amounts-2016.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 routine preventative care which will end up increasing healthcare costs in the long run. The Committee appreciates the ongoing work of CMS and HRSA to analyze the impact of proposed regulations on rural hospitals and other providers and is pleased with the recent establishment of the Rural Health Council to address the unique needs of rural communities. The Committee continues to direct CMS to work with HRSA's Office of Rural Health and provide an update in the fiscal year 2019 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

In 2017, CMS sought to apply a rural lens to the agency's work. As a result, the agency has become increasingly mindful of the consequences for and impacts on rural communities as regulations and initiatives are proposed. To assist in meeting the needs of rural stakeholders, CMS continued to seek input from rural stakeholders through rural listening sessions across the country. Stakeholder concerns included the following: payment rates; the administrative burden associated with quality reporting; transportation issues affecting access to specialty care; and difficulty navigating the varied coverage requirements of a patchwork healthcare system. In addition to these listening sessions, each Medicare payment system invited the public to submit their ideas for regulatory, sub-regulatory, policy, practice, and procedural changes to reduce regulatory burden. Through these efforts, and the recently launched "Patients Over Paperwork" Initiative that will include additional rural listening sessions in 2018, CMS is finding ways to make it easier for rural providers to focus on their patients' and families' needs without excessive regulatory and administrative burden.

To help improve access to care and support innovation in rural communities, CMS expanded access to telehealth, adding new services for both 2017 and 2018, including behavioral health integration services that help to expand access to mental health services in rural areas. The agency launched the Pennsylvania Rural Health Model, which aims to increase rural Pennsylvanians' access to high-quality care and improve their health, while also reducing the growth of hospital expenditures across payers, as well as increasing the financial viability of rural hospitals to ensure continued access to care. The agency also implemented a five-year extension of the Rural Community Hospital Demonstration, which tests cost-based payment for Medicare inpatient services for small rural hospitals too large to qualify as Critical Access Hospitals. CMS' Quality Payment Program provides options to make it easier for clinicians in small and rural practices to participate in the program, such as adding the virtual group option to help individual MIPS-eligible clinicians and small practices come together and participate, and providing five bonus points to the final score to any MIPS-eligible clinician who is in a small practice. Also as a part of the Quality Payment Program, CMS established the Small, Underserved, and Rural Support initiative to provide direct support to small and rural practices, and the ten rural health coordinators based in the CMS regional offices continue to stay in contact with rural providers by performing their outreach, technical assistance, and casework functions.

Finally, to improve access to information that is relevant to rural providers, CMS launched a website in 2017 at go.cms.gov/ruralhealth. This is a portal to assist rural stakeholders in navigating CMS program information and stay better connected to the Agency's rural-related initiatives.

Therapeutic Foster Care - The Committee remains concerned about the lack of a uniform definition within the Medicaid program for therapeutic foster care (TFC) services. A uniform definition would improve the ability for more consistent care and treatment. The Committee requests an update in the fiscal year 2019 CJ on the study requested in House Report 114-699 under this heading.

Action Taken or To Be Taken

CMS is committed to increasing state flexibility within the Medicaid program while reducing burdens for states in order to serve the health and wellness needs of our most vulnerable populations. We are currently examining the impact of a uniform definition of therapeutic foster care services under these objectives, while remaining cognizant of the fact that states may be best-positioned to define these services.

Use of Social Security Numbers on Medicare Beneficiaries' Cards - The Committee is encouraged by CMS plans to start sending new Medicare cards with a Medicare Beneficiary Identifier to Medicare beneficiaries by October 2018. The Committee directs CMS to provide an update on the progress of this initiative in their fiscal year 2019 CJ.

Action Taken or To Be Taken
CMS has assigned all people with Medicare benefits a new, unique Medicare number, which contains a combination of numbers and uppercase letters. Medicare beneficiaries will receive a new Medicare card in the mail, and will be instructed to safely and securely destroy their current Medicare card and keep their new Medicare number confidential. The new Medicare card contains a unique, randomly-assigned number that replaces the current Social Security-based number. CMS will begin mailing the new cards to Medicare beneficiaries in April 2018 to meet the statutory deadline for replacing all existing Medicare cards by April 2019. The design of the new Medicare card is in the 2018 Medicare & You Handbook.

House Report
Transparency in Hospital Reimbursement - The Committee requests CMS provide information in the fiscal year 2019 Congressional Justification identifying all pass-through payments reimbursed from the Hospital Insurance Trust Fund. The Committee expects CMS to address pass-through payments for hospital-based nursing programs, as well as the oversight function CMS performs to ensure such programs are fully accredited.

Action Taken or To Be Taken
The Inpatient Prospective Payment System (IPPS) for acute hospital inpatient care is a per-discharge payment system. The per-discharge payment is based on two national base payment rates: one that provides for operating expenses and another for capital expenses. These base payment rates are adjust to account for the costs associated with the patient's clinical condition and related treatment relative to the costs of the average Medicare case, as well as for market conditions in the hospital's location relative to national conditions.

In addition to the adjusted base payment rates, inpatient hospitals may qualify for additional payments and adjustments. These include direct graduate medical education (DGME) and indirect graduate medical education (IME) payments for teaching hospitals or hospitals that train residents in approved medical residency training programs, outlier payments for extremely costly cases, Medicare disproportionate share (DSH) payments (including uncompensated care payments) for hospitals that treat a disproportionate share of low-income patients, reductions in payments for cases with short lengths of stay that are transferred to certain other facilities, payments for cases where certain new technologies are used, and adjustments for the hospital value based payment (VBP) program, hospital readmissions reduction program (HRRP), and the hospital-acquired conditions reduction program (HAC).

Separate from the IPPS, Medicare makes pass-through payments to hospitals for the costs of nursing and allied health education activities. The regulations at 42 CFR 413.85 set forth the rules for determining these payments. The accreditation standards for the approved educational activities for which Medicare payments will be made are at 413.85(e), which states that CMS will consider an activity an approved nursing and allied health education program if the program is a planned program of study that is licensed by State law, or if licensing is not required, is accredited by the recognized national professional organization for the particular activity. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs, the National League of Nursing Accrediting Commission, the Association for Clinical Pastoral Education Inc., and the American Dietetic Association.

Ambulatory Surgical Centers - CMS is directed to submit a report to the Committees on Appropriations of the House of Representatives and Senate, and the authorizing committees of jurisdiction, on any increased cost to the Medicare program and its beneficiaries due to the migration of procedures from ambulatory surgical centers (ASCs) to higher cost settings. The report will evaluate volume changes over the past ten years to identify procedures that are migrating from ASCs to higher cost settings and make specific recommendations that CMS can implement to reverse this trend.

Action Taken or To Be Taken

Under the Medicare program, there are several services which may be furnished in multiple settings, such as the hospital outpatient department (HOPD), the ASC or the physician office setting. CMS shares concerns about the potential for inappropriate migration of services from lower cost settings to higher cost settings and seeks to promote "site-neutral" payments to the extent permitted by law. Medicare payment in the ASC setting uses the relative payment weights for surgical procedures under the Hospital Outpatient Prospective Payment System as the basis for the payment groups and the relative payment weights for surgical procedures performed in an ASC. These ASC payment weights are then scaled to maintain annual budget neutrality. Generally, Medicare payments for similar services furnished in HOPDs are higher than in the ASCs. Medicare payments for similar services in the physician office setting are generally lower than in the ASC setting.

There are currently over 5,200 ASCs nationwide. Between 2010 and 2015, the number of Medicare-certified ASCs grew by seven percent. The number of beneficiaries in the original Medicare program increased by an average of 0.5 percent per year from 2010 to 2014 and by 1.2 percent in 2015.

ASCs exclusively furnish surgical services to patients who do not require hospitalization and in which the expected duration of services does not exceed 24 hours following admission. Services excluded from Medicare payment in ASCs are those procedures that pose a significant safety risk to patients or are expected to require active medical monitoring at midnight on the day of the procedure when furnished in an ASC.

The 20 most frequently provided ASC services in 2015 were similar to those provided in 2010. Over the ten year period beginning 2008 and ending in 2017, the number of ASC covered surgical procedures increased by 3 percent to almost 3,500 procedures.

Below are some summary data pertaining specifically to ASCs, including relevant changes in the volume of key services. The data shows that volume trends both increase and decrease for certain services with respect to the HOPD setting, the ASC setting and the physician office setting. While it is possible to assess the number of procedures performed in various settings over time, it is difficult to determine whether there is a true migration of services since factors such as beneficiary enrollment, severity of illness, access in rural and urban areas, and physician and patient preference can affect the volume of services furnished within a given service setting or even a given facility. Nonetheless, we have observed certain differences in utilization over time, including:

- Among the 100 most frequently furnished ASC services, between 2012 and 2016, utilization decreased in the HOPD setting and increased in the ASC for 33 procedures . As examples:
    - CPT code 66984 Cataract surgery w/ IOL insert, 1 stage -- utilization in the HOPD decreased 6 percentage points and utilization in the ASC increased 6 percentage points from 2012 to 2016.

- CPT code 45380 Colonoscopy and biopsy -- utilization in the HOPD decreased 2 percentage points and utilization in the ASC increased 2 percentage points from 2012 to 2016.
- CPT code 45378 Diagnostic colonoscopy -- utilization in the HOPD decreased 2 percentage points and utilization in the ASC increased 2 percentage points from 2012 to 2016.

• Among the 100 most frequently furnished ASC services, between 2012 and 2016, utilization decreased in the ASC and increased in the HOPD setting for only two procedures.
- CPT code 11043 Debridement, muscle and/or fascia; first 20 sq cm or less – utilization in the HOPD increased 4 percentage points and utilization in the ASC decreased 1 percentage point from 2012 to 2016.
- CPT code 52204 Cystoscopy w/biopsy(s) – utilization in the HOPD increased 5 percentage points and utilization in the ASC decreased 1 percentage point from 2012 to 2016.

• Among the 100 most frequently furnished ASC services, between 2012 and 2016, utilization decreased in the ASC and increased in the physician office for seven procedures.
- CPT code 13121 Repair of wound or lesion
- CPT code 14040 Skin tissue rearrangement
- CPT code 30140 Resect inferior turbinate
- CPT code 36561 Insert tunneled cv cath
- CPT code 46221 Ligation of hemorrhoid(s)
- CPT code 64479 Inj foramen epidural c/t
- CPT code 64520 N block lumbar/thoracic

As previously noted, overall utilization may change due to a number of factors. We are cognizant of the incentive that comes with higher payments for the same service, after adjusting for factors such as severity of illness and provider access to care. Accordingly, we aim to encourage site-neutral payments to the extent feasible under existing Medicare law.

Chronic Obstructive Pulmonary Disease - Chronic Obstructive Pulmonary Disease (COPD) is the third leading cause of death and fourth most costly condition with respect to hospital readmissions. Respiratory therapists are educated and trained in all aspects of pulmonary medicine and play a critical role in the treatment of COPD patients. The Committee encourages CMS to conduct an analysis of the most recent claims data of services provided to Medicare beneficiaries with COPD in the emergency department, inpatient and physician office settings, and long-term care facilities to determine the role of respiratory therapists in improved health outcomes, reduced readmissions, and potential cost savings. The Committee requests an update on this effort in the fiscal year 2019 Congressional Justification.

Action Taken or To Be Taken

Access to respiratory therapy services is important for Medicare beneficiaries and respiratory therapists are an important part of the care team. Typically, the services furnished by respiratory therapists are billed to Medicare by other entities, such as hospitals or home health agencies. Therefore, the claims data does not indicate specific information about the role of the respiratory therapist. It is important that all members of the care team, including respiratory therapists, work together to promote improved health outcomes for all Medicare beneficiaries.

Colorectal Cancer Screening - The Committee recognizes the inequity in beneficiary cost sharing for screening colonoscopies. The Committee urges CMS to align its interpretation of the colorectal cancer screening cost-sharing requirements for Medicare beneficiaries with the policy

of colorectal cancer cost-sharing requirements for other Federally-funded health programs. The Committee encourages CMS to conduct an analysis of recent scientific literature on the efficacy of colorectal cancer screening. The Committee requests an update on this topic in the fiscal year 2019 Congressional Justification.

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. Early detection is cost-effective or even cost-saving in comparison with no screening. 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.

Evaluation and Management Codes - Over 90 percent of the care provided by infectious disease (ID) physicians is considered evaluation and management (E&M). These face-to-face encounters continue to be undervalued by current payment systems that much more generously reward procedures. This has created a significant compensation disparity between ID physicians and specialists who provide more procedure-based care, as well as primary care physicians who provide similar or identical E&M services but who have received payment increases simply because their specialty enrollment designations as ‘‘primary care physicians.’’ The Committee requests CMS, as part of its ongoing effort to improve valuation and payment accuracy, research the necessary documentation that would more precisely describe the cognitive work in the office visits of ID physicians. The Committee requests an update on this topic in the fiscal year 2019 Congressional Justification.

Action Taken or To Be Taken
The Centers for Medicare & Medicaid Services (CMS) is continuing efforts to explore improvements related to evaluation and management (E&M) services, especially by examining the documentation guidelines for all of these services. CMS maintains guidelines specifying the kind of information that physicians and other practitioners must maintain in the medical record in order to document that the appropriate level of E&M visit has been furnished. (E&M visits are distinguished by level of complexity as well as site of care, and in some cases, between new or established patients.) There are three key E&M documentation components: history of present illness, physical examination, and medical decision making.

Based on previous stakeholder feedback, CMS in general agrees that there may be unnecessary burden with these guidelines and that they are potentially outdated, particularly for the requirements for the history and the physical exam. In the calendar year 2018 Physician Fee Schedule proposed rule, CMS sought input from a broad array of stakeholders, including patient advocates, on the specific changes that should be undertaken to reform the guidelines, reduce the associated burden, and better align E&M coding and documentation with the current practice of medicine. Comments were sought on some specific areas, including how CMS might focus on initial changes to the guidelines for the history and physical exam and the appropriateness of removing documentation requirements for history and physical exam for all E&M visits at all levels. CMS also sought comment on how such reforms may differentially affect physicians and practitioners of different specialties and how the agency could or should account for such effects in examining this issue.

CMS received many comments on potential updates and revisions to the E&M documentation guidelines that were summarized in the calendar year 2018 Physician Fee Schedule final rule. Commenters also suggested that the agency provide additional avenues for collaboration with stakeholders prior to implementing any changes. CMS is currently considering the best approaches for such collaboration, and will take the comments into account as it considers the issues for future rulemaking. CMS will continue to examine options for revising the guidelines, which have the potential to reduce clinical burden and improve documentation in a way that would be more effective in clinical workflows and care coordination.

In addition, some commenters requested that CMS revise or revalue the code set for E&M services. CMS previously has acknowledged the limitations of the current E&M code set. The agency expects to continue to work on the structure and valuation of the E&M code set with stakeholders in future years, although it is immediately focused on revision of the current E&M documentation guidelines in order to reduce unnecessary administrative burden.

Home Health Care - The Committee is aware that the current requirement that home health plans be certified solely by a physician has resulted in problems with access to home health care. The Committee acknowledges CMS' efforts to limit the requirements placed on the certifying physician. The Committee requests an update in the fiscal year 2019 Congressional Justification on the face-to-face encounter performed by an allowed non-physician practitioner (working in collaboration with/under the supervision of the certifying physician or the acute/post-acute-care physician).

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 practitioners.

For medical review purposes, CMS 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 plan of care, as required for payment, and the initial and/or comprehensive assessment of the patient, as required by the home health conditions of participation, can be incorporated into the certifying physician'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 sign and date any information from the home health agency incorporated into the certifying physician's medical record for the patient that is used to support the certification.

CMS has developed voluntary electronic clinical templates with clinical data elements (CDEs) and voluntary paper clinical templates, both of which assist with: (1) documenting the face-to-face encounter and (2) documenting the home health plan of care and certification of patient eligibility for the Medicare home health benefit. The use of these templates would be entirely voluntary. Once completed by the physician or other practitioner, the resulting documentation would become part of the patient's medical record.

CMS developed lists of suggested CDEs for use within appropriate electronic templates. There are separate lists of CDEs to assist with documenting the face-to-face encounter and documenting the home health plan of care and certification. The suggested CDEs could be used by health information technology vendors as guidance in creating or enhancing existing electronic clinical templates within electronic health record systems. The suggested CDEs are not forms but are tools that vendors could integrate into electronic health record systems to create prompts to assist practitioners with their medical record documentation for Medicare purposes. CMS also created paper clinical templates, one to assist with documenting the face-to-face encounter and another to assist with documenting the home health plan of care and certification.

CMS is seeking public comment on the voluntary electronic and paper templates. Additionally, CMS has implemented a Targeted Probe and Educate (TPE) process, which is a risk-based process directed toward those providers and suppliers who, based on data analysis, provide the most risk to the Medicare program, and not to all providers and suppliers billing a particular item or service. The TPE process involves several rounds of review and individualized education to help providers and suppliers quickly come into compliance. Providers and suppliers who continue to have high denial rates may be referred to CMS for next steps.

Hospital Rating System - The Committee is concerned with the implementation of CMS's Hospital Star Rating System. While the Committee supports the goals of transparency for patients, it is concerned with how CMS measures factors in determining these ratings. The Committee requests CMS provide details on the methodology used to determine the ratings in the fiscal year 2019 budget request. The Committee encourages CMS to solicit feedback from the stakeholder community regarding the methodology and factors used to determine ratings.

Action Taken or To Be Taken

The Overall Hospital Quality Star Rating system provides consumers with a summary of hospitals' performance on a broad range of measures on the *Hospital Compare* website. The star ratings were first added to the website in July 2016, and CMS has continued to evaluate the measures included in the star ratings as well as the methodology, working closely with stakeholders in the process. The Overall Star Rating has now been revised to use an enhanced methodology to assign ratings to hospitals. These revisions were based on a multi-disciplinary Technical Expert Panel, a Provider Leadership Workgroup, and a public input period. Based on this stakeholder feedback, CMS implemented four enhancements to the Overall Star Rating methodology beginning with the December 2017 *Hospital Compare* updates. These enhancements are:

- Using an updated approach to improve the stability of measure group scores through the use of adaptive quadrature.

- Updating the approach for assigning hospitals to star categories through the use of multiple iterations of K-means clustering to achieve complete convergence.
- Retaining (and no longer winsorizing) hospital summary score outliers prior to clustering.
- Re-sequencing the application of reporting thresholds so that star ratings are assigned after public reporting thresholds are applied to hospitals.

In December 2017, the Star Ratings were updated on Hospital Compare, and the new methodology with the changes described above was used. A description of the Overall Hospital Quality Star Rating Methodology and the updates to the methodology made in December 2017 can be found here: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1228775959066

As hospitals evaluate their star ratings under the revised methodology, CMS will continue to seek stakeholder feedback on ways to ensure the most accurate reflection of the quality of care furnished in the nation's hospitals.

Medication Diversion - The Committee understands the important role of medication-assisted treatment for beneficiaries with opioid use disorder. At the same time, there are reports from several authorities of rising rates of diversion of these Food and Drug Administration-approved medications. The Committee directs CMS to evaluate diversion data from the Drug Enforcement Administration and State sources to determine the scope of this problem and to include in the fiscal year 2019 Congressional Justification options to reduce diversion.

Action Taken or To Be Taken

On November 16, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule with comment period that proposes to update Medicare Advantage (MA) and the prescription drug benefit program (Part D), including through implementation of requirements under the Comprehensive Addiction and Recovery Act of 2016 (CARA). CMS is proposing to implement new CARA requirements so as to provide an important additional tool to combat the growing opioid epidemic that is devastating families and communities across the nation. CARA requires CMS to establish through regulation a framework that allows Part D sponsors to voluntarily implement a drug management program that limits "at risk" beneficiaries' access to controlled substances that CMS determines are "frequently abused drugs" beginning with the 2019 plan year. CARA defines "frequently abused drug" as a drug that is a controlled substance that the Secretary determines to be frequently abused or diverted. Consistent with the statutory definition, we propose to define "frequently abused drug" at § 423.100 to mean a controlled substance under the federal Controlled Substances Act that the Secretary determines is frequently abused or diverted, taking into account the following factors: (1) The drug's schedule designation by the Drug Enforcement Administration; (2) Government or professional guidelines that address that a drug is frequently abused or misused; and (3) An analysis of Medicare or other drug utilization or scientific data. This definition is intended to provide enough specificity for stakeholders to know how the Secretary will determine a frequently abused drug, while preserving flexibility to update which drugs CMS considers to be frequently abused drugs based on relevant factors, such as actions by the Drug Enforcement Administration and/or trends observed in Medicare or scientific data.

The Budget includes several proposals that work to address the impact that the opioid epidemic has on our nation's seniors. The Medicare population has among the highest and fastest-

growing rates of opioid use disorders, currently at more than 6 of every 1,000 beneficiaries. Many seniors take multiple medications and receive prescriptions from multiple doctors, making tracking and controlling any misuse of these prescriptions a substantial challenge. HHS has made tackling this issue, and the opioid epidemic more broadly, a top priority.

The Budget proposes to conduct a demonstration to expand access to comprehensive substance abuse treatment for Medicare beneficiaries, including medication assisted treatment. This demonstration would be expanded nationwide if successful. A corresponding expansion of medication assisted treatment is also proposed for Medicaid beneficiaries, who likewise have rates of opioid use disorder beyond those of other populations.

The Budget also proposes to address opioid misuse in Medicare by giving the Secretary authority to require plan participation in a program to prevent prescription drug abuse in Part D, essentially strengthening the statutory authority already provided through the Comprehensive Addiction Recovery Act of 2016 to "lock" an at-risk beneficiary into a single prescriber or pharmacy. To address potentially abusive prescribing practices the Budget proposes to allow the Secretary to work with the Drug Enforcement Agency (DEA) to revoke a provider's DEA Certificate of Registration after CMS revokes a provider's Medicare enrollment based on a pattern of abusive prescribing.

National Health Expenditures - The Committee requests CMS include information in its fiscal year 2019 Congressional Justification explaining the methodology for including data in the National Health Expenditure (NHE) database. In addition, the Committee requests an analysis of how CMS-published data compares to other comparable information on health expenditures, such as industry surveys.

Action Taken or To Be Taken
The National Health Expenditures (NHE) include both historical and projected NHE estimates.

NHE Historical:
The National Health Expenditure Accounts (NHEA) are the official estimates of total health care spending in the United States. Dating back to 1960, the NHEA measures annual U.S. expenditures for health care goods and services, public health activities, government administration, the net cost of health insurance, and investment related to health care. The data are presented by type of service, sources of funding, and type of sponsor.

The NHEA are generally compatible with a production-based accounting structure such as the National Income and Product Accounts, but include a more complete picture of the health care sector. Using an expenditures approach to national economic accounting, the NHEA identifies all final consumption of health care goods and services as well as investment in a given year that is purchased or provided by direct or third party payments and programs. Three primary characteristics of the NHEA flow from this framework. First, the NHEA are comprehensive because they contain all of the main components of the health care system within a unified mutually exclusive and exhaustive structure. Second, the NHEA are multidimensional, encompassing not only expenditures for medical goods and services, but also the payers that finance these expenditures. Third, the NHEA are consistent because they apply a common set of definitions that allow comparisons among categories and over time.

The information contained in the NHEA can be used to study numerous topics related to the health care sector including, but not limited to, changes in the amount and cost of health services purchased and the payers or programs that provide or purchase these services, the

economic causal factors at work in the health sector, the impact of policy changes, and comparisons at the international level.

More information on the methodology can be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/DSM-16.pdf.

NHE Projections:
The Office of the Actuary in the Centers for Medicare & Medicaid Services (CMS) produces short-term (10-year) projections of health care spending for categories in the National Health Expenditure Accounts (NHEA) on an annual basis. The NHE projections consist of time series for all of the major spending categories in the NHEA. These categories include trends in aggregate medical spending, medical services consumed, sources of payment, and sources of financing.

For the current spending projections, CMS primarily utilizes the standard NHE Econometric Model, with adjustments to model projections for specific effects as needed. The NHE Econometric Model is based on a multi-equation structural econometric model that reflects relationships in historical time-series data and encompasses the health system as a whole. The primary focus of the NHE Econometric Model is to produce projections of future health care spending by private health insurers, by consumers on an out-of-pocket basis, and by other private payers that are consistent with exogenous projections for Medicare, Medicaid, CHIP, and key macroeconomic variables. Key exogenous inputs to the model include the most recent available macroeconomic and demographic assumptions from the Social Security Administration (SSA), as well as actuarial projections for Medicare, Medicaid, and CHIP spending and enrollment. CMS also projects residual spending for other government programs (excluding the programs mentioned above) to provide a comprehensive projection of all spending within the NHEA.

More information on the methodology can be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/ProjectionsMethodology.pdf.

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 Department of Health and Human Services, together with the Departments of Labor and Treasury, released FAQ’s about Affordable Care Act Implementation: Part XXXI. These FAQ’s are available at the link below. Specifically, Q4 in that set describes the circumstances under which plans and issuers are required to disclose how they calculated the amount under the minimum payment standards, including the method that the plan or issuer generally uses to determine payments for out-of-network services (e.g. the UCR amount). https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-31_Final-4-20-16.pdf

Rural Health Clinics - The Committee encourages CMS to engage States and other stakeholders on outstanding issues of payment recoupment, as it relates to CMS-designated Rural Health Clinics. The Committee also requests an update in the fiscal year 2019 Congressional Justification on the study requested in House Report 114–699 under this heading.

Action Taken or To Be Taken
CMS does not require states to recoup any overpayment funds from Rural Health Clinics, but for any identified overpayment the state must return the federal funds to CMS. CMS staff has discussed these issues with Committee staff, and CMS is happy to continue working with the Committee.

Therapeutic Foster Care Services - The Committee remains concerned about the lack of a uniform definition within the Medicaid program for therapeutic foster care (TFC) services. A uniform definition would improve the ability for more consistent care and treatment. The Committee requests an update in the fiscal year 2019 Congressional Justification on the study requested in House Report 114–699 under this heading.

Action Taken or To Be Taken
CMS is committed to increasing state flexibility within the Medicaid program while reducing burdens for states in order to serve the health and wellness needs of our most vulnerable populations. We are currently examining the impact of a uniform definition of therapeutic foster care services under these objectives, while remaining cognizant of the fact that states may be best-positioned to define these services.

Patient Matching - The Committee recognizes that a lack of a patient matching system for Medicare beneficiaries results in duplicate procedures and poses a significant patient safety risk. The Committee is aware that a number of patient matching systems are currently being used in the commercial sector, but one has yet to be adopted in Medicare. The Committee requests a report not less than 12 months after the date of enactment of this Act on the impact on care improvement, reduction in costs, estimated saved lives or reduction in errors, and improvements in patient safety if hospitals were required to use a patient matching system as a requirement for participation in the Medicare program.

Action Taken or To Be Taken
Accurate patient matching is very important to CMS. The Hospital Conditions of Participation require that hospitals provide to patients the care they need in accordance with a plan of care and doctor's orders. The Conditions of Participation also require hospitals to provide care that is in accordance with the standards of practice, applicable law and regulation, and policies and procedures established by a governing body and medical staff. None of these conditions are possible if accurate and consistent patient identification is not achieved throughout the hospital. The Conditions of Participation also require hospitals to provide care that is safe. Misidentification of patients, administration of improper medications because of misidentification, and application of incorrect diagnostic procedures or incorrect surgical procedures because of misidentification of patients is evidence of providing unsafe care, and is a violation of the Conditions of Participation.

CMS understands that the Office of the National Coordinator is reviewing systems that address and may improve the accuracy of patient identification, and we look forward to their findings. The 21st Century Cures Act also included a provision for a GAO study on patient matching and CMS looks forward to reviewing that study.

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Program Management Proposed Law Summary

CMS' FY 2019 request includes five proposals total, two of which establish offsetting collections. The authority to implement the Survey and Certification proposal will be requested through appropriations language, whereas the remainder require legislative changes. The proposals are 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 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 $14.1 million in FY 2019 – exact collections would be dependent on rule making.

- **Public Reporting of Medicare Survey and Certification Reports**

  CMS proposes a requirement that hospital accreditation organizations that have deeming authority publicly report their survey findings for hospitals in a format as specified by the Secretary. The proposal would not result in any collections for CMS.

- **Adjust Skilled Nursing Facility Survey Frequencies for Top-Performing Nursing Homes**

  CMS proposes to give the Secretary authority to adjust statutorily required survey frequencies for top-performing skilled nursingfacilities and reinvest resources to strengthen oversight and quality improvement for poor performing facilities. The proposal would not result in any collections for CMS.

- **National Medicare & You Education Program (NMEP) User Fee**

  CMS seeks a legislative change to Section 1857 (e)(2)(D)(ii)(V) of the Social Security Act to rebase the user fees from Medicare Advantage and Prescription Drug plans for the NMEP. This change reflects the higher share of enrollees in Medicare Advantage and plans contributing more equitably to NMEP activites. Current estimated collections are $82.6 million. With this proposed change, collections are estimated to be $30 million higher, or $112.6 million in FY 2019.

- **Change Medicare Beneficiary Education Requirements**

  The Budget includes a proposal that provides provides the Secretary with increased flexibility to determine how to efficiently and effectively communicate Medicare benefits information included in the Medicare & You Handbook with beneficiaries, including providing information online as opposed to hard copy. The proposal would not result in administrative efficiencies for CMS until after FY 2019.

Program Management Appropriation Summary
Proposed Law
(Dollars in Thousands)

Activity	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget
Program Operations	$2,816,393	$2,805,640	$2,402,089
Discretionary Appropriation, Proposed Law 1/	$0	$0	$30,000
Appropriation, Net, Proposed Law	$2,816,393	$2,805,640	$2,432,089
Federal Administration	$732,533	$727,558	$702,601
Discretionary Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$732,533	$727,558	$702,601
State Survey & Certification	$397,334	$394,636	$421,135
Discretionary Appropriation, Proposed Law 2/	$0	$0	$14,120
Appropriation, Net, Proposed Law	$397,334	$394,636	$435,255
Research, Demonstration & Evaluation	$20,054	$19,918	$18,054
Discretionary Appropriation, Proposed Law	$0	$0	$0
Appropriation, Net, Proposed Law	$20,054	$19,918	$18,054
Discretionary Appropriation, Net	**$3,966,314**	**$3,947,752**	**$3,543,879**
Discretionary Appropriation, Proposed Law	**$0**	**$0**	**$44,120**
Total Appropriation, Proposed Law	**$3,966,314**	**$3,947,752**	**$3,587,999**

1/ Includes estimated offsetting user fee collections to implement the National Medicare Education Program mandatory proposal contained in the President's Budget.

2/ Includes estimated offsetting user fee collections to implement the Survey and Certification Revisit Fee proposal contained in the President's Budget.

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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	2019	90%	October 31, 2019
	2018	90%	October 31, 2018
	2017	90%	98% (Target Exceeded)
	2016	90%	98% (Target Exceeded)
	2015	90%	97% (Target Exceeded)
	2014	90%	97% (Target Exceeded)
	2013	90%	98% (Target Exceeded)
	2012	90%	(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	2019	90%	October 31, 2019
	2018	90%	October 31, 2018
	2017	90%	97% (Target Exceeded)
	2016	90%	96% (Target Exceeded)
	2015	90%	94% (Target Exceeded)
	2014	90%	98% (Target Exceeded)
	2013	90%	98% (Target Exceeded)
	2012	90%	98% (Target Exceeded)
	2011	90%	98% (Target Exceeded)
	2010	90%	99% (Target Exceeded)
	2009	90%	96% (Target Exceeded)
	2008	90%	94% (Target Exceeded)

Measure	FY	Target	Result
MCR9.1c: Quality Standards: Minimum of 90 percent meets expectations for Knowledge Skills Assessment	2019	90%	October 31, 2019
	2018	90%	October 31, 2018
	2017	90%	97% (Target Exceeded)
	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	2019	90%	October 31, 2019
	2018	90%	October 31, 2018
	2017	90%	93% (Target Exceeded)
	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 Federal 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 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.

For each fiscal year, the CCO has met or exceeded the 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. 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 assisting the increased amount of contacts associated with the incoming baby-boomer population.

Beginning in FY 2009, the CCO (formerly, BCC) has been assessed annually by an independent quality assurance (IQA) contractor. The intent of this assessment 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.

Since 2009, this performance measure has been 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	2019	Maintain an unmodified opinion	November 30, 2019
	2018	Maintain an unmodified opinion	November 30, 2018
	2017	Maintain an unmodified opinion	Target Met
	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 2017 target of maintaining an unmodified opinion on four out of the six principal financial statements. During FY 2017, the auditors could not express an opinion on the CMS Statement of Social Insurance (SOSI) as of January 1, 2017 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 2017 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.

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[1]	2019	17.6%[2]	March 1, 2019 (based on CY 2017 data)
	2018	17.8%	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%	17.60% (Target Exceeded) (based on CY 2013 data)
	2014	18.3%	18.1% (Target Exceeded) (based on CY 2012 data)
	2013	18.5%	18.6% (Target Not Met) (based on CY 2011 data)
	2012	Baseline	18.7% (Baseline – based on CY 2010 data)

One way that the Medicare statute incentivizes hospitals to reduce preventable readmissions is through the Hospital Readmissions Reduction Program (HRRP). Established by Congress beginning in FY 2013, the HRRP reduces a statutorily defined 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, 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.

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 FY 2016 and FY 2017 because the reduction in the

[1] 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.

[2] The CY 2019 target may be adjusted based on CY 2018 actual results.

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. However, given this shift CMS has set somewhat less aggressive targets for FY 2018 and FY 2019. CMS will continue to monitor the data and will report on the CY 2018 target in the first half of 2018. We have set the 2019 target at 17.6 percent based on the CY 2018 target, but the CY 2019 target may be adjusted based on CY 2018 actuals.

MCR30: Shift Medicare Health Care Payments from Volume to Value

Measures	CY	Target	Result Available
MCR30.1: Alternative payment models Baseline: Calendar Year (CY) 2014: 22% Increase the percentage of Medicare Fee-for-Service (FFS) Payments Tied to Alternative Payment Models	2019	TBD	November 30, 2020
	2018	50%	November 30, 2019
	2017	40%	November 30, 2018
	2016	30%	31% (Target Met)
	2015	26%	26% (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 and CMS, through the Center for Medicare and Medicaid Innovation (CMMI), identifies tests, evaluates, and expands, as appropriate, innovative payment and service delivery models. These innovative payment and service delivery models 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 a lower cost. In addition, CMS is implementing payment reforms that reward quality and efficiency of care.

These alternative payment models and payment reforms that increasingly tie 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.

CMS uses the following framework to describe and measure health care payments through the stages of transition from pure FFS to more advanced alternative payment models. This framework classifies payment models into the following 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, CMS 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.

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 Baseline: CY 2014: Medicare Shared Savings Program (MSSP) ACO CAHPS: 74.6% *ACOs Mean Score	2019	TBD	July 31 2020
	2018	TBD	July 31 2019
	2017	76%	July 31 2018
	2016	Historical Actual	75.40%
	2015	Historical Actual	75.17%*

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 when they spoke with their provider about starting or stopping a prescription medicine, did the provider ask what they thought was best for them? It also asks beneficiaries whether they and their provider spoke about how much of their personal health information they wanted shared with family or friends. As beneficiaries become more empowered to actively participate in their care, we 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, the Merit-Based Incentive Program beginning in 2017 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 the 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 are 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. The performance on this measure was 75.40 in CY 2016. For CY 2018 we will delay setting a target, as we anticipate implementing a revised shortened version of the survey in 2018. The revised, shortened version of the survey results in substantive changes to the Shared Decision Making SSM, as the number of questions contained in this SSM is reduced from eight to two questions.

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. The revised, shortened survey was piloted tested with ACOs from November 2016 – February 2017. Results from the pilot study suggest that administration of the shortened version of the survey (i.e., the pilot survey) is likely to result in improvements in overall response rates. Findings show that the response rate to the pilot survey was 3.4 percentage points higher than the response rate to the FY 2016 CAHPS for ACOs survey among ACOs participating in the pilot study. Increases in response rates tended to be larger among ACOs that had lower response rates in the prior year.

Additionally, after accounting for survey questions that were removed from the pilot survey, the average survey responses for ACOs who participated in the pilot study were mostly similar across the two survey versions (pilot and FY 2016).

MMB2: Reduce All-Cause Hospital Readmission Rate for Medicare-Medicaid Enrollees

Measure	CY	Target	Result
MMB2: Reduce All-Cause Hospital Readmission Rate for Medicare-Medicaid Enrollees Baseline 2012: 92.7[1] readmissions per 1000 beneficiaries	2019	1% Reduction From 2018 Actual	April 30, 2021
	2018	1% Reduction From 2017 Actual	April 30, 2020
	2017	Historical Actual	April 30, 2019
	2016	Historical Actual	April 30, 2018
	2015	Historical Actual	84.0 per 1000 (0.8% above 2014 actual)
	2014	Historical Actual	83.4 per 1000 (2.7% below 2013 actual)
	2013	Historical Actual	85.7 per 1000 (7.5% below 2012 baseline)

[1] The methodology for this goal was updated in 2017 to reflect changes in the Yale readmissions measure used in Medicare's Hospital Readmissions Reduction Program (HRRP). This is the measure upon which this goal was developed. As a result of the revised methodology that eliminated the old data coding, CMS re-calculated the prior years' reports (including the 2012 baseline), since they were based on outdated Yale measure specifications. The new calculation ensures consistent methodology across all years.

A "hospital readmission" occurs when a patient who has recently been discharged from a hospital 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 or missed opportunities to better coordinate care, and may 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 2016, an estimated 11.7 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 and higher rates of institutionalization, in addition to challenges posed by socioeconomic issues. As a result, CMS seeks 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 Facility Residents*.

This measure is calculated using the number of readmissions per 1000 eligible beneficiaries. This is a more sensitive measure for dual- eligible beneficiaries than the rate of readmissions (numerator) divided by admissions (denominator) used in other hospital readmissions

measures. There has been concern that this 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.

Based on national trends reflecting a slowing in readmissions reductions for all Medicare beneficiaries, we propose a relatively modest target reduction rate of 1 percent from the prior year's actual result for both CY 2018 and CY 2019.

NOTE: This goal was publicly reported in the FY 2018 Congressional Justification with a goal identifier of MMB1.

MEDICARE SURVEY & CERTIFICATION PROGRAM

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	2019	15.5%	February 28, 2020
	2018	16.0%	February 28, 2019
	2017	16.0%	March 31, 2018
	2016	16.7%	16.7% (Target Met)
	2015	17.9%	17.1% (Target Exceeded)
	2014	19.1%	19.1% (Target Met)
	2013	20.3%	20.3% (Target Met)
	2012	Historical Actual	19.8%
	2011	Baseline – 23.87% (4th Q)	Last Quarter of Pre-Intervention Period

The purpose of this performance measure is to decrease the use of antipsychotic medications in nursing homes with an 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 have 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 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.[14]

Person-centered care is an approach that focuses on residents as individuals, and supports caregivers working most closely with them. It utilizes a continual process of listening, testing new approaches, and changing routines and organizational strategies 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 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 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 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.

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[14] Gitlin LN, Kales HC, Lyketsos CG. Nonpharmacologic Management of Behavioral Symptoms in Dementia. JAMA, November 21, 2012; 308(19): 2020-2029.

MSC6: Percentage of Hospice Facilities that Have Been Surveyed within 36 Months

Measure	FY	Target	Result
MSC6.2: Percentage of facilities that are surveyed within the required 36 month timeframe	2019	98% of hospice facilities are surveyed within the required 36 month timeframe	April 30, 2020
	2018	95% of hospice facilities are surveyed within the required 36 month timeframe	April 30, 2019
MSC6.1: Percentage of States that complete required hospice surveys within 36 months Baseline: N/A	2017	95% of States complete 98% of required hospice surveys	April 30, 2018
	2016	90% of States complete 95% of required hospice surveys	71% (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/caregivers. 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 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 that 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 addition 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 requirement for the hospice survey interval is met nationally. 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 system. SSAs that do not comply with the survey interval instructions contained within the Mission and Priority Document (MPD), 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.

CMS is working through the CMS Regional Offices (ROs) to identify all hospice providers that require surveys 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 is revising the calculation and targets for the goal in order to make them more meaningful and understandable. It was discovered that simultaneously setting both a percentage of states as well as facilities was confusing. The previous methodology used for the calculation of this GPRA goal presents an inaccurate picture of the nationwide compliance with the hospice survey interval requirement. For example, an entire SSA may be found out of compliance based upon one survey when there are acceptable extenuating circumstances.

The new targets set beginning in FY 2018 are concise and clearly indicative of whether or not the work, as required by the Act, is being accomplished. As rewritten, CMS believes that the goal is more responsive of the IMPACT Act requirement that all hospice agencies nationwide be surveyed every 36 months.

MSC7: Improve Staffing Reports to Support Better Outcomes for Residents of Long Term Care (LTC) facilities

Measure	FY	Target	Result
MSC7: Percentage of LTC facilities submitting complete staffing data through the Payroll-Based Journal (PBJ) Baseline: 90.3% (2017)	2019	93.6%	December 31, 2019

This new measure aims to improve CMS' ability to publically report information about the staffing in long-term care (LTC) facilities, and ultimately improve care. Staffing levels, turnover, and tenure can have a significant impact on the quality of care provided by LTC facilities. This information is also very important to consumers when selecting or evaluating a LTC facility.

To publish accurate information, it is critical for CMS to obtain complete data from providers, which this measure seeks to address. Once collected and published, this staffing information can be analyzed to understand its correlation to care and outcomes. Stakeholders and LTC facilities will use the published information to identify targets for staffing that lead to better outcomes for residents. CMS will also use this data to establish staffing thresholds for the *Five-Star Quality Rating System.* Once established, we expect facilities to engage in efforts to reach these targets, thereby improving care.

Baseline data for FY 2017 indicated 90.3 percent (14,162) of facilities submitted staffing data. For FY 2019, we aim for 93.6 percent of facilities to submit staffing data**.** This would be an improvement of 3.3 percentage points, or a 33 percent decrease in the number of facilities that did not meet this measure. We note that this is a new program, and therefore difficult to predict the trajectory of performance. CMS will adjust the targets (lower or higher) as needed to ensure realistic and appropriate goals. Results will be calculated by the end of the first quarter for each fiscal year, and the first results will be available December 31, 2018.

As of July 1, 2016, LTC providers are required to electronically submit staffing data that is auditable back to payrolls and other verifiable information, in accordance with 42 CFR §483.70(q) under current law. Receiving complete staffing data from providers is essential in order to calculate and publically report accurate staffing measures, which is the primary intent of the new program. For example, we believe that providers utilize nurse aides (certified nurse aides and medication aides) every day in their facilities. Therefore, if the data from a facility does not include hours for nurse aides on a particular day, we believe that indicates they have not submitted complete data. CMS does not expect data to be perfect, and facilities may miss a few days in a quarter. However, we believe that a reasonable threshold is for providers to submit data for nurse aides for each day in a quarter or miss no more than 14 days.

To incentivize improvement, CMS adjusts how a provider is reported on Nursing Home Compare and in the Nursing Home Five Star Quality Rating System (e.g., negative icon, suppress ratings). This has proven to be an effective method to improve reporting in the past. Also, CMS has begun to conduct audits of the data submitted by providers, and will use the results of those audits to evaluate other actions that may be needed to improve the data submitted.

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	2019	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 31, 2020
	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 31, 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 31, 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 on at least ten quality measure (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 on at least nine quality measure (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 cores set of quality measures	88% of States reported on at least eight quality measure (Target Not Met)
	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 measure (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 measure (Target Exceeded)

Measure	FY	Target	Result
	2011	Work with States to ensure that 70 percent of States report on at least one quality measures in the CHIPRA children's core set of quality measures.	84% of States reported on at least one quality measure (Target Exceeded)

The purpose of this measure is to improve the quality of children's health care 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 enhance the accuracy and applicability of the pediatric quality measures program. CMS concluded a multi-year, $100 million CHIPRA Quality Demonstration initiative that included support for state activities related to core measure data collection and reporting.

CMS annually releases an updated Child Core Set Technical Specifications and Guidance for Reporting Manual, which contains technical instructions for collecting and calculating the core set measures for Medicaid and CHIP programs. A State Health Official Letter (SHO) (#11-001), 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 (PQMP), which develops 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 Quality Forum (NQF) measure endorsement. In the current NQF pediatric measures endorsement committee, there are six measures developed by the PQMP Centers of Excellence under consideration.

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 them. Further, as the TA/Analytic Support 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 at the state and programmatic levels.

The CHIPRA Quality Demonstration Initiative has 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 2019 will remain at the same level as the FY 2017 and FY 2018 targets so CMS can 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 and on data.medicaid.gov. www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.

This initiative continues to align with the Medicare and 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 specify quality measures for potential inclusion in future annual updates to child core measures and collected through EHRs.

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	2019	+6 percentage points over 2011 baseline	October 15, 2020
	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	48% (Target Exceeded)
	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. Between FY 2007 and FY 2016, 34 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 50 percent 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, which can be found at https://www.medicaid.gov/medicaid/benefits/downloads/ohi-baselines-progress-goals.pdf. To help improve performance, from 2010 to 2015 CMS worked 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.

In 2016, CMS reassessed our approach to the Oral Health Initiative (OHI) and developed a new strategy, which we called Oral Health Initiative 2.0. It comprises six steps and has at its core a stance of integration, both vertical and horizontal, both within CMS and at the state level:

(1) Identifying elements that comprise a strong state Medicaid dental program;

(2) Using performance data to prioritize which states to focus on, then conduct assessments of those states to understand which elements of a strong program are in place and which are missing;

(3) Communicating the results of the assessments to state agency leaders, and invite engagement for improvement.

(4) Identifying opportunities across CMCS to engage with states through existing levers such as Section 1115 demonstration renewals and State Plan Amendment review and approval, and providing technical support to promote oral health's importance within broader Medicaid and CHIP program objectives (beyond dental program staff).

(5) Documenting improvement targets and strategies where appropriate, such as special terms and conditions, approval letters etc; and

(6) Having states take action based on those agreements.

Through this new approach we have brought more explicit leadership support and broader resources to the effort to increase use of dental services among children enrolled in Medicaid and CHIP. In addition, we adjusted our annual goals to better reflect state's current environment and our abilities to drive improvement.

MCD8: Improve Adult Health Care Quality across Medicaid

Measure	FY	Target	Result
MCD8: Improve Adult Health Care Quality Across Medicaid	2019	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 31, 2020
	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 31, 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 31, 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% (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% (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% (Target Exceeded)
	2013	Work with States to ensure that 60 percent of States report on at least three quality measures in the Adult Medicaid core set of quality measures	59% (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 (all 50 states, including District of Columbia) 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.

In December 2012, CMS awarded 2-year grants to 26 States to collect and test up to 15 measures in the Medicaid Adult Core Set and to conduct quality improvement projects focused in these areas as well. Participating grantees submitted data on the measures in early 2014. Since the grant program ended before FY 2014 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 (TA/AS) program, CMS has discussed with grantee states how to sustain quality measurement and improvement efforts currently underway. Since 2014, CMS has hosted a Medicaid and CHIP track at annual CMS Quality Conferences. The conference agendas included in-person interactive sessions on the core measures related to data collection, reporting, and quality improvement. 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. Findings from State reporting on the Adult Core Set are published annually on the Adult Health Care Quality Measures webpage at medicaid.gov and on www.data.medicaid.gov https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html

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 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 2019 will remain at the same level as the FY 2017 and FY 2018 targets so CMS can 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 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.	2019	Requirement for states to submit the data in the reporting platform from a minimum of 10 states.	September 30, 2019
	2018	Requirement for states to submit the data in the reporting platform from a minimum of 5 states.	September 30, 2018
	2017	Testing 1 core metric data set with a minimum of 5 states.	CMS has tested 3 core metric sets with a total of 10 states (Target Exceeded)
	2016	Release of an automated collection and reporting platform for 1115 performance metrics & related requirements for State data submission.	(Target Met)

Section 1115 of the Social Security Act (the Act) provides broad authority to the HHS Secretary to grant waivers to states for testing 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, to accomplish these goals, CMS needs an automated system for data collection of performance metrics, analytics, or reporting to assess quality performance of demonstrations. One improvement in 2016 was the provision of a system to provide a single location for states to submit their monitoring reports. The system signals to project officers when reports are due and when they arrive. Meanwhile, CMS developed several core sets of performance metrics. These have been under review by a Medicaid state technical advisory group (TAG), and also being exposed to states working with CMS to implement new or renewing 1115 demonstration to which the core set is applicable. Additional improvements include the development of a monitoring report template and templates for reporting core metrics. 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 demonstration progress and performance. This initiative aligns with the Medicaid and CHIP Program System (MACPro) initiative to receive more complete and timely Medicaid and CHIP related data from states to support better program oversight, administration, and program integrity.

CMS met our 2016 target to release an automated collection and reporting platform for 1115 performance metrics and related requirements for state data submission. The Performance Metrics Database and Analytics (PMDA) 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 CMS wants to make in 1115 demonstrations generally, and included the use of standardized core metric sets for selected high priority 1115 demonstrations. In early FY 2017 CMS 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 FY 2017 CMS 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. Late in FY 2018, CMS expects to test the submission of data with specified templates into the PMDA system.

CMS has modified the 2018 targets to assure adequate state engagement through the new Technical Advisory Groups (TAGs). CMS experienced a four month delay in implementing the TAG to get all the necessary input from National Association of Medicaid Directors (NAMD) and others to ensure the TAG was structured in a way that would maximize state participation and input. As CMS 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.

CMS's 2018 target is to continue to 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.

CMS's 2019 target reflects the increasing scope of the work to incorporate the standard metric sets into more Medicaid section 1115 demonstrations to improve our capability of monitoring outcomes for demonstrations that are testing similar innovative approaches. As new demonstrations are approved and existing demonstrations are renewed, CMS will work with states to incorporate the appropriate metrics into state reporting to CMS.

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 30, 2022
	2019	63%	April 30, 2021
	2018	61%	April 30, 2020
	2017	59%	April 30, 2019
	2016	57%	April 30, 2018
	2015	55%	55% (Target Met)
	2014	53%	53% (Target Met)
	2013	51%	51% (Target Met)
	2012	Actual-Baseline	49.50%
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 30, 2022
	2019	37 States and District of Columbia (72.5%)	April 30, 2021
	2018	36 States and District of Columbia (70.6 %)	April 30, 2020
	2017	35 States and District of Columbia (68.6%)	April 30, 2019
	2016	38 States and District of Columbia (74.5%)	April 30, 2018
	2015	35 States and District of Columbia (68.6%)	27 States and District of Columbia 55% (Target Not Met)
	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 49.0%

Measure	FY	Target	Result
	2012	Actual-Baseline	23 States and District of Columbia 45.1%

Home and community-based services (HCBS) are more cost- effective than institutional care for many beneficiaries (https://www.medicaid.gov/medicaid/ltss/downloads/money-follows-the-person/mfp-2015-annual-report.pdf). While services can be provided under many different authorities, most are provided under §1915(c) HCBS waiver programs, 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 statutory programs, in addition to §1915(c) HCBS waiver programs, provided options for people to receive long-term services and supports in the community. These included the Community First Choice state plan service; flexibilities in §1915(i) state plan HCBS; the extension of and improvements to the Money Follows the Person Rebalancing Demonstration; and an extension of spousal impoverishment protections to people who receive HCBS.

In fiscal year (FY) 2015, Medicaid spent $158 billion on long term services and supports (LTSS), representing a nearly four percent increase in overall LTSS attributable to HCBS expenditures. The LTSS spending (institutional and HCBS) represented 30 percent of all Medicaid spending, as other Medicaid spending expanded at a faster pace than LTSS spending. 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.

Due to the timing of available information through the Medicaid Budget and Expenditure System (MBES), we update goals annually with data that is available 15 to 18 months after the end of the fiscal year. Managed long term services and supports (MLTSS) expenditures continue to be estimated based on state reporting through the CMS contractor's survey since expenditures for the HCBS portion of MLTSS expenditures were not available through MBES in FY 2015

In MCD 10.1, the FY 2017 target projects HCBS expenditure to grow to 59 percent. CMS expects to meet or exceed targets by supporting the continued development of the previously mentioned programs and activities. Last year, CMS continued efforts to expand HCBS quality initiatives by introducing the Consumer Assessment of Health Care Providers and System (CAHPS) Home and Community-Based Services (HCBS) survey. This CAHPS 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. 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 percent increase over the base year of this measure. The improvement is significant but the goal remains unmet for the third consecutive year.

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 improving quality.

HEALTH CARE FRAUD AND ABUSE CONTROL (HCFAC)

MIP1: Reduce the Improper Payment Rate in the Medicare Fee-for-Service (FFS) Program

Measure	FY	Target	Result
MIP1: Reduce the Improper Payment Rate in the Medicare Fee-for- Service (FFS) Program	2019	9.30%	November 15, 2019
	2018	9.40%	November 15, 2018
	2017	10.40%	9.51% (Target Exceeded)
	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% (Target Not Met)
	2011	8.5%	8.6% (Target Not Met)
	2010	9.5%	9.1% (Target Exceeded)
	2009	3.5%	10.8% (Measure Method Changed)
	2008	3.8%	3.6% (Target Exceeded)

The Medicare Fee-for-Service (FFS) improper payment estimate is calculated under the Comprehensive Error Rate Testing (CERT) program and reported in the Department of Health and Human Services (HHS) Agency Financial Report (AFR). 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 improper payment methodology can be found in the 2017 HHS AFR.

CMS exceeded its FY 2017 target. The Medicare FFS improper payment estimate for FY 2017 is 9.51 percent or $36.21 billion. The decrease from the prior year's reported improper payment estimate of 11.00 percent or $41.08 billion was driven by a reduction in improper payments for Home Health and Inpatient Rehabilitation Facility (IRF) claims. Although the improper payment rate for these services and the overall Medicare FFS improper payment rate decreased, improper payments for Home Health, Skilled Nursing Facility (SNF), and IRF claims were the major contributing factors to the FY 2017 Medicare FFS improper payment rate. While the factors contributing to improper payments are complex and vary from year to year, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors.

Home Health Claims: Insufficient documentation for home health claims continues to be prevalent, despite the improper payment rate decrease from 42.01 percent in FY 2016 to 32.28 percent in FY 2017. The primary reason for these errors was that the documentation to support the certification of home health eligibility requirements was missing or insufficient. Medicare coverage of home health services requires physician certification of the beneficiary's eligibility for the home health benefit (42 CFR 424.22).

SNF Claims: Insufficient documentation was the major error reason for SNF claims. The improper payment rate for SNF claims increased from 7.76 percent in FY 2016 to 9.33 percent in FY 2017. The primary reason for these errors was that the certification/recertification statement was missing or insufficient (e.g., one required element was missing). Medicare coverage of SNF services requires certification and recertification for these services (42 CFR 424.20).

IRF Claims: Medical necessity (i.e. services billed were not medically necessary) continues to be the major reason for error in IRF claims, despite the improper payment rate decrease from 62.39 percent in FY 2016 to 39.74 percent in FY 2017. The primary reason for these errors was that IRF coverage criteria for medical necessity were not met. Medicare coverage of IRF services requires that there must be a reasonable expectation that the patient meets all of the coverage criteria at the time of admission to the IRF (42 CFR 412.622(a) (3)).

CMS uses data from the CERT program and other sources of information to address improper payments in Medicare FFS through various corrective actions. CMS has developed a number of preventive and detective measures for specific service areas with high improper payment rates such as home health, SNF, and IRF claims. CMS believes implementing targeted corrective actions will continue to prevent and reduce improper payments in these areas and reduce the overall improper payment rate. Detailed information on corrective actions can be found in the 2017 HHS AFR.

MIP5: Reduce the Percentage of Improper Payments Made under Medicare Part C, the Medicare Advantage (MA) Program

Measure	FY	Target	Result
MIP5: Reduce the Percentage of Improper Payments Made under Medicare Part C, the Medicare Advantage (MA) Program	2019	TBD	November 15, 2019
	2018	8.08% (target in FY 2017 AFR)	November 15, 2018
	2017	9.50% (target in FY 2016 AFR)	8.31% (Target Exceeded)
	2016	9.14% (target in FY 2015 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 2017, CMS met its Part C Medicare Advantage (MA) error rate target of 9.50 percent, reporting an actual improper payment rate of 8.31 percent, or $14.35 billion. The decrease from the prior year's estimate of 9.99 percent was driven primarily by submission of more accurate diagnoses by MA organizations for payment.

The FY 2018 target is 8.08 percent. The FY 2019 target will be established in the FY 2018 Agency Financial Report (AFR); per OMB starting with FY 2017 CMS will now establish a target for only the next fiscal year.

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 four key initiatives, described below, to improve payment accuracy in the Part C program:

Contract-Level Audits: Contract-level Risk Adjustment Data Validation (RADV) audits are CMS's primary corrective action to recoup overpayments. RADV verifies, through medical record review, the accuracy of enrollee diagnoses submitted by MA organizations for risk adjusted payment. CMS expects that payment recovery will have a sentinel effect on the quality of risk adjustment data submitted by plans for payment, as contract-level RADV audits increase the incentive for MA organizations to submit valid and accurate diagnosis information. It also encourages MA organizations to self-identify, report, and return overpayments they have received. Payment recovery for the pilot audits has been completed, totaling $13.7 million recovered in FY2012 through FY 2014. After completing the pilots, contract-level RADV audits of payment years 2011 through 2013 are in various stages of the audit process. For example, payment year 2013 audits continued in FY 2017, and CMS will initiate payment year 2014 audits in FY 2018. Furthermore, CMS expects to conduct recoveries for the 2011 and 2012 contract-level RADV audits (which began in FY 2014 and FY 2015, respectively) in FY 2018, which will be the first reviews to recoup funds based on extrapolated estimates.

Regulatory Provision (Overpayment Recoveries): As required by the Social Security Act, CMS regulations specify MA organizations report and return overpayments that they identify. In FY 2017, MA organizations reported and returned approximately $78.71 million in self-reported overpayments. CMS believes that this requirement will reduce improper payments by encouraging MA organizations to submit accurate payment information.

Part C RAC: Section 1893(h) of the Social Security Act required the implementation of a Medicare Part C Recovery Audit Contractor (RAC) program. CMS is currently exploring how to fit the Medicare Part C RAC program into the larger Medicare Part C program integrity efforts, including examining refinements that can be made to RAC operations that won't result in activities that excessively burden plans.

Training: Historically, CMS has conducted training sessions on fraud, waste, and abuse, both in-person and via webinar, for MA plans. Only one training session for MA plans was conducted in FY 2017 due to procurement activities that were underway and the termination of contractor support in mid-FY 2017. In late FY 2017, CMS procured a new contractor to support this initiative and will resume training in FY 2018.

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	2019	TBD	November 15, 2019
	2018	1.66% (target in FY 2017 AFR)	November 15, 2018
	2017	3.30% (target in FY 2015 AFR)	1.67% (Target Exceeded)
	2016	3.40% (target in FY 2013 AFR)	3.41%[1] (Target Met)
	2015	3.5% (target in FY 2013 AFR)	3.6% (Target Not Met)
	2014	3.6% (target in FY 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)

[1] Per OMB guidance, target is met if the estimate is within 0.01% of the target.

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 Medicare-covered prescription drug benefits.

The Medicare Part D payment error estimate reported in FY 2017 represents payment error related to Prescription Drug Event (PDE) data.

The estimate for FY 2017 is 1.67 percent, or $1.30 billion. The decrease from the prior year's estimate of 3.41 percent was driven primarily by submission of more accurate data by Part D sponsors for payment. The target for FY 2018 is 1.66 percent. The FY 2019 target will be established in the FY 2018 Agency Financial Report (AFR). Per OMB, starting with FY2017 CMS will establish a target for only the next fiscal year.

CMS has implemented three key initiatives, described below, to improve payment accuracy in the Part D program:

Training: Historically, CMS has conducted training sessions on fraud, waste, and abuse, both in-person and via webinar, for Part D sponsors on payment and data submissions. Only one training session for Part D sponsors was conducted in FY 2017 due to procurement activities that were underway and the termination of contractor support in mid-FY 2017. In late FY 2017, CMS procured a new contractor to support this initiative, and will resume trainings in FY 2018.

Outreach: CMS continued formal outreach to plan sponsors for invalid/incomplete documentation. CMS distributed Plan Sponsor Summary Reports to all plans participating in the national payment error estimate. This report provided feedback on their submission and validation results against an aggregate of all participating plan sponsors.

Regulatory Provision (Overpayment Recoveries): As required by the Social Security Act, CMS requires that Part D sponsors report and return overpayments that they identify (Section 11.22). CMS believes that Part D sponsors pay more attention to ensuring their data is accurate because of the overpayment statute and regulation. In FY 2017, Part D sponsors reported and returned approximately $2.83 million in self-reported overpayments.

MIP9: Reduce the Improper Payment Rates in the Medicaid Program and the Children's Health Insurance Program (CHIP)

Measure	FY	Target	Result
MIP9.1: Reduce the Improper Payment Rate in the Medicaid Program	2019	TBD	November 15, 2019
	2018	7.93%	November 15, 2018
	2017	9.57%	10.10% (Target Not Met)
	2016	11.53%	10.48% (Target Exceeded)
	2015	6.7%	9.78% (Target Not Met)
	2014	5.6%	6.70% (Target Not Met)
	2013	6.4%	5.8% (Target Exceeded)
	2012	7.4%	7.10% (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%.	8.10% (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: Reduce the Improper Payment Rate in the Children's Health Insurance Program (CHIP)	2019	TBD	Nov 15, 2019
	2018	8.20%	Nov 15, 2018
	2017	7.38%	8.64% (Target Not Met)
	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.	6.50% (Target Met)
	2013	Report rolling improper payment rate in the 2013 AFR.	7.1% (Target Met)
	2012	Report national improper payment rates in the 2012 AFR.	8.20% (Target Met)

The Payment Error Rate Measurement (PERM) program measures improper payments in the Fee-For-Service (FFS), 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 reviews and CMS can complete the measurement on time for the Department of Health and Human Services (HHS) and Agency Financial Report (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 2014 AFR were also measured again in the 2017 AFR). Information on the Medicaid and CHIP statistical sampling process and review period can be found in the 2017 HHS AFR.

The national Medicaid improper payment rate (MIP9.1) reported in the 2017 AFR is based on measurements that were conducted in FYs 2015, 2016, and 2017. The FY 2019 target will be established in the FY 2018 AFR. Per OMB, starting with FY 2017 CMS will now establish a target for only the next fiscal year.

The current national Medicaid improper payment rate is 10.10 percent. The national Medicaid component rates are: Medicaid FFS: 12.87 percent and Medicaid managed care: 0.30 percent. The Medicaid eligibility component is held constant at the FY 2014 reported rate of 3.11 percent.

For FY 2015 through FY 2018, CMS will not conduct the eligibility measurement component of PERM. In place of these, all states are required to conduct eligibility review pilots that 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. During this time, for the purpose of computing the overall national improper payment rates, the Medicaid and CHIP eligibility component improper payment rates are held constant at the FY 2014 national rate of 3.11 percent and 4.22 percent, respectively.

CMS used the eligibility review pilots to test updated PERM eligibility processes, and prepare states for the resumption of the PERM eligibility component measurement. Based on the pilots, CMS updated the eligibility component measurement methodology and published a final rule (82 FR 31158, July 5, 2017) to update the methodology for the PERM eligibility component. CMS will resume the eligibility component measurement under this final rule and report an updated national eligibility improper payment estimate in FY 2019.

Since FY 2014, the Medicaid improper payment estimate has been driven by errors due to state non-compliance with provider screening, enrollment, and National Provider Identifier (NPI) requirements. First, all referring/ordering providers are required to be enrolled in Medicaid or CHIP and claims must contain the referring/ordering provider NPI. Second, states are required to screen providers under a risk-based screening process prior to enrollment. Finally, the attending provider NPI is required to be submitted on all electronically filed institutional claims. CMS began reviewing against these requirements for FY 2014 improper payment reporting. Therefore, in FY 2014, CMS saw the first ever increase in the Medicaid improper payment rate when the first cycle of states was reviewed against the new requirements. The Medicaid rate increased in FY 2015 when CMS reviewed the second cycle of states against the new requirements. FY 2016 represented the first “baseline” improper payment rate reflecting the new requirements because all 50 states and the District of Columbia were measured under the same requirements. FY 2017 represents the first cycle of states that has been measured a second time.

Compliance with provider screening, enrollment, and NPI requirements for the 17 states measured in FY 2017 improved, and the improper payment rate related to non-compliance decreased. The Medicaid FFS improper payment rate for non-compliance with these requirements decreased for these states from 5.74 percent in FY 2014 to 4.03 percent in FY 2017. Although the 17 states reviewed this year had better compliance results compared to their previously measured cycle, non-compliance with the provider screening, enrollment, and NPI requirements is still a major contributor to the improper payment rate. Additionally, improper payments due to no or insufficient medical documentation increased in FY 2017.

The national CHIP improper payment rate (MIP 9.2) reported in the 2017 AFR is based on measurements conducted in FYs 2015, 2016, and 2017. The current national CHIP improper payment rate is 8.64 percent. The national CHIP component rates are: CHIP FFS: 10.29 percent and CHIP managed care: 1.62 percent. The CHIP eligibility component is held constant at the FY 2014 reported rate of 4.22 percent. Additional detail about Medicaid and CHIP improper payment rates and underlying components is available in the 2017 HHS AFR.

Similar to Medicaid, CMS began reviewing against provider screening, enrollment, and NPI requirements for FY 2014 improper payment reporting. In FYs 2014 and 2015, the CHIP improper payment estimate increased when CMS reviewed the first two cycles of states against the new requirements. FY 2016 represented the first “baseline” improper payment rate reflecting the new requirements because all 50 states and the District of Columbia were measured under the same requirements. FY 2017 represents the first cycle of states that has been measured a second time.

The CHIP improper payment estimate increased due to continued difficulties with states coming into compliance with provider screening, enrollment, and NPI requirements. The CHIP FFS improper payment rate for non-compliance with these requirements increased for these states, from 4.69 percent in FY 2014 to 5.73 percent in FY 2017. A higher percentage of CHIP providers are not enrolled in Medicare. Therefore, there are more CHIP providers where states cannot rely on Medicare’s screening in lieu of conducting state screening. Additionally, managed care improper payments increased in FY 2017 due to recipients that aged out of CHIP.

The factors contributing to improper payments are complex and vary from year to year. 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. Each year CMS outlines actions the agency will implement to prevent and reduce improper payments for all error categories. Detailed information on corrective actions can be found in the 2017 HHS AFR.

NOTE: 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.

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. Calendar Year (CY) 2015 Baseline: 30.1% This is a CY goal.	2019	TBD	April 30, 2020
	2018	38.7%	April 30, 2019
	2017	36.7%	April 30, 2018
	2016	34%	34.7% (Target Exceeded)
	2015	Baseline	30.1%

*The baseline was established in CY 2015 when the result was measured at 30.1%. The CY 2016 target was established at 34%, based on the expectation of a modest increase over the baseline result. Consistent with this concept, the CY 2017 target is based on an increase of 2% above the CY 2016 result, a target of 36.7%. The CY 2019 target will not be established until CMS can analyze the April 2018 result.

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 and receive payment for services rendered to program beneficiaries. 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 online submission of enrollment applications and reduce the number of paper applications, therefore increasing operational efficiency. Further information or explanation necessitates the return of an estimated 50 to 70 percent applications. 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 for processing a paper enrollment. The annual average of more than a million enrollment applications processed by CMS further amplifies this difference.

This measure will improve operational efficiency by reducing the number of hours needed to process enrollment applications by Medicare Contractors through PECOS, resulting in reduced operating costs and improved 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, reducing overall processing time. The online enrollment application supplies information needed by the provider with quick and easy access to update the information. The

electronic enrollment process will also enhance CMS' capacity to perform its responsibilities under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Quality Payment Program (QPP). The QPP relies on PECOS data for Merit-Based Incentive Payment System (MIPS) eligibility. States leverage PECOS data for screening and enrollment of Medicaid fee-for-service providers. Faster processing and timely updates of enrollment information in PECOS will facilitate data sharing and identifying and determining the eligibility of providers and groups in MACRA programs, such as MIPS, Alternative Payment Models, and State Medicaid Agencies.

CMS is measuring the increase in the proportion of providers enrolling online. The baseline measurement was established in CY 2015 and 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 the year following the calendar year measured.

MIP12: Savings from the Prevention of Improper Medicare Payments by Successful Implementation of Fraud Prevention System (FPS) Edits

Measure	CY	Target*	Result
MIP12: Maintain or increase dollar savings through the prevention of improper payments in Medicare Fee For Service (FFS) claims through innovative edit techniques employed by Fraud Prevention System (FPS) Edits. Developmental	2019	TBD	April 30, 2020
	2018	TBD	April 30, 2019
	2017	Developmental*	April 30, 2018

* The FY 2017 baseline for this goal will be calculated based on the dollar savings resulting from the edits of the Fraud Prevention System (FPS) at the end of the fiscal year (September 2017). The targets for FY 2018 and FY 2019 are based on the previous year's results, coupled with expected changes in the program for the upcoming year. These targets are expressed as dollar savings achieved through prevention and represent a percentage change from the previous year. CMS is still looking at providing these results in 2018. CMS has to wait three months after the end of the fiscal year before we can calculate the savings metric. This 3-month run out time is due to the fact that we want to capture some of the FPS edits that were resubmitted or overturned on appeal within the three months after the end of the fiscal year. The FPS edits methodology was certified by the Office of the Inspector General in the FPS 3rd Implementation Year Report to Congress.

To protect the integrity of the Medicare Trust Funds, CMS must ensure Medicare payments are correct and made to legitimate providers for covered, appropriate, and reasonable services for eligible beneficiaries. This goal targets CMS's ability to prevent improper payments by measuring the dollar savings resulting from claims rejected or denied based on FPS edits. For the purpose of this measure, savings measured by this goal will only include rejected claims not resubmitted and denied claims not overturned on appeal within three months after the end of the reporting period. A provider or supplier can resubmit a rejected claim for reconsideration, but must appeal a denied claim, in order to affect this measurements outcome.

FPS edits screen Medicare fee-for-service claims on a pre-payment basis for improper billing which could result from miscoding, or could indicate intentional fraud, waste or abuse. The FPS has the capability to prevent payment of certain improper claims by communicating a denial or rejection message to the claims payment systems. CMS tested FPS's ability to successfully integrate with several legacy claims processing systems in early 2014. This test validated the capabilities of the FPS system to prevent improper payments in an automated fashion, without the need for human intervention.

CMS has also identified ways that FPS edits could address vulnerabilities in other systematic edits. CMS found that the FPS is more capable of doing a sophisticated data analysis on claims than other systems where edits occur (e.g. the Fiscal Intermediary Standard System (FISS)). The FPS is coded in a way that looks for these types of patterns and still catches the outliers. The FPS also is the only editing system that is built in a manner to allow for coding of "families" of edits, which are edits that are designed based on in similar Medicare policy. Edits that comes from edit families are easier to implement, which is an advantage that FPS has over other systems.

CMS continues to develop new edits for implementation on Part A, Part B, and Durable Medical Equipment (DME). An example of a DME edit is one where the patient needs to have a corresponding Part A claim to receive payment for a DME claim. The edit checks a patient's claims history in one system (e.g. the FISS, which processes Medicare Part A and some Medicare Part B claims) to determine eligibility in the ViPs Medicare System (VMS), which processes DME payments.

CMS is also working on FPS edits that measure accumulated services over a rolling time period (for example, five services allowed in a rolling one-year timeframe), such as facet joint injections, or one service is allowed every month (such as intravitreal injections), and deny payment for services exceeding those limits. Other CMS systems can neither examine one claim at a time nor scrutinize services provided on a single day of service and successfully prevent improper payments. The FPS system is able to accomplish this data analysis, across time and across Medicare Administrative Contractor (MAC) jurisdictions.

Through collaboration with many stakeholders, CMS has developed a process to identify opportunities for the FPS to standardize editing across all MACs for certain billing scenarios. For example, if multiple MACs have similar Local Coverage Determinations, the FPS can implement a single edit on a nationwide basis, in lieu of having each MAC implement a local edit. The first such edit launched in 2015.

CMS has launched FPS 2.0 as part of ongoing efforts to improve FPS system capabilities. FPS 2.0, using lessons learned and innovations achieved in predictive analytics and information technology, represents an updated version of the current FPS. A high priority of the improved system will be to reduce the "time to market" for models and edits. Moving from development to production more quickly accelerates the preventative benefits of the FPS edits. CMS will continue the ongoing edit evaluation process and will work toward adding new edits that support the prevention of improper payments through either automatic denial or rejection, or through claim suspension for medical review.

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 considered the changes made to FPS during its existence and those contemplated by the FPS 2.0 initiative. Those changes promoted alignment with CMS initiatives in targeting high risk providers, through a risk-based supplier and provider screening process and 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 FPS. It is the provisions in these Acts and the improved tracking system using FPS that forms the basis for this goal. It is also important to note, that while the FPS has enhanced CMS's capacity to target improper payments, CMS continues to implement policy changes and other initiatives that may have an impact on Medicare improper payments year to year. The methodology of this measure strives to capture only the effects of the FPS edits, larger changes to payment systems may impact the annual measure as well and should be considered when assessing the outcomes of this measure.

MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS (QIO)

QIO7: Make Nursing Home Care Safer via the National Nursing Home Quality Care Collaboration (NNHQCC)

Measure	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%	111% (Target Exceeded)
	2016	N/A*	N/A*
	2015	50%	72% (Target Exceeded)
QIO7.2 Demonstrate Improvement in Health Care Quality of Participating One- Star Nursing Homes.	2019	5%	October 31, 2020
	2018	6%	October 31, 2019
	2017	Historical Actual	October 31, 2018
	2016	Baseline	8%

*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. A one-star rating is the lowest rating and a five star rating is the highest. CMS tracks nursing home care quality using this rating system.

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 Collaborative's objective to "instill quality and performance improvement practices, eliminate healthcare acquired conditions, and improve resident satisfaction". Although the QIN-QIO recruited 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 involves peer-to-peer learning activities in an "all teach/all learn" environment. This involves both virtual and face-to-face meetings, and other 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 (PDSA) 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 facility's individual quality 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 Quality domain of the Five Star Rating system of each participating nursing home as the project matures.

The QIN-QIOs exceeded the recruitment goal of 50 percent by recruiting 72 percent of the total One-Star Category Target Number (SCTN) in the Collaborative I time period. With the re-balancing of the Medicare.gov 5-Star Rating System effective February 20, 2015, one star homes continued to be recruited by QIN-QIOs as part of Collaborative II in the NNHQCC. For both Collaborative I and II combined, the QIN-QIOs recruited more than 100 percent of the SCTN for the 11th Statement of Work (SOW).

The measure "quality improvement in one star nursing homes" (C.7.2) tracks the change in the percentage of nursing homes with a one-star quality rating over time. CMS monitors quality improvement progress generated at the national, QIN-QIO, and nursing home levels using the quality domain of the Five Star Rating System. The total quality score is one of three domains within CMS' Five Star Rating system, which also rates facilities based on inspections and staffing ratios. As of January 2017, the total quality score is based on data for 13 quality measures for short and long-stay residents derived from the Minimum Data Set and 3 claims based measures for short-stay residents (Nursing Home Compare Five-Star Quality Rating System: Technical User's Guide). The QIO program is focusing on the quality domain because of its capacity to influence this specific domain most effectively.

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 PDSA improvement cycle results, clinical outcomes measures such as falls with major trauma, and measures of quality improvement. Nursing homes participating in the NNHQCC are

encouraged to improve quality as a whole rather than focus on anyone measure. Therefore, the 16 measure total quality score appropriately reflects general quality improvement. A reduction in the percentage of homes that receive the lowest quality score would indicate progress in the hardest to reach nursing homes.

QIO8: Strengthening Person and Family Engagement in Beneficiary Health Care Quality by Increasing Satisfaction of Quality of Care Compliant Resolution

Measure	FY	Target	Result
QIO8: Increase beneficiary satisfaction with the resolution of all beneficiary initiated quality of care complaints.	2019	75% QIO Satisfaction	December 31, 2019
	2018	75% QIO Satisfaction	December 31, 2018
	2017	70% QIO satisfaction	March 31, 2018
	2016	62% - Baseline	65.7% (Target Met)

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 and 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 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 Scope of Work (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	FY	Target	Result
QIO9: Increase Clinician Practice Technical Support	2019	TBD*	January 1, 2020
	2018	540,000 (90% of 600,000 eligible clinicians)	January 1, 2019
	2017	510,000 (85% of 600,000 eligible clinicians)	March 31, 2018

*** FY 2019:** Setting a target may be premature due the uncertainties in the denominator and the needs for Year 2 of the Quality Payment program. Therefore, CMS suggests to wait until FY 2018 to determine targets for FY 2019.

The purpose of this measure is to ensure broad reaching national access to technical assistance (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 and improving care coordination and costs related to care. Measuring the reach of TA provided across programs will ensure these programs achieve successful outcomes.

For FY 2017 and FY 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, the TA provided by the Quality Innovation Networks - Quality Improvement Organizations (QIN-QIOs) and the Quality Payment Program Small, Underserved, and Rural Support (QPP SURS) supports clinicians in meeting their MIPS requirements and compliments the technical assistance provided by the Transforming Clinical Practice Initiative (TCPI). Over the next four years, the TCPI will support more than 140,000 clinician practices in sharing, adapting and further developing their comprehensive quality improvement strategies to achieve large scale health transformation 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. MACRA 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 QPP SURS 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.

Using the most recent cumulative data, there have been 165,789 number of MIPS eligible clinicians that received technical support from QIN-QIOs, TCPI and QPP SURS. The TCPI ultimately supported 29,448 of eligible clinicians and QPP SURs provided technical support to 83,331 of MIPS eligible clinicians as of October 2017.

As of July 2017 and the Quarter 12 Deliverables for the 11th SOW, the QIN-QIOs have provided direct technical assistance related to the Quality Payment Program to 53,010 eligible clinicians. 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 include outreach to non-rural providers to help them comply with their QPP requirements via customized, direct technical assistance as well as through LAN activity, QPP modules, and education/outreach.

Covered areas of technical assistance and educational offerings include the following:

- Merit-Based Incentive Payment System (MIPS) performance categories
- Stages of clinical practice transformation
- Clinical quality measurement strategies

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 Baseline: FY 2015: 10.8%	2019	1% Relative Improvement over 2018 baseline	December 30, 2020
	2018	1% Relative Improvement over 2017 baseline	December 30, 2019
	2017	1% Relative Improvement over 2016 baseline	December 30, 2018
	2016	1% Relative Improvement over 2015 baseline	April 30, 2018

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. Patients who have not received a transplant rely on dialysis to perform the life-saving function of blood filtration. 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 that remove waste from 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 costs exceeding $1 billion annually[38]. While CVCs have the advantage of immediate use for dialysis after placement, they are associated with a number of complications, particularly when used long term. Long term CVC use is defined as 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 AVF and AVG[39]. 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 among hemodialysis patients in the United States in view of the clear disadvantages and evidence-based practice guidelines to the contrary.

[38] 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]

[39] USRDS, 2014

In 2013, the Fistula First Catheter Last Workgroup Coalition (FFCL) was established to build on the success of the Fistula First Breakthrough Initiative, but the FFCL has 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 are: (1) FFCL Data Committee, (2) Access Monitoring, (3) Access Planning and Coordination, and (4) Access Infection Prevention.

CMS established 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 to 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 Baseline: CY 2014: 121 harms per 1,000 discharges	2019	97 harms per 1,000 discharges	December 31, 2020
	2018	101 harms per 1,000 discharges	December 31, 2019
	2017	106 harms per 1,000 discharges	December 31, 2018
	2016	N/A	March 31, 2018
	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 (PrUI)
- Surgical Site Infections (SSI)
- Ventilator-Associated Pneumonia/Events (VAP/VAE)
- Venous Thromboembolism (VTE) and
- Hospital Readmissions

These preventable harms can cause additional pain, stress, and cost to the patient and their family during treatment, as well as increased cost to payers. This measure utilizes the Agency for Healthcare Research and Quality (AHRQ) National Scorecard, which includes an abstraction from a nationally representative sample of approximately 30,000 hospital charts per year that yields clinically 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 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 and the active intervention 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 and 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 the 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 Baseline: 91% (FY 2007)	2019	Contextual Indicator	December 31, 2019
	2018	Contextual Indicator	December 31, 2018
	2017	Contextual Indicator	91%
	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 Baseline: 90% (FY 2007)	2019	Contextual Indicator	December 31, 2019
	2018	Contextual Indicator	December 31, 2018
	2017	Contextual Indicator	91%
	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. We are continuing 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. High rates have continued for this 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-Low Income Subsidy (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	2019	32%	February 28 2021
	2018	37%	February 28 2020
	2017	43%	February 28 2019
	2016	48%	April 30 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 2017, this "gap" in coverage is above $3,700 in total drug costs, and up until a beneficiary spends $4,950 out-of-pocket.

Since 2011, brand-name pharmaceutical manufacturers have been required to provide a 50 percent discount on the negotiated price of their 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 counts toward the annual out-of-pocket threshold (known as True Out-of-Pocket Costs or 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.This performance measure reflects CMS' effort to reduce the average out-of-pocket costs paid by non-Low Income Subsidy (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, making this coverage equivalent to coverage prior to reaching the gap.

CMS' implementation and management of the coverage gap discount program has meant that in most years non-LIS out-of-pocket costs have decreased beyond what is required by statute. This has occurred without any meaningful decreases in plan participation in the Part D market. As generic utilization in the Part D program has remained static, and very high, that is not a strong contributor to the success of this goal. Rather, CMS' application and management of the coverage gap discount program, coupled with the strong incentives for manufacturers to participate in the Part D program, are the primary drivers of this goal's success.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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.	2019	46,556,502 children (Medicaid - 37,245,202/CHIP - 9,311,300)	March 31, 2020
	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* children (Target Not Met)
	2013	45,592,385 children (Medicaid – 37,246,233/CHIP – 8,346,152)	45,292,410 children (Medicaid – 37,198,483/CHIP – 8,093,927) (Target Not Met)
	2012	Historical actual	44,453,639 children (Medicaid – 36,305,242/CHIP – 8,148,397)
	2011	Historical actual	43,542,385 children
	2008	Baseline	37,311,641 children

*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 September 2017, the enrollment total for FY 2014 is 46,013,363. The change is due primarily to improvements in data quality.

The purpose of this measure is to increase enrollment in CHIP and Medicaid from 43,542,385 children in FY 2011 to 46,556,502 children by the end of FY 2019. Under the CHIP and Medicaid programs, States 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 2015 data that show that nationally, 93 percent of children eligible for Medicaid and CHIP are enrolled in these programs, with participation rates at or above 90 percent in 36 states. In contrast, in 2008, only five States had participation rates of at least 90 percent. 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's 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.

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. Obamacare extended federal CHIP funding for an additional two years through September 30, 2015 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. The HEALTHY KIDS Act, as included in P.L. 115-120, extended CHIP funding for six years through September 30, 2023 and provided $120 million in funding for outreach and enrollment activities through FY 2023.

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 2.1 million in 2015.

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 conducted 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 children as well as messaging which resonates with parents of uninsured children. The Campaign is using information gathered 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 in 2017. 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 93 percent of eligible children enrolled in Medicaid and CHIP in 2015, effective and targeted strategies are needed to enroll the remaining 7 percent of eligible uninsured children. As noted above, the remaining eligible but uninsured children are the hardest to reach.

CENTER OF MEDICARE AND MEDICAID INNOVATION (CMMI)

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 Baseline: 1.0 FY2014	2019	7.0	November 30, 2019
	2018	6.0	November 30, 2018
	2017	5.0	5 (Target Met)
	2016	4.0	4 (Target Met)
	2015	3.0	3 (Target Met)

CMS 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 CMS is making toward sustainable success of its models. As of September 30, 2017, five Section 1115A model tests (Pioneer Accountable Care Organization [ACO], the YMCA of the USA Diabetes Prevention Program the Medicare Diabetes Prevention Program (MDPP), lower-extremity joint replacement (LEJR) under the Bundled Payments for Care Improvement Initiative [BPCI] Model 2, Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport (RSNAT), and Maryland All-Payer model) 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 MDPP 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. Evaluation results for BPCI Model 2 during the first 24 months (10/01/2013 – 09/30/2015) show that the total Medicare standardized allowed payments for lower extremity joint replacement decreased by $1,273 per episode while maintaining quality. Based on claims data from the RSNAT model's first two years, spending decreased in the initial three states from an average of $18.9 million to an average of $6.0 million per month for the January 2015 to December 2016 period, and spending decreased in the six geographies added to the model by the Medicare Access and CHIP Reauthorization Act from an average of $5.7 million to an average of $3.1 million per month for the January 2016 to December 2016 period. The model is associated with an approximately $171 million reduction in RSNAT service expenditures for ESRD beneficiaries.

For the Maryland All-Payer model, evaluation data show $293 million savings over the first two years of the model. For other 1115A models, CMS continues to assemble and assess the evidence as it becomes available. CMS targets are intended to increase the number of models indicating positive results to six in FY 2018 and seven in FY 2019, consistent with the evidence available to date.

CMMI3: Accelerate the Spread of Successful Practices and Models

Measure	FY	Target	Result
CMMI3.1: Percentage of Medicare Beneficiaries Participating in Innovation Center models Baseline: 2014 5%	2019	Contextual Indicator	November 30, 2019
	2018	Contextual Indicator	November 30, 2018
	2017	Contextual Indicator	13%
	2016	Contextual Indicator	9%
	2015	Contextual Indicator	9%
CMMI3.2: Number of States Developing and Implementing a Health System Transformation and Payment Reform Plan Baseline: 2014 25	2019	TBD	November 30, 2019
	2018	16	November 30, 2018
	2017	17	20 (Target Exceeded)
	2016	38	38 (Target Met)
	2015	38	38 (Target Met)
CMMI3.3: Number of Providers Participating in Innovation Center Models Baseline: 2014 < 60,000	2019	Contextual Indicator	November 30, 2019
	2018	Contextual Indicator	November 30, 2018
	2017	Contextual Indicator	219,719
	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	2018	Discontinued	N/A
	2017	59.7%	47.6% (Target Not Met)

Measure	FY	Target	Result
Baseline: 2014 56%	2016	64.5%	56.9% (Target Not Met)
	2015	61.0%	58.6% (Target Not Met)
CMMI3.5: Percentage of Model Awardees Participating in Learning Activities Baseline: 2018 TBD	2019	TBD	November 30, 2020
	2018	Baseline TBD	November 30, 2019

Through its mission, CMS aims 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 CMMI 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. CMMI also strives to understand the level of participation from beneficiaries, providers, states, payers, and other stakeholders to effectively design, test, and evaluate its portfolio of models.

To date, CMS has introduced a wide range of Medicare initiatives – involving a broad array of Medicare fee-for-service (FFS) beneficiaries, health care providers, states, payers, and other stakeholders. In FY 2014, nearly 2.7 million Medicare FFS beneficiaries participated in CMS model tests compared to FY 2017, where more than 5.7 million Medicare FFS beneficiaries participated in CMS models, representing approximately 13 percent of Medicare FFS beneficiaries. As a contextual indicator, CMMI3.1 provides a snapshot of Medicare beneficiary model participation at a given point in time (not cumulative participation) in models that have been operational for more than 6 months. The denominator reflects total Medicare Part A FFS beneficiaries. If all Medicare beneficiaries were included in the numerator and in the denominator, including Medicare Advantage beneficiaries, the rate of participation would have been approximately 10 percent in 2017.

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 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, and convening. CMS provides funding and technical assistance to states to test states' ability to utilize these levers in the design or testing of new payment and service delivery models that have the

potential to reduce health care costs and increase the quality of care delivery in Medicare, Medicaid, CHIP, and collaboration with commercial healthcare systems. In FY 2014, 25 participating State Innovation Model (SIM) states designed or implemented a health system transformation and multi-payer payment reform strategy. In FY 2015, CMS reported an additional 9 states, 3 territories, and the District of Columbia (38 in total) were committed to designing or testing new SIM payment and service delivery models in exchange for financial and technical support. By FY 2016, these 38 states continued designing and testing new payment and service delivery models. In FY 2017, the state count is now 20, inclusive of 3 All-Payer models with formal Medicare Alternative Payment Models (APM) participation, and 17 SIM states that continued testing and improving their health system transformation and payment reform plans. CMS saw a reduction in number of SIM states in FY 2017, due to the design award project period ending as intended by the program. No decisions have been made about future rounds of SIM/All-Payer awards. Furthermore for FY 2018, CMMI3.2 targets 16 states to test their delivery system and payment transformation plans, inclusive of All-Payer models.

To accelerate the development and testing of new payment and service delivery models, CMS recognizes that many robust ideas will come from a broad array of health care providers, states, payers, and other stakeholders in communities across the country. CMMI3.3 seeks to understand the level of interest and participation among providers in CMS' model portfolio. In FY 2014, CMS estimated that more than 60,000 providers participated in payment and service delivery models. Moreover in FY 2015, CMS estimated that approximately 61,000 providers participated in CMS payment and service delivery models compared to FY 2016, where CMS estimated that 103,291 providers participated in payment and service delivery models. In FY 2017, CMS estimated that 219,719 providers participated in CMS payment and service delivery models.

CMS has created learning collaboratives for providers and other model participants to promote broad and rapid dissemination of lessons learned and promising practices that have the potential to deliver higher quality and lower cost of care for Medicare, Medicaid, and CHIP beneficiaries. Every 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 (Pioneer ACO), the Comprehensive Primary Care (CPC) initiative, and Health Care Innovation Awards Round 1 (HCIA1)) 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. Participation fell slightly under the proposed target of 61 percent participation, but did demonstrate an improvement in participation in learning events across the models from the previous year. When the data are stratified by specific model, the Pioneer ACOs demonstrated an increased participation rate (from 62.7 percent in 2014 to 84.5 percent in 2015). The participation percentages also increased for CPC.

The term "model participant" refers to the number of organizations or awardees for each model. The approach in calculating the FY 2016 results was based on using the average of model participants attending an event divided by the number of model participants who were targeted to attend the event. An average percentage of event participation was then calculated annually for each model and the overall participation rate was a sum of annual model participation averages divided by the number of models. In the FY 2016 report, data was obtained for 9 models including the ACO Investment Model (AIM), the Comprehensive End-stage Renal Disease (ESRD) Care Initiative (CEC), the Next Generation ACO Model, the Pioneer ACO

Model, the Bundled Payments for Care Improvement (BPCI) Models, the Comprehensive Primary Care Initiative, the Health Care Innovation Awards Round 2 (HCIA2), the Oncology Care Model (OCM), and the Strong Start Model. These models were chosen because they had been operational for more than 6 months as of 9/30/2015.

When data are stratified by each model, approximately half of the models included in FY 2016 reported performing higher than the target of 64.5 percent (79.6 percent for CEC, 81.7 percent for Next Generation ACO, 70.7 percent for Pioneer ACO, and 85.4 percent for OCM). CPC, HCIA2, and Strong Start performed below the target, following the pattern of models that are at the end of their lifecycle when learning events tend to have less participation. The specific approach for calculating the FY 2017 results is based on the same methodology used for reporting for FY 2016 results. In the FY 2017 report, data were obtained for 8 models: AIM, CEC, Next Generation ACO, BPCI, Comprehensive Care for Joint Replacement Model, HCIA2, OCM, and Strong Start. These models were included because they have been operational for more than 6 months as of 9/30/2016, and CMS has obtained learning system event data from these models. Pioneer ACO and CPC were dropped since the testing period for those models has ended. Embedded within report totals are all learning system events for the models including: all awardee events, regional webinars, action groups, affinity groups, in-person learning events, and office hours.

While the methodology for calculating the FY 2017 result stayed the same, one reporting change was made in 2017. For multiple model events, the FY 2017 report captures the hosting model participant attendance only; non-host model attendees tend not to show up as predictably as host model attendees. For this reason, targets and attendee counts for non-host model participants were not included in the count for multiple model events.

The 2017 participation rate of 47.6 percent fell short of the 59.7 percent target. As learning systems have matured, CMS has recognized the need to have more targeted learning events. The current methodology for collecting data, however, does not reflect this targeting. In addition, some learning events are duplicative of an event that includes a large number of attendees that requires flexible scheduling. The target rates for each duplicative event should account for the fact that attendees are not expected to attend the same event more than once. The current methodology shows some affinity and subgroup events that have listed the total population as the target as opposed to the actual subgroup target. There is a lifecycle of event attendance that is not currently accounted for in the CMMI3.4 measure. It may take time for participation to ramp up and as a model is nearing its testing period, participation tends to drop off. For example, during 2017, Strong Start model was nearing the end of its testing period and this resulted in lower model participation compared to FY 2016. For these reasons, a new measure CMMI3.5 has been established for 2018 to replace the existing CMMI3.4 measure.

CMS DISCONTINUED PERFORMANCE MEASURES

Program Operations Discontinued Measures

MSC1: Decrease the Prevalence of Pressure Ulcers in Nursing Homes

The purpose of this measure is to decrease the prevalence of pressure ulcers in nursing homes, which is an indicator of quality of care and is considered a quality of life measure for nursing home residents. Significant progress has been achieved a 29.6 percent reduction in pressure ulcers since 2007, but we have reached the practical limit in reduction of pressure ulcer prevalence that can be highlighted for a national performance goal improvement. This important quality measure continues to be carefully monitored and reported elsewhere.

Measure	FY	Target	Result
MSC1: Decrease the prevalence of pressure ulcers in nursing homes	2018	Discontinued	N/A
	2017	5.5%	5.5% (Target Met)
	2016	5.5%[1]	5.7% (Target Not Met)
	2015	5.7%	5.8% (Target Not Met)
	2014	6.7%[2]	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%	8.0% (Target Exceeded)
	2007	8.6%	8.1% (Target Exceeded)

[1] The FY 2015 target was reduced from 5.6% to 5.5%.

[2] 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.

MSC2: Percentage of States that Survey All Nursing Homes at Least Every 15 Months

This measure evaluates CMS and survey partners' success in meeting core statuary obligations for carrying out surveys with routine frequency to assure quality of care to residents of our nation's nursing homes. CMS has in place a monitoring system that requires the CMS Regional Offices to review compliance with the nursing home survey interval requirement in each of their States annually and State Survey Agencies follow up with Corrective Actions, as necessary. These safeguards ensure continued focus in the important area, so this goal is being discontinued.

Measure	FY	Target	Result
MSC2: Percentage of States that survey nursing homes at least every 15 months	2018	Discontinued	NA
	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)

MSC3: Percentage of States That Survey All Home Health Agencies at Least Every 36 Months

Federal statute requires that every Home Health Agency (HHA) 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 HHAs. However, State Survey Agencies (SA) continue to experience issues with hiring limitations due to individual State government budgets, issues with frequent surveyor turnover and increasingly conflicting priorities, which then impedes the ability of some SAs to complete their HHA workload. CMS has in place a monitoring system that requires the CMS Regional Offices to review compliance with the HHA interval requirement in each of their States annually and any discrepancies are reported to SAs to make adjustments to comply. Given ongoing challenges and the safeguards in place by CMS this goal is being discontinued.

Measure	FY	Target	Result
MSC3: Percentage of States that survey Home Health Agencies at least every 36 months	2018	Discontinued	N/A
	2017	96%	April 30, 2018
	2016	96%	81% (Target Not Met)
	2015	96%	96% (Target Met)
	2014	96%	86% (Target Not Met)
	2013	96%	90% (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)

MCR25: Increase the Number of Medicare Beneficiaries Who Receive an Annual Wellness Visit

The Medicare Annual Wellness Visits (AWVs) benefit is available to Medicare beneficiaries with no copayments or other cost-sharing if the doctor or other health care provider accepts assignment. This measure, tracked as a contextual indicator since 2015, reflected beneficiary awareness and utilization of this benefit. Originally, the main intervention for increasing awareness of this new benefit to Medicare beneficiaries was funded outreach and publicity and CMS tracked modest increases in the measure. There are no significant interventions that CMS currently has/has planned that will influence whether Medicare beneficiaries avail themselves of the AWV, and since there are no levers to move the number, we have discontinued the goal. Additional information about preventive services provided to Medicare beneficiaries is available at Medicare.gov.

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Measure	FY	Target	Result
MCR25: Increase the number of Medicare Part B beneficiaries who receive an annual wellness visit Baseline: 2.3 million CY2011	2018	Discontinued	N/A
	2017	Contextual Indicator	June 30, 2018
	2016	Contextual Indicator	7.16 million
	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

MCR28: Reduce Healthcare-Associated Infections

CMS has been successful in its intra- Agency partnership goal to reduce Catheter-Associated Urinary Tract Infections (CAUTI) in hospitals. CMS introduced a new goal to improve Hospital Safety by Reducing Preventable Patient Harms (QIO11) and 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 FY 2018.

Measure ID	FY	Target	Result
MCR28.2: Reduce by 10%[1] hospital-acquired catheter-associated urinary tract infections (CAUTI) by the end of FY 2017	2018	Discontinued	N/A
	2017	10%	March 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.)

The following two developmental performance goals are discontinued to be consistent with current budget policy:

MCR32: Improve Patient outcomes by expanding participation in the Advancing Care Information category of Merit Based Incentive Payment System (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 (CHs) who report all the measure under the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program

Health Care Fraud and Abuse Discounted Measures

MIP8: Prevent Medicare Fraud and Abuse by Strengthening CMS' Provider Enrollment and Payment Safeguard Actions

The goal is centered on identifying providers as high risk providers when they receive an administrative action to safeguard the Medicare Trust Funds. The recent transition to an upgraded FPS system and ongoing changes to the way that CMS measures FPS outcomes makes this goal is less relevant than it was in FY 2012. As a result, CMS is discontinuing this goal as of FY 2018.

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. FY 2012 Baseline: 27%	2018	Discontinued	N/A
	2017	45%	66.18% (Target Exceeded)
	2016	45%	38.31% (Target Not Met)
	2015	42%	43.63% (Target Exceeded)
	2014	36%	41.15% (Target Exceeded)
	2013	31%	31.80% (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.

Medicare 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

For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend annual vaccination against influenza. Through collaboration among the Centers for Medicare & Medicaid Services (CMS), the Centers for Disease Control and Prevention (CDC) and the National Foundation for Infectious Diseases/National Coalition for Adult Immunization (NFID/NCAI), efforts continue to improve adult immunization rates in the Medicare population. We discontinued this measure after 2015 due to QIO contractual changes that no longer tracks and reports Long Term Care and Nursing Home vaccination data in the QIO contract work; therefore, tracking reported data post 2015 are not due to the interventions of CMS QIO efforts. We discontinued this measure after 2015 in order to focus efforts on other quality improvements.

Measure	FY†	Target	Result
QIO1: Increase influenza immunization (long term care facility or "institutional" subpopulation)	2016	Discontinued	N/A
	2015	85.4%	79.8% (Target Not Met)
	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 76.8 – 82.7% 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.

MCR21: Effectively Manage Information Technology (IT) Systems and Investments to Minimize Risks and Maximize Return

This goal included the four performance measures representing effective management of CMS IT systems and investments to minimize risks and maximize returns. During the implementation and maintenance phases of the Expedited Life Cycle (XLC), this goal was very informative to the process, however it is at this time outdated. In addition, the reporting of the security metrics are duplicative of FISMA and HHS metrics that CMS reports on regularly. As a result, CMS leadership wants to focus on more meaningful directions for reporting IT investments and systems. CMS will discontinue this goal as of FY 2018.

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. For 2017, CMS is reporting (225 out of 230 systems) having an Authorization to Operate (ATO) which aligns to the annual FISMA Report metric(1.1.3) for FY 2017	2018	Discontinued	N/A
	2017	95%	98% (Target Exceeded)
	2016	95%	97.7% (Target Exceeded)
	2015	90%	92% (Target Exceeded)
	2014	90%	93% (Target Exceeded)
	2013	90%	85% (Target Not Met)
	2012	90%	78% (Target Not Met)
	2011	80%	88% (Target Exceeded)
	2010	New in 2011	78% (Trend)
MCR21.2: Percentage of CMS FISMA systems scanned and monitored by a vulnerability management solution Baseline: 0% FY 2009	2018	Discontinued	N/A
	2017	100%	100% (Target Met)
	2016	85%	100% (Target Exceeded)
	2015	85%[1]	87% (Target Exceeded)
	2014	100%	100% (Target Met)
	2013	100%	100% (Target Met)
	2012	100%	100% (Target Met)
	2011	75%	100% (Target Exceeded)
	2010	New in 2011	63% (Trend)
MCR21.3: Percent of information technology (IT) projects that have adapted	2018	Discontinued	N/A
	2017	100%	100% (Target Met)

Measure	FY	Target	Result
to the Expedited Life Cycle (XLC) framework Baseline: 10% FY 2009	2016	100%	100% (Target Met)
	2015	95%	100% (Target Exceeded)
	2014	95%	100% (Target Exceeded)
	2013	95%	100% (Target Exceeded)
	2012	90%	100% (Target Exceeded)
	2011	75%	100% (Target Exceeded)
	2010	New in 2011	N/A
MCR21.4: Determine success of new IT implementation projects by completing post-implementation reviews (PIR) Baseline: 0 PIR FY 2009	2018	Discontinued	N/A
	2017	75% (or 5 PIRs)	40% (or 2 PIRS) (Target Not Met)
	2016	75% (or 4 PIRs)	0%(or 0 PIRs) (Target Not Met)
	2015	70% (or 5 PIRs)	0% (or 0 PIRs) (Target Not Met)
	2014	70% (or 2 PIRs)	100% (or 2 PIRS) (Target Exceeded)
	2013	60% (or 24 PIRs)	31% (or 5 PIRs) (Target Not Met)
	2012	(40% (or 12 PIRs)	53% (or 16 PIRs) (Target Exceeded)
	2011	12% (or 2 PIRs)	47% (or 8 PIRs) (Target Exceeded)
	2010	New in 2011	N/A

[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.

MCR29: Protect the Health of Medicare Beneficiaries by Implementing the First Value-Based Purchasing Program: End-Stage Renal Disease Quality Incentive Program

This goal assessed the total performance of ESRD facilities based on performance standards with respect to the measures for a performance period. Since inception, CMS met its targets for each of the measures. CMS is currently focusing on developing and implementing an outcomes-related goal that captures improvements in the overall quality of care provided to ESRD beneficiaries. CMS will discontinue this goal as of FY 2018.

Measure	FY	Target	Result
MCR29.1: Develop drafts and final rules for each payment year (PY)	2018	Discontinued	N/A
	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	Discontinued	N/A
	2017	Adjust payments for facilities not meeting performance standards (based on 2015 data)	January 1, 2017 (Target Met)
	2016	Adjust payments for facilities not meeting performance standards (based on 2014 data)	January 1, 2016 (Target Met)

Measure	FY	Target	Result
	2015	Adjust payments for facilities not meeting performance standards (based on 2013 data)	January 1, 2015 (Target Met)
	2014	Adjust payments for facilities not meeting performance standards (based on 2012 data)	January 1, 2014 (Target Met)
	2013	Adjust payments for facilities not meeting performance standards (based on 2011 claims data)	January 1, 2013 (Target Met)
	2012	Adjust payments for facilities not meeting performance standards (based on 2010 claims data)	Procedures have been completed and payment reductions began January 1, 2012 (Target Met)
MCR29.3: Obtain monitoring and evaluation (M&E) contractor and implement monitoring strategy	2018	Discontinued	N/A
	2017	Develop and complete ESRD QIP Final Monitoring Report for PY 2016	July 31, 2017 (Target Met)
	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 September 29, 2011 (Target Met)

PHI2: Increase the number of your adults ages 19-25 who are covered as a dependent on their parent's employer-sponsored insurance policy

This goal was focused on the number of young adults under age 26 that were newly allowed to continue health insurance coverage under their parent's employer-sponsored insurance policy. The estimated number of adult children covered as dependents on a parent's insurance policy increased from 11.0 million in FY 2015 to 11.1 million in FY 2016. The underlying data on the number of potentially-affected individuals were derived from the Current Population Survey Annual Social and Economic Supplement (CPS ASEC). While CMS will continue to monitor compliance with the requirement that issuers offer coverage for young adults ages 19 to 25, we will discontinue reporting on this goal as of FY 2018.

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	Discontinued	N/A
	2017	Contextual indicator	November 30, 2018
	2016	Contextual indicator	11.1 million
	2015	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

PHI5: Track the Number of Individuals who have Confirmed Enrollment through the Health Insurance Exchanges

This goal was focused on the number of individuals with confirmed enrollment through the Exchanges. The CY 2016 target was 10 million individuals enrolled and the CY 2017 target was 11.4 million enrollees. The December 2016 effectuated enrollment was 9,115,154 and can be found in the 2017 Effectuated Enrollment Snapshot. We will discontinue reporting on this goal as of FY 2018.

Measure	CY	Target	Result
PHI5: Track the number of individuals who have confirmed enrollment through the Affordable Insurance Exchanges	2018	Discontinued	N/A
	2017	11.4 million	Spring 2018
	2016	10 million	9,115,154
	2015	9.0 million	8,780,545
	2014	Baseline	6,337,860

PHI6: Protect Individual and Small Businesses from Potentially Unreasonable Health Insurance Premium Increases through the Effective Rate Review

This measure tracks health insurers' submissions requesting premium rate increases from year to year both on and off the Exchanges, and the number of those submissions that are subject to review. Rates are subject to review if the requested, rate increase is unreasonable defined under regulation as 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. We will discontinue reporting on this goal as of FY 2018.

Measure	FY	Target	Result
PHI6: Decrease or maintain the percentage of submissions for rate increases equal to or greater than 10% Baseline: 12% FY 2014	2018	Discontinued	N/A
	2017	10%	68% (Target Not Met)
	2016	10%	54% (Target Not Met)
	2015	11%	28% (Target Not Met)
	2014	Baseline	12%

PHI7: Maintain or Reduce Percent of Population Who are Uninsured by Providing Increased Access to Health Care through Private Insurance, Medicaid, and CHIP

This contextual indicator tracked the percentage of the United States civilian nonelderly noninstitutionalized population who were uninsured. The indicator tracked the impact of various legislative and administrative policies on health insurance coverage and served 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. We will discontinue reporting on this contextual measure as of FY 2018.

Measure	CY	Target	Result
PHI7: Percentage of the Nonelderly United States Population Who are Uninsured (Civilian, Noninstitutionalized) Baseline: 18.20% CY 2010	2018	Discontinued	N/A
	2017	Contextual Indicator	May 1, 2018
	2016	Contextual Indicator	10.4%
	2015	Historical Actual	10.5%
	2014	Historical Actual	13.3%
	2013	Historical Actual	16.6%
	2012	Historical Actual	16.9%
	2011	Historical Actual	17.3%

Center for Medicare and Medicaid Innovation Discontinued Measures

ACO1: Reduce the Growth of Health Care Costs while Promoting Better Health and Health Care Quality through Delivery System Reform

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 care they provide to Medicare beneficiaries in return for the opportunity to share in savings realized through care improvement. CMS is no longer singling out a particular class of model in these revised goals. ACOs are one of several areas that CMS focuses on. Instead, CMS is focusing on measures that cut across the portfolio of models. As a result, CMS is discontinuing this goal as of FY 2018.

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	Discontinued	N/A
	2017	Total Estimate= 9,920,000	September 30, 2018
	2016	Total Estimate= 8,710,000	Total Actual = 8,669,462 (Target Not Met)
	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	Discontinued	N/A
	2017	Total Estimate= 275,200	September 30, 2018
	2016	Total Estimate= 266,600	Total Actual = 274,075 (Target Exceeded)
	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	Discontinued	N/A
	2017	Total Estimate = 37%	September 30, 2018
	2016	Total Estimate = 36%	39.35% (Target Exceeded)
	2015	Total Estimate = 37%	34% (Target Not Met)
	2014	Total Estimate = 35%	34% (Target Not Met)
	2013	Baseline	CMS Baseline Result = 34%

Program Operations – Information Technology
(Dollars in Thousands)

Activity	FY 2017 Final	FY 2018 Annualized CR	FY 2019 President's Budget	FY 2019 +/- FY 2018
I. Medicare Parts A&B				
Ongoing Operations	$ 84,451	$ 88,531	$ 81,976	$ (6,555)
Claims Processing Systems	$ 54,532	$ 75,776	$ 75,776	$ -
FFS Operations Support	$ 16,463	$ 8,756	$ 9,062	$ 306
II. Other Medicare Operational Costs				
Accounting & Audits	$ 110,825	$ 90,326	$ 89,826	$ (500)
QIC Appeals	$ 6,200	$ 6,200	$ 6,200	$ -
HIPAA Administrative	$ 17,576	$ 16,169	$ 14,233	$ (1,936)
III. Medicaid & CHIP				
Medicaid & CHIP Initiatives	$ 27,871	$ 50,375	$ 44,726	$ (5,646)
IV. Health Care Planning & Oversight				
Part C&D IT Systems	$ 39,720	$ 44,423	$ 39,792	$ (4,631)
Federal Exchange	$ 471,468	$ 273,906	$ 44,456	$ (229,449)
V. Health Care Quality				
Health Care Improvement	$ 20,247	$ 10,287	$ 13,415	$ 3,128
VI. Outreach & Education				
Beneficiary Outreach/NMEP	$ 20,309	$ 22,544	$ 27,309	$ 4,765
Provider Outreach	$ 1,135	$ 1,091	$ 1,168	$ 77
Consumer Outreach	$ 2,000	$ 1,700	$ 2,000	$ 300
Competitive Bidding	$ 1,566	$ 1,958	$ 3,066	$ 1,108
VII. Information Technology				
Systems and Support	$ 359,149	$ 453,163	$ 397,409	$ (55,754)
TOTAL[1]	**$ 1,233,512**	**$ 1,145,206**	**$ 850,414**	**$ (294,792)**

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