DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

Fiscal Year 2006 Budget Request

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Statement by

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on

Fiscal Year 2006 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) 2006 budget request and to answer your questions. First, I would like to give you an overview of our budget and tell you about some of our recent highlights, as well as the priorities Secretary Leavitt and CMS have for FY 2006. 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 Administrative Simplification, 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 SCHIP Allotments Extension Act of 2003, and, of course, the recently enacted Medicare Prescription Drug, Improvement, and Modernization Act of 2003, known as the Medicare Modernization Act (MMA).

CMS oversees one of the largest budgets of any agency in the Federal government. Its proposed FY 2006 budget is $622 billion, a $103 billion increase over FY 2005. CMS pays about one-third of national health expenditures and pays for more than half of all senior health care. More than 85 million Medicare, Medicaid, and SCHIP beneficiaries, almost 30 percent of all Americans, rely on CMS' programs for health care coverage. For 40 years, Medicare and Medicaid have helped pay the medical bills of millions of older and low-income Americans, providing them with 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 more than 100,000 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 more than 85 million health care consumers and the health care providers that serve them. We are working to implement improvements to the quality of health care provided to our beneficiaries and program integrity efforts in all our programs. However, our biggest challenge and top priority this year and next is implementing major provisions in the MMA. This historic legislation transformed Medicare by adding a voluntary prescription drug benefit to the traditional fee-for-service program and by significantly expanding private health plan options

through the new Medicare Advantage (MA) program. The MMA lays the foundation for addressing Medicare's long-term financing challenge by dramatically increasing beneficiary choices and introducing market-based competition, two essential ingredients for greater efficiency and quality in our health care system. I would like to tell you a little about what we have already accomplished with the MMA.

IMPLEMENTING MEDICARE MODERNIZATION

To date, CMS has implemented 279, or two-thirds, of the 416 provisions in the MMA. We have done this in addition to our ongoing work. Some of these new provisions have required a significant amount of effort. For instance, within six months of enactment, we launched the Medicare-Approved Drug Discount Card Program to help Medicare beneficiaries reduce their out-of-pocket spending on prescription drugs. To date, more than 6.2 million beneficiaries have enrolled in the program, including more than 1.7 million who are receiving the $600 low-income credit. Seniors who have signed up for a card are seeing real savings on their prescription drug costs. Independent studies have found that the card is saving them about 20 percent off the cost of brand name drugs and up to 60 percent off the cost of generic drugs. In addition, drug prices and drug coverage for the top 100 drugs used by seniors have remained stable. Those seniors who have enrolled are very satisfied with the drug card benefits. We will continue running this transitional program until the full drug benefit is implemented next year.

The MMA also included a number of innovative and important cost saving measures. Since January 1, 2005, Medicare beneficiaries have been eligible to begin

receiving new preventive benefits such as cardiovascular screening blood tests and diabetes screening tests and, for beneficiaries newly enrolled in Part B, a comprehensive "Welcome to Medicare" physical examination. We are working to implement several provisions that should save money in traditional Medicare including: competitive acquisition of durable medical equipment; reformed purchasing of outpatient drugs under Part B; and improving CMS' ability to collect overpayments.

CMS has also undertaken various administrative and legislative initiatives to be a more efficient payer for higher quality health care. Some of these, such as the Hospital Quality Initiative which pays the full market basket update for reporting on 10 specific quality measures, were mandated by the MMA. Some were initiated before the MMA was enacted, including our Premier Hospital Quality Incentive which pays bonuses to about 280 hospitals for achieving high performance in treating 5 clinical conditions and a 3-year pay-for-performance demonstration with 10 physician groups. We have also begun to use disease management programs as a tool to improve quality of care and quality of life for beneficiaries living with multiple chronic illnesses. All of these new benefits and initiatives are a step in the direction of improving quality of care.

Our largest tasks—implementing the Medicare Prescription Drug Coverage and the new regional Medicare Advantage (MA) programs—are well under way. Along with the new Medicare preventive benefits described earlier, these major program improvements will bring Medicare's coverage up to date with 21st Century prevention-minded medicine. We recently published the final regulations for the drug coverage and

MA programs. We spent many hours carefully reading and responding to more than 7,000 thousand public comments submitted on the proposed rules. As a result of all the public input, I believe the final regulations represent the most effective and efficient road to better care and better health for beneficiaries.

We have an aggressive timeline for implementing the drug benefit and the new MA plans on time. The first two major steps—selecting the MA and PDP regions and issuing the final regulations—have been completed. CMS has received significant initial interest from potential drug plan sponsors and from insurance plans interested in providing MA services. Plan applications were due in March, formulary information is due in April, and plan bids are due in June. We will enter into contracts in early September. Beneficiary enrollment in the drug benefit will begin November 15, 2005 and continue through May 15, 2006.

These new programs will only be successful if we can educate our beneficiaries, providers, and other partners about the impact MMA will have on them. We plan to implement a comprehensive outreach and support program using a broad range of tools. We learned a lot of lessons from the Medicare-Approved Drug Discount Card Program. As a result, we have refined the process for beneficiary outreach, strengthened our relationships with community organizations, and learned how to facilitate a successful price comparison system. These lessons are already having a positive impact on our work, as we move toward full implementation of the drug benefit and MA programs. Our investments in education and outreach include enhancing the functionality and

availability of the 1-800-MEDICARE number and our web sites, continuing our advertising campaign, distributing the *Medicare & You* handbook and other direct mailings to beneficiaries and stakeholders, and expanding our capacity to interact with our beneficiaries through local, community-based partnerships such as the State Health Insurance Assistance Programs (SHIPs). CMS will make every effort to ensure that there is appropriate staffing to handle the anticipated vast increase in 1-800-MEDICARE calls early next fiscal year. CMS expects to receive 47 million calls in FY 2006–32 million will be answered by its customer service representatives and the balance will be handled by interactive voice response. This is almost 9 million calls more than the current FY 2005 estimate. We have learned how to handle higher call volumes but the high level of calls expected during the open enrollment period beginning November 15, 2005 will require even more innovative solutions. We are working now to develop work management approaches to ensure that all calls are handled effectively.

Another major component of our success in implementing MMA is the ability to hire additional staff at CMS. To date, CMS has hired about 345 highly qualified individuals. We plan to hire a total of 500 new employees for this effort. We have been able to attract talent with a wide range of skills and experience including expertise in pharmacy benefits management, disease management and prevention, hospital management, clinical practice, government contracting, new payment systems, and health information infrastructure. We believe we have recruited a skilled and educated cadre of new employees who will bring fresh perspectives to our MMA implementation initiatives.

The MMA also gives CMS the authority to introduce greater competitiveness and flexibility to the administration of traditional Medicare fee-for-service. The new law creates new Medicare Administrative Contractors (MACs) who will administer both Part A and Part B programs and allows incentive payments to encourage improved contractor performance. CMS plans to award 23 MACs through a competitive bidding process, including 15 primary MACs servicing the majority of all types of providers (both Part A and Part B), four specialty MACs servicing home health and hospice providers, and four specialty MACs servicing durable medical equipment suppliers. We are proposing an accelerated strategy beginning with a recompetition of four durable medical equipment contracts and one primary contract in FY 2006 and ending with the final cycle of transitions by October 2009. We believe that contracting reform will improve service, increase administrative efficiencies, and bring significant savings to the program, primarily by combining Part A and Part B claims processing functions, reducing the number of contractors from about 50 to 15 primary and 8 specialty contractors, and selecting contractors by full and open competition. Although this change will require an investment in administrative spending, we expect to see administrative savings beginning in FY 2007 and trust fund savings beginning in FY 2008.

The MMA requires drug plans offering the new Medicare Prescription Drug Coverage to implement electronic prescribing based on national standards by 2009. CMS published the proposed rule for this provision in February, 2005. E-prescribing has the potential to improve patient safety and reduce avoidable health care costs by reducing

prescription errors and by automating the checking for drug interactions and allergies. E-prescribing can also help ensure that patients and health professionals have the best and latest medical information at hand when they make important decisions about medicines.

Taken together, all of these policies should increase competition, drive the industry toward much greater efficiency, and slow the rate of increases in Medicare costs.

MEDICAID AND SCHIP MODERNIZATION

Other entitlement programs pose similar challenges to the long-term fiscal condition of the Federal government. For example, the Medicaid program, created in 1965, is growing rapidly. In many State budgets, Medicaid has become the largest expenditure. Counting the States' share of costs, total Medicaid expenditures are projected to reach $338 billion in FY 2006. The program's open-ended financing structure encourages States to draw down Federal matching funds, sometimes inappropriately. These practices can jeopardize the financial stability of the program. The Administration is proposing several program integrity measures to reduce inappropriate use of Federal funds and ensure that Medicaid doesn't overpay for drugs or services. Along with an increase in the number of audits and evaluations of State Medicaid programs, CMS again proposes to allocate $20 million from the Health Care Fraud and Abuse Control (HCFAC) account, as well as an additional $5 million in newly requested discretionary funds 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 limit Federal reimbursements to State and local

government providers to no more than the cost of providing services and to build on CMS' efforts to identify and recover payments that are not used for their intended purposes.

Medicaid's current structure is not the most efficient way to deliver modern medical care. The Administration plans to build on the success of the SCHIP program by giving States greater flexibility to construct targeted benefit packages, coordinate with private insurance, and extend coverage to non-traditional Medicaid populations without burdensome waiver applications and without creating additional costs for the Federal government. This budget includes several proposals that expand coverage for the key populations served in Medicaid and SCHIP including a "Cover the Kids" campaign to enroll more eligible uninsured children, and extension of the Qualified Individual and transitional medical assistance programs. It also includes several policies that build on the President's New Freedom initiative to promote home- and community-based care options for people with disabilities. The President, Secretary, and CMS are committed to resolving the growing challenges facing Medicaid. We would like to work with the States to respond to these challenges in a concerted effort.

FY 2006 BUDGET HIGHLIGHTS

We remain committed to improving our financial performance. Our FY 2006 request includes $79.9 million to continue building a financial management system, the Healthcare Integrated General Ledger Accounting System (HIGLAS), which is a vital component in the Secretary's initiative to centralize the Department's financial accounting processes through its Unified Financial Management System. Since we began developing

HIGLAS in 2001, we have demonstrated that the system can process transactions at full production level. This system will meet the Department's financial management goals and will advance CMS' compliance with the Federal Financial Management Improvement Act. When fully implemented, HIGLAS will integrate CMS financial data in a uniform manner and replace our aging legacy systems.

For the first time, we are requesting discretionary funds for the HCFAC program. We are proposing an $80 million discretionary cap adjustment for HCFAC in FY 2006. Of this total, $75 million will be used to enhance our efforts to safeguard the new Medicare prescription drug benefit and Medicare Advantage programs. We believe that this is an investment in protecting the Medicare trust funds. As I mentioned earlier, we will also use $5 million to expand our efforts to safeguard the Medicaid and SCHIP programs.

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. CMS began accepting HIPAA-formatted electronic claims in October 2003. Currently, 99 percent of Medicare claims are HIPAA-compliant. In May 2005, we plan to begin issuing the standard unique National Provider Identifier for health care providers to use in filing claims. Implementing these and other HIPAA standards will promote improved efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.

We continue our efforts to become 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 teleconferences held with provider and beneficiary stakeholder groups that offer an opportunity for stakeholders to speak directly with CMS decision makers. They facilitate information sharing and improve communication between the agency and its partners and beneficiaries. CMS currently hosts fourteen ongoing forums and continues to pilot new forums as well as hold special forums to meet current and evolving provider and beneficiary needs. In 2004, we held 124 of these meetings with more than 66,000 participants.

GOVERNMENT PERFORMANCE AND RESULTS ACT

Finally, I would like to say a word about the Government Performance and Results Act (GPRA) and our annual performance plan. This plan is an integral part of the agency's FY 2006 budget. CMS is committed to the use of performance measurement data to shape and improve policy and management choices. The President's Management Agenda, the Performance Assessment and Rating Tool, and our GPRA measures provide the structure for how we organize, prioritize, and accomplish our work.

We have made tremendous strides in aligning our budget requests with performance information, as evidenced by our score of "Green" in the Department's Budget and Performance Integration scorecard for the President's Management Agenda. Our GPRA goals provide additional opportunities to track performance in areas

representing the vast scope of CMS responsibilities. We have had success in the majority of these goals. In FY 2004, we met or exceeded expectations for 38 of the 43 targets for which we have complete data, an 88 percent success rate.

Now I would like to discuss CMS' FY 2006 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 2006, the Medicaid program expects to serve more than 46 million eligible persons. Federal Medicaid expenditures for FY 2006 are estimated at $193 billion, an increase of 2.3 percent over the comparable FY 2005 estimate. In addition to what we traditionally request for Medicaid, we are requesting $23 billion in obligational authority for a one-time obligation to cover what are referred to as "incurred but not yet reported" (IBNR) services. At any given time, a lag exists between the actual provision of a Medicaid service and its being reported by the State to the Federal government. Making this change will facilitate the accrual accounting standard which seeks elimination of unreported and under-reported obligations. Combined Federal and State Medicaid expenditures are projected to be almost $338 billion in FY 2006, of which the Federal share is about 57 percent.

PAYMENTS TO HEALTH CARE TRUST FUNDS

Our FY 2006 request of $177.8 billion includes a Federal general revenue contribution to the Medicare trust funds. Of this amount, the Supplementary Medical Insurance Trust Fund comprises $128.0 billion, an increase of $14.0 billion from the FY 2005 appropriation. Beginning in FY 2006, we are also requesting indefinite authority to pay the general fund shares of the Part B premium and Part D drug benefit matches.

PROGRAM MANAGEMENT

CMS' FY 2006 Program Management appropriation request is $3.2 billion. This appears to be a large increase, $504.6 million, over the enacted FY 2005 appropriation because this is the first year we are requesting on-going MMA funding ($560 million) in the Program Management account. We did not receive an appropriation for MMA in FY 2005. Instead, the MMA legislation authorized and appropriated $1 billion for CMS in FY 2004, to be used for the two-year period FY 2004 through FY 2005. We expect to spend about $600 million in FY 2005 on MMA activities. If you add the $600 million to the FY 2005 Program Management appropriation, the difference between our FY 2006 request and this comparably-adjusted FY 2005 estimate is actually an $89 million (or 2.7 percent) decrease. However, FY 2005 is a unique year for MMA implementation and required resources. We believe the requested FY 2006 funding level will allow us to perform our operational functions and fund key budget priorities, including implementing MMA. This budget supports a total of 4,843 FTEs, the same as the FY 2005 estimate, including 500 FTEs for MMA activities.

Our Program Management request, while less than one percent of total program outlays, supports a host of activities. In fact, none of the $581 billion in current law Federal program benefits 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. Our MMA request of $560 million is spread among three of these line items: Medicare Operations, Federal Administration, and Research.

MEDICARE OPERATIONS

The FY 2006 Medicare Operations request of $2,190.0 million reflects a decrease of $42.8 million, or 1.9 percent, below the comparably adjusted FY 2005 appropriation. This request funds the 50 or so private Medicare contractors who will process and pay over 1.1 billion fee-for-service claims, handle millions of inquiries and appeals, enroll and educate providers, assist beneficiaries, and carry out other responsibilities on CMS' behalf. In addition, it funds systems maintenance and data communications and supports various legislative mandates including MMA activities.

We are asking for $477.6 million for MMA activities in this line item. This covers support for various new payment and enrollment systems, beneficiary and provider outreach and education, contracting reform, and other contracts needed to implement MMA provisions. Our request includes $51 million to implement BIPA

section 521 reforms including establishing Qualified Independent Contractors (QICs) to process second-level reconsiderations and enhancing the new Medicare appeals data system. We plan to have a total of eight QICs that will begin processing fiscal intermediary reconsiderations in May, 2005. We will phase in the carrier reconsiderations in FY 2006. The Department will take over the Administrative Law Judge Medicare hearing workload from the Social Security Administration in FY 2006. We are asking for a total of $247.2 million to support the National *Medicare & You* Education Program, including $154.3 million associated with MMA-related activities. This includes over $30 million for the State Health Insurance Assistance Program. In addition, we plan to dedicate $39.5 million to HIPAA administrative simplification provisions, including enumeration of providers with unique identification numbers, outreach, and 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 $79.9 million for HIGLAS development, and $10 million to support the Secretary's efforts to modernize and strengthen the Department's systems environment.

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 2006 request of $657.4 million represents an increase of $16.5 million, or 2.6 percent, above the comparable FY 2005 appropriation. This line item covers salaries and benefits of CMS' Federal employees as well as IT costs and operating costs, such as rent, for all of

our offices. It also includes $13 million to continue the *Healthy Start, Grow Smart* program, a series of 13 brochures in English and Spanish sent to new Medicaid mothers. To date, this initiative has disseminated over 20.7 million brochures in 24 States and the District of Columbia.

MEDICARE SURVEY AND CERTIFICATION

The Medicare Survey and Certification activity helps to ensure 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 2006 Medicare Survey and Certification budget request is $260.7 million, an increase of $2.0 million, about one percent, above the FY 2005 appropriation. The FY 2006 request will allow CMS to inspect long-term care facilities and home health agencies at a level that maintains recently improved state performance. One percent of accredited hospitals will be recertified in FY 2006. We expect to complete a total of more than 23,200 inspections and almost 52,500 visits in response to complaints.

CMS' Program Management request includes $37.3 million in discretionary funding for the Nursing Home Oversight Improvement Program (NHOIP), including $32.3 million from the Medicare Survey and Certification account and $5.0 million from the Federal Administration account. The NHOIP has been successful at providing training to State surveyors, monitoring abuse prevention efforts, being more responsive

to complaints, and developing State sanction options. We have made significant strides in the areas targeted by the NHOIP and are committed to working with residents and their families, advocacy groups, providers, States, and Congress to ensure that Medicare beneficiaries receive the quality care and protection they deserve.

RESEARCH, DEMONSTRATIONS AND EVALUATIONS

The FY 2006 request for Research, Demonstrations and Evaluations is $45.2 million, a decrease of $65.0 million from the comparable FY 2005 appropriation. This request includes $19.7 million for research required by the MMA and $25.5 million to continue and refine on-going projects including the Medicare Current Beneficiary Survey. This budget no longer requests funding for the Real Choice System Change Grants. After 5 years, these grants have accomplished their goals of helping States make improvements to their home- and community-based health care delivery service systems.

REVITALIZATION PLAN

CMS' request includes $24.2 million in two-year money, the same as the FY 2005 appropriation, to continue a multi-year investment fund to revitalize CMS' systems operations. In FY 2006, the CMS Revitalization Plan will fund activities related to the modernization of the Medicare fee-for-service claims processing systems and of CMS' data warehousing environment. We expect these modernization efforts to improve efficiency, improve access to data, facilitate healthcare research, support Internet queries on claims status, and expand fraud, waste, and abuse prevention efforts.

CONCLUSION

Our FY 2006 Program Management request is $3,177.5 million which will meet our operational needs as we continue to provide and improve services to more than 85 million beneficiaries, implement the Medicare Modernization Act, and support the goals of the Secretary and Administration, including the commitment to deficit reduction. We believe we can continue to make meaningful changes to the programs we administer within these funding levels.

Our biggest challenge will be implementing the new MMA benefits and facilitating choices in an efficient and cost effective manner while handling our on-going workloads. The MMA provides 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. Although we have made a lot of progress, this unique opportunity requires much work in the year ahead.

Thank you for the opportunity to present CMS' FY 2006 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.