

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

Fiscal Year 2005 Budget Request

**Witness appearing before the
House Subcommittee on Labor-HHS-Education Appropriations**

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Statement by

Dennis Smith

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on

Fiscal Year 2005 President's Budget Request
for the Centers for Medicare & Medicaid Services

Good morning Chairman Regula and members of the Subcommittee. I am pleased to be here today to discuss the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2005 budget request and to answer your questions. First, I'd like to give you an overview of our budget and tell you about some of our recent highlights, as well as the priorities Secretary Thompson and CMS have for FY 2005. Before I begin, I want to thank you all for your continuing support of CMS and the vital programs we administer.

CMS is the Federal agency responsible for overseeing Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). CMS also oversees the Medigap insurance industry and enforces the Clinical Laboratory Improvement Amendments (CLIA) and health insurance reform enacted under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. We are also responsible for implementing hundreds of statutory provisions enacted in recent years, including HIPAA, the Balanced Budget Act (BBA) of 1997, the Balanced Budget Refinement Act (BBRA) of 1999, the Ticket to Work and Work Incentives Improvement Act of 1999, the Benefits Improvement and Protection Act (BIPA) of 2000, the Trade Act

of 2002, the Jobs and Growth Tax Relief Act of 2003, the SCHIP Allotments Extension Act of 2003, and, of course, the recently enacted Medicare Prescription Drug, Improvement, and Modernization Act of 2003, known herein as the Medicare Modernization Act or MMA.

CMS oversees one of the largest budgets of any agency in the Federal government. In FY 2005, its proposed budget is \$482 billion, a \$29 billion increase over FY 2004. CMS pays one-third of national health expenditures and provides over half of the revenues of many hospitals and other health care providers. Approximately 84 million Medicare, Medicaid, and SCHIP beneficiaries, almost 30 percent of all Americans, rely on CMS' programs for health care coverage. For 39 years, Medicare and Medicaid have helped pay medical bills for millions of older and low-income Americans, providing them with comprehensive health benefits they can count on. Few programs, public or private, have such a positive impact on so many Americans. CMS does this with the help of over 65,000 State and local employees and contract employees.

CMS is committed to administering Medicare, Medicaid, and SCHIP effectively and efficiently and to providing essential services to its 84 million health care consumers and the health care providers that serve them. We have worked to expand access to health care coverage for millions of low-income adults and children and to improve the quality of care provided to Medicare and Medicaid beneficiaries. We have helped to make Medicare a more user-friendly, beneficiary-centered program and to

make it clear to the Americans who rely on our programs that CMS is the agency responsible for administering them. We have also become more citizen-centered, and more open and responsive to the needs and concerns of Medicare, Medicaid, and SCHIP beneficiaries, their health care providers, and our stakeholders. We have made many changes and improvements, with more still to come.

I would like to briefly describe the progress we have made on some of the Secretary's on-going priorities. First, we have continued to enhance our outreach and education activities with an improved *Medicare & You* program. This includes a continuing advertising campaign, distribution of the *Medicare & You* handbook to over 40 million beneficiaries and stakeholders, access to customer service representatives (in English and Spanish) 24 hours a day, seven days per week, community-based outreach, and improved Internet access to comparative information. The volume of calls to the 1-800-MEDICARE call centers continues to grow. In FY 2005, we expect to receive over 9 million calls, a 25 percent increase over FY 2004, excluding calls resulting from the new MMA. Our www.medicare.gov website offers several interactive sites—including Nursing Home Compare, Medicare Personal Plan Finder, Prescription Drug and Other Assistance Programs, and our newest site, Home Health Compare—which allow seniors, family members, and caregivers to compare benefits, costs, options, and provider quality information. CMS expects 79 million page views in FY 2005. Finally, CMS partners with State Health Insurance Assistance Programs (SHIPs) to provide counseling and various other outreach activities to beneficiaries. SHIPs are located in all 50 States, the District of Columbia, the U.S. Virgin Islands,

and Puerto Rico. We will continue our alliances with 140 network partners, working in public-private cooperation, to meet the education program goals at the State and local levels. CMS plans to allow the territory of Guam the opportunity of participating in the SHIP program in FY 2005.

We continue to pursue a comprehensive quality strategy. Together with the Department, we launched the national Nursing Home Quality Initiative in 2002 to provide comparative information about the quality of nursing homes. We have recently updated our Nursing Home Compare website with enhanced quality measures and easier navigation. CMS believes that public reporting initiatives improve the quality of health care delivery for our beneficiaries. Since the Nursing Home Quality initiative began, there has been a 15 percent decrease in the use of restraints and a 30 percent decrease in the percentage of residents experiencing chronic pain. In November 2003, CMS launched the Home Health Quality Initiative which includes information at the Home Health Compare website on the quality of care provided by home health agencies across the country. CMS has also just recently announced guidelines for hospitals to use in submitting performance data on ten quality measures. Although some hospitals have been submitting this data voluntarily, section 501 of the MMA now requires all hospitals to either report on these measures or receive lower Medicare inflationary updates in FY 2005.

We are also becoming more accessible and responsive to beneficiaries, providers, and other stakeholders interested in the delivery of quality health care for our

nation's seniors. Our "open door" policy forums are a series of monthly and bimonthly teleconferences held with provider and beneficiary stakeholder groups. These offer an opportunity to speak directly with CMS decision makers and facilitate information sharing and improve communication between the agency and its partners and beneficiaries. Over the last 12 months, we have held 109 of these meetings with more than 21,000 participants. We have also established key contacts to promote direct communication between CMS staff and beneficiary groups. For the first time, we are now accepting comments on proposed Medicare and Medicaid regulations electronically. Our new system will also accept comments on policy notices soliciting public input and notices asking for information such as nominations for advisory committees. We have also worked to develop a new streamlined enrollment process for providers and suppliers to establish Medicare billing privileges. When implemented, this new process will make it easier for qualified providers to serve Medicare beneficiaries while ensuring that unqualified ones do not. Furthermore, through our Physicians Regulatory Issues Team, we have worked to reduce the regulatory burden on physicians so that they can spend more time taking care of patients. We believe these are important strides in our goal to become more customer-focused.

IMPLEMENTING THE MEDICARE MODERNIZATION ACT

Although we have made significant progress, we still have many important plans for the remainder of FY 2004 and FY 2005. First and foremost is implementing the provisions in the MMA. The MMA represents the most significant expansion of the Medicare program since its enactment in 1965 and its implementation over the next 18

months and beyond will require our utmost effort. Major new benefits provided by the MMA include access to a Medicare-endorsed prescription drug discount card beginning June 1, 2004, with a \$600 credit available for certain low-income seniors, and access to standard prescription drug coverage beginning January 2006, with significant financial assistance for low-income seniors. Medicare will also offer new preventive benefits. Beginning in 2005, all newly enrolled Medicare beneficiaries will be covered for an initial physical examination, and all beneficiaries will be covered for cardiovascular screening blood tests, and those at risk will be covered for a diabetes screen. In addition to providing help to beneficiaries, the MMA will also help states by paying an increasing percentage of current state costs for prescription drugs for those who are enrolled in both the Medicare and Medicaid programs.

The MMA replaces the existing Medicare+ Choice program with a new program—Medicare Advantage—which will encourage preferred provider organizations (PPO) to participate in Medicare. PPOs have been a growing form of health insurance and are now the most popular type of coverage in the private market. The MMA also promotes the use of electronic prescribing to help reduce the substantial number of prescribing errors that occur each year. Other major provisions include improving beneficiary and provider education, clarifying provider rights, reforming the Medicare contracting process, easing regulatory burdens, transferring the Medicare hearings workload from the Social Security Administration to the Department of Health and Human Services, new demonstrations and studies, and numerous other provisions which impact Medicaid as well as Medicare.

The MMA appropriated \$1 billion in two-year money for CMS' responsibilities in FY 2004 and FY 2005. We are currently developing a detailed spending plan for these funds. While we continue to refine our plans, we have already begun to implement provisions of this bill. In January 2004, we increased payments to physicians and rural hospitals. We also announced significant increases in federal payment rates to Medicare Advantage (formerly known as Medicare+Choice) health plans for 2004. These increases, which were included in the MMA, will support improvements in services and lower costs for Medicare beneficiaries enrolled in private health plans as well as provide more options for Medicare coverage. We are currently working to meet the June 1, 2004 deadline for establishing the Medicare-endorsed prescription drug discount card program. We are encouraged by the fact that over 100 companies have expressed an interest in being drug card sponsors.

HIGHLIGHTS OF OUR FY 2005 BUDGET

Our FY 2005 budget request continues significant efforts to help disabled persons and those in need of long-term care services. The New Freedom Initiative includes several proposals to promote home and community-based care for disabled individuals as an alternative to institutionalization. This represents part of the Administration's effort to make it easier for Americans with disabilities to be more fully integrated into their communities. Four demonstrations included in the FY 2004 President's Budget are again proposed. Two of the demonstrations provide respite care for caregivers of children and adults with serious disabilities. The third demonstration

will test the effectiveness of providing home and community-based alternatives to that of psychiatric residential treatment for children enrolled in Medicaid. The fourth demonstration will continue to test ways to alleviate workforce shortages for direct care workers in the community.

The Secretary remains interested in building on the foundation of last year's proposals to modernize the Medicaid and SCHIP programs and will look for new and innovative ways to address this issue in the coming year. The budget also includes several proposals that give individuals more flexibility in directing their long-term care. LIFE accounts, a new proposal, would provide States the option of allowing individuals who self-direct their community-based long-term care services to accumulate savings and still retain eligibility for Medicaid and/or Supplemental Security Income. A second proposal, the Partnership for Long-Term Care, which was in the FY 2004 budget, would eliminate the legislative prohibition on developing more Partnership programs. Four States (California, Connecticut, Indiana, and New York) currently have these partnerships whereby private insurance is used to cover the initial cost of long-term care. Consumers who purchase Partnership-approved insurance policies can become eligible for Medicaid services after their private insurance is utilized without divesting all of their assets, as is typically required to meet Medicaid eligibility criteria. We continue to work to improve the Medicaid and SCHIP waiver process. CMS has given States more flexibility to expand insurance coverage to the uninsured and test innovative approaches to health care delivery through waivers, including the newer Health Insurance Flexibility and Accountability (HIFA),

Pharmacy Plus, and Independence Plus waivers. Currently, CMS has approved 27 comprehensive health care reform demonstrations in 23 states, nine HIFA demonstrations, four Pharmacy Plus demonstrations, and five Independence Plus programs.

Another high priority for us is our accountability. We are continuing to refocus our program integrity efforts so that we can better differentiate between fraudulent providers and those who make honest billing mistakes. Our request again includes approximately \$20 million from the Health Care Fraud and Abuse Control account to continue improving the fiscal integrity of the Medicaid and SCHIP programs and strengthening Federal oversight of the States' financial practices. The budget also proposes to restrict the use of certain intergovernmental transfers and to limit Federal payments to individual State and local providers.

We are also committed to improving our financial performance. Our FY 2005 request includes \$78 million to continue building a financial management system, the Healthcare Integrated General Ledger Accounting System (HIGLAS), that is a vital component in the Secretary's initiative to centralize the Department's financial accounting processes through its Unified Financial Management System. These funds will allow HIGLAS to account for 75 percent of Medicare accounts receivable and over 50 percent of Medicare benefit payments, thus ensuring compliance with the Federal Financial Management Improvement Act. When fully implemented, HIGLAS will integrate CMS financial data in a uniform way and replace our aging legacy systems.

In addition, our FY 2005 budget is predicated on achieving greater administrative efficiency. This includes managing our workforce more effectively, increasing employee skill levels, particularly in the clinical/health areas, responding to Congress and other groups more promptly, and managing our work more strategically. Although we already accomplish most of our operational activities through over 65,000 outside contractors, we continue to analyze opportunities for competitive sourcing. With the enactment of the MMA, Congress has provided CMS with greater contracting flexibility through new reform measures that eliminate antiquated statutory procurement practices.

CMS has made progress this past year in implementing HIPAA, one of the Secretary's top priorities, including two HIPAA administrative simplification provisions: the electronic transactions and code sets provision and the provider identifier provision. In October 2003, after a one-year delay, CMS began accepting HIPAA-formatted electronic claims. Currently, about 65 percent of Medicare claims are HIPAA-compliant. CMS continues to work with providers and billing agents to ensure that all electronic billers submit their claims in the HIPAA format as soon as possible. We also recently announced the adoption of the National Provider Identifier as the standard unique identifier for health care providers to use in filing claims. CMS will begin to issue these identifiers shortly after May 23, 2005, the effective date of this regulation. Implementing these and other HIPAA standards will improve the efficiency

and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.

Finally, I would like to say a word about the Government Performance and Results Act (GPRA) and our annual performance plan. This plan complements and supports the agency's FY 2005 budget, and is integral to it. The agency is confident that performance measurement under GPRA will substantially improve management of CMS and its programs.

One of our GPRA goals is reducing improper payments made under the Medicare fee-for-service (FFS) program. The FY 2003 error rate was 5.8 percent when adjusted for the high non-response rate we experienced. This is about the same as the FY 2002 rate and less than half the rate when the Department began tracking this measure in FY 1996. FY 2003 was our first year using the new Comprehensive Error Rate Testing (CERT) program for measuring this rate. This new program identifies provider- and contractor-specific error rates that will allow us to take more effective corrective action and better manage Medicare contractor performance. We have taken steps to improve the CERT's methodology and these improvements ensure that the adjustment to the error rate will not be necessary in 2004. We are also committed to measuring and ultimately reducing Medicaid and SCHIP payment error rates. This request supports the development of payment accuracy models for these programs.

Now I would like to discuss CMS' FY 2005 budget request and the three accounts for which this Committee makes appropriations: Grants to States for Medicaid; Payments to the Health Care Trust Funds; and CMS Program Management. I will briefly highlight the first two accounts and then discuss CMS' Program Management request in more detail since Program Management funds are key to accomplishing our priorities.

GRANTS TO STATES FOR MEDICAID

In FY 2005, the Medicaid program will serve more than 43 million eligible persons. Federal Medicaid obligations for FY 2005 are estimated at \$183 billion, an increase of 3.4 percent over the FY 2004 estimate. Combined Federal and State Medicaid expenditures are projected to be almost \$322 billion in FY 2005, of which the Federal share is about 57 percent.

PAYMENTS TO HEALTH CARE TRUST FUNDS

Our FY 2005 request of \$114.6 billion includes a Federal general revenue contribution to the Medicare trust funds. Of this amount, the Supplementary Medical Insurance (SMI) Trust Fund comprises \$114.0 billion, an increase of \$19.5 billion from the FY 2004 appropriation.

PROGRAM MANAGEMENT

Our FY 2005 Program Management request is \$2.7 billion, an increase of \$109.3 million, or 4.1 percent, over the enacted FY 2004 appropriation. This funding

level will allow us to perform our operational functions and fund key budget priorities such as implementing appeals reform and improving beneficiary education. This budget supports a total of 4,480 FTEs, a decrease of 6 FTEs from our FY 2004 estimate.

Our Program Management request, while less than one percent of total program outlays, supports a host of activities. In fact, none of the \$504 billion in current law Federal program benefit payments could be paid without the activities and projects funded from this discretionary account.

I would now like to discuss the line items that comprise Program Management: Medicare Operations; Federal Administration; Medicare Survey and Certification; Research, Demonstration and Evaluation; and the CMS Revitalization Plan.

MEDICARE OPERATIONS

The FY 2005 Medicare Operations request of \$1,793.9 million reflects an increase of \$92.8 million, or 5.5 percent, over the FY 2004 appropriation. This request funds the 50 or so private Medicare contractors who will process and pay over 1.1 billion fee-for-service claims, answer 51 million inquiries, process almost 8 million appeals, enroll and educate providers, assist beneficiaries, and carry out other responsibilities on CMS' behalf. In addition, it funds other activities that support these contractors, such as systems maintenance and data communications. It also supports various legislative mandates and Medicare Advantage activities.

We are asking for \$142.1 million to continue supporting the various activities in our National *Medicare & You* Education Program, including \$14.0 million for the State Health Insurance Assistance Program. We are also asking for \$126 million to implement BIPA section 521 reforms, as amended by the MMA, including establishing four qualified independent contractors to process second-level appeals, reimbursing the Social Security Administration for continuing to process Medicare hearings, preparing for the transfer of the hearings workload to the Department, and enhancing CMS' new Medicare appeals system. In addition, \$21.1 million will be dedicated to the HIPAA administrative simplification provisions, including \$4 million (and 10 FTEs) to continue HIPAA enforcement activities. We have also placed special emphasis on projects that bolster the Secretary's efforts to move HHS forward in the area of information technology, including \$74.6 million for HIGLAS and \$10 million to support the Secretary's efforts to modernize and strengthen the Department's systems environment. We have also requested \$5 million to develop, in partnership with the Administration on Aging, a national, comprehensive clearinghouse with information on long-term care services and financing options in order to help consumers plan for their long-term care needs.

FEDERAL ADMINISTRATION

The Federal Administration portion of the Program Management account supports the day-to-day operations of CMS' headquarters, as well as our 10 regional offices. The FY 2005 request of \$589.2 million represents an increase of \$12.0 million, or 2.1 percent, over the FY 2004 appropriation. This line item covers salaries and

benefits of CMS' Federal employees as well as information technology costs and the operating costs for all of our offices. It includes \$3 million for BIPA section 522 local and national coverage determinations, \$3.7 million for HIGLAS, and \$13 million in printing and postage costs to continue the *Healthy Start, Grow Smart* program for a series of 13 brochures in English and Spanish sent to new Medicaid mothers.

MEDICARE SURVEY AND CERTIFICATION

The Medicare Survey and Certification activity ensures that facilities participating in Medicare meet Federal health, safety and program standards. The Medicaid counterpart to this activity is funded through the Grants to States for Medicaid appropriation. Survey and certification activities seek to secure quality services for all Medicare and Medicaid beneficiaries. The FY 2005 Medicare Survey and Certification budget request is \$270.4 million, an increase of \$19.1 million or 7.6 percent above the FY 2004 appropriation. The FY 2005 request will allow CMS to inspect all provider types at the same frequency as the FY 2004 appropriation allows. We expect a total of more than 24,000 inspections and almost 52,000 visits in response to complaints.

This budget request includes \$37.6 million in discretionary funding for the Nursing Home Oversight Improvement Program (NHOIP). Of this amount, \$32.6 million will be funded from the Medicare Survey and Certification account and the remaining \$5.0 million will be funded from the Federal Administration account. The NHOIP has been successful at providing training to State surveyors, monitoring

abuse prevention efforts, becoming more responsive to complaints, and developing State sanction options. We will continue these current activities and others to ensure that Medicare beneficiaries in nursing homes receive quality care in a safe environment. We have made significant strides in the areas targeted by the NHOIP and we are committed to continue working with residents and their families, advocacy groups, providers, States, and Congress to ensure that residents receive the quality care and protection they deserve.

RESEARCH, DEMONSTRATIONS AND EVALUATIONS

The FY 2005 request for Research, Demonstrations and Evaluations is \$68.3 million, a decrease of \$9.5 million from the FY 2004 appropriation. This request includes \$40 million for Real Choice Systems Change grants to enable people with disabilities to live and participate in community life, \$2.9 million for the New Freedom Initiative demonstration activities intended to address workforce shortages of community service direct care workers, and \$25.4 million for a limited number of new and continuing projects, including the Medicare Current Beneficiary Survey, and projects mandated by recent legislation. Our request is consistent with the Department's plans to streamline research through its Research Coordination Council.

REVITALIZATION PLAN

CMS' FY 2005 request includes \$24.4 million in two-year money, compared to \$29.6 million in the FY 2004 appropriation, to continue a multi-year investment fund to revitalize CMS' systems operations. Initially proposed in the FY 2004 President's

Budget, this fund begins to address long-term information technology issues that cannot be accommodated in CMS' on-going operations budget.

In FY 2005, the CMS Revitalization Plan will fund modernization activities related to Medicare fee-for-service claims processing systems, CMS' antiquated data environment, and CMS infrastructure. These modernization efforts will improve efficiency, enable e-gov activities, and improve systems security at CMS and our Medicare contractors.

Last, the Administration is proposing user fees to help improve the efficiency of claims and appeals processing. I would like to briefly describe our two user fee proposals for this budget.

USER FEE PROPOSALS

FY 2005 user fee proposals total \$205 million, and include fees for the submission of duplicate or unprocessable claims and a fee for providers who file an appeal with the new qualified independent contractors mandated by BIPA. We believe that these user fees are sound policy that will lead to positive change in the Medicare program, if enacted. For example, the duplicate and unprocessable claims fee (\$5.00) will deter providers from submitting time-consuming, wasteful claims. Similarly, the \$50 appeals filing fee will heighten provider awareness of the reformed appeals process and deter frivolous appeals. No filing fee will be charged to beneficiaries.

Since our FY 2005 request reflects our total funding needs, the enacted user fees would offset our appropriation by the amount of the proposal.

CONCLUSION

As a result of the MMA, passed by Congress and signed by the President, we have a unique opportunity not only to safely lower drug costs for seniors and persons with disabilities, but also to usher in fundamentally better medical care for all Americans in the years ahead. Taking advantage of this unique opportunity requires many urgent steps including immediately implementing a new drug discount program with new financial assistance to lower-income beneficiaries, drafting and finalizing major regulations to provide drug coverage and more modern health insurance options for all beneficiaries, and using the new law to take steps to improve quality of care such as promoting electronic prescribing, developing better evidence on safety and effectiveness of medical treatments, and providing more useful information to patients and health professionals.

Our challenge over the next several months will be adding these new benefits and choices to Medicare in an efficient and cost effective manner while handling our on-going workloads.

Our FY 2005 Program Management request—a 4.1 percent increase above the FY 2004 appropriation— will meet our operational needs while supporting the Administration’s goals. It will allow CMS to continue beneficiary education efforts

and initiate consumer education efforts on long-term care issues, increase access to quality care, provide health care choices for beneficiaries, improve financial management processes, improve relations with stakeholders, and increase efficiencies. We believe we can continue to make meaningful changes to the programs we administer within these funding levels.

Thank you for the opportunity to present CMS' FY 2005 budget request. On behalf of CMS, I look forward to continuing our agency's fine relationship with you, Mr. Regula, and with this Subcommittee. I am happy to respond to any questions or suggestions that you may have.