CMS FINANCIAL REPORT FY 2017

"Putting Patients First"

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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 FY 2017 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.

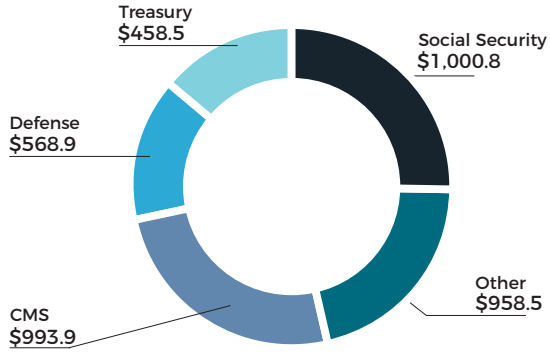
OTHER INFORMATION

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.

2017 FEDERAL OUTLAYS

CMS has outlays of approximately $993.9 billion (net of offsetting receipts and Payments of the Health Care Trust Funds) in fiscal year (FY) 2017, approximately 16 percent of total Federal outlays.

CMS employs approximately 6,400 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.

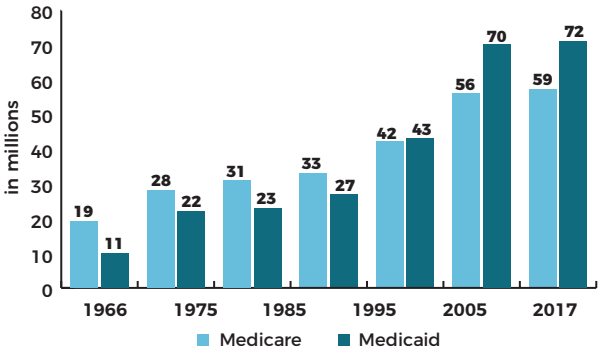


$ in billions

Source: U.S. Treasury

2017 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 59 million beneficiaries. Medicaid enrollment has increased from 11 million beneficiaries in 1966 to about 72 million beneficiaries.



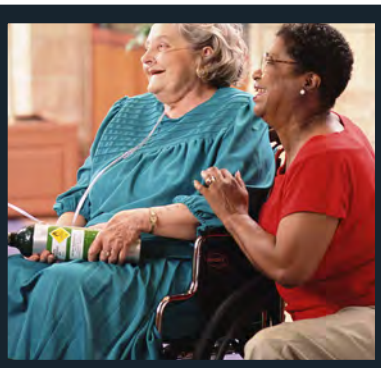
A MESSAGE FROM THE CMS ADMINISTRATOR

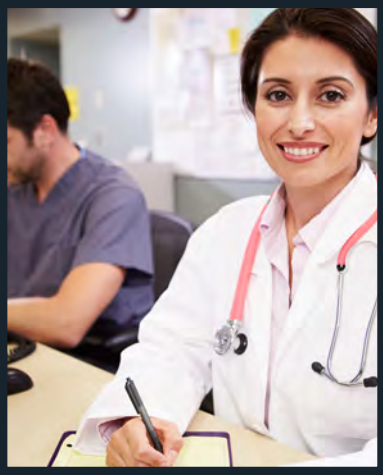
SEEMA VERMA

I am pleased to present the Centers for Medicare & Medicaid Services's (CMS) fiscal year (FY) 2017 Agency Financial Report. This financial report provides insight into CMS's programs and initiatives and serves as the agency's principal publication on stewardship and fiscal management of the resources entrusted to us. This is a critical time in healthcare, and our agency has a responsibility to make healthcare accessible and affordable for all Americans.

Striving to create the best future for health—and healthcare—is something that we do every day here at CMS. We are working to address a range of issues-to ensure that health care is accessible and affordable. Our work at CMS improves the health and well-being of all Americans. We have completely dedicated ourselves to fulfilling one overarching goal of "Putting Patients First." To reach this goal we will focus our efforts and resources on empowering patients and doctors to make decisions about their healthcare; ushering in a new era of state flexibility and local leadership; supporting innovative approaches to improve quality, accessibility, and affordability; and improving the CMS customer experience.

CMS is fully committed to moving toward a healthcare system that will drive costs down, give Americans more choices, and put patients and doctors in control of their healthcare. When people are in charge of their healthcare, the outcomes are better. We will implement programs and initiatives ensuring that people are empowered to make informed decisions about their healthcare. CMS will also develop policies that build a patient-centered system of care that increases competition, quality and access. We will reduce burdensome regulations so that doctors and providers can focus on providing high quality health care to their patients.





We will work to usher in a new era of state flexibility and local leadership and hold states accountable for achieving successful outcomes and measurable results. Our efforts will focus on stabilizing and streamlining the implementation of Federal rules regarding individual market insurance by empowering states and providing them with greater flexibility. The states are in the best position to assess the unique needs of their populations and drive reform. Providing states the freedom to design innovative fiscally responsible programs that work for them and meet the diverse needs of their citizens we believe will result in better healthcare outcomes.

CMS has numerous innovative approaches to support and improve quality, accessibility and affordability of healthcare. By using data-driven insights, we will create new ways to provide cost effective care which improve patient outcomes. We are also leveraging technology to strengthen the integrity and sustainability of Medicare and Medicaid by investing in programs and initiatives that prevent fraud, waste, and abuse. Investments in program integrity allow CMS to promote high quality and efficient healthcare by moving from a "pay-and-chase" model toward identifying and preventing fraudulent or improper payments.

We are expanding our efforts to fight fraud, waste, and abuse by preventing identity theft. Next year, to further protect our seniors, CMS is removing the Social Security numbers from Medicare cards and replacing them with a new Medicare number. These actions will help protect personal identities and prevent fraud.

Improving the customer experience of providers, patients, caregivers, stakeholders and states represents our direct role in putting patients first. We are focused on the way we serve our customers - above all, their needs come first. We will work to ensure that we always put patients first in everything we do. This noble mission inspires me each and every day and makes me proud to be part of the CMS team.

At CMS, each day we have the opportunity to make a difference in the lives of millions of Americans. On behalf of all those we serve, I thank you for your continued support of CMS's programs and initiatives.

SEEMA VERMA
CMS Administrator
November 2017

FINANCING OF CMS PROGRAMS & OPERATIONS

FUNDS FLOW FROM	THROUGH	TO FINANCE
Payroll Taxes	Medicare Trust Funds	Medicare Benefits
Medicare Premiums		Quality Improvement Organizations
Investment Interest		Medicare Integrity Program
Federal Taxes		Program Management
Federal Taxes	General Fund Appropriation	Medicaid
		Children's Health Insurance Program
		Medicaid Integrity Program
		Program Management
Issuers/Health Plan/Providers	Offsetting Collections	CMS User Fees
Beneficiaries		Recovery Audit Contracts
Federal Agencies		Reimbursables
States		
General Public		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

APPROVED LEADERSHIP
as of September 30, 2017

Seema Verma
Administrator

Kimberly Brandt
Principal Deputy Administrator for Operations

Demetrios Kouzoukas
Principal Deputy Administrator for Medicare & Director Center for Medicare

Brady Brookes
Deputy Chief of Staff

Karen Jackson
Deputy Chief Operating Officer

OFFICE OF EQUAL OPPORTUNITY AND CIVIL RIGHTS
Anita Pinder, Director
Alaina Jenkins, Deputy Director

OFFICE OF COMMUNICATIONS
Mary Wallace, Director *
Mary Wallace, Deputy Director

OFFICE OF LEGISLATION
Emily Felder, Director
Jennifer Boulanger, Deputy Director

FEDERAL COORDINATED HEALTH CARE OFFICE
Tim Engelhardt, Director
Sara Vitolo, Deputy Director

OFFICE OF MINORITY HEALTH
Cara V. James, Director
Madeleine Shea, Deputy Director

OFFICE OF THE ACTUARY
Paul Spitalnic, Director and Chief Actuary

OFFICE OF STRATEGIC OPERATIONS AND REGULATORY AFFAIRS
Kathleen Cantwell, Director
Olen Clybourn, Deputy Director

OFFICE OF FINANCIAL MANAGEMENT
Jennifer Main, Director & Chief Financial Officer
Megan Worstell, Deputy Director

OFFICE OF ENTERPRISE DATA AND ANALYTICS
Allison Oelschlaeger, Director & CMS Chief Data Officer

OFFICE OF HUMAN CAPITAL
Elisabeth Handley, Director
Scott Giberson, Deputy Director

OPERATIONS: Karen Jackson, Deputy Chief Operating Officer

EPPS: Bridget Berardino, Director

OAGM: Melissa Starinsky, Director

OTS: Janet Vogel, Director & Deputy Chief Information Officer

OSSO: James Weber, Director

CFMFFSO: Nanette Foster Reilly, Consortium Administrator

CMCHO: Jackie Garner, Consortium Administrator

CMHPO: James T. Kerr, Consortium Administrator

CQISCO: Renard Murray, Consortium Administrator

OHI: Randy Brauer, Director

OIT: George Hoffman, Director & Chief Information Officer *

CENTER FOR CLINICAL STANDARDS AND QUALITY
Kate Goodrich, M.D., Director and CMS Chief Medical Officer
Jean Moody-William, Deputy Director
Debbie Hattery, Deputy Director
Shari Ling, M.D., Deputy Chief Medical Officer

****CENTER FOR MEDICARE AND MEDICAID INNOVATION**
Amy Bassano, Deputy Administrator for Innovation and Quality & Director *
Amy Bassano, Deputy Director
Arrah Tabe-Bedward, Deputy Director

CENTER FOR MEDICARE
Demetrios Kouzoukas, Principal Deputy Administrator for Medicare and Director
Liz Richter, Deputy Center Director
Cheri Rice, Deputy Center Director *

CENTER FOR MEDICAID AND CHIP SERVICES
Brian Neale, Deputy Administrator and Director
Tim Hill, Deputy Center Director
Deidre Gifford, M.D., Deputy Center Director

CENTER FOR PROGRAM INTEGRITY
Jonathan Morse, Deputy Administrator and Director *
Jonathan Morse, Deputy Director
George Mills, Jr., Deputy Director

CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT
Randy Pate, Deputy Administrator and Director
Jeff Grant, Deputy Director for Operations *
Jeff Wu, Associate Deputy Director for Policy Coordination
Bobby Saxon, Center Chief Technology Officer

* Acting
** Reports to Deputy Admin. for Innovation and Quality

MANAGEMENT'S DISCUSSION & ANALYSIS

Our Organization // Overview // Performance Management // CMS Strategic Goals // Overview of Financial Data // Overview of Social Insurance Data

OUR ORGANIZATION

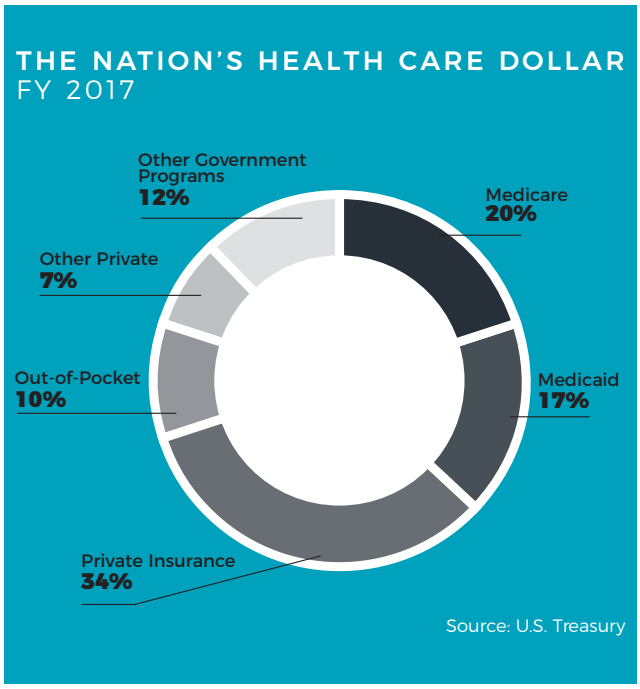
CMS, an operating division of the Department of Health and Human Services (HHS), employs approximately 6,400 federal employees in Maryland, Washington, DC, and 10 regional offices throughout the country. CMS provides direct services to state agencies, health care providers, beneficiaries, sponsors of 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 provides technical assistance to Congress, the Executive branch, universities, and other private sector researchers.

CMS also contracts 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 Medicare claims, provide technical assistance to providers, and answer beneficiary inquiries. Additionally, Quality Improvement Organizations (QIOs) conduct a wide variety of quality improvement programs to ensure quality of care is provided to Medicare beneficiaries.

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 2017 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.



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 was 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 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 16 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 59 million beneficiaries.

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 beneficiaries.

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, outpatient hospital, some home health care, laboratory tests, durable medical equipment, 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 beneficiaries 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 Medicare beneficiaries. 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. Medicare beneficiaries 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. Beneficiaries 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 who are entitled to benefits under Part A or enrolled in Part B. Effective January 1, 2006, 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. Beneficiaries who qualify for both Medicare and Medicaid (full-benefit dual-eligible beneficiaries) are automatically enrolled in the Part D program; assistance with premiums and cost sharing is available to full benefit dual-eligible beneficiaries and other qualified low-income beneficiaries.

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. The Medicaid program is jointly funded by states and the Federal Government, as 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 72 million beneficiaries--about 22 percent of the U.S. population. Over 11 million 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 to qualify for Medicaid. Title XXI of the Social Security Act outlines the program's structure, and establishes a partnership between the federal and state governments. CHIP is administered by states, according to federal requirements. CMS works closely with the states, Congress, and other federal agencies to administer CHIP. CMS ensures that state programs meet statutory requirements that are designed to ensure meaningful coverage and 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 FY 2017, 9.7 million children were enrolled in CHIP for at least one month during the year.

CLIA

CLIA legislation expanded 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 (whether provided to beneficiaries of CMS programs or to others), including those performed in physicians' offices, for a total of 257,263 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. The CDC provides research and technical support, and coordination of the Clinical Laboratory Improvement Advisory Committee, while the FDA performs test categorization.

Health Insurance Exchanges

CMS is charged with implementing many of the provisions of the 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 build health insurance Exchanges where health insurance insurers 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 (including student health plans) 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 requiring that health insurance issuers spend a predetermined portion of premium revenues on clinical services and quality improvement, or rebate the excess premium to policyholders. This mechanism helps ensure that consumers receive a good value for their premium dollar and to make health insurance markets more transparent.

Premium Stabilization Programs

To more evenly spread the financial risk borne by issuers and help stabilize premiums, the PPACA established a transitional reinsurance program (section 1341), a permanent risk adjustment program (section 1343), and a temporary risk corridors program (section 1342).

These programs are collectively referred to as the premium stabilization programs and provide payments to health insurance issuers that cover higher-cost and higher-risk populations. These programs are also intended to mitigate the potential impact of adverse selection and stabilize the price of health insurance in the individual and small group markets.

PERFORMANCE MANAGEMENT

Performance measurement results provide valuable information about the success of CMS's programs and activities. CMS uses performance information to identify opportunities for improvement and to shape its programs. The use of our performance measures also provides a method of clear communication 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 (GPRA) of 1993 mandates that Cabinet-level Agencies have strategic plans, annual performance goals, and annual performance reports that make them accountable stewards of public programs. HHS will release its new Strategic Plan (2018-2022) in early February 2018, as required by the GPRA Modernization Act of 2010 and key CMS performance measures will be featured in the HHS Annual Performance Plan and Report. Consistent with GPRA principles, the CMS GPRA performance goals will 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 we are optimistic about our ability to meet them.

Our FY 2017 performance measures track progress in our major program areas, including through measuring error rates. In addition, we measure quality improvement initiatives geared toward older adults, people with disabilities, and children, as they are served by the Medicare, Medicaid, CHIP, and the QIO programs. Detailed information and available results about CMS performance measures are included in the CMS Budget. Progress on our measures will be reported through the FY 2019 President's Budget process.

CMS STRATEGIC GOALS

This is a critical time for health care in our Nation, and our agency has a responsibility to make healthcare accessible and affordable for all Americans. The CMS Strategic goals guide the agency with fulfilling our one overarching goal to **"Put Patients First."** We will accomplish this by meeting our strategic goals of empowering patients and doctors to make decisions about their healthcare; ushering in a new era of state flexibility and local leadership; supporting innovative approaches to improving quality, accessibility, and affordability; and improving the CMS customer experience. These goals cut across the programs and support functions throughout the agency to improve the quality and affordability of care. Taken together, these strategic goals will help ensure that we always put patients first in everything we do at CMS – including our healthcare system.

Empowering Patients and Doctors to Make Decisions about Their Health Care

When people are in charge of their healthcare, outcomes are better. Our goal is to empower people to take ownership of their healthcare by ensuring that they have the information they need to make informed choices. We continue to bring our dedication, creativity, and compassion to all the Agency's work and initiatives. Some of our work and initiatives are briefly described below.

From Coverage to Care

From Coverage to Care (C2C) is a CMS initiative designed to help educate consumers about their health care coverage and to connect them with primary care and preventive services. In 2017, C2C released Manage Your Health Care Costs, a resource with a series of tools to help a consumer understand health insurance costs and terms, know their own specific health insurance costs, plan for health care costs, and know how to pay their premium. C2C depends on collaboration with community groups, consumers, and providers to focus on prevention, regular primary care, and proper utilization of emergency care to encourage reduced costs and better health outcomes. C2C empowers stakeholders by providing digital and print resources and messages to use to enable a patient-centered approach for accessibility and affordability. Through federal partners, state organizations, and individual community organizations, C2C furthered its partnerships efforts through 20 webinars educating 1,500 partners who then re-share resources and messages.

Consumer Assessment of Health Care Providers and Systems

Through the Consumer Assessment of Healthcare Providers and Systems surveys, CMS asks patients (or in some cases their families) about their experiences with, and ratings of, their health care providers and plans, including hospitals, home health care agencies, doctors, and drug plans. The surveys focus on matters that patients themselves say are important to them and for which patients are the best and/or only source of information. CMS publicly reports the results of its patient experience surveys, and some surveys affect payments to CMS providers.

The Next Generation Accountable Care Organization Model

The Next Generation Accountable Care Organization Model (NGACO) offers an opportunity in accountable care—one that sets prospective financial targets, enables providers and beneficiaries greater opportunities to coordinate care, and aims to attain the highest quality standards of care. Accountable Care Organizations are patient-centered

organizations where the patients and providers are true partners in care decisions. Medicare beneficiaries have better control over their health care, and providers have better information about their patients' medical history, as well as better relationships with patients' other providers. There were 18 model participants in the first performance year, located in multiple states across the country. These NGACOs serve approximately 600,000 aligned beneficiaries.

CMS Public Reporting Programs

The CMS public reporting programs, such as the Compare websites (i.e. Hospital Compare, Home Health Compare), offer consumers and providers vehicles to compare costs, review treatment outcomes, and assess patient satisfaction. By providing access to comparative information on health care quality, efficiency, and other areas of interest, public reporting makes healthcare costs and quality information more transparent to consumers and providers, enabling them to make better choices and health care decisions. CMS successfully launched Hospice Compare in August 2017 and Long Term Care Hospital (LTCH) Compare and Inpatient Rehabilitation Facility (IRF) Compare in December 2016.

Medicare Plan Finder

The Medicare Plan Finder (MPF) is a public web tool that allows beneficiaries to make informed enrollment choices by comparing the costs and quality of available health and drug plans. The plan finder includes prescription drug cost and pharmacy information, benefit descriptions, and the MA and Part D Star Ratings. Beneficiaries also can enroll in an MA or Part D plan via the MPF. CMS is focused on improving the type and accuracy of information available to Medicare beneficiaries and their experience when comparing MA and Part D plans, selecting plans, and enrolling in a plan of their choice. CMS plans to redesign the MPF to feature more detailed information about benefits and cost sharing in MA and Part D Plans in a more beneficiary-friendly format, compare benefits, cost sharing amounts, and quality with Original Medicare, and include a cost calculator as well as MA provider directory look-up capabilities.

Quality Improvement Networks Portfolio

Nationally-scaled quality programs, including the QIOs, ESRD Networks, the Partnership for Patients, and the Transforming Clinical Practice Initiative, have all worked to spread best practices on engaging persons, patients, and families in their healthcare decisions. These best practices have focused on health literacy, patient education, forming Patient and Family Advisory Councils, and fostering a network of empowered patient advocates and family members who interact with healthcare executives, quality improvement teams, and public policy makers.

Ushering in a New Era of State Flexibility and Local Leadership

Extending states the freedom to design Medicaid programs that work for them allows them to meet the unique needs of their citizens. CMS must ensure that we give states – and local communities – the flexibility they need to design innovative, fiscally responsible programs for all of their populations. We have begun many initiatives to provide the states the freedoms needed to develop programs that meet the needs of their citizens.

State Innovation Models Initiative

CMS uses the State Innovation Models (SIM) initiative to help states accelerate health care transformation. By using their policy and regulatory levers, states and local leaders are empowered to develop the infrastructure necessary to achieve transformation goals. SIM funding has been provided to 34 states, three territories and the District of Columbia, representing over 60 percent of the U.S. population.

Accountable Health Communities Model

The Accountable Health Communities Model has funded 32 cooperative agreements with local and community-based entities and organizations such as county governments, hospitals, universities, and health departments, among others, representing rural and urban communities across 193 counties in 23 states. With the Accountable Health Communities Model, CMS is testing whether increased awareness and access to services addressing health-related social needs will impact total health care costs and improve health and quality of care for Medicare and Medicaid beneficiaries in targeted communities by empowering local leaders to strengthen the links between clinical and community-based resources. CMS plans to continue developing and implementing test models with states, particular beneficiary populations, and certain health care provider types present in Medicaid.

Medicare-Medicaid Financial Alignment Initiative

Through the Medicare-Medicaid Financial Alignment Initiative and related work, CMS is partnering with 13 states to test models of integrating primary, acute, and behavioral health care and long-term services and support for Medicare-Medicaid enrollees. The Financial Alignment Initiative includes a capitated model and a managed fee-for-service model. Although the approaches differ in each demonstration, beneficiaries in every version of the model receive their full array of Medicare and Medicaid benefits, with added care coordination, beneficiary protections, and access to additional or enhanced services.

CHIP Health Services Initiatives

CMS is committed to performing a thorough review of its regulations to ensure states have the ability to innovate their Medicaid programs. States can pursue innovative approaches to improving child health through the use of CHIP Health Services Initiatives (HSIs). HSIs provide states with broad flexibility to implement creative, state-designed approaches aimed at improving the health of low-income children. HSIs give states the freedom to create unique programs that address emerging and salient health issues in their state, for example: teen opioid abuse, lead poisoning, childhood asthma, sudden infant death syndrome, and child neglect. HSIs are funded under Title XXI and HSI funding is counted toward a 10 percent administrative cap imposed on states' annual CHIP spending under the statute. Most states have unspent administrative funds that could be used for an HSI, and we are working with those interested in developing new HSIs.

Medicaid Integrity Institute

CMS's interaction with states in Medicaid program integrity continues to evolve toward a more collaborative approach where states are learning how to better identify priority areas, and allows CMS to provide technical assistance and facilitate the sharing of best practices. The Medicaid Integrity Institute course curriculum is more state inclusive. Course content is developed collaboratively with CMS and states to reflect the most relevant and actionable information, while also highlighting best practices. Program integrity reviews now focus on helping states identify program integrity weaknesses in a less punitive and intrusive fashion, while also acknowledging state strengths. CMS has developed new initiatives focused on voluntary state technical assistance, provider enrollment data comparison and exchange services, and the ability for states to participate in voluntary Medicaid site visits. This demonstrates our movement toward a more collaborative consulting approach to working with states.

Supporting Innovative Approaches to Improving Quality, Accessibility, and Affordability

By using data-driven insights, CMS must always search for new ways to provide cost-effective care that improves patient outcomes. There are countless opportunities at CMS to support and drive innovation and enhance our technology to prevent fraud, waste and abuse of taxpayer dollars. Described below are some of CMS's innovative initiatives.

Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 established what is now known as the Quality Payment Program (QPP) for eligible clinicians, replacing a patchwork system of Medicare reporting programs. Under the QPP, eligible clinicians can participate via one of two tracks: Advanced Alternative Payment Models or the Merit-based Incentive Payment System. CMS has worked to reduce administrative burden on clinicians by ensuring meaningful measurement occurs and ensuring that 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.

Connected Care

Connected Care is an educational initiative launched in 2017 to raise awareness of the benefits of chronic care management (CCM) services for Medicare beneficiaries with multiple chronic conditions, and to provide health care professionals with support to implement CCM programs. Connected Care is a nationwide effort within FFS Medicare that includes a focus on racial and ethnic minorities, as well as rural populations who tend to have higher rates of chronic disease. CMS developed new resources for patient education and a toolkit for health care professionals with detailed information about CCM, a partner toolkit that includes downloadable resources and suggested activities to get involved in the Connected Care initiative.

Increasing Physical Accessibility of Health Care

CMS released "Ensuring Physical Accessibility in Health Care Settings: An Overview for Providers," a provider toolkit with resources for clinical and program administration staff working to improve quality in health care settings. The toolkit highlights solution-based best practices, from both consumer and provider perspectives, on successes and challenges in creating accessible health care settings.

Comprehensive Primary Care Plus Model

When designing the Comprehensive Primary Care Plus Model (CPC+), CMS built upon the lessons learned from participants and stakeholders involved in the Comprehensive Primary Care initiative and feedback from the 2015 request for information on Advanced Primary Care Initiatives. While developing CPC+, the CPC+ team also conducted structured interviews with over 15 payment policy and primary care delivery experts, including representatives from academia, national and local payers, think tanks, and physician organizations.

Improving Medicare Post-Acute Care Transformation Act of 2014

CMS is working to meet the requirements of the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT Act). The IMPACT Act requires CMS to modify the post-acute care patient assessment data that are required for submission to CMS of quality measurement, payment, and state surveyor purposes. Post-acute care providers will submit standardized data in specified categories that are comparable and exchangeable across providers. These efforts support the "collect once, use multiple times" mission to reduce reporting burden and improve patient care services and quality of care. Such standardized patient assessment data are intended to inform payment models based on patient characteristics rather than setting, as well as to enable post-acute care engagement in interoperable information exchange to foster safe care transitions. Further, such data are to be used to calculate measures that compare care across post-acute care providers on specific quality domains as required in the Act.

Quality Reporting Programs and Provider Performance

LTCH, IRF, HH, SNF and Hospice Quality Reporting programs also require providers to submit data on specified quality measures aimed at addressing both provider-specific as well as cross-setting quality issues and gaps. As with the Physician and Hospital programs, post-acute care quality reporting programs require that data on quality measures be made public to support consumer choice, as well as enable providers the opportunity to ensure high quality care. For all five post-acute care programs, CMS provides free and on-demand confidential reports to inform providers on data that they can use in real-time for their continuous improvement. A provider's failure to report the data as required results in a two percent reduction of its annual payment update.[1]

In Medicare FFS, CMS links about six percent of applicable Medicare hospital inpatient payments to performance on Hospital Acquired Conditions, 30-day inpatient readmissions, and other quality and cost measures in the Hospital Acquired Condition Reduction Program, the Hospital Readmission Reduction Program, and the Hospital Value-Based Purchasing program. Eligible Hospitals in the lowest performing quartile receive a payment reduction penalty based on their 30-day readmissions and hospital acquired conditions measure performance. In the Hospital Value-Based Purchasing program, eligible hospitals are paid Medicare inpatient hospital payments based on their performance on mortality, health care associated infection, patient safety, patient experience of care, cost, and other measures in an overall budget-neutral manner. Quality of care has improved on the vast majority of these clinical focus areas since the programs' inception.

Quality Improvement Networks Portfolio

CMS also supports national networks of committed expert private industry organizations that aim to improve the safety and quality of health care delivered across multiple settings, while simultaneously generating cost savings through improvement. These programs include the QIOs, ESRD Networks, Partnership for Patients, and Transforming Clinical Practice Initiative which collectively cover various short-stay, acute care hospitals, individual clinician practices, dialysis facilities, communities, nursing homes, home health organizations, hospices, and pharmacies. Through the dissemination of best practices on a national scale, these quality programs drive down health care-acquired conditions, infections, admissions and readmissions, while supporting a national learning community of quality improvement leaders. The most recent data available demonstrate a 21 percent decline in hospital-acquired conditions (HACs)

[1] https://www.congress.gov/113/plaws/publ185/PLAW-113publ185.pdf

since 2010, which represents a cumulative total of approximately 3.1 million fewer HACs, 125,000 lives saved, and $28 billion in health care costs avoided between 2010 and 2015. Medicare coverage and use of new technology through clinical studies help provide access to promising innovation while developing evidence to show improved health outcomes for the Medicare population.[2]

Data Element Library

To further post-acute care engagement in data exchange, CMS is working to implement the Post-Acute Care Data Element Library (DEL). The DEL is intended to serve as a free resource with the goal of fostering the adoption of electronic health records and information exchange in post-acute care. Within the DEL, assessment data will be mapped to associated national health information technology standards and vocabularies.

Medicaid Innovation Accelerator Program

The Medicaid Innovation Accelerator Program (IAP) continues to work with Medicaid state agencies by providing targeted technical assistance to support states' ongoing delivery system reform efforts. By 2017, the IAP has reached all 50 states and the District of Columbia through national webinars. Through direct technical support CMS has worked with 31 states, the District of Columbia, and three territories. The IAP works with states on program and functional areas such as reducing substance use disorders, physical/mental health integration, data analytics, and value-based payment approaches. During 2017, CMS completed a round of technical assistance programs for three program areas: (1) Medicaid beneficiaries with complex care needs and high costs; (2) community integration through long-term services and support; and (3) physical and mental health integration. In addition, the IAP continued to provide strategic design support to states seeking to redesign their substance use disorder programs. IAP also began direct support in two new functional areas (data analytics and value-based payment) along with a second round of state Medicaid-housing agency partnerships cohort as part of its community integration through long-term services program area.

National Quality Measurement Programs

As part of the first national quality measurement programs for Medicaid and CHIP, CMS is working with state and federal partners to promote uniform reporting of quality measures across all Medicaid and CHIP programs, and seeks to align these measures with those used by other payers. CMS has identified core sets of health care access and quality measures to assess the quality of health care provided to children and adults enrolled in Medicaid and CHIP. The goals of this effort are to encourage reporting by states on a uniform set of measures and support states in using these measures to drive quality improvement. Improving quality measure reporting will give states the information they need to focus efforts and develop initiatives tailored to their populations. With better data, states develop a better understanding of their beneficiaries' health and can determine how best to design and implement population health improvement initiatives at the state level.

Health Improvement Initiatives

CMS has health improvement initiatives in several specific areas, including maternal and infant health, oral health, and prevention. **Maternal and Infant Health:** Medicaid covers nearly 50 percent of U.S. births. Medicaid coverage helps keep pregnant women healthy and ensures that infants get a good start in life. The Maternal and Infant Health Initiative (MIHI) is a collaboration between CMS, states, and providers. MIHI builds on strategies identified by maternal and infant health experts and other stakeholders to drive improvements in maternal health and birth outcomes through improving the care provided postpartum and between pregnancies. Twenty-nine states participate in MIHI initiatives. **Oral Health:** Tooth decay continues to be one of the most prevalent chronic diseases of childhood, despite the abundance of scientific evidence demonstrating that it can be prevented. CMS is committed to improving access to dental and oral health services for children enrolled in Medicaid and CHIP. Together, CMS and states have made considerable progress in this area as the percentage of Medicaid-enrolled children who receive dental care continues to increase nationwide. To ensure continued progress, we are working closely with states through our Oral Health Initiative 2.0 and have launched a children's oral health delivery system reform project through CMS's Medicaid IAP. **Prevention:** CMS's Medicaid Prevention Learning Network supports state Medicaid agencies in improving quality of, access to, and utilization of preventive services by providing technical assistance to states and encouraging state-to-state learning. As part of this initiative, CMS has held several affinity groups focusing on specific prevention areas, including tobacco cessation, diabetes prevention,

[2] https://www.ahrq.gov/professionals/quality-patient-safety/pfp/2015-interim.html

and human immunodeficiency virus. Each affinity group provides states with a forum to discuss their successes and challenges, learn what other states have done in these critical topic areas, and request individualized technical assistance to support state action. The groups meet via audio conference monthly for 12 months in addition to monthly one-on-one calls with CMS. The content of these calls is driven by the specific needs of participating states.

State Data Resource Center

Through the State Data Resource Center, CMS provides assistance to states on using and accessing Medicare data, along with hosting webinars and bi-monthly Medicare Data Workgroup calls. This work supports states in innovative approaches to providing coordinated care. In FY 2017, 47 states received or were working with CMS to receive Medicare Parts A, B, and D data to promote program integrity and support care coordination for Medicare-Medicaid enrollees.

Medicare Program Integrity Initiatives

CMS has invested considerable resources in systems and initiatives related to data and analytics to prevent or rapidly identify fraud, waste, and abuse. Our predictive analytics technology identifies and prevents the payment of fraudulent claims in the Medicare FFS program, while our provider screening system automatically screens all current and prospective providers against a number of data sources. CMS is developing a new and expanded provider enrollment system to increase efficiency, and the Healthcare Fraud Prevention Partnership shares data between the Federal Government, state agencies, law enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations. CMS is also consolidating program integrity contractors across Medicare and Medicaid to reduce contractor duplication and increase the ability to share data with state Medicaid programs.

Home and Community Based Services

To help states mitigate risk for fraud, waste, and abuse in HCBS, CMS is systematically reviewing states' fiscal integrity systems to share promising approaches to preventing unallowable and unsupported costs in HCBS. In December 2016, Congress passed the 21st Century Cures Act. This Act includes provisions that address fiscal integrity protections for beneficiaries and requires states to use electronic visit verification systems for personal care and home health care services. CMS continues to work with states to ensure they are prepared to meet this requirement, which is intended to streamline the monitoring of fraud, waste, and abuse for both states and providers.

Improving the CMS Customer Experience

Transforming to a patient first perspective is not just about who we serve, but how we serve all of our customers. We have a direct role in how effectively services are rendered to our internal and external customers including our beneficiaries, providers, states, and stakeholders. Read on to learn more about how CMS is refocusing its main goal of **"putting patients first."**

Transforming Clinical Practice Initiative

The Transforming Clinical Practice Initiative (TCPI) was designed to support and accelerate health care transformation by providing direct technical assistance and sharing of lessons learned with providers, states, and other external stakeholders and customers. More specifically, TCPI aims to improve customer experience and health care provider relations by providing technical assistance and training to support a collection of practices to become alternative payment models.

Post-Acute Care Quality Reporting Programs

CMS offers free, in-person training on the patient assessment instruments that post-acute care providers must use to submit data to CMS. We also provide free data-submission software for providers. Additionally, CMS ensures that there are substantial outreach and educational activities for these quality reporting programs. CMS has held several outreach events in the past year to reach numerous stakeholders, and we have grown our - list serve outreach to subscribers to increase providers' and stakeholders' engagement and access to information updates. CMS ensures the development measures includes opportunities for public input; 24/7 comment access is available through email and help desks, where we provide immediate responses. CMS's ongoing webinars on post-acute care quality reporting programs and our efforts to implement the IMPACT Act have resulted in evaluation ranking in the mid-80's to mid-90's.

Person and Family Engagement

CMS has engaged in significant collaboration with stakeholders. Focus groups, onsite practice visits, webinars, and open door forums have expanded outreach to the medical community, demonstrated transparency, and obtained valuable feedback from clinicians and specialty groups. The CMS Quality Improvement Council chartered the Person and Family Engagement Affinity Group to promote

collaboration between patients and care teams, and improve outreach and two-way communication.

The CMS Person and Family Engagement Affinity Group released a comprehensive Person and Family Engagement Strategy in December of 2016, which is available in two formats at the following link: **https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Person-and-Family-Engagement.html**. This group intends to engage with patient, family, and consumer groups to empower and engage beneficiaries in active participation with CMS policy makers.

Our efforts to implement and support the QPP have increased collaboration and transparency; increased broader knowledge sharing among public and private stakeholders; and improved focus on partnering with patients, families and caregivers, frontline clinicians, and specialty societies. Through a targeted Technical Assistance initiative, CMS employs an integrated approach with several high-level shared goals to help improve the overall customer experience for doctors and clinicians included in the QPP. The effort begins by ensuring that 100 percent of clinicians have access to support, and leverage a "no wrong door" approach. This approach connects clinicians to the appropriate form of help regardless of their entry point. The initiative also requires that 100 percent of clinician inquiries and requests for help receive a response within one business day. The Technical Assistance initiative has also taken significant strides to minimize the learning curve through timely and effective resources that allow clinicians to learn about the program without interrupting the most important aspect of their work –time spent with their patients.

Provider Outreach and Education

CMS is dedicated to providing greater transparency to our stakeholders, allowing them to better understand program integrity issues through education, data and process transparency, and strategic communications. We are phasing in a Targeted Probe and Educate initiative to target individual providers for educational interventions. In addition, CMS provides education, outreach, and training to key program integrity stakeholders, and is enhancing these efforts to allow for flexible and consistent user training. The goal of this outreach is to reduce provider burden, improper payments, claim denials and appeals, while improving beneficiary quality of care and the consumer experience.

Integrity Continuum and Documentation Requirements Simplification Initiative

CMS is working to identify opportunities to reduce provider burden while maintaining program integrity oversight. Accordingly, we have been working to develop and refine the Integrity Continuum, which ensures actions taken are commensurate with provider behavior. In addition, CMS recently launched an initiative to simplify documentation requirements. This effort includes work to review existing Medicare documentation requirements aimed at reducing provider administrative burden and developing processes for streamlining new documentation requirements.

Medicaid and CHIP State Plan Amendments

To better serve our state Medicaid partners, CMS has initiated an effort to streamline the Medicaid and CHIP SPA and waiver review and approval processes. In collaboration with states, we are modifying current processes to promote greater accountability and efficiency, resulting in quicker and less burdensome adjudications for states. CMS has established a joint federal-state workgroup to inform this initiative and ensure that improving the customer experience remains at the forefront of this effort.

Medicaid Prevention Learning Network

CMS understands that customer service is critical to achieving successful partnerships between CMS, beneficiaries, providers, and states. We engage with all stakeholders at each stage of measure development, data collection, reporting, and program and policy support to promote healthy outcomes. CMS uses human-centered design to gather important information about how, why, and when beneficiaries use Medicaid services. We also work with a broad range of stakeholders, including state Medicaid agencies, providers, and advocates, to develop quality measures that are relevant, reliable, and reportable. CMS also offers technical assistance tailored to meet the specific challenges and needs of each state as they set up systems to collect and report data on the process and outcomes measures. To promote healthy outcomes and serve each state's unique population needs, CMS has created a learning network to give state Medicaid agencies policy and programmatic support as they address disease prevention and management.

Program Integrity

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 is moving away from the "pay-and-chase" method of recovery by proactively preventing potentially fraudulent and improper payments. Program integrity efforts must put patients and access to care first.

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 upon its financial management and reporting processes to provide timely, reliable, and accurate financial information that CMS management and other decision makers use 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, 2017 and 2016, 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 $444.2 billion. The bulk of these assets are in Investments totaling $271.8 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 $108.7 billion, most of which is for Medicaid, CHIP, and Payments to Health Care trust funds. Liabilities of $137.5 billion consist primarily of the Entitlement Benefits Due and Payable of $108.3 billion. CMS's Net Position totals $306.7 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, 2017 and 2016. 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 funding are included under the HI trust fund. The costs related to the Program Management appropriation are cost-allocated to Medicare, Other Health and Medicaid. The net cost of operations under "Other Activities" include: State Grants and Demonstrations, Other Health, and Other. 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 2017, our total Net Cost of Operations was $963.3 billion encompassing total Benefit Payments of $1,053.2 billion and Administrative Expenses of $8 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, 2017 and 2016. Changes in CMS's net position result from changes that occur within the Cumulative Results of Operations and Unexpended Appropriations. Funds From Dedicated Collections are shown in a separate column from Other Funds.

The bulk of the change pertains to Appropriations Used of $712.9 billion, which represents the Medicaid and CHIP appropriations, transfers from Payments to Health Care trust funds to HI and SMI, and State Grants and Demonstrations and general fund-financed Program Management appropriations. They 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 $259.7 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, 2017 and 2016. An additional Schedule of Budgetary Resources is provided as Required Supplementary Information (RSI) to present budgetary information by program. In this statement, the Program Management and the Program Management User Fee accounts are combined and are not allocated back to the other programs. Also, there are no intra-CMS eliminations in this statement.

CMS total budgetary resources were $1,528.1 billion ($329 million in non-budgetary). Obligations of $1,502.1 billion ($152 million in non-budgetary) leave unobligated balances of $25.9 billion ($177 million in non-budgetary). Total outlays, net of collections, were $1,438.4 billion. When offset by $444.5 billion relating to collection of premiums and general fund transfers from the Payments to Health Care trust funds, as well as refunds of MAC overpayments, the net outlays were $993.9 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 to be 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 2017 *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) increased from $(3.8) trillion, determined as of January 1, 2016, to $(3.5) trillion, determined as of January 1, 2017.

Including the combined HI and SMI trust fund assets as of January 1, 2017, the future cash flow for all current and future participants was $(3.2) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI trust fund assets, is $(10.4) 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 86 percent at the beginning of FY 2013 to 66 percent at the beginning of FY 2017.

Short-Term Financing

TRUST FUND RATIO

Beginning of Fiscal Year [3]

	2013	2014	2015	2016	2017
HI	86%	77%	73%	67%	66%

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 2017 Trustees Report indicate that the HI trust fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2017 Trustees Report, the HI trust fund ratio is estimated to remain at approximately 68 percent through 2021 and to continue decreasing through 2026. From the end of 2016 to the end of 2022, assets are expected to increase, from $199 billion to $266 billion, but then decrease to $179 billion by the end of 2026.

Long-Term Financing

The short-range outlook for the HI trust fund has improved compared to what was projected last year. After 2021, the trust fund ratio starts to decline quickly until the fund is depleted in 2029, one year later than 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 88 percent in 2029 to 81 percent in 2041 and then to increase to about 88 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 beneficiaries eligible for benefits drops from 3.1 in 2016 to about 2.1 by 2091. 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 $3.3 trillion, which is 0.6 percent of taxable payroll and 0.3 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. This transfer occurred again in February 2016 and has been consistently applied since then. As a result, the Trustees expect the Part D account to include a more substantial balance at the end of most months to reflect the new policy.

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 $(30.0) 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 2016, SMI expenditures were 2.1 percent of GDP. By 2091, SMI expenditures are projected to grow to 3.7 percent of the GDP.

[3] Assets at the beginning of the year to expenditures during the year

The following table presents key amounts from our basic financial statements for fiscal year 2015 through 2017.

TABLE OF KEY MEASURES [4]

DOLLARS IN BILLIONS

	2017	2016	2015
Net Position (end of fiscal year)			
Assets	$444.2	$446.0	$418.6
Less Total Liabilities	$137.5	$137.3	$129.1
Net Position (assets net of liabilities)	$306.7	$308.7	$289.5
Costs (end of fiscal year)			
Net Costs	$963.3	$953.1	$913.8
Total Financing Sources	$984.6	$960.1	$910.3
Net Change in Cumulative Results of Operations	$21.3	$7.0	$(3.5)
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	$(3,532)	$(3,822)	$(3,187)
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	$(3,822)	$(3,187)	$(3,823)
Change in present value	$290	$(635)	$636

[4] The table or other singular presentation showing the measures described above. Although, the closed group measure is not required to be presented in the table or other singular presentation, the CMS presents the closed group measure and open group measure.

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, 2017, decreased by $187 billion due to advancing the valuation date by one year and including the additional year 2091, and by $102 billion due to changes in demographic assumptions. However, changes in the projection base, economic and health care assumptions, and legislation changes increased the present value of future cash flows by $342 billion, $233 billion, and $4 billion, respectively.

Required Supplementary Information

As required by Statement of Federal Financial Accounting Standards (SFFAS) Number 17, Accounting for Social Insurance (as amended by SFFAS Number 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 beneficiaries (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 ***2017 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 have been prepared to report the financial position and results of operations of CMS, pursuant to the requirements of 31 U.S.C. 3515(b). While the financial statements have been prepared from the books and records of CMS in accordance with Generally Accepted Accounting Principles for federal entities and the formats prescribed by OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources that are prepared from the same books and records.

The statements should be read with the realization that they are for a component of the U.S. Government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation that provides resources to do so.

The RSI section is unique to federal financial reporting. This section is required under OMB Circular A-136, Financial Reporting Requirements, and is unaudited.

FINANCIAL SECTION

A Message from the Chief Financial Officer // Financial Statements // Notes to the Financial Statements // Required Supplementary Information // Supplementary Information // Audit Reports

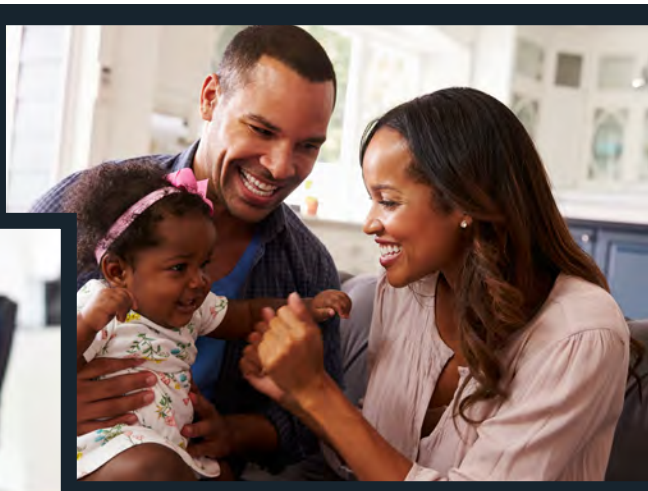
A MESSAGE FROM THE CHIEF FINANCIAL OFFICER

JENNIFER MAIN

I am pleased to present the Centers for Medicare & Medicaid Services (CMS) Agency Financial Report (AFR) for Fiscal Year (FY) 2017. For the 19th straight year, CMS has received an unmodified opinion on four of our six principal financial statements. CMS's unmodified opinion confirms that our agency's financial statements are fairly presented and are free of material misstatement. This is a reflection of our dedicated financial management team, their adherence to internal controls, and their commitment to continuous improvement to the financial stewardship entrusted to us. Financial stewardship, transparency, and integrity of our financial data remain the cornerstone of our commitment.

While CMS remains confident in our FY 2017 Statement of Social Insurance (SOSI) projections and their disclosure, our auditors were not able to express an opinion on the sustainability financial statements, SOSI and the Statement of Changes in Social Insurance Amounts. The uncertainties of the long-range assumptions applied in the SOSI model were the basis surrounding our auditors' decision not to express an opinion. CMS continues to collaborate with our auditors to develop a strategy for reporting the SOSI projections in a manner that will allow the auditors to provide an opinion on these statements.

CMS strives to be financially responsible stewards of the Medicare Trust Funds. Two areas that remain a top priority are program integrity and waste prevention. CMS is continually improving program integrity by identifying improper payments and working hard to determine the source of these improper payments. CMS's waste prevention efforts in the Medicare Secondary Payer (MSP) area saved the Medicare Trust Funds approximately $8.5 billion in FY 2017. These savings are attributable to our coordination of benefit and recovery efforts to ensure that fewer mistaken payments are made while, at the same time, continuing to actively pursue recoveries of Medicare conditional payments.



Transparency of financial information is crucial to our mission of spending each and every taxpayer dollar wisely. As of May 2017, CMS began reporting standardized spending information in compliance with the Digital Accountability and Transparency Act of 2014 (DATA Act). The DATA Act makes it easier for the public to understand how CMS spends its taxpayer dollars and provides for better oversight of that spending.

Integrity of CMS's financial data remains one of the key goals of our dedicated staff. Championing continuous improvement of our processes has strengthened controls over CMS's financial data, eliminated manual processes and therefore decreased the risk of manual errors, and allowed the financial data to be presented more efficiently to meet the changing needs of those we serve.

Financial stewardship, transparency, and integrity are at the center of what we do because we recognize the confidence that the American people have in us. Partnering together with those we serve, CMS remains committed to reducing healthcare costs and providing the best value of the resources entrusted to us.

In closing, I would like to acknowledge those who contributed to this report – our dedicated financial management team and our partners. The accomplishments described in this report are a reflection of your hard work.

Thank you.

JENNIFER MAIN
CMS Chief Financial Officer

November 2017

CONSOLIDATED BALANCE SHEETS

as of September 30, 2017 and September 30, 2016

(IN MILLIONS)

	FY 2017 Consolidated Totals	FY 2016 Consolidated Totals
ASSETS		
Intragovernmental Assets:		
Fund Balance with Treasury *(Note 2)*	$108,676	$140,047
Investments *(Note 3)*	271,845	258,371
Accounts Receivable, Net *(Note 4)*	584	589
Other Assets *(Note 5)*	25	28
TOTAL INTRAGOVERNMENTAL ASSETS	**381,130**	**399,035**
Accounts Receivable, Net *(Note 4)*	31,814	23,579
General Property, Plant and Equipment, Net	1,224	746
Other Assets *(Note 5)*	30,010	22,668
TOTAL ASSETS	**$444,178**	**$446,028**
LIABILITIES		
Intragovernmental Liabilities:		
Accounts Payable	$534	$625
Other Intragovernmental Liabilities	7,325	4,878
TOTAL INTRAGOVERNMENTAL LIABILITIES	7,859	5,503
Accounts Payable	181	272
Entitlement Benefits Due and Payable *(Note 6)*	108,347	108,230
Contingencies *(Note 7)*	13,121	10,826
Other Liabilities	7,977	12,448
TOTAL LIABILITIES *(Note 8)*	**$137,485**	**$137,279**
NET POSITION		
Unexpended Appropriations–Dedicated Collections	$17,287	$36,012
Unexpended Appropriations–Other Funds	42,242	46,847
TOTAL UNEXPENDED APPROPRIATIONS	59,529	82,859
Cumulative Results of Operations–Dedicated Collections	251,620	227,156
Cumulative Results of Operations–Other Funds	(4,456)	(1,266)
TOTAL CUMULATIVE RESULTS OF OPERATIONS	247,164	225,890
TOTAL NET POSITION	**$306,693**	**$308,749**
TOTAL LIABILITIES AND NET POSITION	**$444,178**	**$446,028**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF NET COST

for the years ended September 30, 2017 and September 30, 2016

(IN MILLIONS)

	FY 2017 Consolidated Totals	FY 2016 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS		
GPRA Programs		
Medicare (Dedicated Collections)	$567,129	$566,114
Medicaid	372,986	363,060
CHIP	16,633	14,579
Net Cost: GPRA Programs	956,748	943,753
Other Activities		
State Grants and Demonstrations	556	519
Other Health	1,316	3,168
Other	4,712	5,620
Net Cost: Other Activities	6,584	9,307
NET COST OF OPERATIONS *(Notes 9, 11, and 16)*	$963,332	$953,060

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2017

(IN MILLIONS)

	Consolidated Dedicated Collections	Consolidated Other Funds	FY 2017 Consolidated Total
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	**$227,156**	**$(1,266)**	**$225,890**
Budgetary Financing Sources:			
Appropriations Used	325,548	387,368	712,916
Nonexchange Revenue:			
FICA and SECA Taxes	259,740		259,740
Interest on Investments	9,761	6	9,767
Other Nonexchange Revenue	4,634		4,634
Transfers-in/out Without Reimbursement	(4,934)	2,451	(2,483)
Other Financing Sources (Nonexchange):			
Transfers-in/out Without Reimbursement		2	2
Imputed Financing	29	18	47
Other		(17)	(17)
Total Financing Sources	**594,778**	**389,828**	**984,606**
Net Cost of Operations	**570,314**	**393,018**	**963,332**
Net Change	**24,464**	**(3,190)**	**21,274**
CUMULATIVE RESULTS OF OPERATIONS	**$251,620**	**$(4,456)**	**$247,164**
UNEXPENDED APPROPRIATIONS			
Beginning Balances	**$36,012**	**$46,847**	**$82,859**
Budgetary Financing Sources:			
Appropriations Received	348,468	481,724	830,192
Appropriations Transferred-in/out		(4,344)	(4,344)
Other Adjustments	(41,645)	(94,617)	(136,262)
Appropriations Used	(325,548)	(387,368)	(712,916)
Total Budgetary Financing Sources	(18,725)	(4,605)	(23,330)
Total Unexpended Appropriations	17,287	42,242	59,529
NET POSITION	$268,907	$37,786	$306,693

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2016

(IN MILLIONS)

	Consolidated Dedicated Collections	Consolidated Other Funds	FY 2016 Consolidated Total
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	**$215,354**	**$3,466**	**$218,820**
Budgetary Financing Sources:			
Appropriations Used	323,453	375,019	698,472
Nonexchange Revenue:			
FICA and SECA Taxes	250,472		250,472
Interest on Investments	9,883	17	9,900
Other Nonexchange Revenue	3,689		3,689
Transfers-in/out Without Reimbursement	(4,432)	2,093	(2,339)
Other Financing Sources (Nonexchange):			
Imputed Financing	37	19	56
Other		(120)	(120)
Total Financing Sources	**583,102**	**377,028**	**960,130**
Net Cost of Operations	**571,300**	**381,760**	**953,060**
Net Change	**11,802**	**(4,732)**	**7,070**
CUMULATIVE RESULTS OF OPERATIONS	**$227,156**	**$(1,266)**	**$225,890**
UNEXPENDED APPROPRIATIONS			
Beginning Balances	**$30,284**	**$40,353**	**$70,637**
Budgetary Financing Sources:			
Appropriations Received	351,310	475,603	826,913
Appropriations Transferred-in/out		(4,378)	(4,378)
Other Adjustments	(22,129)	(89,712)	(111,841)
Appropriations Used	(323,453)	(375,019)	(698,472)
Total Budgetary Financing Sources	5,728	6,494	12,222
Total Unexpended Appropriations	36,012	46,847	82,859
NET POSITION	$263,168	$45,581	$308,749

The accompanying notes are an integral part of these statements.

COMBINED STATEMENTS OF BUDGETARY RESOURCES

for the years ended September 30, 2017 and September 30, 2016

(IN MILLIONS)

	FY 2017 Combined Totals Budgetary	FY 2017 Non-Budgetary Credit Reform Financing Account	FY 2016 Combined Totals Budgetary	FY 2016 Non-Budgetary Credit Reform Financing Account
Budgetary Resources:				
Unobligated balance brought forward, October 1	$48,150	$624	$55,748	
Other Adjustments	77		821	
Recoveries of prior year unpaid obligations	47,874	3	32,509	
Other changes in unobligated balance	(31,664)	(476)	(17,119)	
Unobligated balance from prior year budget authority, net	64,437	151	71,959	
Appropriations (discretionary and mandatory)	1,456,873	(96)	1,427,931	
Borrowing authority (discretionary and mandatory)	3,720	152	3,720	$19
Spending authority from offsetting collections	2,736	122	13,994	637
TOTAL BUDGETARY RESOURCES	**$1,527,766**	**$329**	**$1,517,604**	**$656**
Status of Budgetary Resources:				
New Obligations and upward adjustments	$1,501,957	$152	$1,469,454	$32
Apportioned, Unexpired	10,343	3	18,217	8
Exempt from Apportionment, unexpired accounts	(12,301)		(7,909)	
Unapportioned, unexpired accounts	5,988	174	2,890	616
Unexpired unobligated balance, end of year	4,030	177	13,198	624
Expired unobligated balance, end of year	21,779		34,952	
Unobligated balance, end of year	25,809	177	48,150	624
TOTAL BUDGETARY RESOURCES	**$1,527,766**	**$329**	**$1,517,604**	**$656**
Change in Obligated Balance:				
Unpaid obligations:				
Unpaid obligations, brought forward, October 1	$168,271	$37	$152,500	$375
Adjustment to unpaid obligations			(941)	
New Obligations and upward adjustments	1,501,957	152	1,469,454	32
Outlays (gross)	(1,462,694)	(180)	(1,420,233)	(370)
Recoveries of prior year unpaid obligations	(47,874)	(3)	(32,509)	
Unpaid obligations end of year	159,660	6	168,271	37
Uncollected Payments:				
Uncollected payments, Federal sources, brought forward, October 1	(22,419)	(14)	(18,803)	(159)
Other Adjustments			(38)	
Change in uncollected payments, Federal sources	6,248	12	(3,578)	145
Uncollected payments, Federal sources, end of year	(16,171)	(2)	(22,419)	(14)
Memorandum entries:				
Obligated start of year, net	145,852	23	133,697	216
Obligated balance, end of year, net	143,489	4	145,852	23
Budgetary Authority and Outlays, Net:				
Budget authority, gross	$1,463,329	$178	$1,445,645	$656
Actual offsetting collections	(24,367)	(134)	(10,627)	(782)
Change in uncollected customer payments from Federal sources	6,248	12	(3,578)	145
Recoveries of prior year paid obligations	15,460		190	
Budget authority, net	1,460,670	56	1,431,630	19
Outlays, gross	1,462,694	180	1,420,233	370
Actual offsetting collections	(24,367)	(134)	(10,627)	(782)
Outlays, net	1,438,327	46	1,409,606	(412)
Distributed offsetting receipts	(444,507)		(427,252)	
AGENCY OUTLAYS, NET	**$993,820**	**$46**	**$982,354**	**$(412)**

The accompanying notes are an integral part of these statements.

STATEMENT OF SOCIAL INSURANCE

75-Year Projection as of January 1, 2017 and Prior Base Years

(IN BILLIONS)

	2017 (unaudited)	Estimates from Prior Years: 2016 (unaudited)	2015 (unaudited)	2014 (unaudited)	2013 (unaudited)
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 13 and 14)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$10,679	$10,294	$9,134	$8,398	$8,147
SMI Part B	21,641	19,386	17,027	17,127	15,227
SMI Part D	6,929	7,659	6,424	5,928	5,871
Have attained eligibility age (age 65 or over)					
HI	492	455	382	332	301
SMI Part B	4,122	3,660	3,300	2,873	2,620
SMI Part D	958	952	887	775	722
Those expected to become participants					
HI	10,567	9,952	8,386	7,812	7,744
SMI Part B	5,019	4,437	3,668	4,311	3,530
SMI Part D	2,869	3,602	2,845	2,609	2,617
All current and future participants					
HI	21,738	20,701	17,902	16,542	16,192
SMI Part B	30,783	27,484	23,995	24,311	21,377
SMI Part D	10,756	12,213	10,156	9,312	9,211
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 13 and 14)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	17,193	16,800	14,494	14,117	14,629
SMI Part B	21,392	19,178	16,818	17,003	15,075
SMI Part D	6,929	7,659	6,424	5,928	5,871
Have attained eligibility age (age 65 and over)					
HI	4,539	4,285	3,803	3,484	3,422
SMI Part B	4,531	4,026	3,637	3,171	2,887
SMI Part D	958	952	887	775	722
Those expected to become participants					
HI	3,539	3,437	2,791	2,764	2,913
SMI Part B	4,860	4,281	3,540	4,137	3,415
SMI Part D	2,869	3,602	2,845	2,609	2,617
All current and future participants:					
HI	25,270	24,523	21,089	20,365	20,963
SMI Part B	30,783	27,484	23,995	24,311	21,377
SMI Part D	10,756	12,213	10,156	9,312	9,211
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 13 and 14)					
HI	(3,532)	(3,822)	(3,187)	(3,823)	(4,772)
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0
Additional Information					
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 13 and 14)					
HI	$(3,532)	$(3,822)	$(3,187)	$(3,823)	$(4,772)
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0
Trust Fund assets at start of period					
HI	199	194	197	205	220
SMI Part B	88	68	68	74	66
SMI Part D	8	1	1	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 13 and 14)					
HI	(3,333)	(3,628)	(2,990)	(3,618)	(4,551)
SMI Part B	88	68	68	74	66
SMI Part D	8	1	1	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, 2017 and Prior Base Years

(IN BILLIONS)

		Estimates from Prior Years			
	2017 (unaudited)	2016 (unaudited)	2015 (unaudited)	2014 (unaudited)	2013 (unaudited)
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)	$5,572	$5,067	$4,569	$3,980	$3,643
Expenditures	10,027	9,263	8,328	7,430	7,031
Income less expenditures	(4,455)	(4,196)	(3,759)	(3,450)	(3,388)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	39,250	37,339	32,585	31,453	29,244
Expenditures	45,514	43,637	37,736	37,048	35,574
Income less expenditures	(6,264)	(6,298)	(5,151)	(5,595)	(6,330)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(10,719)	(10,493)	(8,909)	(9,045)	(9,718)
Combined Medicare Trust Fund assets at start of period	295	263	266	280	288
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(10,425)	(10,230)	(8,643)	(8,764)	(9,430)
Future Participants: *Actuarial present value for the 75-year projection period:*					
Income (excluding interest)	18,456	17,992	14,898	14,732	13,891
Expenditures	11,268	11,320	9,176	9,510	8,945
Income less expenditures	7,187	6,672	5,722	5,222	4,946
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(3,532)	(3,822)	(3,187)	(3,823)	(4,772)
Combined Medicare Trust Fund assets at start of period	295	263	266	280	288
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	($3,237)	$(3,559)	$(2,921)	$(3,542)	$(4,484)

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, 2016 to January 1, 2017

(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 15)*					
As of January 1, 2016	$60,398	$64,220	($3,822)	$263	($3,559)
Reasons for change					
Change in the valuation period	2,481	2,669	(187)	24	(163)
Change in projection base	(136)	(479)	342	8	350
Changes in the demographic assumptions	(122)	(20)	(102)	0	(102)
Changes in economic and health care assumptions	617	384	233	0	233
Changes in law	40	36	4	0	4
Net changes	2,880	2,590	290	31	321
As of January 1, 2017	63,277	66,809	(3,532)	295	(3,237)
HI: Part A *(Note 15)*					
As of January 1, 2016	20,701	24,523	(3,822)	194	(3,628)
Reasons for change					
Change in the valuation period	792	979	(187)	1	(186)
Change in projection base	133	(209)	342	4	346
Changes in the demographic assumptions	(152)	(50)	(102)	0	(102)
Changes in economic and health care assumptions	265	32	233	0	233
Changes in law	0	(4)	4	0	4
Net changes	1,037	748	290	5	295
As of January 1, 2017	21,738	25,270	(3,532)	199	(3,333)
SMI: Part B *(Note 15)*					
As of January 1, 2016	27,484	27,484	0	68	68
Reasons for change					
Change in the valuation period	1,115	1,115	0	17	17
Change in projection base	281	281	0	3	3
Changes in the demographic assumptions	7	7	0	0	0
Changes in economic and health care assumptions	1,856	1,856	0	0	0
Changes in law	40	40	0	0	0
Net changes	3,299	3,299	0	20	20
As of January 1, 2017	30,783	30,783	0	88	88
SMI: Part D *(Note 15)*					
As of January 1, 2016	12,213	12,213	0	1	1
Reasons for change					
Change in the valuation period	575	575	0	5	5
Change in projection base	(550)	(550)	0	1	1
Changes in the demographic assumptions	22	22	0	0	0
Changes in economic and health care assumptions	(1,504)	(1,504)	0	0	0
Changes in law	0	0	0	0	0
Net changes	(1,457)	(1,457)	0	6	6
As of January 1, 2017	10,756	10,756	0	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, 2015 to January 1, 2016

(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 15)*					
As of January 1, 2015	$52,053	$55,240	($3,187)	$266	($2,921)
Reasons for change					
Change in the valuation period	2,162	2,330	(169)	2	(167)
Change in projection base	306	595	(289)	(5)	(294)
Changes in the demographic assumptions	(391)	(573)	182	0	182
Changes in economic and health care assumptions	6,501	6,867	(366)	0	(366)
Changes in law	(232)	(239)	6	0	6
Net changes	8,345	8,980	(635)	(3)	(638)
As of January 1, 2016	$60,398	$64,220	($3,822)	$263	($3,559)
HI: Part A *(Note 15)*					
As of January 1, 2015	$17,902	$21,089	($3,187)	$197	($2,990)
Reasons for change					
Change in the valuation period	687	855	(169)	2	(167)
Change in projection base	63	352	(289)	(6)	(294)
Changes in the demographic assumptions	63	(120)	182	0	182
Changes in economic and health care assumptions	1,987	2,353	(366)	0	(366)
Changes in law	0	(6)	6	0	6
Net changes	2,799	3,434	(635)	(4)	(638)
As of January 1, 2016	$20,701	$24,523	($3,822)	$194	($3,628)
SMI: Part B *(Note 15)*					
As of January 1, 2015	$23,995	$23,995	$0	$68	$68
Reasons for change					
Change in the valuation period	990	990	0	0	0
Change in projection base	(113)	(113)	0	(0)	(0)
Changes in the demographic assumptions	(350)	(350)	0	0	0
Changes in economic and health care assumptions	3,183	3,183	0	0	0
Changes in law	(221)	(221)	0	0	0
Net changes	3,489	3,489	0	0	0
As of January 1, 2016	$27,484	$27,484	$0	$68	$68
SMI: Part D *(Note 15)*					
As of January 1, 2015	$10,156	$10,156	$0	$1	$1
Reasons for change					
Change in the valuation period	485	485	0	(0)	(0)
Change in projection base	356	356	0	1	1
Changes in the demographic assumptions	(103)	(103)	0	0	0
Changes in economic and health care assumptions	1,330	1,330	0	0	0
Changes in law	(11)	(11)	0	0	0
Net changes	2,057	2,057	0	0	0
As of January 1, 2016	$12,213	$12,213	$0	$1	$1

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

Reporting Entity

The Centers for Medicare & Medicaid Services (CMS), a component of the Department of Health and Human Services (HHS), administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and other health related programs established by Congress. CMS is a separate financial reporting entity of HHS.

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).

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

The preparation of financial statements, in conformity with GAAP, requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the dates of the financial statements and the reported amounts of revenues and expenses during the reporting periods. 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, Cost Sharing Reduction, 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. Medicare contractors are paid by CMS to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these 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 General Fund of Treasury 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. Medicare contractors are paid by CMS to process Medicare claims for physicians, medical suppliers, laboratory services, hospital outpatient services and rehabilitation, ambulatory surgical centers (ASC), end stage renal disease (ESRD), rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these 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 well as the method to make the trust funds whole 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. The program makes a prescription drug benefit available to beneficiaries enrolled in Medicare Part A and/or Part B, though beneficiaries must join a drug plan to obtain coverage. The drug plans are offered by insurance companies and other private companies approved by Medicare and are of two types: Medicare Prescription Drug Plans (which add the coverage to basic Medicare) and Medicare Advantage Prescription Drug Plans and other Medicare Health Plans in which drug coverage is offered as part of a benefit package that includes Part A and Part B services. In addition, Medicare 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 from 100 percent in 2010 (including the $250 rebate) to 25 percent by 2020. Part D is considered part of the SMI trust fund and is reported in the SMI TF 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, and codified Medicare program integrity activities previously known as "payment safeguards." 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 TF and SMI TF 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, the health care program for low-income Americans, is administered by CMS in partnership with the States via grant awards, which limit the funds that can be drawn by the States to cover current expenses. The grant awards, prepared at the beginning of each quarter and amended as necessary, are an estimate of the Federal (CMS) share of the States' Medicaid costs. At the end of each quarter, states report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by CMS for the difference between approved expenses reported for the period and the grant awards previously issued. 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 2017 is 95% and for CY 2018 is 94%). The methodology for estimating the Medicaid Entitlement Benefits Due and Payable includes those claims incurred as the result of Medicaid expanded coverage.

CHIP

CHIP (formerly known as the State Children's Health Insurance Program, or SCHIP) was originally included in the Balanced Budget Act of 1997 (BBA) and the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), and was designed to provide health insurance for children, many of whom come from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. The BBA set aside funds for ten years to provide this insurance coverage. The MMSEA extended the funding through March 2009.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) extended the program through September 2013; the PPACA extended the program through September 2015; and the Medicare Access and CHIP Reauthorization Act of 2015 extends the program through September 2017. CHIPRA also establishes a Child

Enrollment Contingency Fund to cover shortfalls in funding for the States. This fund is invested in interest-bearing Treasury securities.

The CHIP grant awards, prepared at the beginning of each quarter and amended as necessary, are based on a state approved plan to fund CHIP. At the end of each quarter, states report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by CMS for the difference between approved expenses reported for the period and the grant awards previously issued.

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 Affordable Care Act, several new grants were included in the account and the availability of funds for other grants was extended.

The Ticket to Work and Work Incentives Improvement Act of 1999 established Medicaid infrastructure grants to support the design, establishment and operation of state infrastructures to help working people with disabilities purchase health coverage through Medicaid.

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, Marketplace, and Other User Fees

This account operates as a revolving fund without fiscal year restriction. The BBA established the Medicare + Choice program, now known as the Medicare Advantage program under the MMA, that requires Medicare Advantage plans 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 among all programs based on the CMS cost allocation system. It is reported in the Medicare and Health columns of the Consolidating Statement of Net Cost in the Supplementary Information section.

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).

Borrowing Authority increases budgetary resources and enables costs to be financed by borrowing from Treasury. CMS uses indefinite borrowing authority under the Federal Credit Reform Act, as amended, for its Consumer Operated and Oriented Plan program (CO-OP). Any unobligated borrowing authority does not carry forward to the next fiscal year. CMS has issued direct loans for the CO-OP program. CMS also has debt for the amounts borrowed from and owed to Treasury to finance a portion of the direct loans issued under the CO-OP program. CMS reports direct loans in accordance with the Federal Credit Reform Act. However, due to the immateriality of these direct loans, the related receivables and liabilities are reported in Other Assets and Other Liabilities, respectively. Budgetary related activity is reported separately within the Statement of Budgetary Resources.

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. By law, if the monthly disbursement date falls on a weekend or a federal recognized holiday, CMS is required to accelerate the disbursement date to the preceding business day.

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. Monthly Part B premiums paid by Medicare beneficiaries are matched 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 well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. Other premiums collected are for Part A, 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.

Unobligated Balances—beginning of period represent funds brought forward from the previous year.

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.

Estimation of Obligations Related to Canceled Appropriations

As of September 30, 2017, CMS has canceled over $2,380 million in cumulative obligations related to FY 2012 and prior years in accordance with the National Defense Authorization Act of Fiscal Year 1991 (P.L. 101-150). Based on the payments made in FYs 2013 through 2017 related to canceled appropriations, CMS anticipates an additional $5 million will be paid from current year funds for canceled obligations.

The PPACA

The PPACA contains the most significant changes to health care coverage since the passing of the Social Security Act. 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 Affordable Insurance Exchanges (the "Exchanges"). A brief description of these programs is presented below.

Affordable Insurance Exchanges

Grants have been provided to the States to establish Affordable 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.

Transitional Reinsurance Program

The Transitional Reinsurance program was established in each state to help stabilize premiums for coverage in the individual market for benefit years 2014 through 2016. All health insurance issuers and third party administrators on behalf of self-insured group health plans, made contributions to support reinsurance

payments that cover high-cost individuals in non-grandfathered plans in the individual market, inside and outside the Exchange.

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.

Risk Corridors Program

The temporary Risk Corridors program operated for benefit years 2014 through 2016. This program applies to Qualified Health Plans in the individual and small group markets, inside and outside the Exchanges and protects against inaccurate rate-setting by sharing risk (gains and losses) on allowable costs between CMS and Qualified Health Plans.

Reclassifications

Certain FY 2016 balances have been reclassified to conform to FY 2017 financial statement presentations. The effects are immaterial.

NOTE 2:

FUND BALANCE WITH TREASURY

(DOLLARS IN MILLIONS)

	FY 2017	FY 2016
Fund Balances:		
Trust Funds:		
HI Trust Fund Balance	$818	$2,059
SMI Trust Fund Balance	27,466	51,747
Special Funds:		
Affordable Care Act Risk Programs	3,156	2,174
CHIP Child Enrollment Contingency	200	5,359
Revolving Funds:		
COOP Financing	25	630
Appropriated Funds:		
Medicaid	39,250	40,365
CHIP	28,914	26,457
State Grants and Demo	1,240	2,370
Other Health	5,481	6,900
Program Management Direct/Reimbursables	2,090	1,953
Other Fund Types:		
CMS Deposit/Small Escrow	36	33
Total Fund Balances	$108,676	$140,047
Status of Fund Balances with Treasury:		
Unobligated Balance:		
Available	$(1,955)	$10,316
Unavailable	27,941	38,458
Obligated Balance not yet Disbursed	143,493	145,875
Non-Budgetary FBWT	(60,803)	(54,602)
Total Status of Fund Balances with Treasury	$108,676	$140,047

Fund Balances are funds with Treasury that are primarily available to pay current expenditures and liabilities. The Unobligated Balance Available includes $11,216 million ($8,840 million in FY 2016), 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 2017 Medicare Investments *(Dedicated Collections)*	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2018	2 1/8%	$4,706
Bonds	June 2018 to June 2027	1 7/8 - 5 1/8%	193,129
Accrued Interest			1,780
Total HI TF Investments			**$199,615**
SMI TF			
Certificates	June 2018	2 1/4%	$298
Bonds	June 2019 to June 2032	1 7/8 - 5%	70,291
Accrued Interest			498
Total SMI TF Investments			**$71,087**
Total Medicare Investments			**$270,702**

FY 2016 Medicare Investments *(Dedicated Collections)*	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2017	1 5/8%	$3,703
Bonds	June 2017 to June 2026	1 7/8 - 5 1/4%	188,506
Accrued Interest			1,800
Total HI TF Investments			**$194,009**
SMI TF			
Certificates	June 2017	1 5/8 - 1 7/8%	$548
Bonds	June 2019 to June 2031	1 7/8 - 5%	62,788
Accrued Interest			456
Total SMI TF Investments			**$63,792**
Total Medicare Investments			**$257,801**

Trust fund (Dedicated collections) investments are investments (plus the accrued interest on investments) held by Treasury. 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.

Investments consist of the CHIP Child Enrollment Contingency Fund investments also held by Treasury. These investments are Treasury bills purchased at a discount which are fully amortized at the maturity date. These investments will be redeemed as funds are needed by the States to cover shortfalls in the CHIP program.

NOTE 3:

INVESTMENTS *(CONTINUED)*

(DOLLARS IN MILLIONS)

FY 2017 CHIP Child Enrollment Contingency Fund Investments *(Non-Dedicated Collections)*	Maturity Date	Cost	Unamortized Discount	Investments, Net
Treasury Bill	12/07/2017	$1,145	$2	$1,143
Total Non-Dedicated Collections Investments		**$1,145**	**$2**	**$1,143**

FY 2016 CHIP Child Enrollment Contingency Fund Investments *(Non-Dedicated Collections)*	Maturity Date	Cost	Unamortized Discount	Investments, Net
Treasury Bill	3/30/2017	$571	$1	$570
Total Non-Dedicated Collections Investments		**$571**	**$1**	**$570**

CMS INVESTMENT SUMMARY

(DOLLARS IN MILLIONS)

	Medicare (Dedicated Collections)			Non-Dedicated Collections	Consolidated Total
FY 2017	HI TF	SMI TF	Total	CHIP	
Certificates	$4,706	$298	$5,004		$5,004
Bonds	193,129	70,291	263,420		263,420
Treasury Bills				$1,143	1,143
Accrued Interest	1,780	498	2,278		2,278
Total Investments	**$199,615**	**$71,087**	**$270,702**	**$1,143**	**$271,845**

	Medicare (Dedicated Collections)			Non-Dedicated Collections	Consolidated Total
FY 2016	HI TF	SMI TF	Total	CHIP	
Certificates	$3,703	$548	$4,251		$4,251
Bonds	188,506	62,788	251,294		251,294
Treasury Bills				570	570
Accrued Interest	1,800	456	2,256		2,256
Total Investments	**$194,009**	**$63,792**	**$257,801**	**$570**	**$258,371**

Note 4:

ACCOUNTS RECEIVABLE, NET

(DOLLARS IN MILLIONS)

FY 2017	Accounts Receivable Principal	Interest Receivable	Accounts Receivable Gross	Allowance	Net CMS Receivables
Intragovernmental					
Entity	$584		$584		$584
Total Intragovernmental	$584		$584		$584
With the Public					
Entity					
Medicare FFS	$7,484		$7,484	$(2,520)	$4,964
Medicare Advantage/ Prescription Drug Program	15,708		15,708		15,708
Medicaid	7,029		7,029	(993)	6,036
CHIP	1		1		1
Other	5,383		5,383	(318)	5,065
Non-Entity	6	$66	72	(32)	40
Total With the Public	$35,611	$66	$35,677	$(3,863)	$31,814

FY 2016	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	$6,726		$6,726	$(2,740)	$3,986
Medicare Advantage/ Prescription Drug Program	3,467		3,467		3,467
Medicaid	8,382		8,382	(1,186)	7,196
CHIP	3		3		3
Other	8,912		8,912	(19)	8,893
Non-Entity		$58	58	(24)	34
Total With the Public	$27,490	$58	$27,548	$(3,969)	$23,579

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, 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:

OTHER ASSETS

(DOLLARS IN MILLIONS)

As of September 30, 2017, CMS has $30,035 million ($22,696 million in FY 2016) in advances to Federal and non-Federal entities. There are $25 million in advances to other Federal entities and $29,233 million non-Federal advances that represent payment of the Prescription Drug and Medicare Advantage benefit payments for October 2017 that occurred on September 29 instead of October 1. An additional $777 million includes the CDC vaccine program inventory and grant advances.

Note 6:

ENTITLEMENT BENEFITS DUE AND PAYABLE

(DOLLARS IN MILLIONS)

	FY 2017	FY 2016
Medicare FFS	$48,029	$44,866
Medicare Advantage/Prescription Drug Program	12,596	19,045
Medicaid	34,070	35,419
CHIP	1,345	978
Other	12,307	7,922
TOTALS	$108,347	$108,230

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, 2017 and 2016 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 2017. 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, 2017.

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 7:

CONTINGENCIES

(DOLLARS IN MILLIONS)

The contingencies balance as of September 30, 2017 is $13,121 million ($10,826 million in FY 2016). 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. Additionally, CMS may owe amounts to providers for previous years' disputed cost report 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.

The Medicaid amount for $12,195 million ($10,166 million in FY 2016) consists of Medicaid audit and program disallowances of $1,217 million ($2,801 million in FY 2016) and $10,978 million ($7,365 million in FY 2016) for reimbursement of state plan amendments. Contingent liabilities have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the states. The funds could have been returned or CMS can decrease the state's authority. CMS will be required to pay these amounts if the appeals are decided in the favor of the states. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a state. There are also outstanding reviews of the state expenditures in which a final determination has not been made. Examples of these reviews are the Office of Inspector General Audits, Focused Financial Management Reviews, and Quarterly Medicaid Statement of Expenditures Report (Form CMS-64) reviews. The appropriate Center for Medicaid and CHIP Services (CMCS) Regional Office staff is responsible for reviewing the findings and recommendations. The monetary effect of these reviews is not known until a final decision is determined and rendered by the Director of CMCS. The outcome of these reviews may result in funds being owed to CMS.

Appeals at the Provider Reimbursement Review Board

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. However, historical cases that have been appealed and settled by the PRRB are considered in the development of the actuarial Medicare IBNR liability. As of September 30, 2017, 10,067 cases (10,005 in FY 2016) remain on appeal. A total of 2,251 new cases (2,515 in FY 2016) were filed and 11 cases were reopened (10 in FY 2016). The PRRB rendered decisions on 128 cases (66 in FY 2016) and an additional 2,072 cases (2,191 in FY 2016) were dismissed, withdrawn, or settled prior to an appeal hearing. The PRRB receives no information on the value of these cases that are settled prior to a hearing.

Note 8:

LIABILITIES NOT COVERED BY BUDGETARY RESOURCES

(DOLLARS IN MILLIONS)

FY 2017 Intragovernmental	Medicare (Dedicated Collections) HI TF	Medicare (Dedicated Collections) SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
Accrued Payroll and Benefits	$1	$1			$1		$3		$3
Other					15	$56	71	$(15)	56
Total Intragovernmental	1	1			16	56	74	(15)	59
Federal Employee and Veterans' Benefits	3	6	$1		3		13		13
Accrued Payroll and Benefits	16	21	2		15	4	58		58
Other		1			5,984		5,985		5,985
Contingencies	926		12,195				13,121		13,121
Total Liabilities Not Covered by Budgetary Resources	946	29	12,198		6,018	60	19,251	(15)	19,236
Total Liabilities Covered by Budgetary Resources	68,824	74,454	34,084	$1,346	2,457	12,415	193,580	(75,331)	118,249
TOTAL LIABILITIES	$69,770	$74,483	$46,282	$1,346	$8,475	$12,475	$212,831	$(75,346)	$137,485

FY 2016 Intragovernmental	Medicare (Dedicated Collections) HI TF	Medicare (Dedicated Collections) SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
Accrued Payroll and Benefits		$1			$1		$2		$2
Other					127	$3,416	3,543	$(127)	3,416
Total Intragovernmental		1			128	3,416	3,545	(127)	3,418
Federal Employee and Veterans' Benefits	$3	6			2		11		11
Accrued Payroll and Benefits	16	24	$2		13	3	58		58
Other					9,505		9,505		9,505
Contingencies	660		10,166				10,826		10,826
Total Liabilities Not Covered by Budgetary Resources	679	31	10,168		9,648	3,419	23,945	(127)	23,818
Total Liabilities Covered by Budgetary Resources	63,470	81,996	35,452	$978	3,026	8,042	192,964	(79,503)	113,461
TOTAL LIABILITIES	$64,149	$82,027	$45,620	$978	$12,674	$11,461	$216,909	$(79,630)	$137,279

All CMS liabilities other than contingent liabilities are considered current. 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. Section 601 created an "additional premium" charged alongside the normal Part B monthly premiums, beginning in 2016, which will be used to pay back the general fund transfer without interest. As of September 30, 2017, $6,396 million ($3,289 million in FY 2016) is still owed.

Starting January 1, 2014, the PPACA provides for a permanent Risk Adjustment program, a transitional Reinsurance program and a temporary Risk Corridors program that will be 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 Risk Adjustment program was administered in a budget neutral manner in any calendar year. The Reinsurance program is intended to be budget neutral, but in the case that collections exceed claims in

a given year, as happened in 2014, the remaining fund may be applied to future year claims. Both the Risk Adjustment and Reinsurance payments for a year cannot exceed amounts already collected. The Risk Corridors program will be administered over a three-year period. For each of the three programs (which are reflected on the Other line above), collections will not be due and payments will not be made until the year following the calendar year for which the program operates. Regarding the Reinsurance program, the PPACA outlines the amounts that are to be collected for program payments and the General Fund for all three program years – 2014, 2015 and 2016. As of September 30, 2017, accruals were recorded to cover future payments, collections, sequestration, and appeals that are still due for/pertain to program years 2014, 2015 and 2016 for the Risk Adjustment program; program years 2015 and 2016 for the Reinsurance program; and program years 2014, 2015 and 2016 for the Risk Corridors program.

Note 9:

NET COST OF OPERATIONS

(DOLLARS IN MILLIONS)

	Medicare (Dedicated Collections)			Health				
FY 2017	**HI TF**	**SMI TF**	**Total**	**Medicaid**	**CHIP**	**Other Health**	**Other**	**Consolidated Total**
PROGRAM/ACTIVITY COSTS								
Medicare								
Fee for Service	$194,575	$187,001	$381,576					$381,576
Medicare Advantage/ Managed Care	93,060	113,275	206,335					206,335
Prescription Drug (Part D)		63,967	63,967					63,967
Medicaid/CHIP/State Grants & Demos				$373,059	$16,621		$539	390,219
Other Health						$6,642		6,642
Other							4,489	4,489
Total Program/Activity Costs	**$287,635**	**$364,243**	**$651,878**	**$373,059**	**$16,621**	**$6,642**	**$5,028**	**$1,053,228**
OPERATING COSTS								
Medicare Integrity Program	$1,282		$1,282					$1,282
Quality Improvement Organizations	584	$286	870					870
Bad Debt Expense and Writeoffs	149	(460)	(311)	$(193)		$295		(209)
Reimbursable Expenses	37	79	116	6	1	32		155
Administrative Expenses	1,135	1,883	3,018	134	13	744	$1,713	5,622
Depreciation and Amortization	13	27	40	2		16	158	216
Imputed Cost Subsidies	13	16	29	1		13	4	47
Total Operating Costs	**3,213**	**1,831**	**5,044**	**(50)**	**14**	**1,100**	**1,875**	**7,983**
TOTAL COSTS	**$290,848**	**$366,074**	**$656,922**	**$373,009**	**$16,635**	**$7,742**	**$6,903**	**$1,061,211**
Less: Exchange Revenues:								
Medicare Premiums	$4,014	$85,392	$89,406					$89,406
Other Exchange Revenues	131	256	387	$23	$2	$6,426	$1,635	8,473
Total Exchange Revenues	**4,145**	**85,648**	**89,793**	**23**	**2**	**6,426**	**1,635**	**97,879**
TOTAL NET COST OF OPERATIONS	**$286,703**	**$280,426**	**$567,129**	**$372,986**	**$16,633**	**$1,316**	**$5,268**	**$963,332**

Note 9:

NET COST OF OPERATIONS *(CONTINUED)*

(DOLLARS IN MILLIONS)

	Medicare (Dedicated Collections)			Health				
FY 2016	**HI TF**	**SMI TF**	**Total**	**Medicaid**	**CHIP**	**Other Health**	**Other**	**Consolidated Total**
PROGRAM/ACTIVITY COSTS								
Medicare								
Fee for Service	$187,632	$178,500	$366,132					$366,132
Medicare Advantage/ Managed Care	90,615	109,443	200,058					200,058
Prescription Drug (Part D)		75,037	75,037					75,037
Medicaid/CHIP/State Grants & Demos				$363,436	$14,565		$505	378,506
Other Health						$11,645		11,645
Other							5,400	5,400
Total Program/Activity Costs	**$278,247**	**$362,980**	**$641,227**	**$363,436**	**$14,565**	**$11,645**	**$5,905**	**$1,036,778**
OPERATING COSTS								
Medicare Integrity Program	$1,425		$1,425					$1,425
Quality Improvement Organizations	510	$254	764					764
Bad Debt Expense and Writeoffs	84	569	653	$(536)	$(1)			116
Reimbursable Expenses	43	78	121	8	1	$59		189
Administrative Expenses	1,031	1,725	2,756	147	14	998	$1,644	5,559
Depreciation and Amortization	18	40	58	3		26	63	150
Imputed Cost Subsidies	15	22	37	2		14	3	56
Total Operating Costs	**3,126**	**2,688**	**5,814**	**(376)**	**14**	**1,097**	**1,710**	**8,259**
TOTAL COSTS	**$281,373**	**$365,668**	**$647,041**	**$363,060**	**$14,579**	**$12,742**	**$7,615**	**$1,045,037**
Less: Exchange Revenues:								
Medicare Premiums	$3,606	$77,309	$80,915					$80,915
Other Exchange Revenues	4	8	12			9,574	1,476	11,062
Total Exchange Revenues	**3,610**	**77,317**	**80,927**			**9,574**	**1,476**	**91,977**
TOTAL NET COST OF OPERATIONS	**$277,763**	**$288,351**	**$566,114**	**$363,060**	**$14,579**	**$3,168**	**$6,139**	**$953,060**

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. Administrative costs allocated to the Medicare program include $2,031 million ($2,229 million in FY 2016) 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 2017 Part D expense of $63,967 million ($75,037 million in FY 2016) is net of State reimbursements of $11,227 million ($9,171 million in FY 2016). The gross expense would have been $75,194 million ($84,208 million in FY 2016).

Note 10:

FUNDS FROM DEDICATED COLLECTIONS

(DOLLARS IN MILLIONS)

Funds from dedicated collections are financed by specifically identified revenues, often supplemented by other financing sources, which remain available over time. 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. In addition, portions of the Program Management appropriation have been allocated to the HI and SMI trust funds. 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, 2017				
Fund Balance with Treasury	$28,284	$4,539		$32,823
Investments	270,702			270,702
Other Assets	122,260	6,835	$(72,739)	56,356
TOTAL ASSETS	**$421,246**	**$11,374**	**$(72,739)**	**$359,881**
Entitlement Benefits Due and Payable	$60,625	$12,303		$72,928
Other Liabilities	83,628	7,157	$(72,739)	18,046
TOTAL LIABILITIES	**$144,253**	**$19,460**	**$(72,739)**	**$90,974**
Unexpended Appropriations	$17,287			$17,287
Cumulative Results of Operations	259,706	$(8,086)		251,620
Total Net Position	**276,993**	**(8,086)**		**268,907**
TOTAL LIABILITIES AND NET POSITION	**$421,246**	**$11,374**	**$(72,739)**	**$359,881**
Statement of Net Cost for the year ended September 30, 2017				
Benefit Expense	$651,878	$4,489		$656,367
Operating Costs	5,044	6,553		11,597
Total Costs	656,922	11,042		667,964
Less Exchange Revenues	89,793	7,857		97,650
Net Cost of Operations	**$567,129**	**$3,185**		**$570,314**
Statement of Changes in Net Position for the year ended September 30, 2017				
Net Position, Beginning of Period	$268,602	$(5,434)		$263,168
Taxes and Other Nonexchange Revenue	274,135			274,135
Other Financing Sources	301,385	533		301,918
Less Net Cost of Operations	567,129	3,185		570,314
Change in Net Position	8,391	(2,652)		5,739
NET POSITION, END OF PERIOD	**$276,993**	**$(8,086)**		**$268,907**

Note 10:

FUNDS FROM DEDICATED COLLECTIONS *(CONTINUED)*

(DOLLARS IN MILLIONS)

	Medicare	Other Non-Medicare	Eliminations	Total Dedicated Collections
Balance Sheet as of September 30, 2016				
Fund Balance with Treasury	$53,806	$3,122		$56,928
Investments	257,801			257,801
Other Assets	103,171	10,336	$(74,786)	38,721
TOTAL ASSETS	**$414,778**	**$13,458**	**$(74,786)**	**$353,450**
Entitlement Benefits Due and Payable	$63,911	$7,915		$71,826
Other Liabilities	82,265	10,977	$(74,786)	18,456
TOTAL LIABILITIES	**$146,176**	**$18,892**	**$(74,786)**	**$90,282**
Unexpended Appropriations	$36,012			$36,012
Cumulative Results of Operations	232,590	$(5,434)		227,156
Total Net Position	**268,602**	**(5,434)**		**263,168**
TOTAL LIABILITIES AND NET POSITION	**$414,778**	**$13,458**	**$(74,786)**	**$353,450**
Statement of Net Cost for the year ended September 30, 2016				
Benefit Expense	$641,227			$641,227
Operating Costs	5,814	$16,201		22,015
Total Costs	647,041	16,201		663,242
Less Exchange Revenues	80,927	11,015		91,942
Net Cost of Operations	**$566,114**	**$5,186**		**$571,300**
Statement of Changes in Net Position for the year ended September 30, 2016				
Net Position, Beginning of Period	$246,863	$(1,225)		$245,638
Taxes and Other Nonexchange Revenue	264,044			264,044
Other Financing Sources	323,809	977		324,786
Less Net Cost of Operations	566,114	5,186		571,300
Change in Net Position	21,739	(4,209)		17,530
NET POSITION, END OF PERIOD	**$268,602**	**$(5,434)**		**$263,168**

Note 11:

INTRAGOVERNMENTAL COSTS AND EXCHANGE REVENUE

(DOLLARS IN MILLIONS)

FY 2017	Gross Cost			Less: Exchange Revenue			
	Intra-governmental	Public	Total	Intra-governmental	Public	Total	Consolidated Net Cost of Operations
PROGRAM/ACTIVITY COSTS							
GPRA Programs							
Medicare (Dedicated Collections)							
HI TF	$400	$290,448	$290,848	$128	$4,017	$4,145	$286,703
SMI TF	274	365,800	366,074	256	85,392	85,648	280,426
Medicaid	22	372,987	373,009	23		23	372,986
CHIP	41	16,594	16,635	2		2	16,633
Subtotal	**737**	**1,045,829**	**1,046,566**	**409**	**89,409**	**89,818**	**956,748**
Other Activities							
State Grants and Demonstrations	12	546	558	3		3	555
Other Health	200	7,542	7,742	185	6,241	6,426	1,316
Other	132	6,213	6,345		1,632	1,632	4,713
Subtotal	**344**	**14,301**	**14,645**	**188**	**7,873**	**8,061**	**6,584**
PROGRAM/ ACTIVITY TOTALS	$1,081	$1,060,130	$1,061,211	$597	$97,282	$97,879	$963,332

FY 2016	Gross Cost			Less: Exchange Revenue			
	Intra-governmental	Public	Total	Intra-governmental	Public	Total	Consolidated Net Cost of Operations
PROGRAM/ACTIVITY COSTS							
GPRA Programs							
Medicare (Dedicated Collections)							
HI TF	$479	$280,894	$281,373	$4	$3,606	$3,610	$277,763
SMI TF	361	365,307	365,668	8	77,309	77,317	288,351
Medicaid	12	363,048	363,060				363,060
CHIP	42	14,537	14,579				14,579
Subtotal	**894**	**1,023,786**	**1,024,680**	**12**	**80,915**	**80,927**	**943,753**
Other Activities							
State Grants and Demonstrations	45	474	519				519
Other Health	163	12,579	12,742	21	9,553	9,574	3,168
Other	111	6,985	7,096		1,476	1,476	5,620
Subtotal	**319**	**20,038**	**20,357**	**21**	**11,029**	**11,050**	**9,307**
PROGRAM/ ACTIVITY TOTALS	$1,213	$1,043,824	$1,045,037	$33	$91,944	$91,977	$953,060

The charts above display gross costs and earned revenue with Federal agencies and the public by budget functional classification. The intragovernmental expenses relate to the source of services purchased by CMS, and not to the classification of related revenue.

The classification of revenue or cost being identified as "intragovernmental" or with the "public" is defined on a transaction by transaction basis.

Note 12:

STATEMENT OF BUDGETARY RESOURCES DISCLOSURES

(DOLLARS IN MILLIONS)

The amounts of direct and reimbursable obligations incurred against amounts apportioned under Category A, Category B, and Exempt from Apportionment are shown below:

FY 2017	Direct	Reimbursable	Combined Totals
Category A	$20,390	$439	$20,829
Category B	747,775	1,257	749,032
Exempt	732,248		732,248
Total	**$1,500,413**	**$1,696**	**$1,502,109**

FY 2016	Direct	Reimbursable	Combined Totals
Category A	$18,092	$437	$18,529
Category B	725,564	1,255	726,819
Exempt	724,138		724,138
Total	**$1,467,794**	**$1,692**	**$1,469,486**

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 $207,353 million ($201,562 million in FY 2016) are included in Investments on the Balance Sheets. The following table presents trust fund activities and balances for FY 2017 and FY 2016 (in millions):

	FY 2017 Combined Balance	FY 2016 Combined Balance
TRUST FUND BALANCE, BEGINNING	**$201,562**	**$201,111**
Receipts	621,222	608,768
Less Obligations	615,431	608,317
Excess (Shortage) of Receipts Over Obligations	5,791	451
TRUST FUND BALANCE, ENDING	$207,353	$201,562

EXEMPT FROM APPORTIONMENT

This amount includes the FY 2017 recording of obligations required by law where such obligations are in excess of available funding. These obligations were incurred by operation of law; thus, they are reflected as exempt from apportionment. The Antideficiency Act has not been violated, as "[t]he prohibitions contained in the Antideficiency Act are directed at discretionary obligations entered into by administrative officers." B-219161 (Oct. 2, 1985).

EXPLANATIONS OF DIFFERENCES BETWEEN THE COMBINED STATEMENT OF BUDGETARY RESOURCES AND THE BUDGET OF THE UNITED STATES GOVERNMENT FOR FY 2016

(DOLLARS IN MILLIONS)

CMS reconciled the amounts of the FY 2016 column of the SBR to the actual amounts for FY 2016 from the Appendix in the FY 2017 President's Budget for budgetary resources, obligations incurred, offsetting receipts and net outlays (gross outlays less offsetting collections).

FY 2016	Budgetary Resources	Obligations Incurred	Distributed Offsetting Receipts	Net Outlays
Combined Statement of Budgetary Resources	$1,518,260	$1,469,486	$427,252	$1,409,194
Expired Accounts	(35,186)			
Other	4,473	4,395	127	4,446
President's Budget (2016 Actual)	**$1,487,547**	**$1,473,881**	**$427,379**	**$1,413,640**

For the budgetary resources reconciliation, the amount used from the President's Budget was the total budgetary resources available for obligation. Therefore, a reconciling item that is contained in the Combined Statement of Budgetary Resources (SBR) and not in the President's Budget is the budgetary resources reported on CDC and OS statements and a GTAS revision window adjustment. The Expired accounts line in the above schedule includes expired authority, recoveries and other amounts included in the Combined Statement of Budgetary Resources that are not included in the President's Budget.

The Other differences in the resources and obligations incurred include CMS amounts reported on CDC and OS statements that were not in the SBR.

The Other differences in the distributed offsetting receipts are the result of a cash adjustment in CARS and receipt account not in CMS' SBR.

Lastly, the Other differences in the net outlays include CMS amounts reported on CDC and OS statements that were not in the SBR.

UNDELIVERED ORDERS AT THE END OF THE PERIOD

The amount of budgetary resources obligated for undelivered orders totaled $62,751 million for Budgetary and $5 million for Non-Budgetary at September 30, 2017 ($56,996 million for Budgetary and $37 million for Non-Budgetary at FY 2016).

Note 13:

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 2017 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 2017 Trustees Report was developed based on the assumptions and review from the 2010-2011 Technical Review Panel (the 2011 Panel). In September 2017, a more recent final review of the Technical Review Panel (the 2017 Panel) was released. The 2017 Panel generally found that the baseline assumptions used in the Medicare projections under current law to be reasonable. Also, the 2017 Panel felt the assumptions used in long-range projections were broadly reasonable.

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 July 13, 2017, 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 July 13, 2017, 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 2017 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2017. 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 2017

					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 B	SMI D	Real-interest rate[9]
2017	1.90	1,559,000	772.1	1.84	4.00	2.17	2.9	0.5	3.1	–0.2	–0.3
2020	1.98	1,512,000	750.2	1.87	4.47	2.60	2.9	4.1	5.1	5.4	1.7
2030	2.00	1,332,000	686.1	1.29	3.89	2.60	2.1	3.8	4.8	4.5	2.7
2040	2.00	1,282,000	630.8	1.21	3.81	2.60	2.2	4.6	4.2	4.7	2.7
2050	2.00	1,257,000	582.3	1.24	3.84	2.60	2.2	3.8	3.7	4.7	2.7
2060	2.00	1,243,000	539.7	1.21	3.81	2.60	2.1	3.6	3.6	4.5	2.7
2070	2.00	1,234,000	502.0	1.15	3.75	2.60	2.1	3.8	3.6	4.4	2.7
2080	2.00	1,229,000	468.6	1.13	3.73	2.60	2.1	3.8	3.6	4.4	2.7
2090	2.00	1,227,000	438.7	1.15	3.75	2.60	2.0	3.4	3.4	4.3	2.7

[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 2017–2013

					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 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
FY 2014	2.0	1,055,000	419.8	1.13	3.93	2.80	2.1	3.8	3.8	4.5	2.9
FY 2013	2.0	1,030,000	446.0	1.12	3.92	2.80	2.0	3.7	3.8	4.5	2.9

[1] Average number of children per woman. The ultimate fertility rate is assumed to be reached in the 12th year of the projection period.

[2] Includes legal immigration, net of emigration, as well as other, non-legal, immigration. The ultimate level of net legal immigration is 795,000 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 FYs 2013-2015 and is the value assumed in the year 2090 for FY 2016 and FY 2017.

[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 FYs 2013-2015 and is the value assumed in the year 2090 for FY 2016 and FY 2017.

[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 FYs 2013-2015 and is the value assumed in the year 2090 for FY 2016 and FY 2017.

[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 FYs 2013-2015 and is the value assumed in the year 2090 for FY 2016 and FY 2017.

[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 FYs 2013-2015 and is the value assumed in the year 2090 for FY 2016 and FY 2017.

[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 FYs 2013-2015 and is the value assumed in the year 2090 for FY 2016 and FY 2017.

[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 14:

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.

The Trustees assume that the various cost-reduction measures—the most important of which are the reductions in the annual payment rate updates for most categories of Medicare providers by the growth in economy-wide private nonfarm business multifactor productivity and the specified physician updates put in place by MACRA—will occur as current law requires. In order for this outcome to be achievable, health care providers would have to realize productivity improvements at a faster rate than experienced historically. 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 that assumes that, starting in 2020, the economy-wide productivity adjustments gradually phase down to 0.4 percent and, starting in 2026, physician payments transition from a payment update of 0.6 percent to an increase of 2.2 percent. In addition, the illustrative alternative assumes the continuation of the 5 percent bonuses for physicians in advanced alternative models (APMs) and of the $500-million payments for physicians in the merit-based incentive payment system (MIPS). In addition, the projection assumes that the Independent Payment Advisory Board (IPAB) requirements would not be implemented.[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.

The table 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.

MEDICARE PRESENT VALUES

(IN BILLIONS)

	Current law (Unaudited)	Alternative Scenario[1, 2] (Unaudited)
Income		
Part A	$21,738	$21,888
Part B	30,783	38,712
Part D	10,756	10,946
Expenditures		
Part A	25,270	31,529
Part B	30,783	38,712
Part D	10,756	10,946
Income less expenditures		
Part A	(3,532)	(9,641)
Part B	0	0
Part D	0	0

1 These amounts are not presented in the 2017 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 1.1-percent reduction in annual cost growth each year for these providers. If the productivity adjustments were gradually phased out, the physician updates transitioned to the Medicare Economic Index update of 2.2 percent, the 5-percent bonuses paid to physicians in APMs did not expire, and the IPAB requirements were not implemented, 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 25 and 26 percent, respectively. 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 26 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

The Part D values are similar under each projection because the services are not affected by the productivity adjustments or the physician updates. The very minor effect is the result of the removal of the IPAB impact and a slight change in the discount rates that are used to calculate the present values.

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.

Note 15:

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, 2016 to the period beginning on January 1, 2017, and the reconciliation from the period beginning on January 1, 2015 to the period beginning on January 1, 2016. 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 13 summarizes these assumptions for the current year.

Period beginning on January 1, 2016 and ending January 1, 2017

Present values as of January 1, 2016 are calculated using interest rates from the intermediate assumptions of the 2016 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2017. 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 2016 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 2017 Trustees Report.

Period beginning on January 1, 2015 and ending January 1, 2016

Present values as of January 1, 2015 are calculated using interest rates from the intermediate assumptions of the 2015 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2016. 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 2015 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 2016 Trustees Report

Change in the Valuation Period

From the period beginning on January 1, 2016 to the period beginning on January 1, 2017

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2016-90) to the current valuation period (2017-91) 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 2016, replaces it with a much larger negative net cash flow for 2091, and measures the present values as of January 1, 2017, 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 2016-90 to 2017-91. 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 2016 are realized. The change in valuation period increased the starting level of assets in the combined Medicare Trust Funds.

From the period beginning on January 1, 2015 to the period beginning on January 1, 2016

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2015-89) to the current valuation period (2016-90) 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 2015, replaces it with a much larger negative net cash flow for 2090, and measures the present values as of January 1, 2016, 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 2015-89 to 2016-90. 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 2015 are realized. The change in valuation period slightly increased the starting level of assets in the combined Medicare Trust Funds.

Change in Projection Base

From the period beginning on January 1, 2016 to the period beginning on January 1, 2017

Actual income and expenditures in 2016 were different than what was anticipated when the 2016 Trustees Report projections were prepared. Part A income was higher and expenditures were lower 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 an increase in the estimated future net cash flow. Actual experience of the Medicare Trust Funds between January 1, 2016 and January 1, 2017 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

From the period beginning on January 1, 2015 to the period beginning on January 1, 2016

Actual income and expenditures in 2015 were different than what was anticipated when the 2015 Trustees Report projections were prepared. Part A income and expenditures were higher than anticipated, based on actual experience. Part B total income and expenditures were lower than estimated based on actual experience. For Part D, actual income and expenditures were both higher than prior estimates. The net impact of the Part A, B, and D projection base changes is a decrease in the estimated future net cash flow. Actual experience of the Medicare Trust Funds between January 1, 2015 and January 1, 2016 is incorporated in the current valuation and is slightly less than projected in the prior valuation.

Changes in the Demographic Assumptions

From the period beginning on January 1, 2016 to the period beginning on January 1, 2017

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, 2017), with the exception of a small change in marriage rates, 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 2015 indicated slightly lower birth rates than were assumed in the prior valuation.
- Incorporating 2014 mortality data obtained from the National Center for Health Statistics at ages under 65 and preliminary 2014 mortality data from Medicare experience at ages 65 and older resulted in higher death rates for all future years than were projected in the prior valuation.
- More recent legal and other-than-legal immigration data and historical population data were included.

There were no consequential changes in demographic methodology.

These changes slightly lowered overall Medicare enrollment for the current valuation period and resulted in a decrease in the estimated future net cash flow. The present value of estimated expenditures is lower for Part A but slightly higher for Parts B and D; and the present value of estimated income is also higher for Parts B and D but lower for Part A.

From the period beginning on January 1, 2015 to the period beginning on January 1, 2016

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, 2016), with the exception of a small change in marriage rates, 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 2013 and 2014 indicated lower birth rates than were expected in the prior valuation. The data also show an increase in birth rates starting in 2014, one year later than assumed in the prior valuation.
- Incorporating mortality data obtained from the National Center for Health Statistics at ages under 65 for 2012 and 2013 and from Medicare experience at ages 65 and older for 2013 resulted in slightly higher death rates than were projected in the prior valuation.
- Assumed ultimate marriage rates were decreased somewhat to reflect a continuation of recent trends.
- More recent legal and other-than-legal immigration data and historical population data were included.

There were two changes in demographic methodology:

- The transition from recent mortality rates to the ultimate rates starts sooner, immediately after the year of final data. The approach used for the prior valuation extended the trend of the last 10 years through the valuation year for the report and only thereafter started the transition to assumed ultimate rates of decline.
- Historical non-immigrant population counts were revised to match recent totals provided by the Department of Homeland Security. In addition, emigration rates for the never-authorized and visa-overstayer populations were recalibrated to reflect a longer historical period and to be less influenced by the high emigration rates experienced during the recent recession. Finally, the method for projecting emigration of the never-authorized population was altered to reflect lower rates of emigration for those who have resided here longer.

These changes slightly lowered overall Medicare enrollment for the current valuation period and resulted in an increase in the estimated future net cash flow. The present value of estimated expenditures is lower for all parts of Medicare; and the present value of estimated income is also lower for Parts B and D but very slightly higher for Part A.

Changes in Economic and Health Care Assumptions

For the period beginning on January 1, 2016 to the period beginning on January 1, 2017

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, 2017), there was one change to the ultimate economic assumptions.

- The ultimate average real-wage differential is assumed to be 1.20 percent in the current valuation, which is close to a 0.01 percent decrease relative to the previous valuation (even though both ultimate average real-wage differentials are 1.20 when rounded to two decimal places).

In addition to this change in assumption, the assumed real-wage differential for the first ten years of the projection period averaged 0.05 percent lower than in the previous valuation. The lower long-term and near-term real-wage differential assumptions are based on new projections of faster growth in employer sponsored group health insurance premiums. Because these premiums are not subject to the payroll tax, faster growth in these premiums means that a smaller share of employee compensation will be in the form of wages that are subject to the payroll tax.

Otherwise, the ultimate economic assumptions for the current valuation 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. Most significantly, an assumed weaker recovery from the recent recession than previously expected led to a reduction in the ultimate level of actual and potential GDP of about 1.0 percent for all years after the short-range period.

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 and skilled nursing facilities services were decreased.
- The number of beneficiaries enrolled in Medicare Advantage plans and their relative costs are slightly different from last year's assumptions.
- Lower productivity increases through 2025, resulting in higher provider payment updates.
- Higher projected drug rebates.
- Change in projection methodology of drug spending for Part B patients with end-stage renal disease.

The net impact of these changes resulted in an increase 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 income, with 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).

For the period beginning on January 1, 2015 to the period beginning on January 1, 2016

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, 2016), there were three changes to the ultimate economic assumptions.

- The ultimate rate of price inflation (CPI-W) was lowered by 0.1 percentage point, to 2.6 percent from 2.7 percent for the previous valuation.
- The ultimate average real wage differential is assumed to be 1.20 percent in the current valuation period, compared to 1.17 percent in the previous valuation period.
- The ultimate real interest rate was lowered by 0.2 percentage point, to 2.7 percent from 2.9 percent for the previous valuation period

While very low inflation in recent years is reflective of U.S. and international supply and demand factors that have been affected by the global recession, the average rate of change in the CPI-W over the last two complete business cycles (from 1989 to 2007) is 2.63 percent.

The higher real wage differential assumption is based on new projections by the Centers for Medicare & Medicaid Services of slower growth in employer-sponsored group health insurance premiums. Because these premiums are not subject to the payroll tax, slower growth in these premiums means that a greater share of

employee compensation will be in the form of wages that are subject to the payroll tax.

Real interest rates have been low since 2000, and particularly low since the start of the recent recession. An ongoing and much-debated question among experts is how much of this change is cyclic or a temporary response to extraordinary events, versus a fundamental permanent change. The Trustees believe that lowering the long-term ultimate real interest rate somewhat is appropriate at this time. The long-range present values are very sensitive to the ultimate interest rate assumption because they are used as the discount factor. The reduction in the ultimate interest rate assumption from 2.9 percent to 2.7 percent increases each of the present values by roughly 15-16 percent.

Otherwise, the ultimate economic assumptions for the current valuation 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.

- A reduction in the ultimate level of actual and potential gross domestic product (GDP) of about 1.0 percent is assumed. Thus, by the end of the short-range period (2025) and for all years thereafter, projected GDP in 2009 dollars is about 1.8 percent below the level in last year's report.

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 services were increased.
- The number of beneficiaries enrolled in Medicare Advantage plans and their relative costs are slightly different from last year's assumptions.
- Lower productivity increases through 2021, resulting in higher provider payment updates.
- Greater reductions in expenditures attributable to the Independent Payment Advisory Board.
- Inclusion of the income and expenditures for aged non-insured beneficiaries in the Part A long-range analysis.
- Higher projected drug cost trend, particularly for certain high-cost specialty drugs.

The net impact of these changes 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 income, with an overall decrease in 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).

Changes in Law

For the period beginning on January 1, 2016 to the period beginning on January 1, 2017

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 21st Century Cures Act included provisions that affect the HI and SMI Part B programs.
  - For inpatient hospital services, the adjustment to the payment rate increase of 0.5 percentage point for fiscal year 2018, as established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is reduced to an adjustment of 0.4588 percentage point. (The adjustments to the rate increases of 0.5 percentage point for each of fiscal years 2019 through 2023, as also established by MACRA, are unchanged.)
  - For long-term care hospital (LTCH) discharges occurring during fiscal year 2017, the LTCH 25-percent rule is suspended.
  - A change is made to the moratorium that prohibits the classification of new LTCHs and new LTCH satellite facilities and an increase in beds for existing LTCHs and existing LTCH satellite facilities. No exceptions to the moratorium had been provided to allow existing LTCHs and existing LTCH satellite facilities to increase their number of certified beds; however, under the Cures Act, these existing facilities are permitted to do so. This provision is effective as if the exception for these bed increases had always applied during the moratorium. A reduction to high-cost outlier payments to LTCH standard rate cases, through an increase to the qualifying threshold, is also provided for and is intended to offset costs of the moratorium exceptions provision.
  - Several changes are made that involve the LTCH site-neutral provision.
    - The first modification is to the calculation of the average length of stay for certain LTCHs. Under prior law, discharges paid

at the site-neutral payment rate or by an MA plan were excluded from calculations determining the hospital's average length of stay, effective for cost-reporting periods starting on or after October 1, 2015. Under the Cures Act, this carve-out of site-neutral and MA discharges (which is generally advantageous to LTCHs) applies to the average length of stay calculation for newer LTCHs as well. Thus, the average length of stay calculation methodology is now the same for all LTCHs. This provision is effective retroactively, for cost-reporting periods starting on or after October 1, 2015.

  - Next, a temporary exception to the site-neutral criteria is provided for certain LTCHs that primarily treat patients with brain and spinal cord injuries, are non-profit, and have a significant number of admissions from out of state, for all discharges in cost-reporting periods beginning during fiscal years 2018 and 2019.
  - Finally, a temporary exception to the site-neutral criteria is created for certain discharges from certain LTCHs for beneficiaries receiving treatment for specified types of severe wounds. To qualify for the exception, the stay for one of the specified types of severe wounds must be classified under one of four specified Medicare severity LTCH diagnosis-related groups (MS-LTC-DRGs). Further, the facility must be a grandfathered LTCH. This provision is effective for these specified discharges occurring in cost-reporting periods that begin during fiscal year 2018.

- The Secretary of HHS is authorized to deny payment for services provided in temporary moratorium areas (which are geographic areas that have been established by CMS for specified types of providers, for the development and improvement of investigating and prosecuting fraud). Previously, denial was based on the location of the provider rather than on the location of the patient; this provision eliminates the ability of a provider to locate a business office outside of a moratorium area but be paid for services furnished within it.
- Medicare beneficiaries with end-stage renal disease are allowed to enroll in MA plans, effective for plan years beginning in 2021 and later. Standard acquisition costs for kidneys are to be removed from the capitation rates and paid for by traditional Medicare.
- Additional requirements are established for assigning Medicare FFS beneficiaries to accountable care organizations (ACOs) under the Medicare shared savings program. Specifically, the basis for assignment is required to reflect beneficiaries' utilization of not only primary care services provided by ACO physicians but also services furnished in federally qualified health centers or rural health clinics, effective for performance years beginning on or after January 1, 2019.
- Under the competitive bidding program for certain durable medical equipment (DME) items, the transition period is extended, such that the implementation of payments based entirely on the competitively bid rates (rather than on a blend of these rates and rates under the prior fee schedule payment methodology) is delayed retroactively, from July 1, 2016 to January 1, 2017.
  - Also, for DME providers in non-competitively bid areas, new considerations are stipulated for determining adjustments to the competitively bid prices. Specifically, the Secretary of HHS is required to take into account stakeholder input and the highest winning bid in the competitively bid areas and to compare, with respect to non-competitively and competitively bid areas, the average travel distance and cost associated with furnishing the items and services, the average volume of the items and services furnished by suppliers, and the number of suppliers. This provision is effective for services furnished on or after January 1, 2019.
- For infusion drugs furnished by suppliers of DME, the reimbursement methodology is changed from 95 percent of the average wholesale price to the average sales price plus 6 percent (that is, to the methodology used for most physician-administered drugs), effective January 1, 2017. Also, these drugs are removed from the DME competitive acquisition areas, beginning on the date of enactment.
- Qualified home infusion therapy suppliers are to be reimbursed for administering home infusion therapy, effective January 1, 2021. Certain requirements and standards for suppliers, as well as payment methodology,

are established.

- As described in last year's report, the Bipartisan Budget Act of 2015 (BBA) directed that outpatient hospital services provided by new off-campus hospital-based outpatient entities (that is, those established on or after the BBA date of enactment of November 2, 2015 and located more than 250 yards from the hospital campus) are excluded from the outpatient hospital PPS, effective for services provided on or after January 1, 2017 (with certain exceptions, particularly for specific dedicated emergency departments). These services are instead to be reimbursed under the Medicare physician fee schedule or the ambulatory surgical center PPS (both of which provide lower reimbursement rates than the outpatient hospital PPS).
  - The Cures Act provides an exception for off-campus hospital provider-based outpatient entities that were "mid-build" on November 2, 2015. A mid-build entity is one that had a binding written agreement, before November 2, 2015, with an outside unrelated party for actual construction of the new off-campus department. To be eligible under this exception, the host hospital must (i) file a certification that the department meets the mid-build status requirement; (ii) file an attestation that the department is provider-based; and (iii) add the department to the host hospital's Medicare enrollment form. Entities that qualify will be eligible to bill under the outpatient PPS for services provided on or after January 1, 2018.
  - Under the Cures Act, an off-campus outpatient department can also be eligible for payment under the outpatient hospital PPS for services furnished in 2017 if the host hospital submitted a voluntary attestation, prior to December 2, 2015, stating that the department is provider-based. (Under separate guidance from CMS that governs submission of provider-based attestations, for a hospital to have taken this step, the construction of the new off-campus outpatient department would have been completed and the hospital accepting, or poised to accept, patients. Thus, this exception benefits only a small number of departments that fell just outside of the deadline contained in the BBA.)
  - To clarify, while the relief for 2017 applies only to off-campus outpatient departments with provider-based attestations filed before December 2, 2015, the relief for 2018 and beyond applies more broadly to off-campus outpatient departments with construction agreements in place as of November 2, 2015 (including hospitals eligible for the 2017 exception). Hence, most hospitals that qualify for the exception under this provision are not eligible for payment under the outpatient PPS during 2017 and are, instead, subject to lower payments for services furnished during that year, with return to the outpatient hospital PPS effective for services furnished on or after January 1, 2018.
- Off-campus outpatient departments of certain cancer hospitals are also granted exception from the BBA provision described above, thereby confirming that the BBA legislation intended these facilities to remain under their existing separate payment system. To qualify, these locations must file attestations stating that they are provider-based, within 60 days of the date of enactment or within 60 days of meeting the provider-based requirement. The attestations are subject to audit. A reduction to the additional payments that cancer hospitals receive (relative to payments under the inpatient hospital PPS) is also provided for and is intended to offset costs of the BBA exception for off-campus outpatient cancer hospital departments.
- Enforcement is delayed an additional year, through December 31, 2016, for the regulation requiring 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.
- For wheelchair accessories and seat and back cushions furnished in connection with complex rehabilitative power wheelchairs, fee schedule adjustments do not apply until July 1, 2017 (which is a delay of 6 months relative to the previously stipulated date of January 1, 2017).

For the period beginning on January 1, 2015 to the period beginning on January 1, 2016

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 Trade Preference Extension Act of 2015 requires Medicare coverage for renal dialysis services provided by outpatient renal dialysis facilities to individuals with acute kidney injury, effective January 1, 2017.
- The Bipartisan Budget Act of 2015 (BBA) included provisions that affect the HI and SMI programs.
  - The BBA required that the 2016 actuarial rate for enrollees aged 65 and older be determined as if the hold-harmless provision did not apply, thereby lowering the standard Part B premium rate from what it otherwise would have been. The premium revenue that was lost by using the resulting lower premium (excluding the forgone income-related premium revenue) was replaced by a transfer of general revenue from the Treasury, which will be repaid over time to the general fund. Starting in 2016, in order to repay the balance due (which is to include the transfer amount and the forgone income-related premium revenue), the monthly Part B premium otherwise determined is to be increased by $3.00. These repayment amounts are to be added to the Part B premium otherwise determined each year and paid back to the general fund of the Treasury. This $3.00 increase will not be matched by government contributions. These repayment amounts are to continue until the total amount collected is equal to the beginning balance due. (In the final year of the repayment, the additional amounts may be modified to avoid an overpayment.) The repayment amounts (excluding those for high-income enrollees) are subject to the hold-harmless provision. The BBA also stipulated that if the Social Security cost-of-living adjustment (COLA) was 0 percent in 2017, then an additional transfer (and $3 repayment amount) would have again applied. However, the 2017 COLA of 0.3 percent was released on October 18, 2016.
  - Most outpatient hospital services provided on or after January 1, 2017 by new off-campus hospital provider-based outpatient departments (that is, those established on or after the BBA date of enactment of November 2, 2015 and located more than 250 yards from the campus) are excluded from the outpatient hospital prospective payment system, and are instead to be reimbursed under the applicable Part B payment system.
  - The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended by one year, through fiscal year 2025. In addition, Medicare benefit payments for services provided under periods of sequestration incur a payment reduction limited to 2 percent, so that the former differential payment reduction limits imposed for fiscal years 2023 and 2024 are replaced with 2-percent limits. Finally, the 2-percent limit is raised to 4.0 percent for the first 6 months of fiscal year 2025 and reduced to 0.0 percent for the last 6 months of fiscal year 2025.
- The Consolidated Appropriations Act of 2016 included provisions that affect the HI and SMI programs.
  - The payment calculation associated with inpatient hospital operating costs for Puerto Rico hospital discharges on or after January 1, 2016 is to be based on 0 percent of the applicable Puerto Rico percentage and 100 percent of the applicable Federal percentage. (In addition, CMS announced that both the Fiscal Year 2016 Inpatient Prospective Payment System Pricer and the Long-Term Care Hospital Pricer, which are used to determine all inpatient hospital payment rates and certain long-term care hospital payment rates, respectively, for providers nationwide, are to incorporate the Puerto Rico inpatient hospital payment modification. These conforming changes are applicable to inpatient hospital discharges and long-term care hospital discharges on or after January 1, 2016.)
  - Puerto Rico hospitals are eligible to receive incentive payments under the Medicare Electronic Health Records Incentive Program, effective January 1, 2016.
  - Effective January 1, 2017, separate Medicare payment is authorized to home health agencies when they use cost-effective disposable alternatives to negative pressure wound therapy equipment.
  - To incentivize the transition from traditional x-ray imaging to digital radiography, Part B payment for the technical component of film x-rays, under the hospital outpatient prospective payment system and under the physician fee schedule, is reduced by

20 percent beginning in 2017. In addition, payment for the technical component of x-rays taken using computed radiography technology is reduced by 7 percent during 2018 through 2022 and by 10 percent beginning in 2023. Also, the discount in payment for the professional component of multiple imaging services furnished on or after January 1, 2017 is reduced from 25 percent to 5 percent, and the reduction is taken in a non-budget neutral manner.

- A one-year moratorium for calendar year 2017 is placed on the annual fee to be paid by health insurance providers. This fee, which was established by the Affordable Care Act, is imposed on certain large health insurance providers, including those furnishing coverage under Medicare Advantage (Part C) and Medicare Part D. (Since Medicare Advantage is paid for by the HI trust fund and the Part B account of the SMI trust fund, this provision affects all parts of Medicare.)

Overall these provisions resulted in a slight increase in the estimated future net cash flow for total Medicare. For Part A, these changes resulted in a slight decrease to the present value of estimated future expenditures, with an overall increase in the estimated future net cash flow. For Part B, these changes decreased the present value of estimated future expenditures (and also income). For Part D, the above-mentioned changes also resulted in a lower present value of estimated future expenditures (and also income) but only very slightly.

Potential Impact on the Social Insurance Statements of the September 5, 2017 Rescission of the 2012 DACA Policy Directive

The Deferred Action for Childhood Arrivals (DACA) policy directive was implemented on June 15, 2012. On September 5, 2017, the Department of Homeland Security rescinded the 2012 DACA policy directive and scheduled an orderly phase out of the DACA program. The SSA Office of the Chief Actuary has concluded that the phase out of the DACA program has an effect on the actuarial methods and assumptions used in developing the estimates presented in the Statements of Social Insurance and the Statements of Changes in Social Insurance Amounts. We expect that the phase-out of the DACA program, which affects the demographic assumptions used in the Medicare projections, will not have a material impact on the present value estimates in the Statement of Social Insurance and Statement of Changes in Social Insurance Amounts.

Note 16:

RECONCILIATION OF NET COST OF OPERATIONS TO BUDGET

(DOLLARS IN MILLIONS)

	FY 2017	FY 2016
Resources Used to Finance Activities:		
Budgetary Resources Obligated:		
Obligations incurred	$1,502,109	$1,469,486
Less: Spending authority from offsetting collections and recoveries	66,195	47,423
Obligations net of offsetting collections and recoveries	1,435,914	1,422,063
Less: Distributed offsetting receipts	444,507	427,252
Net obligations	991,407	994,811
Other Resources:		
Transfers-In/Out without Reimbursement	2	
Imputed financing from costs absorbed by others	47	56
Other	(17)	(120)
Net other resources used to finance activities	32	(64)
TOTAL RESOURCES USED TO FINANCE ACTIVITIES	$991,439	$994,747
Resources Used to Finance Items not Part of the Net Cost of Operations:		
Change in budgetary resources obligated for goods, services and benefits ordered but not yet provided	$6,514	$30,048
Budgetary offsetting collections and receipts that do not affect net cost of operations	8,950	10,969
Resources that finance the acquisition of assets	854	289
Other resources or adjustments to net obligated resources that do not affect net cost of operations	3,678	(2,002)
Total resources used to finance items not part of the Net Cost of Operations	19,996	39,304
TOTAL RESOURCES USED TO FINANCE THE NET COST OF OPERATIONS	$971,443	$955,443
Components of the Net Cost of Operations that will not Require or Generate Resources in the Current Period:		
Components Requiring or Generating Resources in Future Periods:		
Increase in annual leave liability	$2	$3
Decrease/(Increase) in receivables from the public	(6,815)	(4,488)
Other	(1,338)	2,378
Total components of Net Cost of Operations that will require or generate resources in future periods	(8,151)	(2,107)
Components not Requiring or Generating Resources:		
Depreciation and amortization	216	150
Other	(176)	(426)
Total components of Net Cost of Operations that will not require or generate resources	40	(276)
Total components of Net Cost of Operations that will not require or generate resources in the current period	(8,111)	(2,383)
NET COST OF OPERATIONS	$963,332	$953,060

Accrual-based measures used in the Statement of Net Cost differ from the obligation-based measures used in the Statement of Budgetary Resources, especially in the treatment of liabilities. A liability not covered by budgetary resources may not be recorded as a funded liability in the budgetary accounts of CMS's general ledger, which supports the Report on Budget Execution and Budgetary Resources (SF-133) and the Statement of Budgetary Resources. Therefore, these liabilities are recorded as contingent liabilities on the general ledger. Based on appropriation language, they are considered "funded" liabilities for purposes of the Balance Sheet, Statement of Net Cost, and Statement of Changes in Net Position.

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 *2017 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 and include the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA; Public Law 114-10), which repealed the sustainable growth rate (SGR) formula that set physician fee schedule payments. While the physician payment updates and new incentives put in place by MACRA avoid the significant short-range physician payment issues that would have resulted from the SGR system approach, they nevertheless raise important long-range concerns. In particular, additional payments of $500 million per year for one group of physicians and 5-percent annual bonuses for another group are scheduled to expire in 2025, resulting in a significant one-time payment reduction for most physicians. In addition, the law specifies the physician payment update amounts 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. 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 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.

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); and the Bipartisan Budget Act of 2015 (Public Law 114-74, enacted on November 2, 2015). The sequestration reduces benefit payments by 2 percent from April 1, 2013 through March 31, 2025 and by 4 percent from April 1, 2025 through September 30, 2025. Due to sequestration, non-salary administrative expenses are reduced by an estimated 5 percent from March 1, 2013 through September 30, 2025.

These projections also incorporate the effects of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010. This legislation, referred

to collectively as the Affordable Care Act or ACA, contains roughly 165 provisions affecting the Medicare program by reducing costs, increasing revenues, improving benefits, combating fraud and abuse, and initiating a major program of research and development to identify alternative provider payment mechanisms, health care delivery systems, and other changes intended to improve the quality of health care and reduce costs.

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from provisions of the ACA and MACRA that lower increases in Medicare payment rates to most categories of health care providers. Without fundamental change in the current delivery system, these adjustments would probably not be viable indefinitely. 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 legislative changes that result in (i) physician payment updates that transition from the average 0.6 percent update for 2026 to the rate of growth in the Medicare Economic Index of 2.2 percent for 2041 and later; (ii) no expiration of the 5-percent bonuses for physicians in advanced alternative payment models (APMs) and of the $500-million payments for physicians in the merit-based incentive payment system (MIPS); (iii) a partial phase-out of the ACA reductions in Medicare payment rates from 2020 through 2034; and (iv) an elimination of the cost-reducing actions of the Independent Payment Advisory Board (IPAB). The difference between the illustrative alternative and the current-law projections demonstrates that the long-range costs could be substantially higher than shown throughout much of the report if the MACRA[1] and ACA[2] 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 14 in these financial statements, in appendix 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

The assumed long-range rate of growth in annual Medicare expenditures per beneficiary is based on statutory price updates and volume and intensity growth derived from the "factors contributing to growth" model, which decomposes the major drivers of historical and projected health spending growth into distinct factors. 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. The Trustees' methodology is consistent with Finding III-2 and Recommendation III-3 of the 2010-2011 Medicare Technical Review Panel.[3]

In December 2011, the Technical Panel unanimously recommended a new approach that builds off of the

[1] 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.

[2] 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 private nonfarm business multifactor productivity (1.1 percent over the long range). In addition, the IPAB would be charged with recommending cost savings as are necessary to hold overall per capita Medicare growth to the average of the Consumer Price Index (CPI-U) and CPI-medical care increases in 2015-2019 and to the rate of per capita GDP growth plus 1 percentage point thereafter (subject to certain limits). Unless overridden by lawmakers, these recommendations would be implemented automatically.

[3] The Panel's final report is available at **http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf**.

longstanding Gross Domestic Product (GDP) plus 1 percent assumption while incorporating several key refinements (Recommendation III-1).[4] Specifically, the Panel recommended two separate means of establishing long-range growth rates:

- The first approach is a refinement to the traditional GDP plus 1 percent growth assumption that better accounts for the level of payment rate updates for Medicare (prior to the effects of the ACA) compared to private health insurance and other payers of health care in the U.S. This refinement results in an increase in the long-range pre-ACA baseline cost growth assumption for Medicare to GDP plus 1.4 percent.
- The "factors contributing to growth" model approach builds upon the key considerations underlying the earlier GDP plus 1 percent assumption. The model is based on economic research that decomposes health spending growth into its major drivers—income growth, relative medical price inflation, insurance coverage, and a residual factor that primarily reflects the impact of technological development.[5] It benefits from additional information that was not available when the 2000 Technical Panel recommended the GDP plus 1 percent assumption.

The Trustees used the statutory price updates and the volume and intensity assumptions from the factors model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period.

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 private nonfarm business multifactor productivity,[7] which the Trustees assume will be 1.1 percent per year over the long range. 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:

*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 3.9 percent in 2041, or GDP plus 0.0 percent, declining gradually to 3.5 percent in 2091, or GDP minus 0.3 percent.[8]

*ii. **Physician services***

Payment rate updates are 0.75 percent per year for those physicians assumed to be participating in advanced APMs and 0.25

[4] For convenience, the increase in Medicare expenditures per beneficiary, before consideration of demographic impacts, is referred to as the Medicare cost growth rate. Similarly, these growth rate assumptions are described relative to the per capita increase in GDP and characterized simply as GDP plus X percent

[5] Smith, Sheila, Newhouse, Joseph P., and Freeland, Mark S. "Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?" *Health Affairs*, 28, no. 5 (2009): 1276-1284.

[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.

[7] For convenience the term *economy-wide private nonfarm business multifactor productivity* will henceforth be referred to as *economy-wide productivity*.

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

percent for those assumed to be participating in MIPS. The year-by-year per capita growth rates for physician payments are assumed to be 3.6 percent in 2041, or GDP minus 0.3 percent, declining to 2.8 percent in 2091, 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,[9] care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the per beneficiary year-by-year rates to be 3.1 percent in 2041, or GDP minus 0.8 percent, declining to 2.7 percent in 2091, or GDP minus 1.1 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 16 percent of total Part B expenditures in 2026 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.[10] 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 4.8 percent in 2041, or GDP plus 0.9 percent, declining to 4.3 percent by 2091, 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 3.6 percent per year for the last 50 years of the projection period, or GDP minus 0.3 percent, on average. When Parts A, B, and D are combined, the weighted average growth rate is 3.7 percent over this same time period or GDP minus 0.2 percent, while the growth rate in 2091 is 3.7 percent or GDP minus 0.1 percent.

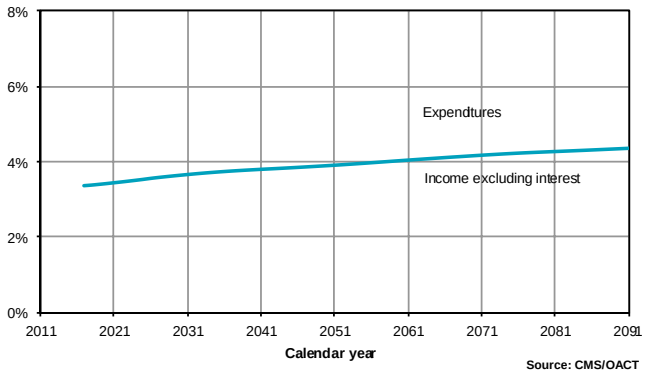
HI Cashflow as a Percentage of Taxable Payroll

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 2017 report are lower than those from the 2016 report for all years largely due to lower utilization assumptions for inpatient hospital services, which were primarily based on lower-than-expected utilization in 2016.

CHART 1

HI Expenditures and Income Excluding Interest as a Percentage of Taxable Payroll // 2017 – 2091



Source: CMS/OACT

[9] Certain durable medical equipment (DME) is subject to competitive bidding, and the price is assumed to grow by the CPI increase less the increase in economy-wide productivity, the same update specified for DME not subject to bidding.

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

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

As indicated in chart 1, the cost rate is projected to decline through 2018, largely due to (i) expenditure growth that was constrained in part by low utilization and low payment updates and (ii) a rebound of taxable payroll growth from 2007-2009 recession levels. After 2018 the cost rate is projected to rise primarily due to 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 2026 and 1.1 percent thereafter. Under the illustrative alternative scenario, if the slower price updates were not feasible in the long range and were phased down during 2020-2034, then the HI cost rate would be 4.8 percent in 2035 and 8.2 percent in 2091. These levels are about 7 percent and 65 percent higher, respectively, than the current-law estimates under the intermediate assumptions.

HI and SMI Cash Flow as a Percentage of GDP

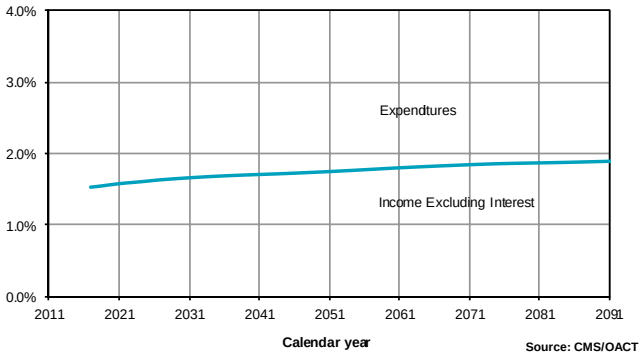
Expressing Medicare incurred expenditures as a percentage of GDP gives a relative measure of the size of the Medicare program compared to the general economy. The GDP represents the total value of goods and services produced in the United States. This measure provides an idea of the relative financial 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 2016, the expenditures were $285.4 billion, which was 1.5 percent of GDP. This percentage is projected to increase steadily until about 2046 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 3.5 percent in 2091.

CHART 2

HI Expenditures and Income Excluding Interest as a Percentage of GDP // 2017 – 2091



SMI

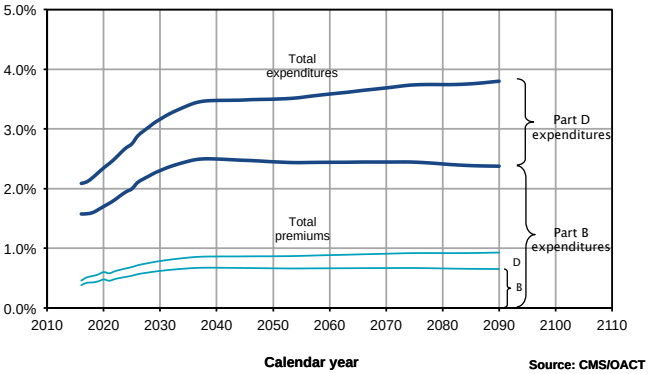
Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and 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 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 2016, SMI expenditures were $393.3 billion, or about 2.1 percent of GDP. Under current law, they would grow to about 3.5 percent of GDP within 25 years and to 3.7 percent by the end of the projection period. (Under the illustrative alternative, total SMI expenditures in 2091 would be 5.4 percent of GDP.)

CHART 3

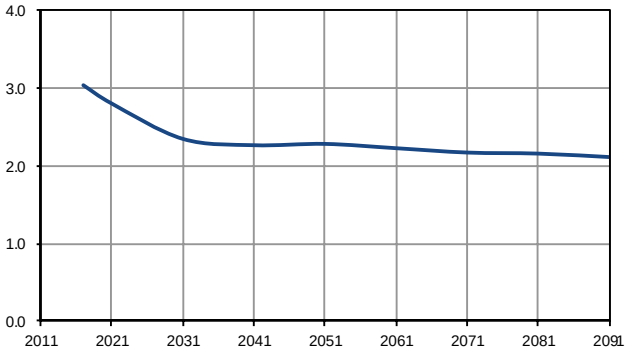
SMI Expenditures and Premiums as a Percentage of GDP // 2017 – 2091



Source: CMS/OACT

CHART 4

Number of Covered Workers per HI Beneficiary // 2016 – 2090



Source: CMS/OACT

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 2016 by about 4.2 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 2016, every beneficiary had 3.1 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 per beneficiary. The projected ratio continues to decline until there are just 2.1 workers per beneficiary by 2091.

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 present 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.[11] The assumptions varied are the health care cost factors, real wage differential, CPI, real interest rate, fertility rate, and net immigration.[12]

[11]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.

[12]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.

For this analysis, the intermediate economic and demographic assumptions in the 2017 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, 2017 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 initially increase, as the effects of the ACA result in trust fund surpluses, and then 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.

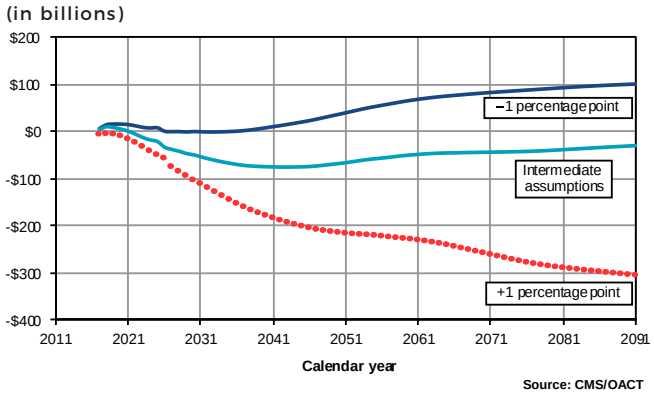
Health Care Cost Factors

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 assumptions.

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $7,194 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 $11,495 billion.

CHART 5

Present Value of HI Net Cash Flow with Various Health Care Cost Factors 2017 – 2091



Source: CMS/OACT

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 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 shows 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.[13] 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 $2,000 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $1,190 billion.

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

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)	$3,662	–$3,532	–$15,028

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)	–$4,961	–$3,532	–$1,135

TABLE 3

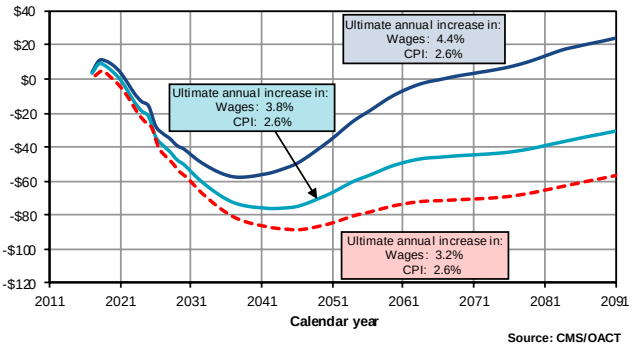
Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

Ultimate percentage increase in wages – CPI	4.4 – 3.2	3.8 – 2.6	3.2 – 2.0
Income minus expenditures (in billions)	–$2,494	–$3,532	–$4,852

CHART 6

Present Value of HI Net Cash Flow with Various Real-Wage Assumptions // 2017 – 2091

(IN BILLIONS)



Source: CMS/OACT

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.

As illustrated in chart 6, faster real-wage growth results in smaller HI cash flow deficits, when expressed in present-value dollars. 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 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

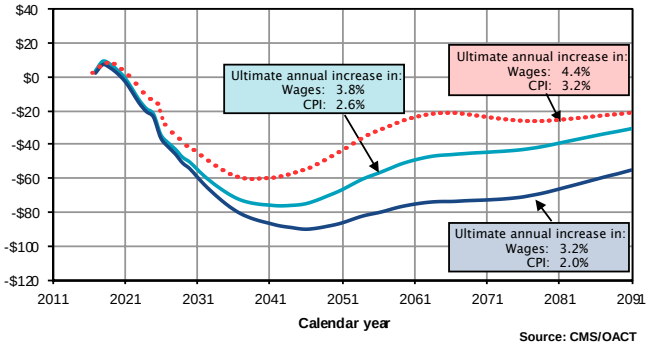
Table 3 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.2, 2.6, and 2.0 percent. In each case, the assumed ultimate real-wage differential is 1.2 percent, which yields ultimate percentage increases in average 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 $1,038 billion. On the other hand, if the ultimate CPI-increase assumption is 2.0 percent, the deficit increases by $1,320 billion.

CHART 7

Present Value of HI Net Cash Flow with Various CPI-Increase Assumptions // 2017 – 2091

(IN BILLIONS)



Source: CMS/OACT

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.

As chart 7 indicates, this assumption has a small impact when the cash flow is expressed as present values. 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 results under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios, but under high-inflation conditions 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: 2.2, 2.7, and 3.2 percent. In each case, the assumed ultimate annual increase in the CPI is 2.6 percent, which results in ultimate annual yields of 4.8, 5.3, and 5.8 percent, respectively.

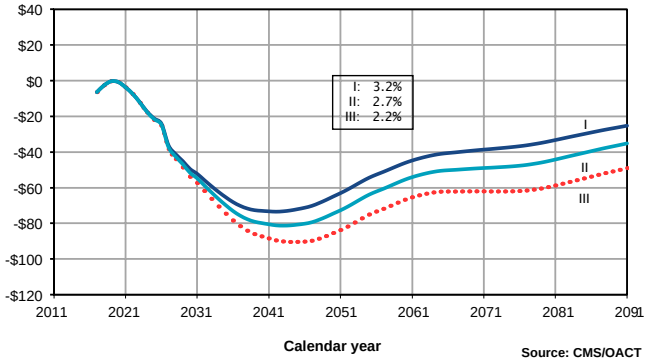
As illustrated in table 4, for every increase of 0.1 percentage point in the ultimate real interest rate, the deficit decreases by approximately $120 billion.

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

CHART 8

Present Value of HI Net Cash Flow with Various Real-Interest Rate Assumptions // 2017 – 2091

(IN BILLIONS)



Source: CMS/OACT

As shown in chart 8, the projected HI cash flow when expressed in present values is fairly sensitive to the interest assumption. 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 2029. 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 $510 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.

As chart 9 indicates, the fertility rate assumption has a substantial impact on projected HI cash flows. 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

TABLE 4

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

Ultimate real-interest rate	2.2 percent	2.7 percent	3.2 percent
Income minus expenditures (in billions)	–$4,197	–$3,532	–$3,006

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)	–$4,018	–$3,532	–$2,995

[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

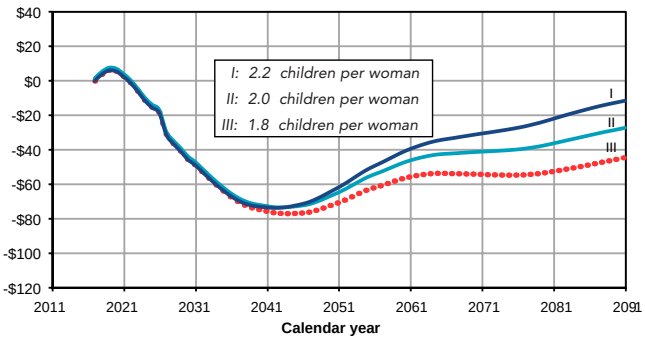
Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Average annual net immigration	961,000	1,286,000	1,623,000
Income minus expenditures (in billions)	–$3,879	–$3,532	–$3,240

CHART 9

Present Value of HI Net Cash FLow with Various Ultimate Fertility Rate Assumptions // 2017 – 2091

(IN BILLIONS)

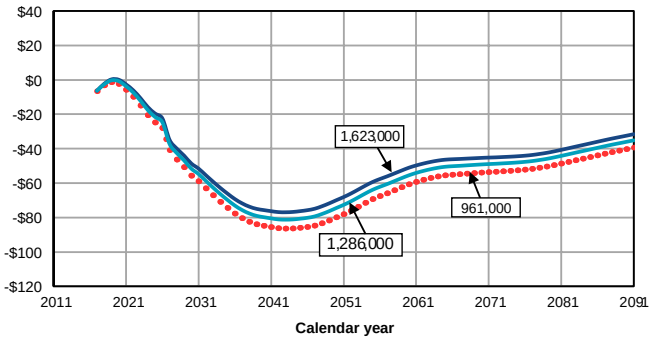


Source: CMS/OACT

CHART 10

Present Value of HI Net Cash FLow with Various Net Immigration Assumptions // 2017 – 2091

(IN BILLIONS)



Source: CMS/OACT

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 shows the net present value of cash flow during the 75-year projection period under three alternative average annual net immigration assumptions: 961,000 persons, 1,286,000 persons, and 1,623,000 persons per year.

As indicated in table 6, if the average annual net immigration assumption is 961,000 persons, the deficit—expressed in present-value dollars—increases by $347 billion. Conversely, if the assumption is 1,623,000 persons, the deficit decreases by $292 billion.

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 illustrated 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 has improved as compared to the projections in last year's annual report. Under the Medicare Trustees' intermediate assumptions, the estimated depletion date for the HI trust fund is 2029, one year later than in last year's report. As in past years, the Trustees have determined that the fund is not adequately financed over the next 10 years. HI expenditures are projected to be lower than last year's estimates, mostly due to lower inpatient hospital utilization assumptions and lower-than-expected spending in 2016.

HI expenditures exceeded income each year from 2008 through 2015. In 2016, however, there was a fund surplus amounting to $5.4 billion. The Trustees project modest surpluses to continue in 2017 through 2022, with a return to deficits in subsequent years until the trust fund becomes depleted in 2029. 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 financing established for the Part B account for calendar year 2017 is adequate to cover 2017 expected expenditures.[14] Similarly, Part D income and outgo would remain in balance as a result of the annual adjustment of premium and general revenue income to cover costs. The appropriation for Part D general revenues has generally been set such that amounts can be transferred to the Part D account on an as-needed basis.

The Part B and Part D accounts in the SMI trust fund are adequately financed because premium and general revenue income are reset each year to cover expected costs. 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 the Board of Trustees to test whether the difference between Medicare outlays and dedicated financing sources[15] is projected to exceed 45 percent of total Medicare outlays under current law within the next 7 fiscal years (2017 2023). If this level is attained within the 7-year timeframe, the law requires a determination of projected excess general revenue Medicare funding. For the 2017 Medicare Trustees Report, this difference is expected to exceed 45 percent of total expenditures in fiscal year 2023, and therefore the Trustees are issuing this determination.

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,

[14] A hold-harmless provision restricted Part B premium increases for most beneficiaries in 2017. However, for beneficiaries to whom the provision did not apply, there was a substantial increase in the 2017 Part B premium.

[15] 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.

if the growth in Medicare costs is comparable to growth under the illustrative alternative projections, then these further policy reforms will have to address much larger financial challenges than those assumed under current law. In their 2017 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." They also stated: "Consideration of such reforms should not be delayed."

COMBINING STATEMENT OF BUDGETARY RESOURCES

for the year ended September 30, 2017

(IN MILLIONS)

	Medicare		Payments to Trust Funds	Medicaid	CHIP	Medicare Part D	Other Health	All Others	Combined Totals Budgetary	Non-Budgetary Credit Reform Financing Account
	HI TF	SMI TF								
BUDGETARY RESOURCES:										
Unobligated balance brought forward, October 1			$23,833	$413	$22,044	$40	$4,852	$(3,032)	$48,150	$624
Other Adjustments								77	77	
Recoveries of prior year unpaid obligations	$2	$2	12,732	34,493	8	70	149	418	47,874	3
Other changes in unobligated balance	6	5	(29,175)	(2,842)		380	(53)	15	(15,936)	(476)
Unobligated balance from prior year budget authority, net	8	7	7,390	32,064	22,052	490	4,948	(2,522)	80,165	151
Appropriations (discretionary and mandatory)	300,894	310,816	338,236	384,922	15,601	95,170	9,858	1,376	1,441,145	(96)
Borrowing authority (discretionary and mandatory)		3,720							3,720	152
Spending authority from offsetting collections				941		(6,569)	78	8,286	2,736	122
TOTAL BUDGETARY RESOURCES	**$300,902**	**$314,543**	**$345,626**	**$417,927**	**$37,653**	**$89,091**	**$14,884**	**$7,140**	**$1,527,766**	**$329**
STATUS OF BUDGETARY RESOURCES:										
New Obligations and upward adjustments	$300,902	$314,543	$339,542	$417,617	$15,969	$89,088	$9,697	$14,599	$1,501,957	$152
Apportioned, Unexpired				2	5,163		3,843	1,335	10,343	3
Exempt from Apportionment, unexpired accounts								(12,301)	(12,301)	
Unapportioned, unexpired accounts				308	1,851		1,339	2,490	5,988	174
Unexpired unobligated balance, end of year				310	7,014		5,182	(8,476)	4,030	177
Expired unobligated balance, end of year			6,084		14,670	3	5	1,017	21,779	
Unobligated balance, end of year			6,084	310	21,684	3	5,187	(7,459)	25,809	177
TOTAL BUDGETARY RESOURCES	**$300,902**	**$314,543**	**$345,626**	**$417,927**	**$37,653**	**$89,091**	**$14,884**	**$7,140**	**$1,527,766**	**$329**
CHANGE IN OBLIGATED BALANCE:										
Unpaid obligations:										
Unpaid obligations, brought forward, October 1	$31,860	$25,831	$27,070	$40,055	$8,292	$14,639	$3,515	$17,009	$168,271	$37
New Obligations and upward adjustments	300,902	314,543	339,542	417,617	15,969	89,088	9,697	14,599	1,501,957	152
Outlays (gross)	(297,566)	(314,067)	(335,137)	(383,847)	(16,251)	(95,253)	(10,254)	(10,319)	(1,462,694)	(180)
Recoveries of prior year unpaid obligations	(2)	(2)	(12,732)	(34,493)	(8)	(70)	(149)	(418)	(47,874)	(3)
UNPAID OBLIGATIONS END OF YEAR (GROSS)	**35,194**	**26,305**	**18,743**	**39,332**	**8,002**	**8,404**	**2,809**	**20,871**	**159,660**	**6**
UNCOLLECTED PAYMENTS:										
Uncollected payments, Federal sources, brought forward, October 1				(105)		(14,110)		(8,204)	(22,419)	(14)
Change in uncollected payments, Federal sources				(289)		6,569		(32)	6,248	12
Uncollected payments, Federal sources, end of year				(394)		(7,541)		(8,236)	(16,171)	(2)
Memorandum entries:										
Obligated balance, start of year, net	$31,860	$25,831	$27,070	$39,950	$8,292	$529	$3,515	$8,805	$145,852	$23
Obligated balance, end of year, net	35,194	26,305	18,743	38,938	8,002	863	2,809	12,635	143,489	4
BUDGETARY AUTHORITY AND OUTLAYS, NET:										
Budget authority, gross	$300,894	$314,536	$338,236	$385,863	$15,601	$88,601	$9,936	$9,662	$1,447,601	$178
Actual offsetting collections	(6)	(5)	(2,237)	(13,456)		(380)	(14)	(8,269)	(24,367)	(134)
Change in uncollected customer payments from Federal sources				(289)		6,569		(32)	6,248	12
Recoveries of prior year paid obligations	6	5	2,237	12,803		380	14	15	15,460	
Budget authority, net (discretionary and mandatory)	300,894	314,536	338,236	384,921	15,601	95,170	9,936	1,376	1,444,942	56
Outlays, gross (discretionary and mandatory)	297,566	314,067	335,137	383,847	16,251	95,253	10,254	10,319	1,462,694	180
Actual offsetting collections (discretionary and mandatory)	(6)	(5)	(2,237)	(13,456)		(380)	(14)	(8,269)	(24,367)	(134)
Outlays, net (discretionary and mandatory)	297,560	314,062	332,900	370,391	16,251	94,873	10,240	2,050	1,438,327	46
Distributed offsetting receipts	(36,146)	(407,733)			(6)			(622)	(444,507)	
AGENCY OUTLAYS, NET (DISCRETIONARY AND MANDATORY)	**$261,414**	**$(93,671)**	**$332,900**	**$370,391**	**$16,245**	**$94,873**	**$10,240**	**$1,428**	**$993,820**	**$46**

SUPPLEMENTARY INFORMATION

- CONSOLIDATING BALANCE SHEET
- CONSOLIDATING STATEMENT OF NET COST
- CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

CONSOLIDATING BALANCE SHEET

as of September 30, 2017

(IN MILLIONS)

	Medicare (Dedicated Collections)			Health (Other Funds)						
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	Combined Totals	Intra-CMS Eliminations	Consolidated Totals
ASSETS										
Intragovernmental Assets:										
Fund Balance with Treasury	$818	$27,466	$28,284	$39,250	$29,114	$8,662	$3,366	$108,676		$108,676
Investments	199,615	71,087	270,702		1,143			271,845		271,845
Accounts Receivable, Net	36,081	35,489	71,570	512	12	1,168	2,668	75,930	$(75,346)	584
Other Assets	24	1	25					25		25
Total Intragovernmental Assets	**236,538**	**134,043**	**370,581**	**39,762**	**30,269**	**9,830**	**6,034**	**456,476**	**(75,346)**	**381,130**
Accounts Receivable, Net	1,255	19,417	20,672	6,036	1	5,011	94	31,814		31,814
General Property, Plant & Equipment, Net	372	329	701	20	2	185	316	1,224		1,224
Other Assets	10,036	19,256	29,292	35		604	79	30,010		30,010
TOTAL ASSETS	**$248,201**	**$173,045**	**$421,246**	**$45,853**	**$30,272**	**$15,630**	**$6,523**	**$519,524**	**$(75,346)**	**$444,178**
LIABILITIES										
Intragovernmental Liabilities:										
Accounts Payable	$38,618	$36,848	$75,466	$3		$393	$3	$75,865	$(75,331)	$534
Other Intragovernmental Liabilities	7	6,400	6,407			871	62	7,340	(15)	7,325
Total Intragovernmental Liabilities	**38,625**	**43,248**	**81,873**	**3**		**1,264**	**65**	**83,205**	**(75,346)**	**7,859**
Accounts Payable	69	15	84	3		50	44	181		181
Entitlement Benefits Due and Payable	30,039	30,586	60,625	34,070	$1,345		12,307	108,347		108,347
Contingencies	926		926	12,195				13,121		13,121
Other Liabilities	111	634	745	11	1	7,161	59	7,977		7,977
TOTAL LIABILITIES	**$69,770**	**$74,483**	**$144,253**	**$46,282**	**$1,346**	**$8,475**	**$12,475**	**$212,831**	**$(75,346)**	**$137,485**
NET POSITION										
Unexpended Appropriations-Dedicated Collections	$1,181	$16,106	$17,287					$17,287		$17,287
Unexpended Appropriations-Other Funds				$5,564	$28,877	$5,750	$2,051	42,242		42,242
Cumulative Results of Operations-Dedicated Collections	177,250	82,456	259,706			1,043	(9,129)	251,620		251,620
Cumulative Results of Operations-Other Funds				(5,993)	49	362	1,126	(4,456)		(4,456)
TOTAL NET POSITION	**$178,431**	**$98,562**	**$276,993**	**$(429)**	**$28,926**	**$7,155**	**$(5,952)**	**$306,693**		**$306,693**
TOTAL LIABILITIES AND NET POSITION	**$248,201**	**$173,045**	**$421,246**	**$45,853**	**$30,272**	**$15,630**	**$6,523**	**$519,524**	**$(75,346)**	**$444,178**

CONSOLIDATING STATEMENT OF NET COST

for the year ended September 30, 2017

(IN MILLIONS)

	Medicare (Dedicated Collections)			Health (Other Funds)				Consolidated Total
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	
NET PROGRAM/ACTIVITY COSTS								
GPRA Programs:								
Medicare (Dedicated Collections)	$286,703	$280,426	$567,129					$567,129
Medicaid				$372,986				372,986
CHIP					$16,633			16,633
Net Cost: GPRA Programs	$286,703	$280,426	$567,129	$372,986	$16,633			$956,748
Other Activities:								
State Grants and Demonstrations							$556	556
Other Health						$1,316		1,316
Other							4,712	4,712
Net Cost: Other Activities						1,316	5,268	6,584
NET COST OF OPERATIONS	**$286,703**	**$280,426**	**$567,129**	**$372,986**	**$16,633**	**$1,316**	**$5,268**	**$963,332**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2017

(IN MILLIONS)

	Medicare (Dedicated Collections)			Health (Other Funds)					Consolidated Total
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	Dedicated Collections	
CUMULATIVE RESULTS OF OPERATIONS									
Beginning Balances	$173,001	$59,589	$232,590	$(2,815)	$36	$412	$1,101	$(5,434)	$225,890
Budgetary Financing Sources:									
Appropriations Used	25,579	299,969	325,548	368,708	16,624	1,235	801		712,916
Nonexchange Revenue:									
FICA and SECA Taxes	259,740		259,740						259,740
Interest on Investments	7,404	2,357	9,761		6				9,767
Other Nonexchange Revenue	480	4,154	4,634						4,634
Transfers-in/out Without Reimbursement	(2,264)	(3,203)	(5,467)	1,099	16	1,076	260	533	(2,483)
Other Financing Sources (Nonexchange):									
Transfers-in/out Without Reimbursement						(15)	17		2
Imputed Financing	13	16	29	1		13	4		47
Other							(17)		(17)
Total Financing Sources	**290,952**	**303,293**	**594,245**	**369,808**	**16,646**	**2,309**	**1,065**	**533**	**984,606**
Net Cost of Operations	**286,703**	**280,426**	**567,129**	**372,986**	**16,633**	**2,359**	**1,040**	**3,185**	**963,332**
Net Change	**4,249**	**22,867**	**27,116**	**(3,178)**	**13**	**(50)**	**25**	**(2,652)**	**21,274**
Cumulative Results of Operations	**$177,250**	**$82,456**	**$259,706**	**$(5,993)**	**$49**	**$362**	**$1,126**	**$(8,086)**	**$247,164**
UNEXPENDED APPROPRIATIONS									
Beginning Balances	$1,073	$34,939	$36,012	$4,995	$31,385	$6,936	$3,531		$82,859
Budgetary Financing Sources:									
Appropriations Received	25,756	322,712	348,468	459,973	21,540	124	87		830,192
Appropriations Transferred-in/out				(4,344)					(4,344)
Other Adjustments	(69)	(41,576)	(41,645)	(86,352)	(7,424)	(75)	(766)		(136,262)
Appropriations Used	(25,579)	(299,969)	(325,548)	(368,708)	(16,624)	(1,235)	(801)		(712,916)
Total Budgetary Financing Sources	**108**	**(18,833)**	**(18,725)**	**569**	**(2,508)**	**(1,186)**	**(1,480)**		**(23,330)**
Total Unexpended Appropriations	**1,181**	**16,106**	**17,287**	**5,564**	**28,877**	**5,750**	**2,051**		**59,529**
Net Position	**$178,431**	**$98,562**	**$276,993**	**$(429)**	**$28,926**	**$6,112**	**$3,177**	**$(8,086)**	**$306,693**

AUDIT REPORTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

NOV - 3 2017

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 2017 (A-17-17-02016)

This memorandum transmits the independent auditors' reports on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2017 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, 2017 and 2016, 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, 2017, 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 17-03, *Audit Requirements for Federal Financial Statements*.

Results of the Independent Audit

Ernst & Young found that the FY 2017 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. With respect to the estimates for the statement of social insurance as of January 1, 2017 and 2016, CMS management noted in the financial statement footnotes that the Medicare Board of Trustees alternative scenario illustrates, when possible, the potential understatement of Medicare cost and projection results. The Trustees assume that the various cost-reduction measures will occur as current law requires.

The most important of these measures—the reduction in the annual payment rate updates for most categories of Medicare providers by the growth in economy-wide multifactor productivity and the specified physician updates put in place by the Medicare Access and CHIP[1] Reauthorization Act of 2015 (MACRA)—will occur as current law requires. Also, the Medicare Board of Trustees, in its annual report to Congress, stated:

> The Trustees are hopeful that U.S. health care practices are in the process of becoming more efficient as providers anticipate more modest rates of reimbursement growth, in both the public and private sectors, than experienced in recent decades. The methodology for projecting Medicare finances assumes a substantial long-term reduction in per capita health expenditure growth rates relative to historical experience, to which the cost-reduction provisions of the Affordable Care Act[2] and MACRA would add substantial savings. Notwithstanding recent favorable developments, current-law projections indicate that Medicare still faces a substantial financial shortfall that will need to be addressed with further legislation.

The range of the social insurance liability estimates in the alternative scenario was significant. As a result, Ernst & Young was unable to obtain sufficient audit evidence for the particular amounts presented in the statements of social insurance as of January 1, 2017, 2016, 2015, 2014, and 2013, and the related statements of changes in social insurance amounts for the periods ended January 1, 2017 and 2016. 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*, which is issued by the Comptroller General of the United States, Ernst & Young identified significant deficiencies in CMS's financial reporting processes and information systems controls:

- *Financial Reporting Processes*—Ernst & Young noted that CMS should continue to develop, refine, and adhere to its financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity. Continued weaknesses in oversight of the Medicaid program included continued delays receiving certain certifications results in a backlog of uncertified claims and delays in grant finalizations. These delays create a risk that certain accruals do not reflect the best available information to use in formulating management's estimate. In addition, issues with CMS's third-party contractors were identified. Also, CMS continues to record Medicare Administrative Contractor account balances through a manual journal voucher process. This process should be configured as a routine systemic set of entries to

[1] Children's Health Insurance Program

[2] The Patient Protection and Affordable Care Act (P.L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. No. 111-152) are collectively referred to as the Affordable Care Act.

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 CMS continues to experience difficulties in implementing and monitoring access controls and the segregation of duties. CMS continues to encounter challenges to monitor its own contractor's adherence of 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 did not meet its error rate target (9.57 percent), and the reported error rate exceeded the mandated 10-percent threshold (10.10 percent). CHIP reported an error rate of 8.64 percent, which did not meet its targeted reduction rate of 7.38 percent for FY 2017. In addition, CMS was not in compliance with section 6411 of the Affordable Care Act as CMS had not yet implemented recovery audit activities for the Medicare Advantage program. Ernst & Young disclosed no other instances of noncompliance that are required to be reported under *Government Auditing Standards* and OMB Bulletin 17-03.

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) 619-3972 or through e-mail at Carrie.Hug@oig.hhs.gov. Please refer to report number A-17-17-02016.

Attachment

cc:
Jennifer Moughalian
Acting Assistant Secretary for Financial Resources
and Acting Chief Financial Officer

Sheila Conley
Deputy Assistant Secretary, Finance
and Deputy Chief Financial Officer

Jennifer Main
Director Office of Financial Management
and Chief Financial Officer

Ernst & Young, LLP
621 East Pratt Street
Baltimore, Maryland
21202

Tel: +1 410 539 7940
Fax: +1 410 783 3832
ey.com

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, 2017 and 2016, 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, 2017, 2016, 2015, 2014, and 2013, the related statements of changes in social insurance amounts for the periods ended January 1, 2017 and 2016, 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, 2017, 2016, 2015, 2014, and 2013, the related statements of changes in social insurance amounts for the periods ended January 1, 2017 and 2016, 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. 17-03, *Audit Requirements for Federal Financial Statements*. Those standards and OMB Bulletin No. 17-03 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 opinion on the consolidated balance sheets as of September 30, 2017 and 2016, 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 13 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 the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act (MACRA).

As further described in Note 14 to the financial statements, with respect to the estimates for the social insurance program presented as of January 1, 2017, 2016, 2015, 2014, and 2013, management has assumed in the projections of the program that the various cost-reduction measures will occur as the ACA and the specified physician updates established by MACRA require. 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 14, 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. 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 an unprecedented change in health care delivery systems and payment mechanisms, the prices paid by Medicare for most health services will fall increasingly short of the costs of providing these services. For example, overriding the scheduled physician payment updates or the productivity adjustments for most providers, as was done repeatedly with the sustainable growth rate formula in the period leading up to passage of MACRA and may be necessary in the future if cost rates prove inadequate, 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, 2017, 2016, 2015, 2014, and 2013, and the related statements of changes in social insurance amounts for the periods ended January 1, 2017 and 2016.

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, 2017, 2016, 2015, 2014, and 2013, and the related changes in the social insurance program for the periods ended January 1, 2017 and 2016.

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, 2017 and 2016, 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.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 3, 2017, on our consideration of CMS' internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations and other matters. The purpose of those reports is 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 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 3, 2017

Ernst & Young, LLP
621 East Pratt Street
Baltimore, Maryland
21202

Tel: +1 410 539 7940
Fax: +1 410 783 3832
ey.com

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. 17-03, *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, 2017 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, 2017, and the related statement of changes in social insurance amounts for the period ended January 1, 2017, and have issued our report thereon dated November 3, 2017. 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, 2017 and the related statement of changes in social insurance amounts for the period ended January 1, 2017.

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, 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. 17-03. 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 of compliance with the laws and regulations described in the second paragraph of this report disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 17-03, 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 activities that may be susceptible to significant improper payments and estimate the amount of the improper payments.

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Although CMS has reported improper payment error rates for each of its high-risk programs, or components of such programs, it is not in full compliance with the Acts. For example, the Medicaid improper payment error rate is greater than the statutorily required maximum of 10 percent and CMS did not meet its improper rate reduction target rates for Medicaid and Children's Health Insurance Program (CHIP). In addition, CMS is not in full compliance with Section 6411 of the Patient Protection and Affordable Care Act, as CMS has not yet implemented recovery activities of the identified improper payments for the Part C program.

CMS' Response to Findings

CMS' response to the findings identified in our audit are described in their letter dated November 3, 2017. 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 3, 2017

Ernst & Young, LLP
621 East Pratt Street
Baltimore, Maryland
21202

Tel: +1 410 539 7940
Fax: +1 410 783 3832
ey.com

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 audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 17-03, *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, 2017 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, 2017, and the related statement of changes in social insurance amounts for the period ended January 1, 2017, and have issued our report thereon dated November 3, 2017. 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, 2017 and the related statement of changes in social insurance amounts for the period ended January 1, 2017.

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. 17-03. 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 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). CMS has made significant improvements during the last few years relative to analytical review procedures and analysis of critical or new financial matters (whitepapers).

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

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. Beginning January 1, 2014, the Affordable Care Act expanded eligibility for Medicaid to certain low-income adults and increased the Federal medical assistance percentage to 100 percent for those qualifying claims for the first three years, and gradually decreasing to 90 percent by FY 2020 and beyond, for states that elected to participate in the program (Medicaid Expansion). The Center for Medicaid and Children's Health Insurance Program (CHIP) Services (CMCS) is responsible for providing the Federal government oversight of the program and executing the internal controls at the Federal level, which includes: approval of the state plans and amendments, which serve as the contract describing how that state administers the program; approval of each state's budget (the authorized amount) on a quarterly or annual basis; reconciling the Federal share of the expenditures to amounts reported by the state; requiring the states to have program audits and performing analytical procedures over program expenditures. The Federal government controls were designed with the intention that the states would have their own set of procedures and controls over program costs. The changes brought about by the Affordable Care Act have identified additional challenges and risks within the Medicaid process that warrant consideration and remediation. During the prior years we noted issues with the quarterly expenditure report certification by certain states. While there have been improvements from the prior year, we continue to see delays receiving certain certifications which results in a backlog of uncertified claims as well as delays in grant finalizations as the regional offices and CMCS reviews are not completed. This delay creates a risk that certain accruals within the financial statements do not reflect the best available information to formulate management's estimate.

CMCS has been working on a multiyear project to develop data and analytics to improve their program and financial management. That project is not operational at a level where it currently provides controls supporting program integrity. CMCS should continue to enhance its financial management systems and its related data analyses capability to develop robust analytical procedures and measures against benchmarks to monitor and identify risks associated with the Medicaid program, including outliers and unusual or unexpected results that may identify abnormalities in state-related Medicaid expenditures. Furthermore, in FY 2016, the Office of the Actuary began to quantify the effects of risk mitigation strategies related to the Medicaid expansion population which will result in recoveries of previous expenditures. During the FY 2017 audit, we observed that while progress has been made CMS management has not updated its quantification of prior year recovery estimates. Discussions were held with management to understand the steps taken to gather additional data necessary to quantify the recoveries for more recent periods, however, due to limitations on the data available, no further quantification was feasible. We believe that the efforts to collect information from the individual states and evaluate the necessary recovery efforts should be augmented. As this process further develops, we expect that management will be able to record estimates related to these recoveries.

We have also observed that CMS does not 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 2017 financial statements. CMS currently does not have timely access to the states' claim data nor the ability to accumulate the detailed claim data by state to perform the analysis described above. CMS is not able to validate its methodology by using a claims-based approach due to the lack of individual claims-level detail and continues to rely on its estimation process to record

the Medicaid EBDP without the ability to confirm the reasonableness of its methodology. The lack of information creates a risk that potential updates to CMS' analysis will not be reflected in CMS' financial statements in a timely manner.

Coordination Between the Office of the Actuary and OFM

In September 2017, CMS made advance prospective payments related to October 2017 for the Medicare Part D Program which were appropriately recorded within other assets; however, CMS also included the advance payments as a component of its Part D accrual estimate, resulting in an overstatement of accounts receivable. This was not identified through the normal financial statement close process because there was a gap in communication between the Office of the Actuary and OFM regarding a change in methodology.

Oversight of Third-Party Contractors

CMS relies heavily on third-party contractors as it outsources substantially all 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. While this approach to financial integrity supports CMS' role in the monitoring of the MACs' financial controls, we identified deficiencies in the oversight/monitoring process related to returned Medicare Summary Notices and the reconciliation, review and monitoring of provider records and provider eligibility status. In addition, 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, as required by OMB Circular A-136, *Financial Reporting Requirements*.

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 error rates in the high-risk CMS programs of Medicare Fee-for-Service (FFS), Medicare Advantage, Medicare Prescription Drugs, Medicaid and CHIP.

As part of our audit procedures, we reviewed the improper payment error rate estimates and activities performed by management to measure, identify, and reduce improper payments. CMS reports that the main purpose of their improper payment error rate programs is to report an accurate measure of improper payments for each program. To accomplish this goal, CMS builds in time to their study 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 error

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. Calling payments improper that were not truly improper payments would lead to a less accurate rate. Allowing the maximum amount of time for this development causes the study to be completed very near the required annual reporting deadline. During the current year, CMS made improvements to the process with the overall goal of reducing the improper payment error rates, which resulted in declines in the Medicare FFS, Medicare Part C and Medicare Part D rates year over year. Despite the extensive processes to increase the accuracy of the improper payment error rates and the significant programs and process changes instituted each year the improper payment error rate remains high in comparison to the Federal Government's stated goals.

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:

- Continue to strengthen CMCS oversight and support of Medicaid Expansion policies and procedures that will serve to prevent a backlog of uncertified claims

- Evaluate the sufficiency of current efforts related to Medicaid risk mitigation so that recoverable amounts are pursued in a timely fashion and to a lesser extent that recovery estimates are properly reflected in the financial statements.

- 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 $34.1 billion accrual.

- When considering changes to established methodologies, we recommend that the Office of the Actuary work with OFM prior to implementation of such changes within their calculations so that all relevant accounting consequences have been considered.

- Ensure that the appropriate policies are established, implemented and adhered to by the various Centers, regional offices and MACs or if the specific policy is not implemented, determine that the required documentation and approval exists to demonstrate how the risk is appropriately mitigated or responded to through other procedures. Consider whether there are portions of the manual journal voucher process that should be configured as routine systematic entries within the system.

- Consider expediting the improper payment error rate development study time to increase the time allocated to analyze the findings and development of the plans for remediation prior to the required reporting deadline. Additional analysis of the improper payment error rate study results may increase observations of specific causes, contributing factors and anomalies to drive investigations of the root causes of the errors and improve prevention, mitigation and recovery plans.

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. CMS has initiated several strategic enhancements to its information security controls, including the development of enhanced policies and procedures and implementation of new protections for beneficiary data.

To manage the operational and financial risk presented by these information systems, CMS established a formal monitoring process of their contractors that is detailed in their information security and configuration management policies and procedures based on control techniques mandated by Federal standards-setting organizations and adopted government-wide. These policies and procedures are used for Medicare fee-for-service shared systems and CMS Central Office systems that affect Medicare FFS, Medicare Advantage, Medicare Prescription Drug, Medicaid and CHIP programs and also are incorporated by reference in CMS' agreements with its contractors. The contractors supporting the administration of the Medicare FFS computerized systems and related beneficiary, provider, payment and financial management data processes include, but are not limited to, MACs, Single Testing Contractor (STC), Shared Systems Maintainers (SSMs) and Virtual Data Centers (VDCs).

For the Medicare FFS shared systems, CMS has contracted with several SSMs to provide application software development, documentation, testing and training support for the majority of the systems used to process Medicare FFS claims. The MACs use the shared systems and are responsible for the configuration of locally programmed edits (for example, a valid provider type was entered for the medical service rendered) and automated adjudication software (scripts) and local information security user administration procedures. The complexity of managing changes as a result of new or revised Medicare FFS policies and other directives issued by CMS impacts the overall integrity of the claims process.

Change requests for the shared systems are developed as a result of numerous events, including medical policy revisions issued by CMS' medical staff based on legislative mandates, national trends, historical analysis, implementation of new or revised business processes to efficiently manage the significant volume of claims processed by CMS every day, and the implementation of new processing technologies.

The SSMs perform the initial program design and coding of changes to the shared systems. CMS coordinates the change control activities for the updates to the shared systems. Integration testing is performed to determine whether modified software components are operating in accordance with CMS' requirements and to verify that unexpected or unintended changes to the shared systems do not occur. Through the VDCs, these changes are applied to the shared systems for the individual MACs at least quarterly. MACs may also implement certain local changes provided they are compliant with CMS' directives.

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.

Governance Over Implementation of Information Systems Control Standards and Processes

CMS continues to encounter challenges to monitor their own and contractors' adherence of their established information systems control standards and processes. For example, most of CMS' business functions, including the operation of computer systems and configuration management, are performed by contractors. In many cases, the implementation of the computer security protocol is dependent upon a contractor's interpretation of and adherence to CMS security and configuration management policies. 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) and the Center for Medicare (CM). These challenges heighten CMS' inability to ensure the accuracy, completeness, and overall integrity of its Medicare systems and other enterprise-wide systems.

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

- Several vulnerabilities related to system configurations were identified with the Central Office and Medicare fee-for-service information systems. The remediation, mitigation of risks, or monitoring of these vulnerabilities was not performed or not performed timely.

- Evidence supporting the testing of claims processing software changes and/or application production support fixes were not always created or retained.

- CMS' process requiring interface control documents (ICDs) to mitigate the risk of insufficient integration of its information systems for its major applications has not been followed consistently to include all of the standard content. In addition, a complete inventory of systems interfaces was not maintained.

- Medicare FFS contractors' information security and configuration management-related findings identified by internal and external audits and tests that test various information systems controls remain unresolved from prior years and not included in the contractors Plan of Action and Milestones.

Without the sufficient 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.

Controls over System Access and Segregation of Duties

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 account management, monitoring of system access, and appropriate segregation of duties are critical to protecting unauthorized usage of CMS information resources, including program and data files. Without maintaining an appropriate level of access controls and segregation of duties within CMS systems, the integrity of CMS' information resources could be compromised.

Deficiencies continued to be identified in the implementation and monitoring of access controls as well as segregation of duties with CMS information systems which included:

- Procedures for adding or removing users were not consistently followed.
- Oversight of periodic access reviews for key applications and system parameters were not performed as required or not adequately performed.
- One user had the ability to develop changes and approve changes into production for two financially significant applications.
- Monitoring of privileged access for key applications was not performed.

Appropriate consideration of the design of controls over access, monitoring of access, and segregating 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 and segregation of duties, the risk of errors, fraud or other illegal acts is increased.

Recommendations

CMS should continually assess the governance and oversight across its organizational units charged with responsibility for the configuration management and information security of its Medicare FFS 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 OIT and CM.

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

- Continued implementation of configuration management activities at the Central Office and the Medicare FFS contractors in accordance with CMS' policies and guidance, related monitoring procedures, mitigation of risk, and timely remediation of identified vulnerabilities.
- Documentation should be created and retained for all phases of the change management process, as required by CMS guidance.

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- Maintain a complete inventory of interfaces and consistently complete ICDs for all of CMS' significant systems.

- Track and timely remediate findings identified in the various audits and tests performed over CMS and its Medicare contractors' IT operations.

Specific to the implementation of access controls and segregation of duties, we recommend that CMS ensure that:

- Relevant CMS guidance is followed for adding and removing users to all systems.

- Access to all systems should be periodically assessed to ensure that access remains appropriate and no incompatible duties exist.

- Segregate access to develop and approve changes to separate members to ensure proper segregation of duties.

- Monitor privileged access for key application to ensure it was authorized and used appropriately.

CMS' Response to Findings

CMS' response to the findings identified in our audit are described in the accompanying letter dated November 3, 2017. 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 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 3, 2017

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT

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

Dear Sir:

We are pleased to receive an unmodified audit opinion on our fiscal year 2017 annual financial statements: Consolidated Balance Sheets, Consolidated Statements of Net Cost and Changes in Net Position, and the Combined Statements of Budgetary Resources. I would also like to take this opportunity to thank your office for its hard work and professionalism exhibited during the audit.

As in previous years, the auditors were not able to express an opinion on the sustainability financial statements, which comprise the Statement of Social Insurance (SOSI) and the Statement of Changes in Social Insurance Amounts (SCSIA). While CMS is confident that our SOSI model projections are fairly presented in accordance with current law, we will continue our efforts, in collaboration with your auditors, for reporting on the SOSI projections that will support the rendering of an opinion on these statements in future audits.

The results of this year's audit identified no material weaknesses in our internal controls; however, significant deficiencies in our financial reporting and information systems were noted. Strengthening our internal controls remains a top agency priority, and CMS is committed to improving these controls. Many of the deficiencies surrounding information systems are multi-year efforts and require a substantial amount of monetary resources to resolve.

CMS welcomes upcoming discussions with your auditors as we collaborate to remediate the issues noted in the audit report. In closing, I would like to once again thank your office for its diligence in completing the audit and look forward to your continued support as we work to remediate the issues noted.

Sincerely,

Jennifer Main
Chief Financial Officer

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OTHER INFORMATION

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

SUMMARY OF FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT REPORT AND OMB CIRCULAR NO. A-123 MANAGEMENT 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 No. 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, 2017, 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 No. A-123 Statement of Assurance

CMS management is responsible for establishing and maintaining effective internal control and financial management systems that meet the objectives of FMFIA and OMB Circular No. 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 No. A-123, CMS evaluated its internal control and financial management systems to determine whether these objectives are being met. Accordingly, as of September 30, 2017, CMS provided a modified statement of reasonable assurance that its internal control 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 IPERIA); 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 OMB Circular No. A-123, Appendix A. Based on the results of this assessment, CMS provided reasonable assurance that internal controls over financial reporting as of June 30, 2017, were operating effectively and no material weaknesses were found in the design or operation of the internal control 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 No. A-123. Based on the results of this evaluation, as of September 30, 2017, CMS provided reasonable assurance that internal control over operations were effective, and no material weaknesses were found in the design or operation of these internal controls. As of September 30, 2017, 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 all CMS financial management and related systems substantially complied with FFMIA as of September 30, 2017.

Noncompliance—Actions and Accomplishments

CMS did not fully comply with IPERIA, and section 6411 of the 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) 2017 IPERIA noncompliance stems from the following:

1. The Medicaid improper payment rate was 10.10 percent. The improper payment rate was higher than 10 percent and CMS did not meet its previously established target of 9.57 percent.

2. The FY 2017 CHIP improper payment rate was 8.64 percent. Although the improper payment rate was lower than 10 percent, CMS did not meet its previously established target of 7.38 percent.

CMS has taken, and continues to take a number of actions outlined in the FY 2017 Agency Financial Report (AFR). CMS continues its efforts to comply with IPERIA and OMB's implementing guidance.

Regarding compliance with section 6411 of the PPACA, CMS began implementation efforts in December 2010, by publishing a solicitation of comments regarding the development of the Medicare Part C Recovery Audit Contractor (RAC) program. In 2014, CMS issued a Request for Proposal for a Part C RAC; however, no proposals were received. In December 2015, CMS issued a Request for Information seeking industry input on the level of contractor interest and capability to conduct this type of work. Currently, CMS is examining refinements which can be made to the operations of RACs such that their activities do not excessively burden plans.

IMPROPER PAYMENTS

IPERIA includes requirements for identifying programs susceptible to significant improper payments, annually reporting estimates of improper payments, and implementing corrective actions to reduce improper payments. IPERIA 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 complied with OMB's implementing guidance and instituted comprehensive processes that measure the payment error rates for the Medicare Fee-for-Service (FFS), Medicaid, CHIP, Medicare Advantage (Part C), and Medicare Prescription Drug (Part D) 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.[1] The estimated percentage of Medicare FFS dollars paid correctly was 90.49 percent. This means Medicare paid an estimated $344.55 billion correctly in FY 2017.

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 2017 is 9.51 percent or $36.21 billion in gross improper payments. Improper payments for home health, skilled nursing facility (SNF), and inpatient rehabilitation facility (IRF) claims were the major contributing factors to the FY 2017 Medicare FFS improper payment rate. While the factors contributing to improper payments are complex and vary from year to year, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors

- Insufficient documentation for home health claims continues to be prevalent, despite the improper payment rate decrease from 42.01 percent in FY 2016, to 32.28 percent in FY 2017. The primary reason for these errors was that the documentation to support the certification of home health eligibility requirements was missing or insufficient. Medicare coverage of home health services requires physician certification of the beneficiary's eligibility for the home health benefit (42 CFR 424.22).
- Insufficient documentation was the major reason for SNF claims errors. The improper payment rate for SNF claim errors increased from 7.76 percent in FY 2016, to 9.33 percent in FY 2017. The primary reason for these errors was that the certification/recertification statement was missing or insufficient (e.g., one required element was missing). Medicare coverage of SNF services requires certification and recertification for these services (42 CFR 424.20).
- Medical necessity (i.e., the services billed were not medically necessary) continues to be the major reason for IRF claim errors, despite the improper payment rate decrease from 62.39 percent in FY 2016, to 39.74 percent in FY 2017. The primary reason for these errors was that the IRF coverage criteria for medical necessity were not met. Medicare coverage of IRF services requires that there must be a reasonable expectation that the patient meets all of the coverage criteria at the time of admission to the IRF (42 CFR 412.622(a)(3)).

[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 2017. 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 0.13 percentage points to 9.51 percent or $36.21 billion in projected improper payments.

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 as well as 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 which help to make sure that applicable coverage, payment, and coding rules are met before services are rendered while also ensuring access to and quality of care. CMS has developed a number of preventative and detective measures for specific service areas with high improper payment rates such as home health, SNF, and IRF claims. 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 has reported a Part C payment error estimate since FY 2008. The Part C error estimate measures improper payments made to Medicare Advantage (MA) plans based on diagnoses submitted by MA organizations for risk adjusted payment. The Part C payment error estimate was 8.31 percent or $14.35 billion in gross improper payments for the FY 2017 reporting period.

The Part D error estimate measures improper payments related to prescription drug event (PDE) data, as determined by a clinical review of prescription records and medication orders as well as a review of claims information. The Part D improper payment error estimate was 1.67 percent or $1.30 billion in gross improper payments for the FY 2017 reporting period.

Medicaid and CHIP

Medicaid and CHIP are also susceptible to erroneous payments. 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 cases.

A sample of 17 states is measured each year to produce and report national program improper payment rates.

The FY 2017 Medicaid and CHIP improper payment rate report period covers payments made through September 30, 2016. It is important to note that, for FY 2015 – FY 2018 reporting, Medicaid and CHIP eligibility review pilots are being conducted in place of the PERM eligibility component reviews due to changes in Medicaid and CHIP eligibility required by the PPACA. During this time, Medicaid and CHIP program improper payment rates are based on the FFS and managed care PERM reviews and an eligibility component improper payment rate that is held constant at the FY 2014 level (which does not reflect eligibility determinations made under new PPACA requirements), while CMS updates the PERM eligibility component review methodology to reflect the new PPACA rules. CMS issued a new final regulation and guidance, and will resume the PERM eligibility component for reporting in FY 2019.

The national Medicaid improper payment rate reported for FY 2017 is 10.10 percent or $36.73 billion in gross improper payments based on measurements conducted in FYs 2015, 2016, and 2017. The national component improper payment rates are as follows, Medicaid FFS: 12.87 percent; Medicaid managed care: 0.30 percent. Medicaid eligibility remains at the FY 2014 level of 3.11 percent. State noncompliance with provider screening, enrollment, and National Provider Identifier (NPI) requirements was the major contributor to the Medicaid improper payment rate. However, compliance with these requirements for the 17 states measured in FY 2017 improved, and CMS saw a decrease in improper payments related to non-compliance. Additionally, improper payments due to no or insufficient medical documentation increased in FY 2017.

The national CHIP improper payment rate reported for FY 2017 is 8.64 percent, or $1.24 billion in gross improper payments based on measurements conducted in FYs 2015, 2016, and 2017. The national component improper payment rates are as follows: CHIP FFS: 10.29 percent; CHIP managed care: 1.62 percent. CHIP eligibility remains at the FY 2014 level of 4.22 percent. State noncompliance with provider screening, enrollment, and NPI requirements was also the major contributor to the CHIP improper payment rate. The CHIP FFS improper payment rate for noncompliance with these requirements increased for the 17 states measured in FY 2017. A higher percentage of CHIP providers are not enrolled in Medicare and, therefore, there are more CHIP providers where states are not able to rely on Medicare's screening

in lieu of conducting state screening. Additionally, there was an increase in managed care improper payments in FY 2017 due to recipients that aged out of CHIP.

CMS works closely with states to develop state-specific corrective action plans. All states are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs, with assistance and oversight from CMS. The Medicaid and CHIP eligibility review pilots provide rapid feedback to states and CMS on the accuracy of Medicaid and CHIP eligibility determinations made during the initial years of the PPACA implementation. The pilots identify strengths and weaknesses in operations and systems to allow states to quickly implement corrective actions.

GLOSSARY

A

Accountable Care Organizations (ACO): A group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will 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. The CMS administrative costs are the costs of operating CMS (e.g., salaries and expenses, facilities, equipment, and rent and utilities). These costs are accounted for in the Program Management account.

Advance Premium Tax Credit: A tax credit in which eligible consumers can receive an advance payment to lower their monthly health insurance premiums for Exchange plans. The amount is based on the costs of health plans in the applicable Exchange and the consumer's estimated annual household income as compared to the poverty line.

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

B

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

Beneficiary: A person enrolled in Medicare or Medicaid (also referred to as an enrollee).

Benefit Payments: Funds outlayed or expenses accrued for services delivered to beneficiaries.

C

Chief Financial Officers Act of 1990 (CFO): The CFO Act of 1990 designated a Chief Financial Officer in each executive department and in 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: The 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 in effect an applicable certificate.

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 will foster the creation of qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets.

Cost Sharing Reduction: Payments to health care insurers in 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 as compared to the poverty line.

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 include a requirement for 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 have to 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 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 equipment is equipment which: 1) can withstand repeated use; 2) for items classified as DME after January 1, 2012, has an expected life of at least 3 years; 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. (also see Health Insurance Exchanges).

Expenditure: Expenditure refers to budgeted funds actually spent. When used in the discussion of the Medicaid program, expenditures refer to funds actually spent as reported by the states. This term is used interchangeably with outlays.

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 the 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 (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 (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 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.

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

H

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 EHR technology among eligible professionals (EPs), hospitals, and critical access hospitals.

Hospital Insurance (HI) (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.

I

Improper Payments Elimination and Recovery Improvement Act (IPERIA): In FY 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 not received (except for such payments authorized by law). In addition, when agency's review is unable to discern whether a payment was proper as a result of insufficient or lack of documentation, this payment must also be considered an improper payment.

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 Durable Medical Equipment.

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 passed that established a new program in Medicare to provide a prescription drug benefit, Medicare Part D, which became available on January 1, 2006. 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): The implementation of the MMA amended Title XVIII of the Social Security Act by establishing a new Part D—the voluntary Prescription Drug Benefit Program. This program became effective January 1, 2006, and established an optional prescription drug benefit for individuals who are entitled to or enrolled in Medicare benefits under Part A and/or Part B. Beneficiaries who qualify for both Medicare and Medicaid (full benefit dual-eligibles) automatically receive the Medicare drug benefit.

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: Budgeted funds committed to be spent.

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 (Affordable Care Act) (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, MR/UR, 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 Affordable Care Act programs. PI activities target the range of causes of improper payments, including 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: Health insurance plans which meet minimum standards for health benefit coverage.

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, Affordable Care Act-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: Medicare's share of SECA is used to fund the HI Trust Fund. Self-employed individuals contribute 2.9 percent of taxable annual net income, with no limitation.

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) Number 18 (SSAE 18): 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

Ticket to Work and Work Incentives Improvement Act of 1999: This legislation amends the Social Security Act and increases beneficiary choices in obtaining rehabilitation and vocational services, removes barriers that require people with disabilities to choose between health care coverage and work, and assures that disabled Americans have the opportunity to participate in the workforce.

CMS KEY FINANCIAL MANAGEMENT OFFICIALS

JENNIFER MAIN
Chief Financial Officer & Director
Office of Financial Management

MARIA MONTILLA, CPA
Deputy Chief Financial Officer & Director
Accounting Management Group

PAUL SPITALNIC
Chief Actuary
Office of the Actuary

FLOYD EPPS
Director
Division of Financial Oversight & Internal Controls

JANET LOFTUS
Director
Division of Accounting Operations

MEGAN WORSTELL
Deputy Director
Office of Financial Management

SHELLAE LOUDEN, CPA
Deputy Director
Accounting Management Group

LATAYSHEIA LANCE, CPA
Director
Division of Financial Reporting & Policy

KURT PLEINES
Director
Division of Accounting Systems

For additional information on the following, please call or email:

FINANCIAL REPORT

CYNTHIA CHAPMAN
410.786.0402
cynthia.chapman@cms.hhs.gov

PERFORMANCE MEASURES

HARRIET RUBINSON
410.786-0366
harriet.rubinson@cms.hhs.gov

More information relating to CMS is available at www.cms.hhs.gov.

CMS welcomes comments and suggestions on both the content and presentation of this report. Please send them to Cynthia Chapman by email at cynthia.chapman@cms.hhs.gov.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

7500 SECURITY BOULEVARD
BALTIMORE, MARYLAND 21244-1850

CMS.GOV // MEDICARE.GOV