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Americans receive care from tens of thousands of

health care facilities participating in Medicare and Medicaid. To ensure the quality of care, the Centers for Medicare and Medicaid Services (CMS) contracts with states to conduct periodic surveys and complaint investigations. This report evaluated survey funding, state workloads, and federal oversight of states¿ use of funds since FY 2000 to determine if federal funding had kept pace with the changing workload. It analyzed: (1) federal funding trends from FY 2000 through 2007 and CMS¿s methodology for determining states¿ allocations and spending; (2) CMS data on the number of participating facilities and completed state surveys; and (3) CMS oversight of state spending. Charts and tables. Medicare affects everyone. If you are a boomer, you are counting on Medicare to protect you from the cost of health care when you retire. If you have turned 65, you already depend on Medicare. If you are a Gen-X or Gen-Y, you are contributing to Medicare from your paycheck. Will Medicare continue to exist as we have known it? Will it be there when you need it? How much will it cost? As the future of Medicare is debated in Washington, Rosemary Gibson and Janardan Prasad Singh shine a light on a rarely-seen side of this storied program: the business of Medicare. Medicare is known as an entitlement for the nation’s seniors. It is also the largest entitlement-based program for any business sector in the US economy. Its beneficiaries include hospitals, doctors, drug companies, device manufacturers, Wall Street

investment banks, private equity firms, hedge funds, and others that rely on the $600 billion that Medicare spends a year. The ties that bind Wall Street and Washington in the healthcare industry are strong, and they will play an outsized role in determining Medicare’s future. Gibson and Singh reveal how the industry’s interests are often at odds with those of seniors and boomers. While some politicians point to the culture of dependence of the public on Medicare, the authors suggest that policymakers turn their attention to the culture of dependence of the healthcare industry on Medicare, which is the predominant force pushing the program toward a fiscal cliff. The amount of waste in the Medicare program is equivalent to the entire economy of New Zealand. For Medicare to be sustained, this culture of dependence -- and the habits it breeds, namely waste, excessive pricing, and overuse of unnecessary services -- should be the first priority for the chopping block. By parings back the excess, the authors argue, Medicare can be sustained for future generations. This is essential reading for anyone interested in how Medicare works, how it could work better, and where it will go if reforms are not made. This report summarizes the President's budget estimates for each section of the CMS budget. Then, for each legislative proposal included in the President's budget, this report provides a description of current law and the President's proposal. The explanations of the President's

legislative proposals are grouped by the following program areas: Medicare, Medicaid, program integrity, and health insurance programs. For fifty years, Medicare and Medicaid have stood at the center of a contentious debate surrounding American government, citizenship, and health care entitlement. In Medicare and Medicaid at 50, leading scholars in politics, government, economics, health policy, and history offer a comprehensive assessment of the evolution of these programs and their impact on society -- from their origins in the Great Society era to the current battles over the Affordable Care Act ("Obamacare"). These highly accessible essays examine Medicare and Medicaid from their origins as programs for the elderly and poor to their later role as a safety net for the middle class. Along the way, they have served as touchstones for heated debates about economics, social welfare, and the role of government. Medicare and Medicaid at 50 addresses key questions for understanding the past and future of health policy in America, including:  What were the origins for these initiatives, and how were they transformed over time?  What marks have Medicare and Medicaid left on society?  In what ways have these programs produced innovation, even in eras of retrenchment?  How did Medicaid, once regarded as a poor person's program, expand its benefits and coverage over the decades to become the platform for the ACA's future expansion? The volume's contributors go on to examine the

powerful role of courts in these transformations, along with the shifting roles of Congress, public opinion, and state governors in the programs' ongoing evolution. From Lyndon Johnson to Barack Obama on the left, and from Ronald Reagan to George W. Bush on the right, American political leaders have tied their political fortunes to the fate of America's entitlement programs; Medicare and Medicaid at 50 helps explain why, and how those ongoing debates are likely to shape the future of the Affordable Care Act. The Centers for Medicare and Medicaid Services (CMS) is the agency in the Department of Health and Human Services responsible for providing health coverage for seniors and people with disabilities, for limited-income individuals and families, and for children-totaling almost 100 million beneficiaries. The agency's core mission was established more than four decades ago with a mandate to focus on the prompt payment of claims, which now total more than 1.2 billion annually. With CMS's mission expanding from its original focus on prompt claims payment come new requirements for the agency's information technology (IT) systems. Strategies and Priorities for Information Technology at the Centers for Medicare and Medicaid Services reviews CMS plans for its IT capabilities in light of these challenges and to make recommendations to CMS on how its business processes, practices, and information systems can best be developed to meet today's and tomorrow's

demands. The report's recommendations and conclusions offered cluster around the following themes: (1) the need for a comprehensive strategic technology plan; (2) the application of an appropriate metamethodology to guide an iterative, incremental, and phased transition of business and information systems; (3) the criticality of IT to high-level strategic planning and its implications for CMS's internal organization and culture; and (4) the increasing importance of data and analytical efforts to stakeholders inside and outside CMS. Given the complexity of CMS's IT systems, there will be no simple solution. Although external contractors and advisory organizations will play important roles, CMS needs to assert well-informed technical and strategic leadership. The report argues that the only way for CMS to succeed in these efforts is for the agency, with its stakeholders and Congress, to recognize resolutely that action must be taken, to begin the needed cultural and organizational transformations, and to develop the appropriate internal expertise to lead the initiative with a comprehensive, incremental, iterative, and integrated approach that effectively and strategically integrates business requirements and IT capabilities. The 140 articles in the 4-volume set represent the efforts of AHRQ-funded patient safety researchers as well as the patient safety initiatives of other parts of the Federal Government. The articles cover a wide range of

research paradigms, clinical settings, and patient populations, and they cover various stages of the research process. The volumes include the articles research that is complete and from research still in process, as well as a series of articles that address implementation issues and provide useful tools and products that can be used to improve patient safety. Manage the Medicare maze — from enrollment dates to plan options! To get the most from Medicare, you need accurate information that steers you clear of bad advice and costly pitfalls. Medicare For Dummies is what you need to navigate Medicare successfully and get the best out of the complex system. AARP’s Medicare expert, Patricia Barry, gives you plain-language explanations of how Medicare works and what steps you need to take to make it work for you, including: How you qualify for Medicare and when to enroll according to your personal situation What Medicare covers and what it costs Ways to reduce out-of-pocket expenses Tips for dealing with doctors and switching plans You'll even get information about proposed changes to Medicare that you should know about and tips for staying healthy. If you're one of the millions of Americans looking to get the lowdown on Medicare, this hands-on, friendly guide has you covered. Medicare and Medicaid Programs - CY 2018 Home Health Prospective Payment System Rate (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) The Law Library presents the complete

text of the Medicare and Medicaid Programs - CY 2018 Home Health Prospective Payment System Rate (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition). Updated as of May 29, 2018 This final rule updates the home health prospective payment system (HH PPS) payment rates, including the national, standardized 60-day episode payment rates, the national per-visit rates, and the non-routine medical supply (NRS) conversion factor, effective for home health episodes of care ending on or after January 1, 2018. This rule also: Updates the HH PPS case-mix weights using the most current, complete data available at the time of rulemaking; implements the third year of a 3-year phase-in of a reduction to the national, standardized 60-day episode payment to account for estimated case-mix growth unrelated to increases in patient acuity (that is, nominal case-mix growth) between calendar year (CY) 2012 and CY 2014; and discusses our efforts to monitor the potential impacts of the rebasing adjustments that were implemented in CY 2014 through CY 2017. In addition, this rule finalizes changes to the Home Health Value-Based Purchasing (HHVBP) Model and to the Home Health Quality Reporting Program (HH QRP). We are not finalizing the implementation of the Home Health Groupings Model (HHGM) in this final rule. This book contains: - The complete text of the Medicare and Medicaid Programs - CY 2018 Home Health Prospective Payment System Rate (US Centers for Medicare and

Medicaid Services Regulation) (CMS) (2018 Edition) - A table of contents with the page number of each section Student Health Insurance Coverage (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) The Law Library presents the complete text of the Student Health Insurance Coverage (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition). Updated as of May 29, 2018 This final rule establishes requirements for student health insurance coverage under the Public Health Service (PHS) Act and the Patient Protection and Affordable Care Act (Affordable Care Act). The final rule defines "student health insurance coverage" as a type of individual health insurance coverage, and specifies that certain PHS Act requirements are inapplicable to this type of individual health insurance coverage. This final rule also amends the medical loss ratio and annual limits requirements for student health insurance coverage under the PHS Act. This book contains: - The complete text of the Student Health Insurance Coverage (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) - A table of contents with the page number of each section Medicare and Medicaid Programs - Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements, etc. (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) The Law Library presents the complete text of the Medicare and Medicaid

Programs - Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements, etc. (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition). Updated as of May 29, 2018 This interim final rule with comment period implements several provisions set forth in the Patient Protection and Affordable Care Act (Affordable Care Act). It implements the provision which requires all providers of medical or other items or services and suppliers that qualify for a National Provider Identifier (NPI) to include their NPI on all applications to enroll in the Medicare and Medicaid programs and on all claims for payment submitted under the Medicare and Medicaid programs. This interim final rule with comment period also requires physicians and eligible professionals to order and refer covered items and services for Medicare beneficiaries to be enrolled in Medicare. In addition, it adds requirements for providers, physicians, and other suppliers participating in the Medicare program to provide documentation on referrals to programs at high risk of waste and abuse, to include durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), home health services, and other items or services specified by the Secretary. This book contains: - The complete text of the Medicare and Medicaid Programs - Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements, etc. (US Centers for Medicare and

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Medicare and Medicaid Programs - Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) - A table of contents with the page number of each section During 1995-1996, Professor Edward Berkowitz, of the History Department at George Washington University, and some of his graduate students, conducted a series of oral history interviews for the Health Care Financing Administration (HCFA). This series focuses on the early years of Medicare and Medicaid and the creation of HCFA in 1977. Each of these interviews provides personal insight and an eye-witness account of the evolution of the Department, the Agency, and the programs. A mismatch between the federal government's revenues and spending, now and in the foreseeable future, requires heavy borrowing, leading to a large and increasing federal debt. That increasing debt raises a serious challenge to all of the goals that various people expect their government to pursue. It also raises questions about the nation's future wealth and whether too much debt could lead to higher interest rates and even to loss of confidence in the nation's long-term ability and commitment to honor its obligations. Many analysts have concluded that the trajectory of the federal budget set by current policies cannot be sustained. In light of these projections, Choosing the Nation's Fiscal Future assesses the

options and possibilities for a sustainable federal budget. This comprehensive book considers a range of policy changes that could help put the budget on a sustainable path: reforms to reduce the rate of growth in spending for Medicare and Medicaid; options to reduce the growth rate of Social Security benefits or raise payroll taxes; and changes in many other government spending programs and tax policies. The book also examines how the federal budget process could be revised to be more far sighted and to hold leaders accountable for responsible stewardship of the nation's fiscal future. Choosing the Nation's Fiscal Future will provide readers with a practical framework to assess budget proposals for their consistency with long-term fiscal stability. It will help them assess what policy changes they want, consistent with their own values and their views of the proper role of the government and within the constraints of a responsible national budget. It will show how the perhaps difficult but possible policy changes could be combined to produce a wide range of budget scenarios to bring revenues and spending into alignment for the long term. This book will be uniquely valuable to everyone concerned about the current and projected fiscal health of the nation. The mission of the Office of Inspector Gen. (OIG) of the Dept. of Health & Human Services (HHS) is to protect the integrity of HHS programs, as well as the health & welfare of beneficiaries served by those programs. This

statutory mission is carried out through a nationwide network of audits, investigations, & inspections conducted by OIG¿s various operating components. The objective of this report is to asses for Medicare hospices certified by State agencies: (1) the timeliness & results of hospice certification surveys performed by State agencies; & (2) the extent of the Centers for Medicare & Medicaid Services oversight of the Medicare hospice program. Includes recommendations. Charts & tables. Medicareâ€™s Quality Improvement Organization Program is the second book in the new Pathways to Quality Health Care series. Focusing on performance improvement, it considers the history, role, and effectiveness of the Quality Improvement Organization (QIO) program and its potential to promote quality improvement within a changing health care delivery environment that includes standardized performance measures and new data collection and reporting requirements. This book carefully examines the QIOs that serve every state as well as the national program that guides and supports them. In addition, it highlights the important roles that a national program with private organizations in each state can play in promoting higher quality care. Medicareâ€™s Quality Improvement Organization Program looks closely at the technical assistance role of the QIO program and the need to encourage and support providers to improve their performance. By providing an in-depth assessment of the federal experience with

quality improvement and recommendations for program improvement, this book helps point the way for those who strive to create higher quality and better value in health care. Intended for multiple audiences, Medicareâ€™s Quality Improvement Organization Program is essential reading for members of Congress, the federal executive branch, the QIOs, health care providers and clinicians, and stakeholder groups. With 1990: Includes trends for medicare enrollees and Medicaid recipients, Medicare and Medicaid expenditures, and the use of and expenditures for hospital inpatient and physicians services in both programs. Also includes a listing of Medicare carriers and intermediaries, as well as Medicaid agencies and fiscal agents. This is a print on demand edition of a hard to find publication. Federal departments and agencies have examined the services they provide and have prepared a plan identifying the steps they will take to provide beneficiaries with limited English proficiency (LEP) with meaningful access to the agencies¿ programs and activities. The Centers for Medicare and Medicaid Services (CMS) intends to take steps to help ensure timely access to language assistance services by eligible LEP beneficiaries to their programs and activities. This report reviews CMS¿s language access policies, efforts to translate Medicare documents, and the challenges health care providers face in communicating with LEP beneficiaries. Includes recommendations.

Illustrations. Medicare Made Easy describes the nuts and bolts of Medicare and Health Insurance in an easily understandable, orderly and readable fashion. This edition is a primer for Medicare and Health Insurance for 2013 and 2014. Things you need to know about Medicare and Health Insurance are covered. Every day, all across America, approximately ten thousand people will turn sixty-five years of age and become eligible for Medicare. It will continue at this rate until the year 2022. Medicare and Medicaid Programs - Home Health Prospective Payment System Rate Update, CY 2015 - Home Health Quality Reporting Requirements (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) The Law Library presents the complete text of the Medicare and Medicaid Programs - Home Health Prospective Payment System Rate Update, CY 2015 - Home Health Quality Reporting Requirements (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition). Updated as of May 29, 2018 This final rule updates Home Health Prospective Payment System (HH PPS) rates, including the national, standardized 60-day episode payment rates, the national per-visit rates, and the non-routine medical supply (NRS) conversion factor under the Medicare prospective payment system for home health agencies (HHAs), effective for episodes ending on or after January 1, 2015. As required by the Affordable Care Act, this rule implements the second year of the four-year phase-in of the rebasing adjustments to the

HH PPS payment rates. This rule provides information on our efforts to monitor the potential impacts of the rebasing adjustments and the Affordable Care Act mandated face-to-face encounter requirement. This rule also implements: Changes to simplify the face-to-face encounter regulatory requirements; changes to the HH PPS case-mix weights; changes to the home health quality reporting program requirements; changes to simplify the therapy reassessment timeframes; a revision to the Speech-Language Pathology (SLP) personnel qualifications; minor technical regulations text changes; and limitations on the reviewability of the civil monetary penalty provisions. Finally, this rule also discusses Medicare coverage of insulin injections under the HH PPS, the delay in the implementation of the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), and a HH value-based purchasing (HH VBP) model. This book contains: - The complete text of the Medicare and Medicaid Programs - Home Health Prospective Payment System Rate Update, CY 2015 - Home Health Quality Reporting Requirements (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) - A table of contents with the page number of each section "Explains for those 65 and older how to make [choices] in the annual Medicare enrollment period to maximize your health coverage without overpaying"-- "The health insurance claims number on Medicare beneficiaries' cards includes as one

component the beneficiary's (or other eligible person's, such as a spouse's) SSN. This introduces risks to beneficiaries' personal information, as the number may be obtained and used to commit identity theft. Many organizations have replaced SSNs on these types of cards with alternative identifiers. However, the introduction of such a new data element into IT environments can require changes to systems that process and share data. Moreover, previous assessments of CMS's IT environment have found that it consists of many aging, "stove-piped" systems that cannot easily share data or be enhanced; thus the agency has ongoing efforts to modernize its environment.As requested, GAO studied CMS's efforts related to the removal of SSNs from Medicare cards. GAO's objectives were to (1) assess actions CMS has taken to identify and implement IT solutions for removing SSNs from Medicare cards and (2) determine whether CMS's ongoing IT modernization initiatives could facilitate SSN removal efforts. To do this, GAO reviewed agency documentation and interviewed officials." Centers for Medicare & Medicaid Services audits of Medicare Part D bids. Medicare and Medicaid Programs - CY 2018 Home Health Prospective Payment System Rate Update and CY 2019 Case-Mix Adjustment Methodology Refinements (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) The Law Library presents the complete text of the Medicare and Medicaid Programs - CY 2018 Home Health

Prospective Payment System Rate Update and CY 2019 Case-Mix Adjustment Methodology Refinements (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition). Updated as of May 29, 2018 This final rule updates the home health prospective payment system (HH PPS) payment rates, including the national, standardized 60-day episode payment rates, the national per-visit rates, and the non-routine medical supply (NRS) conversion factor, effective for home health episodes of care ending on or after January 1, 2018. This rule also: Updates the HH PPS case-mix weights using the most current, complete data available at the time of rulemaking; implements the third year of a 3-year phase-in of a reduction to the national, standardized 60-day episode payment to account for estimated case-mix growth unrelated to increases in patient acuity (that is, nominal case-mix growth) between calendar year (CY) 2012 and CY 2014; and discusses our efforts to monitor the potential impacts of the rebasing adjustments that were implemented in CY 2014 through CY 2017. In addition, this rule finalizes changes to the Home Health Value-Based Purchasing (HHVBP) Model and to the Home Health Quality Reporting Program (HH QRP). We are not finalizing the implementation of the Home Health Groupings Model (HHGM) in this final rule. This book contains: - The complete text of the Medicare and Medicaid Programs - CY 2018 Home Health Prospective Payment System Rate Update and CY 2019 Case-Mix

Adjustment Methodology Refinements (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) - A table of contents with the page number of each section Good news first? The good news is that Americans today are living longer, in part because of continual advances in healthcare. But the bad news is that with our aging population larger than ever before, nothing is being done to ensure that we can continue to afford the increasing costs of care. How Medicare—with the Bush administration's reforms and a slumping economy—will meet the needs of its recipients without adequate financing is among the most pressing issues facing this country today. Daniel N. Shaviro sees the future of our national healthcare system as hinging on the issue of funding. The author of books on the economic issues surrounding Social Security and budget deficits, Shaviro is a skilled guide for anyone seeking to understand the financial aspects of government programs. Who Should Pay for Medicare? offers an accessible overview of how Medicare operates as a fiscal system. Discussions of Medicare reform often focus on the expansion of program treatment choices but not on the question of who should pay for Medicare's services. Shaviro's book addresses this critical issue, examining the underanalyzed dynamics of the significant funding gap facing Medicare. He gives a balanced, nonpartisan evaluation of various reform alternatives—considering everything from the creation of new benefits in

this fiscal crunch to tax cuts to the demographic pressures we face and the issues this will raise when future generations have to pay for the care of today's seniors. Who Should Pay for Medicare? speaks to seniors who feel entitled to expanded coverage, younger people who wonder what to expect from the government when they retire, and Washington policy makers who need an indispensable guidebook to Medicare's future. And introduction -- Traditional Medicare and private health plans -- Issues in designing a premium support system for Medicare -- Health care systems that are similar to premium support -- Potential effects of selected approaches to premium support -- Technical aspects of the analysis -- Supplementary tables. Medicare and Medicaid Programs - Hospital Conditions of Participation - Patients Rights (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) The Law Library presents the complete text of the Medicare and Medicaid Programs - Hospital Conditions of Participation - Patients Rights (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition). Updated as of May 29, 2018 This final rule finalizes the Patients' Rights Condition of Participation (CoP) which is applicable to all Medicare- and Medicaid-participating hospitals and contains standards that ensure minimum protections of each patient's physical and emotional health and safety. It responds to comments on the following standards presented in

the July 2, 1999 interim final rule: Notice of rights; exercise of rights; privacy and safety; confidentiality of patient records; restraint for acute medical and surgical care; and seclusion and restraints for behavior management. As a result of comments received, we have revised the standards regarding restraint and seclusion and set forth standards regarding staff training and death reporting. This book contains: - The complete text of the Medicare and Medicaid Programs - Hospital Conditions of Participation - Patients Rights (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) - A table of contents with the page number of each section As a result of internal control deficiencies discussed in a 2007 report on certain contracts at the Centers for Medicare and Medicaid Services (CMS), the auditor was asked to identify the extent to which CMS: (1) implemented effective control procedures over contract actions; and (2) established a strong control environment for contract management. The auditor used a statistical random sample of 2008 CMS contract actions to assess CMS internal control procedures. The results were projected to the population of 2008 CMS contract actions. The auditor reviewed contract file documentation and interviewed senior acquisition management officials. Includes recommendations. Charts and tables.

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