Facts About The Centers For Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program, and works in partnership with the States to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. CMS is responsible for the administrative simplification standards from the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and quality standards in health care facilities through its survey and certification activity.

Through Medicare, Medicaid and SCHIP, about one in four Americans receive health care coverage. Nearly 40 million people are covered by Medicare, about 33 million are eligible for Medicaid, and SCHIP helps States expand health coverage to as many as 5 million uninsured children. These programs spend about one in three of the Nation's health care dollars, about $429 billion in 2000 (of which the Federal share was $344 billion). CMS spends nearly one in five of the Federal Government's dollars.

THE MEDICARE PROGRAM

Medicare, the nation's largest health insurance program, covers nearly 40 million Americans. Enacted in 1965, the program provides health insurance to people age 65 and over, those who have permanent kidney failure, and certain individuals under 65 with disabilities.

ORIGINAL MEDICARE

The fee-for-service Medicare program has two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Medicare Part A helps pay for inpatient hospital services, skilled nursing facility services, certain home health services, and hospice care. Medicare Part B helps pay for doctor services, outpatient hospital services, certain home health services, medical equipment and supplies, and other health services and supplies. Generally, outpatient prescription drugs are not covered.

Since its inception, Medicare has contracted with insurance companies to administer the program. A Fiscal Intermediary is a private company that Medicare contracts with to pay hospitals, skilled nursing facilities, and home health agencies for their Part A and some Part B bills. A Carrier is a private company that Medicare contracts with to pay physicians and other suppliers for their Part B bills.

Original Medicare is fee for service, available everywhere in the United States. Beneficiaries are free to go to any doctor, specialist, or hospital that accepts Medicare and most providers participate in Medicare. Beneficiaries and Medicare share the bill. About 85 percent of beneficiaries are in Medicare fee for service.

MEDICARE+CHOICE

While Medicare has contracted with health maintenance organizations (HMO) on a risk basis since 1987, the Balanced Budget Act of 1997 (BBA) added Part C to Medicare, called Medicare+Choice. The Act expanded the types of private health plans (such as private fee-for-service, medical savings accounts, preferred provider organizations, and provider-sponsored organizations) with which CMS can contract. Medicare+Choice permits Medicare beneficiaries to select health plans, available in many areas of the country, where beneficiaries go to doctors, specialists, or hospitals that participate in the plan. In a private fee-for-service plan, enrollees generally can see any Medicare-participating provider. Some managed care plans cover extra benefits, like outpatient prescription drugs and hearing aids. In March 2002, there were 149 Medicare+Choice managed care plans with 5 million enrollees.

The BBA reduced the wide geographic variation in payment levels to health plans and adjusted payments for the health status of enrollees. The limits on payment increases, combined with other market forces, have made it difficult for some plans to continue to offer extra benefits - with the result that many plans have scaled back their Medicare offerings or left the Medicare market entirely.

THE MEDICAID PROGRAM

Medicaid beneficiaries include low-income families with children, aged, blind or disabled people on Supplemental Security Income, certain low-income pregnant women and children, and certain people who have very high medical bills. Generally, individuals who are poor, but who have no dependent children and are not disabled, no matter how low their income, may not qualify for Medicaid coverage. Exceptions to this rule are some expansion populations in certain States with "section 1115 waivers."

Medicaid was originally enacted in 1965 as a jointly funded program where the Federal Government matches State spending to provide medical and health-related services. Although there are broad Federal requirements for Medicaid concerning eligibility, benefits, and provider payments, States have a wide degree of flexibility to design their programs. The portion of the Medicaid program that is paid by the Federal Government is known as the Federal Medical Assistance Percentage. It is determined annually for each State by a formula that compares the State's average per capita income level with the national average (the Federal Government matches at least half of State spending).

States have the authority to establish eligibility standards, set the rate of payment for services, and determine the type, amount, duration, and scope of services. Because States have this flexibility, there are considerable variations from State to State.

The option to have a "medically needy" program allows States to extend Medicaid eligibility to additional qualified persons who may have too much income to qualify under the mandatory or optional categorically needy groups. This option allows them to "spend down" to Medicaid eligibility by incurring medical and/or remedial care expenses to offset their higher income. Many elderly in nursing homes eventually become eligible for Medicaid through this program.

The most significant trend in service delivery is the rapid growth in managed care enrollment within Medicaid. By the end of the 1990s, States had moved more than half of their mothers and children into managed care programs (defined broadly) in an effort to contain costs and link participants with a primary care provider.

States often seek waivers of certain Medicaid requirements in order to implement Medicaid managed care. Under "section 1915(b) waiver authority," States can require individuals be covered by Medicaid to enroll in managed care, use the resulting savings to provide additional services and create innovative delivery systems for specialty care. In addition to the changes that are possible under section 1915(b), States with section 1115 waivers can use managed care savings to extend Medicaid eligibility to new populations, or demonstrate new approaches to coverage or payment.

MEDICAID - MEDICARE RELATIONSHIP

Medicare beneficiaries who have low income and limited resources may receive help paying for their Medicare premiums and out-of-pocket medical expenses through Medicaid. There are various benefits available to "dual eligibles," about six million Medicare beneficiaries are eligible for some type of Medicaid benefit.

For persons who are eligible for full Medicaid coverage, the Medicaid program supplements Medicare coverage by providing services and supplies that are available under their State's Medicaid program. For services that are covered by both programs, Medicare pays first, and Medicaid pays for the beneficiary's cost sharing (up to the State's payment limit). Medicaid also covers additional services. Limited Medicaid benefits are also available to pay for out-of-pocket

Medicare cost-sharing expenses and Medicare Part B premium for certain other Medicare beneficiaries with low income and/or disabilities.

BALANCED BUDGET ACT OF 1997

The BBA made the most significant changes to the Medicare and Medicaid programs since 1965. It extended the life of the Medicare Part A Trust Fund by reducing Medicare spending; increasing health care options available to America's seniors; improving Medicare preventive benefits; supporting efforts to fight waste, fraud, and abuse; providing new demonstrations to help Medicare work well in the future; creating a new program, SCHIP, intended to cover half of the Nation's uninsured children; and providing States with new flexibility to administer Medicaid.

The Balanced Budget Refinement Act was enacted in 1999 and modified some of the payment reductions of BBA.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

States may initiate and/or expand health insurance to uninsured, low-income children by designing a new children's health insurance program, expanding current Medicaid programs; or a combination of both strategies. The program is the most significant improvement in access to health care for children since the creation of Medicaid, currently covering about 2 million out of the estimated 11 million uninsured children in the U.S.

SCHIP is a capped entitlement for States, funded by a State-Federal partnership. Congress appropriated $24 billion over 5 years to help States expand health insurance to children whose families earn too much to qualify for Medicaid, yet not enough to afford private insurance. All States are participating in the program. CMS has worked in concert with many partners, in the public and private sectors, to encourage eligible families to sign their children up for coverage.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The Department of Health and Human Services, the Department of Labor, and the Department of Treasury each have roles in implementing the insurance reform provisions of the Health Insurance Portability and Accountability Act (HIPAA). CMS works with States to comply with the small group and individual market provisions of HIPAA. The law is designed to protect health insurance coverage for workers and their families when they change or lose their jobs. For the first time, the Act applies the same rules governing portability of health insurance coverage across the large group, small group, and individual insurance markets. It limits the application of pre-existing condition clauses and imposes requirements concerning mental health parity.

QUALITY IMPROVEMENT

In addition to providing health insurance through our programs, CMS performs a number of quality-focused activities that benefit all Americans. These activities include minimum quality standards through the survey and certification of health care facilities. State surveyors visit a certain number of facilities each year to determine compliance with CMS quality standards and investigate complaints from the public. We also regulate *all* laboratory testing (whether provided to beneficiaries of our programs or to others) under the Clinical Laboratory Improvement Amendments.

Under the Quality Improvement (formerly Peer Review) Organization program, CMS contracts with 53 independent physician organizations to ensure that medical care paid for under the Medicare program is reasonable and medically necessary, meets professionally recognized standards of health care, and is provided in the most economical setting. CMS is further working to improve the quality of health care by measuring and improving outcomes of care, educating health care providers about quality improvement opportunities, and educating beneficiaries to make good health care choices.

PROGRAM INTEGRITY

The Medicare Integrity Program, established by HIPAA, gives CMS authority to try new contracting approaches for program safeguard activities. CMS selects 12 special contractors to do medical reviews and other tasks to stop and prevent fraud, waste and abuse.

HEALTHCARE INTEGRATED GENERAL LEDGER ACCOUNTING SYSTEM

The Healthcare Integrated General Ledger Accounting System (HIGLAS) is the main focus of a long-term project to modernize Medicare's accounting systems in order to improve the program's fiscal accountability to beneficiaries and taxpayers. HIGLAS will replace the many outdated accounting systems currently used by Medicare contractors, which process and pay nearly 3 million Medicare claims a day, with a single, unified system that will better ensure the program pays correctly for the care Medicare beneficiaries need.

CMS—FACTS ABOUT THE AGENCY

CMS's national headquarters is located in Baltimore, Maryland. The 10 regional offices work with the contractors who administer the Medicare program and work with the States who administer the Medicaid, SCHIP, HIPAA, and survey and certification of health care providers. We work closely with the Social Security Administration (SSA) to provide information about Medicare to beneficiaries applying for, or currently receiving, retirement or disability benefits at local SSA district offices.