CMS FINANCIAL REPORT

FY 2016

Continually improving the health and health care for *all* Americans.

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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 2016 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:

1

MANAGEMENT'S DISCUSSION & ANALYSIS

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

2

FINANCIAL SECTION

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

3

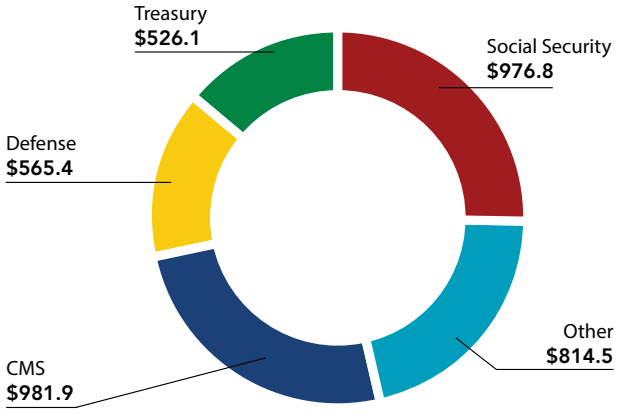
OTHER INFORMATION

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

2016 FEDERAL OUTLAYS

CMS has outlays of approximately $981.9 billion (net of offsetting receipts and Payments of the Health Care Trust Funds) in fiscal year (FY) 2016, approximately 25 percent of total Federal outlays.

CMS employs approximately 6,500 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.

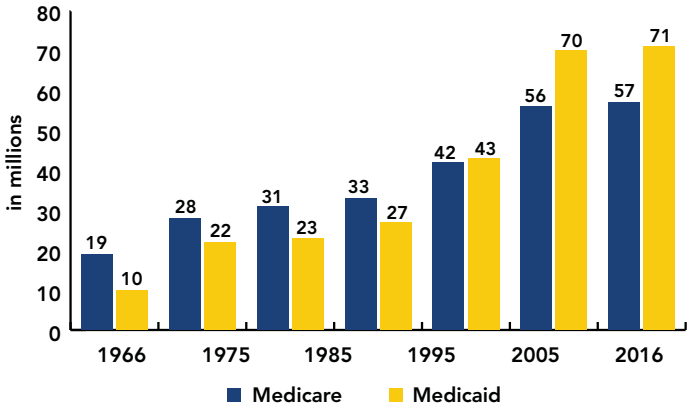


$ in billions

Source: U.S. Treasury

2016 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 57 million beneficiaries. Medicaid enrollment has increased from 10 million beneficiaries in 1966 to about 71 million beneficiaries.



A MESSAGE FROM THE

CMS ACTING ADMINISTRATOR

ANDREW SLAVITT

I am pleased to present the Centers for Medicare & Medicaid Services (CMS) Agency Financial Report (AFR) for Fiscal Year 2016. This AFR highlights our agency's major programs and initiatives and demonstrates our commitment to stewardship and enterprise excellence.

In FY 2016, CMS programs touched the lives of over 125 million Americans enrolled in Medicare, Medicaid, and Children's Health Insurance Program (CHIP). Millions more Americans obtained quality, affordable coverage through the Marketplace. CMS's vision of success is a high quality health care system that ensures better care, access to coverage, and improved health. In FY 2016, we made significant progress in advancing these goals. In particular, I would like to highlight our achievements in three areas of continued focus: expanding access to health coverage, improving the quality and value of health care across the delivery system, and pursuing operational excellence.

Expanding Access to Coverage

Thanks to the Affordable Care Act, Americans' access to the health insurance market has fundamentally transformed in only a few years. By early 2016, 20 million more Americans had quality, affordable coverage and our nation's uninsured rate dropped below 9 percent – the lowest level on record. We achieved these remarkable results at a lower cost than the Congressional Budget Office (CBO) originally projected, with coverage provisions costing 25 percent less than original estimates. Since 2014, for the first time, we have a health insurance system that is providing access to quality care to all Americans regardless of their health or financial status. Millions who were previously denied or unable to afford coverage for chronic conditions or even routine care are now able to get the care they need. Pre-existing conditions no longer preclude individuals from gaining health insurance, and consumers have better access to comprehensive, affordable coverage. Consumers now have the comfort of knowing that if their employment changes or they lose coverage for any reason, they can purchase affordable coverage through the Marketplace—regardless of their personal health history. For the first half of 2016, an average of 10.4 million consumers had Health Insurance Marketplace coverage through the Marketplaces.

CMS made a number of enhancements in advance of Open Enrollment 3 to make the consumer experience quicker and smoother, including a faster and more responsive web experience that will also allow more users to visit the website at the same time; streamlined navigation to better communicate information and next steps to people visiting the website; consumer-specific information to help consumers understand where they are in the enrollment process; simplifying re-enrollment to allow consumers to easily find their current plan and compare it with other available plans in their area; and adding a new "Out of Pocket Cost" feature to help consumers better estimate the cost of their health insurance based on their own personal situation.

As we begin Open Enrollment 4, we are building on this progress and enhancing outreach and communication efforts to encourage consumers to shop for coverage. We are undertaking smarter, more timely, and targeted email and other outreach campaigns. These efforts will complement our successful in-person outreach and assistance programs. Research during the 2016 Open Enrollment showed that young

adults are almost twice as likely as older consumers to enroll when they receive an email about Marketplace coverage. Additionally, this year we will be able to email consumers with important proactive reminders in near-to-real time if they open accounts to start applying or finish applications to select plans, and we will send each consumer a reminder after selecting a plan to pay their first premiums as the last step to gaining coverage.

Medicaid is the primary source of medical assistance for millions of low-income and disabled Americans, providing health coverage to many of those who would otherwise be unable to obtain health insurance. Affordable Care Act's Medicaid expansion, which allows states to expand Medicaid eligibility to individuals under age 65 with family incomes up to 133 percent of the federal poverty level has expanded coverage to millions of additional low-income Americans. Through Medicaid 1115 waivers, CMS is committed to working with states to expand Medicaid in ways that work for them, while protecting the integrity of the program and those it serves.

This year, CMS finalized a long-anticipated rule that updates how Medicaid works for the nearly two-thirds of beneficiaries who get coverage through private managed care plans. These improvements modernize the way these managed care health plans operate so that Medicaid and CHIP continue to provide cost-effective, high quality care to consumers. The rule strengthens states' efforts to support delivery system reform and authorizes the first-ever Medicaid and CHIP quality rating system so that states can publicly report plan quality information, and people can use that information to select plans. It also deploys 21st century tools to improve beneficiary communications, like electronic notices to beneficiaries and creating online provider directories.

"CMS remains committed to creating a better health care system, with smarter spending and healthier people."

Improving Quality and Value in the Delivery System

CMS is committed to finding ways to deliver better care at lower costs. Today, over 55 million Americans are covered by Medicare— and 10,000 become eligible for Medicare every day. For most of the past fifty years, Medicare was primarily a fee-for-service payment system that paid health care providers based on the volume of services they delivered. In the last few years, we have made tremendous progress to transform our nation's health care system into one that works better for everyone by rewarding value over volume.

Key to this effort is changing how we pay physicians and other clinicians, so they can focus on the quality of care they give, and not the quantity of services they deliver or order. Already, we estimate that 30 percent of traditional Medicare payments are tied to alternative payment models (APMs). Generally speaking, an APM is a model that puts the outcome of the patient at the center and holds care teams accountable for the quality and cost of the care they deliver to a population of patients by providing a financial incentive to coordinate care for their patients. This can help patients receive the clinically appropriate care for their conditions and reduces avoidable hospitalizations, emergency department visits, adverse medication interactions, and other problems caused by inappropriate care or siloed care. Hospital and physician participation in APMs is a major milestone in the continued effort towards improving quality and care coordination.

CMS's ongoing work to implement the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) is also helping to move us to a system that rewards quality. MACRA, which replaced the Sustainable Growth Rate (SGR) formula with a more consistent way for paying physicians and other clinicians, provided new tools to modernize Medicare and simplify quality programs and payments for these professionals through the Quality Payment Program. The Quality Payment Program policy will reform Medicare payments for more than 600,000 clinicians across the country, and is a major step in improving care across the entire health care delivery system. The law accelerates our ongoing work to pay Medicare clinicians based on the quality of care they provide, not the number of tests or procedures they perform. CMS has been developing our approach toward implementation of the new law, and published a final rule informed by a months-long listening tour with nearly 100,000 attendees and nearly 4,000 public comments.

The new payment system creates two pathways which allow clinicians to pick the right pace for them to participate in the transition from a fee-for-service health care system to one that uses alternative payment models that reward quality of care over quantity of services. Clinicians will choose between two options. The first path gives clinicians the opportunity to be paid more for better care and investments that support patients. It reduces existing requirements, while still emphasizing and rewarding quality care. In the first year, it also provides a flexible performance period, so that those who are ready can dive in immediately, but those who need more time can prepare for participation later in the year. The second path helps clinicians go further by participating in organizations that get paid primarily for keeping people healthy. For example, they could be part of an Advanced Alternative Payment Model such as a Next Generation Accountable Care Organization where clinicians come together to coordinate high-quality care for the patients they serve. When they get better health results and reduce costs for the care of their patients, the clinicians receive a portion of the savings.

CMS remains committed to working with patients, caregivers, clinicians, and health care professionals on our shared goal of moving towards a future focused on patient care that pays for what works, reduces clinician burden, and better supports and engages the medical community.

Operational Excellence

CMS is committed to continually improving our systems and procedures to more efficiently administer our programs and be better stewards of taxpayer dollars. For example, MACRA will help us protect Medicare beneficiaries and the program from abuse by providing funding to remove social security numbers (SSN) from Medicare cards to protect the privacy of people enrolled in Medicare. CMS will eliminate the use of beneficiaries' social security numbers on Medicare cards by April 2019. CMS has begun the process to redesign Medicare cards, thus removing the current SSN-based identifier, known as the Health Insurance Claim Number (HICN), and replacing it with a Medicare Beneficiary Identifier (MBI). When this work is complete, for the first time, CMS will be able to terminate a Medicare number as soon as we confirm that is has been compromised and issue a new number to a beneficiary, similar to how credit card companies address stolen card numbers. Being able to immediately deactivate a compromised MBI will enable CMS to quickly respond and better prevent further misuse of a compromised number.

To further our efforts to gather more robust key eligibility, enrollment, program, utilization and expenditure data for Medicaid and CHIP, CMS is actively engaged with states to transition from the use of the Medicaid Statistical Information System (MSIS) to the Transformed MSIS (T-MSIS). With T-MSIS, states are now required to provide CMS with monthly files containing specified data elements for persons covered by Medicaid and CHIP. CMS will use this data for program monitoring, health care research and evaluation, program utilization and expenditure forecasting, responses to stakeholder inquires, and technical assistance to states. CMS is in the process of implementing T-MSIS with all states. As of September 2016, there are 18 states/entities submitting T-MSIS data. CMS anticipates T-MSIS data to be available for the various stakeholders in 2017 subject to state T-MSIS transition timelines.

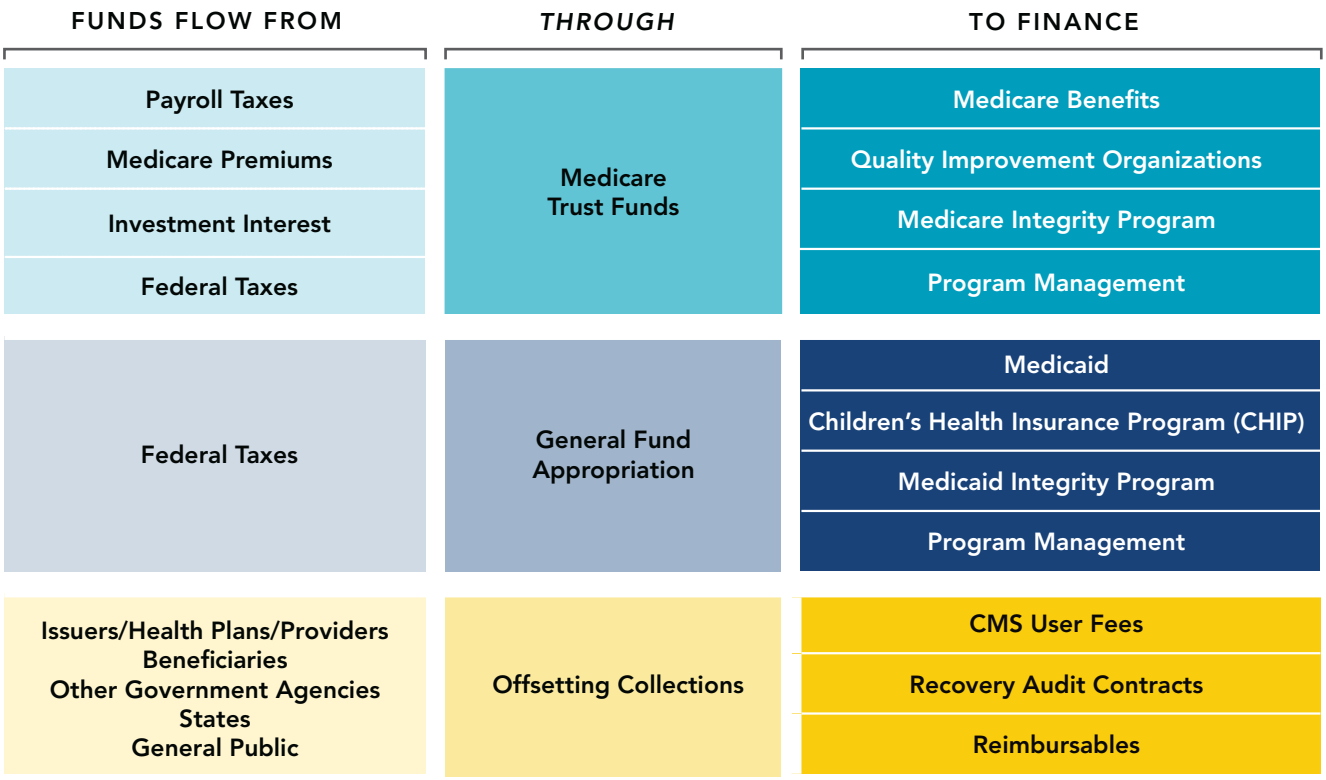
On October 1, 2015, the U.S. health care industry, including Medicare and all state Medicaid agencies, successfully transitioned to using the International Classification of Diseases (ICD-10) codes sets. Proper execution and good implementation by CMS led to a smooth transition for thousands of physicians and other clinicians around the country. CMS efforts included releasing provider training videos, targeted outreach to smaller physician practices, close partnerships with the American Medical Association (AMA), the American Hospital Association, the American Health Information Management Association, state medical societies, physicians and other clinicians, billing agencies, equipment suppliers, and a variety of stakeholders. In the first month of implementation, we received approximately 1,000 inquiries and responded to 100 percent of them within three business days.

These are just a few examples of what we've been able to accomplish this fiscal year. CMS remains committed to creating a better health care system, with smarter spending and healthier people. As more consumers gain access to care, we must continue to focus on the quality of care they receive and ensure that we are spending taxpayer dollars appropriately. Building on our success in transforming America's health care system and making quality, affordable insurance available to millions of Americans continues to be our priority.

ANDREW M. SLAVITT
CMS Acting Administrator

November 2016

FINANCING OF CMS PROGRAMS & OPERATIONS



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

APPROVED LEADERSHIP
as of September 30, 2016

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

1 MANAGEMENT'S DISCUSSION & ANALYSIS

Overview // Programs // Performance and Strategic Goals, Objectives, and Accomplishments // Overview of Financial Data

OUR MISSION

As an effective steward of public funds, CMS is committed to strengthening and modernizing the Nation's health care system to provide access to high quality care and improved health at lower cost.

OUR ORGANIZATION

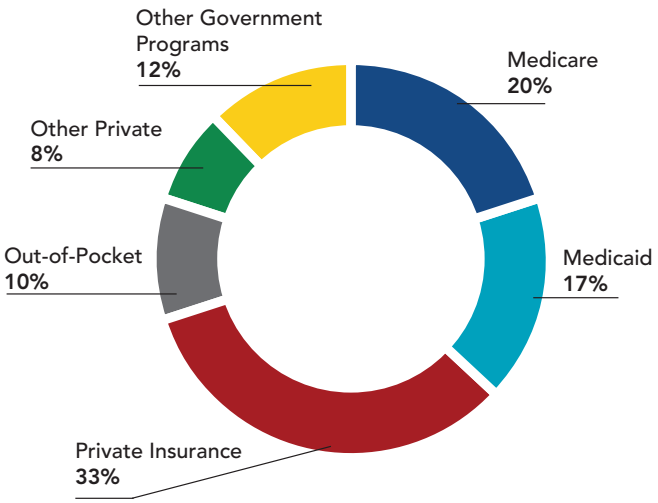
CMS, a component of the Department of Health and Human Services (HHS), employs approximately 6,500 federal employees in Maryland, Washington, DC, and 10 regional offices throughout the country. CMS provides direct services to state agencies, health care providers, beneficiaries, sponsors of group health plans, Medicare health and prescription drug plans, and the general public. Employees also 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. CMS also provides technical assistance to Congress, the Executive branch, universities, and other private sector researchers.

Many important activities for which CMS is responsible for are also handled by third parties. Each state administers the Medicaid program and Children's Health Insurance Program (CHIP), as well as inspects 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, the CHIP, and the Clinical Laboratory Improvement Amendments of 1988 (CLIA). With the passage of the Affordable Care Act, CMS's role in the larger health care arena has been further expanded beyond our traditional role of administering the Medicare, Medicaid, and CHIP Programs. The Affordable Care Act puts in place comprehensive health insurance reforms. Because of this law, all Americans have access to affordable health insurance options. The Marketplace allows individuals and small businesses the opportunity to compare health plans on a level playing field. Middle and low-income families receive advance payments of the premium tax credit that help make insurance coverage more affordable. The Medicaid program was expanded to cover more low-income Americans. These reforms mean that millions of people who were previously uninsured gain coverage and provide significant steps towards expanding coverage and improving access to health care, while also improving the quality and affordability of health care for all Americans. Over the last 50 years, CMS has evolved into the world's largest purchaser of health care.

THE NATION'S HEALTH CARE DOLLAR
FY 2016



Source: U.S. Treasury

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 2016 projections, Medicare and Medicaid (including state funding) represent 38 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, people with end-stage renal disease (ESRD) requiring

dialysis or kidney transplant, and people age 65 or older that elect Medicare coverage. The Medicare program was further expanded in 2003 to include a prescription drug benefit.

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 (Part C), and Medicare Prescription Drug Benefit (Part D). Since 1966, Medicare enrollment has increased from 19.1 million to approximately 57 million beneficiaries.

Hospital Insurance

Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically 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 don't 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, home health, 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 (DME), designated therapy, some outpatient prescription drugs, and other services not covered by HI such as some of the services of physical and occupational therapists. Part B helps pay for these covered services and supplies when they are medically necessary. The SMI coverage is optional, and beneficiaries are subject to monthly premium payments.

Medicare Advantage

The Medicare Prescription Drug Improvement and Modernization Act of 2003 created the Medicare Advantage (MA) program (also known as Medicare Part C), which is designed 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 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 prepaid 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 to beneficiaries. MA plans assume full financial risk for care provided to their Medicare enrollees.

In contrast, cost plans are paid a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the budget. Cost plans must provide all Medicare-covered services, and may also provide the additional services that some risk MA plans offer. Cost plan enrollees may receive services through the plan's network or through Original Medicare. Health Care Prepayment Plans are paid in a manner similar to cost contractors, but cover only non-institutional Part B Medicare services.

Medicare Prescription Drug Benefit

The Medicare Prescription Drug Benefit also known as Medicare Part D, is an optional prescription drug benefit for individuals entitled to benefits under Part A or enrolled in Part B created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. 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 a Medicare Advantage 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 and assistance with premiums and cost sharing is available to full benefit dual-eligible beneficiaries and other qualified low-income beneficiaries.

Medicaid

The Medicaid program is jointly funded by states and the Federal Government. CMS provides matching payments to the states and territories for Medicaid program expenditures and related administrative costs. Medicaid provides health coverage for millions of Americans, including

eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. In order to participate in Medicaid, federal law requires that states cover certain groups of individuals. States have additional options for coverage and may choose to cover other groups, such as individuals receiving home and community based services and children in foster care who are not otherwise eligible. The comprehensive health coverage that Medicaid provides allows individuals to access health care services that may not be affordable otherwise. 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 their Medicaid program differently, resulting in variations in Medicaid coverage across the country. States have flexibility in determining Medicaid benefit packages within federal guidelines. States are required to cover certain mandatory benefits and can choose to provide additional optional benefits.

The Affordable Care Act created the opportunity for states to expand Medicaid to cover nearly all low-income Americans under age 65. Eligibility for children was extended to families with income at least 133 percent of the federal poverty level (FPL) in every state (many states cover children up to higher income limits) and states were given the option to extend eligibility to adults with income at or below 133 percent of the FPL. The majority of states have chosen to expand coverage to adults, and those that have not yet expanded may choose to do so at any time. Now, Medicaid is the primary source of health care for more than 72 million beneficiaries, about 22 percent of the U.S. population. About 10 million people are dually eligible, that is, covered by both Medicare and Medicaid.

CHIP

CHIP was created through the Balanced Budget Act of 1997 and provides health coverage to low-income uninsured children and pregnant women whose income is too high to qualify for Medicaid. CHIP is administered by states, according to federal requirements. CMS works closely with the states, Congress, and other federal agencies to administer CHIP. The program is funded jointly by States and the Federal Government. CHIP funds cover the cost of insurance, reasonable costs for administration, and outreach services to get children enrolled. In FY 2016, an estimated 9.3 million children were enrolled in CHIP for at least one month during the year.

Title XXI of the Social Security Act outlines the program's structure, and establishes a partnership between the federal and state governments. States are given broad flexibility in designing their programs. They can create or expand their own separate CHIP programs, expand Medicaid, or combine both approaches. States set their own eligibility criteria regarding age, income, and residency within broad federal guidelines. They can choose to provide benchmark coverage, benchmark-equivalent coverage, or Secretary-approved coverage. Important cost-sharing protections in CHIP safeguard families from incurring unaffordable out-of-pocket expenses.

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.

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 269,773 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 program, regulatory and financial aspects of the CLIA program. This includes enrollment, regulation and policy development, approval of accrediting organizations, exempt states and proficiency testing providers, certificates and enforcement. The CDC provides research and technical support, and coordination of Clinical Laboratory Improvement Advisory Committee, and the FDA performs test categorization.

Marketplace

CMS is charged with implementing many of the provisions of the Affordable Care Act 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 Marketplaces 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 new rating requirements. CMS also oversees the implementation of rules related to medical loss ratio, a mechanism to help ensure that consumers receive a good value for their premium dollar and to make health insurance markets more transparent. CMS 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 monitoring all rate changes for non-grandfathered products in the individual and small group market and 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.

Consumer Information and Support

CMS continues to provide consumers with clear information about their coverage options. One avenue is via HealthCare.gov, which houses the Plan Finder—the first central database of health coverage options. The Plan Finder combines information about public programs with pricing and benefits information on the individual/family market and the small group market private insurance plans. HealthCare.gov offers consumers a trusted, noncommercial, user-friendly environment that allows consumers to compare plans, obtain information about products that were previously unavailable on commercial sites (such as the number of applicants denied for a specific plan), and weigh options related to cost sharing and covered and not covered benefits among various plans.

Premium Stabilization Programs

To more evenly spread the financial risk borne by issuers and help stabilize premiums, the Affordable Care Act establishes a transitional reinsurance program (section 1341), a permanent risk adjustment program (section 1343), and a temporary risk corridors program (section 1342), collectively referred to as the premium stabilization programs, to provide payments to health insurance issuers that cover higher-cost and higher-risk populations. These programs are intended to mitigate the potential impact of adverse selection and stabilize the price of health insurance in the individual and small group markets. These programs, together with other reforms of the Affordable Care Act, are making high-quality health insurance affordable and accessible to millions of Americans.

Reinsurance

Section 1341 of the Affordable Care Act established a transitional reinsurance program to stabilize premiums in the individual market inside and outside of the Marketplaces. The transitional reinsurance program collects contributions from

contributing entities to fund reinsurance payments to issuers of non-grandfathered reinsurance-eligible individual market plans, the administrative costs of operating the reinsurance program, and the General Fund of the Treasury for the 2014, 2015 and 2016 benefit years.

Risk Adjustment

The risk adjustment program, established by section 1343 of the Affordable Care Act, provides payments to health insurance issuers that attract high-risk enrollees, such as those with chronic conditions. The program also reduces the incentives for issuers to avoid those enrollees, and lessens the potential influence of risk selection on the premiums that plans charge. The program therefore incentivizes issuers to provide coverage with an appropriate level of benefits and services at an affordable premium. On June 30, 2016, CMS announced the determination of Risk Adjustment receipts (charges) and expenditures (payments), collectively known as transfers. Risk Adjustment is a budget neutral program, meaning payments must equal charges within a State market risk pool.

Risk Corridors

Section 1342 of the Affordable Care Act directs the Secretary to establish a temporary risk corridors program that protects against inaccurate rate setting in the 2014 through 2016 benefit years. The risk corridors program applies to qualified health plans (QHPs) in the individual and small group markets. The temporary risk corridors program protects QHPs from uncertainty in rate setting from 2014 to 2016 by limiting the extent of issuer losses and gains. HHS/CMS established a three-year payment framework for the risk corridors program. Under this framework, if risk corridors claims exceed collections for a given benefit year, payments are reduced pro rata, with any shortfall in payments made up from collections from later benefit years.

PERFORMANCE AND STRATEGIC GOALS, OBJECTIVES, AND ACCOMPLISHMENTS

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 programmatic objectives to our partners, such as states and national professional organizations, and to the public. 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 agencies have strategic plans, annual performance goals, and annual performance reports that make them accountable stewards of public programs. CMS's performance measures are included in the Annual Performance Report. HHS released a **FY 2014 – 2018 Strategic Plan**, (http://www.hhs.gov/strategic-plan/priorities.html) as required by the GPRA Modernization Act of 2010 (GPRAMA). Consistent with GPRA principles, the CMS FY 2015 performance plan is structured to reflect the HHS mission: To enhance the health and well-being of Americans by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health and social services. Our measures link to the HHS Strategic Goal 1: Strengthen Health Care and Goal 4: Ensure Efficiency, Transparency, Accountability and Effectiveness of HHS programs. We look forward to the challenges represented by our performance goals and are optimistic about our ability to meet them.

Our FY 2016 performance measures track progress in our major program areas 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. We continue to develop metrics to track progress of health reform efforts as we work to make affordable health insurance available to all Americans. Detailed information and available results about the FY 2016 measures are included in the **FY 2017 HHS Annual Performance Plan and Report** (http://www.hhs.gov/about/budget/performance/index.html) and progress on our measures will be reported through the FY 2018 President's Budget process.

CMS's STRATEGIC PLAN

CMS's Strategic Plan directly aligns with the HHS strategic plan and helps our agency with fulfilling our mission and achieving our vision of a high quality health care system that ensures better care, access to coverage and improved health. CMS's four Strategic Goals and seven Strategic Objectives cut across programs and support functions throughout agency and are:

GOALS

1. **Better Care and Lower Costs**
2. **Prevention and Population Health**
3. **Expanded Health Care Coverage**
4. **Enterprise Excellence**

OBJECTIVES

1. **Improve Quality of Care**
2. **Improve Preventive Health Benefits**
3. **Strengthen Consumer Protections**
4. **Expand Coverage**
5. **Improve Payment Models**
6. **Strengthen Program Integrity**
7. **Transform Business Operations**

Meeting these goals and objectives requires collaboration across CMS. Below is a discussion of some of the major initiatives and accomplishments aimed at achieving the desired outcomes of our strategic plan.

Better Care and Lower Costs

CMS is fully committed to improving the quality and affordability of care received by all Americans. We have been working diligently to ensure that Americans receive better care and that we are spending our health care dollars more wisely. Our efforts to reach this goal are measured by finding better ways to deliver the best possible care at the lowest possible costs to our beneficiaries, pay providers effectively, and share and utilize information more efficiently, thereby reducing health care costs. Some of these efforts are briefly described below.

The Medicare Access and CHIP Reauthorization Act of 2015

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) makes many improvements to the health care system by ending the Sustainable Growth Rate formula for determining Medicare payments for health care professionals' services; introducing a new framework for rewarding health care providers for giving better, smarter care – not just more care; and combining our existing quality reporting programs into one new system. These proposed changes replace a patchwork system of Medicare reporting programs with a flexible system with two paths linking quality to payments, the Merit-Based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APMs). MACRA also requires CMS to develop and post a Quality Development Plan that gives a framework for making clinician quality measures to support the MIPS and APMs.

CMS Equity Plan for Improving Quality in Medicare

CMS published its first health equity plan in late FY 2015 and began implementation in FY 2016. This plan provides a comprehensive and solution-driven approach for increasing understanding of health disparities, creating solutions to achieve health equity, and for accelerating the implementation of sustainable actions. **CMS Equity Plan for Improving Quality in Medicare** FY 2016 accomplishments include the release of the **Mapping Medicare Disparities (MMD) Tool, Disparities Action Statement (DAS) tool, and the publication of the *Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries***. The MMD tool is an interactive web-based map that displays data on Medicare FFS beneficiaries' health care utilization, cost, disease prevalence and readmissions by racial and ethnic group, dual eligibility, gender, and age at the county and state level. The DAS is CMS's first health equity-focused quality improvement tool with steps that organizations can follow to identify health disparities in their service areas, set goals for addressing health disparities, test solutions, and monitor progress. The Readmissions Guide provides an overview of issues related to readmissions among racially and ethnically diverse Medicare beneficiaries, a set of activities that can

help hospitals take action to address readmissions, and case studies of initiatives that are reducing readmissions in diverse populations.

Medicare Advantage Quality Measures

In April 2016, CMS released **Medicare Advantage quality measures stratified by race and ethnicity** at national and contract levels. This is the first time CMS has released data stratified by race and ethnicity (and is a significant step in helping to achieve health equity). The report provides data on eight patient experience measures and 27 clinical care measures to increase understanding and awareness of disparities across these 35 measures so that organizations can develop solutions and take action to reduce or eliminate these disparities. In addition, CMS launched a new set of tools to guide health plans in their response to disparities.

Medicare Shared Savings Program

In January 2015, the Secretary announced an ambitious goal of tying 30 percent of Medicare FFS payments to quality and value by 2016 and by 2018 making 50 percent of payments through alternative payment models, such as the Medicare Shared Savings Program (MSSP). CMS is making significant progress toward the goal announcing that it met the ambitious goal eleven months ahead of schedule. As of January 1, 2016, over 430 Accountable Care Organizations (ACOs) are serving more than 7.7 million Medicare beneficiaries. CMS has released quality and financial performance results for the initial three performance years of the program. These results show ACOs making significant improvements in the quality of care for Medicare beneficiaries, while achieving cost savings.

Value-Based Payment Modifier

The Value-Based Payment Modifier (Value Modifier) Program adjusts Medicare Physician Fee Schedule (PFS) payments to a physician or group of physicians based on the quality and cost of care furnished to their Medicare FFS beneficiaries. The Value Modifier payment adjustment is applied to each claim billed under the PFS and can be an upward, neutral or downward payment adjustment factor that is determined after the close of the performance period. The upward adjustment factor is announced prior to the beginning of the payment adjustment year. It is based on the estimated aggregate amount of downward payment adjustments for failure to report quality data or poor performance. Physician groups and physician solo practitioners can find information about their quality and cost performance in their Annual Quality Resource and Use Reports. The Value Modifier sunsets after 2018 and is replaced by the Merit-Based Incentive Payment System established under MACRA.

Hospital Value-Based Purchasing

The Hospital Value-Based Purchasing (VBP) Program rewards hospitals for the quality and efficiency of care they provide. The Hospital VBP Program does not increase overall Medicare spending for inpatient stays in acute care hospitals; rather it reduces the base operating diagnosis-related group payment amounts that determine the Medicare payment for each hospital inpatient discharge to fund the aggregate incentive payments. The law set the payment reduction at one percent in FY 2013, raising it to two percent by FY 2017. Under the Hospital VBP Program, CMS evaluates hospitals' performance during a performance period based on both achievement and improvement on selected measures. Hospitals receive points on each measure based on the higher of their level of achievement relative to an established standard or their improvement in performance from their performance during a prior baseline period.

Home and Community Based Services

The Home and Community Based Services (HCBS) Experience of Care (EoC) survey, developed under the Testing Experience and Functional Tools (TEFT) grant, was awarded the Consumer Assessment of Healthcare Providers and Systems (CAHPS) trademark in June 2016. The CAHPS HCBS Survey can be used by states, providers and health plans to elicit feedback on beneficiaries' experience with the services provided through Medicaid HCBS programs. It is designed as a cross-disability survey and intended for use with beneficiaries in the various community-based long-term services and support programs serving people with all types of disabilities including frail elderly individuals, persons with physical disabilities those with intellectual and/or developmental disabilities persons with acquired brain injury and persons with severe mental illness. Results can be used to assess and improve program quality.

Medicaid Innovation Accelerator Program

CMS's Medicaid Innovation Accelerator Program (IAP) is a collaborative, internal cross-component initiative to promote transformation in state Medicaid delivery and payment systems. The goal of IAP is to improve the care and health of Medicaid beneficiaries and to reduce costs by supporting states' ongoing service delivery and payment reforms through targeted technical

support. IAP works closely with state Medicaid agencies to build capacity in key program and functional areas by offering targeted technical support, tool development, and cross-state learning opportunities. As of June 2016, IAP has engaged 50 states and the District of Columbia (DC) through its two web-based learning series and 28 states through direct technical support opportunities.

Prevention and Population Health

The availability of preventive benefits and necessary health services directly impacts one's health status because it can help prevent or reduce the onset of disease or illness, thus enhancing the quality of life. CMS has continued to address the areas of prevention and population health by improving preventive health benefits and closing the gap on access to care. Many initiatives, some are described below, are underway at CMS to ensure that all Americans are healthier, and their care is less costly because of improved health status resulting from the use of preventive benefits and necessary health services.

Medicaid Prevention Learning Network

In order to encourage states to expand coverage of and focus on prevention, CMS established the Medicaid Prevention Learning Network (MPLN). The MPLN provides an opportunity for state Medicaid programs to engage in state-to-state learning and receive enhanced technical assistance to improve delivery of preventive healthcare in Medicaid and CHIP. The MPLN includes affinity groups that have focused on prevention topics of common interest to states. To date, there have been affinity groups on Tobacco Cessation, Diabetes Prevention and Management, Antipsychotic Drug Use in Children, and HIV Health Improvement.

Diabetes Prevention Program

Type II diabetes is at epidemic levels in the Medicare population, affecting more than 25 percent of Americans aged 65 or older. To address this issue, CMS recently proposed to expand the Diabetes Prevention Program (DPP) model for all eligible Medicare beneficiaries. The program provides a 12-month, CDC-approved evidence-based lifestyle intervention delivered in community settings by trained coaches. The 2017 Medicare Physician Fee Schedule proposed rule, published in July, outlines the policy and operation proposals for the Medicare DPP.

CMS Innovation Center's Million Hearts® Cardiovascular Risk Reduction Model

The CMS Innovation Center's Million Hearts® Cardiovascular Risk Reduction Model (known as the MH Model) is part of the broader Million Hearts® Initiative, a collaboration between CMS, the CDC and several private partners who have come together with the common goal of preventing 1 million heart attacks and strokes across the nation by 2017. Under the MH Model, participating Intervention Group healthcare practitioners are tasked with reducing the risk for heart attacks and strokes among high-risk Medicare beneficiaries.

Expanded Healthcare Coverage

CMS is leading the charge in setting and enforcing standards for health insurance that promote fair and reasonable practices to ensure that affordable, quality health coverage is available to all Americans. We also provide consumers with comprehensive information on coverage options currently available so they may make informed choices on the best health insurance for their family. CMS continually seeks innovative approaches to improve access to affordable health insurance options that protect all Americans from financial hardship and ensure quality healthcare coverage.

Affordable Care Act

The Affordable Care Act emphasized the importance of prevention by expanding coverage of preventive services without cost sharing for millions of Americans.

- **Private Health Insurance:** section 2713 of the Affordable Care Act, requires that private health plans, with the exception of grandfathered plans, provide coverage without cost sharing of preventive services that are recommended by either the U.S. Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration's (HRSA's) Bright Futures Project, and HRSA and the Institute of Medicine (IOM) Committee on Women's Clinical Preventive Services.

- **Medicare:** sections 4103 and 4104 of the Social Security Act expanded coverage of recommended preventive services within the Medicare program without cost sharing. Specifically, section 4103 added an annual well visit without cost-sharing, and section 4104 eliminated the cost sharing for both the Initial Preventive Physical Examination (Welcome to

Medicare Visit) and for all USPSTF recommended preventive services.

- **Medicaid:** The Affordable Care Act expanded coverage of preventive services for adults.
  - **Adult Group Expansion:** The alternative benefit plan includes coverage of preventive services that are recommended by either the USPSTF, the ACIP, the HRSA's Bright Futures Project, and HRSA and the IOM Committee on Women's Clinical Preventive Services without cost sharing.
  - **Traditional Medicaid coverage:** States have the option to expand coverage of preventive services for adults who receive Medicaid coverage through other eligibility groups like the parent group. Under section 4106 of the Affordable Care Act, a state that chooses to provide coverage of the USPSTF recommended services, the recommended ACIP vaccines and their administration without cost sharing can receive a 1 percent increase in the federal medical assistance percentage for these preventive services. To date, 11 states have chosen this option.

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 2016, C2C released (post-open enrollment) resources to increase consumer connections to primary care and free, preventive services. In partnership with federal partners, C2C launched 10 prevention resources to increase awareness of free, preventive services and the importance of prevention. CMS also released two new C2C resources in Spring 2016: (1) **5 Ways to Make the Most of Your Health Coverage** a quick reference on how individuals can make the most of their health coverage, available in multiple languages, and (2) a **Partner Toolkit** with sample language for blogs and drop-in articles, social media graphics, and more assistance in English and Spanish, designed for community partners to adapt C2C messaging and health insurance literacy information into their own outreach and education work.

Alternative Benefit Plan

CMS continues to expand Medicaid coverage through the Alternative Benefit Plan (ABP). The Affordable Care Act's newly eligible adult group has allowed many states to increase the number of individuals receiving Medicaid benefits. While the majority of states launched expansion programs from 2012-2015, states continue to expand Medicaid coverage through the ABP. Most recently Louisiana was approved in April 2016, to expand their Medicaid program for newly eligible adults.

Enterprise Excellence

CMS defines "Enterprise Excellence" as aligning their programs and business functions across the agency to achieve the CMS strategic vision. We are focused on measurably improving and transforming the U.S. health care system into an integrated and accountable delivery system that continuously improves care, reduces unnecessary costs, prevents illness and disease progression, and promotes health. CMS will achieve "Enterprise Excellence" through high quality work performed by a strong diverse workforce that develops, supports and utilizes innovative strategies, tools, and processes; and collaborates effectively with its partners and agents to reach and accomplish its goals.

Fraud Prevention System

The Fraud Prevention System (FPS) has run predictive algorithms and other sophisticated analytics nationwide against all Medicare FFS claims on a continuous basis prior to payment in order to identify, prevent, and stop potentially fraudulent claims. The FPS assists CMS to target fraudulent providers and suppliers, reduce the administrative and compliance burdens on legitimate providers and suppliers, and prevent fraud so that funds are not diverted from providing beneficiaries with access to quality health care. The FPS helped identify or prevent $604.7 million in inappropriate payments through investigations expedited, augmented, or corroborated by the FPS. Since implementation, the FPS has identified or prevented over $1.4 billion in inappropriate payments by the identification of new leads or through its contributions to existing investigations.

Provider Enrollment and Chain Ownership and National Plan and Provider Enumeration System Improvements

Provider Enrollment and Chain Ownership System (PECOS) is the internet-based system that providers and suppliers use to enroll, revalidate, or make changes to their enrollment information in the Medicare fee-for-service program. CMS made significant improvements to the system to make it easier for providers and suppliers to access and use the system. CMS engaged providers and suppliers regularly in FY 2016 to better understand the challenges users face and prioritized the improvements based upon the information learned

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through; 1) Sponsoring quarterly focus groups with providers and suppliers; 2) Attending sponsored outreach events (e.g., Decision Health); 3) Holding Open Door Forums with providers and suppliers; and 4) Conducting education and outreach through listservs, CMS.gov, PECOS homepage, Medicare Learning Network Matters Articles, change requests and national provider calls. Also in FY 2016, CMS made significant changes to PECOS to simplify access and improve the usability of the system, including; 1) Enhanced address verification software in PECOS to better detect vacant or invalid addresses or commercial mail reporting agencies (CMRA); 2) Migrated PECOS Administrative Interface to Enterprise Portal for authentication bringing stability to environment; and 3) Implemented the production of customized reporting and data downloads for PECOS that enables Extract consolidation.

CMS also released the new National Plan and Provider Enumeration System (NPPES) Registry. This was a major milestone in the NPPES Modernization project. The NPPES is the system that supplies National Provider Identification (NPI) numbers to healthcare providers, maintains their NPI record, and publishes the records online. The registry is the searchable portion of NPPES, also unofficially named the "Public Search." The Registry publishes the information in NPPES, for free and anonymous public view. It also offers the data in downloadable files, and through an Application Programming Interface. Highlights of the new registry included a redesign to be consumer-oriented and has an open source tech platform with simpler layouts, faster performance and unlimited search results.

Medicare National Correct Coding Initiative

The Medicare National Correct Coding Initiative (NCCI) (also known as CCI) was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI Procedure-to-Procedure (PTP) code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services. In addition to PTP code pair edits, the NCCI includes a set of edits known as Medically Unlikely Edits (MUEs). An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) code billed by a provider on a date of service for a single beneficiary. The use of procedure-to-procedure edits developed through the NCCI saved the Medicare program $393.9 million in FY 2016. In addition, MUE edits within Medicare Part B and DME saved the Medicare program an estimated $222.1 million during the first nine months of FY 2016.

Zone Program Integrity Contractors

Zone Program Integrity Contractors (ZPICs) develop investigations and identify improper payments to prevent Medicare Trust Fund monies from being inappropriately paid to Medicare providers. During the first nine months of FY 2016, the ZPICs saved an estimated $462.6 million in potentially improper payments by taking appropriate action to initiate collection, prevent payment to Medicare providers and suppliers, or refer cases to law enforcement. Of this total amount, the ZPIC investigations resulted in revoking billing privileges that avoided an estimated $239 million in improper payments. The ZPICs worked with the MACs to implement automatic denials or prepayment reviews on the providers' and suppliers' billing that stopped an estimated $61.4 million from being inappropriately paid to these Medicare providers and suppliers. CMS estimates that the ZPICs saved the Medicare Trust Funds another $20.8 million by implementing payment suspensions during the first nine months of FY 2016.

Recovery Audit Programs (Medicare FFS, Medicaid, and Part D)

CMS also continues to monitor and make continuous enhancements to the Recovery Audit Program. During the first nine months of FY 2016, the Medicare FFS recovery auditors saved the Medicare program an estimated $232.7 million in improper payments. There were $333.5 million collected in overpayments and $101 million in identified underpayments paid back to providers. The Medicare Secondary Payer (MSP) Commercial Repayment Center (CRC) contractor continues to report substantial savings to the Medicare Trust Fund. The CRC identified approximately $243.68 million and collected $106.29 million in mistaken payments in FY 2016. Additionally, the Part D recovery auditor contractors recouped approximately $1.8 million in FY 2016. In addition, notifications of improper payment were sent to plan sponsors in FY 2016 totaling approximately $7.9 million; recoupments are expected to continue in FY 2017.

The Affordable Care Act also required states to establish Medicaid Recovery Audit contractor programs by submitting state plan amendments. As of the end of FY 2016, 47 states and the District of Columbia had implemented Medicaid RAC programs. Four states currently have HHS-approved exceptions to Medicaid RAC implementation due to small beneficiary populations or high managed care penetration. For the first nine months of FY 2016, states reported a total combined federal and state share amount of Medicaid RAC recoveries of $68.1 million and returned the federal share of $39.1 million to the Treasury.

Healthcare Fraud Prevention Partnership

The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary, public-private partnership consisting of the Federal Government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations. The purpose of the HFPP is to improve the detection and prevention of healthcare fraud, waste, and abuse by: 1) Exchanging data and information between the public and private sectors; 2) Leveraging various analytic tools against data sets provided by HFPP partner organizations; and 3) Providing a forum for public and private leaders and subject matter experts to share successful practices and effective methodologies for detecting and preventing healthcare fraud, waste, and abuse. In FY 2016, the HFPP reached a membership level of 70 partner organizations, representing over 65 percent of covered lives within the United States, and an increase of 30 percent since FY 2015. The amount of data collected in support of studies has increased by 300 percent in FY 2016, leading to the performance of new studies, the replication of prior studies with new data, and the attainment of actionable leads.

Medicare Drug Integrity Contractors

There are two Medicare Drug Integrity Contractors (MEDICs), each with distinct responsibilities related to Medicare Advantage and Part D benefits. The National Benefit Integrity (NBI) MEDIC is responsible for processing and tracking all Medicare Advantage and Part D complaints, requests for information, proactive data analysis, conducting investigations, and referrals to law enforcement. The Outreach and Education MEDIC is responsible for conducting outreach and education activities for Medicare Advantage and Part D stakeholders. During the first nine months of FY 2016, NBI MEDIC referrals have resulted in sentences ordering restitution of $72.4 million and $900 thousand in civil settlements, according to FY 2016 notifications from law enforcement. The NBI MEDIC was responsible for assisting the HHS Office of Inspector General (OIG) and the Department of Justice, through data analysis and investigative case development, in achieving convictions, arrests, and indictments from FY 2016 notifications. As a result of the NBI MEDIC's data analysis projects, HHS recovered $78.5 million during the first nine months of FY 2016 from Part D sponsors.

Transition to Cloud Services – Email as a Service Initiative

Consistent with the **Federal Cloud Computing Strategy**, the Federal Information Technology Acquisition Reform Act driven by Federal Data Center Consolidation Initiative guidance established under OMB M-15-14, along with other mandates, CMS undertook and accomplished a key information technology strategic initiative aimed at supporting business operations transformation. Through a collaborative engagement with the HHS, CMS successfully transitioned our legacy government owned/contractor operated email system to a Government Community Cloud hosted by a commercial provider of cloud computing services. The implemented solution included all commercial cloud computing and support services required to transition, deploy, operate, maintain, and safeguard an enterprise-wide email and collaboration environment. By moving email services—one of the principle means of business

communications—to a cloud-based technology platform and advancing the state of IT technology to support cross departmental collaboration, business transformation opportunities and value associated with efficiency, agility, innovation and cost savings were delivered.

Cybersecurity and Privacy Program

During FY 2016, CMS continued to make strides to strengthen cybersecurity and privacy across the agency. By creating the CMS cybersecurity and privacy strategy and defining four strategic outcomes, CMS is positioned to respond rapidly and efficiently to cyber-attacks, create an agile and innovative enterprise security architecture, achieve full operational visibility of sensitive assets and data and drive towards a risk based governance and engagement model. FY 2016 initiatives and accomplishments were driven by the FY 2016 program plan. The plan included three primary goals focused on accountability, governance and responding to evolving threats. The accomplishments achieved in FY 2016 have led to the continued transformation of the agencies cybersecurity and privacy program as we chart a course to be a leader across HHS and the Federal Government. Specific activities included:

- Leveraging the Beneficiary Data Protection Initiative to raise the cybersecurity and privacy risk awareness of all staff and contractors. The initial effort focused on cyber threats encountered during our everyday work, such as malicious emails received by staff. Through an in-depth training and exercise program, the agency has increased our average success rate to over 98 percent;
- Implementing the Cybersecurity Risk Advisor (CRA) role to streamline the center/office experience of implementing information security and privacy policy and guidance. The CRA represents the interests of the Chief Information Security Officer and the Chief Information Officer and works to evaluate and achieve an acceptable level of security and privacy risk to CMS. CRAs ensure centers and offices have a single point-of-contact for communication, education, and compliance information;
- Aligning privacy specialists to support the CRA role in the evaluation of acceptable levels of risk for the collection, use, storage, and disclosure of sensitive information across CMS;
- Promoting proper protections and compliance when handling sensitive information; personally identifiable information, protected health information, and federal tax information while ensuring transparency to consumers and beneficiaries;
- Evolving CMS's information security continuous monitoring maturity to integrate federal continuous diagnostics and monitoring, and laid the groundwork for ongoing authorization;
- Conducting enhanced security assessments starting with the organization's high value assets;
- Integrating processes to track and report on the quality, progress, and status of finding remediation efforts to ensure information security and privacy weaknesses from IT audits, Security Control Assessments, and penetration tests are addressed promptly and completely; and
- Creating a strategic security operations plan to gain visibility, detection, protection, and response capability for all Federal Information Security Management Act systems across the CMS enterprise.

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 Officer's 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 management of CMS. 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, 2016 and 2015, 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 $446 billion. The bulk of these assets are in Investments totaling $258.4 billion, which are invested in Treasury Special Issues, special public obligations for exclusive purchase by the Medicare Trust Funds. Trust fund holdings not necessary to meet current expenditures are invested in interest-bearing obligations of the U.S. or in obligations guaranteed as to both principal and interest by the U.S. The next largest asset is the Fund Balance with Treasury of $140 billion, most of which is for Medicaid, Other Health, and CHIP. Liabilities of $137.3 billion consist primarily of the Entitlement Benefits Due and Payable of $108.2 billion. CMS's net position totals $308.7 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, 2016 and 2015. The three major programs that CMS administers are: Medicare, Medicaid, and CHIP. The majority of CMS's expenses are allocated to 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 all three major components. 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 funds from dedicated collection vs. other fund components of net cost as additional information. In FY 2016, our total net cost of operations were $953.1 billion encompassing total Benefit Payments of $1,037 billion and Administrative Expenses of $8.3 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, 2016 and 2015. 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 $698.5 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. Medicaid and CHIP are financed by a general fund appropriation provided by Congress. Employment tax revenue is Medicare's portion of payroll and self-employment taxes collected under

the Federal Insurance Contributions Act and Self Employment Contributions Act (SECA) for the HI Trust Fund, and totaled $250.5 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, 2016 and 2015. An additional Schedule of Budgetary Resources is provided as Required Supplementary Information to present each budgetary account. 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 $1,518.3 billion ($656 million in non-budgetary). Obligations of $1,469.5 billion ($32 million in non-budgetary) leave unobligated balances of $48.8 billion ($624 million in non-budgetary). Total outlays, net of collections, were $1,409.2 billion. When offset by $427.3 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 $981.9 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 2016 *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:

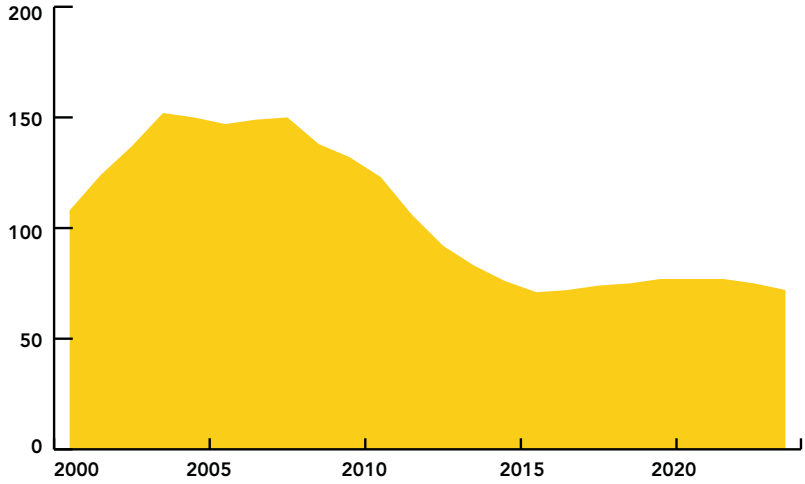
- The present value of future income (income excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income to be received from or on behalf of current 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 $(3.2) trillion, determined as of January 1, 2015, to $(3.8) trillion, determined as of January 1, 2016.

Including the combined HI and SMI Trust Fund assets increases the present value, as of January 1, 2016, of future cash flow for all current and future participants to $(3.6) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI Trust Fund assets, is $(10.2) 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 95 percent at the beginning of FY 2012 to 67 percent at the beginning of FY 2016.

HI TRUST FUND RATIO



Source: CMS/OACT

TRUST FUND RATIO

Beginning of Fiscal Year[2]

	2012	2013	2014	2015	2016
HI	95%	86%	77%	73%	67%

Short-Term Financing: The HI Trust Fund is deemed adequately financed for the short term when actuarial estimates of trust fund assets for the beginning of each calendar year are at least as large as program obligations for the year. Estimates in the 2016 Trustees Report indicate that the HI Trust Fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2016 Trustees Report, the HI Trust Fund ratio is estimated to continue decreasing through 2025 and remain at approximately 70 percent through 2022. From the end of 2015 to the end of 2020, assets are expected to increase, from $194 billion to $217 billion, but then decrease to $138 billion by the end of 2025.

Long-Term Financing: The short-range outlook for the HI Trust Fund has worsened as compared to what was projected last year. After 2020, the trust fund ratio starts to decline quickly until the fund is depleted in 2028, two years earlier than projected last year. HI financing is not projected to be sustainable over the long term with the tax rates and expenditure levels projected. 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 87 percent in 2028 to 79 percent in 2040 and then to increase to about 86 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 2015 to about 2.1 by 2090. 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 $3.6 trillion, which is 0.7 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.

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

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 general revenues 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 is expected to occur consistently thereafter. 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 $(28.6) 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 2015, SMI expenditures were 2.1 percent of GDP. By 2090, SMI expenditures are projected to grow to 3.8 percent of the GDP.

The following table presents key amounts from our basic financial statements for fiscal year 2014 through 2016.

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.

TABLE OF KEY MEASURES[3]

DOLLARS IN BILLIONS

	2016	2015	2014
Net Position (end of fiscal year)			
Assets	$446.0	$418.6	$380.0
Less Total Liabilities	$137.3	$129.1	$104.7
Net Position (assets net of liabilities)	$308.7	$289.5	$275.3
Costs (end of fiscal year)			
Net Costs	$953.1	$913.8	$837.8
Total Financing Sources	$960.1	$910.3	$820.4
Net Change in Cumulative Results of Operations	$7.0	$(3.5)	$(17.4)
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	$(3,822)	$(3,187)	$(3,823)
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	$(3,187)	$(3,823)	$(4,772)
Change in present value	$(635)	$636	$949

[3] 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.

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, 2016, decreased by $169 billion due to advancing the valuation date by one year and including the additional year 2090, by $289 billion due to changes in the projection base, and by $366 billion due to the changes in economic and health care assumptions. However, changes in demographic assumptions and legislation changes increased the present value of future cash flows by $182 billion and $6 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 Required Supplementary Information (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 *2016 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 Required Supplementary Information section is unique to federal financial reporting. This section is required under OMB Circular A-136, *Financial Reporting Requirements*, and is unaudited.

2

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) 2016. As the newly appointed Chief Financial Officer, I take great pleasure in announcing our receipt of an unmodified opinion from our independent auditors on four of our six principal financial statements for the 18th straight year. I would like to recognize the ongoing dedication and commitment to excellence of our financial management community at CMS for making this happen. CMS takes very seriously its commitment to financial excellence by ensuring the highest level of integrity and transparency of our financial data.

Due to the uncertainty of the long-range assumptions used in the Statement of Social Insurance (SOSI) model, our auditors were not able to express an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts. CMS continues to be confident that our FY 2016 SOSI projections are fairly represented and properly disclose the purpose of these projections. We are collaborating closely 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.

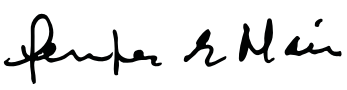
Under the requirements of the Federal Managers' Financial Integrity Act (FMFIA), and further supported by the results of our annual financial statement audit, we continue to provide reasonable assurance that our internal controls are sound and report no material weaknesses. Although no material weaknesses were detected in our internal control structure, internal control deficiencies were identified, and we will make it a top priority to correct these deficiencies. We recognize that continuous improvement is necessary to mitigate any identified risks. We demonstrate our commitment to excellence by acknowledging that strong internal controls are imperative to reliable financial management.

We strive to be responsible financial stewards of public funds and recognize the high level of accountability and transparency required to further our mission of spending taxpayer dollars wisely, preventing waste, and reducing costs while ensuring access to high quality healthcare for our beneficiaries. Throughout 2016, we have been diligently working to ensure that we are on track for compliance with all of the requirements of the Digital Accountability and Transparency (DATA) Act of 2014. The DATA Act aims at making Federal spending data more accessible, searchable, and reliable by consistently reporting data across the Federal Government. It will make it easier for the public to understand how the Federal Government spends taxpayer dollars and will also serve as a tool for better oversight, data-centric decision-making, and innovation both inside and outside of government.

Ensuring the solvency of our trust funds is another high priority for CMS. In FY 2016, we took further action to safeguard the assets in these funds. We continue to enhance our processes for collecting debts owed to CMS and the Federal Government. Medicare Secondary Payer provisions are designed to protect the Medicare Trust Funds by ensuring that Medicare does not pay for items and services that certain health insurance coverage is primarily responsible for paying. In addition to these administrative efforts to enhance our debt collection processes, CMS continues to strengthen its fraud, waste, and abuse efforts by assisting HHS and the Department of Justice in executing the Health Care Fraud and Abuse Control Program.

In closing, I would again like to recognize the ongoing dedication and commitment to excellence of our financial management team. This report and the accomplishments described within are a reflection of our loyal and dedicated employees, partners, and taxpayers. I would like to thank all who contributed.

Thank you for your interest in our FY 2016 Agency Financial Report.



JENNIFER MAIN
CMS Chief Financial Officer

November 2016

CONSOLIDATED BALANCE SHEETS

as of September 30, 2016 and September 30, 2015

(IN MILLIONS)

	FY 2016 Consolidated Totals	FY 2015 Consolidated Totals
ASSETS		
Intragovernmental Assets:		
Fund Balance with Treasury *(Note 2)*	$140,047	$128,534
Investments *(Note 3)*	258,371	266,045
Accounts Receivable, Net *(Note 4)*	589	635
Other Assets *(Note 5)*	28	25
TOTAL INTRAGOVERNMENTAL ASSETS	**399,035**	**395,239**
Accounts Receivable, Net *(Note 4)*	23,579	20,860
General Property, Plant and Equipment, Net	746	905
Other Assets *(Note 5)*	22,668	1,621
TOTAL ASSETS	$446,028	$418,625
LIABILITIES		
Intragovernmental Liabilities:		
Accounts Payable	$625	$427
Accrued Payroll and Benefits	9	8
Other Intragovernmental Liabilities	4,869	1,341
TOTAL INTRAGOVERNMENTAL LIABILITIES	5,503	1,776
Accounts Payable	272	142
Federal Employee and Veterans' Benefits	11	12
Entitlement Benefits Due and Payable *(Note 6)*	108,230	108,149
Accrued Payroll and Benefits	82	77
Contingencies *(Note 7)*	10,826	7,540
Other Liabilities	12,355	11,472
TOTAL LIABILITIES *(Note 8)*	$137,279	$129,168
NET POSITION		
Unexpended Appropriations–Dedicated Collections *(Note 10)*	$36,012	$30,284
Unexpended Appropriations–Other Funds	46,847	40,353
TOTAL UNEXPENDED APPROPRIATIONS	82,859	70,637
Cumulative Results of Operations–Dedicated Collections *(Note 10)*	227,156	215,354
Cumulative Results of Operations–Other Funds	(1,266)	3,466
TOTAL CUMULATIVE RESULTS OF OPERATIONS	225,890	218,820
TOTAL NET POSITION	$308,749	$289,457
TOTAL LIABILITIES AND NET POSITION	$446,028	$418,625

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF NET COST

for the years ended September 30, 2016 and September 30, 2015

(IN MILLIONS)

	FY 2016 Consolidated Totals	FY 2015 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS		
GPRA Programs		
Medicare (Dedicated Collections)	$566,114	$547,135
Medicaid	363,060	349,877
CHIP	14,579	9,105
Net Cost: GPRA Programs	943,753	906,117
Other Activities		
State Grants and Demonstrations	519	601
Other Health	3,168	4,465
Other	5,620	2,643
Net Cost: Other Activities	9,307	7,709
NET COST OF OPERATIONS *(Notes 9, 11, and 16)*	$953,060	$913,826

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.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2015

(IN MILLIONS)

	Consolidated Dedicated Collections	Consolidated Other Funds	FY 2015 Consolidated Total
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	**$220,795**	**$1,538**	**$222,333**
Budgetary Financing Sources:			
Appropriations Used	295,986	363,353	659,339
Nonexchange Revenue:			
FICA and SECA Taxes	237,697		237,697
Interest on Investments	10,795	4	10,799
Other Nonexchange Revenue	3,553		3,553
Transfers-in/out Without Reimbursement	(4,659)	3,063	(1,596)
Other	518	(518)	
Other Financing Sources (Nonexchange):			
Transfers-in/out Without Reimbursement		458	458
Imputed Financing	29	22	51
Other		12	12
Total Financing Sources	**543,919**	**366,394**	**910,313**
Net Cost of Operations	**549,360**	**364,466**	**913,826**
Net Change	**(5,441)**	**1,928**	**(3,513)**
CUMULATIVE RESULTS OF OPERATIONS	**$215,354**	**$3,466**	**$218,820**
UNEXPENDED APPROPRIATIONS			
Beginning Balances	**$16,315**	**$36,683**	**$52,998**
Budgetary Financing Sources:			
Appropriations Received	288,636	424,678	713,314
Appropriations Transferred-in/out		(3,815)	(3,815)
Other Adjustments	21,319	(53,840)	(32,521)
Appropriations Used	(295,986)	(363,353)	(659,339)
Total Budgetary Financing Sources	13,969	3,670	17,639
Total Unexpended Appropriations	30,284	40,353	70,637
NET POSITION	$245,638	$43,819	$289,457

The accompanying notes are an integral part of these statements.

COMBINED STATEMENTS OF BUDGETARY RESOURCES

for the years ended September 30, 2016 and September 30, 2015

(IN MILLIONS)

		FY 2016 Non-Budgetary Credit Reform Financing Account	FY 2015 Combined Totals Budgetary	
Budgetary Resources:				
Unobligated balance brought forward, October 1	$55,748		$29,896	
Other Adjustments	821			
Recoveries of prior year unpaid obligations	32,509		23,347	
Other changes in unobligated balance	(3,908)		20,908	
Unobligated balance from prior year budget authority, net	85,170		74,151	
Appropriations (discretionary and mandatory)	1,414,720		1,304,074	
Borrowing authority (discretionary and mandatory)	3,720	$19		$50
Spending authority from offsetting collections	13,994	637	23,285	80
TOTAL BUDGETARY RESOURCES	**$1,517,604**	**$656**	**$1,401,510**	**$130**
Status of Budgetary Resources:				
New Obligations and upward adjustments	$1,469,454	$32	$1,345,762	$130
Apportioned, Unexpired	18,217	8	20,311	
Exempt from Apportionment, unexpired accounts	(7,909)		(2,805)	
Unapportioned, unexpired accounts	2,890	616	6,122	
Unexpired unobligated balance, end of year	13,198	624	23,628	
Expired unobligated balance, end of year	34,952		32,120	
Unobligated balance, end of year	48,150	624	55,748	0
TOTAL BUDGETARY RESOURCES	**$1,517,604**	**$656**	**$1,401,510**	**$130**
Change in Obligated Balance:				
Unpaid obligations:				
Unpaid obligations, brought forward, October 1	$152,500	$375	$135,768	$1,000
Other Adjustments	(941)		(448)	(2)
New Obligations and upward adjustments	1,469,454	32	1,345,762	130
Outlays (gross)	(1,420,233)	(370)	(1,305,235)	(753)
Recoveries of prior year unpaid obligations	(32,509)		(23,347)	
Unpaid obligations end of year	168,271	37	152,500	375
Uncollected Payments:				
Uncollected payments, Federal sources, brought forward, October 1	(18,803)	(159)	(7,789)	(429)
Other Adjustments	(38)		(29)	
Change in uncollected payments, Federal sources	(3,578)	145	(10,985)	270
Uncollected payments, Federal sources, end of year	(22,419)	(14)	(18,803)	(159)
Memorandum entries:				
Obligated start of year, net	133,697	216	127,979	571
Obligated balance, end of year, net	145,852	23	133,697	216
Budgetary Authority and Outlays, Net:				
Budget authority, gross	$1,432,434	$656	$1,327,359	$130
Actual offsetting collections	(10,627)	(782)	(12,300)	(350)
Change in uncollected customer payments from Federal sources	(3,578)	145	(10,775)	270
Recoveries of prior year paid obligations	190		210	
Anticipated offsetting collections				
Budget authority, net	1,418,419	19	1,304,494	50
Outlays, gross	1,420,233	370	1,305,235	753
Actual offsetting collections	(10,627)	(782)	(12,300)	(350)
Outlays, net	1,409,606	(412)	1,292,935	403
Distributed offsetting receipts	(427,252)		(379,257)	
AGENCY OUTLAYS, NET	**$982,354**	**($412)**	**$913,678**	**$403**

The accompanying notes are an integral part of these statements.

STATEMENT OF SOCIAL INSURANCE

75-Year Projection as of January 1, 2016 and Prior Base Years

(IN BILLIONS)

		Estimates from Prior Years			
	2016 (unaudited)	2015 (unaudited)	2014 (unaudited)	2013 (unaudited)	2012 (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	$10,294	$9,134	$8,398	$8,147	$7,929
SMI Part B	19,386	17,027	17,127	15,227	14,431
SMI Part D	7,659	6,424	5,928	5,871	5,866
Have attained eligibility age (age 65 or over)					
HI	455	382	332	301	302
SMI Part B	3,660	3,300	2,873	2,620	2,395
SMI Part D	952	887	775	722	694
Those expected to become participants					
HI	9,952	8,386	7,812	7,744	7,367
SMI Part B	4,437	3,668	4,311	3,530	3,333
SMI Part D	3,602	2,845	2,609	2,617	2,568
All current and future participants					
HI	20,701	17,902	16,542	16,192	15,598
SMI Part B	27,484	23,995	24,311	21,377	20,159
SMI Part D	12,213	10,156	9,312	9,211	9,128
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	16,800	14,494	14,117	14,629	14,919
SMI Part B	19,178	16,818	17,003	15,075	14,303
SMI Part D	7,659	6,424	5,928	5,871	5,866
Have attained eligibility age (age 65 and over)					
HI	4,285	3,803	3,484	3,422	3,369
SMI Part B	4,026	3,637	3,171	2,887	2,646
SMI Part D	952	887	775	722	694
Those expected to become participants					
HI	3,437	2,791	2,764	2,913	2,891
SMI Part B	4,281	3,540	4,137	3,415	3,211
SMI Part D	3,602	2,845	2,609	2,617	2,568
All current and future participants:					
HI	24,523	21,089	20,365	20,963	21,179
SMI Part B	27,484	23,995	24,311	21,377	20,159
SMI Part D	12,213	10,156	9,312	9,211	9,128
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 13 and 14)					
HI	(3,822)	(3,187)	(3,823)	(4,772)	(5,581)
SMI Part B	0	0	0	0	
SMI Part D	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	$(3,822)	$(3,187)	$(3,823)	$(4,772)	$(5,581)
SMI Part B	0	0	0	0	
SMI Part D	0	0	0	0	
Trust Fund assets at start of period					
HI	194	197	205	220	244
SMI Part B	68	68	74	66	80
SMI Part D	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	(3,628)	(2,990)	(3,618)	(4,551)	(5,337)
SMI Part B	68	68	74	66	80
SMI Part D	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, 2016 and Prior Base Years

(IN BILLIONS)

		Estimates from Prior Years			
	2016 (unaudited)	2015 (unaudited)	2014 (unaudited)	2013 (unaudited)	2012 (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)	$5,067	$4,569	$3,980	$3,643	$3,391
Expenditures	9,263	8,328	7,430	7,031	6,709
Income less expenditures	(4,196)	(3,759)	(3,450)	(3,388)	(3,319)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	37,339	32,585	31,453	29,244	28,227
Expenditures	43,637	37,736	37,048	35,574	35,088
Income less expenditures	(6,298)	(5,151)	(5,595)	(6,330)	(6,861)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(10,493)	(8,909)	(9,045)	(9,718)	(10,180)
Combined Medicare Trust Fund assets at start of period	263	266	280	288	325
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(10,230)	(8,643)	(8,764)	(9,430)	(9,855)
Future Participants: *Actuarial present value for the 75-year projection period:*					
Income (excluding interest)	17,992	14,898	14,732	13,891	13,268
Expenditures	11,320	9,176	9,510	8,945	8,669
Income less expenditures	6,672	5,722	5,222	4,946	4,599
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(3,822)	(3,187)	(3,823)	(4,772)	(5,581)
Combined Medicare Trust Fund assets at start of period	263	266	280	288	325
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$(3,559)	$(2,921)	$(3,542)	$(4,484)	$(5,256)

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, 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.

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

January 1, 2014 to January 1, 2015

(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, 2014	$50,166	$53,988	($3,823)	$280	($3,542)
Reasons for change					
Change in the valuation period	2,106	2,308	(202)	(17)	(219)
Change in projection base	1,174	1,256	(82)	3	(79)
Changes in the demographic assumptions	149	184	(35)	0	(35)
Changes in economic and health care assumptions	(1,884)	(2,638)	755	0	755
Changes in law	342	142	201	0	201
Net changes	1,887	1,251	636	(14)	622
As of January 1, 2015	52,053	55,240	(3,187)	266	(2,921)
HI: PART A *(Note 15)*					
As of January 1, 2014	16,542	20,365	(3,823)	205	(3,618)
Reasons for change					
Change in the valuation period	610	812	(202)	(14)	(216)
Change in projection base	(38)	44	(82)	6	(77)
Changes in the demographic assumptions	3	38	(35)	0	(35)
Changes in economic and health care assumptions	784	30	755	0	755
Changes in law	0	(201)	201	0	201
Net changes	1,360	724	636	(8)	628
As of January 1, 2015	17,902	21,089	(3,187)	197	(2,990)
SMI: PART B *(Note 15)*					
As of January 1, 2014	24,311	24,311	0	74	74
Reasons for change					
Change in the valuation period	1,054	1,054	0	(3)	(3)
Change in projection base	360	360	0	(3)	(3)
Changes in the demographic assumptions	82	82	0	0	0
Changes in economic and health care assumptions	(2,168)	(2,168)	0	0	0
Changes in law	356	356	0	0	0
Net changes	(316)	(316)	0	(6)	(6)
As of January 1, 2015	23,995	23,995	0	68	68
SMI: PART D *(Note 15)*					
As of January 1, 2014	9,312	9,312	0	1	1
Reasons for change					
Change in the valuation period	443	443	0	0	0
Change in projection base	852	852	0	0	0
Changes in the demographic assumptions	63	63	0	0	0
Changes in economic and health care assumptions	(500)	(500)	0	0	0
Changes in law	(13)	(13)	0	0	0
Net changes	844	844	0	0	0
As of January 1, 2015	10,156	10,156	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. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 as the basis for conducting quarterly certification of regular wages.

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 everyone who is in Medicare, 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 Affordable Care Act 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. The 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." Through the Medicare Integrity Program, CMS contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews, cost report audits, and the education of providers and beneficiaries with respect to payment integrity and benefit quality assurance issues. 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. Under the Medicaid Integrity Program, CMS contracts with eligible entities to review provider claims and perform audits, with respect to Medicaid providers, similar to those activities currently performed by Medicare Integrity Program contractors with respect to Medicare providers.

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 Fund 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 Fund 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. Grant awards 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 Affordable Care Act expanded eligibility for Medicaid to certain low-income adults with the Federal government paying 100% of those claims for Medicaid expansion for the first three years, phasing down to 90% in 2020 and beyond. 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 Affordable Care Act 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 Affordable Care Act requires the collection of a user fee from each issuer offering coverage through a Federally-facilitated Marketplace 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 Affordable Care Act 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.

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 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 (see Note 3).

Investments consist of the CHIP Child Enrollment Contingency Fund investments (net of any accrued amortized or unrealized discounts) also held by Treasury.

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 (CO-OP) program. 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.

Change in Presentation

Effective for FY 2016, changes have been made to the Statement of Budgetary Resources to reflect the new format prescribed by OMB's Circular A-136.

Estimation of Obligations Related to Canceled Appropriations

As of September 30, 2016, CMS has canceled over $730 million in cumulative obligations related to FY 2011 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 2012 through

2016 related to canceled appropriations, CMS anticipates an additional $3 million will be paid from current year funds for canceled obligations.

The Affordable Care Act

The Affordable Care Act contains the most significant changes to health care coverage since the passing of the Social Security Act. The Affordable Care Act 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). The programs under CCIIO include: Affordable Insurance Marketplaces (the "Marketplaces") and the Consumer Operated and Oriented Plan (CO-OP) program. A brief description of these programs and their impact on the CMS financial statements is presented below.

Affordable Insurance Marketplaces

Grants have been provided to the States to establish Affordable Insurance Marketplaces. 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. All Marketplaces were launched on October 1, 2013.

CO-OP Program

The CO-OP Program was established to foster and encourage the creation of consumer-governed non-profit health plans in the individual and small group markets, with a goal of having at least one CO-OP in each state. Under this program, assistance was provided to organizations applying to become qualified, nonprofit health insurance issuers through loans to assist in meeting start-up costs, and state solvency requirements. In accordance with proposed regulations, as well as legislative requirements, loans shall be repaid within five years for start-up loans and 15 years for solvency loans, considering state reserve requirements and solvency regulations.

Transitional Reinsurance Program

The Transitional Reinsurance program was established in each state to help stabilize premiums for coverage in the individual market from 2014 through 2016. All health insurance issuers and third party administrators on behalf of self-insured group health plans, must make contributions to support reinsurance payments that cover high-cost individuals in non-grandfathered plans in the individual market, inside and outside the Marketplace. The Transitional Reinsurance program is a critical element in helping to ensure a stabilized individual market in the first years of the Exchange operation of the Marketplace.

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 Marketplaces. 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 Corridor Program

The temporary Risk Corridors program will operate during the years 2014 through 2016. This program applies to qualified health plans in the individual and small group markets, inside and outside the Marketplaces and protects against inaccurate rate-setting by sharing risk (gains and losses) on allowable costs between CMS and qualified health plans to help ensure stable health insurance premiums.

NOTE 2:

FUND BALANCE WITH TREASURY

(DOLLARS IN MILLIONS)

	FY 2016	FY 2015
FUND BALANCES:		
Trust Funds:		
HI Trust Fund Balance	$2,059	$1,363
SMI Trust Fund Balance	51,747	43,422
Special Funds:		
Affordable Care Act Risk Programs	2,174	2,207
CHIP Child Enrollment Contingency	5,359	53
Revolving Funds:		
COOP Financing	630	113
Appropriated Funds:		
Medicaid	40,365	41,895
CHIP	26,457	26,119
State Grants and Demo	2,370	3,053
Other Health	6,900	8,800
Program Management Direct/Reimbursables	1,953	1,510
Other Fund Types:		
CMS Deposit/Small Escrow	33	(1)
Total Fund Balances	$140,047	$128,534
STATUS OF FUND BALANCES WITH TREASURY:		
Unobligated Balance:		
Available	$10,316	$17,506
Unavailable	38,458	38,242
Obligated Balance not yet Disbursed	145,875	133,913
Non-Budgetary FBWT	(54,602)	(61,127)
Total Status of Fund Balances with Treasury	$140,047	$128,534

Fund Balances are funds with Treasury that are primarily available to pay current expenditures and liabilities. The Unobligated Balance Available includes $8,840 million ($14,499 million in FY 2015), which is restricted for future use and is not apportioned for current use for Affordable Care Act, CHIP, Program Management, and State Grants and Demonstrations.

NOTE 3:

INVESTMENTS

(DOLLARS IN MILLIONS)

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**

FY 2015 MEDICARE INVESTMENTS *(Dedicated Collections)*	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2016	2 1/8%	$10,292
Bonds	June 2016 to June 2025	2 – 5 5/8%	185,166
Accrued Interest			1,960
Total HI TF Investments			**$197,418**
SMI TF			
Certificates	June 2016	2 1/8%	$12,217
Bonds	June 2019 to June 2029	2 1/8 – 5 %	53,911
Accrued Interest			447
Total SMI TF Investments			**$66,575**
Total Medicare Investments			**$263,993**

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 2016 **CHIP CHILD ENROLLMENT CONTINGENCY FUND INVESTMENTS** *(Non-Dedicated Collections)*	Maturity Date	Cost	Unamortized Discount	Investments, Net
Treasury Bill	3/30/17	**$571**	$1	$570
Total Non-Dedicated Collections Investments		**$571**	**$1**	**$570**

FY 2015 **CHIP CHILD ENROLLMENT CONTINGENCY FUND INVESTMENTS** *(Non-Dedicated Collections)*	Maturity Date	Cost	Unamortized Discount	Investments, Net
Treasury Bill	01/07/2016	**$2,053**	$1	$2,052
Total Non-Dedicated Collections Investments		**$2,053**	**$1**	**$2,052**

CMS INVESTMENT SUMMARY

(DOLLARS IN MILLIONS)

	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**

	Medicare (Dedicated Collections)			Non-Dedicated Collections	Consolidated Total
FY 2015	HI TF	SMI TF	Total	CHIP	
Certificates	$10,292	$12,217	$22,509		$22,509
Bonds	185,166	53,911	239,077		239,077
Treasury Bills				$2,052	2,052
Accrued Interest	1,960	447	2,407		2,407
Total Investments	**$197,418**	**$66,575**	**$263,993**	**$2,052**	**$266,045**

Note 4:

ACCOUNTS RECEIVABLE, NET

(DOLLARS IN MILLIONS)

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

FY 2015	Accounts Receivable Principal	Interest Receivable	Accounts Receivable Gross	Allowance	Net CMS Receivables
Intragovernmental					
Entity	$635		$635		$635
Total Intragovernmental	$635		$635		$635
With the Public					
Entity					
Medicare FFS	$6,919		$6,919	$(2,031)	$4,888
Medicare Advantage/ Prescription Drug Program	1,887		1,887		1,887
Medicaid	5,828		5,828	(1,722)	4,106
CHIP	6		6	(1)	5
Other	9,964		9,964	(17)	9,947
Non-Entity		$53	53	(26)	27
Total With the Public	$24,604	$53	$24,657	$(3,797)	$20,860

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 Marketplace 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 Marketplace activities.

Note 5:

OTHER ASSETS

(DOLLARS IN MILLIONS)

As of September 30, 2016, CMS has $22,696 million ($1,646 million in FY 2015) in Other Assets. CMS recorded nonfederal advances that represent payment of the Prescription Drug and Medicare Advantage benefit payments for October 2016 that occurred on September 30 instead of October 1. Both federal and nonfederal Other Assets include the direct loans for the CO-OP programs net of subsidy allowance, CDC vaccine program inventory and grant advances.

Note 6:

ENTITLEMENT BENEFITS DUE AND PAYABLE

(DOLLARS IN MILLIONS)

	FY 2016	FY 2015
Medicare FFS	$44,866	$45,268
Medicare Advantage/Prescription Drug Program	19,045	20,953
Medicaid	35,419	36,758
CHIP	978	773
Other	7,922	4,397
TOTALS	$108,230	$108,149

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, 2016 and 2015 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 2016. 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, 2016.

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 Marketplace activities.

Note 7:

CONTINGENCIES

The contingencies balance as of September 30, 2016 is $10,826 million ($7,540 million in FY 2015). Additionally, CMS may owe amounts to providers for previous years' disputed cost report adjustments. 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. 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 $10,166 million ($7,530 million in FY 2015) consists of Medicaid audit and program disallowances of $2,801 million ($2,398 million in FY 2015) and $7,365 million ($5,132 million in FY 2015) 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, 2016, 10,005 cases (9,737 in FY 2015) remain on appeal. A total of 2,515 new cases (3,473 in FY 2015) were filed and 10 cases were reopened (9 in FY 2015). The PRRB rendered decisions on 66 cases (84 in FY 2015) and additional 2,191 cases (2,972 in FY 2015) 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 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

FY 2015 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									
Total Intragovernmental		$1			$1		$2		$2
Federal Employee and Veterans' Benefits	$3	$4	$1		$4		$12		$12
Accrued Payroll and Benefits	13	19	2		18	$2	54		54
Other					10,419		10,419		10,419
Contingencies		10	7,530				7,540		7,540
Total Liabilities Not Covered by Budgetary Resources	16	34	7,533		10,442	2	18,027		18,027
Total Liabilities Covered by Budgetary Resources	63,202	90,862	36,762	$773	3,023	2,942	197,564	$(86,423)	111,141
TOTAL LIABILITIES	$63,218	$90,896	$44,295	$773	$13,465	$2,944	$215,591	$(86,423)	$129,168

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, 2016, $3.3 billion is still owed.

Starting January 1, 2014, the Affordable Care Act 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 Marketplace that began on January 1, 2014, as well as the broader individual and small group markets. The Risk Adjustment program will be 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, with any deficits or surpluses from earlier years being held over into later years. In the event of a shortfall through the 2016 program year, CMS will explore other sources of funding for risk corridor payments, subject to the availability of appropriations. 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 Affordable Care Act 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, 2016, 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 and 2015 for the Risk Corridors program. However with respect to the Risk Corridors program, any potential liabilities and accounts receivable amounts for the 2016 program year can only be determined with any degree of certainty when data is submitted and calculations are performed. Therefore, CMS cannot reasonably estimate outflows/inflows for the 2016 program year as of September 30, 2016, and no amounts are recorded.

Note 9:

NET COST OF OPERATIONS

(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**

Note 9:

NET COST OF OPERATIONS *(CONTINUED)*

(DOLLARS IN MILLIONS)

	Medicare (Dedicated Collections)			Health				
FY 2015	**HI TF**	**SMI TF**	**Total**	**Medicaid**	**CHIP**	**Other Health**	**Other**	**Consolidated Total**
PROGRAM/ACTIVITY COSTS								
Medicare								
Fee for Service	$197,652	$179,271	$376,923					$376,923
Medicare Advantage/ Managed Care	77,431	91,898	169,329					169,329
Prescription Drug (Part D)		71,097	71,097					71,097
Medicaid/CHIP/State Grants & Demos				$349,590	$9,090		$571	359,251
Other Health						$23,766		23,766
Other							2,870	2,870
Total Program/Activity Costs	**$275,083**	**$342,266**	**$617,349**	**$349,590**	**$9,090**	**$23,766**	**$3,441**	**$1,003,236**
OPERATING COSTS								
Medicare Integrity Program	$1,527		$1,527					$1,527
Quality Improvement Organizations	496	$190	686					686
Bad Debt Expense and Writeoffs	247	70	317	$114	$(2)		1	430
Reimbursable Expenses	57	117	174	11	1	$106	3	295
Administrative Expenses	955	1,774	2,729	160	16	1,403	1,310	5,618
Depreciation and Amortization	8	17	25	1		2		28
Imputed Cost Subsidies	12	17	29	2		18	2	51
Total Operating Costs	**$3,302**	**$2,185**	**$5,487**	**$288**	**$15**	**$1,529**	**1,316**	**$8,635**
TOTAL COSTS	**$278,385**	**$344,451**	**$622,836**	**$349,878**	**$9,105**	**$25,295**	**$4,757**	**$1,011,871**
Less: Exchange Revenues:								
Medicare Premiums	$3,724	$71,275	$74,999					$74,999
Other Exchange Revenues	4	698	702	$1		$20,830	1,513	23,046
Total Exchange Revenues	**$3,728**	**$71,973**	**$75,701**	**$1**		**$20,830**	**1,513**	**$98,045**
TOTAL NET COST OF OPERATIONS	**$274,657**	**$272,478**	**$547,135**	**$349,877**	**$9,105**	**$4,465**	**$3,244**	**$913,826**

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 $2,229 million ($2,489 million in FY 2015) 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 2016 Part D expense of $75,037 million ($71,097 million in FY 2015) is net of State reimbursements of $9,171 million ($9,604 million in FY 2015). The gross expense would have been $84,208 million ($80,701 million in FY 2015).

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, 2016				
ASSETS				
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 10:

FUNDS FROM DEDICATED COLLECTIONS *(CONTINUED)*

(DOLLARS IN MILLIONS)

	Medicare	Other Non-Medicare	Eliminations	Total Dedicated Collections
Balance Sheet as of September 30, 2015				
ASSETS				
Fund Balance with Treasury	$44,785	$3,015		$47,800
Investments	263,993			263,993
Other Assets	92,199	10,415	$(84,872)	17,742
TOTAL ASSETS	$400,977	$13,430	$(84,872)	$329,535
Entitlement Benefits Due and Payable	$66,221	$4,195		$70,416
Other Liabilities	87,893	10,460	$(84,872)	13,481
TOTAL LIABILITIES	$154,114	$14,655	$(84,872)	$83,897
Unexpended Appropriations	$30,284			$30,284
Cumulative Results of Operations	216,579	$(1,225)		215,354
Total Net Position	**246,863**	**(1,225)**		**245,638**
TOTAL LIABILITIES AND NET POSITION	**$400,977**	**$13,430**	**$(84,872)**	**$329,535**
Statement of Net Cost for the year ended September 30, 2015				
Benefit Expense	$617,349			$617,349
Operating Costs	5,487	$24,519		30,006
Total Costs	622,836	24,519		647,355
Less Exchange Revenues	75,701	22,294		97,995
Net Cost of Operations	**$547,135**	**$2,225**		**$549,360**
Statement of Changes in Net Position for the year ended September 30, 2015				
Net Position, Beginning of Period	$237,110			$237,110
Taxes and Other Nonexchange Revenue	252,045			252,045
Other Financing Sources	304,843	$1,000		305,843
Less Net Cost of Operations	547,135	2,225		549,360
Change in Net Position	9,753	(1,225)		528
NET POSITION, END OF PERIOD	$246,863	$(1,225)		$245,638

Note 11:

INTRAGOVERNMENTAL COSTS AND EXCHANGE REVENUE

(DOLLARS IN MILLIONS)

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

FY 2015	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	$787	$277,598	$278,385	$4	$3,724	$3,728	$274,657
SMI TF	239	344,212	344,451	8	71,965	71,973	272,478
Medicaid	12	349,866	349,878	1		1	349,877
CHIP	31	9,074	9,105				9,105
Subtotal	**1,069**	**980,750**	**981,819**	**13**	**75,689**	**75,702**	**906,117**
Other Activities							
State Grants and Demonstrations	25	576	601				601
Other Health	197	25,098	25,295	14	20,816	20,830	4,465
Other	116	4,040	4,156		1,513	1,513	2,643
Subtotal	**338**	**29,714**	**30,052**	**14**	**22,329**	**22,343**	**7,709**
PROGRAM/ ACTIVITY TOTALS	$1,407	$1,010,464	$1,011,871	$27	$98,018	$98,045	$913,826

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 2016	Direct	Reimbursable	Combined Totals
Category A	$18,092	$437	$18,529
Category B	725,564	1,255	726,851
Exempt	724,138		724,106
Total	**$1,467,794**	**$1,692**	**$1,469,486**

FY 2015	Direct	Reimbursable	Combined Totals
Category A	$15,631	$391	$16,022
Category B	658,749	1,055	659,804
Exempt	670,066		670,066
Total	**$1,344,446**	**$1,446**	**$1,345,892**

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 $201,562 million ($201,111 million in FY 2015) are included in Investments on the Balance Sheets. The following table presents trust fund activities and balances for FY 2016 and FY 2015 (in millions):

	FY 2016 Combined Balance	FY 2015 Combined Balance
TRUST FUND BALANCE, BEGINNING	**$201,111**	**$225,453**
Receipts	608,768	542,336
Less Obligations	608,317	566,678
Excess (Shortage) of Receipts Over Obligations	451	(24,342)
TRUST FUND BALANCE, ENDING	$201,562	$201,111

EXEMPT FROM APPORTIONMENT

This amount includes the FY 2016 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 2015

(DOLLARS IN MILLIONS)

CMS reconciled the amounts of the FY 2015 column of the SBR to the actual amounts for FY 2015 from the Appendix in the FY 2016 President's Budget for budgetary resources, obligations incurred, offsetting receipts and net outlays (gross outlays less offsetting collections).

FY 2015	Budgetary Resources	Obligations Incurred	Distributed Offsetting Receipts	Net Outlays
Combined Statement of Budgetary Resources	$1,401,640	$1,345,892	$379,257	$1,293,338
Expired Accounts	(33,112)			
Other	3,785	2,955	(110)	3,858
President's Budget (2015 Actual)	**$1,372,313**	**$1,348,847**	**$379,147**	**$1,297,196**

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 SBR and not in the President's Budget is the budgetary resources that were not available. The Expired accounts line in the above schedule includes expired authority, recoveries and other amounts included in the Combined SBR 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, a portion of Risk Adjustment and GTAS revision window adjustments 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's SBR.

Lastly, the Other differences in the net outlays include outlays reported in the President's Budget for CDC, CIIO and a portion of Risk Adjustment not in CMS's Combined SBR.

UNDELIVERED ORDERS AT THE END OF THE PERIOD

The amount of budgetary resources obligated for undelivered orders totaled $56,996 million for Budgetary and $37 million for Non-Budgetary at September 30, 2016 ($26,909 million for Budgetary and $374 million for Non-Budgetary at FY 2015).

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 *2016 Annual Report of the Medicare Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and healthcare-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent review occurred with the 2010–2011 Technical Review Panel.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. The Trustees' projections are based on the current Medicare laws, regulations, and policies in effect on June 22, 2016 and do not reflect any actual or anticipated changes subsequent to that date. 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.

Beginning with this year's projections, the Part A present values in the SOSI include the income and expenditures for the roughly 1 percent of beneficiaries who are 65 or over but are uninsured because they do not meet the normal insured status or related requirements to qualify for entitlement to Part A benefits. The reason that these beneficiaries were previously excluded is that their costs were separately funded either through general revenue appropriations or through premium payments, and accordingly the exclusion of such amounts did not materially affect the financial balance of Part A.

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 June 22, 2016. 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 2016 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2016. 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]

Table 1:
SIGNIFICANT ASSUMPTIONS AND SUMMARY MEASURES USED FOR THE STATEMENT OF SOCIAL INSURANCE 2016

					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	
2016	1.90	1,579,000	773.0	2.08	2.94	0.86	2.8	0.9	2.1	0.9	1.2
2020	2.00	1,508,000	742.8	1.68	4.28	2.60	2.8	3.9	5.6	6.7	1.9
2030	2.00	1,332,000	679.1	1.30	3.90	2.60	2.1	3.9	4.5	4.7	2.7
2040	2.00	1,284,000	624.5	1.22	3.82	2.60	2.2	4.7	4.0	4.7	2.7
2050	2.00	1,259,000	576.8	1.25	3.85	2.60	2.2	3.8	3.7	4.6	2.7
2060	2.00	1,244,000	534.8	1.21	3.81	2.60	2.1	3.6	3.6	4.5	2.7
2070	2.00	1,235,000	497.6	1.15	3.75	2.60	2.1	3.8	3.6	4.4	2.7
2080	2.00	1,230,000	464.6	1.14	3.74	2.60	2.1	3.8	3.6	4.4	2.7
2090	2.00	1,228,000	435.1	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.

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.

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 2016–2012

					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 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
FY 2012	2.0	1,030,000	443.2	1.2	4.0	2.8	2.1	3.3	3.7	4.4	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 2012-2015 and is the value assumed in the year 2090 for FY 2016.

[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 2012-2015 and is the value assumed in the year 2090 for FY 2016.

[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 2012-2015 and is the value assumed in the year 2090 for FY 2016.

[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 2012-2015 and is the value assumed in the year 2090 for FY 2016.

[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 2012-2015 and is the value assumed in the year 2090 for FY 2016.

[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. 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 2012-2015 and is the value assumed in the year 2090 for FY 2016.

[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. The Board of Trustees believes that this outcome is achievable if health care providers are able 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 anticipate 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, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term under current law. Overriding the productivity adjustments and specified physician updates, 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 2025, physician payments transition from a payment update of 0.0 percent to an increase of 2.2 percent. In addition, the illustrative alternative assumes that the 5-percent bonuses paid to physicians in alternative payment models (APMs) would continue and 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 SGR was replaced in 2015.

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	$20,701	$20,874
Part B	27,484	34,465
Part D	12,213	12,411
Expenditures		
Part A	24,523	30,598
Part B	27,484	34,465
Part D	12,213	12,411
Income less expenditures		
Part A	(3,822)	(9,723)
Part B	0	0
Part D	0	0

1 These amounts are not presented in the 2016 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 percent. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario, and the present value of Part B income is also 25 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, 2015 to the period beginning on January 1, 2016, and the reconciliation from the period beginning on January 1, 2014 to the period beginning on January 1, 2015. 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, 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.

Period beginning on January 1, 2014 and ending January 1, 2015

Present values as of January 1, 2014 are calculated using interest rates from the intermediate assumptions of the 2014 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2015. 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 2014 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 2015 Trustees Report.

Change in the Valuation Period

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.

From the period beginning on January 1, 2014 to the period beginning on January 1, 2015

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2014-88) to the current valuation period (2015-89) is measured by using the assumptions for the prior valuation period and applying them, in the absence of any other changes, to the current valuation period. Changing the valuation period removes a small negative net cash flow for 2014 and replaces it with a much larger negative net cash flow for 2089. The present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) was therefore decreased (made more negative) when the 75-year valuation period changed from 2014-88 to 2015-89. 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 2014 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

Change in Projection Base

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.

From the period beginning on January 1, 2014 to the period beginning on January 1, 2015

Actual income and expenditures in 2014 were different than what was anticipated when the 2014 Trustees Report projections were prepared. Part A income was very slightly lower and expenditures were very slightly higher than anticipated, based on actual experience. Part B total income and expenditures were also higher 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, 2014 and January 1, 2015 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

Changes in the Demographic Assumptions

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.

From the period beginning on January 1, 2014 to the period beginning on January 1, 2015

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, 2015), with the exception of changes made due to the executive action on immigration, 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 2012 and preliminary data for 2013 indicated lower birth rates than were expected in the prior valuation. In this year's report, the total fertility rate reaches the ultimate in 2027, which is eleven years earlier than in last year's projections.
- Incorporating mortality data obtained from Medicare experience at ages 65 and older for 2012 resulted in slightly higher death rates for 2012 and a slightly slower rate of decline in mortality over the next 25 years than were projected last year. Incorporating mortality data obtained from the National Centers for Health Statistics at ages under 65 for 2011 resulted in slightly lower death rates for 2011 and a slightly faster rate of decline in mortality over the next 25 years than were projected last year.
- Historical legal immigration was revised to include single age data (rather than 5-year age groups); including more recent marriage, legal immigration, and other-than-legal immigration data; historical data since 2001 was revised to be more consistent with the most recent estimates from the Census Bureau.

These changes slightly lowered overall Medicare enrollment for the current valuation period resulting in a decrease in the estimated future net cash flow, and had a very minor impact on the present value of estimated income and estimated expenditures for Part A, Part B, and Part D.

Changes in Economic and Health Care Assumptions

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).

For the period beginning on January 1, 2014 to the period beginning on January 1, 2015

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, 2015), there was one change to the ultimate economic assumptions.

- The ultimate real-wage differential is assumed to be 1.17 percent in the current valuation period, compared to 1.13 percent in the previous valuation period.

The higher real-wage differential assumption is more consistent with recent experience and expectations of slower growth in employer-sponsored group health insurance premiums from the Office of the Actuary at the Centers for Medicare & Medicaid Services. 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.

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.

- The ratio of average taxable earnings to the average wage averages about 0.6 percentage point higher during the long-range period, compared to the previous valuation period.
- The projected suspense file contains fewer wage items, which is consistent with having fewer workers (many of whom are undocumented immigrants) with wages on the suspense file and more of these workers with earnings in the underground economy, compared to the previous valuation.

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

- Lower long-range growth rate assumptions
- Utilization rate assumptions for inpatient hospital services were decreased
- Lower assumed hospice spending
- Higher assumed enrollment in Medicare Advantage plans where benefits are more costly
- Introduction of high-cost specialty drugs used to treat hepatitis C

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 and Part D, these changes decreased the present value of estimated future expenditures (and also income).

Changes in Law

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.

For the period beginning on January 1, 2014 to the period beginning on January 1, 2015

Although Medicare legislation was enacted since the prior valuation date, some of the

provisions have a negligible impact on the present value of the 75-year estimated future income, expenditures, and net cash flow. The Veteran's Access, Choice, and Accountability Act of 2014 established a temporary program that allows eligible veterans to receive hospital care and medical services from eligible providers outside of the Veteran's Administration (VA) system, rather than waiting for a VA appointment or traveling to a VA facility. The Improving Medicare Post-Acute Care Transformation Act of 2014 standardized the collection of data for post-acute providers and aligned the inflation of the hospice aggregate cap with that of hospice reimbursement. The Tax Increase Prevention Act of 2014 accelerated the start date for the payment adjustment of misvalued codes under the physician fee schedule from 2017 to 2016, and delayed inclusion of oral-only ESRD-related drugs into the ESRD bundled payment system from 2024 to 2025. The Medicare Access and CHIP Reauthorization Act of 2015 included many provisions affecting Medicare spending, including the repeal of the SGR formula for determining payments under the physician fee schedule, the continuation of extensions for several provisions from prior legislation, a reduction in payment updates for most post-acute providers in 2018, the replacement of a 3.2 percent reduction to inpatient hospitals in 2018 with a 0.5 percent reduction in 2018 through 2023, and a revision to the income thresholds for determining the income-related monthly adjustment amounts under Part B and Part D.

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

Potential Impact on the Social Insurance Statements of the June 23, 2016 Supreme Court Judgment on the 2014 DACA and DAPA Executive Actions

In November 2014, Presidential executive actions expanded the Deferred Action for Childhood Arrivals program (DACA) and established the Deferred Action for Parents of Americans program (DAPA). On June 23, 2016, the Supreme Court was divided (tied 4-4) on the ruling of the legality of the expanded DACA and DAPA programs, so the lower court's ruling, temporarily blocking these programs from being implemented, was upheld. As a result, the expanded DACA and DAPA programs will be either delayed or never implemented. The SSA Office of the Chief Actuary has concluded that the Supreme Court's judgment has an effect on the actuarial methods and assumptions used in developing the estimates presented in the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts. Whether the expanded DACA and DAPA programs are delayed or never implemented, we expect the judgment will not have a material impact on the present value of future noninterest income less future costs for current and future participants (open group measure) presented in the Statements 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 2016	FY 2015
Resources Used to Finance Activities:		
Budgetary Resources Obligated:		
Obligations incurred	$1,469,486	$1,345,892
Less: Spending authority from offsetting collections and recoveries	47,423	46,712
Obligations net of offsetting collections and recoveries	1,422,063	1,299,180
Less: Distributed offsetting receipts	427,252	379,257
Net obligations	994,811	919,923
Other Resources:		
Transfers-In/Out without Reimbursement		458
Imputed financing from costs absorbed by others	56	51
Other	(120)	12
Net other resources used to finance activities	(64)	521
TOTAL RESOURCES USED TO FINANCE ACTIVITIES	$994,747	$920,444
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	$30,048	$(14,134)
Budgetary offsetting collections and receipts that do not affect net cost of operations	10,969	10,898
Resources that finance the acquisition of assets	289	1,277
Other resources or adjustments to net obligated resources that do not affect net cost of operations	(2,002)	3,293
Total resources used to finance items not part of the Net Cost of Operations	39,304	1,334
TOTAL RESOURCES USED TO FINANCE THE NET COST OF OPERATIONS	$955,443	$919,110
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	$3	$2
Decrease/(Increase) in receivables from the public	(4,488)	(10,755)
Other	2,378	8,172
Total components of Net Cost of Operations that will require or generate resources in future periods	(2,107)	(2,581)
Components not Requiring or Generating Resources:		
Depreciation and amortization	150	28
Other	(426)	(2,731)
Total components of Net Cost of Operations that will not require or generate resources	(276)	(2,703)
Total components of Net Cost of Operations that will not require or generate resources in the current period	(2,383)	(5,284)
NET COST OF OPERATIONS	$953,060	$913,826

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 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 2016 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 period, and the Trustees anticipate 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, the Trustees expect access to Medicare-participating physicians to 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 difficulty 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 0-percent update specified in current law for 2025 to the rate of growth in the Medicare Economic Index of 2.2 percent for 2040 and later; (ii) no expiration of the 5-percent bonuses for physicians in alternative payment models; (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-2 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 longstanding Gross Domestic Product (GDP) plus 1 percent assumption while incorporating several key

[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. 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 for all Urban Consumers (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**.

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 healthcare 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 2040, or GDP plus 0.0 percent, declining gradually to 3.5 percent in 2090, 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 alternative payment models and 0.25 percent for those assumed to be participating in the merit-based incentive

[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. The law did not specify any such adjustments after 2009.

[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.

payment system. The year-by-year per capita growth rates for physician payments are assumed to be 3.6 percent in 2040, or GDP minus 0.3 percent, declining to 2.8 percent in 2090, 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 2040, or GDP minus 0.8 percent, declining to 2.7 percent in 2090, 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 15 percent of total Part B expenditures in 2025 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 2040, or GDP plus 0.9 percent, declining to 4.3 percent by 2090, 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 3.8 percent over this same time period or GDP minus 0.1 percent, while the growth rate in 2090 is 3.6 percent or GDP minus 0.2 percent.

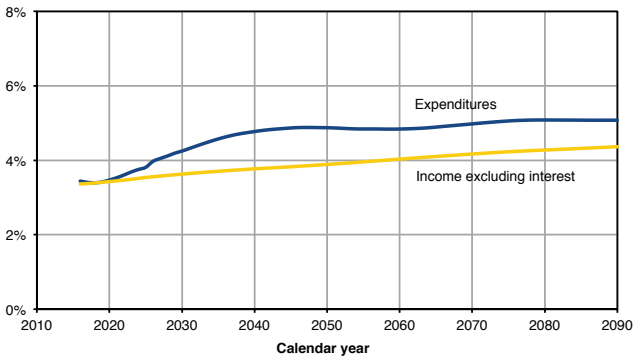
HI Cashflow as a Percentage of Taxable Payroll

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 income and cost rates shown in the 2016 report are higher than those from the 2015 report for all years primarily due to the inclusion of the income and costs for the uninsured beneficiaries. Without the inclusion of these income and cost amounts, the income rate would have been slightly lower for the entire projection period, and the cost rate would have been slightly higher initially (due to the increased hospital utilization) but would have eventually become slightly lower by 2040.

CHART 1

HI Expenditures and Income Excluding Interest as a Percentage of Taxable Payroll // 2016 – 2090



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

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 the sequester 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 0.9 percent through 2025 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 4.9 percent in 2035 and 8.4 percent in 2090. These levels are about 8 percent and 65 percent higher, respectively, than the current-law estimates under the intermediate assumptions.

HI and SMI Cashflow as a Percentage of GDP

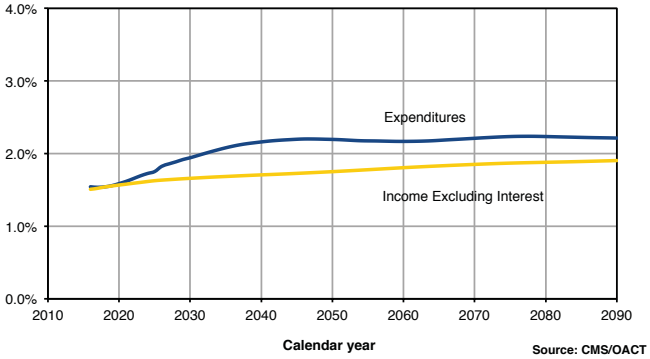
Expressing Medicare incurred expenditures as a percentage of GDP gives a relative measure of the size of the Medicare program compared to the general economy. The GDP represents the total value of goods and services produced in the United States. This measure provides an idea of the relative financial 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 2015, the expenditures were $278.9 billion, which was 1.6 percent of GDP. This percentage is projected to increase steadily until about 2045 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 3.6 percent in 2090.

CHART 2

HI Expenditures and Income Excluding Interest as a Percentage of GDP // 2016 – 2090



SMI

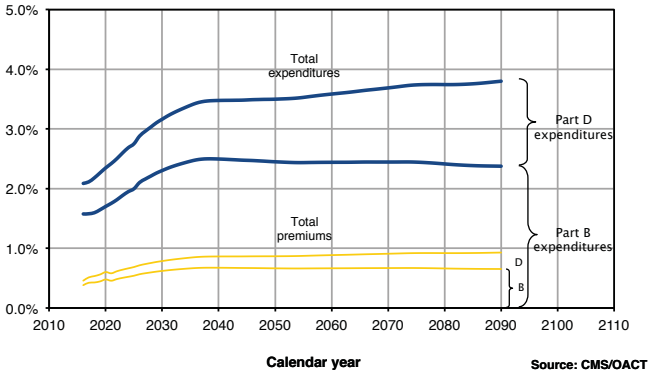
Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and 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 2015, SMI expenditures were $368.8 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 3.8 percent by the end of the projection period. (Under the illustrative alternative, total SMI expenditures in 2090 would be 5.4 percent of GDP.)

CHART 3

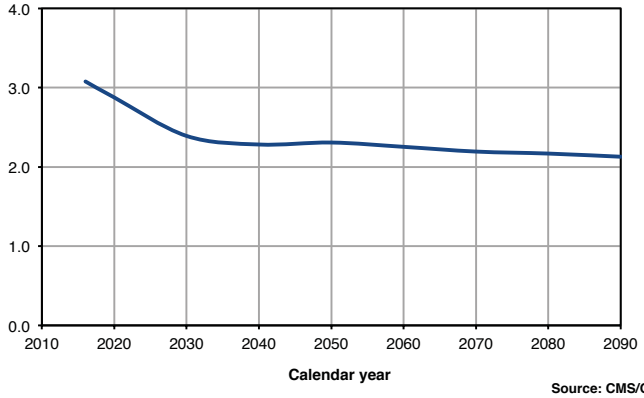
SMI Expenditures and Premiums as a Percentage of GDP // 2016 – 2090



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 2015 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 2015, 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 2090.

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]

For this analysis, the intermediate economic and demographic assumptions in the 2016 Annual

[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.

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, 2016 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 $7,020 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 $11,232 billion.

CHART 5

Present Value of HI Net Cash Flow with Various Health Care Cost Factors 2016 – 2090

IN BILLIONS

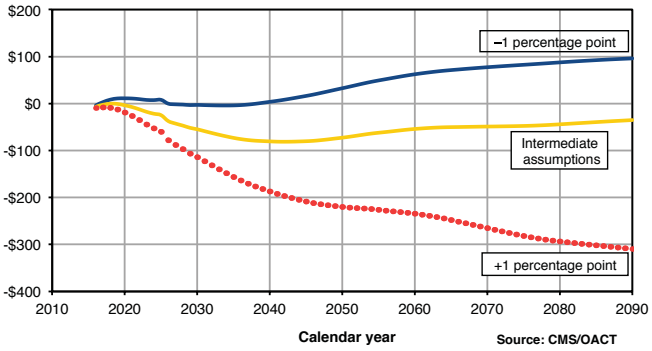


Chart 5 shows projections of the present value of the estimated net cash flow under the three alternative annual growth rate assumptions presented in table 1.

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 $1,730 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)	$3,198	–$3,822	–$15,054

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)	–$5,116	–$3,822	–$1,748

TABLE 3

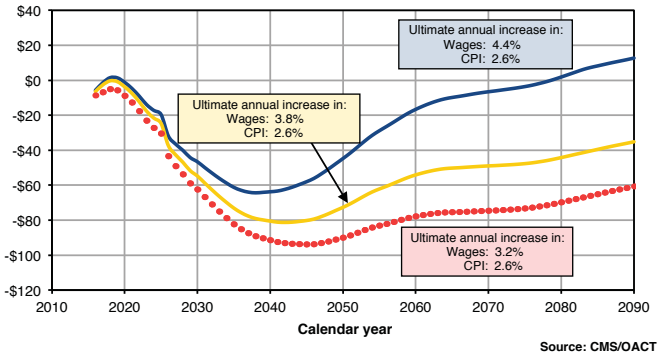
Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

Ultimate percentage increase in wages – CPI	4.4 – 3.2	3.8 – 2.6	3.2 – 2.0
Income minus expenditures (in billions)	–$2,902	–$3,822	–$5,133

CHART 6

Present Value of HI Net Cash FLow with Various Real-Wage Assumptions // 2016 – 2090

(IN BILLIONS)



Source: CMS/OACT

Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $1,080 billion.

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

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 long-range feasibility 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

CHART 7

Present Value of HI Net Cash Flow with Various CPI-Increase Assumptions // 2016 – 2090

(IN BILLIONS)

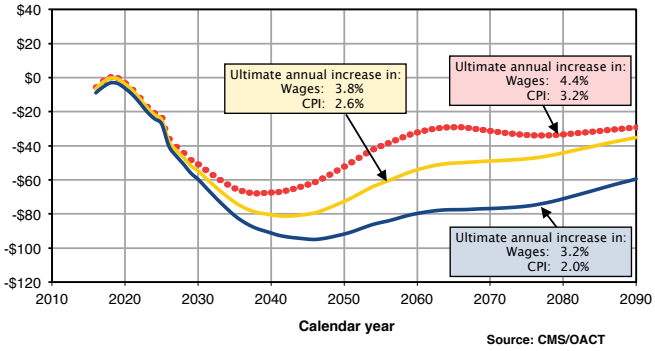
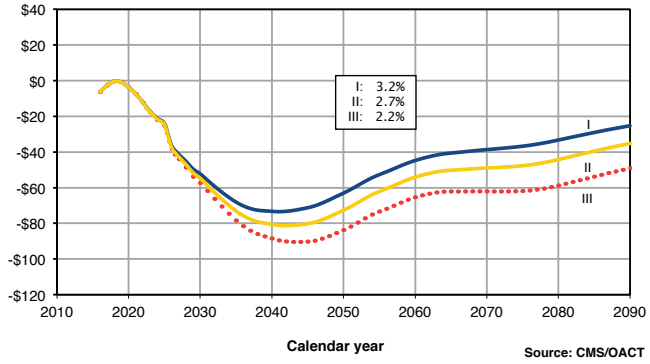


CHART 8

Present Value of HI Net Cash Flow with Various Real-Interest Rate Assumptions // 2016 – 2090

(IN BILLIONS)



decreases by $920 billion. On the other hand, if the ultimate CPI-increase assumption is 2.0 percent, the deficit increases by $1,311 billion.

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

As chart 7 indicates, this assumption has a small impact when the cash flow is expressed as present values. The relative insensitivity of the projected present values of HI cash flow to different levels of general inflation occurs because inflation tends to proportionately affect both income and costs in a similar manner. 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 $125 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.

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 2028. 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 $480 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.

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)	–$4,505	–$3,822	–$3,266

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)	–$4,280	–$3,822	–$3,318

[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

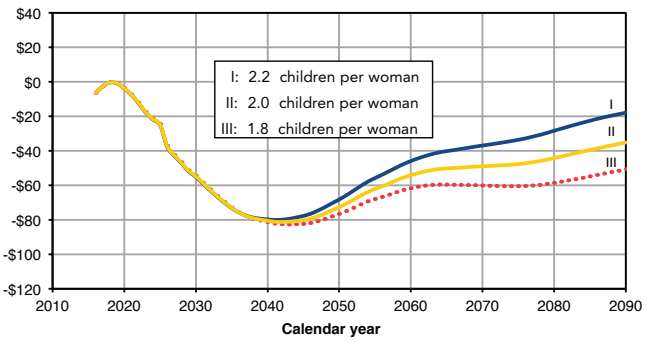
Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Average annual net immigration	**961,000**	**1,291,000**	**1,629,000**
Income minus expenditures *(in billions)*	**–$4,153**	**–$3,822**	**–$3,558**

CHART 9

Present Value of HI Net Cash FLow with Various Ultimate Fertility Rate Assumptions // 2016 – 2090

(IN BILLIONS)

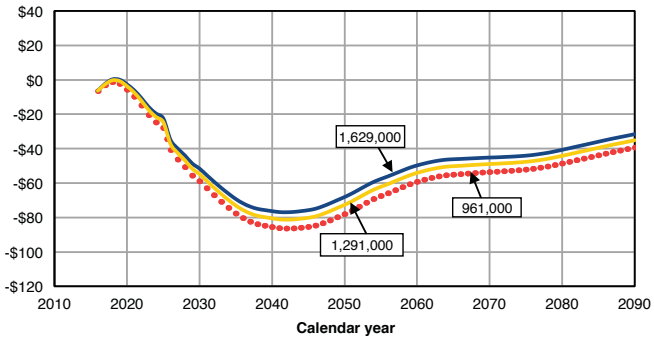


Source: CMS/OACT

CHART 10

Present Value of HI Net Cash FLow with Various Net Immigration Assumptions // 2016 – 2090

(IN BILLIONS)



Source: CMS/OACT

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 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, 1,291,000 persons, and 1,629,000 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 $331 billion. Conversely, if the assumption is 1,629,000 persons, the deficit decreases by $264 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 worsened 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 2028, 2 years earlier 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 tax income and expenditures are projected to be lower than last year's estimates, mostly due to lower CPI assumptions. The impact on expenditures is mitigated by lower productivity increases.

HI expenditures have exceeded income annually since 2008. However, the Trustees project slight surpluses in 2016 through 2020, with a return to deficits thereafter until the trust fund becomes depleted in 2028. 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 2016 is adequate to cover 2016 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 program is the impact of the rapid growth of SMI costs, which places steadily increasing demands on beneficiaries and taxpayers.

[14] A hold-harmless provision restricts Part B premium increases for most beneficiaries in 2016. The Bipartisan Budget Act of 2015 required that the 2016 monthly Part B premium be calculated as if the hold-harmless provision did not apply. However, it required a transfer of funds from the general fund to cover the premium income that is lost as a result of the provision. In 2017 there may be a substantial increase in the Part B premium rate for some beneficiaries.

[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.

Medicare Overall

The law requires the Board of Trustees to determine 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 (2016 – 2022). If this level is attained within the 7-year timeframe, Federal law requires a determination of projected excess general revenue Medicare funding. For the 2016 Medicare Trustees Report, this difference is not expected to exceed 45 percent of total expenditures in fiscal years 2016-2022 (the first 7 years of the projection), and therefore the Trustees are not 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, 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 2016 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, 2016

(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			$27,047	$334	$19,448	$131	$5,921	$2,867	$55,748	
Other Adjustments							941	(120)	821	
Recoveries of prior year unpaid obligations	$2	$1	484	30,726	417	14	480	385	32,509	
Other changes in unobligated balance	2	4	(3,659)	7		39	(246)	(55)	(3,908)	
Unobligated balance from prior year budget authority, net	4	5	23,872	31,067	19,865	184	7,096	3,077	85,170	
Appropriations (discretionary and mandatory)	296,844	314,009	333,197	362,295	16,473	78,550	11,039	2,313	1,414,720	
Borrowing authority (discretionary and mandatory)		3,720							3,720	$19
Spending authority from offsetting collections		(11,172)		872		14,110		10,184	13,994	637
TOTAL BUDGETARY RESOURCES	$296,848	$306,562	$357,069	$394,234	$36,338	$92,844	$18,135	$15,574	$1,517,604	$656
STATUS OF BUDGETARY RESOURCES:										
New Obligations and upward adjustments	$296,848	$306,562	$333,236	$393,821	$14,294	$92,804	$13,283	$18,606	$1,469,454	$32
Apportioned, Unexpired				140	11,711		4,630	1,736	18,217	8
Exempt from Apportionment, unexpired accounts								(7,909)	(7,909)	
Unapportioned, unexpired accounts				273	237		222	2,158	2,890	616
Unexpired unobligated balance, end of year				413	11,948		4,852	(4,015)	13,198	624
Expired unobligated balance, end of year			23,833		10,096	40		983	34,952	
Unobligated balance, end of year			23,833	413	22,044	40	4,852	(3,032)	48,150	624
TOTAL BUDGETARY RESOURCES	$296,848	$306,562	$357,069	$394,234	$36,338	$92,844	$18,135	$15,574	$1,517,604	$656
CHANGE IN OBLIGATED BALANCE:										
Unpaid obligations:										
Unpaid obligations, brought forward, October 1	$32,217	$23,290	$14,161	$41,573	$8,773	$17,555	$4,371	$10,560	$152,500	$375
Other Adjustments							(941)		(941)	
New Obligations and upward adjustments	296,848	306,562	333,236	393,821	14,294	92,804	13,283	18,606	1,469,454	32
Outlays (gross)	(297,203)	(304,020)	(319,843)	(364,613)	(14,358)	(95,706)	(12,718)	(11,772)	(1,420,233)	(370)
Recoveries of prior year unpaid obligations	(2)	(1)	(484)	(30,726)	(417)	(14)	(480)	(385)	(32,509)	
Unpaid obligations end of year (gross)	31,860	25,831	27,070	40,055	8,292	14,639	3,515	17,009	168,271	37
UNCOLLECTED PAYMENTS:										
Uncollected payments, Federal sources, brought forward, October 1		(11,172)						(7,631)	(18,803)	(159)
Other Adjustments								(38)	(38)	
Change in uncollected payments, Federal sources		11,172		(105)		(14,110)		(535)	(3,578)	145
Uncollected payments, Federal sources, end of year				(105)		(14,110)		(8,204)	(22,419)	(14)
Memorandum entries:										
Obligated balance, start of year, net	$32,217	$12,118	$14,161	$41,573	$8,773	$17,555	$4,371	$2,929	$133,697	$216
Obligated balance, end of year, net	31,860	25,831	27,070	39,950	8,292	529	3,515	8,805	145,852	23
BUDGETARY AUTHORITY AND OUTLAYS, NET:										
Budget authority, gross	$296,844	$306,557	$333,197	$363,167	$16,473	$92,660	$11,039	$12,497	$1,432,434	$656
Actual offsetting collections	(2)	(4)	(111)	(774)		(39)	(2)	(9,695)	(10,627)	(782)
Change in uncollected customer payments from Federal sources		11,172		(105)		(14,110)		(535)	(3,578)	145
Recoveries of prior year paid obligations	2	4	111	7		39	2	25	190	
Anticipated offsetting collections										
Budget authority, net (discretionary and mandatory)	296,844	317,729	333,197	362,295	16,473	78,550	11,039	2,292	1,418,419	19
Outlays, gross (discretionary and mandatory)	297,203	304,020	319,843	364,613	14,358	95,706	12,718	11,772	1,420,233	370
Actual offsetting collections (discretionary and mandatory)	(2)	(4)	(111)	(774)		(39)	(2)	(9,695)	(10,627)	(782)
Outlays, net (discretionary and mandatory)	297,201	304,016	319,732	363,839	14,358	95,667	12,716	2,077	1,409,606	(412)
Distributed offsetting receipts	(35,450)	(391,627)			(20)			(155)	(427,252)	
AGENCY OUTLAYS, NET (DISCRETIONARY AND MANDATORY)	$261,751	$(87,611)	$319,732	$363,839	$14,338	$95,667	$12,716	$1,922	$982,354	$(412)

SUPPLEMENTARY INFORMATION

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

CONSOLIDATING BALANCE SHEET

as of September 30, 2016

(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	$2,059	$51,747	$53,806	$40,365	$31,816	$9,704	$4,356	$140,047		$140,047
Investments	194,009	63,792	257,801		570			258,371		258,371
Accounts Receivable, Net	34,092	39,833	73,925	190	9	479	5,616	80,219	$(79,630)	589
Other Assets	26	2	28					28		28
Total Intragovernmental Assets	**230,186**	**155,374**	**385,560**	**40,555**	**32,395**	**10,183**	**9,972**	**478,665**	**(79,630)**	**399,035**
Accounts Receivable, Net	1,053	6,400	7,453	7,196	3	8,781	146	23,579		23,579
General Property, Plant & Equipment, Net	95	155	250	12	1	54	429	746		746
Other Assets	6,889	14,626	21,515	37		1,006	110	22,668		22,668
TOTAL ASSETS	**$238,223**	**$176,555**	**$414,778**	**$47,800**	**$32,399**	**$20,024**	**$10,657**	**$525,658**	**$(79,630)**	**$446,028**
LIABILITIES										
Intragovernmental Liabilities:										
Accounts Payable	$35,065	$41,673	$76,738			$98	$3	$76,839	$(76,214)	$625
Accrued Payroll and Benefits	2	4	6			3		9		9
Other Intragovernmental Liabilities	4	3,289	3,293			1,537	3,455	8,285	(3,416)	4,869
Total Intragovernmental Liabilities	**35,071**	**44,966**	**80,037**			**1,638**	**3,458**	**85,133**	**(79,630)**	**5,503**
Accounts Payable	161	32	193	$3		41	35	272		272
Federal Employee and Veterans' Benefits	3	6	9			2		11		11
Entitlement Benefits Due and Payable	27,756	36,155	63,911	35,419	978		7,922	108,230		108,230
Accrued Payroll and Benefits	23	34	57	2		19	4	82		82
Contingencies	660		660	10,166				10,826		10,826
Other Liabilities	475	834	1,309	30		10,974	42	12,355		12,355
TOTAL LIABILITIES	**$64,149**	**$82,027**	**$146,176**	**$45,620**	**$978**	**$12,674**	**$11,461**	**$216,909**	**$(79,630)**	**$137,279**
NET POSITION										
Unexpended Appropriations-Dedicated Collections	$1,073	$34,939	$36,012					$36,012		$36,012
Unexpended Appropriations-Other Funds				$4,995	$31,385	$6,936	$3,531	46,847		46,847
Cumulative Results of Operations-Dedicated Collections	173,001	59,589	232,590			(941)	(4,493)	227,156		227,156
Cumulative Results of Operations-Other Funds				(2,815)	36	1,355	158	(1,266)		(1,266)
TOTAL NET POSITION	**$174,074**	**$94,528**	**$268,602**	**$2,180**	**$31,421**	**$7,350**	**$(804)**	**$308,749**		**$308,749**
TOTAL LIABILITIES AND NET POSITION	**$238,223**	**$176,555**	**$414,778**	**$47,800**	**$32,399**	**$20,024**	**$10,657**	**$525,658**	**$(79,630)**	**$446,028**

CONSOLIDATING STATEMENT OF NET COST

for the year ended September 30, 2016

(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)	$277,763	$288,351	$566,114					$566,114
Medicaid				$363,060				363,060
CHIP					$14,579			14,579
Net Cost: GPRA Programs	277,763	288,351	566,114	363,060	14,579			943,753
Other Activities:								
State Grants and Demonstrations							$519	519
Other Health						$3,168		3,168
Other							5,620	5,620
Net Cost: Other Activities						$3,168	6,139	9,307
NET COST OF OPERATIONS	**$277,763**	**$288,351**	**$566,114**	**$363,060**	**$14,579**	**$3,168**	**$6,139**	**$953,060**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2016

(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	$169,630	$46,949	$216,579	$1,742	$19	$574	$1,131	$(1,225)	$218,820
Budgetary Financing Sources:									
Appropriations Used	24,314	299,139	323,453	357,471	14,562	2,226	760		698,472
Nonexchange Revenue:									
FICA and SECA Taxes	250,472		250,472						250,472
Interest on Investments	7,855	2,028	9,883		17				9,900
Other Nonexchange Revenue	826	2,863	3,689						3,689
Transfers-in/out Without Reimbursement	(2,348)	(3,061)	(5,409)	1,030	17	886	160	977	(2,339)
Other									
Other Financing Sources (Nonexchange):									
Transfers-in/out Without Reimbursement						(123)	123		
Imputed Financing	15	22	37	2		14	3		56
Other						3	(123)		(120)
Total Financing Sources	**281,134**	**300,991**	**582,125**	**358,503**	**14,596**	**3,006**	**923**	**977**	**960,130**
Net Cost of Operations	**277,763**	**288,351**	**566,114**	**363,060**	**14,579**	**3,168**	**953**	**5,186**	**953,060**
Net Change	**3,371**	**12,640**	**16,011**	**(4,557)**	**17**	**(162)**	**(30)**	**(4,209)**	**7,070**
Cumulative Results of Operations	**$173,001**	**$59,589**	**$232,590**	**$(2,815)**	**$36**	**$ 412**	**$ 1,101**	**$ (5,434)**	**$225,890**
UNEXPENDED APPROPRIATIONS									
Beginning Balances	$895	$29,389	$30,284	$171	$27,446	$8,821	$3,915		$70,637
Budgetary Financing Sources:									
Appropriations Received	24,841	326,469	351,310	451,155	23,180	601	667		826,913
Appropriations Transferred-in/out				(4,377)		(1)			(4,378)
Other Adjustments	(349)	(21,780)	(22,129)	(84,483)	(4,679)	(259)	(291)		(111,841)
Appropriations Used	(24,314)	(299,139)	(323,453)	(357,471)	(14,562)	(2,226)	(760)		(698,472)
Total Budgetary Financing Sources	**178**	**5,550**	**5,728**	**4,824**	**3,939**	**(1,885)**	**(384)**		**12,222**
Total Unexpended Appropriations	**1,073**	**34,939**	**36,012**	**4,995**	**31,385**	**6,936**	**3,531**		**82,859**
Net Position	**$174,074**	**$94,528**	**$268,602**	**$2,180**	**$31,421**	**$7,348**	**$4,632**	**$(5,434)**	**$308,749**

AUDIT REPORTS

The following reports were prepared by Ernst & Young.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

NOV 04 2016

TO: Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson
Inspector General

SUBJECT: Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2016 (A-17-16-02016)

This memorandum transmits the independent auditors' reports on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2016 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, 2016 and 2015, 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, 2016, 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 15-02, *Audit Requirements for Federal Financial Statements*.

Results of the Independent Audit

Ernst & Young found that the FY 2016 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, 2016 and 2015, CMS management noted in the financial statement footnotes the Medicare Board of Trustees alternative scenario that illustrates, when possible, the potential understatement of Medicare cost and projection results. This scenario assumes that the various cost-reduction measures will occur as current law requires.

The most important of these measures are 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, 2016, 2015, 2014, 2013, and 2012, and the related statements of changes in social insurance amounts for the periods ended January 1, 2016 and 2015. 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*, 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. During the FY 2016 audit, errors were noted that were not detected by the organization's monitoring and review function, which showed the control was not functioning as designed or intended. There were continued weaknesses in oversight of the Medicaid program. In addition, issues with CMS's third-party contractors were identified. Required actions have not resolved issues or been taken. Also, CMS lacks needed functionality in its Healthcare Integrated General Ledger and Accounting System, which prompts the need for system interventions to properly categorize information in the financial statements. These deficiencies collectively represent a significant deficiency in internal control.

[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.

Page 3 – Andrew M. Slavitt

- *Information Systems Controls*—Ernst & Young noted that CMS continues to experience difficulties in implementing and monitoring of access controls and segregation of duties. CMS continues to experience deficiencies in the implementation and monitoring of compliance with its 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 Medicare Fee-for-Service and Medicaid program error rates exceeded the mandated 10-percent threshold. In addition, CMS's other programs: Medicare Advantage, and CHIP programs did not meet their targeted reduction rates for FY 2016. Also, CMS was not in compliance with section 6411 of the Patient Protection and 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 15-02.

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 Gloria L. Jarmon, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at Gloria.Jarmon@oig.hhs.gov. Please refer to report number A-17-16-02016.

Attachment

cc:
Ellen Murray
Assistant Secretary for Financial Resources
and 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

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Report of Independent Auditors

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

Report on the Financial Statements

We have audited the accompanying consolidated balance sheets of the Centers for Medicare and Medicaid Services (CMS) as of September 30, 2016 and 2015, 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 engaged to audit the statements of social insurance as of January 1, 2016, 2015, 2014, 2013 and 2012, the related statements of changes in social insurance amounts for the periods ended January 1, 2016 and 2015, and the related notes to these 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, 2016, 2015, 2014, 2013 and 2012, the related statements of changes in social insurance amounts for the periods ended January 1, 2016 and 2015, 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 Bulletin No. 15-02, *Audit Requirements for Federal Financial Statements*. Those standards and bulletin 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

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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, 2016 and 2015, 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. 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, 2016, 2015, 2014, 2013 and 2012, 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, 2016, 2015, 2014, 2013 and 2012, and the related statements of changes in social insurance amounts for the periods ended January 1, 2016 and 2015.

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, 2016, 2015, 2014, 2013 and 2012, and the related changes in the social insurance program for the periods ended January 1, 2016 and 2015.

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, 2016 and 2015, 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

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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 4, 2016 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 4, 2016

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

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

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 15-02, *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, 2016 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, 2016, and the related statement of changes in social insurance amounts for the period ended January 1, 2016, and have issued our report thereon dated November 4, 2016. 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, 2016 and the related statement of changes in social insurance amounts for the period ended January 1, 2016.

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. 15-02. 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. 15-02, and which are described below.

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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 2013 (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. 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 Medicare fee-for-service and Medicaid improper payment error rates are greater than the statutorily required maximum of 10 percent and CMS did not meet its improper rate reduction target rates for Children's Health Insurance Program (CHIP) and Medicare Advantage (Part C). 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. To date, CMS posted a Request for Quote in June 2014; however, no responses were received but CMS anticipates executing a contract in fiscal year 2017.

CMS' Response to Findings

CMS' response to the findings identified in our audit are described in their letter dated November 4, 2016. 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 4, 2016

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

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

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 15-02, *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, 2016 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, 2016, and the related statement of changes in social insurance amounts for the period ended January 1, 2016, and have issued our report thereon dated November 4, 2016. 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, 2016 and the related statement of changes in social insurance amounts for the period ended January 1, 2016.

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 the CMS' internal control. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 15-02. 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

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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). We identified deficiencies in implementing new program processes, designing financial controls, and the precision used in executing financial controls. We also have recommendations to improve controls by validating the CMS liability estimation methodologies by using a claims-based approach and monitoring adherence to established policies and procedures. We observed that at times there appears to be a lack of coordination and collaboration within the organization to resolve either the symptoms of or the broader organizational findings. CMS should continue to focus its efforts on identifying the

underlying cause of the deficiencies, establishing the proper set of controls and implementing an effective monitoring function to mitigate the risks over its financial management programs and related systems.

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. Additional focus is required to minimize the risk of current and unresolved prior year deficiencies.

Analyses Required for an Effective Financial Management System

Critical or new financial matters resulting from new laws implemented during or prior to the current financial reporting period require a robust analysis and review process. This requires coordination and collaboration with Centers and Offices as well as the Department of Health and Human Services and other agencies as appropriate, as well as the summarization of considerations and conclusions, and documentation of the significant accounting and budget matters. Improvements were made in this area during fiscal 2016; however, CMS should continue to focus on the timely identification of matters requiring analysis and communication with appropriate parties.

During our procedures, certain errors were identified that were not detected by the organization's monitoring and review function, and accordingly, the related control was not functioning as designed or intended. The errors identified by our audit procedures at the Central Office and regional offices may be summarized, as follows: (i) policies and procedures are not properly designed and implemented; (ii) review or monitoring functions are established but failed to adhere to policies and procedures (for example, the Statement of Social Insurance (SOSI) model review process did not identify an error within an assumption utilized to project Part B expenditures); and (iii) activity or accounts for which no formal, documented review or monitoring function was established.

Because of its size and complexity, CMS by design relies upon a vast decentralized set of controls, performed by a very large number of people. Oversight of the effectiveness of that control structure at the Central Office could be enhanced by increasing the use of data analytics. Developing robust analytical review procedures or measures against benchmarks to monitor and mitigate risks associated within the decentralized nature of CMS operations should be enhanced and documented as part of the entity level control structure. It may be beneficial for CMS to identify a cross-functional working group to perform such analyses.

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

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Medicaid claims and certain services related to the Medicare Part C and Part D programs. We identified areas where improvements could be made in the control environment related to the oversight of third-party contractors.

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, the oversight/monitoring process historically has not been fully effective in identifying and resolving financial recording and reporting issues or ensuring that the issues are timely remediated by the MACs.

As noted in the prior year, we identified deficiencies where actions are required but have not been taken or resolved in the following circumstances: (1) the Medicare Summary Notices, which are returned to the MACs but are not investigated as to why they are returned; (2) the claims outstanding greater than one year – periodic review, track or monitor those aged claims other than those identified as bankruptcy, fraud or abuse; and (3) the provider records – reconcile, review or monitor provider records and provider eligibility status on a periodic basis to verify that all changes were timely, accurately and completely processed.

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, Medicare Advantage, Medicare Prescription Drugs, Medicaid and Children's Health Insurance Program (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 they build 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. Over the past couple of years, CMS made improvements in developing and implementing action plans to reduce improper payment error rates, which resulted in declines in the Medicare Fee-For-Service (FFS) and Medicare Part D rates year over year. Despite CMS' extensive actions to reduce improper payment vulnerabilities to increase payment accuracy, the improper payment error rates for the Medicare FFS and Medicaid still remain high in comparison to the Federal Government's stated goals.

Continued Implementation of the Integrated Financial Management System

CMS continues their efforts to implement a web-based accounting system, Healthcare Integrated General Ledger Accounting System (HIGLAS), which will integrate the reporting of financial data related to the CMS contractors' standard claims processing systems. All of the MACs have implemented HIGLAS, except for the Durable Medical Equipment MACs. For these contractors, the accuracy of the financial reports remains heavily dependent on inefficient, labor-intensive, manual processes that are also subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to CMS.

HIGLAS is the system of record and CMS is preparing financial statements using HIGLAS. In the prior year, CMS implemented an upgrade of HIGLAS; however, the full functionality of HIGLAS has not yet been implemented. The MACs' accounts receivable balances are recorded at Central Office through the manual journal voucher process. Although the creation of the periodic financial statements is largely system dependent, there is a need for manual interventions to properly categorize the information within the financial statements, as required by OMB A-136.

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 90 percent thereafter, for states that elected to participate in the program (Medicaid Expansion). The Center for Medicaid and 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

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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.

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, the Office of the Actuary (OACT) has begun to quantify the effects of risk mitigation strategies related to the Medicaid expansion population which are expected to result in recoveries of previous expenditures. 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 2016 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.

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:

- Continued focus on the timely identification and evaluation of unique, newly implemented, non-routine or significant transactions, such as law changes, and communication with appropriate parties both inside and outside of CMS in a timely manner to ensure that the financial statements appropriately reflect these transactions.

- Develop robust analytical procedures or measures against benchmarks to monitor and mitigate risks associated with the decentralized nature of CMS operations should be enhanced and documented as part of the entity level control structure.

- 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. Revise and enhance the design of the financial review guidance, as necessary, for the various Centers, regional offices and MACs to incorporate more analyses and scrutiny in the review of the financial information.

- 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.

- Continue to implement its integrated financial management system for use by CMS and the Medicare fee-for-service contractors to promote consistency and reliability in accounting and financial reporting and assess the capability of and implement the full functionality of HIGLAS.

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

- 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 $35.4 billion accrual.

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, implementation of new protections for beneficiary data, and more restrictive system authentication access methods.

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 fee-for-service, 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 fee-for-service 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 fee-for-service 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 fee-for-service 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 fee-for-service 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

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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 Technology Solutions (OTS), Office of Enterprise Information (OEI), 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. In several instances, the remediation, mitigation of risks, or monitoring of these vulnerabilities was not performed or not performed timely.

- CMS has not developed sufficient oversight procedures to monitor configuration deviations at SSMs.

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

- 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 fee-for-service 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 (POA&M).

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.
- Users for two Central Office applications did not have adequate segregation of duties in place as they were provided additional administrator rights.

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 fee-for-service systems and data at both the Central Office and the CMS Medicare fee-for-service contractors. Such an approach will require continued and active communication and integration of efforts by the OTS, OEI 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 fee-for-service contractors in accordance with CMS' policies and guidance, related monitoring procedures, mitigation of risk, and timely remediation of identified vulnerabilities.
- Develop and implement sufficient oversight procedures for configuration deviations.

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- Documentation should be prepared and retained for all phases of the change management process, as required by CMS guidance.
- 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.
- Appropriate segregation of duties is established and maintained for all systems that support CMS' programs, including Medicare fee-for-service claims and related financial processing at the MACs and VDCs to prevent excessive or inappropriate access.

CMS' Response to Findings

CMS' response to the findings identified in our audit are described in the accompanying letter dated November 4, 2016. 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 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 4, 2016

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

November 4, 2016

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

Dear Sir:

On behalf of the Centers for Medicare & Medicaid Services, I would like to thank your office for its diligence and hard work while conducting this year's Chief Financial Officers Act audit. We are pleased with the results of your audit of our fiscal year 2016 financial statements, and are proud of the continued achievement of an unmodified opinion on our Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position and the Combined Statement of Budgetary Resources.

Again, you were not able to express an opinion on the Statement of Social Insurance (SOSI) and the related Statement of Changes in Social Insurance Amounts (SCSIA). However, we look forward to continuing our collaboration with you to explore options for reporting the SOSI and the SCSIA in a manner that may allow you to opine on these statements for future annual financial statement audits.

While you identified no material weaknesses in our internal controls, you continue to cite significant deficiencies in our financial reporting processes and information systems controls. We acknowledge that we must take swift action to address these issues, and we remain fully committed to strengthening our controls to mitigate these risks.

Again, I would like to thank your office for its work in completing the audit efficiently and effectively, and look forward to our continued partnership in working to remediate the issues for the future.

Sincerely,

Jennifer Main
Chief Financial Officer

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OTHER INFORMATION

Summary of Federal Managers' Financial Integrity Act and OMB Circular 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 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) 16 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 Officer (CFO) Act audit; (8) security assessment and authorization of systems; and (9) Department Enterprise Risk Management efforts. As of September 30, 2016, 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 controls and financial management systems to determine whether these objectives are being met. Accordingly, as of September 30, 2016, CMS provided a qualified statement of reasonable assurance that its internal controls and financial management systems met the objectives of FMFIA due to noncompliance with the Improper Payments Information Act of 2002 (IPIA), as amended by the Improper Payments Elimination and Recovery Act (IPERA), signed into law on July 22, 2010, and the Improper Payments Elimination and Recovery Improvement Act (IPERIA), signed into law on January 10, 2013; and Section 6411 of the Affordable Care Act, hereafter referenced as IPERIA.

Assurance for Internal Control over Financial Reporting

CMS conducted its assessment of the effectiveness of internal control over financial reporting, which includes the safeguarding of assets and compliance with applicable laws and regulations, in accordance with the requirements of Appendix A of OMB Circular No. A-123. Based on the results of this assessment, CMS provided reasonable assurance that internal controls over financial reporting as of June 30, 2016, 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, 2016, CMS provided reasonable assurance that internal controls over operations were effective, and no material weaknesses were found in the design or operation of these internal controls. As of September 30, 2016, 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 comply with FFMIA as of September 30, 2016.

Noncompliance—Actions and Accomplishments

CMS did not fully comply with IPERIA, and Section 6411 of the Affordable Care Act. For Medicare fee-for-service (FFS), CMS and HHS work together to set aggressive reduction targets in an effort to drive improvement in payment accuracy levels. CMS has several 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 FY 2016 IPERIA noncompliance stems from the following:

1. The Medicare FFS improper payment rate was 11.00 percent, meeting the IPERIA reduction target but not meeting the compliance threshold of reporting an improper payment rate below 10 percent.
2. The Medicare Part C improper payment rate was 9.99 percent, meeting the IPERIA compliance threshold of reporting an improper payment rate below 10 percent. However, the Part C improper payment rate did not meet its previously established target of 9.14 percent.
3. The Medicaid improper payment rate was 10.48 percent. Although the improper payment rate was higher than 10 percent, CMS did meet its previously established target of 11.53 percent.
4. The FY 2016 CHIP improper payment rate was 7.99 percent. Although the improper payment rate was lower than 10 percent, CMS did not meet its previously established target of 6.81 percent.

CMS has taken, and continues to take a number of actions outlined in the FY 2016 Agency Financial Report (AFR). CMS continues its efforts to comply with IPERIA and OMB's implementing guidance.

Regarding compliance with Section 6411 of the Affordable Care Act, 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. A Request for Quote was posted in June 2014; however, no responses were received from that solicitation. More recently, a Request for Information (RFI) was posted in December 2015 to solicit additional feedback from industry. CMS continues its implementation efforts and anticipates awarding a contract in 2017.

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 FFS, Medicaid, CHIP, Medicare Advantage (Part C), and Medicare Prescription Drug (Part D) programs.

Medicare Fee-for-Service (FFS)

CMS measures the national Medicare FFS improper payment rate annually, through the Comprehensive Error Rate Testing (CERT) program. The Medicare FFS measurement methodology is the same as the FY 2015 methodology. The estimated percentage of Medicare FFS dollars paid correctly was 89.00 percent. This means Medicare paid an estimated $332.57 billion correctly.

The CERT program calculates the Medicare FFS payment accuracy rate by reviewing claims and the supporting medical records. These reviews uncover more complex issues including lack of information and lack of medical necessity. These issues are not detectable through automated methods. CMS believes that more can be done to achieve an even greater payment accuracy rate. To do this, CMS must focus its corrective actions on specific areas that are most vulnerable to improper payments.

To reduce improper payments within Medicare FFS, CMS is implementing a number of measures that focus on prevention. CMS's corrective actions include policy clarifications and simplifications, when appropriate, and more individualized education through smaller probe reviews, followed by specific education based on the findings of these reviews. CMS is also committed to exploring opportunities to implement prior authorization and pre-claim review programs. In addition to helping educate providers and suppliers and reduce appeals, these programs also help reduce improper payments.

FY 2016 Gross Improper Payments and Error Rates in the Medicare FFS Program

GROSS[1]			
Overpayments	Underpayments	Improper Payment Amount (Overpayments + Underpayments)	Improper Payment Rate
$39.84 B	$1.24 B	$41.08 B	11.00%

[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 in FY 2016. This approach is consistent with: (1) Administrative Law Judge (ALJ) and Departmental Appeals Board (DAB) decisions that directed HHS 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 0.19 percentage points to 11.00 percent or $41.08 billion in projected improper payments.

Medicare Advantage (Part C) and Prescription Drugs (Part D)

CMS has reported a Part C payment error rate since FY 2008. The Part C error rate measures improper payments made to Medicare Advantage (MA) plans based on diagnoses submitted by MA plans for payment (or risk adjustment error). The Part C payment error rate was 9.99 percent for the FY 2016 reporting period.

From FY 2011 to FY 2015, CMS reported a composite payment error rate for the Medicare Prescription Drug Benefit, a Medicare benefit effective calendar year 2006. The Part D composite payment error rate combined four component error rates into a single measure for total Part D payments: (1) Payment Error Related to Low Income Status (PELS); (2) Payment Error Related to Incorrect Medicaid Status (PEMS); (3) Payment Error Related to Prescription Drug Event (PDE) Data Validation (PEPV); and (4) Payment Error Related to Direct and Indirect Remuneration (PEDIR). Due to the year over year decline and low amount of error in the PELS, PEDIR, and PEMS measures, CMS will no longer include these components in the error rate. Beginning with FY 2016 reporting, the Part D error rate is based on PDE validation measured by PEPV. The Part D payment error rate was 3.41 percent for the FY 2016 reporting period.

Medicaid and CHIP

Medicaid and CHIP are susceptible to erroneous payments as well. Thus, the federal government and the states both have a strong financial interest in ensuring that claims are paid accurately.

CMS measures the national improper payment rate for Medicaid and CHIP annually, through the Payment Error Rate Measurement (PERM) program. Through PERM, CMS measures three areas of Medicaid and CHIP: FFS claims, managed care payments, and eligibility cases. A sample of 17 states is measured each year to produce and report national program improper payment rates.

The FY 2016 Medicaid and CHIP improper payment rate report period covers payments made through September 30, 2015. 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 Affordable Care Act. 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 Affordable Care Act requirements),while CMS updates the PERM eligibility component review methodology to reflect the new Affordable Care Act rules. CMS published a PERM Notice of Proposed Rule-Making (NPRM) on June 22, 2016. CMS will issue a new final regulation and guidance, and resume the PERM eligibility component for reporting in FY 2019.

The national Medicaid improper payment rate reported for FY 2016 is 10.48 percent or $36.25 billion in gross improper payments based on measurements conducted in FYs 2014, 2015, and 2016. The national component improper payment rates are as follows, Medicaid FFS: 12.42 percent;

Medicaid managed care: 0.25 percent. Medicaid eligibility remains at the FY 2014 level of 3.11 percent.

The Medicaid improper payment rate increased from 9.78 percent in FY 2015 to 10.48 percent in FY 2016. The increase was due to state difficulties bringing systems into compliance with new requirements for: (1) all referring or ordering providers to be enrolled in Medicaid and the inclusion of the referring or ordering National Provider Identifier (NPI) on claims, (2) states to screen providers under a risk-based screening process prior to enrollment, and (3) the inclusion of the attending provider NPI on all electronically filed institutional claims. While these requirements will ultimately strengthen Medicaid's integrity, it is not unusual to see increases in improper payment rates following the implementation and initial measurement of new requirements because it takes time for states to make the changes required for compliance. As in FY 2015, the 17 states reviewed in FY 2016 are still in the process of implementing these requirements.

The national CHIP improper payment rate reported for FY 2016 is 7.99 percent, or $737.59 million in gross improper payments based on measurements conducted in FYs 2014, 2015, and 2016. The national component improper payment rates are as follows: CHIP FFS: 10.15 percent; CHIP managed care: 1.01 percent. CHIP eligibility remains at the FY 2014 level of 4.22 percent.

The CHIP improper payment rate increased from 6.80 percent in FY 2015 to 7.99 percent in FY 2016. The increase was due to state difficulties bringing systems into compliance with the new requirements described above for Medicaid.

CMS works closely with states to develop state-specific corrective action plans which address improper payments identified and describe system updates to bring states into compliance.

Although all states are included in the improper payment rates, CMS only reviews 17 states each year. In FY 2014, CMS reported a rate reflecting the first 17 states measured under the new requirements. The 2015 improper payment rates reflected the second group of 17 states subject to new requirements for a total of 34 states. The FY 2016 rate reflects the measurement of the final group of 17 states subject to new requirements. CMS expects to see a decrease in improper payment rates in following years as states that have implemented corrective actions are measured again.

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 Affordable Care Act implementation. The pilots identify strengths and weaknesses in operations and systems to allow states to quickly implement corrective actions.

Affordable Care Act Risk Assessments

In accordance with IPERIA, CMS has conducted risk assessments to determine areas that might affect Advance Premium Tax Credit (APTC), Cost-Sharing Reduction (CSR), and other Marketplace programs' payment accuracy. CMS concluded that the APTC and CSR programs are susceptible to significant improper payments. CMS is deferring a final risk assessment conclusion for the Basic Health Program (BHP) to allow the program to become more fully established, and has determined that the remaining programs are not susceptible to significant improper payments. CMS will begin piloting improper payment measurement methodologies in FY 2017 for those programs deemed susceptible to significant improper payments. The BHP risk assessment conclusion and updates on the APTC and CSR improper payment measurement methodology development will be provided in the FY 2017 CMS Financial Report.

Additional information on the Affordable Care Act Risk Assessments can be found in the HHS and Department of the Treasury's 2016 Agency Financial Reports.

More information on the pilots can be found at: **https://www.cms.gov/Research- Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/FY2014_FY2016EligibilityReviewPilots-.html.**

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 basis of accounting that recognizes costs when incurred and revenues when earned and includes the effect of accounts receivable and accounts payable when determining annual net income.

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 eligible consumers can receive in advance to lower their monthly health insurance premiums. The amount is based on the costs of health plans in the applicable Marketplace 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, healthcare, 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 entitled under the law to receive Medicare or Medicaid benefits (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 Balanced Budget Act of 1997 (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 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.

Corrective Action Plan (CAP): The detailed actions and milestones management plans to use to resolve an audit finding or internal control deficiency.

Cost-Based Health Maintenance Organization (HMO)/Competitive Medical Plan (CMP): A type of managed care organization that will pay for all of the enrollees/members' medical care costs in return for a monthly premium, plus any applicable deductible or co-payment. The HMO will pay for all hospital costs (generally referred to as Part A) and physician costs (generally referred to as Part B) that it has arranged for and ordered. Like a health care prepayment plan (HCPP), except for out-of-area emergency services, if a Medicare member/enrollee chooses to obtain services that have not been arranged for by the HMO, he/she is liable for any applicable deductible and co-insurance amounts, with the balance to be paid by the regional Medicare intermediary and/or carrier.

Cost Sharing Reduction: Payments to health care insurers on behalf of eligible insured 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; restrain Medicaid spending by reducing Federal overpayment for prescription drugs so that taxpayers do not have to pay inflated markups; and includes 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.

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 Information Security Management Act of 2002 (FISMA): A law that outlines a mandate for improving the information security framework of Federal agencies, contractors and other entities that handle Federal data (i.e., state and local governments). Consists of a set of directives governing what security responsibilities Federal entities have, and it outlines oversight and management roles to the implementation of those directives. FISMA requires an annual review of agencies' information security programs, along with a report of the results to OMB.

Federal Insurance Contribution Act (FICA) Payroll Tax: Medicare's share of FICA is used to fund the 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.

Federal Medical Assistance Percentage (FMAP): The portion of the Medicaid program that is paid by the Federal Government.

G

Government and 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 the Office of Management and Budget (OMB) on the first Monday in February of any year following that in which the term of the President commences and to notify the President and Congress.

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

H

Health Care Prepayment Plan (HCPP): A type of managed care organization. In return for a monthly premium, plus any applicable deductible or co-payment, all or most of an individual's physician services will be provided by the HCPP. The HCPP will pay for all services it has arranged for (and any emergency services) whether provided by its own physicians or its contracted network of physicians. If a member enrolled in an HCPP chooses to receive services that have not been arranged for by the HCPP, he/she is liable for any applicable Medicare deductible and/or coinsurance amounts, and any balance would be paid by the regional Medicare carrier.

Health Information Technology (HIT): Health information technology (HIT) involves the exchange of health information in an electronic environment.

Health Information Technology for Economic and Clinical Health Act (HITECH): The American Recovery and Reinvestment Act of 2009 (ARRA) includes the "HITECH Act," which established programs under Medicare and Medicaid to incentivize payments to eligible professionals (EPs), hospitals, and critical access hospitals that demonstrate "meaningful use" of certified EHR technology. For those eligible professionals (EPs), hospitals, and critical access hospitals who do not demonstrate "meaningful use" of certified EHR technology, their payments are adjusted downward.

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

I

Improper Payments Elimination and Recovery Act (IPERA): In FY 2010, Congress amended the Improper Payment Information Act (IPIA), which is now known as the Improper Payment Eliminations and Recovery Act of 2010 (IPERA) (Public Law 111-204), to aim in standardizing the way Federal agencies report improper payments in programs they oversee or administer. The IPERA 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). Incorrect payments also include payments to ineligible recipients or payments for ineligible services, as well as duplicate payments and payments for services not received.

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

Internal Controls: Process effected 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

Marketplace: A mechanism for facilitating the purchase of Qualified Health Plans and evaluating eligibility for Advance Premium Tax Credits and Cost Sharing Reductions.

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: Medicare is 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, extends the Children's Health Insurance Program (CHIP), and makes 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 Federal Managers' Financial Integrity Act of 1982.

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 comprehensive health insurance reforms, lower costs, and improve health care accessibility. The Affordable Care Act intends to increase health insurance quality and affordability, lower the uninsured rate by expanding insurance coverage, and reduce the cost of healthcare through mandates, subsidies and competitive insurance exchanges. 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.

Pre-Existing Condition Insurance Plan (PCIP): PCIP is a plan created by the Affordable Care Act to make health coverage available to people with pre-existing conditions and those who have been denied health coverage because of their health condition.

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.

R

Recipient: An individual covered by the Medicaid program (also referred to as a beneficiary).

Reinsurance: The transitional reinsurance program stabilizes premiums in the individual market inside and outside of the Marketplaces. The transitional reinsurance program will collect 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: The recognition of income earned and the use of appropriated capital from the rendering of services in the current period.

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 provides 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 Marketplace. This program, which was modeled after a similar program used in the Medicare prescription drug benefit, encourages issuers to keep their rates stable as they adjust to the new health insurance reforms in the early years of the Marketplaces.

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: 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.

Solo Practitioners: A single Taxpayer Identification Number (TIN) with one eligible professional who is identified by an individual National Provider Identifier (NPI) billing under the TIN.

Statement on Standards for Attestation Engagements Number 16 (SSAE 16): 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 16 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.

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

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