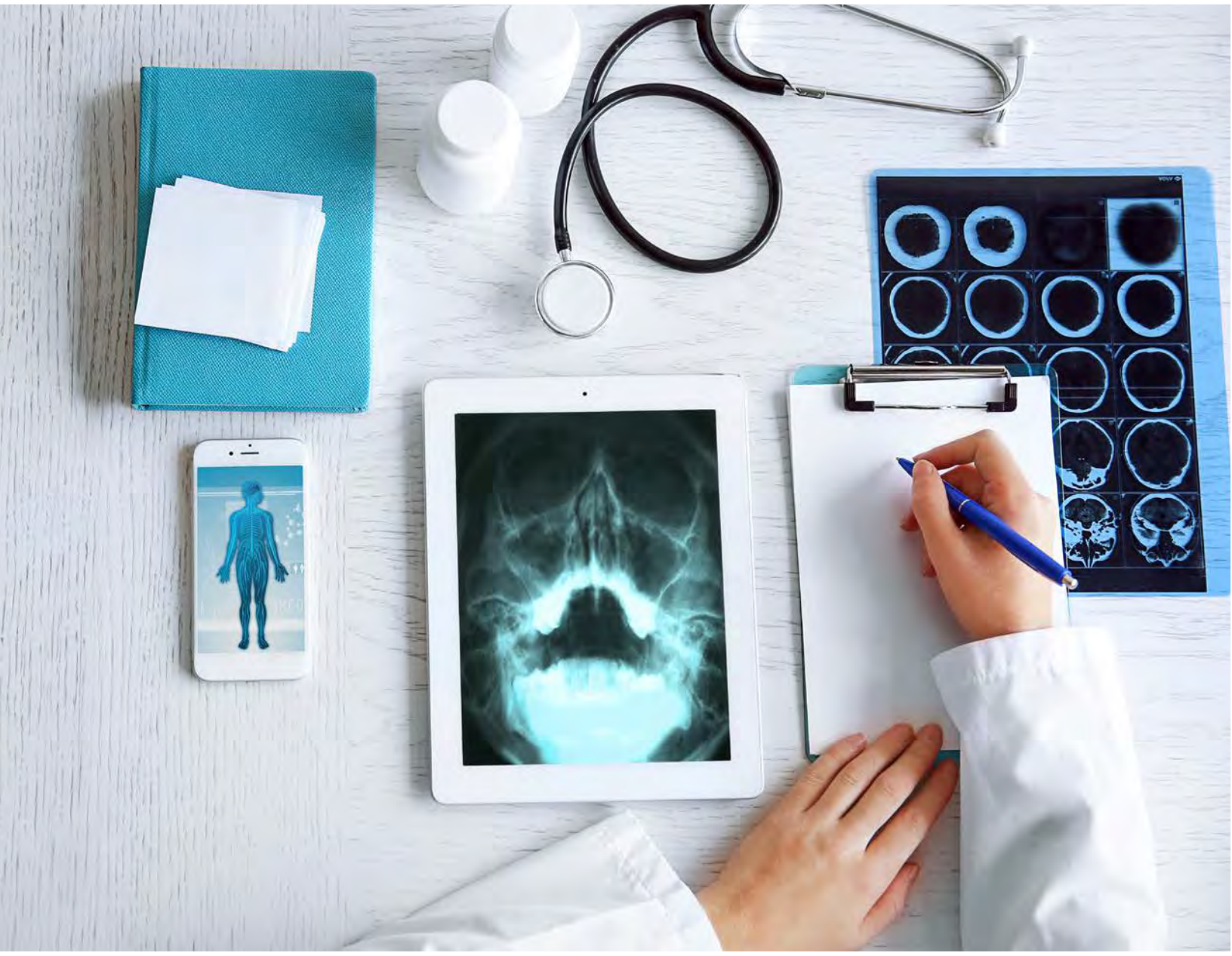
Transforming the Healthcare System through Competition and Innovation



FINANCIAL REPORT

FISCAL YEAR 2019

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Original Publication:
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AT A GLANCE

The Centers for Medicare & Medicaid Services (CMS) is an operating division within the Department of Health and Human Services (HHS). The CMS Annual Financial Report for fiscal year (FY) 2019 presents the agency's detailed financial information relative to our mission and the stewardship of those resources entrusted to us. This report is organized into the following three sections:

MANAGEMENT'S DISCUSSION & ANALYSIS

This section gives an overview of our organization, programs, performance goals, and overview of financial data.

FINANCIAL SECTION

This section contains the message from our Chief Financial Officer, financial statements and notes, required supplementary information, and audit reports.

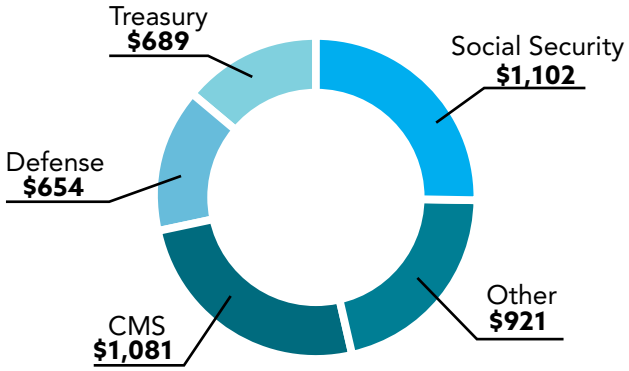
OTHER INFORMATION

This section includes the Summary of the Federal Managers' Financial Integrity Act Report and the Office of Management and Budget (OMB) Circular A-123—Management Responsibility for Enterprise Risk Management and Internal Control.

2019 FEDERAL OUTLAYS

CMS has outlays of approximately $1,081 billion (net of offsetting receipts and payments of the Health Care Trust Funds) in fiscal year (FY) 2019, approximately 15 percent of total Federal outlays.

CMS employs approximately 6,200 Federal employees, but does most of its work through third parties. CMS and its contractors process over one billion Medicare claims annually, monitor quality of care, provide the states with matching funds for Medicaid benefits, and develop policies and procedures designed to give the best possible service to beneficiaries. CMS also assures the safety and quality of medical facilities, provides health insurance protection to workers changing jobs, and maintains the largest collection of health care data in the United States (U.S.).

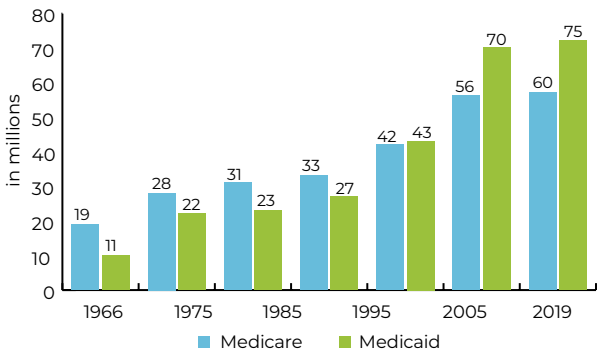


$ in billions

Source: U.S. Department of the Treasury

2019 PROGRAM ENROLLMENT

CMS is one of the largest purchasers of health care in the world. Medicare, Medicaid, and Children's Health Insurance Program (CHIP) provide health care for one in four Americans. Medicare enrollment has increased from 19 million beneficiaries in 1966 to approximately 60 million beneficiaries. Medicaid enrollment has increased from 11 million beneficiaries in 1966 to about 75 million beneficiaries.



A MESSAGE FROM THE ADMINISTRATOR

SEEMA VERMA

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2019 CMS Agency Financial Report (AFR). This year's AFR not only provides full transparency around how CMS exercised its fiduciary responsibilities over the taxpayer funds entrusted to us, but also provides a glimpse into our initiatives and programs targeted to empower patients, focusing on value, and unleashing innovation across Medicaid, Medicare, the Exchanges, and our oversight responsibilities.

Through strengthening negotiation and maximizing competition, we contributed to lowering the average MA premiums and have more plan choices for beneficiaries in 2019 and 2020. On average, Medicare Advantage premiums declined by 23 percent, and will be the lowest in the last thirteen years for the more than 24 million people with Medicare. We have added 1,200 plans choices since 2018. Enrollment is expected to increase by 10 percent compared to last year to over 24 million enrollees. For the first time in a decade, we launched a modernized and redesigned Medicare Plan Finder which provides users with a mobile friendly and easy-to-read design that will help them learn about different options and select coverage that best meets their health needs. For Medicare Part D, the average basic premium for prescription drug plans is projected to decline for the third year in a row, to an 11 year low, which has resulted in significant cost savings for beneficiaries.

During 2019, CMS worked to finalize policies that make prices for items and services provided by all hospitals in the United States more transparent for patients so that they can be more informed about what they might pay for hospital items and services. We are proposing additional price transparency from insurers that would give Americans access to information on the negotiated rates and cost-sharing information for all healthcare services before they get care.

CMS has made tremendous strides in fulfilling its vision to create a more competitive American healthcare system that delivers affordable, high quality care, at a sustainable cost for Medicare, Medicaid, the Children's Health Insurance Program, and the Exchanges. I am proud of the work we have accomplished this year on behalf of the American people.

With patients at the core of our health care system, our goal is to empower them see the whole picture by ensuring they have the resources needed to make the best healthcare decisions for themselves and their families. Initiatives such as MyHealthEData, outreach efforts to encourage people with Medicare to sign up for a MyMedicare account, and development of tools to permit provider sharing of secure healthcare data puts patients in control of their Medicare information. We are already seeing tangible results of providing access to information by improving care coordination and increasing positive health outcomes for our patients.

Innovation is needed to make a health care system where providers and health plans compete to deliver better care to patients at lower costs. CMS is empowering patients with the information they need to make informed decisions about their care which will make our health care system evolve into one that competes for patients. CMS is ensuring patients have access to the latest medical innovations, and that barriers are removed to support unleashing innovation across our healthcare system.

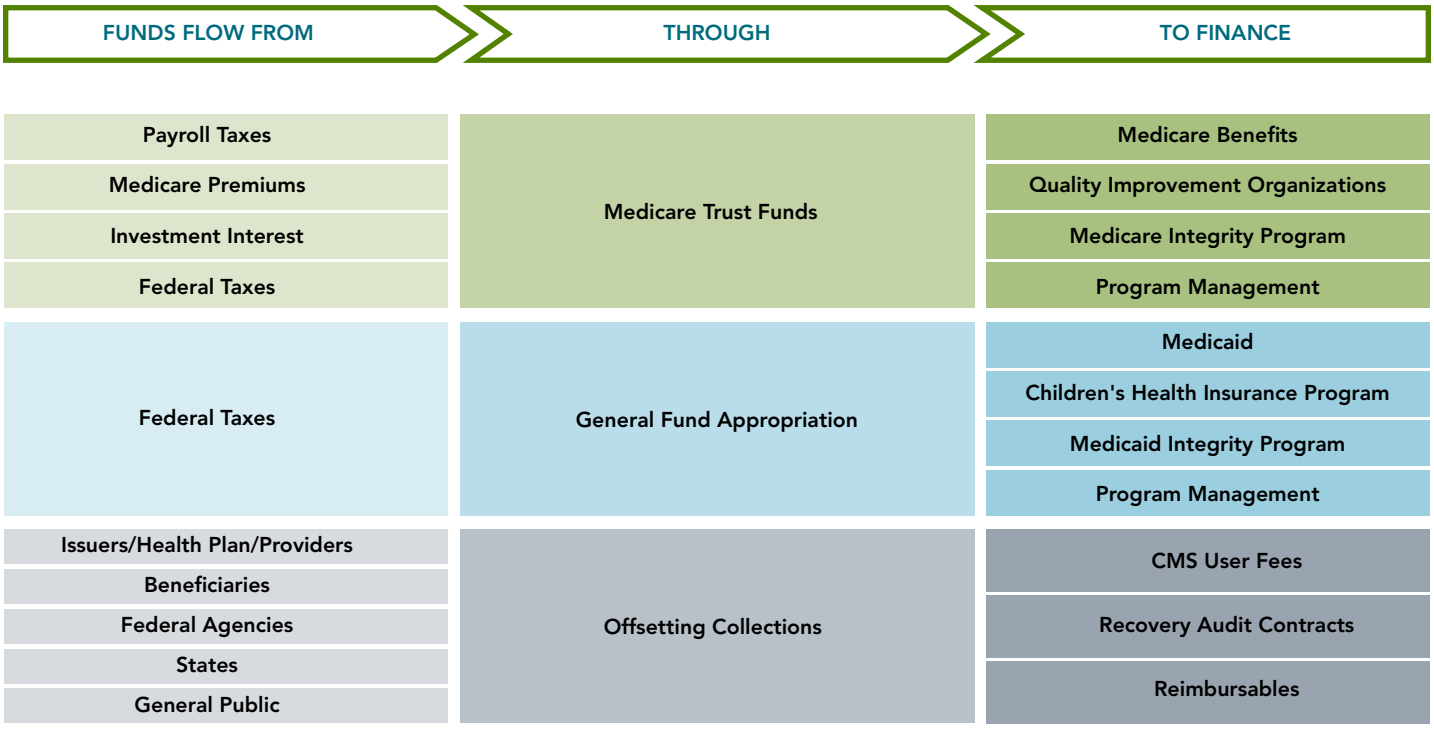
CMS has continued to promote states' strong lead role in addressing health issues in their states, as well as maximizing consumer choice and engagement, giving people flexibility to make decisions about what care options are best for them. We continued to offer a seamless consumer experience for those who want coverage through the Exchanges, fostering collaboration with our private partners to offer more ways to apply, enroll, and manage their coverage. CMS has continued to evaluate and streamline regulations to reduce unnecessary burden, allowing providers to spend more time with their patients, and allowing states to drive reforms based on the unique needs of their populations. Finally, our program integrity initiatives continue to be targeted in preventing fraudulent or improper payments and other waste and abuse.

As the nation's largest healthcare purchaser, it is critical for CMS to lead in being the catalyst for change in transforming our healthcare system into one that delivers optimal value and results for patients through competition and innovation. CMS must continue to build on the successes of these last two years to improve healthcare quality, accessibility, and outcomes in the most cost-effective manner possible. There is more demanding work ahead of us, but we have accepted the challenge to provide the American people with quality, affordable healthcare which they deserve.

On behalf of all those we serve, I thank you for your continued support of CMS and its programs.

SEEMA VERMA
CMS Administrator
November 2019

FINANCING OF CMS PROGRAMS & OPERATIONS



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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* Acting

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MANAGEMENT'S DISCUSSION & ANALYSIS

Our Organization // Overview // Performance Management // CMS Strategic Goals, Initiatives & Objectives // Overview of Financial Data // Overview of Social Insurance Data

OUR ORGANIZATION

The Centers for Medicare & Medicaid Services (CMS), an operating division of the Department of Health and Human Services (HHS), employs approximately 6,200 federal employees in Maryland, Washington, DC, and 10 regional offices throughout the country. CMS provides direct services to state agencies, health care providers, individuals with Medicare, sponsors of group health plans, Medicare health and prescription drug plans, and the general public.

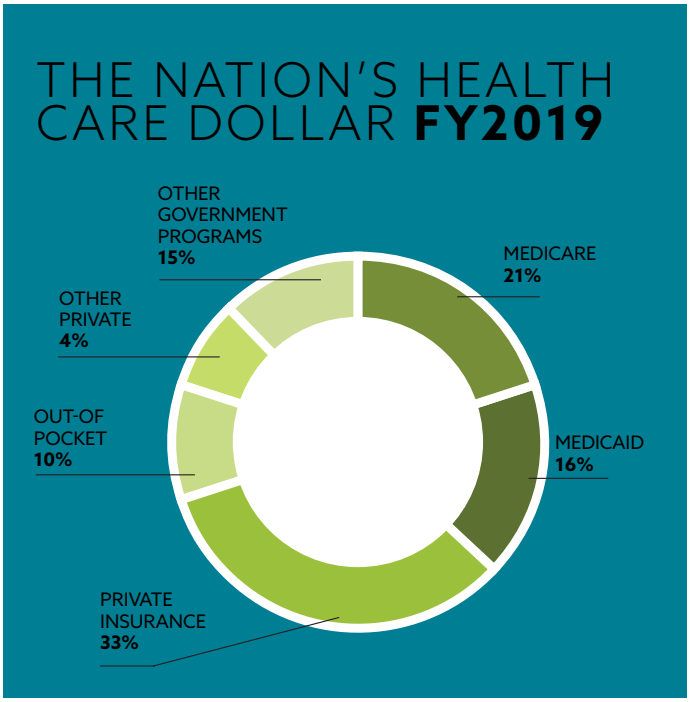
CMS's employees write policies and regulations that establish program eligibility and benefit coverage; set payment rates; safeguard the fiscal integrity of the programs it administers from fraud, waste, and abuse; and develop quality measurement systems to monitor quality, performance, and compliance. In addition, CMS's staff provides technical assistance to Congress, the Executive branch, universities, and other private sector researchers.

CMS also contracts and/or partners with third parties to operate many of its important activities. Each state administers the Medicaid program and the Children's Health Insurance Program (CHIP). States also inspect hospitals, nursing homes, and other facilities to ensure that health and safety standards are met. The Medicare Administrative Contractors (MACs) process claims, provide technical assistance to providers, and answer inquiries from individuals with Medicare. Additionally, Quality Improvement Organizations (QIOs) conduct a wide variety of quality improvement programs to ensure quality of care is provided to individuals with Medicare.

OVERVIEW

CMS administers Medicare, Medicaid, CHIP, and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) program. The passage of the *Patient Protection and Affordable Care Act* (PPACA) led to the expansion of CMS's role in the health care arena beyond our traditional role of administering the Medicare, Medicaid, and CHIP Programs. Over the last 50 years, CMS has evolved into the world's largest purchaser of health care.

As the largest purchaser of health care in the world, CMS maintains the nation's largest collection of health care data. Based on the latest 2019 projections, Medicare and Medicaid (including state funding) represent 37 cents of every dollar spent on health care in the United States (U.S.)—or looked at from three different perspectives: 54 cents of every dollar spent on nursing homes, 44 cents of every dollar received by U.S. hospitals, and 34 cents of every dollar spent on physician services.



Source: U.S. Department of the Treasury

Medicare

Medicare was established in 1965 as Title XVIII of the *Social Security Act*. It was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people aged 65 and over. In 1972, the program expanded to cover people with disabilities and people with end-stage renal disease (ESRD). The Medicare program was further expanded in 2003 with the *Medicare Prescription Drug, Improvement, and Modernization Act* (MMA), which included a prescription drug benefit for all Americans with Medicare beginning January 1, 2006.

Medicare processes over one billion fee-for-service (FFS) claims a year and accounts for approximately 15 percent of the federal budget. Medicare is a combination of four programs: Hospital Insurance (Part A), Supplementary Medical Insurance (Part B), Medicare Advantage (MA, also known as Part C), and Medicare Prescription Drug Benefit (Part D). Since 1966, Medicare enrollment has increased from 19 million to almost 60 million individuals.

Hospital Insurance

Hospital Insurance, also known as HI or Medicare Part A, is provided to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most people entitled to Social Security or Railroad Retirement benefits. Most people do not pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. The HI program pays for hospital, skilled nursing facility (SNF), home health (HH), and hospice care, and is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current individuals with Medicare.

Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI or Medicare Part B, is voluntary and available to nearly all people aged 65 and over, people with disabilities, and people with ESRD who are entitled to Part A benefits. Medicare Part B helps cover doctors' services and outpatient care. The SMI program pays for physician services, outpatient hospital services, some home health care, laboratory tests, durable medical equipment (DME), designated therapy, some outpatient prescription drugs, and other services not covered by HI, such as some of the services of physical and occupational therapists. Part B helps pay for these covered services and supplies when they are medically necessary. The SMI coverage is optional, and individuals who elect SMI are subject to monthly premium payments.

Medicare Advantage

The *Balanced Budget Act of 1997* (BBA) established the Medicare + Choice program, now known as the Medicare Advantage Program or Medicare Part C, to provide more health care coverage choices for individuals with Medicare. Those who are eligible because of age (65 or older) or disability may choose to join a Medicare Advantage (MA) plan servicing their area if they are entitled to Part A and enrolled in Part B. Those who are eligible for Medicare because of ESRD may join a MA plan only under special circumstances. Individuals with Medicare have long had the option to choose to enroll in health care plans that contract with CMS instead of receiving services under traditional FFS arrangements offered under original Medicare. Many MA plans offer additional services such as prescription drugs, vision, and dental benefits, and also may cover some or all of an enrollee's out-of-pocket costs. MA plans assume full financial risk for care provided to their Medicare enrollees. Individuals with Medicare can also enroll in cost plans where they can receive services through the cost plan's network or Original Medicare.

Medicare Prescription Drug Benefit

The Medicare Prescription Drug Benefit, also known as Medicare Part D, is an optional prescription drug benefit created by the MMA for individuals with Medicare who are entitled to benefits under Part A or enrolled in Part B. Eligible individuals have the opportunity to enroll in either a stand-alone prescription drug plan to supplement their traditional Medicare coverage, or in a MA prescription drug plan, which integrates basic medical coverage with added prescription drug coverage. Individuals who qualify for both Medicare and Medicaid (full-benefit dual-eligible) are automatically enrolled in the Part D program; assistance with premiums and cost sharing is available to full benefit dual-eligible, and other qualified low-income individuals.

Medicaid

Enacted in 1965 as Title XIX of the *Social Security Act*, Medicaid is administered by CMS in partnership with the states. Although the federal government establishes certain parameters for all states to follow, each state administers its Medicaid program differently, resulting in variations in Medicaid coverage across the country. States have flexibility in determining Medicaid benefit packages within federal guidelines, and are required to cover certain mandatory benefits. States have additional options for coverage and may choose to cover other groups, such as individuals receiving home- and community-based services (HCBS) and children in state-funded foster care, who are not otherwise eligible for another group. The Medicaid program is jointly funded by states and the federal government; CMS provides matching payments to the states and territories for Medicaid program expenditures and related administrative costs. Medicaid provides access to comprehensive health coverage that may not be affordable otherwise for millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is the primary source of health care for more than 75 million individuals. Over 10 million[1] people are dually eligible, that is, covered by both Medicare and Medicaid.

CHIP

CHIP was created through the BBA and provides health coverage to low-income uninsured children and pregnant women whose income is too high

1 These are annual enrollment figures.

to qualify for Medicaid. Title XXI of the *Social Security Act* outlines the program's structure and establishes a partnership between federal and state governments. States administer CHIP according to federal requirements while working closely with CMS, Congress, and other federal agencies to administer CHIP. CMS ensures state programs meet statutory requirements designed to ensure meaningful coverage. CMS provides extensive guidance and technical assistance so states can further develop their CHIP state plans and use federal funds to provide health care coverage to as many children as possible. CHIP funds cover the cost of health care services, reasonable costs for administration, and outreach services to enroll children. States are given broad flexibility in designing their programs, such as choosing to provide benchmark coverage, benchmark-equivalent coverage, or Secretary-approved coverage. In addition, states can create or expand their own separate CHIP programs, expand Medicaid, or combine both approaches. Important cost-sharing protections in CHIP safeguard families from incurring unaffordable out-of-pocket expenses. In fiscal year (FY) 2019, CMS projects that approximately 10 million children were enrolled in CHIP for at least one month during the year.

CLIA

CLIA legislation expanded the survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing human specimens for health purposes, regardless of location. CMS regulates all laboratory testing on patients, including those performed in physicians' offices, for a total of 259,967 facilities.

The CLIA program is 100 percent user-fee financed and is jointly administered by three HHS components: CMS, Centers for Disease Control and Prevention (CDC), and the Food and Drug Administration (FDA). CMS manages the overall CLIA program, including its regulatory and financial aspects. This includes enrollment, regulation, and policy development; approval of accrediting organizations and exempt states; proficiency testing and certification of providers; and enforcement. CDC provides research, technical support, and coordination of the Clinical Laboratory Improvement Advisory Committee, while FDA performs test categorization.

Health Insurance Exchanges

CMS is charged with implementing many of the provisions of PPACA that relate to private health insurance. CMS works to hold health insurance companies accountable for compliance with new market reforms, increase industry transparency, and provide access to private health insurance through the oversight of Health Insurance Exchanges (Exchanges) where health insurance issuers compete on the basis of price and quality.

CMS works in conjunction with states to ensure compliance with market reforms that protect consumers through policies like prohibiting health insurance issuers from denying coverage for pre-existing conditions, prohibiting annual and lifetime dollar limits on essential health benefits, and ensuring that health insurance issuers are complying with rating requirements. CMS also implements a process for states or CMS to review rates of non-grandfathered health insurance products in the individual and small group markets to determine compliance with federal health insurance rating rules and whether proposed rate increases are unreasonable. CMS is also responsible for enforcing compliance with a federal minimum medical loss ratio (MLR) requiring that health insurance issuers spend a predetermined portion of premium revenues on clinical services and quality improvement, or provide a rebate to policyholders if the MLR standard is not met. This mechanism helps ensure that consumers receive a good value for their premium dollar and that health insurance markets are more transparent.

Permanent Risk Adjustment Transfers

The risk adjustment program transfers funds from plans with lower risk enrollees to plans with higher risk enrollees (such as those with chronic conditions) in a state market to incentivize health insurance issuers that attract high risk enrollees and reduce the incentives for issuers to avoid those enrollees. The risk adjustment program also lessens the potential influence of risk selection on the premiums that plans charge. The risk adjustment program is designed to support plans offering a wide range of benefits available to consumers.

State Relief and Empowerment Waivers

Under section 1332 of the PPACA, states can apply for a State Relief and Empowerment Waiver (also referred to as a "state innovation waiver" or "section 1332 waiver" or "1332 waiver") from HHS and the Department of the Treasury (collectively, the Departments) that, if approved, allows states to implement innovative programs to

provide access to quality health care. Through section 1332 waivers, the Departments aim to assist states with developing health insurance markets that offer more choice, competition, and affordability to Americans. State innovation waivers became available beginning January 1, 2017 and can be approved for up to a 5-year period. Waivers must not increase the federal deficit.

Enhanced Direct Enrollment

Enhanced Direct Enrollment (EDE) is a new way for consumers to apply for and enroll in health coverage through the Federally-facilitated Exchanges and State-based Exchanges that use the federal platform without needing to visit **HealthCare.gov**. This new capability improves the consumer experience while shopping for, applying for, and enrolling in Exchanges coverage through third party websites. It allows consumers to interact directly with private enrollment partners and complete all steps in the eligibility and enrollment process for qualified health plans on an approved single website. EDE is the result of years of work between CMS, issuers, and other third party partners seeking to provide consumers a more tailored enrollment experience and manage their information and coverage year-round.

PERFORMANCE MANAGEMENT

Performance measurement results provide valuable information on the success of CMS's programs and activities. CMS uses performance information for improvement opportunities and to shape its programs. The use of performance measures also provides a clear communication method of CMS's programmatic objectives to the public and our partners, such as states and national professional organizations. Performance data are extremely useful in shaping policy and management choices in both the short and long term.

The *Government Performance and Results Act of 1993* (GPRA) mandates that Cabinet-level Agencies have strategic plans, annual performance goals, and annual performance reports that make them accountable stewards of public programs.

HHS released its current **Strategic Plan (2018-2022)** in March 2018, as required by the *GPRA Modernization Act of 2010*, and key CMS performance measures from the Strategic Plan are featured in the **HHS Annual Performance Plan and Report**. Consistent with GPRA principles, the CMS GPRA performance goals reinforce the mission, goals, and objectives of the Administration's new Strategic Plan. We look forward to the challenges represented by our performance goals and are optimistic of our ability to meet them.

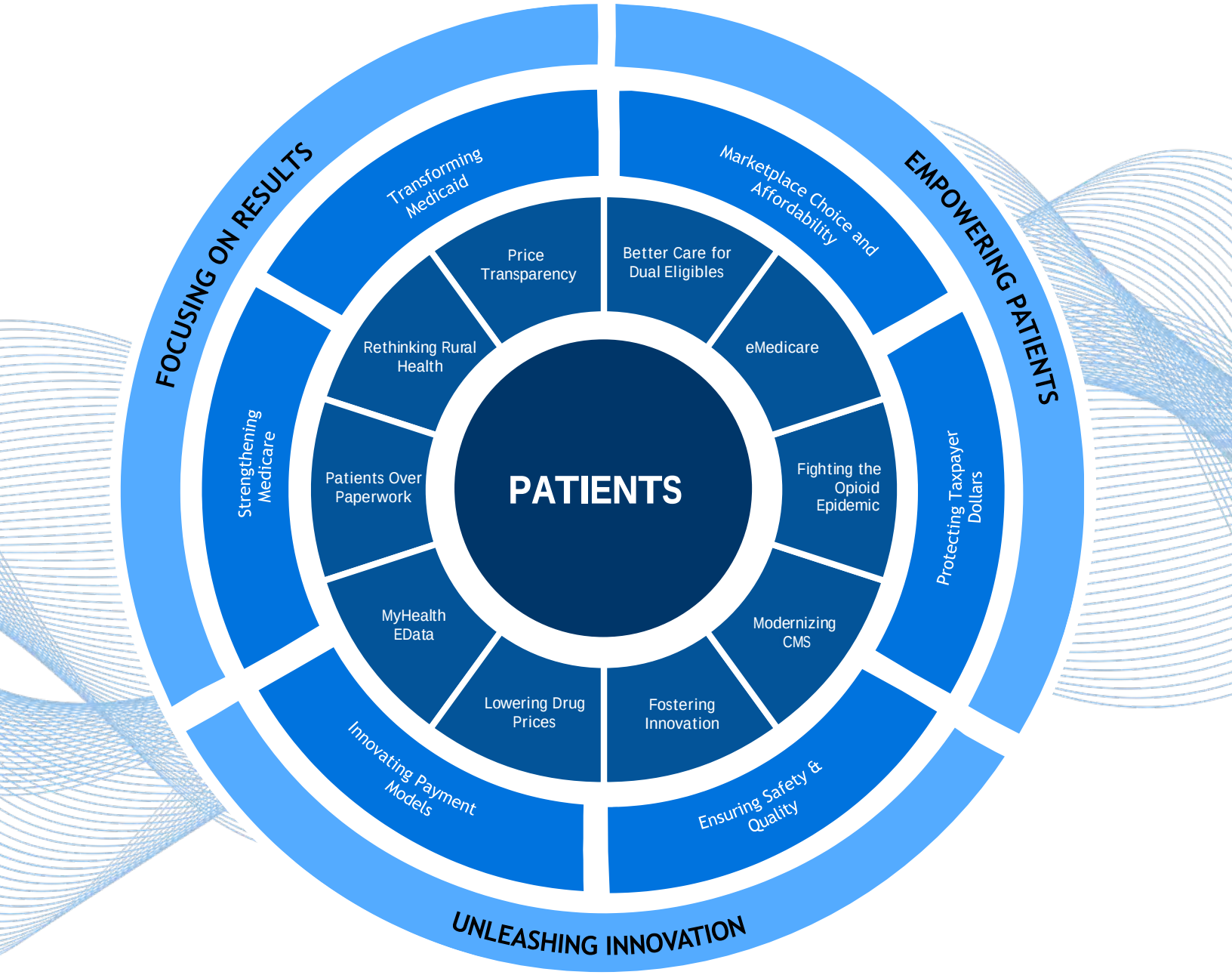
Our FY 2019 performance measures track progress in our major program areas, including measuring error rates. In addition, we measure quality improvement initiatives geared toward older adults, children, and people with disabilities, who are served by the Medicare, Medicaid, CHIP, and the QIO programs. Detailed CMS performance measure information and available results are included in the **CMS Budget**. Progress on our measures will be reported through the FY 2021 President's Budget process.

CMS STRATEGIC GOALS, INITIATIVES & OBJECTIVES

CMS pledges to put patients first in all of our programs – Medicaid, Medicare, and the Health Insurance Exchanges. To do this, we are empowering patients to work with their doctors to assist them in making health care decisions that are best for them. This means giving patients meaningful information about quality and costs that allows them to be active health care consumers. It also includes supporting innovative approaches to improving quality, accessibility, and affordability, while finding the best ways to use innovative technology to support patient-centered care.

To achieve this, we will focus on three main goals: empowering patients, focusing on results, and unleashing innovation. ***Empowering Patients*** - CMS is working to put patients at the center of our health care system. These initiatives will enable individuals to have more access to their health information than ever before. By giving patients more resources and quality information, they can make the best decisions for themselves and their families. ***Focusing on Results*** - Through new flexibilities and incentives, CMS is working to ensure that patients receive the right care, at the right time, and in the right place. We are protecting taxpayers by paying for care based on results. We are using every lever to create innovative payment structures to move our health care system toward greater value by rewarding quality, innovation, and improved health outcomes. ***Unleashing Innovation*** - CMS is ensuring America continues to have a world-class health care system by unleashing innovation in technology. By removing the barriers to innovation and competition, providers and health plans can compete to deliver better care for individuals at a lower cost.

The graphic below depicts how CMS will achieve these goals. It begins with patients in the center, representing our core. The inner circle represents our strategic initiatives, the next circle represents our broad objectives, and the final outer circle represents our main strategic goals. CMS is focused on implementing a vision to transform the health care system into one that delivers better value to patients through competition and innovation. The following provides a brief overview of how CMS is working together with individuals, partners, and stakeholders to ensure all patients get the very best health care.



Strengthening Medicare

Protecting the Medicare program to make it sustainable for future generations is one of CMS's highest priorities. Modernizing Medicare will empower choices and unleash private sector innovation to improve care for individuals with Medicare. CMS is modernizing Medicare with new technology to provide more choices and information and to make care more affordable for individuals with Medicare.

Reducing Prescription Drug Costs

To improve access to prescription drugs for individuals with Medicare, CMS is working to reduce the average out-of-pocket share of prescription drug costs and close the Medicare Part D coverage gap for applicable individuals. Using innovative policy approaches, CMS also finalized a Part C/D rule to lower drug prices and reduce out-of-pocket costs in the Part D program. We are working to improve price transparency under Part D by developing policies that educate beneficiaries on costs and formulary alternatives and to provide Part D sponsors with additional tools to help negotiate lower drug prices.

Medicare Shared Savings Program

CMS published a final rule in December 2018, which set a new direction for Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs) referred to as "Pathways to Success." The rule redesigned the participation options available under the program to encourage ACOs to transition to performance based risk models more quickly and increase the potential for savings for the Medicare trust funds. The final rule also included changes to address the additional tools and flexibilities for ACOs established by the *Bipartisan Budget Act of 2018* (BBA of 2018), specifically in the areas of new beneficiary incentives, telehealth services, and choice of beneficiary assignment methodology. The final rule is expected to increase savings for the Medicare trust funds; promote competition by encouraging low revenue ACO participation; ensure rigorous benchmarking to measure financial performance and strengthen financial incentives; promote engagement from individuals with Medicare; and strengthen program integrity. To facilitate ACOs' transition to Pathways to Success, ACOs were given a special one-time July 1, 2019, agreement period start date. For the July 1, 2019, start date, CMS approved 206 ACOs under the Pathways to Success policies, which increased the number of ACOs in the Shared Savings Program that qualify as advanced alternative payment models under the Quality Payment Program. CMS is offering a second application cycle in 2019 for a January 1, 2020, start date and expects to approve additional ACOs into Pathways to Success.

Hospice Regulations

To strengthen the Medicare program, CMS also finalized a policy to recognize physician assistants as attending physicians, thereby allowing providers more flexibility in providing care to hospice individuals. This policy allows hospices to be more responsive to the needs of their patients.

Home Health Regulations

CMS finalized a new case-mix system called the Patient-Driven Groupings Model (PDGM), effective for home health periods of care beginning on and after January 1, 2020. The PDGM will strengthen Medicare by shifting the focus from volume of services to a more value-based approach relying more heavily on patient characteristics to pay for home health services. Additionally, CMS is implementing a new benefit for infusion therapy provided in the home.

Inpatient Prospective Payment System

CMS has taken steps towards increasing accuracy and equity in payments across all geographic areas in the country. CMS finalized a policy to increase the wage index of certain low-wage-index hospitals, including many rural hospitals, to reduce the disparity between high and low wage index hospitals.

Reduction of Clinical Burden

CMS has made significant changes to the physician fee schedule rule in an effort to reduce clinical burden and improve payment accuracy in the office outpatient setting with clearer documentation, as well as coding payment changes. In addition, CMS is modernizing physician payment by finalizing proposals to pay separately for two newly defined physicians' telehealth services, furnished using communication technology. These include virtual check-ins and patient-transmitted photo or video transmissions, allowing the practitioners to assess if a visit is needed.

The *Medicare Access and CHIP Reauthorization Act of 2015* established the Quality Payment Program (QPP) for eligible clinicians, replacing a patchwork system of Medicare reporting programs. CMS has worked to reduce administrative burden on clinicians by ensuring meaningful measurement occurs and clinicians have the time and ability to put their patients' needs and

outcomes first. Through partnering with the United States Digital Services, we have designed the QPP to have a strong focus on user-oriented design for our policies as well as our systems.

Outpatient Prospective Payment System/Ambulatory Surgical Center

In an effort to increase patient choices and encourage site neutrality in Medicare payment, the Outpatient Prospective Payment System/Ambulatory Surgical Center rule will reduce payment differences between hospitals and ambulatory surgical centers. By doing this, patients may better benefit from high-quality care at lower costs, while receiving care that is provided safely and clinically appropriate.

Transforming Medicaid

CMS has increased state flexibility and innovation, promoting greater accountability for outcomes and ensuring stronger program integrity for taxpayers. CMS continues to give states even greater flexibility in their Medicaid programs as the states move toward more accountable, value-based payment delivery systems.

21st Century Cures Act

CMS issued a state Medicaid director letter in November 2018 about opportunities to design innovative service delivery systems for adults with a serious mental illness or children with a serious emotional disturbance. The letter provides state Medicaid agencies with information about best practices for development and implementation of a continuum of services and treatment available for individuals with mental illness through current Medicaid authorities. In addition, the letter also offered an option through the section 1115 demonstration authority to receive Medicaid funding for individuals during short-term stays in institutions for mental disease (IMD), while ensuring quality outcomes.

Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act

To assist state Medicaid agencies with strategies to avoid opioid overuse for pain management, CMS issued an informational bulletin in February 2019 on non-opioid approaches for pain management. The informational bulletin included guidance on several provisions in the *Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act* (SUPPORT for Patients and Communities Act) that will provide opportunities for state Medicaid agencies to address the opioid epidemic. Section 1007 of the SUPPORT for Patients and Communities Act includes a new definition for "residential pediatric recovery centers" (RPRCs) and describes the services that can be provided through the RPRCs for which medical assistance is available for babies with neonatal abstinence syndrome. Section 1012 of the SUPPORT for Patients and Communities Act provides a limited exception to the IMD exclusion under the state plan. States may claim federal financial participation for items and services provided outside the IMD for pregnant/post-partum women diagnosed with substance use disorders (SUDs) and who are residing in an IMD. CMS also issued an information bulletin regarding drug utilization review requirements as a result of the provisions of section 1004 of the SUPPORT for Patients and Communities Act.

In May 2019, an informational bulletin was issued by CMS to provide guidance to states regarding the availability of an extension of the enhanced Federal Medical Assistance Percentage (FMAP) period for certain Medicaid health homes for individuals with SUD, as authorized under section 1006(a) in the SUPPORT for Patients and Communities Act. In addition, CMS released a notice of funding opportunity on June 25, 2019, to provide at least 10 state Medicaid agencies with planning grants ($50 million aggregate) that will aid in the treatment and recovery of SUDs, including opioid use disorder. The application for planning grants is the first step CMS is taking in implementing section 1003 of the SUPPORT for Patients and Communities Act.

Oversight of State Medicaid Claiming and Program Integrity Expectations

CMS issued a bulletin which sets out CMS's higher expectations for states to ensure the accuracy of eligibility determinations and federal funding at the appropriate matching rate to improve accountability for Medicaid program integrity performance. The bulletin is particularly important for states that have expanded or may be considering expanding their Medicaid programs to the new adult group, which is financed with 90 percent or more in federal funding. The bulletin addresses CMS's expectations for disallowing claims of federal funding, increased audits and oversight, and data sharing and partnerships.

Methods for Assuring Access to Covered Medicaid Services

CMS issued a notice of proposed rulemaking to rescind outdated 2015 access to care requirements

that impose complex administrative burdens on states without meaningful impact to individuals with Medicaid. This proposed rule is designed to help streamline federal oversight of access to care requirements that protect individuals with Medicaid. CMS also issued an informational bulletin to remind states of their ongoing statutory responsibilities to ensure appropriate access to care for individuals with Medicaid, while also outlining a strategy to develop a more comprehensive data specific approach to monitoring access in Medicaid.

Medicaid Section 1115 Authority

CMS and six states are testing new models of Medicaid eligibility and coverage that include community engagement incentives for individuals with Medicaid to be more self-reliant and engaged in their coverage and health care choices with the goal of improving health outcomes and the sustainability of the Medicaid program. In addition, under this same authority and in the interest of bringing under control the national opioid crisis, CMS and states are testing models of comprehensive treatment to address opioid and other SUDs in 26 states, with another 2 pending applications from states under consideration by CMS. These Medicaid demonstrations are subject to robust monitoring and evaluation to support needed mid-course correction, and the identification and diffusion of best practices across states.

Marketplace Choice and Affordability

CMS is focused on creating a robust, affordable, stable, consumer-directed individual health insurance market so that all Americans have access to quality health care at the lowest possible cost and are empowered to make the best health care decisions for themselves and their families.

Health Reimbursement Arrangements

During FY 2019, CMS partnered with the Departments of Labor and the Treasury to finalize a rule to expand health reimbursement arrangements, giving businesses a new alternative in offering health insurance coverage. Under the rule, employers will be able to provide their workers with tax-preferred funds to pay for the cost of health insurance coverage purchased in the individual market.

State Relief and Empowerment Waivers

CMS released updated guidance on State Relief and Empowerment 1332 Waivers aimed to allow states to increase choice and competition within their insurance market while protecting people with pre-existing conditions. To foster discussions with states, CMS also released 1332 waiver concepts and templates to illustrate how states might take advantage of the updated guidance and to assist states with preparation and submission of waiver applications.

Enhanced Direct Enrollment

CMS developed a new "enhanced" direct enrollment pathway for consumers to enroll in health insurance coverage offered by the Federally-facilitated Exchange or State-based Exchange that use the federal platform. Through this new capability, consumers, agents, and brokers assisting consumers are able to go directly to an approved, third-party enrollment partner's website to complete the entire eligibility and enrollment experience and manage coverage throughout the year without needing to be redirected to **HealthCare.gov**. Several new enhanced direct enrollment partners were approved in FY 2019.

Protecting Taxpayer Dollars

Our program integrity function for Medicare, Medicaid, and the Exchanges helps us hold health care systems accountable, protects individuals with Medicare from harm, and safeguards taxpayer dollars while minimizing unnecessary provider burden. CMS is committed to the prevention of fraud, waste, and abuse in its programs. CMS's program integrity strategy strikes an important balance by preventing and addressing potentially fraudulent and improper payments while reducing the administrative burden on legitimate providers and suppliers. CMS uses a multifaceted approach, including provider enrollment and screening standards, enforcement authorities, and advanced data analytics such as predictive modeling. More importantly, CMS continues to move away from the "pay-and-chase" method of recovery after claims are paid by proactively preventing potentially fraudulent and improper payments before they are made. Program integrity efforts put patients and access to care first. CMS is intensifying our program integrity efforts by utilizing innovative strategies such as artificial intelligence and appropriate private sector best practice methods to fight against fraud, waste, and abuse. During FY 2019, CMS focused on results by ensuring that the right payments were made at the right time to the right individual or entity for covered, reasonable, and medically necessary services.

Vulnerability Collaboration Council

CMS established the Vulnerability Collaboration Council, bringing together the key players to collaborate and discuss the underlying vulnerabilities that can lead to fraud, waste and abuse, as well as mitigation strategies that can be implemented to address them. Such mitigation strategies include implementing sophisticated data analytics and models, executing innovative medical review programs, coordinating with law enforcement on fraud investigations, recommending regulatory and other policy changes, and educating providers and individuals with Medicare on how to avoid these vulnerabilities in the future.

New Beneficiary Eligibility Audits

During FY 2019, CMS conducted reviews of Medicaid and CHIP eligibility determinations made by states for the newly eligible adult Medicaid population subject to the enhanced federal match. These reviews will help CMS validate if state eligibility determinations for the new adult group population were appropriate and that the federal match percentage was assessed appropriately. This provides additional safeguards for taxpayer dollars and a reduction of improper payments. Reviews are currently being conducted in four states (New York, Kentucky, California, and Louisiana) that have been identified as potentially high-risk by the Office of Inspector General (OIG) or state auditors.

Medical Loss Ratio Audit

CMS is currently engaged in an audit of Medicaid managed care plans to determine if the financial information submitted by the plans and used by the state to perform the MLR calculations is consistent with contractual obligations and matches each plan's internal data and accounting systems. For states that elect to mandate a minimum medical loss ratio for their Medicaid management care plans, that minimum must be equal to 85 percent or higher. CMS's auditing of Medicaid managed care plans' medical loss ratios ensures plans are not being overpaid. CMS will also be able to recover any identified overpayments.

Medicaid Eligibility Quality Control Program

During FY 2019, CMS began working with states to implement pilots under the revised Medicaid Eligibility Quality Control program, which requires states to conduct reviews of their own eligibility processes in error prone areas and areas that are not reviewed under CMS's improper payment rate measurement program for Medicaid and CHIP. This work complements CMS's improper payment rate measurement work by allowing CMS to have continuous oversight of states' eligibility determination processes and quickly and effectively work with states to address any issues.

Healthcare Fraud Prevention Partnership

The Healthcare Fraud Prevention Partnership (HFPP) published an internal issue paper entitled, *Fraud and Abuse in Recovery Treatment Services for Substance Use Disorders: An Issue Paper by the HFPP*. The issue paper provides information that characterizes the key elements of substance use treatment fraud and abuse and provides partners with information to support their individual efforts to detect and deter these issues. The HFPP is a voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and health care anti-fraud associations. The HFPP aims to foster a proactive approach to detect and prevent health care fraud through data and information sharing. This year, the HFPP membership has grown by 27 percent from 112 to 142 partner organizations.

Investigative Priorities

Medicare's investigative priorities continued to support our federal law enforcement partners during FY 2019, as evidenced by the Department of Justice's (DOJ) announcement of charges in a case involving a massive DME telemarketing fraud scheme including 130 DME companies believed to have submitted over $1.7 billion in fraudulent claims to Medicare. In April 2019, DOJ announced the largest ever prescription opioid law enforcement operation aimed at worst-offending prescribers, doctors, and other medical professionals in the Appalachian region. The enforcement actions involved charging 60 defendants across 11 federal districts for their alleged participation in the illegal prescribing and distributing of opioids and other dangerous narcotics, and for other health care fraud schemes.

Durable Medical Equipment, Prosthetics and Orthotics Supplier

In FY 2019, CMS proposed to simplify the Durable Medical Equipment, Prosthetics and Orthotics Supplier (DMEPOS) ordering requirements to reduce provider burden and decrease appeals and improper payments. CMS also proposed lowering the DMEPOS prior authorization threshold which will reduce provider burden and decrease appeals and improper payments. CMS proposed eliminating the existing DMEPOS face-to-face encounter requirements and suggested a structure that will allow the Secretary to identify items

requiring a face-to-face encounter via a Federal Register Notice. This will reduce provider burden because of the large number of items that currently require a face to face encounter but will also give the Secretary greater flexibility in adding a face to face encounter requirement to DMEPOS as needed.

Review Choice Demonstration for Home Health Services

CMS began the Review Choice Demonstration for Home Health Services in Illinois and Ohio. This is a 5-year demonstration aimed at identifying potential fraud and reducing appeals, improper payments, and provider burden in home health.

Targeted Probe and Educate Program

CMS continued to improve the Targeted Probe and Educate (TPE) program by implementing a pilot for DMEPOS suppliers, which included an initial 10-claim probe review. If the supplier had a 100 percent approval rate, the supplier would not have to continue with additional review. This effort was aimed at reducing burden for large DMEPOS suppliers who have multiple national provider identifiers. The TPE 10-claim preview pilot was implemented on December 31, 2018, and CMS's results are still preliminary at this time. Approximately 10 percent (94/965) of suppliers have been released after the 10-claim preview pilot since June 2019. Intra-probe education was also implemented in the TPE program to allow for more discussion between the contractor and the provider and to get additional records necessary to allow payment for the claim when possible.

Provisional Period of Enhanced Oversight for New Home Health Agencies – Request for Anticipated Payment Suppression

Abuse of the Request for Anticipated Payment (RAP) billing process is the primary type of fraud, waste, or abuse perpetrated by new Home Health Agencies (HHAs). Historically, HHAs have been able to submit a RAP before providing services for a home health episode of care to receive 50-60 percent of the monies upfront. A common fraud scheme perpetrated by HHAs in the Medicare program involves submitting multiple RAPs, receive substantial payments, and then disappear without ever providing services. Accordingly, in FY 2019, CMS elected to suppress RAP payments for new HHAs under the provisional period of enhanced oversight statutory authority, thereby narrowly targeting the fraudulent behavior described above. On July 18, 2019 CMS published a proposed rule (84 FR 34598) that included proposals to reduce the split percentage payment amounts for existing HHAs in calendar year 2020, and proposes to eliminate split-percentage payments entirely beginning in calendar year 2021, thus eliminating the RAP billing process.

Exchange Integrity Contractor

CMS strives to ensure program integrity throughout the Exchanges. In May 2019, the Exchange Program Integrity Contractor collaborated with law enforcement to convict an owner of a health insurance brokerage company for submitting false health insurance applications for plans available under the PPACA.

Hospital Safety Initiatives

The hospital safety initiatives such as the QIOs program and the Hospital Quality/Value-based Purchasing programs (described in detail below under "Ensuring Safety & Quality") also contributed to protecting taxpayers dollars. Hospitals and clinicians reduced over 900,000 hospital acquired conditions, saving $7.7 billion in overall health care costs. For more details, see the "Ensuring Safety & Quality" section on the next page.

Programs of All-inclusive Care for the Elderly and 1915(c) Home and Community-Based Services Waivers

To improve oversight of rate setting and financial reporting in Medicaid arrangements, CMS is working with two rate contractors to ensure proper billing and reimbursement through activities such as conducting reviews and analyses of rate methodologies, fiscal integrity systems, and quality improvement systems and providing technical assistance and training to states. As of July 2019, CMS conducted 96 fiscal reviews of 1915(c) waiver applications and 23 Programs of All-inclusive Care for the Elderly. In addition, since 2016, CMS has conducted and/or posted 26 presentations on topics related to rates and fiscal integrity in HCBS programs. These resources are available at **https://www.medicaid.gov/medicaid/hcbs/training/index.html**.

Electronic Visit Verification Systems

To ensure proper documentation supports billing for specific home services and to help verify the delivery of services, CMS is supporting states in their implementation of the new requirement to incorporate functional electronic visit verification (EVV) systems for Personal Care Services no later than January 1, 2020, and for home health care services no later than January 1, 2023, absent a one-year good faith effort exemption. Rate contractors provide EVV education, training, and

technical assistance to states to ensure they successfully initiate this fiscal integrity control, and that it is linked directly to billing and/or payment through pre- or post-payment audits. CMS has also facilitated three EVV Learning Collaborative meetings for states and other stakeholders to collaborate and openly discuss EVV policy guidance and noteworthy practices.

Ensuring Safety & Quality

CMS is focused on ensuring individuals with Medicare are empowered to make decisions about their health care based on quality and cost information. To achieve this, we are moving our quality programs to more robustly measure value and to give consumers access to understandable and actionable information. We are ensuring safety by partnering with state agencies and accrediting organizations who are responsible for ensuring all facilities meet the minimum health and safety standards. We are evaluating our oversight effectiveness to ensure entities are held accountable for consistent and effective service and improve transparency for individuals with Medicare. We are taking a hard look at how we oversee these entities, and we are strengthening our oversight to make sure that entities are accountable for consistency and effectiveness in serving this vital public trust role, and ensure more transparency for individuals with Medicare.

Real-time Safety Alerts

To reduce opioid overutilization, CMS is ensuring smooth implementation of new real-time safety alerts at the time of dispensing and other advanced policies mandated by the *Comprehensive Addiction and Recovery Act*.

HCBS Incident Management Survey

To ensure the provision of quality services to individuals with Medicaid and in response to health and welfare concerns identified in 1915(c) HCBS waiver programs, CMS is issuing a survey to identify methods and promising practices for identifying, reporting, tracking, and resolving incidents of abuse, neglect, and exploitation. Results of the survey will help inform technical assistance activities and ensure states have necessary guidance for meeting 1915(c) waiver reporting requirements.

Health & Welfare Special Review Team

CMS has specifically identified a contractor to identify, prevent, and appropriately deal with systemic problems in state implementation of and compliance with health and safety oversight systems for home and community based settings, including group homes and assisted living programs. Activities initiated include health and welfare issue research and analysis, special onsite reviews, data compilation, and education and training. CMS collaborated with a contractor and has completed three onsite visits to date.

Accrediting Organization Oversight

One of CMS's objectives is to improve the oversight of accrediting organizations. These are private organizations that accredit providers and suppliers and automatically convey approval to receive Medicare/Medicaid funding for services. By strengthening oversight of accrediting organizations, CMS is intensifying our commitment to quality and patient safety. CMS's efforts include seeking additional transparency about accrediting organization findings and processes, ensuring identification of quality issues, and reviewing all areas of the application and oversight process to maximize our efficiency and effectiveness.

Strengthening Nursing Home Quality & Safety

As part of the Strengthening Nursing Home Quality & Safety initiative, CMS has released revisions to Appendix Q to the State Operations Manual (SOM), which provides guidance for identifying immediate jeopardy. The revisions include updated guidance and a new template that clarifies and supports increased consistency in the identification of immediate jeopardy by nursing home surveyors. Immediate jeopardy is a situation in which a recipient of care has suffered or is likely to suffer serious injury, harm, impairment, or death as a result of a provider's noncompliance with one or more health and safety requirements. The memo describing the Revisions to Appendix Q is located at this link: **https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-19-09-ALL-REVISED.pdf**.

In addition, CMS made improvements to the Nursing Home Compare and the Five Star Rating System in April 2019. The memo describing these changes is located at **https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO19-08-NH.pdf**. CMS is also planning future improvements to this program that include making it easier for consumers to identify nursing homes that have been cited for abuse. Lastly, the State Performance Standards System is used to monitor state agencies' performance to oversee providers' compliance. We are in the process of revising this program for FY 2020 in order to strengthen our oversight of state agencies.

Quality Improvement in Hospitals

The quality improvement hospital initiatives support the spread of best practices across a wide array of hospitals throughout the nation such as small, rural, critical access hospitals and underserved areas. These initiatives concentrate on implementing a vision to transform the health care system into one that delivers the best value to patients through measurement, cooperation, transparency and innovation. To achieve this, we focus on empowering patients and families, focusing on results, and unleashing innovation that fosters accountability. Some of these initiatives include hospital quality reporting and value based programs. As a result of these initiatives, nationwide data reveals hospital acquired conditions that cause patients to be harmed have declined by approximately 900,000 cases. The reductions in adverse drug events, falls, infections, and other forms of patient harm are estimated to have prevented over 20,500 deaths in hospitals and have saved $7.7 billion in overall health care costs, showing front line provider commitment to patient safety and quality of care for individuals with Medicare.

Quality Innovation Network-Quality Improvement Organizations

In partnership with CMS, Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) provide education, technical assistance, and targeted quality improvement to reduce readmissions and admissions in hospitals. The Hospital Readmission Reduction program levies up to a three percent penalty for hospitals with excessive readmissions. The QIOs specifically had a community-wide quality improvement approach to ensure patients who left the hospital were equipped to care for their condition. Some strategies that QIOs helped to implement and identify as best practices were developing effective community coalitions involving hospitals, nursing facilities, home care, hospice agencies, physicians, pharmacies, community service providers and others to help meet needs that may prevent patients from getting or staying well; generating and implementing standard transition processes across all local health care settings; transferring patient clinical information between providers in a timely and effective way; and helping patients and their family members become actively engaged in their transitions.

The Transforming Clinical Practice Initiatives

The Transforming Clinical Practice Initiatives (TCPI) was launched in 2015 to provide technical assistance to 140,000 enrolled clinicians and practices to prepare them for participation in value-based payment arrangements through nationwide, collaborative, and peer-based learning networks that facilitate quality improvement through practice transformation and subsequent alternative payment models adoption. Quality improvement is focused on improving health outcomes for millions of individuals with Medicare, improving the safe delivery of care through the reduction of unnecessary utilization, and transforming clinical delivery operations through patient-centered care. TCPI is a 4-year model test that ended on September 28, 2019.

Beneficiary & Family Centered Care Quality Improvement Organizations

Beneficiary & Family Centered Care Quality Improvement Organizations (BFCC-QIOs) serve to protect the integrity of the Medicare trust fund by conducting reviews to ensure that care and services provided under the Medicare program adhere to statutory and regulatory requirements, thus protecting the rights of individuals with Medicare. BFCC-QIO services include quality of care reviews, diagnosis-related group claim reviews, short stay (less than two midnights) claim reviews, *Emergency Medical Treatment and Labor Act* reviews, appropriateness of setting reviews, medical necessity reviews, readmission reviews, physician acknowledgement statement monitoring, appeals, and issuing provider sanctions for gross and flagrant negligence.

Innovative Payment Models

Through innovative payment models, CMS can test new opportunities for providers to accept higher levels of risk and new financial arrangements that ease providers into value-based agreements. These models are designed to offer clinicians an array of new payment models that reward them for doing the job they were trained to do – spending time caring for patients. Advanced innovative payment structures move our health care system to one that incentivizes value by rewarding quality and performance, lower program costs, innovation, and improved health outcomes. CMS is testing models that empower patients as consumers, utilize providers as accountable patient navigators, modernize payment for outcomes, and focus on the prevention of disease before

it occurs. We are working to develop new payment models that are transparent, simple, and accountable. The following models were announced in FY 2019 to support this work.

Part D Payment Modernization Model

The Part D Payment Modernization model will test the impact of a revised Part D program design and incentive alignment on overall Part D prescription drug spending and out-of-pocket costs for individuals with Medicare. The model aims to reduce Medicare expenditures while preserving or enhancing quality of care for individuals with Medicare.

Emergency Triage, Treat, and Transport

Emergency Triage, Treat, and Transport (ET3) is a voluntary, five-year payment model that will test providing greater flexibility to ambulance care teams in addressing emergency health care needs of individuals with Medicare following a 911 call. Under the ET3 model, CMS will pay participating ambulance suppliers and providers to 1) transport an individual to a hospital emergency department (ED) or other destination covered under the regulations, 2) transport to an alternative destination (such as a primary care doctor's office or an urgent care clinic), or 3) provide treatment in place with a qualified health care practitioner, either on the scene or connected using telehealth.

Primary Care First

Primary Care First is a set of voluntary five-year payment options that reward value and quality by offering an innovative payment structure to support delivery of advanced primary care. In response to input from primary care clinician stakeholders, Primary Care First is based on the underlying principles of the existing Comprehensive Primary Care Plus (CPC+) model design: prioritizing the doctor-patient relationship; enhancing care for patients with complex chronic needs and high need, seriously ill patients; reducing administrative burden; and focusing financial rewards on improved health outcomes.

Direct Contracting

Direct contracting is a three-year voluntary payment

model option aimed at reducing expenditures and preserving or enhancing quality of care for individuals with Medicare. The payment model options available under direct contracting create opportunities for a broad range of organizations to participate with CMS in testing the next evolution of risk-sharing arrangements to produce value and high quality health care.

Kidney Care First and Comprehensive Kidney Care Contracting

The Kidney Care First and Comprehensive Kidney Care Contracting Graduated, Professional, and Global Models are designed to build upon the existing Comprehensive ESRD Care Model structure, in which dialysis facilities, nephrologists, and other health care providers form ESRD focused accountable care organizations to manage care for individuals with ESRD. These models add strong financial incentives for health care providers to manage the care for individuals with Medicare and chronic kidney disease stages 4 and 5 and ESRD, to delay the onset of dialysis, and to incentivize kidney transplantation.

Radiation Oncology Model

The Radiation Oncology Model is proposed to test whether prospective episode-based payments to physician group practices, hospital outpatient departments, and freestanding radiation therapy centers for radiotherapy episodes of care would reduce Medicare expenditures while preserving or enhancing the quality of care for individuals with Medicare. This patient-centric and provider-focused model would improve the quality of care cancer patients receive and improve patient experience by rewarding high-quality patient-centered care that results in better outcomes through a prospective, episode-based payment methodology.

Medicare-Medicaid Financial Alignment Initiative

Through the Medicare-Medicaid Financial Alignment Initiative and related work, CMS is partnering with 10 states to test models of integrating primary, acute, behavioral health care, long-term services, and support for individuals dually eligible for Medicare and

Medicaid. The Financial Alignment Initiative includes a capitated model and a managed fee-for-service model. Although the approaches differ in each demonstration, individuals in every version of the model receive their full array of Medicare and Medicaid benefits, with added care coordination, protections, and access to additional or enhanced services. Additionally, unnecessary hospitalizations can be disruptive and dangerous for nursing facility residents and costly for Medicare. CMS is testing strategies to reduce avoidable hospitalizations for Medicare and Medicaid enrollees who are long-stay residents of nursing facilities.

OVERVIEW OF FINANCIAL DATA

Sound financial management is an integral part of CMS's efforts to deliver services and administer our programs. CMS maintains strong financial management operations and continues to improve its financial management and reporting processes to provide timely, reliable, and accurate financial information. CMS management and other decision makers use this information to make timely and accurate program and administrative decisions.

The basic financial statements in this report are prepared pursuant to the requirements of the *Government Management Reform Act of 1994* and the *Chief Financial Officers Act of 1990*. Other requirements include the *OMB Circular A-136, Financial Reporting Requirements*. The responsibility for the integrity of the financial information included in these statements rests with CMS management. The OIG selects an independent certified public accounting firm to audit the CMS financial statements and related notes.

Consolidated Balance Sheets

The Consolidated Balance Sheets present as of September 30, 2019 and 2018, amounts of future economic benefits owned or managed by CMS (assets), amounts owed (liabilities), and amounts that comprise the difference (net position). A Consolidating Balance Sheet by Major Program is provided as additional information. CMS's Consolidated Balance Sheet has reported assets of $502.0 billion. The bulk of these assets is in Investments totaling $305.4 billion, which are invested in Treasury Special Issues, special public obligations for exclusive purchase by the Medicare trust funds. Trust fund holdings not necessary to meet current expenditures are invested in interest-bearing obligations of the U.S. or in obligations guaranteed as to both principal and interest by the U.S. The next largest asset is the Fund Balance with Treasury of $170.8 billion, most of which is for Medicaid, CHIP, and Payments to Health Care trust funds. Liabilities of $134.2 billion consist primarily of the Entitlement Benefits Due and Payable of $110.1 billion. CMS's Net Position totals $367.8 billion and reflects primarily the Cumulative Results of Operations for the Medicare trust funds and the unexpended balances for Medicaid and CHIP.

Consolidated Statements of Net Cost

The Consolidated Statements of Net Cost present the actual net cost of CMS's operations by program for the years ended September 30, 2019 and 2018. The three major programs that CMS administers are: Medicare, Medicaid, and CHIP. The majority of CMS's expenses are in these programs. Both Medicare and Medicaid program integrity and fraud and abuse funding are included under the HI trust fund. The net cost of operations under "Other" includes: State Grants and Demonstrations and Other Health. Program Management expenses are allocated and shown separately under each major program. A Consolidating Statement of Net Cost is provided to show the Medicare funds as Dedicated Collection versus Other Fund components of net cost as additional information. In FY 2019, our total Net Cost of Operations was $1,087.3 billion encompassing program/activity costs of $1,195.8 billion and operating costs of $6.5 billion.

Consolidated Statements of Changes in Net Position

The Consolidated Statements of Changes in Net Position present the change in net position (i.e., difference between assets and liabilities) for the years ended September 30, 2019 and 2018. Changes in the Cumulative Results of Operations and Unexpended Appropriations affect CMS's net position balance. Funds From Dedicated Collections are shown in a separate column from Other Funds. The bulk of the change pertains to Appropriations Used of $787.5 billion, which represents the Medicaid and CHIP appropriations, transfers from Payments to the Health Care Trust Funds to HI and SMI, and State Grants and Demonstrations and general fund-financed Program

Management appropriations. Medicaid and CHIP are financed by a general fund appropriation provided by Congress. Employment tax revenue is Medicare's portion of payroll and self-employment taxes collected under the *Federal Insurance Contributions Act* and *Self Employment Contributions Act* for the HI trust fund and totaled $281.4 billion.

Combined Statements of Budgetary Resources

The Combined Statements of Budgetary Resources provide information about the availability of budgetary resources, as well as their status for the years ended September 30, 2019 and 2018. An additional Schedule of Budgetary Resources is provided as Required Supplementary Information (RSI) to present budgetary information by program. In this statement, Program Management is shown separately and Other includes State Grants and Demonstrations, Other Health and Medicare and Medicaid program integrity and fraud and abuse activities. Also, there are no intra-CMS eliminations in this statement.

CMS total budgetary resources were $1,748.6 billion. Obligations of $1,654 billion leave unobligated balances of $94.6 billion. Total outlays, net of collections, were $1,571.7 billion. When offset by $491 billion relating to collection of premiums and general fund transfers from the Payments to the Health Care Trust Funds, as well as refunds of MAC overpayments, the CMS net outlays were $1,080.7 billion.

OVERVIEW OF SOCIAL INSURANCE DATA

Statement of Social Insurance

The Statement of Social Insurance (SOSI) presents the 75-year actuarial present value of the income and expenditures of the HI and SMI trust funds. Future expenditures are expected to arise for current and future program participants. This projection is considered important information regarding the potential future cost of the program. These projected potential future obligations are not included in the Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position, or Combined Statement of Budgetary Resources.

Actuarial present values are computed under the intermediate set of assumptions specified in the 2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

The SOSI presents the following estimates:

- The present value of future income (income excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future cost of providing benefits to those same individuals;

- The present value of future income to be received from or on behalf of current participants who have not yet attained eligibility age and the future cost of providing benefits to those same individuals;

- The present value of future income less future cost for the closed group, which represents all current participants who attain age 15 or older in the first year of the projection period, *plus* the assets in the combined HI and SMI trust funds as of the beginning of the valuation period;

- The present value of income to be received from or on behalf of future participants and the cost of providing benefits to those same individuals;

- The present value of future income less future cost for the open group, which represents all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program, *plus* the assets in the combined HI and SMI trust funds as of the beginning of the valuation period; and

- The present value of future cash flows for all current and future participants over the next 75 years (open group measure) decreased from $(4.7) trillion, determined as of January 1, 2018, to $(5.5) trillion, determined as of January 1, 2019.

Including the combined HI and SMI trust fund assets increases the present value. As of January 1, 2019, the future cash flow for all current and future participants was $(5.2) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI trust fund assets, is $(12.7) trillion.

HI Trust Fund Solvency

Pay-as-you-go Financing

The HI trust fund is deemed to be solvent as long as assets are sufficient to finance program obligations. Such solvency is indicated, for any point in time, by the maintenance of positive trust fund assets. In recent years, current expenditures have exceeded program income for the HI program, and thus, the HI trust fund assets have been declining. The following table shows that HI trust fund assets, expressed as a ratio of the assets at the beginning of the fiscal year to the expenditures for the year. This ratio has steadily dropped from 73 percent at the beginning of FY 2015 to 62 percent at the beginning of FY 2019.

TRUST FUND RATIO

Beginning of Fiscal Year [2]

	2015	2016	2017	2018	2019
HI	**73%**	**67%**	**66%**	**66%**	**62%**

Short-Term Financing

The HI trust fund is deemed adequately financed for the short term when actuarial estimates of trust fund assets for the beginning of each calendar year are at least as large as program obligations for the year. Estimates in the 2019 Trustees Report indicate that the HI trust fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2019 Trustees Report, the HI trust fund ratio is estimated to decline steadily until the fund is depleted in calendar year 2026. Assets at the end of calendar year 2018 were $200.4 billion and are expected to decrease steadily until depleted in 2026.

Long-Term Financing

The short-range outlook for the HI trust fund is similar to what was projected last year. The trust fund ratio declines until the fund is depleted in 2026, the same date as projected last year. HI financing is not projected to be sustainable over the long term with the projected tax rates and expenditure levels. Program cost is expected to exceed total income in all years. When the HI trust fund is exhausted, full benefits cannot be paid on a timely basis. The percentage of expenditures covered by tax revenues is projected to decrease from 89 percent in 2026 to 78 percent in 2043 and then to increase to about 83 percent by the end of the projection period.

The primary reasons for the projected long-term inadequacy of financing under current law relate to the fact that the ratio of the number of workers paying taxes relative to the number of individuals eligible for benefits drops from 3.0 in 2018 to about 2.2 by 2093. In addition, health care costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $5.3 trillion, which is 0.9 percent of taxable payroll and 0.4 percent of Gross Domestic Product (GDP) over the same period. Significant uncertainty surrounds the estimates for the SOSI. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near-term and ultimate assumptions used in the projections. For more information, please refer to the *Required Supplementary Information: Social Insurance* disclosures required by the Federal Accounting Standards Advisory Board.

SMI Trust Fund Solvency

The SMI trust fund consists of two accounts – Part B and Part D. In order to evaluate the financial status of the SMI trust fund, each account needs to be assessed individually, since financing rates for each part are established separately, and their program benefits are quite different in nature.

While differences between the two accounts exist, the financing mechanism for each part is similar in that the financing is determined on a yearly basis. The Part B account is generally financed by premiums and general revenue matching appropriations determined annually to cover projected program expenditures and to provide a contingency for unexpected program variation. The Part D account is financed by premiums, general revenues, and transfers from state governments. Unlike the Part B account, the appropriation for Part D has generally been set such that amounts can be transferred to the Part D account on an as-needed basis; under this process, there is no need to maintain a contingency reserve. In September 2015, a new policy was implemented to transfer amounts from the Treasury into the account 5 business days before the benefit payments to the plans.

As a result, the Trustees expect the Part D account to include a more substantial balance at the end of most months to reflect this policy.

2 Assets at the beginning of the year to expenditures during the year.

Since both the Part B and Part D programs are financed on a yearly basis, from a program perspective, there is no unfunded liability in the short or long-range. Therefore, in this financial statement the present value of estimated future excess of income over expenditures for current and future participants over the next 75 years is $0. However, from a government wide perspective, general fund transfers as well as interest payments to the Medicare trust funds and asset redemption represent a draw on other federal resources for which there is no earmarked source of revenue from the public. Hence, from a government wide perspective, the corresponding estimate of future income less expenditures for the 75-year projection period is $(36.8) trillion.

Even though from a program perspective the unfunded liability is $0, there is concern over the rapid increase in cost of the SMI program as a percent of GDP. In 2018, SMI expenditures were 2.1 percent of GDP. By 2093, SMI expenditures are projected to grow to 4.2 percent of the GDP.

The following table presents key amounts from our basic financial statements for fiscal years 2017 through 2019.

TABLE OF KEY MEASURES [3]

Dollars in billions

	2019	2018	2017
Net Position (end of fiscal year)			
Assets	**$502.0**	**$467.3**	**$444.2**
Less Total Liabilities	**$134.2**	**$123.5**	**$137.5**
Net Position (assets net of liabilities)	**$367.8**	**$343.8**	**$306.7**
Costs (end of fiscal year)			
Net Costs	**$1,087.3**	**$1,009.1**	**$963.3**
Total Financing Sources	**$1,079.0**	**$1,017.7**	**$984.6**
Net Change in Cumulative Results of Operations	**$(8.3)**	**$8.6**	**$21.3**
Statement of Social Insurance (calendar year basis)			
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation (as of 1/1/2019)	**$(5,484)**	**$(4,708)**	**$(3,532)**
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), prior year valuation (as of 1/1/2018)	**$(4,708)**	**$(3,532)**	**$(3,822)**
Change in present value	**$(776)**	**$(1,176)**	**$290**

3 The table or other singular presentation showing the measures described above.

Statement of Changes in Social Insurance Amounts

The Statement of Changes in Social Insurance Amounts reconciles the change (between the current valuation period and the prior valuation period) in the present value of future tax income less future cost for current and future participants (the open group measure) over the next 75 years. This reconciliation identifies those components of the change that are significant and provides reasons for the changes. In general, an increase in the present value of net cash flow represents a positive change (improving financing), while a decrease in the present value of net cash flow represents a negative change (worsening financing).

The present value as of January 1, 2019, decreased by $201 billion due to advancing the valuation date by one year and including the additional year 2093, by $200 billion due to changes in projection base, and by $402 billion due to changes in economic and health care assumptions. However, the present value increased by $27 billion due to changes in demographic assumptions. The net overall impact of these changes is a decrease in the present value of $776 billion.

Required Supplementary Information

As required by *Statement of Federal Financial Accounting Standards (SFFAS) 17, Accounting for Social Insurance (as amended by SFFAS 37, Social Insurance: Additional Requirements for Management Discussion and Analysis and Basic Financial Statements)*, CMS has included information about the Medicare trust funds – HI and SMI. The RSI presents required long-range cash-flow projections, the long-range projections of the ratio of contributors to individuals with Medicare (dependency ratio), and the sensitivity analysis illustrating the effect of the changes in the most significant assumptions on the actuarial projections and present values. The SFFAS 37 does not eliminate or otherwise affect the SFFAS 17 requirements for the supplementary information, except that actuarial projections of annual cash flow in nominal dollars are no longer required; as such, it will not be reported in the RSI. The RSI assesses the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the *2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds.

Limitations of the Financial Statements

The principal financial statements are prepared to report the financial position and results of operations of CMS, pursuant to the requirements of 31 U.S.C. § 3515(b). The statements are prepared from the books and records of CMS in accordance with Federal Generally Accepted Accounting Principles and the formats prescribed by OMB. Reports used to monitor and control budgetary resources are prepared from the same books and records. The financial statements should be read with the realization that they are for a component of the U.S. Government.


INVACARE

FINANCIAL SECTION

2

A Message from the Chief Financial Officer //
Financial Statements // Notes to the Financial Statements //
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A MESSAGE FROM THE CHIEF FINANCIAL OFFICER

MEGAN WORSTELL

I am pleased to present the Centers for Medicare & Medicaid Services fiscal year (FY) 2019 Agency Financial Report (AFR). Once again, we have received an unmodified opinion on the audit of our basic financial statements. Even though we have received an unmodified opinion for 21 straight years, we don't take this accomplishment lightly. We recognize the dedication our staff employs every day to ensure that taxpayer dollars are being used in the most cost-effective way possible.

The auditors issued an unmodified opinion on four of our six principal financial statements which signifies CMS's commitment to financial management excellence. The unmodified opinion indicates that our financial statements are fairly presented. CMS's auditors are still not able to express an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts due to uncertainty in the long-range assumptions applied in our projection models. However, we remain confident that our projections are sound and we continue to collaborate with our auditors to develop strategies that will give them the same confidence in expressing an opinion on these statements.

At CMS, our challenge is always to provide better care while lowering costs to our beneficiaries. Our goal is to provide a value-based healthcare system that will help deliver each patient the right care, at the right price, in the right setting, from the right provider. To achieve this, CMS announced several updates to current payment systems and new payment models this year designed to ensure the continued sustainability of our Medicare Trust Funds.

CMS announced an overhaul of the program for Accountable Care Organizations (ACOs) in Medicare. ACOs serve a large number of Medicare beneficiaries – over 10.4 million individuals in Fee-for-Service Medicare (of the 38 million total Fee-for-Service beneficiaries) receive care from providers participating in Medicare ACOs. CMS has put a high priority on accelerating a value-based transformation of America's healthcare system – which is the move from paying for the volume of services to paying for outcomes and health. CMS is hard at work to move to a value-based system, not just because we want to, but because the American healthcare system is on an unsustainable trajectory, with one in five dollars spent in our economy projected to be spent on healthcare by 2026. Therefore, it is incumbent for us to not just pay for healthcare services as they are billed but rather to ensure that patients are getting value for the care that is provided.

CMS finalized changes that remove unnecessary and inefficient payment

differences between certain provider and supplier types so patients can have more affordable choices and options. The final rule revises policies under the Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System. This revision will further advance the agency's priority of creating a patient-centered healthcare system by achieving greater price transparency.

One model, the Emergency Triage, Treat and Transport (ET3) model, will make it possible for participating ambulance suppliers and providers to partner with qualified health care practitioners to deliver treatment in place (either on-the-scene or through telehealth) and with alternative destination sites (such as primary care doctors' offices or urgent-care clinics) to provide care for Medicare beneficiaries. This model will better use taxpayer dollars since it no longer creates an incentive to transport all beneficiaries to the hospital even when an alternative treatment option may be more appropriate.

CMS has taken actions to drive down prescription drug costs. We are providing clinicians with more information on out-pocket-costs and lower cost alternatives for prescription drugs so they can discuss with beneficiaries at the time a prescription is written. CMS is also providing beneficiaries with more drug choices and empowering beneficiaries to select a plan that best meets their needs by allowing plans to cover prescription drugs differently depending on the reasons for which they are prescribed, an approach used in the private sector.

In our continued efforts to intensify our fight against fraud, waste, and abuse, CMS announced new enforcement authorities to reduce criminal behavior in Medicare, Medicaid, and CHIP. CMS issued a final rule (Program Integrity Enhancements to the Provider Enrollment Process) that strengthens the agency's ability to stop fraud before it happens by keeping unscrupulous providers out of our federal health insurance programs. This first-of-its-kind action – stopping fraudsters before they get paid – marks a critical step forward in CMS's longstanding fight to end "pay and chase" in federal healthcare fraud efforts and replace it with smart, effective and proactive measures.

For the third consecutive year, the Medicare FFS improper payment rate has been below the 10 percent threshold for compliance established in the Improper Payments Eliminations and Recovery Act of 2010. CMS continues to see a reduction in improper payments as noted by a decrease in the Medicare FFS improper payment rate from 9.51 percent in 2017 to 7.25 percent in 2019. This represents a $7.30 billion decrease in estimated improper payments from 2017 to 2019[1].

CMS challenges itself to leverage technology to improve and modernize its processes. As a result, CMS is upgrading to a more efficient automated budget system. This system will deliver operating efficiencies through greater visibility into the budget and enhanced analytics capabilities. Additionally, CMS now has the capability for Medicare Secondary Payer (MSP) debtors to submit electronic payments via Automated Clearing House, debit card, or PayPal. Further, CMS is modernizing our financial management system, Healthcare Integrated General Ledger Accounting System (HIGLAS), to interface with our procurement system, the Comprehensive Acquisition Management System (CAMS).

Partnering together with those we serve, we remain committed to financial stewardship over the Medicare Trust Funds. We know you expect your taxpayer dollars that you have entrusted to us to be used in the most efficient way possible. We recognize your confidence in our work and stay dedicated to our mission of reducing healthcare costs.

In closing, I would like to thank our financial management team and our partners for their dedication. The success of our work depends on you.

Thank you for your interest in CMS's FY 2019 Agency Financial Report.

Megan Worstell

MEGAN WORSTELL
CMS Chief Financial Officer
November 2019

1 Between 2018 and 2019, the estimated overall improper payments decreased $2.71 billion.

CONSOLIDATED BALANCE SHEETS

as of September 30, 2019 and September 30, 2018

(in millions)

	FY 2019 Consolidated Totals	FY 2018 Consolidated Totals
ASSETS		
Intragovernmental Assets:		
Fund Balance with Treasury *(Note 2)*	$170,796	$135,672
Investments *(Note 3)*	305,378	303,253
Accounts Receivable, Net *(Note 4)*	589	612
Other Assets		25
TOTAL INTRAGOVERNMENTAL ASSETS	476,763	439,562
Accounts Receivable, Net *(Note 4)*	23,356	26,035
General Property, Plant and Equipment, Net	1,460	1,318
Other Assets	446	452
TOTAL ASSETS	$502,025	$467,367
LIABILITIES		
Intragovernmental Liabilities:		
Accounts Payable	$1,476	$1,405
Other Intragovernmental Liabilities	3,403	5,550
TOTAL INTRAGOVERNMENTAL LIABILITIES	4,879	6,955
Accounts Payable	233	167
Entitlement Benefits Due and Payable *(Note 5)*	110,100	99,148
Contingencies *(Note 6)*	10,032	7,118
Other Liabilities	8,989	10,148
TOTAL LIABILITIES *(Note 7)*	$134,233	$123,536
NET POSITION		
Unexpended Appropriations–Dedicated Collections *(Note 9)*	$57,968	$22,934
Unexpended Appropriations–Other Funds	62,316	65,147
Cumulative Results of Operations–Dedicated Collections *(Note 9)*	252,377	256,977
Cumulative Results of Operations–Other Funds	(4,869)	(1,227)
TOTAL NET POSITION - DEDICATED COLLECTIONS *(Note 9)*	310,345	279,911
TOTAL NET POSITION - OTHER FUNDS	57,447	63,920
TOTAL NET POSITION	$367,792	$343,831
TOTAL LIABILITIES AND NET POSITION	$502,025	$467,367

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF NET COST

for the years ended September 30, 2019 and September 30, 2018

(in millions)

	FY 2019 Consolidated Totals	FY 2018 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS GPRA PROGRAMS		
Medicare HI		
Benefit/Program	$318,030	$300,654
Program Management	1,625	1,505
Net Cost Medicare HI	$319,655	$302,159
Medicare SMI		
Benefit/Program (Part B)	$263,511	$238,808
Benefit/Program (Part D)	71,324	73,715
Program Management	2,333	2,149
Net Cost Medicare SMI	$337,168	$314,672
Medicaid		
Benefit/Program	$411,183	$383,583
Program Management	149	147
Net Cost Medicaid	$411,332	$383,730
CHIP		
Benefit/Program	$17,470	$17,315
Program Management	15	14
Net Cost CHIP	$17,485	$17,329
Other		
Benefit/Program	$1,033	$(9,684)
Program Management	598	869
Net Cost Other	$1,631	$(8,815)
NET COST OF OPERATIONS (NOTE 8)	$1,087,271	$1,009,075

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2019

(in millions)

	Funds from Dedicated Collections (Note 9)	All Other Funds	FY 2019 Consolidated Total
UNEXPENDED APPROPRIATIONS			
Beginning Balances	$22,934	$65,147	$88,081
Budgetary Financing Sources:			
Appropriations Received	402,356	515,950	918,306
Appropriations Transferred-in/out		(4,167)	(4,167)
Other Adjustments	(5,861)	(88,552)	(94,413)
Appropriations Used	(361,461)	(426,062)	(787,523)
Total Budgetary Financing Sources	35,034	(2,831)	32,203
Total Unexpended Appropriations	$57,968	$62,316	$120,284
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	$256,977	$(1,227)	$255,750
Budgetary Financing Sources:			
Appropriations Used	361,461	426,062	787,523
Nonexchange Revenue:			
FICA and SECA Taxes	281,441		281,441
Interest on Investments	9,435	254	9,689
Other Nonexchange Revenue	3,253		3,253
Transfers-in/out Without Reimbursement	(3,212)	164	(3,048)
Other Financing Sources (Nonexchange):			
Transfers-in/out Without Reimbursement		115	115
Imputed Financing	49	7	56
Total Financing Sources	$652,427	$426,602	$1,079,029
Net Cost of Operations	657,027	430,244	1,087,271
Net Change	(4,600)	(3,642)	(8,242)
CUMULATIVE RESULTS OF OPERATIONS	$252,377	$(4,869)	$247,508
NET POSITION	$310,345	$57,447	$367,792

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2018

(in millions)

	Dedicated Collections (Note 9)	All Other Funds	FY 2018 Consolidated Total
UNEXPENDED APPROPRIATIONS			
Beginning Balances	**$17,287**	**$42,242**	**$59,529**
Budgetary Financing Sources:			
Appropriations Received	**376,964**	**517,077**	**894,041**
Appropriations Transferred-in/out		**(4,384)**	**(4,384)**
Other Adjustments	**(34,640)**	**(84,373)**	**(119,013)**
Appropriations Used	**(336,677)**	**(405,415)**	**(742,092)**
Total Budgetary Financing Sources	**5,647**	**22,905**	**28,552**
Total Unexpended Appropriations	**$22,934**	**$65,147**	**$88,081**
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	**$251,620**	**$(4,456)**	**$247,164**
Budgetary Financing Sources:			
Appropriations Used	**336,677**	**405,415**	**742,092**
Nonexchange Revenue:			
FICA and SECA Taxes	**264,566**		**264,566**
Interest on Investments	**9,677**	**27**	**9,704**
Other Nonexchange Revenue	**4,641**		**4,641**
Transfers-in/out Without Reimbursement	**(5,180)**	**1,760**	**(3,420)**
Other Financing Sources (Nonexchange):			
Transfers-in/out Without Reimbursement			
Imputed Financing	**54**	**24**	**78**
Total Financing Sources	**$610,435**	**$407,226**	**$1,017,661**
Net Cost of Operations	**605,078**	**403,997**	**1,009,075**
Net Change	**5,357**	**3,229**	**8,586**
CUMULATIVE RESULTS OF OPERATIONS	**$256,977**	**$(1,227)**	**$255,750**
NET POSITION	**$279,911**	**$63,920**	**$343,831**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENTS OF BUDGETARY RESOURCES (NOTE 10)

for the years ended September 30, 2019 and September 30, 2018

(in millions)

	FY 2019 Combined Totals Budgetary	FY 2018 Combined Totals Budgetary
Budgetary Resources:		
Unobligated balance from prior year budget authority, net (discretionary and mandatory)	$104,727	$85,963
Appropriations (discretionary and mandatory)	1,631,744	1,504,939
Borrowing authority (discretionary and mandatory)	5	(127)
Spending authority from offsetting collections (discretionary and mandatory)	12,141	564
TOTAL BUDGETARY RESOURCES	**$1,748,617**	**$1,591,339**
Status of Budgetary Resources:		
New Obligations and upward adjustments	$1,654,043	$1,526,914
Unobligated balance, end of year		
Apportioned, unexpired accounts	39,640	34,639
Unapportioned, unexpired accounts	29,386	7,963
Unexpired unobligated balance, end of year	$69,026	$42,602
Expired unobligated balance, end of year	25,548	21,823
Unobligated balance, end of year (total)	$94,574	$64,425
TOTAL BUDGETARY RESOURCES	**$1,748,617**	**$1,591,339**
Outlays, net		
Outlays, net (discretionary and mandatory)	$1,571,678	$1,461,724
Distributed offsetting receipts	(490,978)	(467,019)
AGENCY OUTLAYS, NET (DISCRETIONARY AND MANDATORY)	**$1,080,700**	**$994,705**

The accompanying notes are an integral part of these statements.

STATEMENT OF SOCIAL INSURANCE

75-Year Projection as of January 1, 2019 and Prior Base Years

(in billions)

		Estimates from Prior Years (unaudited)			
	2019 (unaudited)	2018	2017	2016	2015
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 11 and 12)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$11,995	$11,323	$10,679	$10,294	$9,134
SMI Part B	27,556	24,143	21,641	19,386	17,027
SMI Part D	7,181	7,176	6,929	7,659	6,424
Have attained eligibility age (age 65 or over)					
HI	559	525	492	455	382
SMI Part B	5,232	4,725	4,122	3,660	3,300
SMI Part D	1,052	1,015	958	952	887
Those expected to become participants					
HI	11,805	10,959	10,567	9,952	8,386
SMI Part B	6,864	5,586	5,019	4,437	3,668
SMI Part D	3,000	2,932	2,869	3,602	2,845
All current and future participants					
HI	24,359	22,807	21,738	20,701	17,902
SMI Part B	39,652	34,453	30,783	27,484	23,995
SMI Part D	11,232	11,124	10,756	12,213	10,156
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 11 and 12)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$20,028	$18,604	$17,193	$16,800	$14,494
SMI Part B	27,270	23,832	21,392	19,178	16,818
SMI Part D	7,181	7,176	6,929	7,659	6,424
Have attained eligibility age (age 65 and over)					
HI	5,348	5,027	4,539	4,285	3,803
SMI Part B	5,741	5,180	4,531	4,026	3,637
SMI Part D	1,052	1,015	958	952	887
Those expected to become participants					
HI	4,467	3,884	3,539	3,437	2,791
SMI Part B	6,641	5,442	4,860	4,281	3,540
SMI Part D	3,000	2,932	2,869	3,602	2,845
All current and future participants:					
HI	29,843	27,515	25,270	24,523	21,089
SMI Part B	39,652	34,453	30,783	27,484	23,995
SMI Part D	11,232	11,124	10,756	12,213	10,156
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 11 and 12)					
HI	$(5,484)	$(4,708)	$(3,532)	$(3,822)	$(3,187)
SMI Part B					
SMI Part D					
Additional Information					
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 11 and 12)					
HI	$(5,484)	$(4,708)	$(3,532)	$(3,822)	$(3,187)
SMI Part B					
SMI Part D					
Trust Fund assets at start of period					
HI	$200	$202	$199	$194	$197
SMI Part B	96	80	88	68	68
SMI Part D	8	8	8	1	1
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over expenditures (Notes 11 and 12)					
HI	$(5,283)	$(4,506)	$(3,333)	$(3,628)	$(2,990)
SMI Part B	96	80	88	68	68
SMI Part D	8	8	8	1	1

Totals do not necessarily equal the sum of the rounded components. The accompanying notes are an integral part of these financial statements. Current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or both.

STATEMENT OF SOCIAL INSURANCE *(CONTINUED)*

75-Year Projection as of January 1, 2019 and Prior Base Years

(in billions)

		Estimates from Prior Years (unaudited)			
	2019 (unaudited)	2018	2017	2016	2015
Medicare Social Insurance Summary					
Current Participants: *Actuarial present value for the 75-year projection period from or on behalf of:*					
Those who, in the starting year of the projection period, have attained eligibility age:					
Income (excluding interest)	$6,843	$6,266	$5,572	$5,067	$4,569
Expenditures	12,140	11,222	10,027	9,263	8,328
Income less expenditures	(5,297)	(4,957)	(4,455)	(4,196)	(3,759)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	46,731	42,643	39,250	37,339	32,585
Expenditures	54,479	49,612	45,514	43,637	37,736
Income less expenditures	(7,748)	(6,970)	(6,264)	(6,298)	(5,151)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(13,045)	(11,926)	(10,719)	(10,493)	(8,909)
Combined Medicare Trust Fund assets at start of period	305	290	295	263	266
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(12,740)	(11,637)	(10,425)	(10,230)	(8,643)
Future Participants: *Actuarial present value for the 75-year projection period:*					
Income (excluding interest)	$21,669	$19,477	$18,456	$17,992	$14,898
Expenditures	14,108	12,258	11,268	11,320	9,176
Income less expenditures	7,561	7,219	7,187	6,672	5,722
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(5,484)	(4,708)	(3,532)	(3,822)	(3,187)
Combined Medicare Trust Fund assets at start of period	305	290	295	263	266
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$(5,179)	$(4,418)	$(3,237)	$(3,559)	$(2,921)

Totals do not necessarily equal the sum of the rounded components. The accompanying notes are an integral part of these financial statements. Current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or both.

STATEMENT OF CHANGES IN SOCIAL INSURANCE AMOUNTS (UNAUDITED) MEDICARE HOSPITAL AND SUPPLEMENTARY MEDICAL INSURANCE

January 1, 2018 to January 1, 2019

(in billions)

	Actuarial present value over the next 75 years (open group measure)			Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures		
Total Medicare *(Note 13)*					
As of January 1, 2018	$68,385	$73,092	$(4,708)	$290	$(4,418)
Reasons for change					
Change in the valuation period	2,427	2,628	(201)	7	(193)
Change in projection base	251	451	(200)	8	(193)
Changes in the demographic assumptions	(852)	(879)	27		27
Changes in economic and health care assumptions	5,032	5,435	(402)		(402)
Changes in law					
Net changes	6,858	7,634	(776)	15	(761)
As of January 1, 2019	$75,243	$80,727	$(5,484)	$305	$(5,179)
HI: Part A *(Note 13)*					
As of January 1, 2018	$22,807	$27,515	$(4,708)	$202	$(4,506)
Reasons for change					
Change in the valuation period	748	949	(201)	(5)	(206)
Change in projection base	(100)	100	(200)	4	(197)
Changes in the demographic assumptions	(243)	(270)	27		27
Changes in economic and health care assumptions	1,146	1,548	(402)		(402)
Changes in law					
Net changes	1,552	2,328	(776)	(2)	(778)
As of January 1, 2019	$24,359	$29,843	$(5,484)	$200	$(5,283)
SMI: Part B *(Note 13)*					
As of January 1, 2018	$34,453	$34,453		$80	$80
Reasons for change					
Change in the valuation period	1,232	1,232		13	13
Change in projection base	70	70		3	3
Changes in the demographic assumptions	(507)	(507)			
Changes in economic and health care assumptions	4,404	4,404			
Changes in law					
Net changes	5,199	5,199		16	16
As of January 1, 2019	$39,652	$39,652		$96	$96
SMI: Part D *(Note 13)*					
As of January 1, 2018	$11,124	$11,124		$8	$8
Reasons for change					
Change in the valuation period	447	447		(1)	(1)
Change in projection base	281	281		1	1
Changes in the demographic assumptions	(103)	(103)			
Changes in economic and health care assumptions	(517)	(517)			
Changes in law					
Net changes	108	108			
As of January 1, 2019	$11,232	$11,232		$8	$8

Totals do not necessarily equal the sum of the rounded components. The accompanying notes are an integral part of these financial statements.

STATEMENT OF CHANGES IN SOCIAL INSURANCE AMOUNTS (UNAUDITED) MEDICARE HOSPITAL AND SUPPLEMENTARY MEDICAL INSURANCE *(CONTINUED)*

January 1, 2017 to January 1, 2018

(in billions)

	Actuarial present value over the next 75 years (open group measure)			Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures		
Total Medicare *(Note 13)*					
As of January 1, 2017	$63,277	$66,809	$(3,532)	$295	$(3,237)
Reasons for change					
Change in the valuation period	2,355	2,523	(168)		(168)
Change in projection base	(502)	419	(921)	(5)	(926)
Changes in the demographic assumptions	(551)	(985)	434		434
Changes in economic and health care assumptions	3,176	3,162	14		14
Changes in law	629	1,165	(535)		(535)
Net changes	5,107	6,283	(1,176)	(5)	(1,181)
As of January 1, 2018	$68,385	$73,092	$(4,708)	$290	$(4,418)
HI: Part A *(Note 13)*					
As of January 1, 2017	$21,738	$25,270	$(3,532)	$199	$(3,333)
Reasons for change					
Change in the valuation period	747	915	(168)	11	(157)
Change in projection base	(612)	309	(921)	(8)	(929)
Changes in the demographic assumptions	(214)	(648)	434		434
Changes in economic and health care assumptions	1,223	1,208	14		14
Changes in law	(74)	461	(535)		(535)
Net changes	1,069	2,245	(1,176)	3	(1,173)
As of January 1, 2018	$22,807	$27,515	$(4,708)	$202	$(4,506)
SMI: Part B *(Note 13)*					
As of January 1, 2017	$30,783	$30,783		$88	$88
Reasons for change					
Change in the valuation period	1,154	1,154		(10)	(10)
Change in projection base	197	197		2	2
Changes in the demographic assumptions	(358)	(358)			
Changes in economic and health care assumptions	2,087	2,087			
Changes in law	591	591			
Net changes	3,670	3,670		(8)	(8)
As of January 1, 2018	$34,453	$34,453		$80	$80
SMI: Part D *(Note 13)*					
As of January 1, 2017	$10,756	$10,756		$8	$8
Reasons for change					
Change in the valuation period	455	455		(1)	(1)
Change in projection base	(87)	(87)		1	1
Changes in the demographic assumptions	21	21			
Changes in economic and health care assumptions	(133)	(133)			
Changes in law	113	113			
Net changes	368	368			
As of January 1, 2018	$11,124	$11,124		$8	$8

Totals do not necessarily equal the sum of the rounded components. The accompanying notes are an integral part of these financial statements.

NOTE 1:

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Accounting and Presentation

The financial statements were prepared from CMS's accounting records in accordance with accounting principles generally accepted in the United States (GAAP) and the form and content specified by the Office of Management and Budget (OMB) in OMB Circular A-136, *Financial Reporting Requirements*. GAAP for federal entities are the standards prescribed by the Federal Accounting Standards Advisory Board (FASAB). In accordance with Statement of Federal Financial Accounting Standards (SFFAS) 47, *Reporting Entity*, CMS has included all consolidation entities for which it is accountable in this general purpose federal financial report.

The financial statements have been prepared to report the financial position, net cost, changes in net position, and budgetary resources for all programs administered by CMS. CMS's fiscal year ends September 30. These financial statements reflect both accrual and budgetary accounting transactions. Under the accrual method of accounting, revenues are recognized when earned and expenses are recognized when incurred, without regard to the receipt or payment of cash. Budgetary accounting is designed to recognize the obligation of funds according to legal requirements which, in many cases, is made prior to the occurrence of an accrual-based transaction. Budgetary accounting is essential for compliance with legal constraints and controls over the use of federal funds.

Use of Estimates

Financial statements prepared in accordance with GAAP are based on a selection of accounting policies and the application of significant accounting estimates. Some estimates require management to make significant assumptions. Further, the estimates are based on current conditions that may change in the future. Actual results could differ materially from the estimated amounts. The financial statements include information to assist in understanding the effect of changes in assumptions to the related information.

Parent/Child Reporting

CMS is a party to allocation transfers with other federal agencies as both a transferring (parent) entity and/or a receiving (child) entity. Allocation transfers are legal delegations by one agency of its authority to obligate budget authority and outlay funds to another agency. Most financial activity related to these allocation transfers (e.g., budget authority, obligations, outlays) is reported in the financial statements of the parent entity, from which the underlying legislative authority, appropriations and budget apportionments are derived. For example, CMS has a child relationship with the Internal Revenue Service for the payment of Advance Premium Tax Credit, and Basic Health Program payments; these payments are not included in CMS's financial statements.

Funds from Dedicated Collections

Funds from dedicated collections are financed by specifically identified revenues, often supplemented by other financing sources, which remain available over time. Funds from dedicated collections meet the following criteria:

- A statute committing the federal government to use specifically identified revenues and/or other financing sources that are originally provided to the federal government by a non-federal source only for designated activities, benefits or purposes;
- Explicit authority for the fund to retain revenues and other financing sources not used in the current period for future use to finance the designated activities, benefits, or purposes; and
- A requirement to account for and report on the receipt, use, and retention of the revenues and other financing sources that distinguishes the fund from the federal government's general revenues.

CMS's major funds from dedicated collections include:

Medicare Hospital Insurance Trust Fund – Part A

Section 1817 of the *Social Security Act* established the Medicare Hospital Insurance (HI) trust fund. Benefit payments made by the Medicare contractors for Medicare Part A services, as well as administrative costs, are charged to the HI trust fund. A portion of CMS payments to Medicare Advantage plans are also charged to this fund. The financial statements include HI trust

fund activities administered by the Department of the Treasury (Treasury). The HI trust fund has permanent indefinite authority.

Employment tax revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under the *Federal Insurance Contribution Act* (FICA) and *Self-Employment Contribution Act* (SECA). Employees and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI trust fund. Self-employed individuals contribute the full 2.9 percent of their net income. The *Social Security Act* requires the transfer of these contributions from the U.S. Government (general fund) to the HI trust fund based on the amount of wages certified by the Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports.

Medicare Supplementary Medical Insurance Trust Fund – Part B

Section 1841 of the *Social Security Act* established the Supplementary Medical Insurance (SMI) trust fund. Benefit payments made by the Medicare contractors for Medicare Part B services, as well as administrative costs, are charged to the SMI trust fund. A portion of CMS payments to Medicare Advantage plans are also charged to this fund. The financial statements include SMI trust fund activities administered by Treasury. The SMI trust fund has permanent indefinite authority.

SMI benefits and administrative expenses are financed primarily by monthly premiums paid by Medicare beneficiaries with matching by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the *Social Security Act* authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as the method to fully compensate the trust fund if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

Medicare Supplementary Medical Insurance Trust Fund – Part D

The *Medicare Modernization Act of 2003* (MMA), established the Medicare Prescription Drug Benefit – Part D. Medicare also helps employers or unions continue to provide retiree drug coverage that meets Medicare's standards through the Retiree Drug Subsidy (RDS). In addition, the Low Income Subsidy (LIS) helps those with limited income and resources.

The *Patient Protection and Affordable Care Act* (PPACA) provides that beneficiary cost sharing in the Part D coverage gap is reduced for brand-name and generic drugs by 7 percentage points per year until coinsurance is 25 percent by 2019. Part D is considered part of the SMI trust fund and is reported in the SMI column of the financial statements.

Medicare and Medicaid Integrity Programs

The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) established the Medicare Integrity Program at section 1893 of the Social Security Act. HIPAA section 201 also established the Health Care Fraud and Abuse Control Account, which provides a dedicated appropriation for carrying out the Medicare Integrity Program. The Medicare Integrity Program is funded by the HI trust fund.

Separately, the Medicaid Integrity Program was established by the *Deficit Reduction Act of 2005* (DRA), and codified at section 1936 of the Social Security Act. The Medicaid Integrity Program represents the federal government's first national strategy to detect and prevent Medicaid fraud and abuse.

Payments to the Health Care Trust Funds Appropriation

The *Social Security Act* provides for payments to the HI and SMI trust funds for SMI (e.g., appropriated funds to provide for federal matching of SMI premium collections) and HI (e.g., for the Uninsured and Federal Uninsured Payments). The Act also prescribes that funds covering the Medicare Prescription Drug Benefit and associated administrative costs, retiree drug coverage, reimbursements to the states and Transitional Assistance benefits be transferred from the general fund to the SMI trust fund; this occurs via the Payments to the Health Care Trust Funds account. The Act also prescribes that criminal fines and civil monetary penalties arising from health care cases be transferred to the Health Care Fraud and Abuse Control (HCFAC) account of the HI trust fund as well as payments to support FBI activities related to health care fraud and abuse activities. There is permanent indefinite authority for the transfer of general funds containing criminal fines and civil monetary penalties to the HCFAC account of the HI trust

fund. In addition, funds are provided by the Payments to the Health Care Trust Funds account to cover CMS's administrative costs that are not related to the Medicare program. To prevent duplicative reporting, the Fund Balance, Unexpended Appropriation, Financing Sources and Expenditure Transfers of this appropriation are reported only in the Medicare HI and SMI columns of the financial statements.

There is permanent indefinite authority for the transfer of general funds to the HI trust fund in amounts equal to SECA tax credits and receipts from taxation of Old Age Survivors and Disability Insurance (OASDI) beneficiaries. The Social Security Amendments of 1994, provided for additional tax payments from Social Security OASDI benefits and Tier 1 Railroad Retirement beneficiaries.

The Health (Other Funds) programs managed by CMS include:

Medicaid

Medicaid is administered via grant awards, which limit the funds that can be drawn by the states to cover current expenses. Medicaid also provides funding for the Health Information Technology for Economic and Clinical Health (HITECH) incentive payments made to the states. Beginning January 1, 2014, the PPACA expanded eligibility (based upon a state's choice) for Medicaid to certain low-income adults with the federal government paying 100% of claims for those newly eligible under Medicaid expansion for the first three years, phasing down to 90% in calendar year (CY) 2020 and beyond (the rate for CY 2018 is 94% and for CY 2019 is 93%).

CHIP

CHIP is administered via grant awards, which limit the funds that can be drawn by the states to cover current expenses.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) established a Child Enrollment Contingency Fund to cover shortfalls in funding for the states. This fund is invested in interest-bearing Treasury securities.

State Grants and Demonstrations

Several grant programs have been established through the 75-0516 State Grants and Demonstrations appropriation fund group. With the passage of the PPACA, several new grants were included in the account and the availability of funds for other grants was extended.

The *Deficit Reduction Act* Section 6201 provided Federal payments for several projects, including the Money Follows the Person demonstration, the Medicaid Integrity Program, and the establishment of alternative non-emergency providers.

CHIPRA provided for transition grants to provide funding to states to assist them in transitioning to a prospective payment system and grants to improve outreach and enrollment.

Program Management User Fees: Medicare Advantage, Clinical Laboratory Improvement Program, Exchange, and Other User Fees

This account operates as a revolving fund without fiscal year restriction. Medicare Advantage plans are required to make payments for their share of the estimated costs related to enrollment, dissemination of information, and certain counseling and assistance programs. These user fees are devoted to educational efforts for beneficiaries and outreach partners. The Clinical Laboratory Improvement Amendments of 1988 (CLIA) marked the first comprehensive effort by the federal government to regulate medical laboratory testing. Fees for registration, certificates, and compliance determination of all U.S. clinical laboratories are collected to finance the program. Beginning January 1, 2014, the PPACA requires the collection of a user fee from each issuer offering coverage through a Federally-facilitated Exchange to offset operating costs. Other user fees are charged for certification of some nursing facilities and for sale of the data on nursing facilities surveys, for coordination of benefits for the Part D program, and for new providers of medical or other items or services. Proceeds from the sale of data from the public use files and publications under the *Freedom of Information Act* (FOIA) are also credited to this fund.

Program Management Appropriation

The Program Management Appropriation provides CMS with the major source of administrative funds to manage the Medicare and Medicaid programs. The funds for this activity are provided from the HI and SMI trust funds, the general fund, and reimbursable activities. The Payments

to the Health Care Trust Funds Appropriation reimburses the Medicare HI trust fund to cover the Health programs' share of CMS administrative costs. User fees collected from Medicare Advantage plans seeking federal qualification and funds received from other federal agencies to reimburse CMS for services performed for them are credited to the Program Management Appropriation.

The cost related to the Program Management Appropriation is allocated a based on the CMS cost allocation system. It is reported under the Program Management (administrative) and Other (user fees) columns in the supplemental statements in the Supplementary Information section. Both of these activities are reported as dedicated collections.

The American Recovery and Reinvestment Act of 2009 (ARRA) provides additional funding for Program Management to manage and operate health information technology to develop performance measures and payment systems, to make incentive payments, and to validate the appropriateness of those payments.

The PPACA provides additional funding for Program Management to address activities such as Medicaid adult health quality measures, a nationwide program for national and state background checks on long-term care employees, evaluations of community prevention and wellness programs, quality measurements, State Health Insurance Programs, the Medicare Independence at Home Demonstration program, and the complex diagnostic laboratory tests demonstration project.

Description of Concepts Unique to CMS and/or the Federal Government

Fund Balances with Treasury are funds with Treasury that are primarily available to pay current liabilities. Cash receipts and disbursements are processed by Treasury. CMS also maintains lockboxes at commercial banks for the deposit of SMI premiums from the states and third parties.

Investments consist of trust fund (Dedicated collections) investments which are investments (plus the accrued interest on investments) held by Treasury. The FASAB SFFAS 27 prescribes certain disclosures concerning dedicated collections investments, such as the fact that cash generated from funds from dedicated collections is used by the U.S. Treasury for general Government purposes and that, upon redemption of investments to make expenditures, the Treasury will finance those expenditures in the same manner that it finances all other expenditures. Additionally, investments consist of the CHIP Child Enrollment Contingency Fund investments (net of any accrued amortized or unrealized discounts) also held by Treasury (see Note 3).

Unexpended Appropriations include the portion of CMS's appropriations represented by undelivered orders and unobligated balances.

Benefit Payments are payments made by Medicare contractors, CMS, and State Medicaid agencies to health care providers for their services. CMS recognizes the cost associated with payments in the period incurred and based on entitlement. In accordance with Public Law and existing Federal accounting standards, no expense or liability is recorded for any future payment to be made on behalf of current workers contributing to the Medicare HI trust fund.

State Phased-Down Contributions are reimbursements to the SMI trust fund for the Federal assumption of Medicaid prescription drug costs for dually eligible beneficiaries pursuant to the MMA. The MMA prescribes a formula for computing the states' contributions and allows states to make monthly payments. Amounts billed and collected under the State Phased-Down provision are recognized as a reduction to expense.

Medicare Premiums Collected are used to help finance benefits and administrative expenses. Premiums collected are for Part A, Part B, Medicare Advantage and Part D.

Budgetary Financing Sources (Other than Exchange Revenues) arise primarily from exercise of the Government's power to demand payments from the public (e.g., taxes, duties, fines, and penalties). These include appropriations used, transfers of assets from other Government entities, donations, and imputed financing. The major sources of Budgetary financing sources are as follows:

- **Appropriations Used and Federal Matching Contributions** are described in the Medicare Premiums Collected section above. For financial statement purposes, appropriations used are recognized as a financing source as expenses are

incurred. A transfer of general funds to the HI trust fund in an amount equal to SECA tax credits is made through the Payments to the Health Care Trust Funds account.

- **Nonexchange Revenues** arise primarily from the exercise of the Government's power to demand payment from the public (e.g., taxes, duties, fines and penalties) but also include donations. Employment tax revenue is the primary source of financing for Medicare's HI program. Interest earned on HI and SMI trust fund investments, as well as on the Child Enrollment Contingency Fund investments, is also reported as nonexchange revenue.

Obligations Incurred consists of expended authority and the change in undelivered orders. OMB has exempted CMS from the Circular No. A-11 requirement to report Medicare's refunds of prior year obligations separately from refunds of current year obligations on the SF-133. OMB has mandated that CMS report all Medicare cash collections as an offsetting receipt.

The PPACA

The PPACA provided funding for the establishment by CMS of a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. It also allowed for the establishment of a Center for Consumer Information and Insurance Oversight (CCIIO). One of the main programs under CCIIO is the Health Insurance Exchanges (the "Exchanges"). A brief description of the remaining programs is presented below. There were two additional programs - Transitional Reinsurance and Risk Corridors – that are no longer in operation.

Health Insurance Exchanges

Grants have been provided to the states to establish Health Insurance Exchanges. The initial grants were made by HHS to the states "not later than one (1) year after the date of enactment." Thus, HHS made the initial grants by March 23, 2011. Subsequent grants were issued by CMS through December 31, 2014, after which time no further grants could be made. All Exchanges were launched on October 1, 2013.

Risk Adjustment Program

The Risk Adjustment program is a permanent program. It applies to non-grandfathered individual and small group plans inside and outside the Exchanges. It provides payments to health insurance issuers that disproportionately attract higher-risk populations (such as individuals with chronic conditions) and transfers funds from plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to protect against adverse selection. States that operate a State-based Exchange are eligible to establish a risk adjustment program. States operating a risk adjustment program may have an entity other than the Exchange perform this function. CMS operates a risk adjustment program for each state that does not operate its own risk adjustment program.

Changes, Reclassifications and Adjustments

Effective FY 2019, the Statement of Net Cost (SNC) has changed to separately show CMS's costs for its programs by benefit/program expenses and program management. Changes have been made to the principal and supplementary SNC to reflect these changes for both the current and prior year for comparability. Additionally, the change to report program management separately is shown in the other supplementary statements. These changes, as well as various changes to the footnotes and any needed reclassifications, have been made in order to comply with the new requirements of OMB's Circular A-136.

NOTE 2:

FUND BALANCE WITH TREASURY

(Dollars in Millions)

	FY 2019	FY 2018
Status of Fund Balances with Treasury:		
Unobligated Balance:		
Available	**$39,640**	**$34,639**
Unavailable	**54,934**	**29,786**
Obligated Balance not yet Disbursed	**149,132**	**137,140**
Non-Budgetary FBWT	**(72,910)**	**(65,893)**
Total Status of Fund Balances with Treasury	**$170,796**	**$135,672**

The Unobligated Balance Available includes $16,609 million ($14,734 million in FY 2018), which is restricted for future use and is not apportioned for current use for PPACA, CHIP, Program Management, and State Grants and Demonstrations.

NOTE 3:

INVESTMENTS

(Dollars in Millions)

FY 2019 **Medicare Investments** ***(Dedicated Collections)***	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2020	1.625%	$13,460
Bonds	June 2020 to June 2029	1.875 - 5.125%	185,165
Accrued Interest			1,490
Total HI TF Investments			**$200,115**
SMI TF			
Certificates	June 2020	1.625 - 2.125%	$20,450
Bonds	June 2022 to June 2034	1.875 - 5.000%	84,267
Accrued Interest			546
Total SMI TF Investments			**$105,263**
Total Medicare Investments			**$305,378**

FY 2018 **Medicare Investments** ***(Dedicated Collections)***	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2019	2 7/8%	$14,087
Bonds	June 2019 to June 2028	1 7/8 - 5 1/8%	188,718
Accrued Interest			1,682
Total HI TF Investments			**$204,487**
SMI TF			
Certificates	June 2019	2 7/8 - 3%	$23,511
Bonds	June 2020 to June 2033	1 7/8 - 5%	74,687
Accrued Interest			568
Total SMI TF Investments			**$98,766**
Total Medicare Investments			**$303,253**

Sections 1817 for HI and 1841 for SMI of the *Social Security Act* require that trust fund investments not necessary to meet current expenditures be invested in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December) and was adjusted to include an accrual for interest earned from July 1 to September 30.

The federal government does not set aside assets to pay future benefits or other expenditures associated with the HI trust fund or the SMI trust fund. The cash receipts collected from the public for a fund from dedicated collections are deposited in the U.S. Treasury, which uses the cash for general government purposes. Treasury securities are issued to the HI and SMI trust funds as evidence of their receipts. Treasury securities are an asset to the HI and SMI trust funds and a liability to the U.S. Treasury. Because the HI and SMI trust funds and the U.S. Treasury are both parts of the federal government, these assets and liabilities offset each other from the standpoint of the federal government as a whole. For this reason, they do not represent an asset or a liability in the U.S. government-wide financial statements.

Treasury securities provide the HI and SMI trust funds with authority to draw upon the U.S. Treasury to make future benefit payments or other expenditures. When the HI and SMI trust funds require redemption of these securities to make expenditures, the government finances those expenditures out of accumulated cash balances, by raising taxes, raising the federal match of SMI premiums or other receipts, by borrowing from the public or repaying less debt, or by curtailing other expenditures. This is the same way that the government finances all other expenditures.

NOTE 3:

CMS INVESTMENT SUMMARY

(Dollars in Millions)

FY 2019	Medicare (Dedicated Collections)			Consolidated Total
	HI TF	SMI TF	Total	
Certificates	$13,460	$20,450	$33,910	$33,910
Bonds	185,165	84,267	269,432	269,432
Accrued Interest	1,490	546	2,036	2,036
Total Investments	**$200,115**	**$105,263**	**$305,378**	**$305,378**

FY 2018	Medicare (Dedicated Collections)			Consolidated Total
	HI TF	SMI TF	Total	
Certificates	$14,087	$23,511	$37,598	$37,598
Bonds	188,718	74,687	263,405	263,405
Accrued Interest	1,682	568	2,250	2,250
Total Investments	**$204,487**	**$98,766**	**$303,253**	**$303,253**

NOTE 4:

ACCOUNTS RECEIVABLE, NET

(Dollars in Millions)

FY 2019	Accounts Receivable Principal	Interest Receivable	Accounts Receivable Gross	Allowance	Net CMS Receivables
Intragovernmental					
Entity	$589		$589		$589
Total Intragovernmental	$589		$589		$589
With the Public					
Entity					
Medicare FFS	$8,606		$8,606	$(3,502)	$5,104
Medicare Advantage/Prescription Drug Program	9,909		9,909	(5)	9,904
Medicaid	4,943		4,943	(785)	4,158
CHIP	204		204		204
Other	4,381		4,381	(427)	3,954
Non-Entity	4	72	76	(44)	32
Total With the Public	$28,047	$72	$28,119	$(4,763)	$23,356

FY 2018	Accounts Receivable Principal	Interest Receivable	Accounts Receivable Gross	Allowance	Net CMS Receivables
Intragovernmental					
Entity	$612		$612		$612
Total Intragovernmental	$612		$612		$612
With the Public					
Entity					
Medicare FFS	$7,917		$7,917	$(3,281)	$4,636
Medicare Advantage/Prescription Drug Program	13,122		13,122	(5)	13,117
Medicaid	5,101		5,101	(957)	4,144
Other	4,424		4,424	(323)	4,101
Non-Entity	4	$65	69	(32)	37
Total With the Public	$30,568	$65	$30,633	$(4,598)	$26,035

Intragovernmental accounts receivable represent CMS claims for payment from other federal agencies. CMS accounts receivable for transfers from the HI and SMI trust funds maintained by the Treasury Bureau of Public Debt (BPD) are eliminated against BPD's corresponding liabilities to CMS in the Consolidated Balance Sheets. No allowance for uncollectible amounts is established for intragovernmental accounts receivable because they are considered fully collectible.

Accounts receivable with the public are primarily composed of provider and beneficiary overpayments, Medicare Prescription drug overpayments, Medicare premiums, State phased-down contributions, Medicaid/CHIP overpayments, audit disallowances, civil monetary penalties and restitutions [restitutions balances for FY 2019 are $2.2 billion (gross) and $67 million (net of allowance) [$2 billion (gross) and $65 million (net of allowance) in FY 2018], the recognition of Medicare secondary payer (MSP) accounts receivable, and Exchange activities. Accounts receivable with the public is presented net of an allowance for uncollectible amounts. The allowance is based on past collection experience and an analysis of outstanding balances. For Medicare accounts receivable, the allowance for uncollectible accounts receivable derived this year has been calculated from data based on the agency's collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the past five years. The Medicaid accounts receivable has been recorded at a net realizable value based on a historic analysis of actual recoveries and the rate of disallowances found in favor of the states. The other accounts receivable have been recorded to account for amounts due related to collections for Exchange activities.

NOTE 5:

ENTITLEMENT BENEFITS DUE AND PAYABLE

(Dollars in Millions)

	FY 2019	FY 2018
Medicare FFS	**$54,752**	**$51,031**
Medicare Advantage/Prescription Drug Program	**16,839**	**11,165**
Medicaid	**37,147**	**35,570**
CHIP	**1,360**	**1,377**
Other	**2**	**5**
TOTALS	**$110,100**	**$99,148**

Entitlement Benefits Due and Payable represents a liability for Medicare FFS, Medicare Advantage and the Prescription Drug Program, Medicaid, and CHIP owed to the public for medical services/claims incurred but not reported (IBNR) as of the end of the reporting period.

The Medicare FFS liability is primarily an actuarial liability which represents (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (d) periodic interim payments for services rendered in the current fiscal year but paid in the subsequent fiscal year and (e) an estimate of retroactive settlements of cost reports. The September 30, 2019 and 2018 estimate also includes amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals and teaching hospitals as well as amounts which may be due/owed to hospitals for adjusted prospective payments.

The Medicare Advantage and Prescription Drug program liability represents amounts owed to plans after the completion of the Prescription Drug payment reconciliation and estimates relating to risk and other payment related adjustments including the estimate for the first nine months of calendar year 2019. In addition, it includes an estimate of payments to plan sponsors of retiree prescription drug coverage incurred but not yet paid as of September 30, 2019.

The Medicaid and CHIP estimates represent the net Federal share of expenses that have been incurred by the states but not yet reported to CMS.

The Other liability line item includes estimates of payments due to those participating in Exchange activities.

NOTE 6:

CONTINGENCIES

(Dollars in Millions)

The contingencies balance as of September 30, 2019 is $10,032 million ($7,118 million in FY 2018), which includes $9,859 million for Medicaid ($6,277 million in FY 2018) for audit and program disallowances and reimbursement of state plan amendments. Additionally, CMS is a party in various administrative proceedings, legal actions, and tort claims which may ultimately result in settlements or decisions adverse to the federal government. CMS accrues contingent liabilities where a loss is determined to be probable and the amount can be estimated. CMS may owe amounts to providers for previous years' disputed cost report and claims adjustments. Other contingencies exist where losses are reasonably possible, and an estimate can be determined or an estimate of the range of possible liability has been determined. CMS does not record an accrual for a contingent liability if it is not estimable and probable but does disclose those contingencies in the financial statements, if the future settlement could be material to the financial statements.

NOTE 7:

LIABILITIES NOT COVERED BY BUDGETARY RESOURCES

(Dollars in Millions)

Liabilities not covered by budgetary resources are incurred when funding has not yet been made available through Congressional appropriations or current earnings. CMS recognizes such liabilities for employee annual leave earned but not taken and amounts billed by the Department of Labor for *Federal Employee's Compensation Act* (FECA) payments. For CMS revolving funds, all liabilities are funded as they occur.

Additionally, the *Balanced Budget Act of 2015* (Section 601) authorized a transfer from the general fund to SMI, to temporarily replace the reduction in Part B premiums for calendar years 2016 and 2017. Section 601 created an "additional premium" charged alongside the normal Part B monthly premiums which will be used to pay back the general fund transfer without interest. These repayments are transferred quarterly. As of September 30, 2019, $3,152 million ($5,024 million in FY 2018) is still owed.

Starting January 1, 2014, the PPACA provides for a permanent Risk Adjustment program and a temporary transitional Reinsurance program administered by CMS. With these programs, amounts may be owed to or due from private health insurers who participate in the Exchange that began on January 1, 2014, as well as the broader individual and small group markets. The Reinsurance program is no longer in operation and there are no accruals that have been recorded for this program as of September 30, 2019. The Risk Adjustment program will be administered in a budget neutral manner in any calendar year and collections will not be due and payments will not be made until the year following the calendar year for which the program operates. As of September 30, 2019, accruals were recorded to cover future payments, collections, sequestration, and appeals that are still due for/pertain to program years 2017 and 2018 for the Risk Adjustment program and are reflected on the Other line below.

FY 2019 Intragovernmental	Medicare (Dedicated Collections)								
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
Other					$33	$2	$35		$35
Total Intragovernmental					33	2	35		35
Federal Employee and Veterans' Benefits						14	14		14
Other	$4	$1			5,067	48	5,120		5,120
Contingencies	173		$9,859				10,032		10,032
Total Liabilities Not Covered by Budgetary Resources	177	1	9,859		5,100	64	15,201		15,201
Total Liabilities Covered by Budgetary Resources	78,414	84,884	37,267	$1,360	3,149	150	205,224	$(87,070)	118,154
Total Liabilities Not Requiring Budgetary Resources	158	633			87		878		878
TOTAL LIABILITIES	$78,749	$85,518	$47,126	$1,360	$8,336	$214	$221,303	$(87,070)	$134,233

FY 2018 Intragovernmental	Medicare (Dedicated Collections)								
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
Other	$1	$1			$1	$38	$41		$41
Total Intragovernmental	1	1			1	38	41		41
Federal Employee and Veterans' Benefits	3	7			3		13		13
Other	16	24	$2		6,945	6	6,993		6,993
Contingencies	841		6,277				7,118		7,118
Total Liabilities Not Covered by Budgetary Resources	861	32	6,279		6,949	44	14,165		14,165
Total Liabilities Covered by Budgetary Resources	71,226	73,429	35,611	$1,379	2,979	65	184,689	$(76,060)	108,629
Total Liabilities Not Requiring Budgetary Resources	80	599				63	742		742
TOTAL LIABILITIES	$72,167	$74,060	$41,890	$1,379	$9,928	$172	$199,596	$(76,060)	$123,536

NOTE 8:

NET COST OF OPERATIONS

(Dollars in Millions)

	Medicare (Dedicated Collections)		Health			
FY 2019	**HI TF**	**SMI TF**	**Medicaid**	**CHIP**	**Other**	**Consolidated Total**
BENEFIT/PROGRAM COSTS						
Medicare						
Fee for Service	$204,592	$212,311				$416,903
Medicare Advantage/ Managed Care	115,165	149,163				264,328
Prescription Drug (Part D)		76,866				76,866
Medicaid/CHIP			$411,355	$17,470		428,825
Other					$8,847	8,847
Bad Debt Expense and Writeoffs	101	44	(172)		66	39
Total Benefit/Program Costs	**$319,858**	**$438,384**	**$411,183**	**$17,470**	**$8,913**	**$1,195,808**
OPERATING COSTS						
Medicare Integrity Program	$1,342					$1,342
Quality Improvement Organizations	604	$272				876
Program Management and Other Expenses	2,136	1,274	$149	$15	$688	4,262
Total Operating Costs	4,082	1,546	149	15	688	6,480
TOTAL COSTS	**$323,940**	**$439,930**	**$411,332**	**$17,485**	**$9,601**	**$1,202,288**
Less: Exchange Revenues:						
Medicare Premiums	$4,128	$102,627				$106,755
Other Exchange Revenues	4	10			$8,248	8,262
Total Exchange Revenues	4,132	102,637			8,248	115,017
Intra-CMS Eliminations	(153)	(125)			278	
TOTAL NET COST OF OPERATIONS	**$319,655**	**$337,168**	**$411,332**	**$17,485**	**$1,631**	**$1,087,271**

NOTE 8:

NET COST OF OPERATIONS *(CONTINUED)*

(Dollars in Millions)

	Medicare (Dedicated Collections)		Health			
FY 2018	**HI TF**	**SMI TF**	**Medicaid**	**CHIP**	**Other**	**Consolidated Total**
BENEFIT/PROGRAM COSTS						
Medicare						
Fee for Service	$210,541	$211,827				$422,368
Medicare Advantage/ Managed Care	92,182	117,727				209,909
Prescription Drug (Part D)		78,976				78,976
Medicaid/CHIP			$383,619	$17,315		400,934
Other					$(5,100)	(5,100)
Bad Debt Expense and Writeoffs	549	164	(36)		(5)	672
Total Benefit/Program Costs	$303,272	$408,694	$383,583	$17,315	$(5,105)	$1,107,759
OPERATING COSTS						
Medicare Integrity Program	$1,254					$1,254
Quality Improvement Organizations	638	$295				933
Program Management and Other Expenses	1,023	1,977	$155	$15	$2,449	5,619
Total Operating Costs	2,915	2,272	155	15	2,449	7,806
TOTAL COSTS	$306,187	$410,966	$383,738	$17,330	$(2,656)	$1,115,565
Less: Exchange Revenues:						
Medicare Premiums	$3,983	$96,204				$100,187
Other Exchange Revenues	45	90	$8	$1	$6,159	6,303
Total Exchange Revenues	4,028	96,294	8	1	6,159	106,490
TOTAL NET COST OF OPERATIONS	$302,159	$314,672	$383,730	$17,329	$(8,815)	$1,009,075

For purposes of financial statement presentation, non-CMS administrative costs are considered expenses to the Medicare trust funds when outlayed by Treasury even though some funds may have been used to pay for assets such as property and equipment. CMS administrative costs have been allocated to programs based on the CMS cost allocation system. Program Management costs allocated to the Medicare program include $2,248 million ($2,334 million in FY 2018) paid to Medicare contractors to carry out their responsibilities as CMS's agents in the administration of the Medicare program.

For reporting purposes, Medicare Part D expense has been reduced by actual and accrued reimbursements made by the states pursuant to the State Phased-Down provision. The FY 2019 Part D expense of $76,866 million ($78,976 million in FY 2018) is net of State reimbursements of $13,897 million ($11,785 million in FY 2018). The gross expense would have been $90,763 million ($90,761 million in FY 2018).

NOTE 9:

FUNDS FROM DEDICATED COLLECTIONS

(Dollars in Millions)

CMS has designated as funds from dedicated collections the Medicare HI and SMI trust funds which also include the Payments to the Health Care Trust Funds appropriation and the HCFAC account. Other Non-Medicare includes user fees and program management (administrative) activities. Condensed information showing assets, liabilities, gross cost, exchange and nonexchange revenues and changes in net position appears below.

	Medicare	Other Non-Medicare	Eliminations	Total Dedicated Collections
Balance Sheet as of September 30, 2019				
ASSETS				
Fund Balance with Treasury	$63,442	$7,175		$70,617
Investments	305,378			305,378
Other Assets	93,327	13,459	$(86,036)	20,750
TOTAL ASSETS	**$462,147**	**$20,634**	**$(86,036)**	**$396,745**
LIABILITIES				
Entitlement Benefits Due and Payable	$71,591	$3		$71,594
Other Liabilities	92,676	8,166	$(86,036)	14,806
TOTAL LIABILITIES	**$164,267**	**$8,169**	**$(86,036)**	**$86,400**
Unexpended Appropriations	$57,895	$73		$57,968
Cumulative Results of Operations	239,985	12,392		252,377
TOTAL LIABILITIES AND NET POSITION	**$462,147**	**$20,634**	**$(86,036)**	**$396,745**
Statement of Net Cost for the year ended September 30, 2019				
Benefit/Program Costs	$758,242	$7,439		$765,681
Operating Costs	1,656	4,698	$(278)	6,076
Total Costs	759,898	12,137	(278)	771,757
Less Exchange Revenues	106,755	8,253	(278)	114,730
Net Cost of Operations	**653,143**	**3,884**		**657,027**
Statement of Changes in Net Position for the year ended September 30, 2019				
Net Position, Beginning of Period	$275,348	$4,563		$279,911
Taxes and Other Nonexchange Revenue	294,129			294,129
Other Financing Sources	381,546	11,786		393,332
Net Cost of Operations	**653,143**	**3,884**		**657,027**
Change in Net Position	**22,532**	**7,902**		**30,434**
NET POSITION, END OF PERIOD	**$297,880**	**$12,465**		**$310,345**

NOTE 9:

FUNDS FROM DEDICATED COLLECTIONS *(CONTINUED)*

(Dollars in Millions)

	Medicare	Other Non-Medicare	Eliminations	Total Dedicated Collections
Balance Sheet as of September 30, 2018				
ASSETS				
Fund Balance with Treasury	$27,389	$7,203		$34,592
Investments	303,253			303,253
Other Assets	90,933	6,530	$(74,037)	23,426
TOTAL ASSETS	**$421,575**	**$13,733**	**$(74,037)**	**$361,271**
LIABILITIES				
Entitlement Benefits Due and Payable	$62,196	$3		$62,199
Other Liabilities	84,031	9,167	$(74,037)	19,161
TOTAL LIABILITIES	**$146,227**	**$9,170**	**$(74,037)**	**$81,360**
Unexpended Appropriations	$22,855	$79		$22,934
Cumulative Results of Operations	252,493	4,484		256,977
TOTAL LIABILITIES AND NET POSITION	**$421,575**	**$13,733**	**$(74,037)**	**$361,271**
Statement of Net Cost for the year ended September 30, 2018				
Benefit/Program Costs	$711,253	$(6,608)		$704,645
Operating Costs	5,900	946		6,846
Total Costs	717,153	(5,662)		711,491
Less Exchange Revenues	100,322	6,091		106,413
Net Cost of Operations	**616,831**	**(11,753)**		**605,078**
Statement of Changes in Net Position for the year ended September 30, 2018				
Net Position, Beginning of Period	$276,993	$(8,086)		$268,907
Taxes and Other Nonexchange Revenue	278,884			278,884
Other Financing Sources	336,302	896		337,198
Less Net Cost of Operations	616,831	(11,753)		605,078
Change in Net Position	**(1,645)**	**12,649**		**11,004**
NET POSITION, END OF PERIOD	**$275,348**	**$4,563**		**$279,911**

NOTE 10:

STATEMENT OF BUDGETARY RESOURCES DISCLOSURES

(Dollars in Millions)

Legal Arrangements Affecting Use of Unobligated Balances

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Combined Statement of Budgetary Resources (SBR). The portion of trust fund receipts collected in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in that fiscal year is precluded by law from being available for obligation. This excess of receipts over obligations is Temporarily Not Available Pursuant to Public Law and is included in the calculation for appropriations on the Statement of Budgetary Resources and, therefore, is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the trust funds and currently become available for obligation as needed. The entire trust fund balances in the amount of $223,554 million ($230,855 million in FY 2018) are included in Investments on the Balance Sheets. The following table presents trust fund activities and balances for FY 2019 and FY 2018 (in millions):

	FY 2019 Combined Balance	FY 2018 Combined Balance
TRUST FUND BALANCE, BEGINNING	**$230,855**	**$207,353**
Receipts	**695,681**	**653,853**
Less Obligations	**702,982**	**630,351**
Excess (Shortage) of Receipts Over Obligations	**(7,301)**	**23,502**
TRUST FUND BALANCE, ENDING	**$223,554**	**$230,855**

Explanations of Differences Between the Combined Statement of Budgetary Resources and the Budget of the United States Government for FY 2018

CMS reconciled the amounts of the FY 2018 column of the SBR to the actual amounts for FY 2018 from the Appendix in the FY 2019 President's Budget for budgetary resources, obligations incurred, offsetting receipts and net outlays (gross outlays less offsetting collections). The Budget with the actual amounts for the current year (FY 2019) will be available at a later date at https://www.whitehouse.gov/omb/budget/.

FY 2018	Budgetary Resources	Obligations Incurred	Distributed Offsetting Receipts	Net Outlays
Combined Statement of Budgetary Resources	**$1,591,339**	**$1,526,914**	**$467,019**	**$1,461,724**
Expired Accounts	**(21,994)**			
Other	**4,362**	**4,360**	**(1)**	**4,165**
Budget of the US Govt (2018 Actual)	**$1,573,707**	**$1,531,274**	**$467,018**	**$1,465,889**

For the budgetary resources reconciliation, the amount used from the President's Budget was the total budgetary resources available for obligation. The Expired Accounts line included expired authority, recoveries and other amounts included in the Combined SBR that are not included in the President's Budget. The Other line contained in the SBR and also not in the President's Budget for budgetary resources, obligations incurred and net outlays are CMS amounts reported on CDC and OS statements and GTAS adjustments.

Undelivered Orders at the End of the Period

The amount of budgetary resources obligated for undelivered orders totaled $34,789 million ($34,497 million FY18).

	FY 2019		FY 2018	
	Federal	Non-Federal	Federal	Non-Federal
Undelivered orders (unpaid)	$379	$34,182	$389	$33,852
Undelivered orders (paid)	3	225	27	229
Total	$382	$34,407	$416	$34,081

NOTE 11:

STATEMENT OF SOCIAL INSURANCE (UNAUDITED)

The Statement of Social Insurance (SOSI) presents, for the 75-year projection period, the present values of the income and expenditures of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds for both the open group and closed group of participants. The open group consists of all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program. The closed group comprises only current participants—those who attain age 15 or older in the first year of the projection period.

Actuarial present values are computed under the intermediate set of assumptions specified in the 2019 Annual Report of the Medicare Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and healthcare-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent completed review occurred with the 2016-2017 Technical Review Panel.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. The Trustees' projections are based on the current Medicare laws, regulations, and policies in effect on April 22, 2019, with one exception, and do not reflect any actual or anticipated changes subsequent to that date. The one exception is that the projections disregard payment reductions that would result from the projected depletion of the Medicare Hospital Insurance trust fund. The present values are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments and administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of FICA and SECA payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, premiums paid by, or on behalf of, aged uninsured beneficiaries, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and transfers from the general fund of the Treasury. Fees related to brand-name prescription drugs, required by the *Affordable Care Act*, are included as income for Part B of SMI, and transfers from State governments are included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

Actuarial present values of estimated future income (excluding interest) and estimated future expenditures are presented for three different groups of participants: (1) current participants who have not yet attained eligibility age; (2) current participants who have attained eligibility age; and (3) new entrants, those who are expected to become participants in the future. Current participants are the closed group of individuals who are at least age 15 at the start of the projection period and are expected to participate in the program as either taxpayers, beneficiaries, or both.

The SOSI sets forth, for each of these three groups, the projected actuarial present values of all future expenditures and of all future non-interest income for the next 75 years. The SOSI also presents the net present values of future net cash flows, which are calculated by subtracting the actuarial present value of estimated future expenditures from the actuarial present value of estimated future income. The HI trust fund is expected to have an actuarial deficit indicating that, under these assumptions as to economic, demographic, and health care cost trends for the future, HI income is expected to fall short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar deficits because each account is automatically in financial balance every year due to its statutory financing mechanism.

In addition to the actuarial present value of the estimated future excess of income (excluding interest) over expenditures for the open group of participants, the SOSI also sets forth the same calculation for the closed group of participants. The closed group consists of those who, in the starting year of the projection period, have attained retirement eligibility age or have attained ages 15 through 64. In order to calculate the actuarial net present value of the excess of estimated future income over estimated future expenditures

for the closed group, the actuarial present value of estimated future expenditures for or on behalf of current participants is subtracted from the actuarial present value of estimated future income (excluding interest) for current participants.

Since its enactment in 1965, the Medicare program has experienced substantial variability in expenditure growth rates. These different rates of growth have reflected new developments in medical care, demographic factors affecting the relative number and average age of beneficiaries and covered workers, and numerous economic factors. The future cost of Medicare will also be affected by further changes in these inherently uncertain factors and by the application of future payment updates. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and could differ materially from the projections shown in the SOSI. Moreover, these differences could affect the long-term sustainability of this social insurance program.

To develop projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the trust funds will continue to operate under the law in effect on April 22, 2019, except that the projections disregard payment reductions that would result from the projected depletion of the Medicare Hospital Insurance trust fund. In addition, the estimates depend on many economic, demographic, and healthcare-specific assumptions, including changes in per beneficiary health care costs, wages, and the consumer price index (CPI); fertility rates; mortality rates; immigration rates; and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75 year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The following table includes the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. The assumptions underlying the 2019 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2019. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions. Similar detailed information for the prior years is publicly available on the CMS website at http://www.cms.hhs.gov/CFOReport/. [1]

1 The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation.

TABLE 1:

SIGNIFICANT ASSUMPTIONS AND SUMMARY MEASURES USED FOR THE STATEMENT OF SOCIAL INSURANCE 2019

					Annual percentage change in: Per beneficiary cost[8]						
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI		Real-interest rate[9]
									B	D	
2019	1.75	1,409,000	785.9	2.19	4.02	1.83	2.8	3.5	5.5	-1.5	1.0
2020	1.76	1,413,000	779.9	2.08	4.71	2.63	2.4	3.8	5.0	3.5	0.7
2030	2.00	1,329,000	716.5	1.29	3.89	2.60	2.0	4.2	5.6	4.9	2.5
2040	2.00	1,280,000	657.7	1.20	3.80	2.60	2.0	4.5	4.4	4.7	2.5
2050	2.00	1,251,000	606.0	1.25	3.85	2.60	2.1	4.0	4.0	4.7	2.5
2060	2.00	1,236,000	560.6	1.25	3.85	2.60	2.0	3.7	3.8	4.5	2.5
2070	2.00	1,227,000	520.6	1.19	3.79	2.60	2.0	3.8	3.7	4.4	2.5
2080	2.00	1,221,000	485.1	1.16	3.76	2.60	2.1	3.9	3.8	4.5	2.5
2090	2.00	1,218,000	453.5	1.16	3.76	2.60	2.0	3.5	3.6	4.3	2.5

1 Average number of children per woman.

2 Includes legal immigration, net of emigration, as well as other, non-legal, immigration.

3 The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.

4 Difference between percentage increases in wages and the CPI.

5 Average annual wage in covered employment.

6 Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services.

7 The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.

8 These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.

9 Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

The projections presented in the SOSI are based on various economic and demographic assumptions. The values for each of these assumptions move from recently experienced levels or trends toward long-range ultimate values. Table 2 below summarizes these ultimate values assumed for the current year and the prior 4 years, based on the intermediate assumptions of the respective Medicare Trustees Reports.

TABLE 2:

SIGNIFICANT ULTIMATE ASSUMPTIONS USED FOR THE STATEMENT OF SOCIAL INSURANCE, FY 2019–2015

					Annual percentage change in:						
									Per beneficiary cost[8]		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI		Real-interest rate[9]
									B	D	
FY 2019	2.0	1,218,000	453.5	1.16	3.76	2.60	2.0	3.5	3.6	4.3	2.5
FY 2018	2.0	1,218,000	444.7	1.15	3.75	2.60	2.1	3.4	3.5	4.3	2.7
FY 2017	2.0	1,227,000	438.7	1.15	3.75	2.60	2.0	3.4	3.4	4.3	2.7
FY 2016	2.0	1,228,000	435.1	1.15	3.75	2.60	2.0	3.4	3.4	4.3	2.7
FY 2015	2.0	1,060,000	458.4	1.13	3.83	2.70	2.1	3.8	4.1	4.4	2.9

1 Average number of children per woman. The ultimate fertility rate is assumed to be reached in 2027.

2 Includes legal immigration, net of emigration, as well as other, non-legal, immigration. (Beginning with FY 2018 legal immigration is referred to as lawful permanent resident (LPR) immigration, and other, non-legal, immigration is referred to as other-than-LPR immigration.) The ultimate level of net legal immigration is 788,000 persons per year, and the assumption for annual net other immigration varies throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080 for FY 2015 and is the value assumed in the year 2090 for FYs 2016-2019.

3 The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080 for FY 2015 and is the value assumed in the year 2090 for FYs 2016-2019.

4 Difference between percentage increases in wages and the CPI. The value presented is the average of annual real-wage differentials for the last 65 years of the 75-year projection period, is consistent with the annual differentials shown in table 1, and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080 for FY 2015 and is the value assumed in the year 2090 for FYs 2016-2019.

5 Average annual wage in covered employment. The value presented is the average annual percentage change from the 10th year of the 75-year projection period to the 75th year and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080 for FY 2015 and is the value assumed in the year 2090 for FYs 2016-2019.

6 Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services. The ultimate assumption is reached within the first 10 years of the projection period.

7 The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080 for FY 2015 and is the value assumed in the year 2090 for FYs 2016-2019.

8 These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceuticals). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. Since the annual rate of growth declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080 for FY 2015 and is the value assumed in the year 2090 for FYs 2016-2019.

9 Average rate of interest earned on new trust fund securities, above and beyond rate of inflation. The ultimate assumption is reached soon after the 10th year of each projection period.

NOTE 12:

ALTERNATIVE SOSI PROJECTIONS (UNAUDITED)

The Medicare Board of Trustees, in its annual report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results.

Certain features of current law may result in some challenges for the Medicare program. Physician payment update amounts are specified for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. Payment rate updates for most non-physician categories of Medicare providers are reduced by the growth in economy-wide private nonfarm business multifactor productivity although these health providers have historically achieved lower levels of productivity growth. For those providers affected by the productivity adjustments and the specified updates to physician payments, sustaining the price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services and that physician costs will grow at a faster rate than the specified updates. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time.

The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. The gap will continue to widen throughout the projection, and the Trustees estimated that physician payment rates under current law will be lower than they would have been under the sustainable growth rate (SGR) formula by 2048. Absent a change in the delivery system or level of update by subsequent legislation, access to Medicare-participating physicians may become a significant issue in the long term under current law. Overriding the price updates in current law, as lawmakers repeatedly did in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in this report.

To help illustrate and quantify the potential magnitude of the cost understatement, the Trustees asked the Office of the Actuary at CMS to prepare an illustrative Medicare trust fund projection under a hypothetical alternative. This scenario illustrates the impact that would occur if the payment updates that are affected by the productivity adjustments transition from current law to the payment updates assumed for private health plans over the period 2028 to 2042. It also reflects physician payment updates that transition from current law to the increase in the Medicare Economic Index over the same period. Finally, the scenario assumes the continuation of the 5 percent bonuses for qualified physicians in advanced alternative models (advanced APMs) and of the $500-million payments for physicians in the merit-based incentive payment system (MIPS), which are set to expire in 2025 [2]. This alternative was developed for illustrative purposes only; the calculations have not been audited; no endorsement of the policies underlying the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation affecting the productivity adjustments and physician updates under Medicare and of the broad range of uncertainty associated with such impacts.

2 The illustrative alternative projections included changes to the productivity adjustments starting with the 2010 annual report, following enactment of the *Affordable Care Act*. The assumption regarding physician payments is being used because the enactment of MACRA in 2015 replaced the SGR with specified physician updates.

Table 3 below contains a comparison of the Medicare 75-year present values of estimated future income and estimated future expenditures under current law with those under the illustrative alternative scenario.

TABLE 3:
MEDICARE PRESENT VALUES

(in billions)

	Current law (Unaudited)	Alternative Scenario[1, 2] (Unaudited)
Income		
Part A	**$24,359**	**$24,420**
Part B	**39,652**	**46,342**
Part D	**11,232**	**11,232**
Expenditures		
Part A	**29,843**	**34,890**
Part B	**39,652**	**46,342**
Part D	**11,232**	**11,232**
Income less expenditures		
Part A	**(5,484)**	**(10,470)**
Part B	**0**	**0**
Part D	**0**	**0**

1 These amounts are not presented in the 2019 Trustees Report.

2 At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare trust fund projections that differs from current law. No endorsement of the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred.

The difference between the current-law and illustrative alternative projections is substantial for Parts A and B. All Part A fee-for-service providers and roughly half of Part B fee-for-service providers are affected by the productivity adjustments, so the current-law projections reflect an estimated 1.0-percent reduction in annual cost growth each year for these providers. If the payment updates that are affected by the productivity adjustments were to gradually transition from current law to the payment updates assumed for private health plans, the physician updates transitioned to the Medicare Economic Index, and the 5-percent bonuses paid to qualified physicians in advanced APMs did not expire, as illustrated under the alternative scenario, the estimated present values of Part A and Part B expenditures would each be higher than the current-law projections by roughly 17 percent. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario, and the present value of Part B income is 17 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

The Part D values are the same under each projection because the services are not affected by the productivity adjustments or the physician updates.

The extent to which actual future Part A and Part B costs exceed the projected amounts due to changes to the productivity adjustments and physician updates depends on what specific changes might be legislated and whether Congress would pass further provisions to help offset such costs. As noted, these examples reflect only hypothetical changes to provider payment rates.

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NOTE 13:

STATEMENT OF CHANGES IN SOCIAL INSURANCE AMOUNTS (UNAUDITED)

The Statement of Changes in Social Insurance Amounts (SCSIA) reconciles the change (between the current valuation and the prior valuation) in the (1) present value of estimated future income (excluding interest) for current and future participants; (2) present value of estimated future expenditures for current and future participants; (3) present value of estimated future noninterest income less estimated future expenditures for current and future participants (the open-group measure) over the next 75 years; (4) assets of the combined Medicare Trust Funds; and (5) present value of estimated future non-interest income less estimated future expenditures for current and future participants over the next 75 years plus the assets of the combined Medicare Trust Funds. The SCSIA shows the reconciliation from the period beginning on January 1, 2018 to the period beginning on January 1, 2019, and the reconciliation from the period beginning on January 1, 2017 to the period beginning on January 1, 2018. The reconciliation identifies several components of the change that are significant and provides reasons for the changes.

Because of the financing mechanism for Parts B and D of Medicare, any change to the estimated future expenditures has the same effect on estimated total future income, and vice versa. Therefore, any change has no impact on the estimated future net cash flow. In order to enhance the presentation, the changes in the present values of estimated future income and estimated future expenditures are presented separately.

The five changes considered in the Statement of Changes in Social Insurance Amounts are, in order:

- change in the valuation period,
- change in projection base,
- changes in the demographic assumptions,
- changes in economic and health care assumptions, and
- changes in law.

All estimates in the Statement of Changes in Social Insurance Amounts represent values that are incremental to the prior change. As an example, the present values shown for demographic assumptions, represent the additional effect that these assumptions have, once the effects from the change in the valuation period and projection base have been considered. In general, an increase in the present value of net cash flows represents a positive change (improving financing), while a decrease in the present value of net cash flows represents a negative change (worsening financing).

Assumptions Used for the Statement of Changes in Social Insurance Amounts

The present values included in the Statement of Changes in Social Insurance Amounts are for the current and prior year and are based on various economic and demographic assumptions used for the intermediate assumptions in the Trustees Reports for those years. Table 1 of Note 11 summarizes these assumptions for the current year.

Period beginning on January 1, 2018 and ending January 1, 2019

Present values as of January 1, 2018 are calculated using interest rates from the intermediate assumptions of the 2018 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2019. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2018 Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2019 Trustees Report.

Period beginning on January 1, 2017 and ending January 1, 2018

Present values as of January 1, 2017 are calculated using interest rates from the intermediate assumptions of the 2017 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2018. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2017

Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2018 Trustees Report.

Change in the Valuation Period

From the period beginning on January 1, 2018 to the period beginning on January 1, 2019

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2018-92) to the current valuation period (2019-93) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2018, replaces it with a much larger negative net cash flow for 2093, and measures the present values as of January 1, 2019, one year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (made more negative) when the 75-year valuation period changed from 2018-92 to 2019-93. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2018 are realized. The change in valuation period resulted in a slight increase in the starting level of assets in the combined Medicare Trust Funds. Accordingly, the present value of the estimated future net cash flow, including combined trust fund assets, decreased by $193 billion.

From the period beginning on January 1, 2017 to the period beginning on January 1, 2018

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2017-91) to the current valuation period (2018-92) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2017, replaces it with a much larger negative net cash flow for 2092, and measures the present values as of January 1, 2018, one year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (made more negative) when the 75-year valuation period changed from 2017-91 to 2018-92. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2017 are realized. The change in valuation period resulted in a very slight increase in the starting level of assets in the combined Medicare Trust Funds. Accordingly, the present value of the estimated future net cash flow, including combined trust fund assets, decreased by $168 billion.

Change in Projection Base

From the period beginning on January 1, 2018 to the period beginning on January 1, 2019

Actual income and expenditures in 2018 were different than what was anticipated when the 2018 Trustees Report projections were prepared. Part A income in 2018 was lower and expenditures were higher than anticipated based on actual experience. For both Part B and Part D, total income and expenditures were higher than estimated based on actual experience. The net impact of the Part A, B, and D projection base changes is a decrease of $193 billion in the present value of the estimated future net cash flow, including combined trust fund assets. Actual experience of the Medicare Trust Funds between January 1, 2018 and January 1, 2019 is incorporated in the current valuation and is more than projected in the prior valuation.

From the period beginning on January 1, 2017 to the period beginning on January 1, 2018

Actual income and expenditures in 2017 were different than what was anticipated when the 2017 Trustees Report projections were prepared. Part A payroll tax income in 2017 was lower attributable to lowered wages and expenditures were higher than anticipated based on actual experience. Part B total income and expenditures were higher than estimated based on actual experience. For Part D, actual income and expenditures were both lower than prior estimates. The net impact of the Part A, B, and D projection base changes is a decrease of $926 billion in the present value of the estimated future net cash flow including combined trust fund assets. Actual experience of the Medicare Trust Funds between January 1, 2017 and January 1, 2018 is incorporated in the current valuation and is less than projected in the prior valuation.

Changes in the Demographic Assumptions

From the period beginning on January 1, 2018 to the period beginning on January 1, 2019

The demographic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2019) are the same as those for the prior valuation. However, the starting demographic values and the way these values transition to the ultimate assumptions were changed. The numbers of new lawful permanent residents (LPR) for calendar years 2018 and 2019 were assumed to be slightly lower than projected in the prior valuation period, due to recent lower annual refugee ceilings set by the Administration.

- The current valuation incorporated a gradual rise in 2017 and 2018 of other-than-LPR immigrants, reaching the ultimate assumed level in 2019. In contrast, the prior valuation incorporated a surge in the number of other-than-LPR immigrants for years 2016 through 2021.
- Final birth rate data for 2017 indicated slightly lower birth rates than were assumed in the prior valuation.
- Incorporating 2016 mortality data obtained from the National Center for Health Statistics (NCHS) for ages under 65 and 2016 and preliminary 2017 mortality data from Medicare experience for ages 65 and older resulted in higher death rates for all future years than were projected in the prior valuation.

There were two notable changes in demographic methodology:

- Improved the method for projecting fertility rates by better incorporating detailed provisional birth rate data available from NCHS.
- Incorporated more comprehensive Medicare mortality data from CMS.

These changes lowered overall Medicare enrollment for the current valuation period and resulted in a slight increase in the estimated future net cash flow. The present values of estimated income and expenditures are lower for Parts A, Part B, and Part D. Overall, these changes increased the present value of the estimated future net cash flow by $27 billion.

From the period beginning on January 1, 2017 to the period beginning on January 1, 2018

The demographic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2018), with the exception of a small decrease of 10,000 lawful-permanent-resident (LPR) immigrants per annum in the future, are the same as those for the prior valuation. However, the starting demographic values and the way these values transition to the ultimate assumptions were changed.

- Final birth rate data for 2016 indicated slightly lower birth rates than were assumed in the prior valuation.
- Recent fertility data suggests that the short-term increase in the total fertility rate used in the prior valuation to account for an assumed deferral in childbearing (resulting from the recent economic downturn) was no longer warranted. The observed persistent drop in the total fertility rate in recent years is now assumed to be a loss of potential births rather than just a deferral for this period.
- Incorporating 2015 mortality data obtained from the National Center for Health Statistics for ages under 65 and preliminary 2015 mortality data from Medicare experience for ages 65 and older resulted in higher death rates for all future years than were projected in the prior valuation.
- More recent LPR and other-than-LPR immigration data and historical population data were included.

There was one notable change in demographic methodology:

- Improved the method for projecting mortality rates by marital status by utilizing recent data from NCHS and the American Community Survey.

These changes lowered overall Medicare enrollment for the current valuation period and resulted in an increase in the estimated future net cash flow. The present values of estimated income and expenditures are both lower for Part A and Part B but higher for Part D. Overall, these changes increased the present value of the estimated future net cash flow by $434 billion.

Changes in Economic and Health Care Assumptions

For the period beginning on January 1, 2018 to the period beginning on January 1, 2019

The economic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

For the current valuation (beginning on January 1, 2019), there were four changes to the ultimate economic assumptions.

- The ultimate annual rate of change in total-economy labor productivity was lowered from 1.68 percent in the prior valuation to 1.63 percent in the current valuation, reflecting an expected slower rate of productivity growth in the long term.
- The difference between the ultimate growth rates for the Consumer Price Index for Urban Wage Earners and Clerical Workers and the GDP implicit price deflator (the "price differential"), was decreased from 0.40 percentage point in the prior valuation to 0.35 percentage point in the current valuation.
- The ultimate average real-wage differential was increased from 1.20 percentage points in the prior valuation to 1.21 percentage points in the current valuation.
- The ultimate real interest rate was lowered by 0.2 percentage point, from 2.7 percent in the prior valuation to 2.5 percent in the current valuation.

In addition to these changes in ultimate assumptions, the starting economic values and the way these values transition to the ultimate assumptions were changed. The most notable change was to include the July 2018 revisions in historical GDP estimated by the Bureau of Economic Analysis (BEA) of the Department of Commerce. This and other smaller changes in starting values and near-term growth assumptions combined to increase the present value of estimated future net cash flows.

There was one notable change in economic methodology:

- Incorporated more recent projections of disability prevalence in the labor force participation model.

The health care assumptions are specific to the Medicare projections. The following health care assumptions were changed in the current valuation.

- Lower assumed growth in economy-wide productivity, which results in higher payment updates for certain providers.
- Faster projected spending growth for physician-administered drugs under Part B.
- Higher projected drug manufacturer rebates and slower overall drug price increases assumed in the short-range period.

The net impact of these changes resulted in a decrease in the estimated future net cash flow for total Medicare. For Part A and Part B, these changes increased the present value of estimated future income and expenditures. For Part D, these changes resulted in a decrease in the present value of estimated expenditures (and also income). Overall, these changes decreased the present value of the estimated future net cash flow by $402 billion.

For the period beginning on January 1, 2017 to the period beginning on January 1, 2018

The economic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

The ultimate economic assumptions for the current valuation (beginning on January 1, 2018) are the same as those for the prior valuation. However, the starting economic values and the way these values transition to the ultimate assumptions were changed.

- The estimated level of potential GDP was reduced by about 1 percent in 2017 and throughout the projection period, primarily due to the slow growth in labor productivity for 2010 through 2017 and low unemployment rates in 2017. This lower estimated level of potential GDP means that cumulative growth in actual GDP is 1 percent less over the remainder of the projected recovery than was assumed in the prior valuation.
- Near-term interest rates were decreased, reflecting a more gradual path for the rise to the ultimate real interest rate than was assumed in the prior valuation.
- New data from the Bureau of Economic Analysis (BEA) indicated lower-than-expected ratios of labor compensation to GDP for 2016 and 2017, while new data from the Internal Revenue Service (IRS) indicated lower-than-expected ratios of taxable payroll to GDP for 2016 and 2017. This new data led to assumed extended recoveries in these ratios to the unchanged ultimate ratios.

There was one notable change in economic methodology:

- Improved the method for projecting educational attainment among women in age groups 45-49 and 50-54 in the labor force participation model.

The health care assumptions are specific to the Medicare projections. The following health care assumptions were changed in the current valuation.

- Utilization rate assumptions for inpatient hospital were decreased.
- Utilization rate and case mix for skilled nursing facilities services were decreased.
- Payment rates to private health plans are higher than projected in last year's report primarily due to higher risk scores and increased coding by plans.
- Higher projected drug manufacturer rebates.

The net impact of these changes resulted in a small increase in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in an overall increase in the estimated future net cash flow. For Part B, these changes increased the present value of estimated future expenditures (and also income).

For Part D, these changes decreased the present value of estimated expenditures (and also income). Overall, these changes increased the present value of the estimated future net cash flow by $14 billion.

Changes in Law

For the period beginning on January 1, 2018 to the period beginning on January 1, 2019

The provisions enacted as part of Medicare legislation since the prior valuation date had no measurable impact on program expenditures. For more information on the legislation please see section V.A of the 2019 Medicare Trustees Report.

For the period beginning on January 1, 2017 to the period beginning on January 1, 2018

Most of the provisions enacted as part of Medicare legislation since the prior valuation date had little or no impact on the program. The following provisions did have a financial impact on the present value of the 75-year estimated future income, expenditures, and net cash flow.

- The *Disaster Tax Relief and Airport and Airway Extension Act of 2017* (Public Law 115-63, enacted on September 29, 2017) included one provision that affects the HI and SMI Part B programs.
  - » The funding amount of $270 million previously provided to the Medicare Improvement Fund, for services provided during and after fiscal year 2021, is decreased to $220 million. (This fund was intended to be available for improvements to the original fee-for-service program under Parts A and B.)
- An Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018 (Public Law 115-97, enacted on December 22, 2017, and also referred to as the *Tax Cuts and Jobs Act of 2017*) included three provisions that affect the HI program.
  - » Federal income tax rates for individuals are reduced, effective for taxable years beginning after December 31, 2017 and ceasing to apply after December 31, 2025. In addition, the inflation index applied to the tax bracket thresholds and standard deductions is changed, effective for taxable years beginning after December 31, 2017, such that these amounts will permanently grow more slowly than under prior law.
  - » The requirement that most individuals be covered by a health insurance plan or pay a financial penalty, commonly referred to as the individual mandate, is repealed, effective January 1, 2019. Accordingly, the percentage of people without health insurance is expected to increase. Because the change in this percentage is a factor used in determining payments to Medicare disproportionate share hospitals for uncompensated care, these payments are expected to increase as well. In addition, in light of this repeal, it is expected that some individuals will drop their employer-sponsored health insurance, thereby slightly increasing HI covered wages and taxable payroll.
  - » Temporary tax changes for certain small businesses are made that will affect reported self-employment income and, in turn, HI covered wages and taxable payroll.
- An Act Making Further Continuing Appropriations for the Fiscal Year Ending September 30, 2018, and for Other Purposes (Public Law 115-120, enacted on January 22, 2018) included one provision that affects the HI and SMI programs.
  - » A moratorium for calendar year 2019 is placed on the annual fee to be paid by health insurance providers. This fee is imposed on certain large health insurance providers, including those furnishing coverage under Medicare Advantage (Part C) and Medicare Part D.
- The *Bipartisan Budget Act of 2018* (BBA 2018; Public Law 115-123, enacted on February 9, 2018) included provisions that affect the HI and SMI programs.
  - » The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines, as described in previous annual reports, is extended by 2 years, through fiscal years 2026 and 2027.
  - » The Independent Payment Advisory Board (IPAB) and all related provisions are repealed, effective upon enactment. (The IPAB was established by the *Affordable Care Act* to develop and submit proposals aimed at extending the solvency of Medicare, slowing Medicare cost growth, and improving the quality of care delivered to Medicare beneficiaries.)

- For Medicare Advantage plans and stand-alone Part D plans that undergo a contract consolidation approved on or after January 1, 2019, the star rating (and any quality bonus payment) for the surviving contract is to reflect an enrollment-weighted average of the ratings for the continuing and closed contracts.

- The authority for Medicare Advantage Special Needs Plans (SNPs), which was due to expire on December 31, 2018, is permanently extended. A number of reforms to dual-eligible SNPs and chronic-condition SNPs are also mandated.

- For Medicare Advantage plans, certain provisions are enacted, effective January 1, 2020, which permit plans to offer to chronically ill enrollees (i) a broader range of supplemental benefits (which may include services that are not primarily health care services), as long as the benefit offers a reasonable expectation of improving or maintaining health or overall function, and (ii) expanded telehealth services as supplemental benefits, subject to certain specified requirements. In addition, the Value-Based Insurance Design (VBID) Model, which is a pilot program allowing certain plans to offer supplemental benefits or reduced cost sharing to enrollees with certain chronic conditions, is expanded, effective no later than January 1, 2020, to allow plans in all States the opportunity to participate in it. The VBID program is also made exempt, through December 31, 2021, from certain spending and quality-of-care testing to which it would otherwise be subjected.

- For Medicare Accountable Care Organizations (ACOs), certain provisions are enacted to (i) provide more opportunities for beneficiaries to be assigned to, or voluntarily align with, ACOs; (ii) allow for the use of beneficiary incentive programs; and (iii) allow for expanded use of telehealth services. The specific types of ACOs to which each of these changes apply, as well as the effective dates, vary.

- Funding for the National Quality Forum is provided from the HI and SMI trust funds for the remainder of fiscal year 2017 and for fiscal years 2018 and 2019.

- Funding for certain low-income outreach and assistance programs is extended 2 years, through September 30, 2019.

- Certain existing civil and criminal penalties are substantially increased for providers and suppliers who violate health care fraud and abuse laws, effective upon enactment.

- For home health agencies serving beneficiaries in rural areas, the 3 percent add-on payment is extended 1 year, through December 31, 2018. Then, for services furnished in rural areas from 2019 through 2022, three separate tiers of add-on adjustments are established, based on Medicare home health utilization and low-population density; these adjustments diminish over varying periods of time (and become 0 percent no later than 2020). Also, for services furnished on or after January 1, 2019, home health agencies are required to report the county in which the services are furnished.

- For the Medicare home health prospective payment system (PPS), the annual update for calendar year 2020 is set at 1.5 percent.

- Under the home health PPS, the unit of payment for home health services is changed from a 60 day to a 30-day episode of care, beginning in 2020. This change must be made in a budget-neutral manner, but adjustments to offset anticipated behavior changes that could result from the modified methodology are allowed. Also beginning in 2020, therapy thresholds are removed from the home health case mix adjustment.

- To demonstrate home-bound and medical-necessity status when determining if a patient is eligible for home health services, documentation in the medical records of home health agencies can be used as supporting material, in addition to documentation in the medical records of the certifying physician, effective January 1, 2019.

- For telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke, the geographic restriction that limits originating sites to rural areas is eliminated, provided that all other Medicare telehealth coverage requirements are satisfied. In addition, no originating site facility fee is to be paid to sites that do not meet the current geographic and site type requirements. This provision is effective beginning on January 1, 2019.

- For the Medicare electronic health records incentive program, the provision requiring more stringent measures of meaningful use, over time, is eliminated, effective upon enactment.

- The funding amount of $220 million previously provided for the Medicare Improvement Fund (as noted above) is eliminated.

- The Medicare-Dependent Hospital (MDH) program is extended for 5 fiscal years, through September 30, 2022. In addition, the program is extended to certain rural hospitals that are located in all-urban States and that otherwise meet the MDH criteria.

- Medicare inpatient hospital add-on payments for low-volume hospitals are extended for 5 fiscal years, through September 30, 2022. In addition, for fiscal years 2019 through 2022, changes are made to the qualifying criteria (which are to be based on total discharges or Medicare discharges, depending on the year, and on the distance from another inpatient hospital) and to the add-on adjustments (which are to be based on a sliding scale ranging from 25 percent to 0 percent).

- Two changes are made to the long-term care hospital (LTCH) site-neutral provision. First, the originally mandated 2-year transition period is extended for 2 additional years, covering fiscal years 2018 and 2019. Second, the inpatient hospital PPS comparable amount used in the site-neutral payment rate calculations for fiscal years 2018 through 2026 is to be reduced by 4.6 percent.

- For the inpatient hospital diagnosis-related groups (DRGs) subject to the post-acute care transfer policy, hospice is added as a setting of care, effective October 1, 2023.

- For the Medicare skilled nursing facility PPS, the annual update for fiscal year 2019 is set at 2.4 percent.

- Physician assistants are added to the types of providers who may serve as attending physicians for the purposes of hospice care, effective January 1, 2019. (Previously, only physicians and nurse practitioners could serve.) Like nurse practitioners, physician assistants are not permitted to provide the written certification of terminal illness required for hospice services.

- A new income-related premium threshold is established. Specifically, beginning in calendar year 2019, individuals with incomes at or above $500,000 (and couples with incomes at or above $750,000) will pay premiums covering 85 percent (rather than 80 percent) of the average program cost for aged beneficiaries. These new threshold levels will not be inflation-adjusted until 2028 and later.

- The 1.00 floor on the geographic index for physician work is extended for 2 additional years, through December 31, 2019.

- The physician fee schedule update for 2019, which had been set at 0.5 percent, is decreased to 0.25 percent.

- A number of changes are made to the merit-based incentive payment system (MIPS) for physicians, including that it be applied only to covered professional services instead of to items and services (thereby excluding, most prominently, physician-administered Part B drugs) and that its transition period be extended by 3 years (such that the post-transition period now begins in 2022, not 2019). Certain additional changes to the system are mandated for the extended transition period, and others are mandated for the period thereafter. Effective dates vary.

- The annual payment limits on therapy services are permanently repealed, beginning on January 1, 2018. The threshold for the targeted manual medical review process is lowered, from $3,700 to $3,000, effective as of the same date and until 2028, after which the threshold is to be increased by a specified formula.

- Outpatient physical and occupational therapy services furnished by a therapy assistant are paid at 85 percent of the amount that otherwise would have been paid under the fee schedule, effective January 1, 2022.

- The freeze on coding and valuation of certain radiation therapy services reimbursed under the fee schedule, in place for 2017 and 2018, is extended through 2019.

- For qualified home infusion therapy suppliers, a temporary transitional payment for administering home infusion therapy is established, beginning on January 1, 2019. Payment rates in three categories will apply during the transition period, which will end on December 31, 2020, after which a new payment methodology will begin.

- Certain ground ambulance add-on payments are extended 5 additional years, through December 31, 2022. (These add-on payments include a 3 percent bonus for services originating in rural areas, a 2 percent bonus for services originating in other locations, and a 22.6-percent super rural bonus for rural areas with the lowest population densities.) The development of a system to collect certain data from providers and suppliers of ground ambulance services is also mandated.

- For non-emergency ground ambulance transports of beneficiaries with end-stage renal disease (ESRD) to and from renal dialysis services, the reduction in payments is increased from 10 percent to 23 percent for transports furnished on or after October 1, 2018.

- For beneficiaries with ESRD who receive home dialysis, all monthly physician visits can be provided via telehealth, beginning on January 1, 2019, as long as the beneficiary receives one in-person visit monthly for the initial 3 months and at least one every 3 months thereafter. (Previously, at least one in-person visit per month was required.) Also, the originating site requirements are modified in several ways, and no site facility fee is to be paid if the beneficiary's home is the originating site.

- Conditions are added to those that allow a beneficiary who qualifies for cardiac rehabilitation services to qualify for the more

intensive set of services, effective upon enactment. Also, the supervision requirements for cardiac rehabilitation, intensive cardiac rehabilitation, and pulmonary rehabilitation are changed to allow physician assistants, nurse practitioners, and clinical nurse specialists (in addition to physicians) to supervise these programs, effective January 1, 2024.

» A provision of the *Steve Gleason Act of 2015*, requiring that Medicare payment for rental or lump-sum purchase of speech-generating devices and accessories be made without a cap on the amount, is made permanent.

» Enforcement is delayed an additional year, through December 31, 2017, for the instruction that, for outpatient therapeutic services provided in critical access and small rural hospitals, a physician or non-physician practitioner must provide direct supervision throughout the performance of a procedure. (In the 2018 outpatient hospital PPS rule, CMS extended these non-enforcement instructions for 2018 and 2019 and noted that, for 2017, while there was not a non-enforcement instruction in place, Medicare administrative contractors were directed not to prioritize enforcement of this requirement for these hospitals. This legislation provides the non-enforcement instruction that had been lacking for 2017.)

» Under the Part D standard benefit structure, the coverage gap closes 1 year earlier than previously scheduled for brand-name drugs only; that is, for brand-name drugs, beneficiaries in the coverage gap (excluding low-income enrollees eligible for cost-sharing subsidies) will pay 25 percent of drug costs beginning on January 1, 2019 (instead of 30 percent in 2019 and 25 percent thereafter). Also beginning on that date, these beneficiaries will receive a 70 percent manufacturer discount (instead of 50 percent) and a 5 percent benefit (instead of 20 percent in 2019 and 25 percent thereafter) from their Part D plans for applicable prescription drugs. (For purposes of drug discounts while beneficiaries are in the Part D coverage gap, applicable drugs are generally covered brand-name Part D drugs, while non-applicable drugs are generally covered generic Part D drugs.) For generic drugs, the law remains the same, with beneficiaries paying 37 percent of drug costs in 2019 and 25 percent thereafter.

» For purposes of drug discounts while beneficiaries are in the Part D coverage gap, the definition of applicable drugs is expanded to include biosimilars, effective January 1, 2019. (Applicable drugs previously included biologics but not biosimilars.)

Overall these provisions resulted in a decrease in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in an increase to the present value of estimated future expenditures and a slight decrease to the present value of estimated future income, with an overall net decrease of $535 billion in the present value of the estimated future net cash flow. For Part B and Part D, these changes increased the present value of estimated future expenditures (and also income).

NOTE 14:

BUDGET AND ACCRUAL RECONCILIATION

(DOLLARS IN MILLIONS)

FY2019	Intra-Government	With the Public	Total
NET COST OF OPERATIONS (SNC)	**$992**	**$1,086,279**	**$1,087,271**
Components of net cost not part of the budget outlays			
Property, plant, and equipment Depreciation		**$(408)**	**$(408)**
Other		**432**	**432**
		$24	**$24**
Increase/(Decrease) in Assets:			
Accounts receivable		**$(2,685)**	**$(2,685)**
Loans receivable		**(7)**	**(7)**
Other asset - Regulatory Assets	**(25)**	**(3)**	**(28)**
	$(25)	**$(2,695)**	**$(2,720)**
(Increase)/Decrease in Liabilities:			
Accounts Payable	**$(30)**	**$(11,017)**	**$(11,047)**
Other liabilities (Salaries and Benefits, Unfunded Leave, Unfunded FECA, Actuarial FECA)	**(30)**	**(1,730)**	**(1,760)**
	$(60)	**$(12,747)**	**$(12,807)**
Other Financing Sources:			
Federal employee retirement benefit costs paid by OPM and imputed to the agency	**$(56)**		**$(56)**
Transfers out (in) without reimbursement	**3,515**		**3,515**
	$3,459		**$3,459**
Components of the budget outlays that are not part of net cost:			
Other	**$(519)**	**$5,946**	**$5,427**
	$(519)	**$5,946**	**$5,427**
Other			**$46**
NET OUTLAYS	**$3,847**	**$1,076,807**	**$1,080,700**
Related Amounts on the Statement of Budgetary Resources			
Outlays, net			**$1,571,678**
Distributed offsetting receipts			**(490,978)**
AGENCY OUTLAYS, NET			**$1,080,700**

FY2018	Intra-Government	With the Public	Total
NET COST OF OPERATIONS (SNC)	$893	$1,008,182	$1,009,075
Components of net cost not part of the budget outlays			
Property, plant, and equipment Depreciation		$(336)	$(336)
Other		446	446
		$110	$110
Increase/(Decrease) in Assets:			
Accounts receivable		$(5,775)	$(5,775)
Other asset - Regulatory Assets		(29,554)	(29,554)
		$(35,329)	$(35,329)
(Increase)/Decrease in Liabilities:			
Accounts Payable	$(4)	$9,206	$9,202
Other liabilities (Salaries and Benefits, Unfunded Leave, Unfunded FECA, Actuarial FECA)	(839)	3,842	3,003
	$(843)	$13,048	$12,205
Other Financing Sources:			
Federal employee retirement benefit costs paid by OPM and imputed to the agency	$(79)		$(79)
Transfers out (in) without reimbursement	4,057		4,057
	$3,978		$3,978
Components of the budget outlays that are not part of net cost:			
Other	$(423)	$5,038	$4,615
	$(423)	$5,038	$4,615
Other			$51
NET OUTLAYS	$3,605	$991,049	$994,705
Related Amounts on the Statement of Budgetary Resources			
Outlays, net			$1,461,724
Distributed offsetting receipts			(467,019)
AGENCY OUTLAYS, NET			$994,705

REQUIRED SUPPLEMENTARY INFORMATION

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for over five decades. A brief description of the provisions of Medicare's Hospital Insurance (HI, or Part A) trust fund and Supplementary Medical Insurance (SMI, or Parts B and D) trust fund is included in this financial report.

The Required Supplementary Information (RSI) contained in this section is presented in accordance with the requirements of the Federal Accounting Standards Advisory Board (FASAB). Included are descriptions of the long term sustainability and financial condition of the program and a discussion of trends revealed in the data.

RSI material is generally drawn from the *2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

The projections in this year's report are based on current law, certain features of which may result in some challenges for the Medicare program. Physician payment update amounts are specified for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. These rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. Payment rate updates for most non-physician categories of Medicare providers are reduced by the growth in economy-wide private nonfarm business multifactor productivity[1] although these health providers have historically achieved lower levels of productivity growth. If the health sector cannot transition to more efficient models of care delivery and if the provider reimbursement rates paid by commercial insurers continue to be based on the same negotiated process used to date, then the availability, particularly with respect to physician services, and quality of health care received by Medicare beneficiaries would, under current law, fall over time compared to that received by those with private health insurance.

Incorporated in these projections is the sequestration of non-salary Medicare expenditures as required by the following laws: the *Budget Control Act of 2011* (Public Law 112-25, enacted on August 2, 2011), as amended by the *American Taxpayer Relief Act of 2012* (Public Law 112-240, enacted on January 2, 2013); the *Continuing Appropriations Resolution, 2014* (Public Law 113-67, enacted on December 26, 2013); Sections 1 and 3 of Public Law 113-82, enacted on February 15, 2014; the *Protecting Access to Medicare Act of 2014* (Public Law 113-93, enacted on April 1, 2014); the *Bipartisan Budget Act of 2015* (Public Law 114-74, enacted on November 2, 2015); and the *Bipartisan Budget Act of 2018* (Public Law 115-123, enacted on February 9, 2018). The sequestration reduces benefit payments by 2 percent from April 1, 2013 through March 31, 2027 and by 4 percent from April 1, 2027 through September 30, 2027. Due to sequestration, non-salary administrative expenses are reduced by an estimated 5 to 7 percent from March 1, 2013 through September 30, 2027.

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from specific provisions of the *Patient Protection and Affordable Care Act*, as amended by the *Health Care and Education Reconciliation Act of 2010* (referred to collectively as the Affordable Care Act or ACA) and the *Medicare Access and CHIP Reauthorization Act of 2015* (MACRA). These ACA and MACRA provisions lower increases in Medicare payment rates to most categories of health care providers, but such adjustments would probably not be viable indefinitely without fundamental change in the current delivery system. It is conceivable that providers could improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. For such efforts to be successful in the long range, however, providers would have to generate and sustain unprecedented levels of productivity gains—a very challenging and uncertain prospect.

In view of the factors described above, it is important to note that Medicare's actual future costs are highly uncertain for reasons apart from the inherent challenges in projecting health care cost growth over time. The current-law expenditure projections reflect the physicians' payment levels expected under the MACRA payment rules and the ACA-mandated reductions in other Medicare payment rates. In addition, the Trustees reference in their report an illustrative alternative scenario, which assumes that (i) there would be a transition from current-law payment updates for providers affected by the economy-wide productivity adjustments to payment updates that reflect adjustments for health care productivity; (ii) the average physician payment updates would transition from current law to payment updates that reflect the Medicare Economic Index; and

1 For convenience the term economy-wide private nonfarm business multifactor productivity will henceforth be referred to as economy-wide productivity.

(iii) the 5-percent bonuses for qualified physicians in advanced alternative payment models (advanced APMs) and the $500-million payments for physicians in the merit-based incentive payment system (MIPS) would continue indefinitely rather than expire in 2025. The difference between the illustrative alternative and the current-law projections continues to demonstrate that the long-range costs could be substantially higher than shown throughout much of the report if the MACRA[2] and ACA[3] cost-reduction measures prove problematic and new legislation scales them back.

Additional information on the current-law and illustrative alternative projections is provided in Note 12 in these financial statements, in section V.C of this year's annual Medicare Trustees Report, and in an auxiliary memorandum prepared by the CMS Office of the Actuary at the request of the Board of Trustees.

Printed copies of the Trustees Report and auxiliary memorandum may be obtained from the CMS Office of the Actuary (410 786-6386) or can be downloaded from **https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds**.

ACTUARIAL PROJECTIONS

Long-Range Medicare Cost Growth Assumptions

Beginning with the 2013 report, the Trustees used the statutory price updates and the volume and intensity assumptions from the "factors contributing to growth" model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period.[4] The Trustees assume that the productivity reductions to Medicare payment rate updates will reduce volume and intensity growth by 0.1 percent below the factors model projection.[5]

For some time, the Trustees have assumed that it is reasonable to expect over the long range that the drivers of health spending will be similar for the overall health sector and for the Medicare program. This view was affirmed by the 2010-2011 Technical Panel, which recommended use of the same long-range assumptions for the increase in the volume and intensity of health care services for the total health sector and for Medicare. Therefore, the overall health sector long-range cost growth assumptions for volume and intensity are used as the starting point for developing the Medicare-specific assumptions.

Prior to the ACA, Medicare payment rates for most non-physician provider categories were updated annually by the increase in providers' input prices for the market basket of employee wages and benefits, facility costs, medical supplies, energy and utility costs, professional liability insurance, and other inputs needed to produce the health care goods and services.[6] To the extent that health care providers can improve their productivity each year, their net costs of production (other things being equal) will increase more slowly than their input prices—but the Medicare payment rate updates prior to the ACA were not adjusted for potential productivity gains. Accordingly, Medicare costs per beneficiary would have increased somewhat faster than for the health sector overall. The ACA requires that many of these Medicare payment updates be reduced by the 10 year moving average increase in economy-wide productivity, which the Trustees assume will be 1.0 percent per year over the long range—a lower rate than that of 1.1 percent assumed in the 2018 report. The different statutory provisions for updating payment rates require the development of separate long-range Medicare cost growth assumptions for four categories of health care provider services:

2 Under MACRA, a significant one-time payment reduction is scheduled for most physicians in 2025. In addition, the law specifies physician payment rate updates of 0.75 percent or 0.25 percent annually thereafter for physicians in advanced APMs or MIPS, respectively. These updates are notably lower than the projected physician cost increases, which are assumed to average 2.2 percent per year in the long range.

3 Under the ACA, Medicare's annual payment rate updates for most categories of provider services would be reduced below the increase in providers' input prices by the growth in economy-wide productivity (1.0 percent over the long range).

4 This assumed increase in the average expenditures per beneficiary excludes the impacts of the aging of the population and changes in the gender composition of the Medicare population, which the Trustees estimated separately. For convenience, the increase in Medicare expenditures per beneficiary, before consideration of demographic impacts, is referred to as the Medicare cost growth rate.

5 The Trustees' methodology is consistent with Finding III-2 and Recommendation III-3 of the 2010-2011 Medicare Technical Review Panel and with Finding 3-2 of the 2016-2017 Medicare Technical Review Panel. The Panels' final reports are available at **http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf** and at **https://aspe.hhs.gov/system/files/pdf/257821/MedicareTechPanelFinalReport2017.pdf**.

6 Historically, lawmakers frequently reduced the payment updates below the increase in providers' input prices in an effort to slow Medicare cost growth or to offset unwarranted changes in claims coding practices.

i. All HI, and some SMI Part B, services that are updated annually by provider input price increases less the increase in economy-wide productivity.

HI services are inpatient hospital, skilled nursing facility, home health, and hospice. The primary Part B services affected are outpatient hospital, home health, and dialysis. Under the Trustees' intermediate economic assumptions, the year-by-year per capita increases for these provider services start at 4.0 percent in 2043, or GDP plus 0.1 percent, declining gradually to 3.6 percent in 2093, or GDP minus 0.2 percent.[7]

ii. Physician services.

Payment rate updates are 0.75 percent per year for those qualified physicians assumed to be participating in advanced APMs and 0.25 percent for those assumed to be participating in MIPS. The year-by-year per capita growth rates for physician payments are assumed to be 3.4 percent in 2043, or GDP minus 0.5 percent, declining to 2.8 percent in 2093, or GDP minus 1.0 percent.

iii. Certain SMI Part B services that are updated annually by the Consumer Price Index (CPI) increase less the increase in economy-wide productivity.

Such services include durable medical equipment that is not subject to competitive bidding,[8] care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the per beneficiary year-by-year rates to be 3.2 percent in 2043, or GDP minus 0.7 percent, declining to 2.8 percent in 2093, or GDP minus 1.0 percent.

iv. All other Medicare services, for which payments are established based on market processes, such as prescription drugs provided through Part D and the remaining Part B services.

These Part B outlays constitute an estimated 21 percent of total Part B expenditures in 2027 and consist mostly of payments for laboratory tests, physician-administered drugs, and small facility services. Medicare payments to Part D plans are based on a competitive-bidding process and are not affected by the productivity adjustments. Similarly, payments for the other Part B services are based on market factors.[9] The long-range per beneficiary cost growth rate for Part D and these Part B services is assumed to equal the increase in per capita national health expenditures as determined from the factors model. The corresponding year-by-year per capita growth rates for these services are 4.7 percent in 2043, or GDP plus 0.8 percent, declining to 4.3 percent by 2093, or GDP plus 0.5 percent.

In addition, these long-range cost growth rates must be modified to reflect demographic impacts. For example, beneficiaries at ages 80 and above use Part A skilled nursing and home health services much more frequently than do younger beneficiaries. As the beneficiary population ages, Part A costs will grow at a faster rate due to increased use of these services. In contrast, the incidence of prescription drug use is more evenly distributed by age, and an increase in the average age of Part D enrollees has significantly less of an effect on Part D costs.

After combining the rates of growth from the four long-range assumptions, the weighted average growth rate for Part B is 3.7 percent per year for the last 50 years of the projection period, or GDP minus 0.2 percent, on average. When Parts A, B, and D are combined, the weighted average growth rate is 3.8 percent over this same time period or GDP minus 0.1 percent, while the growth rate in 2093 is 3.7 percent or GDP minus 0.1 percent.

HI Cashflow as a Percentage of Taxable Payroll

Each year, estimates of the financial and actuarial status of the HI trust fund are prepared for the next 75 years. It is difficult to meaningfully compare dollar values for different periods without some type of relative scale; therefore, income and expenditure amounts are shown relative to the earnings in covered employment that are taxable under HI (referred to as taxable payroll).

Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected HI cost rates shown in the 2019 report are higher than those from the 2018 report for all years largely due to higher spending and lower taxable payroll in all projected years.

Since the standard HI payroll tax rates are not scheduled to change in the future under current law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent.

7 These growth rate assumptions are described relative to the per capita increase in GDP and characterized simply as GDP plus X percent.

8 The portion of durable medical equipment that is subject to competitive bidding is included with all other Medicare services since the price is determined by a competitive bidding process.

9 For example, physician-administered Part B drugs are reimbursed at the level of the average sales price in the market plus 6 percent.

CHART 1

HI Expenditures and Income Excluding Interest as a Percentage of Taxable Payroll // 2019 – 2093

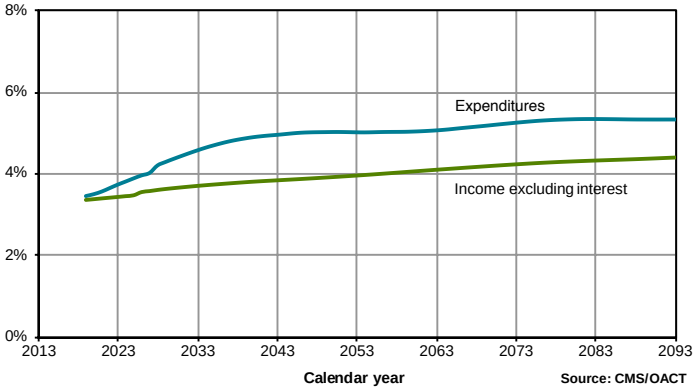
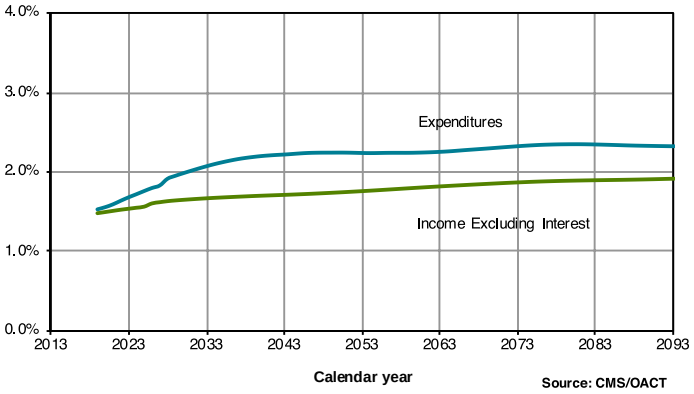


CHART 2

HI Expenditures and Income Excluding Interest as a Percentage of GDP // 2019 – 2093



In addition, starting in 2013, high-income workers pay an additional 0.9 percent of their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns). Because these income thresholds are not indexed, over time an increasing proportion of workers will become subject to the additional HI tax rate, and consequently total HI payroll tax revenues will increase steadily as a percentage of taxable payroll. Income from taxation of benefits will also increase as a greater proportion of Social Security beneficiaries become subject to such taxation, since the income thresholds determining taxable benefits are not indexed for price inflation. Thus, as Chart 1 shows, the income rate is expected to gradually increase over current levels.

In 2019 and beyond, as indicated in Chart 1, the cost rate is projected to rise, primarily due to the continued retirements of those in the baby boom generation and partly due to a projected return to modest health services cost growth. This cost rate increase is moderated by the accumulating effect of the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average of 0.8 percent through 2028 and 1.0 percent thereafter. Under the illustrative alternative scenario, the HI cost rate would be 5.3 percent in 2044 and 7.9 percent in 2093.

HI and SMI Cash Flow as a Percentage of GDP

Expressing Medicare incurred expenditures as a percentage of GDP gives a relative measure of the size of the Medicare program compared to the general economy. The GDP represents the total value of goods and services produced in the United States. This measure provides an idea of the relative financial resources that will be necessary to pay for Medicare services.

HI

Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2018, the expenditures were $308.2 billion, which was 1.5 percent of GDP. As Chart 2 illustrates, this percentage is projected to increase steadily until about 2045 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 3.4 percent in 2093.

SMI

Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and federal general revenue payments.

Chart 3 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. The growth rates are estimated year by year

CHART 3

SMI Expenditures and Premiums as a Percentage of GDP // 2019 - 2093

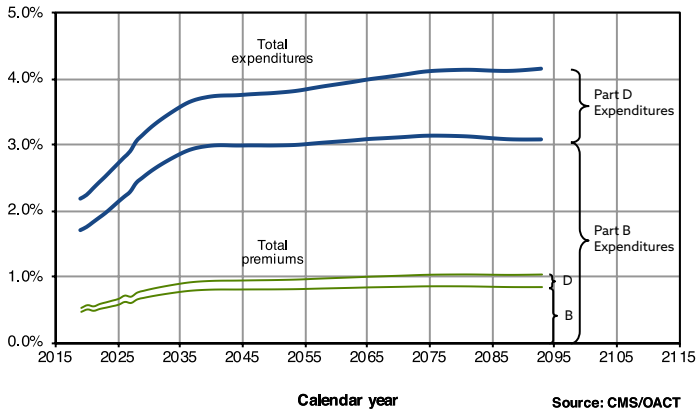
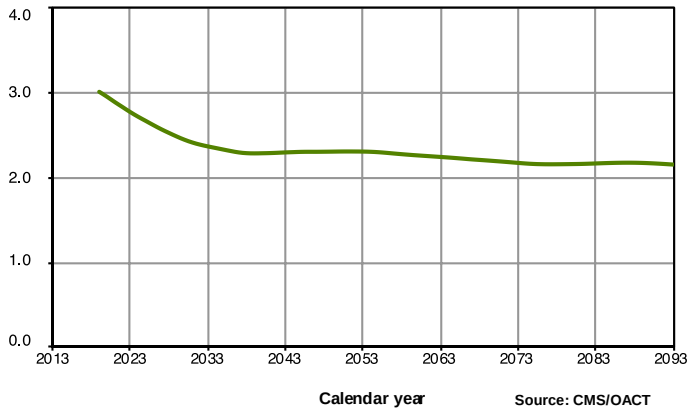


CHART 4

Number of Covered Workers per HI Beneficiary // 2019 – 2093



for the next 10 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 11 to 25 is assumed to grade smoothly into the long range assumption described previously.

In 2018, SMI expenditures were $432.4 billion, or about 2.1 percent of GDP. Under current law, they would grow to about 3.8 percent of GDP within 25 years and to 4.2 percent by the end of the projection period, as demonstrated in Chart 3. (Under the illustrative alternative, total SMI expenditures in 2093 would be 5.6 percent of GDP.)

To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time but at a slower rate compared to the last 10 years. Average per beneficiary costs for Part B and Part D benefits are projected to increase after 2018 by about 4.4 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate. The special state payments to the Part D account are set by law at a declining portion of the states' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the state payments are also expected to increase faster than GDP.

Worker-to-Beneficiary Ratio

HI

Another way to evaluate the long range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 4 illustrates this ratio over the next 75 years. For the most part, current workers pay for current benefits. The relatively smaller number of persons born after the baby boom will therefore finance the retirement of the baby boom generation. In 2018, every beneficiary had about 3.0 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.4 workers for each beneficiary, as indicated in Chart 4. The projected ratio continues to decline until there are only 2.2 workers per beneficiary by 2093.

Sensitivity Analysis

To prepare projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that both trust funds will continue under current law. In addition, the estimates depend on many economic and demographic assumptions. Because of revisions to these assumptions, due to either changed conditions or updated information, estimates sometimes change substantially compared to those made in prior years. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty.

To illustrate the sensitivity of the long range projections and determine the impact on the HI actuarial present values, six of the key assumptions were varied individually.[10] The assumptions varied are the health care

10 Sensitivity analysis is not done for Parts B or D of the SMI trust fund due to the financing mechanism for each account. Any change in assumptions would have a negligible impact on the net cash flow, since the change would affect income and expenditures equally.

CHART 5

Present Value of HI Net Cash Flow with Various Health Care Cost Factors // 2019 – 2093 *(in billions)*

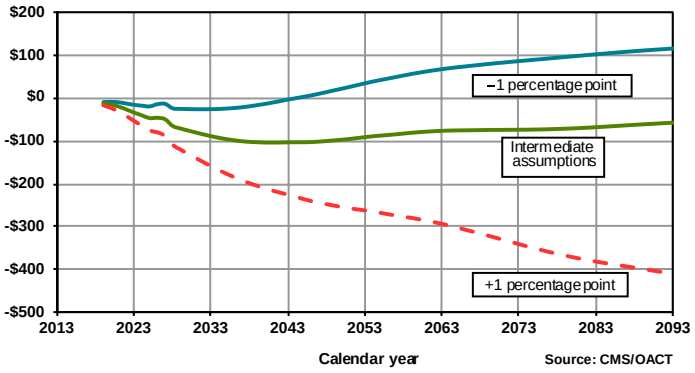
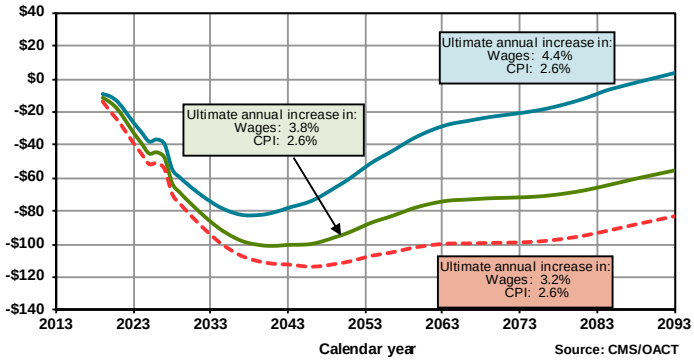


CHART 6

Present Value of HI Net Cash Flow with Various Real-Wage Assumptions // 2019 – 2093 *(in billions)*



cost factors, real wage differential, CPI, real interest rate, fertility rate, and net immigration.[11]

For this analysis, the intermediate economic and demographic assumptions in the *2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2019 and are based on estimates of income and expenditures during the 75 year projection period.

Charts 5 through 10 show the present value of the estimated net cash flow for each assumption varied. Generally, under all three scenarios, the present values decrease through the first 25 to 30 years of the projection period, at which point they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process for computing present values, which is used to help interpret the net cash flow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75 year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

Health Care Cost Factors

Table 1 shows the net present value of cash flow during the 75 year projection period under three alternative assumptions for the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, relative to taxable payroll, will be 1 percent slower than the intermediate assumptions, the same as the intermediate assumptions, and 1 percent faster than the intermediate assumptions. In each case, the taxable payroll will be the same as assumed for the intermediate projections.

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $8,606 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by $13,837 billion.

Chart 5 shows projections of the present value of the estimated net cash flow under the three alternative annual growth rate assumptions presented in Table 1.

This assumption has a dramatic impact on projected HI cash flow. The present value of the net cash flow under the ultimate growth rate assumption of 1 percentage point lower than the intermediate assumption actually

11 The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures. As a result, it is not possible at present to prepare meaningful estimates of the HI mortality sensitivity.

TABLE 1

Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	**–1 percentage point**	**Intermediate Assumptions**	**+1 percentage point**
Income minus expenditures (in billions)	**$3,122**	**–$5,484**	**–$19,321**

TABLE 2

Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions

Ultimate percentage increase in wages – CPI	**3.2 – 2.6**	**3.8 – 2.6**	**4.4 – 2.6**
Ultimate percentage increase in real-wage differential	**0.6**	**1.2**	**1.8**
Income minus expenditures (in billions)	**–$6,887**	**–$5,484**	**–$2,898**

TABLE 3

Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

Ultimate percentage increase in wages – CPI	**4.4 – 3.2**	**3.8 – 2.6**	**3.2 – 2.0**
Income minus expenditures (in billions)	**–$4,331**	**–$5,484**	**–$6,946**

becomes a surplus due to the improved financial outlook for the HI trust fund as a result of the ACA. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As Chart 5 indicates, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs.

Real-Wage Differential

Table 2 illustrates the net present value of cash flow during the 75 year projection period under three alternative ultimate real wage differential assumptions: 0.6, 1.2, and 1.8 percentage points.[12] In each case, the assumed ultimate annual increase in the CPI is 2.6 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 3.2, 3.8, and 4.4 percent, respectively.

As indicated in Table 2, for a half point increase in the ultimate real wage differential assumption, the deficit—expressed in present-value dollars—decreases by approximately $2,155 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $1,170 billion.

Chart 6 shows projections of the present value of the estimated net cash flow under the three alternative real wage differential assumptions presented in Table 2.

Faster real-wage growth results in smaller HI cash flow deficits, when expressed in present-value dollars, as demonstrated in Chart 6. A higher real-wage differential immediately increases both HI expenditures for health care and wages for all workers. There is a full effect on wages and payroll taxes, but the effect on benefits is only partial, since not all health care costs are wage-related. In practice, faster real-wage growth always improves the financial status of the HI trust fund, regardless of whether there is a small or large imbalance between income and expenditures. Also, as noted previously, the closer financial balance for the HI trust fund under the ACA and

12 The real-wage differential is the difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.

CHART 7

Present Value of HI Net Cash Flow with Various CPI-Increase Assumptions // 2019– 2093 *(in billions)*

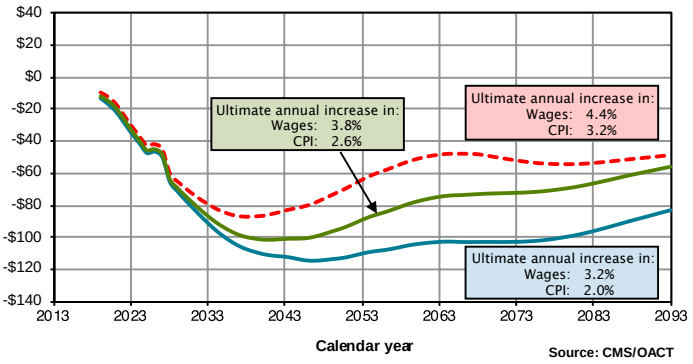
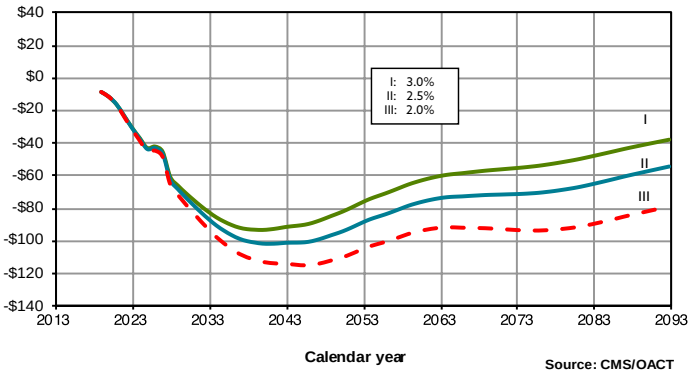


CHART 8

Present Value of HI Net Cash Flow with Various Real-Interest Rate Assumptions // 2019 – 2093 *(in billions)*



MACRA depends critically on the sustainability of the lower Medicare price updates for hospitals and other HI providers. Sustaining these price reductions will be challenging for health care providers, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services.

Consumer Price Index

Table 3 illustrates the net present value of cash flow during the 75 year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.2, 2.6, and 2.0 percent. In each case, the assumed ultimate real wage differential is 1.2 percent, which yields ultimate percentage increases in average annual wages in covered employment of 4.4, 3.8, and 3.2 percent, respectively.

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.2 percent, the deficit decreases by $1,153 billion. On the other hand, if the ultimate CPI-increase assumption is 2.0 percent, the deficit increases by $1,462 billion.

Chart 7 shows projections of the present value of net cash flow under the three alternative CPI rate-of-increase assumptions presented in Table 3.

This assumption has a small impact when the cash flow is expressed as present values, as Chart 7 indicates. The projected present values of HI cash flow are relatively insensitive to the assumed level of general price inflation because price inflation has about the same proportionate effect on income as it does on costs. In present value terms, a smaller deficit is the result under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios; under high-inflation conditions, however, the present value of HI income increases as more people become subject to the additional 0.9 percent HI tax rate required by the ACA for workers with earnings above $200,000 or $250,000 (for single and joint income-tax filers, respectively). Since the thresholds are not indexed, additional workers become subject to the additional tax more quickly under conditions of faster inflation, and vice versa.

Real-Interest Rate

Table 4 shows the net present value of cash flow during the 75 year projection period under three alternative ultimate annual real interest assumptions: 2.0, 2.5, and 3.0 percent. In each case, the assumed ultimate annual increase in the CPI is 2.6 percent, which results in ultimate annual yields of 4.6, 5.1, and 5.6 percent, respectively.

As demonstrated in Table 4, for every increase of 0.1 percentage point in the ultimate real interest rate, the deficit decreases by approximately $185 billion.

Chart 8 illustrates projections of the present value of the estimated net cash flow under the three alternative real interest assumptions presented in Table 4.

The projected HI cash flow when expressed in present values is fairly sensitive to the interest assumption, as

TABLE 4

Present Value of Estimated HI Income Less Expenditures under Various Real-Interest Assumptions

Ultimate real-interest rate	2.0 percent	2.5 percent	3.0 percent
Income minus expenditures (in billions)	**–$6,534**	**–$5,484**	**–$4,664**

TABLE 5

Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate fertility rate[1]	1.8	2.0	2.2
Income minus expenditures (in billions)	**–$6,105**	**–$5,484**	**–$4,851**

[1] The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year and if she were to survive the entire childbearing period.

TABLE 6

Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Average annual net immigration	949,000	1,265,000	1,601,000
Income minus expenditures (in billions)	**–$5,705**	**–$5,484**	**–$5,299**

shown in Chart 8. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI trust fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2026. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

Fertility Rate

Table 5 shows the net present value of cash flow during the 75 year projection period under three alternative ultimate fertility rate assumptions: 1.8, 2.0, and 2.2 children per woman.

As Table 5 demonstrates, for an increase of 0.2 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $625 billion.

Chart 9 shows projections of the present value of the net cash flow under the three alternative fertility rate assumptions presented in Table 5.

The fertility rate assumption has a substantial impact on projected HI cash flows, as Chart 9 indicates. Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, and many will become subject to the additional HI tax, thereby lowering the deficit proportionately more on a present-value-dollar basis. On the other hand, under the lower fertility rate assumptions, there will be fewer workers in the workforce with a smaller number subject to the additional tax, in turn raising the HI deficit. It is important to point out that if a longer projection period were used, the impact of a fertility rate change would be more pronounced.

Net Immigration

Table 6 illustrates the net present value of cash flow during the 75-year projection period under three alternative average annual net immigration assumptions: 949,000 persons, 1,265,000 persons, and 1,601,000 persons per year.

As indicated in Table 6, if the average annual net immigration assumption is 949,000 persons, the deficit—expressed in present-value dollars—increases by $222 billion. Conversely, if the assumption is 1,601,000 persons, the deficit decreases by $185 billion.

CHART 9

Present Value of HI Net Cash Flow with Various Ultimate Fertility Rate Assumptions // 2019 – 2093 *(in billions)*

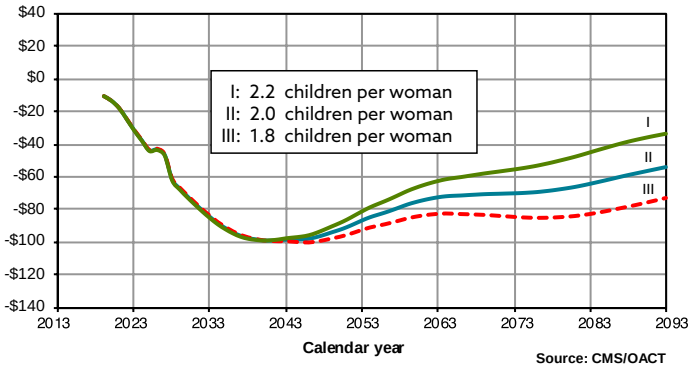


CHART 10

Present Value of HI Net Cash Flow with Various Net Immigration Assumptions // 2019 – 2093 *(in billions)*

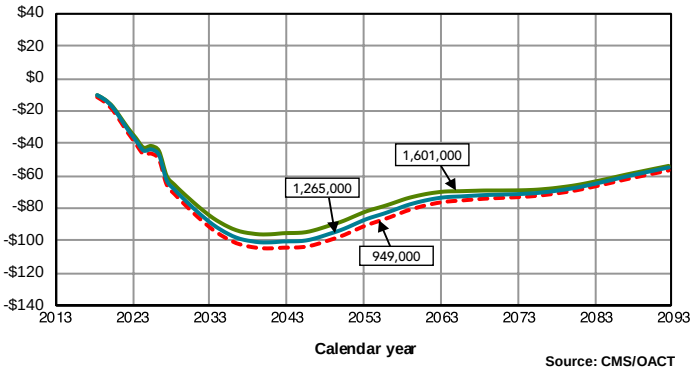


Chart 10 shows projections of the present value of net cash flow under the three alternative average annual net immigration assumptions presented in Table 6.

Higher net immigration results in smaller HI cash flow deficits, as demonstrated in Chart 10. Since immigration tends to occur most often among people at working ages, who work and pay taxes into the HI system, a change in the net immigration assumption affects revenues from payroll taxes almost immediately. However, the impact on expenditures occurs later as those individuals age and become beneficiaries.

Trust Fund Finances and Sustainability

HI

The short-range financial outlook for the HI trust fund is similar to the projections in last year's annual report. The estimated depletion date for the HI trust fund is 2026, the same as in the 2018 report. As in past years, the Trustees have determined that the fund is not adequately financed over the next 10 years. HI income is projected to be lower than last year's estimates due to lower payroll taxes and lower income from the taxation of Social Security benefits. HI expenditures are projected to be slightly higher than last year's estimates because of higher-than-projected 2018 spending and higher projected provider payment updates, factors that are mostly offset by the effect of lower assumed utilization of skilled nursing facility services.

HI expenditures exceeded income each year from 2008 through 2015. In 2016 and 2017, however, there were fund surpluses amounting to $5.4 billion and $2.8 billion, respectively. In 2018, once again expenditures exceeded income, and there was a trust fund deficit of $1.6 billion. The Trustees project deficits in all future years until the trust fund becomes depleted in 2026. If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs. Beneficiary access to health care services would rapidly be curtailed. To date, Congress has never allowed the HI trust fund to become depleted.

The HI trust fund remains out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require significant increases in revenues and/or reductions in benefits. Policy makers should determine effective solutions to ensure the financial integrity of HI in the long term and should also consider the likelihood that the price adjustments in current law may prove difficult to adhere to fully and may require even more changes to address this challenge.

SMI

The SMI trust fund will remain adequate, both in the near term and into the indefinite future, because of the automatic financing established for Parts B and D. There is no provision in the law for transferring assets between the Part D and Part B accounts; therefore, it is necessary to evaluate each account's financial adequacy separately.

The nature of the financing for both parts of SMI is similar in that the law establishes a mechanism by which income from the Part B premium and the Part D premium, and the corresponding general revenue transfers for each part, are sufficient to cover the following year's estimated expenditures. Accordingly,

each account within SMI is automatically in financial balance under current law. Such financing, however, would have to increase faster than the economy to cover expected expenditure growth. A critical issue for the SMI trust fund is the impact of the rapid growth of SMI costs, which places steadily increasing demands on beneficiaries and taxpayers.

Medicare Overall

Federal law requires that the Board of Trustees issue a determination of excess general revenue Medicare funding if they project that under current law the difference between program outlays and dedicated financing sources[13] will exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2019 2025). For the 2019 Medicare Trustees Report, this difference is expected to exceed 45 percent of total expenditures in fiscal year 2021, and therefore the Trustees are issuing this determination. Since this determination was made last year as well, this year's determination triggers a Medicare funding warning, which (i) requires the President to submit to Congress proposed legislation to respond to the warning within 15 days after the submission of the Fiscal Year 2021 Budget and (ii) requires Congress to consider the legislation on an expedited basis. Such funding warnings were previously issued in each of the 2007 through 2013 reports and in the 2018 report. To date, elected officials have not enacted legislation responding to these funding warnings.

The projections shown continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the projected depletion of the HI trust fund, this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures. Furthermore, if the growth in Medicare costs is comparable to growth under the illustrative alternative projections, then policy reforms will have to address much larger financial challenges than those assumed under current law. In their 2019 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to "work closely together with a sense of urgency to address these challenges."

13 Dedicated Medicare financing sources used in this year's determination include HI payroll taxes; income from taxation of Social Security benefits; State transfers for the prescription drug benefit; premiums paid under Parts A, B, and D; fees allocated to Part B related to brand-name prescription drugs; and any gifts received by the Medicare trust funds.

COMBINING STATEMENT OF BUDGETARY RESOURCES

for the year ended September 30, 2019

(in millions)

	Medicare			Payments to Trust Funds	Medicaid	CHIP	Other	Program Management	Combined Total
	HI TF	SMI TF	Part D						
BUDGETARY RESOURCES:									
Unobligated balance from prior year budget authority, net (discretionary and mandatory)	$11	$55		$18,722	$60,625	$14,398	$9,575	$1,341	$104,727
Appropriations (discretionary and mandatory)	331,476	371,498	$85,639	402,347	406,923	25,178	8,679	4	1,631,744
Borrowing authority (discretionary and mandatory)							5		5
Spending authority from offsetting collections (discretionary and mandatory)			2,564		1,182		3,400	4,995	12,141
TOTAL BUDGETARY RESOURCES	$331,487	$371,553	$88,203	$421,069	$468,730	$39,576	$21,659	$6,340	$1,748,617
STATUS OF BUDGETARY RESOURCES:									
New Obligations and upward adjustments	$331,487	$371,553	$88,203	$373,052	$454,051	$17,718	$12,976	$5,003	$1,654,043
Unobligated balance, end of year									
Apportioned, unexpired accounts				29,312	62	5,352	4,782	132	39,640
Exempt from Apportionment, unexpired accounts									
Unapportioned, unexpired accounts					14,617	10,530	3,845	394	29,386
Unexpired unobligated balance, end of year				29,312	14,679	15,882	8,627	526	69,026
Expired unobligated balance, end of year				18,705		5,976	56	811	25,548
Unobligated balance, end of year (total)				48,017	14,679	21,858	8,683	1,337	94,574
TOTAL BUDGETARY RESOURCES	$331,487	$371,553	$88,203	$421,069	$468,730	$39,576	$21,659	$6,340	$1,748,617
OUTLAYS, NET:									
Outlays, net (discretionary and mandatory)	$327,856	$367,587	$85,140	$358,881	$404,899	$17,692	$9,711	$(88)	$1,571,678
Distributed offsetting receipts	(35,733)	(454,676)				(253)	(316)		(490,978)
AGENCY OUTLAYS, NET (DISCRETIONARY AND MANDATORY)	$292,123	$(87,089)	$85,140	$358,881	$404,899	$17,439	$9,395	$(88)	$1,080,700

SUPPLEMENTARY INFORMATION

CONSOLIDATING BALANCE SHEET

CONSOLIDATING STATEMENT OF NET COST

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

CONSOLIDATING BALANCE SHEET

as of September 30, 2019

(in millions)

	Medicare (Dedicated Collections)		Health (Other Funds)						
	HI TF	SMI TF	MEDICAID	CHIP	Other	Program Management	Combined Totals	Intra-CMS Eliminations	Consolidated Totals
ASSETS									
Intragovernmental Assets:									
Fund Balance with Treasury	$1,276	$62,166	$61,925	$33,307	$11,904	$218	$170,796		$170,796
Investments	200,115	105,263					305,378		305,378
Accounts Receivable, Net	38,490	39,690	853		3,682	4,944	87,659	$(87,070)	589
Other Assets									
Total Intragovernmental Assets	239,881	207,119	62,778	33,307	15,586	5,162	563,833	(87,070)	476,763
Accounts Receivable, Net	713	14,295	4,158	204	3,984	2	23,356		23,356
General Property, Plant & Equipment, Net	136				454	870	1,460		1,460
Other Assets	3		31		314	98	446		446
TOTAL ASSETS	$240,733	$221,414	$66,967	$33,511	$20,338	$6,132	589,095	$(87,070)	$502,025
LIABILITIES									
Intragovernmental Liabilities:									
Accounts Payable	$43,937	$44,583	$1		$2	$21	$88,544	$(87,068)	$1,476
Other Intragovernmental Liabilities	5	3,149			242	9	3,405	(2)	3,403
Total Intragovernmental Liabilities	43,942	47,732	1		244	30	91,949	(87,070)	4,879
Accounts Payable	28		86		39	80	233		233
Entitlement Benefits Due and Payable	34,445	37,146	37,147	$1,360	2		110,100		110,100
Contingencies	173		9,859				10,032		10,032
Other Liabilities	161	640	33		8,051	104	8,989		8,989
TOTAL LIABILITIES	$78,749	$85,518	$47,126	$1,360	$8,336	$214	$221,303	$(87,070)	$134,233
NET POSITION									
Unexpended Appropriations-Dedicated Collections	$1,008	$56,887			$68	$5	$57,968		$57,968
Unexpended Appropriations-Other Funds			$25,541	$31,631	5,144		62,316		62,316
Cumulative Results of Operations-Dedicated Collections	160,976	79,009			6,479	5,913	252,377		252,377
Cumulative Results of Operations-Other Funds			(5,700)	520	311		(4,869)		(4,869)
Total Net Position - Dedicated Collections	161,984	135,896			6,547	5,918	310,345		310,345
Total Net Position - Other Funds			19,841	32,151	5,455		57,447		57,447
TOTAL NET POSITION	$161,984	$135,896	$19,841	$32,151	$12,002	$5,918	$367,792		$367,792
TOTAL LIABILITIES AND NET POSITION	$240,733	$221,414	$66,967	$33,511	$20,338	$6,132	$589,095	$(87,070)	$502,025

CONSOLIDATING STATEMENT OF NET COST

for the year ended September 30, 2019

(in millions)

	Program	Program Management	Intra-CMS Eliminations	Total
Medicare HI				
Benefit/Program Expenses	$319,858			$319,858
Operating Expenses	2,453	$1,629	$(153)	3,929
Total Cost	322,311	1,629	(153)	323,787
Less: Exchange Revenues	(4,128)	(4)		(4,132)
Net Cost Medicare HI	$318,183	$1,625	$(153)	$319,655
Medicare SMI				
Benefit/Program Expenses (Part B)	$361,518			$361,518
Benefit Expenses (Part D)	76,866			76,866
Operating Expenses	(797)	$2,343	$(125)	1,421
Total Cost	437,587	2,343	(125)	439,805
Less: Exchange Revenues	(102,627)	(10)		(102,637)
Net Cost Medicare SMI	$334,960	$2,333	$(125)	$337,168
Medicaid				
Benefit/Program Expenses	$411,183			$411,183
Operating Expenses		$149		149
Total Cost	411,183	149		411,332
Less: Exchange Revenues				
Net Cost Medicaid	$411,183	$149		$411,332
CHIP				
Benefit/Program Expenses	$17,470			$17,470
Operating Expenses		$15		15
Total Cost	17,470	15		17,485
Less: Exchange Revenues				-
Net Cost CHIP	$17,470	$15		$17,485
Other				
Program Expenses	$8,913			$8,913
Operating Expenses	86	$602		688
Total Cost	8,999	602		9,601
Less: Exchange Revenues	(8,244)	(4)	$278	(7,970)
Net Cost Other	$755	$598	$278	$1,631
NET COST OF OPERATIONS	$1,082,551	$4,720		$1,087,271

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2019

(in millions)

	Dedicated Collections					All Other Funds				
	Medicare		Health		Total Funds From Dedicated Collections	Health (Other Funds)			Total All Other Funds	Consolidated Total
	HI TF	SMI TF	Other	Program Management		Medicaid	CHIP	Other		
UNEXPENDED APPROPRIATIONS										
Beginning Balances	$1,114	$21,741	$79		$22,934	$25,013	$33,638	$6,496	$65,147	$88,081
Budgetary Financing Sources:										
Appropriations Received	25,125	377,221		$10	402,356	488,175	27,120	655	515,950	918,306
Appropriations Transferred-in/out						(4,151)		(16)	(4,167)	(4,167)
Other Adjustments	(52)	(5,809)			(5,861)	(77,091)	(11,453)	(8)	(88,552)	(94,413)
Appropriations Used	(25,179)	(336,266)	(11)	(5)	(361,461)	(406,405)	(17,674)	(1,983)	(426,062)	(787,523)
Total Budgetary Financing Sources	(106)	35,146	(11)	5	35,034	528	(2,007)	(1,352)	(2,831)	32,203
Total Unexpended Appropriations	$1,008	$56,887	$68	$5	$57,968	$25,541	$31,631	$5,144	$62,316	$120,284
CUMULATIVE RESULTS OF OPERATIONS										
Beginning Balances	$170,987	$81,506	$4,484		$256,977	$(1,965)	$76	$662	$(1,227)	$255,750
Budgetary Financing Sources:										
Appropriations Used	25,179	336,266	11	$5	361,461	406,405	17,674	1,983	426,062	787,523
Nonexchange Revenue:										
FICA and SECA Taxes	281,441				281,441					281,441
Interest on Investments	6,734	2,701			9,435		254		254	9,689
Other Nonexchange Revenue	843	2,410			3,253					3,253
Transfers-in/out Without Reimbursement	(6,029)	(8,914)	1,145	10,586	(3,212)	1,043	(14)	(865)	164	(3,048)
Other Financing Sources (Nonexchange):										
Transfers-in/out Without Reimbursement								115	115	115
Imputed Financing	4		3	42	49			7	7	56
Other										
Total Financing Sources	$308,172	$332,463	$1,159	$10,633	$652,427	$407,448	$17,914	$1,240	$426,602	$1,079,029
Net Cost of Operations	318,183	334,960	(836)	4,720	657,027	411,183	17,470	1,591	430,244	1,087,271
Net Change	(10,011)	(2,497)	1,995	5,913	(4,600)	(3,735)	444	(351)	(3,642)	(8,242)
Cumulative Results of Operations	$160,976	$79,009	$6,479	$5,913	$252,377	$(5,700)	$520	$311	$(4,869)	$247,508
Net Position	$161,984	$135,896	$6,547	$5,918	$310,345	$19,841	$32,151	$5,455	$57,447	$367,792

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

NOV – 6 2019

TO: Seema Verma, M.P.H.
Administrator
Centers for Medicare & Medicaid Services

FROM: Gloria L. Jarmon
Deputy Inspector General for Audit Services

SUBJECT: *Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2019*, A-17-19-53000

This memorandum transmits the independent auditors' reports on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2019 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and other matters. The Chief Financial Officers Act of 1990 (P.L. No. 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the CMS financial statements in support of the U.S. Department of Health and Human Services audit.

We contracted with the independent certified public accounting firm of Ernst & Young, LLP, to audit the CMS (1) consolidated balance sheets as of September 30, 2019 and 2018, and the related consolidated statements of net cost and changes in net position, (2) the combined statement of budgetary resources for the years then ended, and (3) the statement of social insurance as of January 1, 2019, and related statement of changes in social insurance amounts. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 19-03, *Audit Requirements for Federal Financial Statements*.

Results of the Independent Audit

Ernst & Young found that the FY 2019 CMS consolidated balance sheets and the related consolidated statements of net cost and changes in net position and the combined statement of budgetary resources were fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. Ernst & Young was unable to obtain sufficient audit evidence for the particular amounts presented in the statements of social insurance as of January 1, 2019, 2018, 2017, 2016, and 2015, and the related statements of changes in social insurance amounts for the periods ended January 1, 2019 and 2018. As a result, Ernst & Young was not able and did not express an opinion on the financial condition of

the CMS social insurance program and related changes in the social insurance program for the specified periods.

Ernst & Young also noted two matters involving internal controls with respect to the financial reporting. Under the standards established by the American Institute of Certified Public Accountants and *Government Auditing Standards*, Ernst & Young identified significant deficiencies in CMS's financial reporting processes and information systems controls:

- *Financial Reporting Processes*—Ernst & Young noted that CMS continues its efforts to enhance internal controls as part of the financial reporting processes. Weaknesses in oversight of the Medicaid program included the need to further refine robust analytical procedures and benchmarks to monitor and identify risks associated with the Medicaid program. Also, the process to perform a detailed claims-level look-back analysis related to the Entitlement Benefits Due and Payable accrual that would determine the reasonableness of the various State calculations of the incurred but not reported liability should be further developed.

  Ernst & Young also identified weaknesses in the following areas: formula errors in the spreadsheets that are used in the preparation of the statement of social insurance were not detected by the organization's monitoring and review function and the recording of Medicare Administrative Contractor (MAC) account balances that utilized a manually prepared journal voucher. The recording of MAC account balances should be configured as a routine, systemic set of entries to properly categorize the information within the financial statements. These deficiencies collectively represent a significant deficiency in internal control.

- *Information Systems Controls*—Ernst & Young noted that deficiencies continue to be identified in implementing and monitoring access controls with CMS's information systems. CMS continues to encounter challenges in monitoring both its own and its contractor's adherence to CMS's established information systems control standards and processes. Ernst & Young noted that additional focus is required to minimize the risk of current and unresolved prior-year deficiencies. The deficiencies found continue to constitute a significant deficiency in internal control.

Ernst & Young identified that CMS was not in full compliance with the Improper Payments Information Act of 2002 (P.L. No. 107-300) (IPIA), as amended. Notably, the Medicaid program and the Children's Health Insurance Program (CHIP) reported error rates in excess of 10 percent. Both the Medicaid program and CHIP did not have an error rate target for FY 2019. CMS was incorporating a new eligibility measurement process, which would defer the establishment of error rate reduction targets until a baseline measurement was in place.

CMS was not in compliance with section 6411 of the Affordable Care Act. CMS had not yet implemented recovery activities of the identified improper payments for the Medicare Advantage (Part C) program. In addition, CMS was notified that it may have potential violations of the Anti-Deficiency Act related to certain contract obligations related to FYs 2014 and 2015.

Ernst & Young disclosed no other instances of noncompliance that are required to be reported under *Government Auditing Standards* and OMB Bulletin 19-03.

Evaluation and Monitoring of Audit Performance

We reviewed the audit of the CMS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the audit;
- attending key meetings with auditors and CMS officials;
- monitoring the progress of the audit;
- examining audit documentation related to the review of internal controls over financial reporting;
- reviewing the auditors' reports; and
- reviewing CMS's "Management Discussion and Analysis," "Financial Statements and Footnotes," "Required Supplementary Information," "Supplementary Information," and "Other Information."

Ernst & Young is responsible for the attached auditors' reports and the conclusions expressed in the reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on CMS's financial statements, the effectiveness of internal controls, whether financial management systems substantially complied with the Federal Financial Management Improvement Act of 1996 (P.L. No. 104-208), or compliance with other laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which Ernst & Young did not comply, in all material respects, with U.S. generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Carrie A. Hug, Assistant Inspector General for Audit Services, at (202) 619-1157 or through e-mail at Carrie.Hug@oig.hhs.gov. Please refer to report number A-17-19-53000.

Attachment

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Report of Independent Auditors

The Administrator and Chief Financial Officer of the Centers for Medicare and Medicaid Services and the Inspector General of the U.S. Department of Health and Human Services

Report on the Financial Statements

We have audited the accompanying consolidated balance sheets of the Centers for Medicare and Medicaid Services (CMS) as of September 30, 2019 and 2018, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal years then ended, and the related notes to the financial statements. We were also engaged to audit the sustainability financial statements, which comprise the statements of social insurance as of January 1, 2019, 2018, 2017, 2016, and 2015, the related statements of changes in social insurance amounts for the periods ended January 1, 2019 and 2018, and the related notes to the sustainability financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audits. Except as discussed in the Basis for Disclaimer of Opinion paragraphs with respect to the accompanying statements of social insurance as of January 1, 2019, 2018, 2017, 2016, and 2015, the related statements of changes in social insurance amounts for the periods ended January 1, 2019 and 2018, and the related notes to these financial statements, we conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 19-03, *Audit Requirements for Federal Financial Statements*. Those standards and OMB Bulletin No. 19-03 require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions on the consolidated balance sheets as of September 30, 2019 and 2018, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal years then ended, and the related notes to these financial statements.

Basis for Disclaimer of Opinion on the Statements of Social Insurance and the related Changes in the Social Insurance Program

As discussed in Note 11 to the financial statements, the statement of social insurance presents the actuarial present value of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds' estimated future income to be received from or on behalf of the participants and estimated future expenditures to be paid to or on behalf of participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. The sustainability financial statements are intended to aid users in assessing whether future resources will likely be sufficient to sustain public services and to meet obligations as they come due. The statements of social insurance and changes in social insurance amounts are based on income and benefit formulas in current law and assume that scheduled benefits will continue after any related trust funds are exhausted. The sustainability financial statements are not forecasts or predictions. The sustainability financial statements are not intended to imply that current policy or law is sustainable. In preparing the statement of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statement. Because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. Projections of Medicare costs are sensitive to assumptions about future decisions by policymakers and about the behavioral responses of consumers, employers, and health care providers as policies, incentives, and the health care sector change over time. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, and as discussed below, significant additional variability and issues regarding the sustainability of the underlying assumptions under current law were introduced by the passage of

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the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act (MACRA).

With respect to the estimates for the social insurance program presented as of January 1, 2019, 2018, 2017, 2016, and 2015, the current-law expenditure projections reflect the physicians' payment levels expected under the MACRA payment rules and the ACA-mandated reductions in other Medicare payment rates. Management has developed an illustrative alternative scenario and projections intended to quantify the potential understatement of projected Medicare costs to the extent that certain payment provisions were not fully implemented in all future years. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 12, the ability of health care providers to sustain these price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services and that physician costs will grow at a faster rate than the specified updates. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. Absent a change in the health care delivery system or level of update by subsequent legislation, access to Medicare-participating providers may become a significant issue in the long term under current law. Overriding the price updates in current law, as lawmakers repeatedly did in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in this report. As a result of these limitations, we were unable to obtain sufficient audit evidence for the amounts presented in the statements of social insurance as of January 1, 2019, 2018, 2017, 2016, and 2015, and the related statements of changes in social insurance amounts for the periods ended January 1, 2019 and 2018.

Disclaimer of Opinion on the Statements of Social Insurance and the related Changes in the Social Insurance Program

Because of the significance of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the financial condition of the CMS social insurance program as of January 1, 2019, 2018, 2017, 2016, and 2015, and the related changes in the social insurance program for the periods ended January 1, 2019 and 2018.

Opinion

In our opinion, the consolidated balance sheets, consolidated statements of net cost and changes in net position, and combined statements of budgetary resources referred to above present fairly, in all material respects, the financial position of CMS as of September 30, 2019 and 2018, and its net cost, changes in net position, and budgetary resources for the years then ended in conformity with U.S. generally accepted accounting principles.

Other Matters

Required Supplementary Information

U.S. generally accepted accounting principles require that Management's Discussion and Analysis and Required Supplementary Information as identified on CMS' Annual Financial Report Table of Contents, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Federal Accounting Standards Advisory Board which considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Supplementary and Other Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise CMS' basic financial statements. The Supplementary Information is presented for purposes of additional analysis and is not a required part of the basic financial statements.

The Supplementary Information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the Supplementary Information is fairly stated, in all material respects, in relation to the basic financial statements as a whole.

The Other Information has not been subjected to the auditing procedures applied in the audit of the basic financial statements, and, accordingly, we do not express an opinion or provide any assurance on it.

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Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 6, 2019, on our consideration of CMS' internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of those reports is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of CMS' internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* in considering CMS' internal control over financial reporting and compliance.

Ernst & Young LLP

November 6, 2019

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Report of Independent Auditors on Compliance and Other Matters Based on an Audit of the Financial Statements Performed in Accordance with *Government Auditing Standards*

The Administrator and Chief Financial Officer of the Centers for Medicare and Medicaid Services and the Inspector General of the U.S. Department of Health and Human Services

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 19-03, *Audit Requirements for Federal Financial Statements*, the financial statements of the Centers for Medicare and Medicaid Services (CMS), which comprise the consolidated balance sheet as of September 30, 2019, and the related consolidated statements of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal year then ended, and the related notes to the financial statements, and we were engaged to audit the statement of social insurance as of January 1, 2019, and the related statement of changes in social insurance amounts for the period ended January 1, 2019, and have issued our report thereon dated November 6, 2019. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2019, and the related statement of changes in social insurance amounts for the period ended January 1, 2019.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether CMS' financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in OMB Bulletin No. 19-03. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. We limited our tests of compliance to these provisions, and we did not test compliance with all laws and regulations applicable to CMS. The results of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 19-03, and which are described below:

The Improper Payments Information Act of 2002 as amended by the Improper Payments Elimination and Recovery Act of 2010 and the Improper Payments Elimination and Recovery Improvement Act of 2012 (hereinafter the Acts) require federal agencies to identify programs and

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activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. Although CMS has reported improper payment rates for each of its high-risk programs, or components of such programs, it is not in full compliance with the Acts. The Medicaid and CHIP improper payment rates exceeded the statutorily required maximum of 10 percent. In addition, CMS was not in full compliance with Section 6411 of the Affordable Care Act as CMS had not yet implemented recovery activities of the identified improper payments for the Medicare Advantage (Part C) program.

During FY2019, CMS management was notified that it may have potential violations of the Anti-Deficiency Act related to certain contract obligations related to fiscal years 2014 and 2015.

CMS' Response to Findings

CMS' response to the findings identified in our audit are described in their letter dated November 6, 2019. CMS' response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of compliance and the results of that testing, and not to provide an opinion on the entity's compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's compliance. Accordingly, this communication is not suitable for any other purpose.

Ernst & Young LLP

November 6, 2019

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Report of Independent Auditors on Internal Control Over Financial Reporting Based on an Audit of Financial Statements Performed in Accordance with *Government Auditing Standards*

The Administrator and Chief Financial Officer of the Centers for Medicare and Medicaid Services and the Inspector General of the U.S. Department of Health and Human Services

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial statement audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 19-03, *Audit Requirements for Federal Financial Statements*, the financial statements of the Centers for Medicare and Medicaid Services (CMS), which comprise the consolidated balance sheet as of September 30, 2019, and the related consolidated statements of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal year then ended, and the related notes to the financial statements, and we were engaged to audit the statement of social insurance as of January 1, 2019, and the related statement of changes in social insurance amounts for the period ended January 1, 2019, and have issued our report thereon dated November 6, 2019. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2019, and the related statement of changes in social insurance amounts for the period ended January 1, 2019.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered CMS' internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of CMS' internal control. Accordingly, we do not express an opinion on the effectiveness of CMS' internal control. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 19-03. We did not test all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982, such as those controls relevant to ensuring efficient operations.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a

material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist, that were not identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified. We did identify certain deficiencies in internal control related to Financial Reporting Processes and Information Systems Controls, as described below that we consider to be significant deficiencies.

Significant Deficiencies

Financial Reporting Processes

Financial management in the Federal government requires accountability of financial and program managers for financial results of actions taken, control over the Federal government's financial resources and protection of Federal assets. To enable these requirements to be met, financial management systems and internal controls must be in place to process and record financial events effectively and efficiently and to provide complete, timely, reliable and consistent information for decision-makers and the public. CMS is a very large organization that is responsible for the management of complex programs that are continuing to increase in scope and size. CMS is entrusted with the lead role in overseeing health services in the United States. Financial reporting of the cost of health programs and the oversight role is important as the country continues to make decisions about this critical mission.

CMS relies on a decentralized organization and a high number of complex financial management systems to operate and accumulate data for financial reporting. The business owners and users of the systems are located at contracted organizations, providers, regional offices, Centers and Offices outside of the Office of Financial Management (OFM). Providing oversight requires a common set of accounting and reporting standards, proper execution of those standards/policies, an integrated financial system, properly trained personnel, and meaningful collaboration within CMS and with the Department of Health and Human Services (HHS).

As CMS continues its efforts to enhance internal controls, the following areas identified in the current year audit merit continued focus as part of the financial reporting processes significant deficiency.

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Medicaid Oversight

The Medicaid program is the primary source of medical assistance for low-income Americans. Medicaid operates as a partnership between the states and the Federal government. The Federal government establishes the minimum requirements and provides oversight for the program and the states design, implement, administer and oversee their own Medicaid programs within the Federal parameters.

The CMS regional offices are responsible for reviewing the states' quarterly Medicaid CMS-37 budgetary and CMS-64 expenditure reports. This is a critical process in CMS's oversight of the Medicaid program administered by each state. As a result of changes in regulations, increasing complexity including eligibility requirements, and the overall growth of the Medicaid program, these reviews have become more complex. Standard operating procedures and review guides designed to promote consistency in these reviews across regions continue to require increasing efforts. In the current year, EY identified multiple instances of inadequate review and documentation across various regional offices. Inaccuracies in amounts reported by the states, as well as unapproved expenditures, may go undetected as a result of insufficient reviews.

CMS previously completed implementation of the Transformed-Medicaid Statistical Information System (T-MSIS). T-MSIS modernizes and enhances the way states submit operational data about beneficiaries, providers, health plans, claims and encounters. Although operational data is currently available, CMS must continue to work with states to assess and improve T-MSIS state data quality to support national and state level program analysis with timely, accurate, and complete data for policymaking and research. At this time the information contained within T-MSIS requires additional verification before it would be considered reliable. CMS should continue to enhance the usefulness of T-MSIS data so they will be able to perform robust analytical procedures and develop benchmarks to monitor and identify risks associated with the Medicaid program. Examples of risks to monitor could include outliers and unusual or unexpected results that demonstrate abnormalities in state-related Medicaid expenditures and/or allow CMS to assess the reliability of the T-MSIS data. Given that CMS does not currently maintain reliable historical claims level detail for Medicaid, data analyses have been limited. At this time, CMS is unable to perform a claims-level detailed look-back analysis for the Medicaid Entitlement Benefits Due and Payable (EBDP) to determine the reasonableness of the various state calculations of incurred (unpaid claims) but not reported liability. The Medicaid EBDP is a significant liability on the FY 2019 financial statements and is subject to volatility based on the complexity and judgement required in establishing this estimate. From time to time, claim processing cycle changes, such as a claims inventory buildup, may arise. As such, the lack of detailed claims data limits the ability to detect this type of situation on a timely basis or consider the potential volatility from this occurrence.

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Despite the implementation of T-MSIS, CMS must continue to evaluate and improve the quality and completeness of data reported by the states in T-MSIS before a claims level detailed look-back analysis for Medicaid EBDP can be suitably relied upon. Until further analysis is developed and performed to verify the reliability of T-MSIS data, there remains a risk that potential updates to CMS' analysis will not be reflected in CMS' financial statements in a timely manner.

Oversight of Third-Party Contractors

CMS relies heavily on third-party contractors as it outsources substantially all of the day-to-day operations for its information technology systems, the payment of Medicare Fee-for-Service and Medicaid claims and certain services related to the Medicare Part C and Part D programs. The contracts between CMS and its Medicare Fee-for-Service contractors include provisions that require the Medicare Administrative Contractors (MACs) to develop policies and procedures that satisfy the objectives established by CMS. Through the established procedures, CMS monitors the MACs' compliance with its policies and procedures, established internal controls and the completeness and accuracy of financial reporting. The MACs' account balances are recorded at Central Office through the manual journal voucher process and should be configured as routine systematic entries within the system to properly categorize the information within the financial statements and reduce risk of manual error, as required by OMB Circular A-136, *Financial Reporting Requirements*.

Statements of Social Insurance

The Statements of Social Insurance (SOSI) for CMS presents a long-term projection of the present value of the benefits to be paid for the closed and open groups of existing and future participants of the Medicare social insurance programs less the inflows to be received from, or on behalf of, those same individuals. The SOSI models are complex, 75-year projections that contain a high degree of estimation. The models and their results are heavily reviewed by actuaries and others within CMS. The veracity of the underlying data remains critical to the accuracy of the model, and as a result the reviews of the underlying data is robust, in line with CMS' policies and procedures. As part of this review, the input into the spreadsheet is checked against the original data sources to ensure that no input errors have been made. In addition, output data, including those that are generated from updating and running any macro in the spreadsheet, are checked by the reviewer. These checks include a comparison to the results from the year before, and testing of the formulas that are part of the spreadsheet or macro, to ensure that the projection output from the program is as expected and reasonable. During our procedures, formula errors were identified that were not detected by the organization's monitoring and review function, and accordingly, the related control was not functioning as designed.

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Improper Payments

The nature and volume of its expenditures present a substantial challenge to CMS in the quantification, evaluation and remediation of improper payments. Health insurance claims represent the vast majority of the CMS payments. These payments are complex and involve the evaluation of the program eligibility of both the recipient of the services and of the health provider, oversight of the medical necessity of each covered treatment and concurrence with the cost to be paid, some of which is based on complex financial formulas and/or coding decisions. CMS has developed sophisticated sampling processes for estimating improper payment rates in the high-risk CMS programs of Medicare Fee-for-Service (FFS), Medicare Advantage, Medicare Prescription Drugs, Medicaid and CHIP.

CMS builds in time to their processes to allow all payments sampled for review sufficient time to allow for appeals of the errors and submission of additional documentation by the claimant. CMS believes that expediting the improper payment rate calculations would result in less time for sampled payments to complete the measurement process allowing errors to be cited solely due to the fact that not enough time was given for things such as appeals or documentation submission. Allowing the maximum amount of time for this development causes the processes to be completed very near the required annual reporting deadline. CMS remains committed to achieving reductions in improper payment rates. As a result, improper payment rates declined for Medicare FFS, Medicare Part C, and Medicare Part D. For Medicaid and CHIP, CMS reintegrated the eligibility component of the measurement in 2019 resulting in an increase in the improper payment rates; however, the 2019 rates are not comparable to the prior year as a result of this reintegration of the new eligibility component. Rates between years will not be comparable until a baseline is established in 2021 when all states have been measured under the new eligibility requirements. CMS has specific initiatives underway to address these new results.

Recommendations

We recommend that CMS continue to develop, refine and adhere to its financial management systems and processes to improve its accounting, analysis and oversight of financial management activity. Specifically, we recommend that CMS implement the following:

- Refine the review guides and standard operating procedures to define clear expectations of what is required by the regional offices in their review of the CMS-37 and CMS-64 reports, including potentially developing a robust analysis example to aid the regional offices in reviewing and approving these.

- Consider additional processes or controls, including the use of analytics, that can be implemented at Central Office to mitigate the risk that unsupported Medicaid budget and expenditure amounts are not detected as part of the regional office review.

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- Continue to enhance the data analyses on Medicaid claims level data to develop robust analytical procedures and measures against benchmarks to monitor and identify risks associated with the Medicaid program.

- Establish a process to perform a claims-level detailed look-back analysis on the Medicaid EBDP to determine the reasonableness of the methodology utilized to record the approximately $37.1 billion accrual.

- Consider whether there are portions of the manual journal voucher process to record MAC data at Central Office that should be configured as routine systematic entries within the system.

- Continue to adhere to established policies and procedures to ensure that the SOSI model methodology and related calculation and estimates are reviewed at a level of sufficient precision.

- Consider additional opportunities to further reduce improper payments which are consistent with the organization's objectives of improving payment accuracy levels.

Information Systems Controls

Information systems controls are a critical component of the Federal government's operations to manage the integrity, confidentiality and reliability of its programs and activities and assist with reducing the risk of errors, fraud or other illegal acts. The nature, size and complexity of CMS' operations require the organization to administer its programs under a decentralized business model by using numerous geographically dispersed contractors operating complex and extensive information systems.

As CMS continues its efforts to enhance its internal controls, the following items identified in the current year audit merit continued focus on the information systems controls and processes. Additional focus is required to minimize the risk of current and unresolved prior year deficiencies.

Controls over System Access

CMS has a large number of users required to have access to CMS systems to process claims and to support beneficiaries in a timely and effective manner. As such, properly implemented system access controls including user and system account management and monitoring of system access are critical to preventing and detecting unauthorized usage of CMS information resources, including program and data files. Without maintaining an appropriate level of access controls within CMS systems, the integrity of CMS' information resources could be compromised.

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Improvements in this area were noted as compared to the prior year, however, deficiencies continued to be identified in the implementation and monitoring of access controls, including controls over privileged access to the CMS information systems. Examples included:

- Procedures for the removal of users who no longer required access were not consistently followed.

- Monitoring of privileged access for key applications and underlying IT infrastructure was not performed or evidence of such monitoring activity was not retained.

Appropriate consideration of the design of controls over access and monitoring of access is essential to provide a suitable framework for subsequent implementation and operation of the controls. Without adequate controls over managing access to critical systems, the risk of errors, fraud or other illegal acts is increased.

Governance Over Implementation of Information Systems Control Standards and Processes

While progress has been made towards implementing greater oversight and uniformity in the design and operation of CMS' IT controls, CMS continues to encounter challenges with monitoring their own and contractors' adherence to their established information systems control standards and processes, particularly as it relates to the organization's access monitoring controls. Further, the oversight of the information systems control standards and processes is performed by multiple business units within the CMS Central Office, such as the Office of Information Technology (OIT), Office of Financial Management (OFM), and the Center for Medicare (CM). The multiple business units involved in oversight activities heighten CMS' inability to enforce enterprise-wide risk management strategy, and overall integrity of its Medicare systems and other enterprise-wide systems.

Deficiencies continued to be identified, similar to previous years, in the contractors' implementation and CMS' monitoring of compliance with CMS' information systems control standards and processes, which included:

- CMS' risk management strategy is decentralized and lacks an enterprise viewpoint, which has resulted in several vulnerabilities related to system configurations with the Central Office information systems hosted at the Baltimore Data Center (BDC) and Leidos Managed Data Center (LMDC). The remediation, mitigation of risks, or monitoring of these vulnerabilities was not performed or not performed timely.

- The distributed nature of CMS' IT environment has resulted in the identification of control deficiencies stemming from inadequate implementation of access controls. Commonality in access control deficiencies across the business units indicates monitoring and oversight is an enterprise level risk for which standardized processes should be developed to allow the varying IT environments to implement common access controls.

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Without sufficient and consistent oversight by CMS Central Office to monitor and enforce compliance with its established information security and configuration management policies and procedures, Medicare systems and other enterprise-wide systems may be susceptible to error, fraud, and/or security vulnerabilities that may impact claims processing and financial reporting.

Recommendations

CMS should continue to improve the operating effectiveness of the access controls to ensure that:

- Relevant CMS guidance is followed for the removal of users to all systems.
- Privileged access for key applications and the underlying IT infrastructure is monitored to detect and correct unauthorized access or activities, and evidence of such monitoring activities is retained.

Specific to the governance over implementation of information systems controls standards and processes, CMS should continually assess the governance and oversight across its organizational units charged with responsibility for the information security of its systems and data at both the Central Office and the CMS Medicare FFS contractors. Such an approach will require continued and active communication and integration of efforts by the OFM, OIT and CM.

An improved enterprise governance-based approach should result in strengthened control, monitoring, and oversight processes that will enhance the overall integrity and resiliency of CMS' information systems. Examples of such processes that should be improved include:

- Enhanced risk management policies, procedures, and practices that focus on the role of the IT system within the enterprise and a clear definition of responsibilities associated with the oversight and implementation of controls to address identified risks.
- Ensuring that remediation of findings identified as a part of OIG and OMB A-123 audits including tests performed on CMS and its Medicare contractors' IT operations is performed timely.

CMS' Response to Findings

CMS' response to the findings identified in our audit are described in the accompanying letter dated November 6, 2019. CMS' response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Building a better working world

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control. Accordingly, this communication is not suitable for any other purpose.

Ernst & Young LLP

November 6, 2019

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT

November 6, 2019

Ernst & Young, LLP
1101 New York Avenue, N.W.
Washington, DC 20005

Dear Sir:

This letter is in response to your audit report on the Centers for Medicare & Medicaid Services' (CMS) fiscal year 2019 financial statements and annual Agency Financial Report. We have reviewed your report and are pleased to receive an unmodified opinion on our Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position, and the Combined Statement of Budgetary Resources.

As in previous years, you were not able to express an opinion on the sustainability financial statements, the Statement of Social Insurance (SOSI) and the Statement of Changes in Social Insurance Amounts (SCSIA). CMS remains confident that our SOSI model projections are fairly presented, and have provided sufficient disclosures regarding the nature and uncertainty of these projections. We look forward in continuing our partnership with you to find a solution to report the SOSI projections that will allow auditors to opine on these statements in future annual financial statement audits.

While your audit identified no material weaknesses in our internal controls, you continue to report two significant internal control deficiencies in our financial reporting processes and information systems. We are committed in establishing effective corrective actions that will strengthen our internal controls and remediate the deficiencies you have noted.

Acknowledging the complexity of our programs, we would like to thank you for your hard work in successfully completing the audit, and are most appreciative of the professional conduct and manner displayed by your audit team.

Sincerely,

Megan Worstell

Megan Worstell
Chief Financial Officer

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3

OTHER INFORMATION

Summary of Federal Managers' Financial Integrity Act Report and OMB Circular No. A-123, Management's Responsibility for Enterprise Risk Management and Internal Control // Improper Payments

SUMMARY OF FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT REPORT AND OMB CIRCULAR A-123, MANAGEMENT'S RESPONSIBILITY FOR ENTERPRISE RISK MANAGEMENT AND INTERNAL CONTROL

CMS assesses its internal controls through: (1) management self-assessments, including annual tests of security controls; (2) *Office of Management and Budget (OMB) Circular A-123*, Appendix A self-assessments; (3) assessments of internal control over the acquisition function; (4) Office of Inspector General (OIG) audits, and Government Accountability Office (GAO) audits and High-Risk reports; (5) Statement on Standards for Attestation Engagements (SSAE) 18 internal control audits; (6) evaluations and tests of Medicare contractor controls conducted pursuant to section 912 of the *Medicare Modernization Act*; (7) the annual *Chief Financial Officers* (CFO) *Act* audit; (8) security assessment and authorization of systems; and (9) Department Enterprise Risk Management efforts. As of September 30, 2019, the internal controls and financial management systems of CMS provided reasonable assurance that the objectives of the *Federal Managers' Financial Integrity Act* (FMFIA) were achieved with the exception of two instances of noncompliance described below.

OMB Circular A-123 Statement of Assurance

CMS management is responsible for establishing and maintaining effective internal controls and financial management systems that meet the objectives of FMFIA and *OMB Circular A-123*, Management's Responsibility for Enterprise Risk Management and Internal Control, dated July 2016. These objectives are to ensure: (1) effective and efficient operations, (2) compliance with applicable laws and regulations, and (3) reliable financial reporting.

As required by *OMB Circular A-123*, CMS evaluated its internal controls and financial management systems to determine whether these objectives are being met. Accordingly, as of September 30, 2019, CMS provided a modified statement of reasonable assurance that its internal controls and financial management systems met the objectives of FMFIA due to noncompliance with the *Improper Payments Information Act of 2002* (IPIA), as amended by the *Improper Payments Elimination and Recovery Act* (IPERA), signed into law on July 22, 2010, and the *Improper Payments Elimination and Recovery Improvement Act* (IPERIA), signed into law on January 10, 2013 (hereafter referenced as IPIA); and Section 6411 of the *Patient Protection Affordable Care Act* (PPACA).

Assurance for Internal Control over Financial Reporting

CMS conducted its assessment of the effectiveness of internal control over financial reporting, which includes the safeguarding of assets and compliance with applicable laws and regulations, in accordance with the requirements of Appendix A of *OMB Circular A-123*. Based on the results of this assessment, CMS provided reasonable assurance that internal controls over financial reporting as of June 30, 2019 were operating effectively and no material weaknesses were found in the design or operation of the internal controls over financial reporting.

Assurance for Internal Control over Operations and Compliance

CMS conducted its assessment of internal control over the effectiveness and efficiency of operations and compliance with applicable laws and regulations in accordance with *OMB Circular A-123*. Based on the results of this evaluation, as of September 30, 2019, CMS provided reasonable assurance that internal controls over operations were effective, and no material weaknesses were found in the design or operation of these internal controls. As of September 30, 2019, CMS also complied with applicable laws and regulations, except for the noncompliance noted above.

Assurance for the Federal Financial Management Improvement Act of 1996

The *Federal Financial Management Improvement Act of 1996* (FFMIA) requires agencies to implement and maintain financial management systems that are substantially in compliance with Federal financial management systems requirements, Federal accounting standards, and the United States Standard General Ledger at the transaction level. CMS conducted its assessment of financial management systems for compliance with FFMIA. Based on the results of this evaluation, CMS provided reasonable assurance that CMS financial management and related systems substantially comply with FFMIA as of September 30, 2019.

Noncompliance – Actions and Accomplishments

CMS did not fully comply with the requirements of the IPIA, and section 6411 of the Patient Protection Affordable Care Act (PPACA). CMS and HHS work together to set aggressive reduction targets in an effort to drive improvement in payment accuracy levels. CMS has multiple corrective actions in place or under development to reduce improper payments. CMS believes these major undertakings will have a larger impact through time.

CMS's fiscal year (FY) 2019 IPIA, as amended, noncompliance stems from the following:

1. The Medicaid improper payment rate was 14.90 percent, higher than 10 percent IPIA required threshold.

2. The FY 2019 Children's Health Insurance Program (CHIP) improper payment rate was 15.83 percent, higher than 10 percent IPIA required threshold.

CMS has taken, and continues to take a number of actions outlined in the FY 2019 Agency Financial Report (AFR). CMS continues its efforts to comply with the requirements of the IPIA and OMB's implementing guidance. Regarding compliance with section 6411 of the PPACA, as part of the A-19 process, CMS is seeking to remove authority requiring CMS to expand the recovery audit program to Medicare Parts C and D programs. To more efficiently use program integrity resources, the FY 2020 budget included a proposal to remove the requirement for HHS to expand the RAC program to Medicare Part C. The proposal also requires plan sponsors to report Part C fraud and abuse incidents and corrective actions. Given that the functions of the Part C RAC program are being performed through other program integrity mechanisms, the proposal creates programmatic and administrative efficiencies while strengthening fraud and abuse reporting. The primary corrective action on the Part C payment error has been the Risk Adjustment Data Validation (RADV) audits. RADV verifies that diagnoses submitted by Medicare Advantage (MA) organizations for risk adjusted payment are supported by medical record documentation. The RADV program is currently operational with the support

of contractors that the government has procured. As part of the effort to effectively implement a successful Part C RAC program, in 2015, CMS issued a Request for Information on the proposal to put RADV under the purview of a Part C RAC. In the responses, the MA industry expressed concerns of burden related to the high overturn rate in the early experience of the Parts A and B RAC programs. Additionally, potential RAC vendors expressed concerns with the unlimited delay in the contingency payment due to time frames not being established for appeal decisions in the MA appeal process (42 C.F.R. § 423.2600).

The functions of the Part C RAC are being performed by the RADV program. The proposed scope of the Part C RAC has been subsumed by an updated RADV methodology that addresses recommendations in the GAO report, "Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments" (GAO-16-76). The new methodology targets payment error using historical payment error data. In January 2019, HHS hosted an industry-wide training providing an overview of the RADV program for MA organizations' representatives, Programs of All-Inclusive Care for the Elderly, Cost Plans, Demonstration Projects, and Third Party Submitters. In April 2019, HHS launched the payment year 2014 RADV audit and held a training webinar for MA organizations selected for audits. The purpose of the training was to prepare the MA industry for the selection of audited MA organizations for RADV audits. The payment year 2014 RADV audit is currently underway and is expected to conclude in late FY 2020. HHS launched payment year 2015 RADV audits in late FY 2019.

IMPROPER PAYMENTS

IPIA includes requirements for identifying programs susceptible to significant improper payments, annually reporting estimates of improper payments, and implementing corrective actions to reduce improper payments. IPIA defines improper payments as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments). Improper payments also include payments to ineligible recipients, payments for ineligible services, duplicate payments, payments for services not received, as well as payments that are lacking sufficient documentation. Since FY 2012, CMS has complied with OMB's implementing guidance and instituted comprehensive processes that measure the payment error rates for the Medicare Fee-for-Service (FFS), Medicare Advantage (Part C), Medicare Prescription Drug (Part D), Medicaid, and CHIP programs.

Medicare FFS

CMS measures the national Medicare FFS improper payment rate annually, through the Comprehensive Error Rate Testing (CERT) program. The Medicare FFS measurement methodology remains the same since FY 2012. The estimated percentage of Medicare FFS dollars paid correctly was 92.75 percent. This means Medicare paid an estimated $369.72 billion correctly in FY 2019.

The CERT program estimates the Medicare FFS payment accuracy rate by reviewing claims and the submitted medical records. These reviews uncover causes of improper payments including insufficient documentation and lack of medical necessity. These types of improper payments are not detectable through automated reviews. To achieve an even greater payment accuracy rate, CMS must focus its corrective actions on specific areas that are most vulnerable to improper payments.

The national Medicare FFS estimated improper payment rate for FY 2019 is 7.25 percent or $28.91 billion in gross improper payments.[1] Improper payments for skilled nursing facility (SNF), hospital outpatient, inpatient rehabilitation facility (IRF), and home health claims were the major contributing factors to the FY 2019 Medicare FFS improper payment rate. While the factors contributing to improper payments are complex and vary by year, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors.

- Insufficient documentation continues to be the major error reason for SNF claims. The SNF claims improper payment rate increased from 6.55 percent in FY 2018 to 8.54 percent in FY 2019. The primary reason for

1 Beginning in FY 2012, in consultation with OMB, CMS refined the improper payment methodology to account for the impact of rebilling denied Part A inpatient hospital claims for allowable Part B services when a Part A inpatient hospital claim is denied because the services (i.e. improper payments due to inpatient status reviews) should have been provided as outpatient services. CMS continued using this methodology from FY 2013 through FY 2019. This approach is consistent with: (1) Administrative Law Judge (ALJ) and Departmental Appeals Board (DAB) decisions that directed CMS to pay hospitals under Part B for all of the services provided if the Part A inpatient claim was denied, and (2) recent Medicare policy changes that allow rebilling of denied Part A claims under Part B.

CMS calculated an adjustment factor based on a statistical subset of inpatient claims that were in error because the services should have been provided as outpatient. This adjustment factor reflects the difference between what was paid for the inpatient hospital claims under Medicare Part A and what would have been paid had the hospital claim been properly submitted as an outpatient claim under Medicare Part B. Application of the adjustment factor decreased the overall improper payment rate by 0.20 percentage points to 7.25 percent or $28.91 billion in projected improper payments.

the errors was missing or insufficient certification/ recertification statements. Medicare coverage of SNF services requires certification and recertification for these services (42 Code of Federal Regulation [CFR] §424.20).

- Insufficient documentation continues to be the major reason for error for hospital outpatient claims. The improper payment rate for hospital outpatient claims increased from 3.25 percent in FY 2018 to 4.37 percent in FY 2019. The primary reason for the errors was that the order (or intent to order for certain services) or medical necessity documentation was missing or insufficient (42 United States Code [U.S.C.] §1395y, 42 CFR 410.32).

- Medical necessity (i.e., the services billed were not medically necessary) continues to be the major error contributor for IRF claims. The IRF claims improper payment rate decreased from 41.55 percent in FY 2018 to 34.87 percent in FY 2019. The primary reason for these errors was that the IRF coverage criteria for medical necessity were not met. Medicare coverage of IRF services requires a reasonable expectation that the patient meets all coverage criteria at the time of IRF admission (42 CFR §412.622(a)(3)).

- Insufficient documentation for home health claims continues to be prevalent, despite the improper payment rate decrease from 17.61 percent in FY 2018 to 12.15 percent in FY 2019. The primary reason for the errors was insufficient or missing documentation to support the certification of home health eligibility requirements. Medicare coverage of home health services requires physician certification of the beneficiary's eligibility for the home health benefit (42 CFR 424.22).

CMS uses data from the CERT program and other sources of information to address improper payments in Medicare FFS through various corrective actions, such as policy clarifications and simplifications, when appropriate, as well as targeted probe and educate reviews, which include more individualized education through smaller probe reviews, followed by specific education based on the findings of these reviews. CMS is also continuing prior authorization initiatives, as appropriate, which help to make sure that applicable coverage, payment, and coding rules are met before services are rendered while ensuring access to and quality of care. CMS has developed a number of preventative measures for specific service areas with high improper payment rates. CMS believes implementing targeted corrective actions in these areas will prevent and reduce improper payments in these areas and reduce the overall improper payment rate.

Medicare Advantage and Prescription Drugs

CMS improper payments made to Medicare Advantage (MA) plans based on diagnoses submitted by MA organizations for payment (or risk adjustment error). The Part C payment error rate was 7.87 percent for the FY 2019 reporting period.

From FY 2011 to FY 2015, CMS reported a composite improper payment rate for Part D, a Medicare benefit effective calendar year 2006. With OMB's approval for FY 2016 and subsequent years, the Part D payment error estimate measures payment errors related to prescription drug event data, where the majority of errors for the program exists. The Part D improper payment error rate was .75 percent for the FY 2019 reporting period.

With respect to compliance with section 6411 of the PPACA, CMS is seeking to remove authority requiring CMS to expand the recovery audit program to Medicare Parts C and D programs through the A-19 process.

Medicaid and CHIP

Medicaid and CHIP are susceptible to erroneous payments as well. Thus, the Federal government and the states both have a strong financial interest in ensuring that claims are paid accurately. CMS measures the national improper payment rate for Medicaid and CHIP annually, through the Payment Error Rate Measurement (PERM) program. Through PERM, CMS measures three areas of Medicaid and CHIP: FFS claims, managed care payments, and eligibility determinations. A sample of 17 states is measured each year to produce and report national program improper payment rates.

The FY 2019 Medicaid and CHIP improper payment rate report period covers payments made through June 30, 2018. It is important to note that CMS resumed the eligibility component measurement under the PERM final rule (82 FR 31158, July 5, 2017) for the first cycle of 17 states and reported an updated national eligibility improper payment estimate for FY 2019. The national eligibility improper payment rate also includes a proxy estimate for the remaining 34 states that have not yet been measured since the reintegration of the PERM eligibility component.

The national Medicaid improper payment rate reported for FY 2019 is 14.90 percent or $57.36 billion in improper payments based on measurements

conducted in FYs 2017, 2018, and 2019.[2] The national component improper payment rates are: Medicaid FFS: 16.30 percent; Medicaid managed care: 0.12 percent; Medicaid eligibility: 8.36 percent. State non-compliance with provider screening, enrollment, and National Provider Identifier (NPI) requirements is a major contributor to the Medicaid improper payment rate. Another area driving the FY 2019 Medicaid improper payment estimate is the FY 2019 reintegration of the PERM eligibility component, mentioned above. This measurement has been conducted by a federal contractor, allowing for consistent insight into the accuracy of Medicaid eligibility determinations and increases the oversight of identified vulnerabilities. Based on the measurement of the first cycle of states, eligibility errors are mostly due to insufficient documentation to verify eligibility or non-compliance with eligibility redetermination requirements. The majority of the insufficient documentation errors represent both situations where the required verification was not done at all and where there is indication that the verification was initiated but there was no documentation to validate the verification process was completed. These insufficient documentation situations are related primarily to income or resource verification. CMS will complete the measurement of all states under the new eligibility requirements and establish a baseline in FY 2021.

The national CHIP improper payment rate reported for FY 2019 is 15.83 percent or $2.74 billion in improper payments based on measurements conducted in FYs 2017, 2018, and 2019. The national component improper payment rates are: CHIP FFS: 13.25 percent; CHIP managed care: 1.25 percent; CHIP eligibility: 11.78 percent. The majority of CHIP improper payments are a result of eligibility errors, mostly due to insufficient documentation to verify eligibility or non-compliance with eligibility redetermination requirements. The majority of the insufficient documentation errors represent both situations where the required verification was not done at all and where there is indication that the verification was initiated but there was no documentation to validate the verification process was completed. These insufficient documentation situations are related primarily to income verification. The CHIP improper payment rate was also driven by claims where the beneficiary was inappropriately deemed eligible for CHIP, but was eligible for Medicaid, again, mostly related to beneficiary income. Additionally, state non-compliance with provider screening, enrollment, and National Provider Identifier (NPI) requirements continues to be a contributor to the CHIP improper payment rate.

CMS works closely with states to develop state-specific corrective action plans to reduce improper payments. All states are responsible for implementing, monitoring, and evaluating the effectiveness of their plans, with assistance and oversight from CMS.

2 Beginning in FY 2012, in consultation with OMB, CMS refined the improper payment methodology to account for the impact of rebilling denied Part A inpatient hospital claims for allowable Part B services when a Part A inpatient hospital claim is denied because the services (i.e. improper payments due to inpatient status reviews) should have been provided as outpatient services. CMS continued using this methodology from FY 2013 through FY 2019. This approach is consistent with: (1) Administrative Law Judge (ALJ) and Departmental Appeals Board (DAB) decisions that directed CMS to pay hospitals under Part B for all of the services provided if the Part A inpatient claim was denied, and (2) recent Medicare policy changes that allow rebilling of denied Part A claims under Part B.

CMS calculated an adjustment factor based on a statistical subset of inpatient claims that were in error because the services should have been provided as outpatient. This adjustment factor reflects the difference between what was paid for the inpatient hospital claims under Medicare Part A and what would have been paid had the hospital claim been properly submitted as an outpatient claim under Medicare Part B. Application of the adjustment factor decreased the overall improper payment rate by 0.20 percentage points to 7.25 percent or $28.91 billion in projected improper payments.

GLOSSARY

A

Accountable Care Organizations (ACO): A group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) who work together to coordinate care for the patients they serve.

Accrual Accounting: A system of accounting in which revenues are recorded when earned and expenses are recorded when goods are received or services are performed, even though the actual receipt of revenues and payment for goods or services may occur, in whole or in part, at a different time.

Administrative Costs: General term that refers to Medicare and Medicaid administrative costs, as well as CMS administrative costs. Medicare administrative costs are comprised of the Medicare-related outlays and non-CMS administrative outlays. Medicaid administrative costs refer to the federal share of the states' expenditures for administration of the Medicaid program. CMS administrative costs are the costs of operating CMS (e.g., salaries, expenses, facilities, equipment, rent and utilities). These costs are accounted for in the Program Management account.

Advance Premium Tax Credit: Advance Premium Tax Credit (APTC) payments are amounts calculated by the Exchange and paid to an eligible consumer's insurance company on the consumer's behalf to lower the consumer's out-of-pocket cost for health insurance premiums. The amount the consumer is eligible for is based on the cost of the second lowest silver plan available through the applicable Exchange and the consumer's estimated annual household income compared to the Federal poverty line. Consumers that receive the benefit of APTC payments must file a tax return to reconcile the amount of APTC payments with the amount of the actual premium tax credit they are eligible.

American Recovery and Reinvestment Act (ARRA) of 2009: An economic stimulus package enacted by the 111th U.S. Congress in February 2009. This act of Congress was based largely on proposals made by the President and was intended to stimulate the U.S. economy in the wake of the economic downturn. This act includes Federal tax cuts, expansion of unemployment benefits and other social welfare provisions, and domestic spending in education, healthcare, and infrastructure, including the energy sector.

B

Balanced Budget Act of 1997 (BBA): Major provisions of the BBA provided for the Children's Health Insurance Program, Medicare + Choice (currently known as the Medicare Advantage program), and expansion of preventive benefits.

Benefit Payments: Expenses accrued or funds outlayed for services delivered to beneficiaries.

C

Chief Financial Officers Act of 1990 (CFO Act): The CFO Act designated a Chief Financial Officer in each executive department and each major executive agency in the Federal Government. It provides for production of complete, reliable, timely, and consistent financial information for use by the executive branch of the Government and the Congress in the financing, management, and evaluation of Federal programs.

Children's Health Insurance Program (CHIP) (also known as Title XXI): CHIP (previously known as the State Children's Health Insurance Program, or SCHIP) was originally created in 1997 as Title XXI of the *Social Security Act*. CHIP is a state and Federal partnership that targets uninsured children and pregnant women in families with incomes too high to qualify for Medicaid, but often too low to afford private coverage.

***Children's Health Insurance Program Reauthorization Act* (CHIPRA) of 2009:** CHIPRA extended and expanded CHIP, which was enacted as part of the BBA.

Clinical Laboratory Improvement Amendments of 1988 (CLIA): Requires any laboratory that performs testing on specimens derived from humans to meet the requirements established by the Department of Health and Human Services and have an applicable certificate in effect.

Consumer Operated and Oriented Plan Program (CO-OP): *The Patient Protection and Affordable Care Act* calls for the establishment of the CO-OP Program, which fosters the creation of qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets.

Cost-Sharing Reduction Payment: Payments to health insurance issuers on the Exchange on behalf of eligible insured individuals that lower the amount consumers pay for deductibles, copayments, and coinsurance. Eligibility is limited to those in silver plans receiving advance premium tax credits and is based on the amount of household income for the insured compared to the poverty line. These payments to issuers ceased starting in Fiscal Year 2018 in light of a legal opinion from the Attorney General of the U.S. that a valid appropriation does not exist for Cost-Sharing Reduction payments. However, issuers are still required by law to reduce cost-sharing for eligible enrollees.

D

Deficit Reduction Act of 2005: The *Deficit Reduction Act* restrains Federal spending for entitlement programs (i.e., Medicare and Medicaid) while ensuring that Americans who rely on these programs continue to get needed care. Provisions of the act require wealthier seniors to pay higher premiums for their Medicare coverage; a restraint on Medicaid spending by reducing Federal overpayment for prescription drugs so that taxpayers do not pay inflated markups; and increased benefits to students and to those with the greatest need.

Demonstrations: Projects that allow CMS to test various or specific attributes such as payment methodologies, preventive care, and social care, and to determine if such projects/pilots should be continued or expanded to meet the health care needs of the nation. Demonstrations are used to evaluate the effects and impact of various health care initiatives and the cost implications to the public.

Disproportionate Share Hospital (DSH): A hospital with a disproportionately large share of low-income patients. Under Medicaid, states augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

Durable Medical Equipment (DME): Purchased or rented items such as iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home, as well as blood glucose monitors for individuals with diabetes. DME is equipment which: 1) can withstand

repeated use; 2) has an expected life of at least 3 years if classified as DME after January 1, 2012; 3) is primarily and customarily used to serve a medical purpose; 4) generally is not useful to a person in the absence of an illness or injury; and 5) is appropriate for use in the home.

E

End Stage Renal Disease: Permanent kidney failure requiring dialysis or a transplant.

Exchanges: A mechanism for facilitating the purchase of Qualified Health Plans and evaluating eligibility for Advance Premium Tax Credits and Cost-Sharing Reductions. (See Health Insurance Exchanges for additional information).

Expenditure: Budgeted funds which are actually spent. When used in the discussion of the Medicaid program, expenditure refers to funds actually spent as reported by the states.

Expense: An outlay or an accrued liability for services incurred in the current period.

F

Federal Financial Management Improvement Act of 1996 (FFMIA): The FFMIA requires agencies to have financial management systems that substantially comply with Federal management systems requirements, standards promulgated by the Federal Accounting Standards Advisory Board (FASAB), and the U.S. Standard General Ledger (USSGL) at the transaction level.

Federal General Revenues: Federal tax revenues (principally individual and business income taxes) not identified for a particular use.

Federal Insurance Contribution Act (FICA) Payroll Tax: Medicare's share of FICA is used to fund the Hospital Insurance (HI) trust fund. Employers and employees each contribute 1.45 percent of taxable wages, with no compensation limits, to the HI trust fund.

Federal Managers' Financial Integrity Act of 1982 (FMFIA): FMFIA requires agencies to establish internal control and financial systems that provide reasonable assurance of achieving control objectives, including the effectiveness and efficiency of operations; compliance with laws and regulations; and reliability of financial reporting. FMFIA requires agency heads to conduct an annual evaluation and report on the adequacy of internal control systems.

G

Government Performance and Results Act Modernization Act of 2010 (GPRA Modernization Act): Amends the *Government Performance and Results Act of 1993* to require each executive agency to make its strategic plan available on its public website and to Office of Management and Budget (OMB) on the first Monday in February of any year following that in which the term of the President commences, and to notify the President and Congress that the strategic plan is available.

Government Management Reform Act of 1994: Requires the auditing of executive agencies' annual financial statements prior to submission to OMB.

H

Healthcare Fraud Prevention Partnership (HFPP): a voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations.

Health Information Technology for Economic and Clinical Health Act (HITECH): ARRA includes the "HITECH Act," which established programs under Medicare and Medicaid to incentivize the meaningful use of certified electronic health record technology among eligible professionals, hospitals, and critical access hospitals.

Hospital Insurance (HI) (or Part A): The part of Medicare that pays hospital and other institutional provider benefit claims. Also referred to as Part A.

Health Insurance Exchanges: A mechanism for facilitating the purchase of Qualified Health Plans and evaluating eligibility for Advance Premium Tax Credits and Cost-Sharing Reductions. States can establish their own Exchange or the Federal government can operate an Exchange on their behalf.

I

Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA): In 2002, Congress passed the *Improper Payments Information Act* (IPIA) (Public Law 107-300), which was amended by the *Improper Payments Eliminations and Recovery Act of 2010* (IPERA) (Public Law 111-204) and the *Improper Payments Elimination and Recovery Improvement Act of 2012* (IPERIA) (Public Law 112-248). These laws aim to standardize the way Federal agencies report improper payments in programs they oversee or administer, and direct agencies to reduce improper payments through corrective actions and reduction targets. IPERIA includes requirements for identifying and reporting improper payments and defines improper payments as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments). OMB Circular A-123, Appendix C, further defines improper payments as any payment that was made to an ineligible recipient for an ineligible good or service, or payments for goods or services not received (except for such payments authorized by law).

Information Technology (IT): The term commonly applied to maintenance of data through computer systems.

Internal Control: Process affected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. Management's tools, such as the organization's policies and procedures, that help program and financial managers achieve results and safeguard the integrity of their programs. Such controls include program, operational, and administrative areas, as well as accounting and financial management.

M

Material Weakness: A deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis.

Medicaid: A joint federal and state program that helps with medical costs for persons with limited income and resources.

Medicare: The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): Legislation passed to strengthen Medicare, extend CHIP, and make numerous other improvements to the health care system.

Medicare Administrative Contractor (MAC): A private entity that CMS contracts with under section 1874A of the *Social Security Act*, as added by the *Medicare Prescription Drug Improvement and Modernization Act* (MMA) of 2003. The Part A and Part B MACs handle Medicare Part A and Medicare Part B claims processing and related services under the MMA, and DME MACs handle Medicare claims for DME.

Medicare Advantage (MA) Program (Part C): This program reforms and expands the availability of private health options that were previously offered to Medicare beneficiaries by allowing for the establishment of new regional preferred provider organizations plans as well as a new process for determining beneficiary premiums and benefits. Title II of MMA modified and renamed the existing Medicare + Choice program established under Title XVIII of the Social Security Act to the MA program.

Medicare Integrity Program (MIP): The program established by HIPAA to promote the integrity of the Medicare program, as specified in Section 1893 of the *Social Security Act*.

Medicare, Medicaid, and State Children's Health Insurance Program Extension Act 2007: Legislation that extended the original CHIP budget authority.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA): Legislation that established a new Medicare program (Medicare Part D) to provide a prescription drug benefit. Additionally, MMA sets forth numerous changes to existing programs, including a revised managed care program, certain payment reforms, rural health care improvements, and other changes involving administrative improvements, regulatory reduction, administrative appeals, and contracting reform.

Medicare Prescription Drug Program (Part D): Also known as Medicare Part D, is an optional prescription drug benefit created by the MMA for individuals with Medicare who are entitled to benefits under Part A or enrolled in Part B. Eligible individuals have the opportunity to enroll in either a stand-alone prescription drug plan to supplement their traditional Medicare coverage, or in a MA prescription drug plan, which integrates basic medical coverage with added prescription drug coverage. Individuals who qualify for both Medicare and Medicaid (full-benefit dual-eligible) are automatically enrolled in the Part D program; assistance with premiums and cost sharing is available to full-benefit dual-eligible and other qualified low-income individuals.

Medicare Secondary Payer (MSP): A statutory requirement that private insurers who provide general health insurance coverage to Medicare beneficiaries must pay beneficiary claims as primary payers.

Medicare Trust Funds: Treasury accounts established by the *Social Security Act* for the receipt of revenues, maintenance of reserves, and disbursement of payments for the HI and SMI programs.

O

Obligation: Legal requirement to pay funds.

Office of Management and Budget (OMB) Circular A-123, Management's Responsibility for Enterprise Risk Management and Internal Control: Circular that provides guidance to federal managers on improving the accountability and effectiveness of federal programs and operations by establishing, assessing, correcting, and reporting on management's controls. The Circular is issued under the authority of the FMFIA.

Outlay: Budgeted funds actually spent. When used in the discussion of the Medicaid program, outlays refer to amounts advanced to the states for Medicaid benefits.

P

Part A: The part of Medicare that pays hospital and other institutional provider benefit claims, also referred to as Medicare Hospital Insurance or "HI."

Part B: The part of Medicare that pays physician and supplier claims, also referred to as Medicare Supplementary Medical Insurance or "SMI."

Patient Protection and Affordable Care Act (PPACA) (P .l. 111-148): A Federal statute enacted in 2010 to drive health insurance reforms. The law requires insurers to accept all (legal) applicants, to cover a specific list of conditions, and to charge the same rates regardless of pre-existing conditions.

Payment Safeguards: Activities to prevent and recover inappropriate Medicare benefit payments, including MSP, medical review/utilization review provider audits, and fraud and abuse detection.

Program Integrity (PI): Encompasses the operations and oversight necessary to ensure that accurate payments are made to legitimate providers for appropriate and reasonable services for eligible beneficiaries of the Medicare, Medicaid, CHIP, and PPACA programs. PI activities target the range of causes of improper payments, errors, fraud, waste, and abuse.

Program Management: The CMS operational account which supplies CMS with the resources to administer Medicare, the Federal portion of Medicaid, and other CMS responsibilities. The components of Program Management are: program operations, survey and certification, research, and federal administrative costs.

Provider: A health care professional or organization that provides medical services.

Q

Qualified Health Plans: Certified health insurance plans which meet minimum standards for health benefit coverage, as required by the PPACA.

Quality Improvement Organizations (QIOs): Formerly known as Peer Review Organizations (PROs), QIOs monitor the quality of care provided to Medicare beneficiaries to ensure that health care services are medically necessary, appropriate, provided in a proper setting, and are of acceptable quality.

Quality Payment Program (QPP): Established by MACRA, which repeals the sustainable growth rate formula and streamlines multiple quality reporting programs into a new Merit-based Incentive Payment System. Under the QPP, incentive payments are provided to clinicians for their participation in Advanced Alternative Payment Models or the Merit-based Incentive Payment System. Clinicians can choose how they want to participate based on their practice size, specialty, location, or patient population.

R

Recipient: An individual covered by the Medicaid program. Also referred to as a beneficiary.

Reinsurance: The transitional reinsurance program stabilized premiums in the individual market inside and outside of the Exchanges. The transitional reinsurance program collected contributions from contributing entities to fund reinsurance payments to issuers of non-grandfathered, PPACA-compliant reinsurance-eligible individual market plans, the administrative costs of operating the reinsurance program, and the General Fund of the U.S. Treasury for the 2014, 2015, and 2016 benefit years.

Retiree Drug Subsidy Program: The retiree drug subsidy (RDS) is one of several options available under Medicare that is designed to encourage employers and unions to continue to provide high-quality prescription drug coverage to their retirees.

Revenue: An inflow of resources that the government earns, demands, or receives by donation. Resources arise when the government entity provides goods and services, or from the government's power to demand payments from the public (e.g., taxes, duties, fines, and penalties).

Risk Adjustment: The risk adjustment program is designed to protect issuers that attract a high-risk population, such as those with chronic conditions. Under this program, money is transferred from issuers with lower-risk enrollees to issuers with higher-risk enrollees. This is a state-based program that applies to non-grandfathered plans in the individual and small group markets, inside and outside of Exchanges.

Risk Corridors: The risk corridor program provided issuers of qualified health plans (QHPs) in the individual and small group markets additional protection against uncertainty in claims costs during the first three years of the Exchange. This program, which was modeled after a similar program used in the Medicare prescription drug benefit, encouraged issuers to keep their rates stable as they adjusted to the new health insurance reforms in the early years of the Exchanges.

S

Self-Employment Contribution Act (SECA) Payroll Tax: A tax on self-employed individuals of 2.9% of taxable net income, with no limitation. Medicare's share of SECA is used to fund the HI Trust Fund.

Significant Deficiency: A deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Statement on Standards for Attestation Engagements (SSAE) 18 (SSAE 18): For the purposes of CMS, this is a report on the internal controls of a servicing organization issued by an independent public accountant in accordance with standards promulgated by the American Institute of Certified Public Accountants (AICPA). The AICPA SSAE 18 defines the professional standards to assess the internal controls at a service organization.

Supplementary Medical Insurance (SMI) (Part B):
The part of Medicare that pays physician services, outpatient hospital services, other related medical and health services for voluntarily insured aged and disabled individuals, as well as private plans to provide prescription drug coverage. The prescription drug benefit is funded through the SMI Trust Fund.

T

Twenty-first (21st) Century Cures Act (Cures Act):
Legislation which promotes and funds the acceleration of research into preventing and curing serious illnesses; accelerates drug and medical device development; attempts to address the opioid abuse crisis; and tries to improve mental health service delivery. The act includes a number of provisions that push for greater interoperability, adoption of electronic health records (EHRs), and support for human services programs.

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Copies of this report are also available on the Internet at http://www.cms.hhs.gov/CFOReport/.

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