CMS FINANCIAL REPORT

fiscal year
2012

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 2012 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 major sections:

MANAGEMENT'S DISCUSSION & ANALYSIS:
This section gives an overview of our organization, programs, performance goals, and financial accomplishments.

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

OTHER ACCOMPANYING INFORMATION:
This section includes the Summary of the Federal Manager's Financial Integrity Act and the Office of Management and Budget (OMB) Circular A-123—Statement of Assurance, Improper Payments, Review of Medicare's Program for Oversight for Accreditation Organizations, and Clinical Laboratory Improvement Validation Program.

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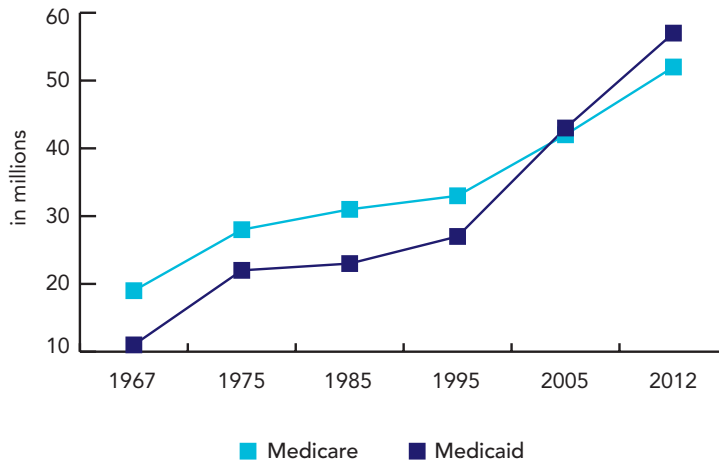
2012 PROGRAM ENROLLMENT

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 over 50 million beneficiaries. Medicaid enrollment has increased from 10 million beneficiaries in 1967 to about 57 million beneficiaries.

2012 PROGRAM ENROLLMENT

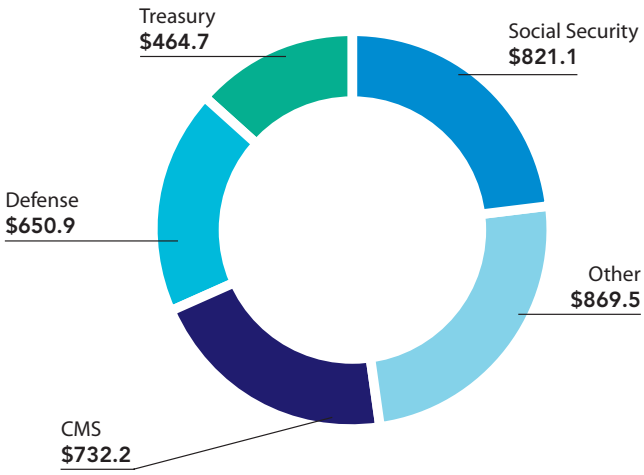


2012 FEDERAL OUTLAYS

CMS has outlays of approximately $732.2 billion (net of offsetting receipts and Payments of the Health Care Trust Funds) in fiscal year (FY) 2012, approximately 21 percent of total Federal outlays.

CMS has over 5,000 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

2012 FEDERAL OUTLAYS



$ in billions

Source: U.S. Treasury

A MESSAGE FROM THE ACTING ADMINISTRATOR

MARILYN TAVENNER

As the Acting Administrator of the Centers for Medicare & Medicaid Services (CMS), I welcome the opportunity to present the CMS Financial Report for fiscal year (FY) 2012. This financial report provides valuable insight into CMS' many programs and initiatives, and reports to the American people our efforts to protect the financial resources entrusted to us. We take our role very seriously, as our fiduciary responsibilities impact the health care of millions of American citizens. As the largest health care purchaser in the country, we are continually seeking strategies that will promote high quality health care. To this end, there were many initiatives undertaken during FY 2012 to further enhance our efforts for better care, better health, and lower health care costs.

CMS is continuing in its implementation of electronic health records (EHRs). Adoption of EHRs will make it easier for physicians, hospitals, and others serving Medicare beneficiaries to assess a patient's medical status and make sure that care is appropriate. They will also help eliminate redundant and costly procedures. CMS plans to increase its outreach efforts with beneficiaries regarding the importance of reviewing their records and reporting potential inaccuracies and intends to pilot enhanced auditing and investigation procedures.

Since the enactment of the Affordable Care Act, 5.6 million seniors and people with disabilities have saved nearly $4.8 billion on prescription drugs. Just this year, 2.3 million people in the Medicare prescription drug coverage gap known as the "donut hole" have saved an average of $657. In 2010, anyone with Medicare who hit the prescription drug donut hole received a $250 rebate. In 2011, people with Medicare who hit the donut hole began receiving a 50 percent discount on covered brand-name drugs and coverage for generic drugs. These discounts and Medicare coverage will gradually increase until 2020, when the donut hole is closed. Thus, the out-of-pocket savings on medications for people with Medicare will continue to grow.

CMS is currently partnering with 152 organizations in Medicare shared savings or accountable care organization (ACO) arrangements that reward healthcare providers for providing patients with high quality care that lowers the growth in cost to Medicare. In 2012 alone, CMS launched the initial performance periods of the Medicare Shared Savings Program and the Pioneer ACO Model, joining six physician group practices participating in the Physician Group Practice Transition Demonstration in offering care to more than 2.5 million beneficiaries. ACOs participating in CMS programs are significantly diverse, and include integrated health systems and networks of individual practices offering care in rural and urban areas in over 30 states. Later this year, CMS will announce another group of ACOs with a January 2013 start date for the Medicare Shared Savings Program.

In May 2012, CMS published a final rule for hospitals and critical access hospitals (CAHs) that achieved the regulatory reforms called for by both Executive Order 13563 on Improving Regulation and Regulatory Review and the Department's Plan for Retrospective Review of Existing Rules. This rule and its reforms will save hospitals and CAHs nearly $1 billion annually.

During 2012, Medicare beneficiaries continued to show great interest in Medicare Advantage (MA) plans. Access to the MA program remained strong, with 99.6 percent of beneficiaries having access to a plan. Enrollment in the MA program is projected to increase by 11 percent in the next year and premiums will remain steady. Since the Affordable Care Act was passed in 2010, MA premiums have fallen by 10 percent and enrollment has risen by 28 percent, while access to supplemental benefits remains steady and beneficiaries' average out-of-pocket spending remains constant. CMS is doing more to promote enrollment in high quality plans and alert beneficiaries who are enrolled in lower quality plans. Now, persons with Medicare enrolled in consistently low performing plans (those receiving less than 3 stars for at least the past 3 years) will receive notifications to let them know how they can change to a higher quality plan if they choose

"This financial report provides valuable insight into CMS' many programs and initiatives, and reports to the American people our efforts to protect the financial resources entrusted to us."

to do so. In addition, 5-star plans are rewarded by being allowed to continuously market and enroll beneficiaries throughout the year. In 2012, thousands of people with Medicare took advantage of this opportunity to join a top performing plan.

The Agency has made important strides in reducing fraud, waste, and improper payments across our programs. This past year, CMS has implemented powerful new anti-fraud tools provided by Congress, as well as designed and implemented large-scale, innovative improvements to our Medicare program integrity strategy to shift beyond a "pay and chase" approach to preventing fraud. CMS has recently implemented a twin pillar approach for advancing our fraud prevention strategy in Medicare. The first pillar is the new Fraud Prevention System (FPS) that applies predictive analytic technology on claims prior to payment to identify aberrant and suspicious billing patterns. The second pillar is the Automated Provider Screening (APS) system which will automate screening checks of providers and suppliers against thousands of private and public databases to more efficiently identify and remove ineligible providers and suppliers from Medicare. Together, these two innovative, comprehensive new systems (the FPS and APS) are growing in their capacity to protect patients and taxpayers from those intent on defrauding our programs.

While our highest priority is to make payments correctly the first time, CMS is also aggressively working to recover improper payments when they do occur. One of the ways that we recapture improper payments is through the use of recovery auditors. The recovery auditors identify and correct improper payments, which include overpayments and underpayments. The Medicare fee-for-service (FFS) recovery audit program has been very successful in this effort. In addition to the Medicare FFS recovery audit program, the Affordable Care Act expanded the recovery audit program to other parts of Medicare and requires states to establish Medicaid recovery audit programs. We are currently establishing and implementing these new recovery audit programs and are drawing from the lessons learned during the Medicare FFS recovery audit program.

The Agency furthered its work to establish Affordable Insurance Exchanges, which are one-stop marketplaces that will offer individuals and small businesses the opportunity to purchase affordable, quality health insurance coverage beginning in 2014. Consumers in every state will be able to buy insurance from qualified health plans directly through these marketplaces and may be eligible for tax credits to help pay for their health insurance. These competitive marketplaces promote competition in the insurance marketplace and provide consumers with more insurance choices. In FY 2012, CMS awarded $1.6 billion in exchange establishment grants. To ensure states have the flexibility they need to best serve their residents, CMS has provided states the option to operate an exchange in Partnership with the federal government allowing states to perform some functions and the Federal Government to perform others. A total of 49 states, the District of Columbia, and four territories have received grants to begin planning their Affordable Insurance Exchanges, and 34 states and the District of Columbia have received grants to begin building their Affordable Insurance Exchanges.

CMS continues to have an enormous impact on the health care for those who need it most. We recognize that aggressively pursuing meaningful improvements in the delivery and efficiency of health care is paramount to the success of the Agency. We will continue to administer our programs and initiatives with the goal to improve the well-being of seniors, children, low-income individuals, persons with disabilities, and in doing so, the overall health of the people we serve.

MARYLYN TAVENNER
Acting CMS Administrator

November 2012

OUR MISSION: We envision ourselves as a major force and trustworthy partner for continual improvement of health and health care for *all* Americans.

FINANCING OF
CMS PROGRAMS & OPERATIONS

FUNDS FLOW FROM	THROUGH	TO FINANCE
Payroll Taxes	Medicare Trust Funds	Medicare Benefits
Medicare Premiums		Quality Improvement Organizations
Investment Interest		Medicare Integrity Program
Federal Taxes		Program Management
Federal Taxes	General Fund Appropriation	Medicaid
		Children's Health Insurance Program (CHIP)
		Medicaid Integrity Program
		Program Management
Offsetting Collections		CMS User Fees
		Recovery Audit Contracts
		Reimbursables

TABLE OF CONTENTS

A Message from the Acting Administrator ii

Financing of CMS Programs and Operations. iv

Agency Organization vi

Management's Discussion and Analysis 1
- Overview 2
- Programs 3
- Performance Goals 20
- Financial Accomplishments 20

Financial Section 37
- A Message from the Chief Financial Officer 38
- Financial Statements 40
- Notes to the Financial Statements 49
- Required Supplementary Information 93
- Supplementary Information 107
- Audit Reports 111

Other Accompanying Information 141
- Summary of Federal Manager's Financial Integrity Act 142
- OMB Circular A-123 Statement of Assurance 142
- Improper Payments 143
- Review of Medicare's Program for Oversight for Accreditation Organizations 145
- Clinical Laboratory Improvement Validation Program 183

Glossary 186

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

APPROVED LEADERSHIP
as of November 1, 2012

Marilyn Tavenner
Acting Administrator

Jonathan Blum
Acting Principal Deputy Administrator

Marilyn Tavenner
Chief Operating Officer

Aryana Khalid
Chief of Staff

Michelle Snyder
Deputy Chief Operating Officer

Jacqueline White
Senior Advisor

Ajay Gupta
Senior Advisor

OFFICE OF EQUAL OPPORTUNITY AND CIVIL RIGHTS
Arlene E. Austin, Director
Anita Pinder, Dep. Dir.

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Michelle Snyder
Deputy Chief Operating Officer

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OIS: Tony Trenkle, Director & CMS Chief Information Officer

OOM: James Weber, Director

CFMFFSO: Nanette Foster Reilly, Consortium Administrator

CMCHO: Jackie Garner, Consortium Administrator

CMHPO: James T. Kerr, Consortium Administrator

CQISCO: James Randolph Farris, M.D., Consortium Administrator

OEM: Mark Loper, Director

*****OPMP:*** *Sandra Kraft, Director*

*****OESS:*** *Robert Tagalicod, Director*

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*****OIPDA:*** *Niall Brennan, Director*

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Shari Ling, M.D., Dep. Chief Medical Officer

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Sean Cavanaugh, Dep. Dir.*
Thomas Reilly, Dep. Dir.

* Acting
** Reports to Office of Enterprise Management

MANAGEMENT'S DISCUSSION AND ANALYSIS

- Overview
- Programs
- Performance Goals
- Financial Accomplishments

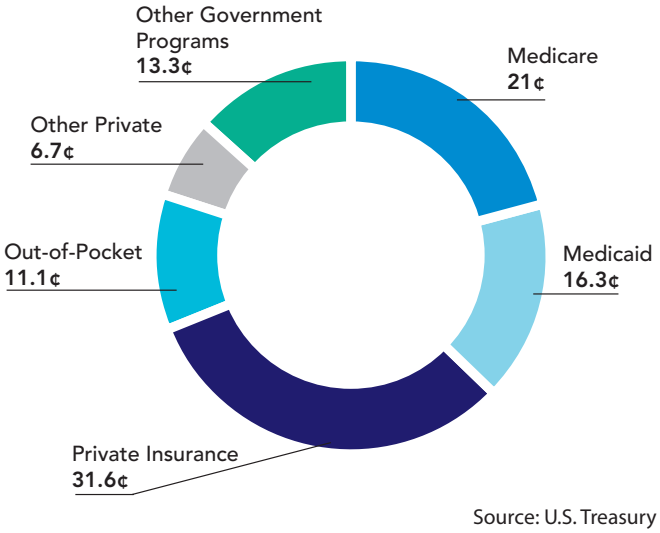
OVERVIEW

CMS, a component of HHS, administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Along with HHS, CMS also has begun to implement the provisions of the Affordable Care Act.

CMS establishes policies for program eligibility and benefit coverage, processes over one billion Medicare claims annually, matches state expenditures with funds for Medicaid and CHIP, ensures quality of health care for beneficiaries, and safeguards funds from fraud, waste, and abuse. CMS is one of the largest purchasers of health care in the world and maintains the Nation's largest collection of health care data. Based on the latest projections, Medicare and Medicaid (including state funding), represent 37 cents of every dollar spent on health care in the United States (U.S.)—or looked at from three different perspectives, 54 cents of every dollar spent on nursing homes, 49 cents of every dollar received by U.S. hospitals, and 33 cents of every dollar spent on physician services. CMS **outlays** totaled approximately $732.2 billion (net of offsetting collections and receipts) in FY 2012. Our **expenses** totaled approximately $802.9 billion, of which $3.7 billion (less than one percent) were administrative expenses.

CMS employs over 5,000 Federal employees in Baltimore, Maryland, Washington, DC, and 10 regional offices (ROs) throughout the country. The RO employees mainly provide direct services to Medicare Administrative Contractors (MAC) and Durable Medical Equipment Medicare Administrative Contractors (DMAC), state agencies, health care providers, beneficiaries, sponsors of group health plans, Medicare health and prescription drug plans, and the general public. The employees in Baltimore and Washington provide funds to MACs and DMACs; write policies and regulations; set payment rates; safeguard the fiscal integrity of the Medicare, Medicaid, and CHIP to ensure that benefit payments for medically necessary services are paid correctly the first time; recover improper payments; assist law enforcement agencies in the prosecution of fraudulent activities; monitor contractor performance; develop and implement customer service improvements; provide education and outreach activities to Medicare providers, survey hospitals, nursing homes, labs, home health agencies and other health care facilities for compliance with Medicare health and safety standards; work with state insurance companies; and assist the states and territories with Medicaid and CHIP. CMS develops quality measurement systems for the Medicare Advantage and Medicare Prescription Drug programs and monitors quality, performance, and compliance of plans; feedback is provided directly to the plans and to the beneficiaries through the Medicare Plan Finder web tool. CMS also provides technical assistance to the Congress, the Executive branch, universities, and other private sector researchers.

THE NATION'S HEALTH CARE DOLLAR 2012



Many important activities are also handled by third parties. The states administer the Medicaid program and CHIP, as well as inspect hospitals, nursing homes, and other facilities to ensure that health and safety standards are met. The Medicare contractors 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 provided to Medicare beneficiaries.

EXPENSES are computed using the accrual basis of accounting that recognizes costs when incurred and revenues when earned regardless of the timing of cash received or disbursed. Expenses include the effect of accounts receivable and accounts payable on determining the net cost of operations.

OUTLAYS refer to cash disbursements made to liquidate an expense regardless of the FY the expense was incurred.

PROGRAMS

Medicare

Introduction

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 the disabled, people with end-stage renal disease (ESRD) requiring dialysis or kidney transplant, and people age 65 or older that elect Medicare coverage. In 2003, the Medicare program was further expanded to include a drug benefit. In 2010, the President signed legislation to place comprehensive reforms that strengthen the Medicare program—the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act, collectively referred to as the *Affordable Care Act.* The Affordable Care Act is the most recent legislation passed which has had significant impact to CMS.

Medicare processes over one billion fee-for-service (FFS) claims a year, is the Nation's largest purchaser of managed care, and accounts for approximately 14 percent of the Federal Budget. Medicare is a combination of four programs: Hospital Insurance, Supplementary Medical Insurance, Medicare Advantage, and Medicare Prescription Drug Benefit. Since 1966, Medicare enrollment has increased from 19 million to over 50 million beneficiaries.

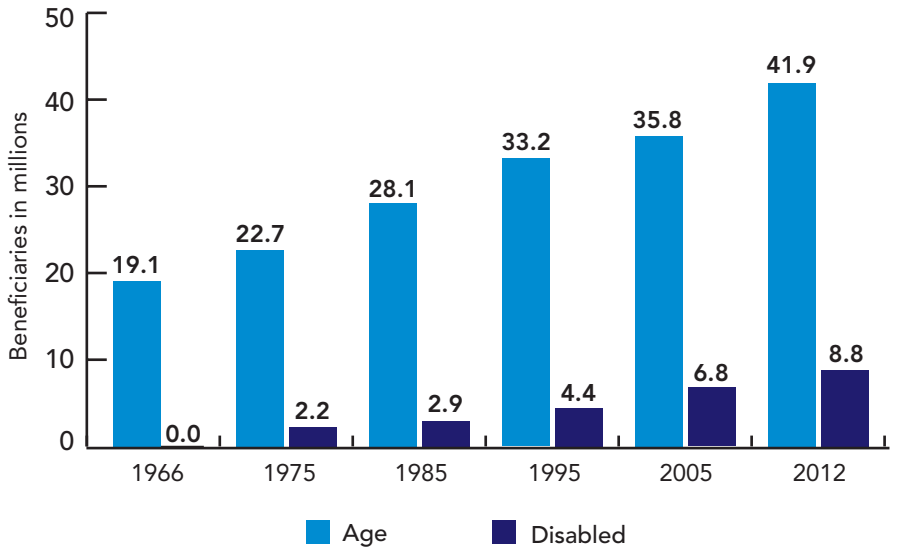
Hospital Insurance

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 disabled people entitled to Social Security or Railroad Retirement benefits. 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. Funds not currently needed to pay benefits and related expenses are held in the HI trust fund, and invested in Treasury securities. Based on estimates from the Midsession Review of the FY 2013 President's budget, inpatient hospital spending accounted for 54 percent of HI benefit outlays in FY 2012. Managed care spending comprised 25 percent of total HI outlays. During FY 2012, HI benefit outlays decreased by 0.4 percent and the HI benefit outlays per enrollee were projected to decrease by 3.9 percent to $5,090.

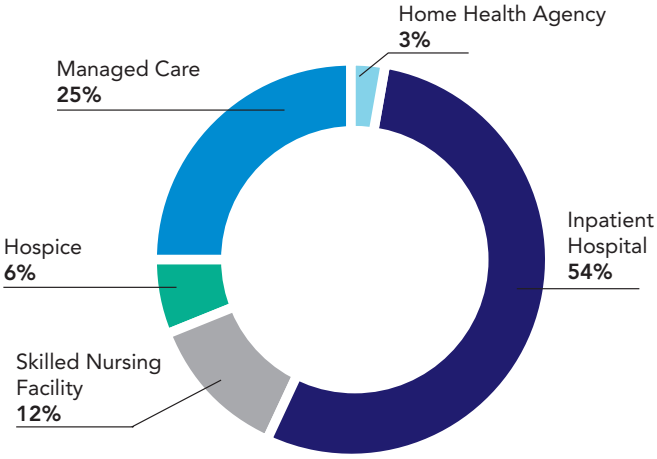
Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI or Medicare Part B, is voluntary and available to nearly all people aged 65 and over, the disabled, and people with ESRD who are entitled to Part A benefits. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy, some outpatient prescription drugs, and other services not covered by HI. The SMI coverage is

MEDICARE ENROLLMENT

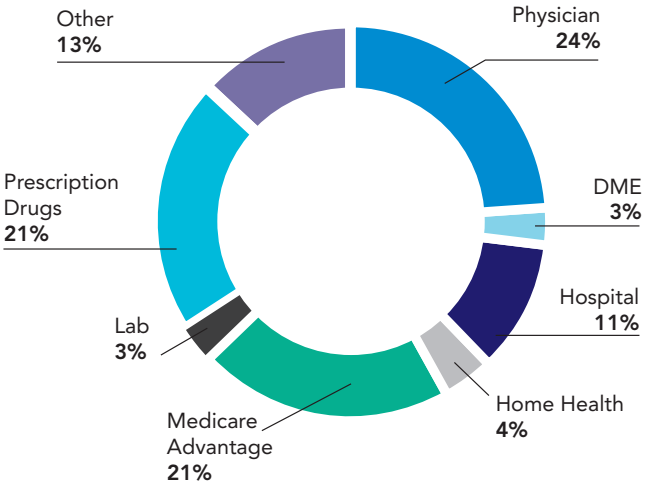


HI MEDICARE BENEFIT PAYMENTS



Source: CMS/OACT

SMI MEDICARE BENEFIT PAYMENTS



Source: CMS/OACT

optional and beneficiaries are subject to monthly premium payments. About 93 percent of HI enrollees elect to enroll in SMI to receive Part B benefits. The SMI program is financed primarily by transfers from the general fund of the U.S. Treasury and by monthly premiums paid by beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the SMI trust fund and invested in U.S. Treasury securities.

Also based on estimates from the Midsession Review of the FY 2013 President's budget, SMI benefit outlays decreased by 2.6 percent during FY 2012. Physician services, the largest component of SMI, accounted for 24 percent of SMI benefit outlays. During FY 2012, the SMI benefit outlays per enrollee were projected to decrease 5.9 percent to $6,270.

Medicare Advantage

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) created the Medicare Advantage (MA) program, 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. The types of MA plans are as follows: (1) coordinated care plans, which include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Provider-Sponsored Organizations (PSOs), and other network plans; (2) Medical Savings Accounts (MSA) plans; and (3) Private Fee-For-Service (PFFS) plans. MA coordinated care plans have their own providers or a network of contracting health care providers who agree to provide health care services for members. Non-network PFFS plans, for example, do not have an established network of contracted providers and plan members can receive services from any provider who is eligible to receive payment from Medicare and agrees to the terms and conditions of the PFFS plan sponsor. MA demonstration projects, as well as cost plans and Health Care Prepayment Plans (HCPPs), also exist.

All MA plans are currently paid a per capita premium, and must provide certain Medicare covered services. MA plans assume full financial risk for care provided to their Medicare enrollees. Many MA plans offer additional services such as prescription drugs, vision, and dental benefits to beneficiaries. In contrast, cost contractors 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, but do not always 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. The HCPPs are paid in a manner similar to cost contractors, but cover only non-institutional Part B Medicare services. There can be no new section 1876 cost based contractors.

Managed care expenses were approximately $133.5 billion of the total $537.1 billion in Medicare benefit payment expenses in FY 2012.

Medicare Prescription Drug Benefit

The addition of the voluntary Prescription Drug Benefit program via MMA recognizes the vital role of prescription drugs in our health care delivery system, and the need to modernize Medicare to assure their availability to Medicare beneficiaries. The prescription drug benefit is funded through the SMI Trust Fund.

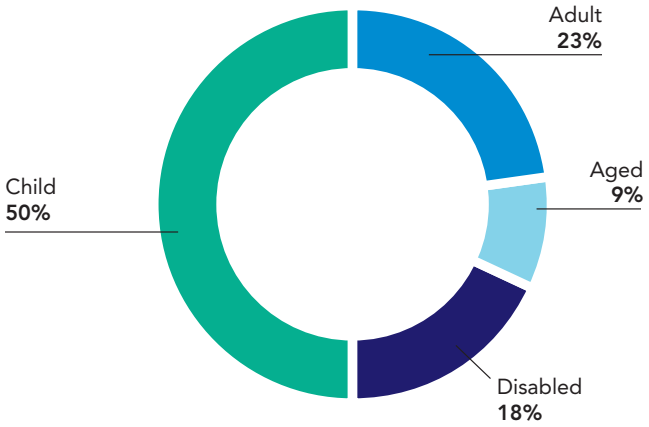
The program was effective January 1, 2006, and established an optional prescription drug benefit (Medicare Part D) for individuals who are entitled to or enrolled in Medicare benefits under Part A or Part B. Beneficiaries who qualify for both Medicare and Medicaid (full-benefit dual-eligibles) are automatically enrolled in the Medicare drug program. The statute also provides for assistance with premiums and cost sharing to full benefit dual-eligibles and other qualified low-income beneficiaries. In general, coverage for this benefit is provided under private prescription drug plans (PDPs), which offer only prescription drug coverage, or through Medicare Advantage prescription drug plans (MA PDs), which offer prescription drug coverage that is integrated with the health care coverage they provide to Medicare beneficiaries under Medicare Advantage

Participating Part D plans must offer a statutorily defined standard benefit or an alternative that is at least actuarially equivalent to standard coverage benefit. The 2012 standard benefits generally have a $320 deductible and coinsurance of 25 percent after the deductible up to the initial coverage limit of $2,930 in total drug spending. This was historically followed by a coverage gap for which beneficiaries paid 100 percent to an out-of-pocket spending limit of $4,700. Once the out-of-pocket spending reaches this level, Medicare pays 80 percent, the plan pays 15 percent, and the beneficiary generally pays 5 percent of drug costs for catastrophic coverage. Starting in year 2011, the Affordable Care Act added additional coverage for prescription drugs to gradually eliminate the coverage gap by year 2020 for qualifying beneficiaries. For year 2012, it includes a 14 percent plan coverage for generic drugs and a 50 percent discount on the ingredient cost of brand name drugs. PDPs and MA PDs submit annual bids to CMS reflecting expected benefit payments plus administrative costs after a deduction for expected reinsurance subsidies. Payment for basic Part D benefits is made using five funding streams. Throughout the benefit year, CMS pays plans monthly prospective payments through a direct subsidy, a prospective payment for the low-income cost-sharing subsidy (LICS), a payment for the low income premium subsidy (LIPS), and a prospective payment for the reinsurance subsidy.

After each plan year, the prospective payments are reconciled with actual plan costs. Either additional payments to plans or refunds to Part D will result from this reconciliation. Since the reinsurance and low-income benefits are fully funded by the Federal government, the prospective reinsurance and low-income cost sharing payments to drug plans will be reconciled with actual expenses on a dollar-for-dollar basis. A fifth funding mechanism—risk sharing—occurs because of an arrangement in which the Federal government shares in the risk that the actual costs for the basic Part D benefit will differ from the plan's expectation.

Employer, union, and other Plan Sponsors (PS) of group health plans that offer a prescription drug benefit that is actuarially equivalent to Part D are able to apply for the Retiree Drug Subsidy (RDS) program. A PS may only receive subsidy payments for qualifying covered retirees. All PS that provide a drug benefit plan to their retirees may apply annually for participation in the RDS program. To qualify for the subsidy, PS are required to demonstrate that their coverage is "actuarially equivalent" to defined standard prescription coverage under Medicare Part D. However, the actuarially equivalent standard does not apply to the Affordable Care Act provisions which fill in the coverage gap.

FY 2012 MEDICAID ENROLLEES



Source: CMS/OACT

Medicaid

Introduction

Medicaid is the means-tested health care program for low-income Americans, administered by CMS in partnership with the states. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally legislated to provide medical assistance to recipients of cash assistance. At the time, cash assistance was provided to low-income families and children through the Aid to Families with Dependent Children (AFDC) program, while the Supplemental Security Income (SSI) program provided cash assistance to low-income aged, blind and disabled individuals. Over the years, Congress incrementally expanded Medicaid well beyond these original traditional populations. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including low-income families, pregnant women, people of all ages with disabilities, and people who require long-term care services, who all should receive coordinated, quality care. The average enrollment for Medicaid was estimated at about 57 million in FY 2012, about 18 percent of the U.S. population. About 9.6 million people are dually eligible, that is, covered by both Medicare and Medicaid.

CMS provides matching payments to the states and territories for Medicaid program expenditures and related administrative costs. State medical assistance payments are matched according to a formula relating each state's per capita income to the national average. In FY 2012, the basic Federal matching rate for Medicaid program costs among the states according to the formula ranged from 50 to 74.2 percent. The weighted average matching rate for FY 2012 was about 57 percent. Federal matching rates for various state and local administrative costs are set by statute. The Federal government currently pays about 56 percent of these costs. Medicaid payments to states are funded by Federal general revenues provided to CMS through an annual appropriation. There is no cap on Federal matching payments to the states, except with respect to the DSH payments, payments for Part B premiums for Qualifying Individuals (QI), and payments to territories

States set eligibility, coverage, and payment standards within broad statutory and regulatory guidelines that include providing coverage to persons receiving Supplemental Security Income (disabled, blind, and elderly population), low-income families, the medically needy, pregnant women, young children, low-income Medicare beneficiaries, and certain other groups; and covering at least 10 services mandated by law, including hospital and physician services, laboratory tests, family planning services, nursing facility services, and comprehensive health services for individuals under age 21. State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to their individual circumstances and priorities. Accordingly, there is a wide variation in the services offered by the states.

Medicaid is the largest single source of payment for health care services for persons with Acquired Immune Deficiency Syndrome (AIDS). Medicaid now serves over 50 percent of all AIDS patients and pays for the health care costs of most of the children and infants with AIDS. In FY 2012, Medicaid spending for persons with AIDS as well as others infected with the Human Immunodeficiency Virus (HIV) is estimated to be about $9.8 billion in Federal and state funds. In addition, the Medicaid programs of all 50 States and the District of Columbia provide coverage of all drugs approved by the Food and Drug Administration (FDA) for treatment of AIDS.

Payments

Under Medicaid, state payments for both medical assistance payments (MAP) and administrative (ADM) costs are matched with Federal funds. In FY 2012, state and Federal ADM gross outlays are estimated at $24.3 billion, about 5 percent of the gross Medicaid outlays. State and Federal MAP total outlays were $428.2 billion or 95 percent of total Medicaid outlays, an increase of 3.5 percent

over FY 2011. Thus, state and Federal MAP and ADM outlays for FY 2012 totaled $452.5 billion. CMS share of Medicaid outlays totaled $260.1 billion in FY 2012.

Enrollees

Children comprise about half of Medicaid enrollees, but account for only an estimated 21 percent of Medicaid outlays. In contrast, the elderly and disabled comprise 27 percent of Medicaid enrollees, but accounted for an estimated 64 percent of program spending. The elderly and disabled use more expensive services in all categories, particularly nursing home services.

Service Delivery Options

Many states are pursuing managed care as an alternative to the FFS system for their Medicaid programs. Managed health care provides several advantages for Medicaid beneficiaries, such as enhanced continuity of care, improved preventive care, and prevention of duplicative and contradictory treatments and/or medications. Most states have taken advantage of waivers provided by CMS to introduce managed care plans tailored to their state and local needs, and 49 states now offer a form of managed care. The number of Medicaid beneficiaries enrolled in managed care has grown from 40 percent in 1996 to 74 percent in 2011[1].

CMS and the states have worked in partnership to offer managed care to Medicaid beneficiaries. Moreover, as a result of the Balanced Budget Act of 1997 (BBA), the states may amend their state plan to require certain Medicaid beneficiaries in their state to enroll in a managed care program, such as a managed care organization or primary care case manager. Medicaid law provides for two kinds of waivers of existing Federal statutes and two other options through the state plan process to implement managed care delivery systems.

1. **Medicaid waivers**—section 1115 of the Social Security Act provides discretion to waive certain provisions of Medicaid law for experimental, pilot, or demonstration projects. Many of the pioneering efforts to develop Medicaid managed care were authorized as section 1115 demonstrations and states continue to use this authority to develop innovative programs.
2. **Freedom of choice waivers**—section 1915(b) of the Social Security Act allows certain provisions of Medicaid law to be waived to allow the states to develop innovative managed health care delivery systems.
3. **Other state plan options to implement managed care**—section 1932(a) of the Social Security Act allows the states to mandate managed care enrollment for certain groups of Medicaid beneficiaries. Certain populations—including dual eligibles, children receiving SSI, children with special health care needs, and American Indians—are exempted from the state plan option. For these groups, the states require waivers to mandate enrollment into managed care.

States may also elect to include the Program of All-Inclusive Care for the Elderly (PACE) as a state plan option. The PACE is a prepaid, capitated plan that provides comprehensive health care services to frail, older adults in the community, who enroll on a voluntary basis, who are eligible for care in nursing homes according to state standards.

Congress has recently passed several pieces of legislation that have impacted Medicaid. The Affordable Care Act expanded eligibility for Medicaid to all legal adult residents with incomes below 133 percent of the Federal Poverty Level beginning January 1, 2014, with a state option to begin coverage earlier. The Affordable Care Act also provided additional funding for CHIP. Several provisions of the Affordable Care Act provide substantial new funding for developing a Medicaid adult quality measurement program to complement the Children's Health Insurance Program Reauthorization Act (CHIPRA). In addition, the law includes other provisions that expand the Federal-state partnership in disease prevention and quality improvement in health care.

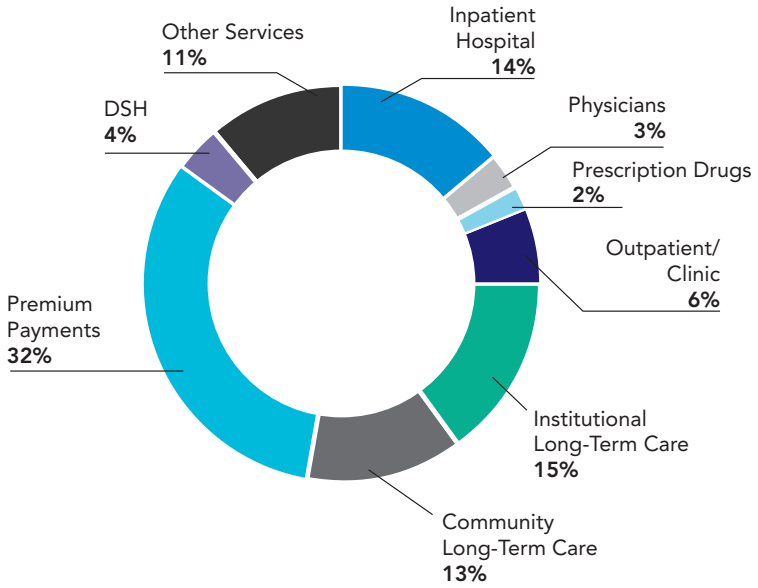
The American Recovery and Reinvestment Act of 2009 (ARRA) directly affected the Medicaid Program under title XIX of the Social Security Act. The ARRA provisions provided Medicaid programs with temporarily increased Federal match rates and considerable new resources to promote and expand the use of health information technology (HIT) in the health care system. The law provides incentives to encourage the use of electronic health records (EHR) for exchanging information across the health care system. This investment in HIT is key to CMS efforts to better measure, monitor and assure the quality of care provided in Medicaid. Finally,

[1] 49 states offer managed care; the number includes DC and PR. AK, NH, VI, and WY do not offer managed care. For MS, we counted them as having managed care because they have a capitated transportation program. The July 1, 2011 data is collected from the states and represents that point-in-time.

MEDICAL ASSISTANCE PAYMENTS BY AGGREGATE SERVICE CATEGORIES

IN BILLIONS

Total Payments: $410 billion



Source: President's FY 2012 Budget, Mid-session Review

CHIPRA established a new foundation for building a comprehensive, high quality system of care for children by addressing key components essential to accessing coverage and implementing quality improvement strategies related to health care.

Medicaid Quality Improvement Initiatives

Recent provisions under the Affordable Care Act, ARRA and CHIPRA also expand the federal-state partnership in disease prevention and quality improvement in health care. These initiatives include:

- Establishing an initial core set of child and adult quality performance measures for voluntary reporting by State Medicaid and CHIP programs;
- $100 million across ten grants (that include 18 states) to test innovative approaches to using performance measures, HIT, EHR, and provider delivery models to improve the quality of care for children;
- Establishing an EHR format specifically for children;
- Establishing Medicaid incentive payments for Medicaid eligible providers to demonstrate meaningful use of certified EHRs—which includes exchange of health information and reporting of clinical quality measures selected by the Secretary of HHS;
- Improved data collection for measuring, evaluating, and addressing health disparities in Medicaid and CHIP by race, ethnicity, primary language, and disability status;
- Developing a Medicaid policy regarding payment for health care acquired conditions;
- Demonstration grants to states to test approaches that encourage healthier lifestyles among Medicaid and CHIP enrollees with chronic health problems;
- Demonstration grants to establish value based incentive payments to hospitals that meet performance standards; and
- Incentive payments to states that eliminate cost-sharing requirements for Medicaid recommended clinical preventive services.

Additionally, CMS is in the early stages of partnering with states to implement several national Medicaid and CHIP quality improvement initiatives:

- A Neonatal Outcomes Improvement Project based on evidence-based clinical intervention strategies;
- A Children's Oral Health Improvement initiative; and
- Improving access, data collection/reporting, and assessment of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

FMAP Increases for Territories

Under section 1905 (b) of the Social Security Act, as amended, the FMAP for the territories was increased from 50 percent to 55 percent effective July 1, 2011. The Affordable Care Act also provided for a total increase to the territories of $6.3 billion for the period July 1, 2011 through September 30, 2019, to be allocated among the territories on the basis of their section 1108 caps as available on the date of enactment of the Affordable Care Act. Section 1323 of the Affordable Care Act, also provided for $1 billion in funding for the territories to be available either to increase the territories' section 1108 cap or to provide for premium and cost-sharing assistance to the residents of the territories who obtain health insurance coverage through an Affordable Insurance Exchange. Under that provision, $925 million of the $1 billion is allocated to Puerto Rico and the remaining $75 million is allocated to the other four territories in accordance with basis specified by the Secretary of HHS.

Medicaid Home and Community-Based Services Quality Improvement

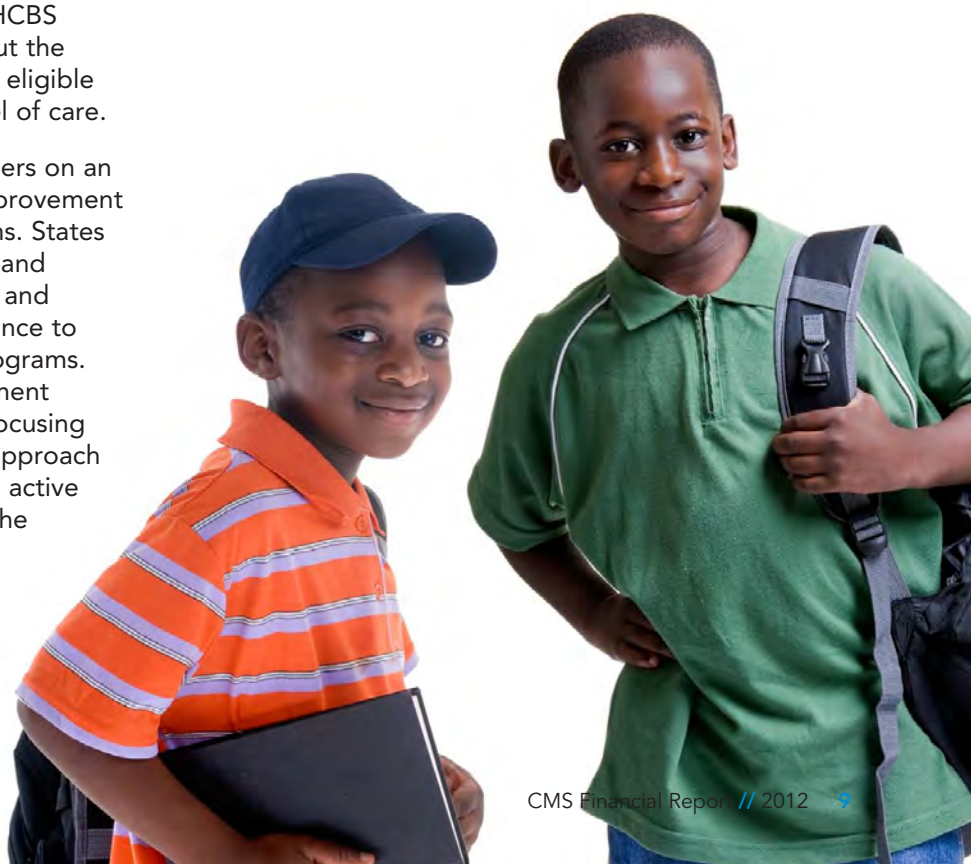
Medicaid affords states with opportunities to provide home and community-based services as an alternative to institutional services. Section 1915 (c) Home and Community-Based Services (HCBS) waivers allow states the option to provide HCBS to individuals who would otherwise require services in an institution. Section 1915 (i), implemented under the Deficit Reduction Act (DRA) of 2005 and amended under the Affordable Care Act, provides states with an opportunity to provide HCBS through the Medicaid state plan without the need for a waiver but does not require eligible individuals to meet an institutional level of care.

CMS works closely with our state partners on an evidence-based, continuous quality improvement process for 1915 (b) (c) waiver programs. States are responsible for assuring the health and welfare of individual service recipients, and CMS is responsible for providing guidance to and oversight of the State's Waiver programs. The HCBS continuous quality improvement process starts with a program design focusing on a continuous quality improvement approach to key assurances and culminating with active oversight and reporting by the state. The National Quality Enterprise (NQE), CMS' national Technical Assistance (TA) provider for HCBS quality, provides technical assistance to states. The TA to states covers quality in all HCBS programs, including sections 1915(c), 1915(i), 1915(c) (b), and is provided through a variety of methods including state visits, training forums, a web site with targeted HCBS quality information, and the regular release of pertinent manuscripts.

The DRA authorized the Agency for Healthcare Research and Quality (AHRQ) to address measure development for the HCBS population, and that activity was furthered in the Affordable Care Act. Measure development works are presently being expanded with a focus on a variety of provisions targeting the HCBS populations, and are related to individual outcomes, quality of care, experience of care, and the health care of the HCBS populations.

Children's Health Insurance Program (CHIP)

CHIP was created through the BBA of 1997 to address the fact that at the time nearly 11 million American children—one in seven— were uninsured and therefore at increased risk for preventable health problems. Many of these children were in working families that earned too little to afford private insurance on their own, but too much to be eligible for Medicaid. Congress and the Administration agreed to set aside nearly $40 billion



over ten years, beginning in FY 1998, to create CHIP—the largest health care investment in children since the creation of Medicaid in 1965. The original CHIP budget authority expired September 30, 2007, but was extended by Congress through March 31, 2009 in the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007. On February 4, 2009, CHIPRA further extended appropriating funds through FY 2013 for the purposes of providing allotments to the states for their CHIP programs. CHIPRA also changed the availability of the states' annual CHIP allotments from three to two years beginning with the FY 2009 CHIP allotments. The Affordable Care Act appropriated additional funding for allotment to states through September 30, 2015.

CHIP funds cover the cost of insurance, reasonable costs for administration, and outreach services to get children enrolled. To maximize coverage of children, states must cover previously uninsured children, and ensure that CHIP coverage does not replace existing public or private coverage. Important cost-sharing protections in CHIP protect families from incurring unaffordable out-of-pocket expenses.

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. States can create or expand their own separate insurance programs, expand Medicaid, or combine both approaches. States can choose among benchmark benefit packages, develop a benefit package that is actuarially equivalent to one of the benchmark plans, use the Medicaid benefit package, use existing comprehensive state-based coverage, or provide coverage approved by the Secretary of HHS.

States also set their own eligibility criteria regarding age, income, and residency within broad Federal guidelines. The Federal role is to ensure that state programs meet statutory requirements that are designed to ensure meaningful coverage under the program. CMS works closely with the states, Congress, and other Federal agencies to meet the challenges of implementing this program. CMS provides extensive guidance and technical assistance so the states can further develop their CHIP state plans and use Federal funds to provide health care coverage to as many children as possible. All 50 states, the District of Columbia, and the territories had approved CHIP state plans. As of November 1, 2012, state programs for CHIP included 12 Medicaid expansions (includes District of Columbia and all of the territories), 15 separate children health programs and 29 combination CHIP programs.

Other Programs and Activities

In addition to making health care payments to providers and the states on behalf of our beneficiaries, CMS makes other important contributions to the delivery of health care in the U.S.

Center for Consumer Information and Insurance Oversight (CCIIO)

CMS is charged with implementing many of the provisions of the Affordable Care Act that relate to private health insurance. CCIIO, within CMS, works to hold insurance companies accountable for compliance with new market reforms, increase industry transparency, and build state-based health insurance marketplaces where private insurers compete on the basis of price and quality.

CMS works to ensure compliance with a Patient's Bill of Rights that protects consumers through policies like prohibiting insurers from denying coverage to children with pre-existing conditions and prohibiting lifetime dollar limits on coverage. CMS also oversees the implementation of new insurance market rules related to rate review and medical loss ratio.

Health Insurance Rate Review. Between FY 2010 and FY 2012, CMS has issued $163 million in Health Insurance Rate Review Grants to states, territories and the District of Columbia, to help strengthen and improve their rate review processes. The Affordable Care Act requires insurance companies in every state to publicly justify their actions if they want to raise rates by 10 percent or more. CMS posts these justifications from insurance companies on www.healthcare.gov. Concurrently, independent experts review the submissions for non-effective rate review states to determine whether or not the proposed increase is reasonable.

CMS is also charged with enforcing compliance with a federal minimum medical loss ratio (MLR) requiring that issuers spend at least 80 percent (for individuals or small groups) or 85 percent (for large group markets) of premium dollars on patient care or refund the difference to enrollees.

Consumer Information Support. CMS has given consumers an unprecedented amount of clear information about their coverage options. One avenue is via www.healthcare.gov, the first central database of health coverage options, combining

information about public programs with information on more than 10,000 private insurance plans. CMS updates this data regularly to allow consumers to review options specific to their personal situation and local community. Additionally, to support states efforts to establish or strengthen programs that provide direct services to consumers with questions about health insurance. CMS also provides limited direct assistance and referral services to consumers with Affordable Care Act related questions who reside in states without Consumer Assistance Programs. In FY 2012, CMS made an additional $30 million available to Consumer Assistance Programs across the country. CMS has direct jurisdictional authority over non-Federal governmental plans and provides some health insurance assistance services to consumers enrolled in such plans.

Affordable Insurance Exchanges. CMS is working closely with states to implement the Affordable Insurance Exchanges. Starting in 2014, these Affordable Insurance Exchanges will provide individuals and small business with a "one-stop shop" to find and compare affordable, quality health insurance options. In FY 2011, CMS awarded a series of grants to assist with the construction of state-based Affordable Insurance Exchanges, including: approximately $54 million in Affordable Insurance Exchange Planning to forty-nine states, four territories and the District of Columbia; approximately $250 million for "Early Innovator" model IT development to six states and a multi-state consortium; and over $221 million for Affordable Insurance Exchange Establishment to 16 states and the District of Columbia. In FY 2012, CMS awarded $1.6 billion in Exchange Establishment grants. To ensure states have the flexibility they need to best serve their residents, CMS proposed the Affordable Insurance Exchange "Partnership Options" Opportunities initiative that allows states to perform some functions (for example, plan management or consumer assistance) and let the Federal government perform others for them.

Access to Affordable Health Benefits Coverage. To help increase consumer access to affordable benefits coverage options today, CMS oversees the Pre-Existing Condition Insurance Plan (PCIP) program, the Early Retiree Reinsurance Program (ERRP) and the Consumer Operated and Oriented Plan (CO-OP) Program. The PCIP makes health insurance available to Americans who are uninsured and have a pre-existing condition. The temporary program covers a broad range of health benefits and is designed as a bridge for people with pre-existing conditions who cannot obtain health insurance coverage in today's private insurance market. CMS directly administers the PCIP program on behalf of 23 states and the District of Columbia, while 27 states have chosen to run their own programs. The PCIP program began accepting applications for enrollment July 2010. As of July 31, 2012, there were 82,000 enrollees in PCIP nationwide.

ERRP provides reimbursement to sponsors of qualified employment-based health plans for a portion of the cost of health benefits for early retirees and their spouses, surviving spouses and dependents. ERRP reimburses 80 percent of the actual cost of health benefit expenses (paid by the plan or paid by or on behalf of an individual) between a cost threshold and cost limit. As of September 2012, ERRP has supported the availability of affordable health benefits coverage to early retirees and their families through the disbursement of over $4.7 billion in payments to plan sponsors.

The CO-OP Program fosters and encourages the creation of new non-profit, consumer-governed health insurance companies to provide more competition and choice in the Affordable Insurance Exchanges that is responsive to consumer needs. The goal is to have at least one CO-OP in every state and the District of Columbia. Interested organizations apply to CMS for loans for start-up costs and State solvency requirements necessary for licensure. CO-OPs that improve the coordination of care, can operate statewide, and have private support are more likely to be funded. After a rigorous selection process, 23 CO-OPs have been established and are operating in 23 states in every region of the country, coast-to-coast and border-to-border. All bring plans for better coordination of care to the market to improve health outcomes. As of September 2012, CMS has awarded $1.7 billion in CO-OP loans with $90 million disbursed and expects additional loans to be awarded as the rolling application process continues in FY 2013.

Federal Coordinated Health Care Office

Under the Affordable Care Act, CMS established the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) in December 2010. The Medicare-Medicaid Coordination Office is charged with better integrating Medicare and Medicaid services, improving health care quality and coordination of care, reducing costs, and improving the beneficiary experience for Medicare-Medicaid enrollees. To date, CMS has implemented a number of initiatives to assure it meets the statutory goals and

responsibilities in section 2602 of the Affordable Care Act since its creation. In FY 2012, CMS invested approximately $12 million to support ongoing initiatives. Medicare-Medicaid enrollees have significant health needs and account for a disproportionate share of Medicare and Medicaid program expenditures. Improved care coordination for this population could dramatically improve health outcomes for the Medicare-Medicaid enrollee population, but the current lack of alignment between the two programs often creates barriers to better care coordination, improved quality and lower costs.

Through the Initiative to Align Medicare and Medicaid Programs (Alignment Initiative), CMS is identifying and implementing solutions that advance better care for individuals, better health for populations, and reduced costs through improvement. The Alignment Initiative was launched as a Notice for Public Comment in the Federal Register in May of 2011. Through it, CMS identified 29 specific alignment opportunities in six categories, and solicited public feedback. Comments were received from a variety stakeholders, including beneficiary advocacy groups, states, health plans, national health insurance associations, national provider groups, and supplier organizations. A common theme was the basic need for increased communication and coordination between Medicaid and Medicare, as well as with states and Federal government, to assure that beneficiaries have a seamless care experience across the two programs. Since its development, the Alignment Initiative has served as CMS' guide for streamlining Medicare and Medicaid program rules, requirements, and policies.

The Medicare-Medicaid Coordination Office, in coordination with CMS' program components, has created opportunities to develop, test, and rapidly deploy innovative and effective care models for Medicare-Medicaid enrollees. In 2011 CMS announced several new opportunities and resources: State Design Contracts to Integrate Care for Medicare-Medicaid Enrollees, the Financial Alignment Initiative, and the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents. These initiatives are designed to improve the overall beneficiary care experience and coordination of services while addressing inefficiencies in care delivery that may result in health care savings.

As a first step to partnering with States to better integrate care, in April 2011 CMS awarded 15 States up to $1 million each to design person-centered approaches to coordinate care across primary, acute, behavioral health, prescription drugs, and long term services and support (LTSS) for Medicare-Medicaid enrollees. These States were selected to develop new ways to meet the often complex and costly needs of Medicare-Medicaid enrollees. Early work with these States confirmed that a key component of a fully integrated system would be testing new payment and service delivery models to promote better care and align the incentives for improving care with lowering costs for Medicare and Medicaid. Each of the 15 States has submitted a demonstration proposal to CMS, the majority of which are for one of the two models described in the Financial Alignment Initiative below.

In July 2011, CMS announced the Financial Alignment Initiative, an opportunity for Medicare and Medicaid programs to test cost-effective integrated care and payment systems to better coordinate care for Medicare-Medicaid enrollees. The initiative seeks to align the service delivery and financing of the programs to better align incentives for improving quality and costs between Medicare and Medicaid. Medicare benefits focus primarily upon the acute medical care needs of beneficiaries, resulting in little incentives for State Medicaid programs to invest in care coordination for services for which Medicare is the primary payer. Financial savings gained through State-led care improvement efforts, resulting in decreases in hospitalization, emergency department uses, and skilled nursing care, are believed to primarily accrue to the Medicare program. This financial misalignment between the two programs has been a major barrier to better serving Medicare-Medicaid enrollees.

Through the Financial Alignment Initiative, CMS offered two models to test alignment of the payment and service delivery between the Medicare and Medicaid programs while preserving or enhancing the quality of care furnished to Medicare-Medicaid enrollees. The first is a capitated model in which a state, CMS, and health plan or other qualified entity will enter into a three-way contract through which the health plan or other qualified entity will receive a prospective blended payment to provide comprehensive, coordinated care. The second is a managed fee-for-service model (MFFS) under which a State and CMS will enter into an agreement by which the State would support care coordination networks in a fee-for-service context and would be eligible to benefit from savings resulting from MFFS initiatives that improve quality and reduce costs for both Medicare and Medicaid. Both models are designed to achieve State and Federal health care savings while improving health

care delivery, encouraging high-quality, efficient care, and better streamlining services.

Twenty-six States,[2] after extensive consultation with and public comment from a range of stakeholders (including providers, beneficiaries, and their advocates), submitted Financial Alignment Demonstration (Demonstration) proposals to CMS. State approaches to financial alignment vary by scope, population, and model of care coordination, among other key factors. In August, Massachusetts became the first State to enter a Memorandum of Understanding agreement to launch the Demonstration. CMS continues to work with States on this initiative to strengthen the Medicare and Medicaid programs to better serve beneficiaries.

In addition to these programs, CMS announced an initiative to improve the quality of care for residents of nursing facilities by reducing preventable inpatient hospitalizations. Through this initiative, CMS will competitively select and partner with independent organizations that will provide enhanced clinical services to people in approximately 145 nursing facilities. Interventions will be targeted to nursing facilities with high hospitalization rates and a high concentration of residents who are Medicare-Medicaid enrollees. This Initiative is expected to begin implementation in the late 2012.

CMS is also providing ongoing technical assistance to providers to enable them to better integrate care for beneficiaries eligible for both Medicare and Medicaid. This effort will identify promising provider led practices that have positively impacted, or have the potential to positively impact, the care received by Medicare-Medicaid enrollees; develop partnerships with such providers to understand the promising practice and the impact (or potential impact) on Medicare-Medicaid enrollees; and develop actionable products for other providers seeking to integrate care for Medicare-Medicaid enrollees. CMS also established the Integrated Care Resource Center to support states to provide better and more integrated care for high-cost, high-risk individuals, including Medicare-Medicaid enrollees. This resource will provide technical assistance to states at all levels of readiness to better serve beneficiaries, improve quality and reduce costs.

A major barrier for states in providing integrated care for Medicare-Medicaid enrollees has been lack of access to Medicare data. In May 2011, CMS announced the availability of timely Medicare A, B, and D claims/event data to state Medicaid Agencies to support care coordination efforts for Medicare-Medicaid enrollees. This long-awaited announcement provided states with new, valuable information to allow them to fully understand all of the health care needs utilization patterns for Medicare-Medicaid enrollees, thus supporting efforts to better coordinate care across the full spectrum of care needs. CMS is working to assure states are aware of this new resource and provide technical advice to states so that they can better read, understand and use Medicare data to enhance the ability to link Medicare experience with Medicaid data to improve care coordination for Medicare-Medicaid enrollees. CMS has worked with many states to access Medicare data and create new state pathways to better integrate care for Medicare-Medicaid enrollees.

As part of our efforts to better coordinate the Medicare and Medicaid programs, in June, 2012 CMS released Medicare-Medicaid Enrollee State Profiles[3] (State Profiles). CMS hopes these State Profiles will help provide policymakers, researchers, and other interested parties with a greater understanding and awareness of the population to foster program improvement. The information released includes a national summary and overview of data methodology underlying the analysis, along with individual profiles for each of the 50 States and the District of Columbia. State-level profiles contain demographic characteristics, utilization and the spending patterns of the Medicare-Medicaid enrollees and the State Medicaid programs that serve them while the national summary provides a composite sketch of Medicare-Medicaid enrollees including demographics, selected chronic conditions, service utilizations, expenditures and availability of integrated delivery programs. CMS expects to update the State Profiles annually and continually engage with States and other key stakeholders to improve the data to better inform policy.

CMS is also working to leverage existing CMS databases to provide necessary tools for CMS, State Medicaid Agencies, and other relevant entities to complete comprehensive analyses aligning Medicare and Medicaid data for Medicare-Medicaid enrollees. This work specifically involves enhancing CMS systems by expanding the existing

[2] These 26 States are: Arizona, California, Colorado, Connecticut, Hawaii, Idaho, Illinois, Iowa, Massachusetts, Michigan, Minnesota, Missouri, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, and Wisconsin.

[3] http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html

data to include high prevalence conditions among Medicare-Medicaid enrollees, such as serious mental illness.

CMS is charged with improving the quality of health and long term care services and supports for Medicare-Medicaid enrollees. CMS has begun a review of potential options for sub setting existing measures as well as developing new measures specific to Medicare-Medicaid enrollees within the overall framework of health care quality measurement. To accomplish this, CMS is partnering with HHS, as well as with external stakeholders, such as the National Quality Forum and National Committee for Quality Assurance, to ensure this initiative aligns with and informs quality initiatives already underway within Medicare and Medicaid as well as other health care improvement projects.

Center for Medicare and Medicaid Innovation (CMMI)

CMMI, within CMS, was created to test innovative payment and service delivery models that have the potential to reduce Medicare and Medicaid costs while preserving or enhancing quality of care for beneficiaries. The Affordable Care Act provides $10 billion in budget authority for fiscal years 2011 through 2019 to be made available for the design, implementation, and evaluation of innovative payment and service delivery models. CMS' efforts, coupled with transformational payment changes in the Affordable Care Act, will help drive continual improvement of health and health care for Medicare and Medicaid beneficiaries and better value for our health care dollars.

CMS envisions a people-centered health care system where individuals receive the right care, in the right setting, at the right time, all the time. Utilizing CMMI, CMS is transforming from a claims payer in a fragmented care system into a partner working with health care providers to provide better quality health care at lower cost.

CMS communicates and consults with a wide array of stakeholders, meeting with providers at conferences and professional meetings and holding listening sessions with targeted groups, such as insurers, academic medical systems, and State Medicaid Directors. It has sponsored numerous events and learning opportunities, such as an Innovation Summit that drew leaders in health care innovation from across the country, Accelerated Development Learning Sessions for providers interested in becoming Accountable Care Organizations, call-in Open Door Forums for both providers and beneficiaries, and numerous webinars and conference calls about new health care initiatives.

CMS has actively sought to partner with professional societies, provider education, news, media, and other organizations to spread knowledge regarding the goals and aims of CMMI and has developed a significant online presence, including a website (http://innovations.cms.gov).

CMS has fulfilled its legislative charge to test and evaluate new models of health care payment and delivery in three primary ways: (1) through initiatives designed to advance and diffuse best practices, (of which 14 initiatives have been developed between January 2011 and August 2012), (2) through the development and oversight of Congressionally-mandated demonstrations (of which 23 mandated demonstrations have been developed and implemented between January 2011 and August 2012), and (3) through a broad array of initiatives based on innovations from the caregiver community and on specific models suggested in the enabling legislation.

CMS is organized to support the development and testing of new payment and service delivery models, as well as support CMS' additional demonstration and research requirements. To better coordinate initiatives, demonstrations, and research projects at CMS, the former Office of Research, Development and Information (ORDI) was merged with the Innovation Center in early 2011. As a result, CMMI oversees not only initiatives that are authorized under section 3021 of the Affordable Care Act, but also activities under several other authorities, including other provisions of the Affordable Care Act or other laws, and section 402 of the Social Security Amendments of 1967. Managing these varied responsibilities as part of a single portfolio of activity allows for better coordination and more efficient operations. These models testing and evaluation activities include, but are not limited to the following:

1. **Diffusion of best practices:**
   - the Partnership for Patients initiative;
   - the Million Hearts initiative; and
   - the Innovation Advisors Program.
2. **Other demonstrations authorized under Affordable Care Act and previously implemented demonstrations:**
   - the Multi-payer Advanced Primary Care Practice demonstration;

- the Independence at Home Demonstration;
- the Graduate Nurse Education Demonstration;
- the Appropriate Use of Imaging Services Demonstration;
- the Medicaid Emergency Psychiatric Demonstration; and
- the Medicaid Incentives for Prevention of Chronic Disease.

3. **Initiatives designed to test new models of health care payment and delivery under Section 3021 of the Affordable Care Act:**
   - the Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration, in partnership with the Health Resources Services Administration (HRSA);
   - the Comprehensive Primary Care (CPC) Initiative;
   - the Pioneer Accountable Care Organization Model;
   - the Advance Payment ACO Model;
   - Strong Start for Mothers and Newborns;
   - the Bundled Payments for Care Improvement Initiative;
   - the State Design Contracts to Integrate Care for Medicare-Medicaid Enrollees, in partnership with the Medicare-Medicaid Coordination Office (MMCO);
   - the Financial Alignment Initiative, in partnership with MMCO;
   - the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, in partnership with MMCO;
   - the Health Care Innovation Awards; and
   - the State Innovation Models Initiative.

The programs listed above offer significant opportunities for advancing the aim of providing better health care, better health, and reduced cost for beneficiaries of Medicare, Medicaid, and the CHIP. As it manages and evaluates these programs, CMMI is continuing to research and develop new models of care delivery and payment for future testing and evaluation.

Survey and Certification Program

CMS is responsible for assuring the safety and quality of medical facilities, laboratories, providers, and suppliers by setting standards, training inspectors, conducting inspections, certifying providers as eligible for program payments, and ensuring that corrective actions are taken where deficiencies are found. The survey and certification program is designed to ensure that providers and suppliers comply with Federal health, safety, and program standards. We administer agreements with state survey agencies to conduct onsite facility inspections. Funding is provided through the Program Management and the Medicaid appropriations. Only certified providers, suppliers, and laboratories are eligible for Medicare or Medicaid payments. Currently, CMS Survey and Certification staff oversee compliance with Medicare health and safety standards in approximately 303,854 currently active medical facilities of different types, including hospitals, laboratories,

nursing homes, home health agencies, hospices, rural health clinics, ambulatory surgical centers, organ transplant centers, and end stage renal disease facilities at any point during the year.

Clinical Laboratory Improvement Amendments Program (CLIA)

The 1988 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 239,999 facilities. The CLIA standards are based on the complexity of testing; thus, the more complex the test is to perform, the more stringent the requirements. There are three categories of tests: waived, moderate and high. Waived laboratories are not subject to the quality standards or routine oversight. Laboratories which perform moderate and high complexity testing are subject to routine onsite surveys. These laboratories have a choice of the agency they wish to survey their laboratory. They can select CMS via the state agencies or a CMS-approved accrediting organization. CMS partners with the states to certify and inspect approximately 20,403 laboratories on a biennial basis. CMS-approved accrediting organizations conduct onsite surveys of an additional 16,826 laboratories biennially. Data from these inspections reflect significant improvements in the quality of testing over time. The CLIA program is 100 percent user-fee financed and is jointly administered by three HHS components: (1) CMS manages the financial aspects, contracts and trains state surveyors to inspect labs, and oversees program administration including enrollment, fee assessment, regulation and policy development, approval of accrediting organizations, exempt states and proficiency testing providers, certificate generation, enforcement and data system design; (2) the Centers for Disease Control and Prevention (CDC) provides research and technical support, and coordinates the Secretary's Clinical Laboratory Improvement Advisory Committee (CLIAC); and (3) the Food and Drug Administration (FDA) performs test categorization.

Health Care Quality Improvement

CMS seeks to improve health and health care for all Medicare beneficiaries and promote quality of care to ensure the right care at the right time, every time. HHS has developed the National Quality Strategy, which begins to establish national priorities to achieve these goals and proposes as its foundation three broad aims of 1) better health care 2) better health for people and communities; and 3) affordable care through lowering costs by improvement. The strategy also articulates six priorities that build on the broad aims including:

- Making care safer;
- Promoting effective coordination of care;
- Assuring care is person and family-centered;
- Promoting the best possible prevention and treatment of the leading cases of mortality, starting with cardiovascular disease;
- Helping communities support better health; and
- Making care more affordable for individuals, families, employers, and governments by reducing the costs of care through continual improvement.

The National Quality Strategy notes that an effective national strategy must support effective local strategies. National standards and consistency in their measurement are essential components of the National Quality Strategy. At the same time, the unique needs and characteristics of local communities must be supported to ensure activities that are responsive to and driven by local circumstances, needs and capabilities.

Medicare and Quality Improvement Organizations (QIO)

One of CMS' resources and the largest Federal program dedicated to improving health quality at the state and local levels is the QIO Program. Created by Congress in 1982, QIOs provide a nationwide network of health organizations aimed at helping practitioners and providers improve healthcare quality. As Medicare contractors, QIOs, work to improve quality of care, assess medical necessity and appropriateness of care, and review beneficiary and hospital appeals of discharge decisions and review beneficiary complaints. The QIOs are authorized to work to improve services to Medicare beneficiaries with a focus on effectiveness, efficiency, economy and quality. CMS administers the program through a national network of 53 independent QIO contractors located in each of the 50 states, the District of Columbia, Puerto Rico and the Virgin Islands.

Through the QIO program's 9th Statement of Work (SOW), which extended from August 2008 through July 2011, health care providers nationwide have delivered safer, more effective care to Medicare beneficiaries. The success of hospitals, nursing homes and physicians who worked with their local QIO in preventing health care-associated infections, reducing health care-acquired conditions, improving rated of preventive services and decreasing avoidable rehospitalizations have established a foundation for related, future QIO Program Initiatives.

In August of 2011, CMS launched the QIO Program's 10th SOW, through which QIOs will support and partner with CMS to achieve the aims of better care for individuals, better health for the population and lower cost through improvement. The QIO will serve an essential role in helping to achieve the goals of the National Quality Strategy by working to achieve their own goals at the local level.

During the 9th SOW, and in the first year of the 10th SOW, health care providers who worked with their QIO improved clinical performance and contributed to national progress in five key areas:

- **Patient Safety:** More than 1,250 nursing homes virtually eliminated the use of physical restraints and decreased pressure ulcer rates by 22.2 percent. Hundreds of hospitals reduced surgical complications and more than 450 began reporting information about hospital-acquired infections to the Centers for Disease Control and Prevention.
- **Prevention:** More than 1,700 primary care physicians used the capabilities of their electronic health record system to coordinate preventive care, leading to increased rated of screening mammograms, colorectal screening, and influenza and pneumonia vaccination. In the QIO 10th SOW a cardiac disease prevention focus was implemented to promote the goals of the HHS One Million Hearts effort. According to the QIO quarter 4 reports (as of July 31, 2012), the QIOs have recruited a total of 1,676 providers and 453 partners nationally for the Cardiac Population Health Learning and Action Networks.
- **Care Transitions:** More than 1,125,500 Medicare beneficiaries were affected by community-based initiatives to reduce avoidable hospital readmissions in 14 states as a result of QIO efforts through July 30, 2011. In total, participating communities reduced admissions per 1,000 beneficiaries by 5.6 percent, compared to a 3.4 percent reduction in 52 peer communities. This work has evolved into a National effort and as of August 1, 2011, all QIOs began work to actively convene communities of providers and stakeholders to come together to improve the quality of care for Medicare FFS beneficiaries as they transition from one health setting to another and thereby reduce hospitalizations/re-hospitalizations. QIOs are assisting communities to perform a community specific root cause analysis and select, implement and measure the impact of evidence based care transitions interventions. QIOs are also providing technical assistance to communities choosing to apply for funding for formal care transitions programs such as the Community Base Care Transition Program (CCTP). As of August 2012, the Integrating Care for Populations & Communities national monthly scorecard estimates that QIOs have recruited over 200 communities nation-wide to engage in this work.
- **Health Disparities:** Through community-based initiatives in seven states, more than 8,600 disadvantaged Medicare beneficiaries with diabetes completed self-management education that equipped them to better control their disease and live a healthier life.

CMS calls upon the QIO to fulfill its statutory requirement of promoting the quality of services by securing commitments and by being conveners, organizers, motivators and change agents and providing a call to action through outreach, education and social marketing; serving as a trusted partner in improvement with beneficiaries, health care providers, practitioners, and stakeholders; achieving measurable quality improvement results through data collection, analysis, education, and

monitoring for improvement; facilitating information exchange within the healthcare system; and, dissemination and spread of best practices.

The QIOs are currently working on the following topics in the 10th SOW:

Beneficiary and Family Centered Care

- Case Review
- Patient and Family Engagement Activities

Improving Individual Patient Care

- Reduction of Health-Care Acquired Conditions
- Reduction of Adverse Drug Events
- Quality Reporting and Improvement

Integrating Care for Populations and Communities

- Improving Care Transitions Leading to the Reduction of Readmissions

Improving Health for Populations and Communities

- Assist eligible professionals to begin reporting to the Physician Quality Reporting System (PQRS) via EHRs
- Creating a Learning & Action Network among Regional Extension Centers-assisted offices in the state for care management, reducing disparities, and engaging patients and their families to improve clinical prevention and cardiac services
- Creating a Learning & Action Network in the state to address the Cardiac Population Health that supports the HHS Million Hearts Initiative
- Integrating Health IT to promote CMS' Incentive Programs and reporting to the state Immunization Information System (IIS)

Medicare and the End-Stage Renal Disease Quality Initiative

CMS works to continuously improve the quality of care for Medicare's End-Stage Renal Disease (ESRD) patients through the ESRD Network Program and the Quality Incentive Program (QIP). The ESRD Networks are CMS contractors that work in 18 geographic regions of the U.S. to monitor the quality of care ESRD patients receive, provide technical assistance to ESRD providers and patients to address issues with quality of and access to ESRD care, and collect data that ESRD Networks and CMS use to administer the national Medicare ESRD program. The ESRD Networks' lead National Quality Initiatives such as Fistula First and the Kidney Community Emergency Response (KCER) Coalition. Fistula First efforts have resulted in improved beneficiary care by increasing the rate of appropriate vascular access in dialysis patients to an April 2012 national arteriovenous fistula rate for prevalent hemodialysis patients of 60.6 percent. For more information on fistula first, see: http://www.fistulafirst.org KCER is the leading authority on emergency preparedness and response for the kidney community, bringing private and public stakeholders together to provide organization and guidance to seamlessly bridge care in the event of an emergency that impacts dialysis services.

A Redesigned ESRD Network Contract aligning with the National Quality Strategy and incorporating recent policy and legislative changes impacting ESRD care will take effect on January 1, 2013. The work of this contract represents a heighted focus on patient-centered care, including patient and family engagement. The Redesigned ESRD Network Contract will introduce Population Health: Innovation Pilot Projects which are quality improvement projects designed to improve outcomes in clinical areas significant to the ESRD Population while reducing disparities in care. The ESRD Network Program achieves rapid cycle quality improvement through the monitoring, trending, analysis and evaluation of data. These data will be used to intervene and provide technical assistance, where necessary, and to spread the best practices of the highest performers.

CMS' Quality Incentive Program (QIP), required by Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), encourages the continuous improvement of quality in dialysis facilities by tying a portion of a facility's payments to their performance on specific measures of quality. The Quality Incentive Program has been implemented and the first dialysis facility payment impact began as of January 1, 2012, along with public reporting of facility QIP performance scores. CMS also collects data for Quality Measurement that:

- facilities use to gauge their own quality of care,
- ESRD Networks use to target interventions, and
- CMS can use to assess the state of dialysis care in the nation.

For more information on dialysis facility quality, see https://www.cms.gov/dialysisfacilitycompare.

Coverage Policy

Medicare's coverage policy affects every insurer and health care purchaser in today's health care market since many third-party payers tend to follow CMS' lead. To that end, CMS has established an open and transparent National Coverage Determination (NCD) process that provides multiple opportunities

for public participation. Specifically, CMS holds numerous meetings each year that are open to the public and there are two public comment periods that occur for every open NCD. All public comments, as well as other useful up-to-date coverage issue information, are available on CMS' coverage web site. CMS also involves the public through its Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) which provides independent guidance and expert advice to CMS on specific clinical topics. The MEDCAC is comprised of experts in the fields of clinical and administrative medicine, biologic and physical sciences, public health administration, patient advocacy, health care data and information management and analysis, health care economics, and medical ethics. The MEDCAC is used to supplement CMS' internal expertise and to allow an unbiased and current deliberation of "state of the art" technology and science. It reviews and evaluates medical literature, technology assessments, and examines data and information on the effectiveness and appropriateness of medical items and services that are covered under Medicare, or that may be eligible for coverage under Medicare and makes recommendations on the quality of the evidence reviewed. Also, CMS relies on state-of-the-art technology assessment and additional support from other Federal agencies.

Insurance Oversight and Data Standards

CMS has primary responsibility for implementing and enforcing Federal standards for the Medigap insurance offered to Medicare beneficiaries to help pay the coinsurance and deductibles that Medicare does not cover. CMS works with the State Insurance Commissioners' offices to ensure that suspected violations of Federal laws governing the marketing and sales of Medigap are addressed.

CMS is responsible for implementing and enforcing most of the Health Insurance Portability and Accountability Act (HIPAA) Title II administrative simplification provisions, which are aimed at increasing the use of electronic health transactions to increase efficiency and reduce administrative costs across all sectors of the health care industry. Title II of HIPAA required HHS to adopt uniform national standards for the electronic transmission of certain health information. As a result, "covered entities" such as health plans, health care clearinghouses, and health care providers who conduct certain transactions electronically, must use the adopted standards for certain transactions, code sets, and identifiers. The HIPAA requires that adopted standards be used for the electronic transmission of specific transactions, including claims, remittance advices eligibility requests and responses, and coordination of benefits. Title II of HIPAA also requires that an individual's electronic personal health information be maintained securely while being stored or transmitted.

In January 2009, HHS published two final rules to update the HIPAA code set and transactions standards. The first rule adopts the updated X12 standard (Version 5010) and the National Council for Prescription Drug Programs standard (Version D.0) for electronic transactions, such as health care claims. It also adopts a new standard for Medicaid pharmacy subrogation. The compliance date for these changes was January 1, 2012. The second rule adopts the ICD-10 code set for diagnosis and inpatient hospital procedure coding as of October 1, 2013. During FY 2011 and FY 2012, CMS conducted implementation activities on Version 5010 and worked with industry stakeholders on resolution of identified issues which caused scheduling delays. In response to industry request for extension, CMS implemented enforcement discretion until July 1, 2012, when routine enforcement procedures went back into effect. HHS also finalized a one-year delay in the October 1, 2013, compliance date for the ICD-10 code sets, which will impact CMS and industry implementation schedules.

With regard to HIPAA enforcement activities, CMS continues to operate based on a complaint-driven process, addressing transaction and code set complaints filed against covered entities by requesting and reviewing documentation of their compliance status and/or corrective actions. In addition, CMS has the authority to conduct compliance reviews of covered entities. Reviews target covered entities for which CMS had already received and investigated a HIPAA transaction and code set complaint.

The Affordable Care Act included a number of provisions related to Administrative Simplification. HHS has adopted operating rules for claims status and eligibility and a standard for eft. In addition, HHS published a proposed rule that finalized will establish a unique health plan identifier. Over the next three years, four to five more regulations will be released adopting operating rules, new standards, new compliance requirements and new penalty provisions. CMS will be responsible for all of these new provisions and will collaborate across the public and private sector on implementation.

Medicare Shared Savings Program
The Medicare Shared Savings Program (Shared Savings Program) facilitates coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by participating in an Accountable Care Organization (ACO). The program will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first.

Over the course of the agreement period ACOs will better coordinate care, engage their beneficiaries, report on quality and promote evidence-based medicine. CMS will measure ACO performance on 33 quality measures relating to care coordination and patient safety, appropriate use of preventive health services, improved care for at-risk populations, and patient and caregiver experience of care. CMS will also monitor ACO activity throughout the length of the agreement period.

As part of the final rule, 42 CFR 425, CMS estimated that between 50 and 270 ACO would participate in the Shared Savings Program and generate $470 million in net Federal savings between 2012 and 2015. In 2012, the Shared Savings Program began accepting applications and welcomed a total of 114 ACOs to the program. The 114 ACOs serve over 1.7 million people with traditional fee-for-service Medicare. Going forward, the Shared Savings Program will accept applications on an annual basis with the next group scheduled to start January 1, 2013.

PERFORMANCE GOALS

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' performance measures are included in the Annual Performance Budget. CMS participated in the Department-directed development of the Department of Health and Human Services Strategic Plan for Fiscal Years 2010 through 2015, which can be viewed at http://www.hhs.gov/secretary/about/stratplan fy2010-15.pdf. Consistent with GPRA principles, CMS FY 2012 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: Increase Efficiency, Transparency, and Accountability of its programs.

Our FY 2012 performance measures track progress in our major programs areas. We track program integrity in Medicare, Medicaid and the CHIP through measuring error rates. In addition, we measure quality improvement initiatives geared toward elderly, disabled and child populations as they are served by the Medicare, Medicaid, CHIP and the QIO programs. We have also begun 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 2012 measures are included in the Online Performance Appendix and can be viewed at http://www.cms.gov/performanceappendix-fy2013.pdf/. Progress on our measures will be reported through the FY 2013 President's Budget request process.

Our future plans will be revised to reflect the requirements of the GPRA Modernization Act of 2010, which retains and amplifies some aspects of the original 1993 law. Performance measurement results provide valuable information about the success of CMS' 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. Performance data are extremely useful in shaping policy and management choices in both the short and long term. We look forward to the challenges represented by our performance goals and are optimistic about our ability to meet them.

FINANCIAL ACCOMPLISHMENTS

CMS has maintained a strong financial management operation, by implementing many initiatives throughout the Agency for FY 2012. Although all may not be discussed in detail below, CMS continues to improve CMS' financial management and reporting processes in order to provide timely, reliable, and accurate financial information to allow CMS management, and other decision makers to make timely and accurate program and administrative decisions.

Financial Management and Reporting

There are several initiatives that fall under this category that assist CMS in achieving accurate and reliable financial management and reporting.

Healthcare Integrated General Ledger Accounting System

CMS Healthcare Integrated General Ledger Accounting System (HIGLAS) is a single, integrated dual-entry accounting system that standardizes and centralizes Federal financial accounting and replaces the existing accounting/payment systems for Medicare and Medicaid. The phased roll-out for HIGLAS initially started with the Medicare contractor community. The Medicare contractors' claims processing systems are operating effectively in adjudicating healthcare claims; however, they were not designed to meet the requirements of a dual entry general ledger accounting system. As a result, they did not meet the provisions of the Federal Financial Management Improvement Act of 1996 (FFMIA). Following the guidance of the Office of Management and Budget (OMB) Circular A-130, *Management of Federal Information Resources*, CMS acquired a commercial off-the-shelf (COTS) product. During FY 2010, CMS became substantially compliant with the FFMIA and considers our financial systems to be integrated in accordance with OMB Circular A-127, Financial Management Systems. As of September 2012, 99.49 percent of total CMS program payments (Medicare, Medicaid, and CHIP) are accounted for in HIGLAS. Since going "live" in May of 2005, HIGLAS has processed more than 3.96 billion financial transactions and processed over 150.9 million payments worth $1.44 trillion, as of September 2012. During FY 2013, CMS plans to roll out the remaining internal CMS Administrative Program Accounting functionality to HIGLAS. HIGLAS will continue to enhance CMS' oversight of claims administration contractor financial operations and the accounting and reporting of other CMS activities as well as, provide high quality, timely data for decision making and performance measurement.

Federal Payment Levy Program

In July 2000, the Internal Revenue Service (IRS), in conjunction with the Department of the Treasury, Financial Management Service (FMS), started the Federal Payment Levy Program (FPLP) which is authorized by Internal Revenue Code, section 6331 (h), as prescribed by the Taxpayer Relief Act of 1997, section 1024. Through this program, the IRS can collect overdue taxes through a continuous levy on certain Federal payments.

CMS began participating in the FPLP in October 2008, for Medicare FFS payments made through HIGLAS. Specifically, the MIPPA legislation requires that Medicare FFS payments to providers will be offset by a maximum of 15 percent to satisfy payment of delinquent Federal tax debt and 100 percent to satisfy payment of Administrative Offsets for Federal non-tax debt. Non-tax debts include unpaid loans, overpayments or duplicate payments to Federal salary or benefit payment receipts, misused grant funds and fines, penalties, or fees assessed by Federal agencies. As of September 30, 2012, CMS has realized a cumulative total of $176 million in tax levy offsets and $67.9 million in non-tax offsets through HIGLAS on behalf of FPLP.

Communication & Financial Reporting

During FY 2012, CMS continued to improve its communication through the Risk Management and Financial Oversight Committee, which is comprised of members of CMS' senior leadership. The Risk Management and Financial Oversight Committee acts as the conduit for discussing financial management issues impacting the Agency and its financial statements. This committee ensures effective communication and a coordinated process among cross-functional areas within CMS. The Office of Financial Management (OFM) also meets monthly with upper-level management from various program centers/offices to discuss financial and budget concerns that could impact the CFO audit and day-to-day operations.

CMS continued to prepare "white papers" to ensure that any significant changes/updates to CMS' accounting and financial reporting policies are properly evaluated by CMS financial managers (and, for some cases, managers in other CMS components) and approved in writing. This process ensures that changes are implemented in an effective and efficient manner and that changes/updates to the financial statements conform to generally accepted accounting principles and Federal Financial Accounting Standards.

Recovery Audit Contractor Program

Medicare

Section 302 of the *Tax Relief and Health Care Act* of 2006 required HHS to implement the Medicare FFS Recovery Audit program in all 50 States no later than January 1, 2010. In February 2009, HHS awarded contracts to four Recovery Auditors. Each Recovery Auditor is responsible for identifying and correcting improper payments in approximately 25 percent of the country.

In FY 2012, the Medicare FFS Recovery Audit program demanded approximately $2.6 billion and recovered $2.3 billion. FY 2012 recoveries continued to grow and were 187 percent higher than recoveries in FY 2011. The Recovery Auditors continued to focus their reviews on short hospital stays and claims for Durable Medical Equipment. This is consistent with CMS' focus to lower the Medicare error rate. CMS expects that implementation of certain corrective actions will lower collections for some types of claims; however, collections will remain stable or increase slightly as Recovery Auditors continue to expand their reviews to other claim types. CMS continues to monitor the Recovery Audit Program and makes continuous improvements to activities, such as, the appeals process, feedback to providers, and system improvements. CMS is also focused on taking the findings identified by the Recovery Auditors and putting actions into place to prevent future improper payments. For example, in FY 2011, CMS released four Provider Compliance Newsletters that provided detailed information on 36 findings identified by the Recovery Auditors. CMS also implemented local and/or national system edits to automatically prevent improper payments.

Medicaid

Section 6411 (a) of the Affordable Care Act required the expansion of the Recovery Audit Contractor (RAC) program to Medicaid. The statue required States to establish Medicaid RAC programs by December 31, 2010. All States complied with the statue by submitting a State Plan amendment (SPA) to CMS attesting to the requirements of the statue. CMS then published a final rule in September 2011 requiring states to implement Medicaid RAC programs effective January 1, 2012. States that have been unable to implement Medicaid RAC programs by January 1, 2012, have been submitting SPAs to CMS requesting implementation delay exceptions. In the Medicaid RAC final rule, CMS has projected a savings of $2.1 billion over the next five years, of which $910 million will be returned to the states. The final rule aligned the Medicaid RAC requirements to existing Medicare FFS RA program requirements where feasible, and provided State flexibility to tailor their programs where appropriate.

Debt Management

The Debt Collection Improvement Act of 1996 (DCIA), requires agencies to refer all eligible debt over 180 days delinquent to the Department of Treasury for collection. Treasury uses a variety of collection tools, including sending additional demand letters, referring debts to the Treasury Offset Program (TOP), referring debts to private collection agencies, negotiating repayment agreements, and referring some debts to the Department of Justice (DOJ) for litigation. As of September 2012, the total amount of delinquent debt referred by CMS to the PSC to process and transfer to Treasury is approximately $973 million.

Administrative Payments

To date in FY 2012, we have continued to make all of our payments on-time in accordance with the Prompt Payment Act. We also continue to have more than 99 percent of our vendor payments made via Automated Clearing House (ACH) and nearly 100 percent of our travel payments via ACH.

Budget Execution

For FY 2012, CMS' budget execution function continues to be a major strength. CMS Chief Operating Officer works closely with the Chief Financial Officer to ensure that an Administrator approved operating plan is developed timely and supports CMS' priorities. Strong fund control procedures ensure resources are only used for those activities in the operating plan that has been approved by the Administrator. CMS closely monitors available resources throughout the year to ensure the Anti-Deficiency Act is not violated, while at the same time meeting reasonable but aggressive lapse targets.

Medicare Secondary Payer (MSP)

CMS efforts in the MSP area saved the Medicare trust funds approximately $7.17 billion through the first eleven months of FY 2012. CMS continues to expand and improve its coordination of benefits activities to ensure that fewer mistaken payments are made while, at the same time, continuing to actively pursue delinquent debts owed the Medicare program in compliance with DCIA. CMS is confident that savings attributable to the MSP Program will grow as new and improved methods of collecting MSP information are implemented.

During calendar year 2008, CMS began implementing Section 111 of the Medicare and Medicaid SCHIP Extension Act of 2007. Section 111 amended existing MSP provisions, adding a new mandatory MSP reporting requirement for all Group Health Plan (GHP) insurance and Workers' Compensation, Liability Insurance (including Self-Insurance) and No-Fault insurance. Implementation of the reporting requirements is being phased in. Group Health Plans began limited reporting of

data in January 2009 and were fully phased in as of January 2011. Workers' Compensation, Liability Insurance (including Self-Insurance) and No-Fault Insurance, began limited reporting of data in June 2010, and reporting thresholds will gradually be implemented through January 1, 2015.

To date, data submitted under Section 111 has quickly become the primary source of new MSP information for CMS. Most significantly, with the dramatic increase in the number of insurers reporting data today, the volume of MSP data flowing into CMS has doubled. For example, under the Voluntary Data Sharing Agreement Program, which was developed by CMS to facilitate better coordination of benefits, CMS had entered into data sharing agreements with 95 large insurers. As of October 2012, there were over 1,900 insurers reporting data to CMS under Section 111.

The incoming MSP data from insurers via the Section 111 reporting process makes our initial primary or secondary payment decisions more precise. In turn, receipt of so many new MSP records on a timelier basis reduces the need for CMS post-pay "pay-and-chase" efforts. This is confirmed in that cost-avoided savings continue to grow at a faster rate than recoveries. Finally, in those situations where past mistaken payments are identified as the result of the Section 111 data, the more comprehensive Section 111 data assists in more efficient recovery operations. The implementation of Section 111 is the single largest contributor to growth of Medicare savings of $6.5 billion in FY 2007 to over $7 billion per year in FY 2011 and FY 2012.

In addition, CMS continues to contract for the financial and medical review of proposed Workers' Compensation Medicare Set-aside Arrangement (WCMSA) amounts that represent monies earmarked in a workers' compensation settlement for future medical services/items that would otherwise be payable by the Medicare program. As a result, CMS has calculated and approved WCMSA amounts totaling approximately $1.52 billion over the period October 1, 2011 through July 31, 2012 (payments that Medicare might otherwise erroneously make in terms of beneficiaries' future medical expenses related to their associated accident, illness, or injury).

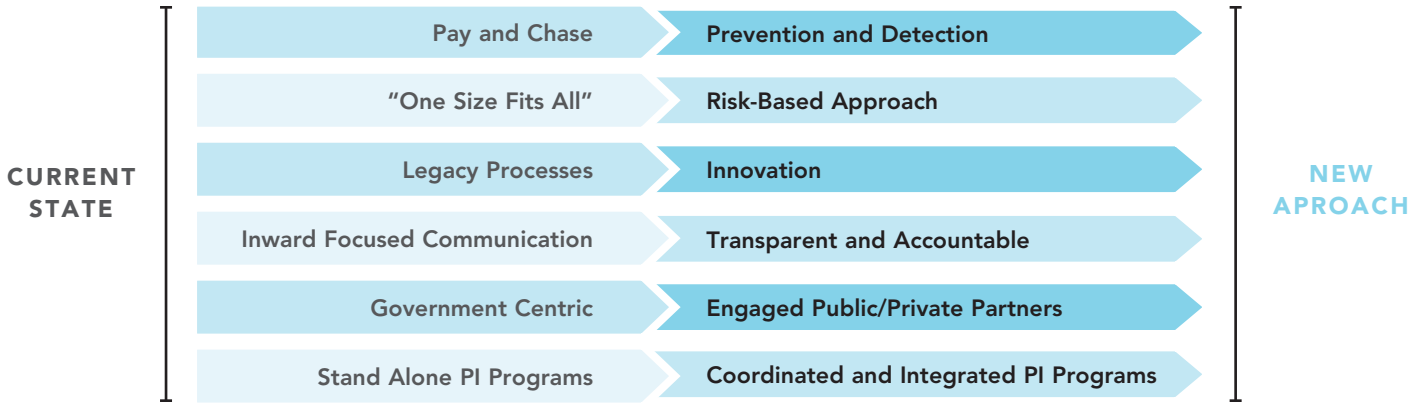
Finally, with CMS' recovery functions for all new MSP GHP and Non-GHP debt being consolidated into one Medicare Secondary Payer Recovery Contractor (the MSPRC), CMS recoveries realized under the MSPRC have gradually increased each year. Total recoveries by the MSPRC during the first eleven months of FY 2012 was $548 million, which has already exceeded the $526 recovered in all of FY 2011.

Program Integrity

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, and CHIP programs. PI activities target the range of causes of improper payments, including errors, fraud, waste, and abuse. The Center for Program Integrity (CPI) was created to support a coordinated and strategic direction, as PI activities cut across the Agency.

Strategic Direction

CMS' Program Integrity direction has six key strategies for becoming more effective while reducing burden on legitimate providers and suppliers. The first is moving beyond "pay and chase" operations to innovative prevention and detection activities. The second shift is to develop a risk-based approach for program integrity requirements, rather than operating as if "one size fits all." The third strategy is to rethink legacy



processes with innovation as a requirement. The fourth strategy to become more transparent and accountable complements the fifth strategy of meaningfully engaging our public and private partners. Finally, CMS is dedicated to continuing to coordinate and integrate Medicare and Medicaid program integrity activities.

The four major approaches CMS uses to organize its key anti-fraud activities:

- **Fraud Prevention:** the National Fraud Prevention Program, providing enrollment and screening, engaging Medicare beneficiaries, educating state Medicaid program integrity staff, antifraud marketing, and improving payment accuracy;
- **Fraud Detection:** Greatly enhanced data analytics, partnering with providers, law enforcement, Part C and D compliance activities, Medicaid data analytics and audit activities;
- **Transparency and Accountability:** Increasing coordination with law enforcement, collaborating with the private sector and states; and
- **Recovery:** Collaborating with law enforcement (HEAT) and implementation of the Medicaid and Medicare Part C/D RACs.

The Affordable Care Act

CMS has implemented many of the important PI provisions included in the Affordable Care Act. These are helping not only to move the PI strategy beyond "pay-and-chase," but also to better align Medicare and Medicaid program integrity requirements. CMS published a final rule with comment titled, "Medicare, Medicaid and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions, and Compliance Plans for Providers and Suppliers" in February 2011. This final rule established risk-based provider enrollment screening requirements that are parallel between Medicare and Medicaid, and permits states to rely on the results of Medicare screening for providers who participate in both programs. CMS has embarked on an ambitious project to revalidate the enrollments of all existing 1.5 million Medicare suppliers and providers by 2015 under the new Affordable Care Act screening requirements. Since March 25, 2011, CMS enrolled or revalidated enrollment information for approximately 275,439 Medicare providers and suppliers under the enhanced screening requirements of the Affordable Care Act. These efforts will ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries, and only legitimate providers and suppliers can bill the Medicare program.

The final rule also established CMS' authority to suspend payments pending the investigation of a credible allegation of fraud, provider enrollment application fees, and for the first time, authority to impose temporary provider enrollment moratoriums when the Secretary of HHS determines there is a risk of fraud. The Affordable Care Act also requires the termination of providers from Medicaid if they have been terminated for cause from Medicare or any other Medicaid program; and enables CMS to terminate from Medicare if the provider has been terminated from any Medicaid program.

Medicare Program Integrity

The Medicare Program Integrity functions include the detection and deterrence of fraudulent billing in the Medicare FFS program. This is accomplished through the use of enhanced provider enrollment activities, proactive data analysis, close collaboration among law enforcement, subject matter experts and program integrity contractors, the investigation of complaints from various sources, provider on-site visits, and beneficiary interviews.

- **Provider and Supplier Enrollment:** Provider enrollment is the gateway to the Medicare program, and this function serves to ensure that only eligible providers and suppliers that meet the Medicare enrollment criteria furnish, order, refer or certify services for Medicare beneficiaries. This function prevents "bad" providers and suppliers from program entry while also helping to ensure the quality of services provided to Medicare beneficiaries.
- **Benefit Integrity (BI):** Benefit Integrity activities identify, detect, and prevent payment of fraudulent or otherwise improper claims. Responsibilities include managing CMS' program integrity contractors and acting as law enforcement liaisons to ensure coordination on crosscutting issues.

CMS is significantly enhancing its approach to fraud and abuse oversight activities of the Medicare Program. As part of its National Fraud Prevention Program, CMS has implemented a twin pillar approach to fraud prevention. The first pillar is the new Fraud Prevention System (FPS), which applies predictive analytic technology on claims prior to payment to identify aberrant and suspicious billing patterns. The second pillar is the Automated Provider Screening (APS) system, which identifies ineligible providers or suppliers

prior to their enrollment or revalidation. Together these innovative new systems, the FPS and APS, are growing in their capacity to protect patients and taxpayers from those intent on defrauding our programs. These pillars represent an integrated approach to program integrity—preventing fraud before payments are made, keeping bad providers and suppliers out of Medicare in the first place, and quickly removing wrongdoers from the program once they are detected.

The FPS is the predictive analytic technology authorized under the Small Business Jobs Act. Since June 30, 2011, the FPS has been running predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims prior to payment. CMS is well ahead of the statutory implementation schedule, which called for phasing in the technology in the 10 highest fraud states in the Medicare fee-for-service program by July 1, 2011. Nationwide implementation of the technology maximizes the benefits of the FPS and permitted CMS to efficiently integrate the technology into the Medicare fee-for-service program and train our anti-fraud contractors.

CMS launched the APS technology on December 31, 2011. Medicare Administrative Contractors (MACs) and the National Supplier Clearinghouse (NSC) for DMEPOS enrollment are responsible for provider and supplier enrollment. Historically, the MACs and the NSC have processed paper applications and crosschecked information manually against various databases to verify provider and supplier enrollment requirements such as licensure status. Medicare Administrative Contractors (MACs) and the National Clearinghouse (NSC) for DMEPOS enrollment are responsible for provider and supplier enrollment. Historically, the MACs and the NSC have processed paper applications and crosschecked information manually against various databases to verify provider and supplier enrollment requirements such as licensure status. CMS will use the APS technology to conduct routine and automated screening checks of providers and suppliers, while enabling CMS to continuously monitor the accuracy of its enrollment data and to assess applicants' risk to the program using standard analyses of provider and supplier data.

The APS technology complements our approach to implementing the enhanced screening requirements enacted in the Affordable Care Act. This new requirement expanded on-site visits to many providers and suppliers that were previously not subject to such site visits as a requirement for enrolling in the Medicare program. As a result, CMS estimates that approximately 50,000 additional site visits are being conducted between March 2011 and March 2015 to ensure providers and suppliers are operational and meet certain enrollment requirements. CMS completed the procurement of a national site visit contractor to increase efficiency and

standardization of the site visits and the contractor recently started performing these site visits. The National Site Visit Contractor (NSVC) began performing site visits in late January 2012. As of April 30, 2012, the NSVC completed 6,871 site visits; of those completed, the NSVC determined 223 sites to be nonoperational; those enrollments were either denied or revoked as deemed appropriate.

To support the work of the twin pillars, CMS opened a new Command Center in July 2012. The Command Center provides the advanced technologies and collaborative environment for a multi-disciplinary team of experts and decision makers to more efficiently coordinate policies and case actions, reduce duplication of efforts, continuously improve and update data analytics, and streamline fraud investigations for more immediate administrative action.

CMS has nearly completed the process of transitioning from Program Safeguard Contractors (PSCs) to Zone Program Integrity Contractors (ZPICs). CMS created seven program integrity zones to align with the MAC jurisdictions. The ZPICs focus exclusively on a wide range of program integrity issues and projects. Six of the seven ZPICs have been awarded. The ZPICs and remaining PSC perform program integrity functions in these zones.

CMS has also embarked on projects directed at new vulnerabilities, aimed to improve the infrastructure required for the data analysis that is the foundation of all PI work, and designed to address the numerous administrative and congressional priorities. Working under the direction of CMS, our PI contractors continue to produce savings for Medicare Parts A and B by identifying overpayments, referring cases to law enforcement, and by taking an aggressive approach with other administrative actions such as payment suspensions, prepaid claims edit denials, auto denial edits, and revocations.

Medicare Drug Integrity Contractor (MEDIC)
In FY 2012, the National Benefit Integrity MEDIC received approximately 4901 actionable complaints (within the MEDIC's scope) which is an average of 408 per month; processed an average of 41 requests for information from law enforcement per month; and referred an average of 36 cases per month for further investigation. The National Benefit Integrity MEDIC was responsible for assisting the Office of the Inspector General (OIG) and the Department of Justice (DOJ) through data analysis and investigative case development) in achieving thirteen convictions, twenty seven arrests, and twenty eight indictments. A particular case produced a nine-count indictment on a Miami physician, and 23 others on charges of Medicare Part D fraud. The network's alleged theft from Medicare was estimated to be $40 million. The physician was found guilty on four counts and was sentenced to 365 months incarceration, 3 years probation, and fined $400 along with restitution in the amount of $5.5 million.

Medicare Program Integrity Field Offices
The designated Program Integrity Field Offices (FOs) in Los Angeles, Miami, and New York provide a boots-on-the-ground presence in high risk fraud areas of the country. The FOs conduct data analysis to identify local vulnerabilities and coordinate special projects with contractors and agencies on issues that have a national or regional impact.

The Miami FO has implemented a comprehensive, multipronged approach to address all aspects of healthcare fraud in South Florida and has served as a testing ground for efforts that have been expanded to a national level. A key Miami FO's initiative has been a provider enrollment special study. The project is designed to stop fraudulent providers from receiving new Medicare provider numbers and remove "bad" actors that are in the program. Results from a dedicated fraud hotline are used to target follow-up site visits or other activities for providers and suppliers on the watch list.

The Compromised Number Checklist (CNC) is both a repository and searchable database of all compromised Medicare beneficiary identification numbers (Health Insurance Claim Numbers (HICNs)) and provider identification numbers (National Provider Identifiers) used to bill or order Medicare services. The creation of the CNC has facilitated data analysis for fraud detection and prevention by consolidating compromised numbers into one location for the first time.

In FY 2012, as part of its refinement of and assignment of risk assessment indicators to the CNC database, CMS and the PSCs/ZPICs and MEDIC have removed some providers and beneficiaries whose identifiers were closely linked to compromised providers or beneficiaries but were not themselves compromised. This refinement process has reduced the number of providers from approximately, 5,000 to 2,185, and reduced the number of beneficiaries from approximately 284,000 to 226,000.

Health Care Fraud Prevention and Enforcement Team (HEAT)
CMS is a major participant in the HEAT, the joint initiative between HHS and DOJ to target tools

and resources to fight fraud. Since 2009, HEAT has resulted in cabinet-level coordination and collaboration on efforts to prevent and detect health care fraud. These efforts include:

- **Coordination of nationwide takedowns:** CMS has used its new payment suspension authority from the Affordable Care Act in coordination with two law enforcement multi-state takedowns. In February 2012, CMS suspended payment to over 70 home health agencies connected to the target of the takedown, and in May 2012, CMS suspended payments or took other administrative actions against an additional 52 providers.
- **Expanding the Medicare Fraud Strike Forces:** The Strike Forces are a key component of the HEAT strategy designed to reduce Medicare fraud. The Strike Forces combine data analysis capabilities of CMS and the investigative resources of the Federal Bureau of Investigation (FBI) and HHS/OIG with the prosecutorial resources of the DOJ Criminal Division, Fraud Section and the United States Attorney Offices. There are currently nine Strike Force cities.
- **Health Care Fraud Prevention Summits:** CMS partnered with the DOJ to host Health Care Fraud Prevention Summits in four cities during FY 2011—Brooklyn, NY; Boston, MA; Detroit, MI; and Philadelphia, PA. These summits bring together a wide array of federal, state and local partners, beneficiaries, and providers to discuss innovative ways to eliminate fraud across the U.S. health care system. The summits are part of the larger joint effort of the DOJ and HHS through the HEAT.

Medicaid Program Integrity

The Deficit Reduction Act of 2005 established the Medicaid Integrity Program in section 1936 of the Social Security Act and represents a substantial milestone in CMS' first national strategy to detect and prevent Medicaid provider fraud and abuse. States have primary responsibility for policing fraud, waste, and abuse in their Medicaid programs, and CMS plays a significant role through the provision of technical assistance, guidance, and oversight in the state-based efforts.

The Medicaid Integrity Group (MIG) within CPI is tasked with developing a strong, effective, and sustainable program to combat Medicaid provider fraud, waste, and abuse. Section 1936 of the Social Security Act provides CMS with the authorities to fight fraud and abuse by Medicaid providers by requiring CMS to contract with private sector entities to review provider claims data, audit providers, identify overpayments, and educate providers and other individuals about program integrity and quality of care. CMS works with partner agencies at the Federal and state levels to enhance these efforts, including preventing the enrollment of individuals and organizations that would abuse or defraud the Medicaid program and removing fraudulent or abusive providers when detected.

CMS' fraud research and detection activities focus on the use of state Medicaid claims and statistical data to identify potential high-risk areas for overpayments. Using data analytics, CMS and the Review Medicaid Integrity Contractors (MICs) collaborate on the development and refinement of algorithms and other data-mining techniques to help identify providers with billing patterns that may warrant audits by the Audit MICs. In 2011, CMS evaluated the current process for data analytics and audit target selection which had been in place but was not leading to high success outcomes for audits. As a result of the evaluation, CMS identified areas for improvement including developing ways to overcome the data limitations of Medicaid Statistical Information System (MSIS) data, our main Medicaid data source. CMS' fraud research and detection activities focus on the use of state Medicaid claims and statistical data to identify potential high-risk areas for overpayments. Using data analytics, CMS and the Review Medicaid Integrity Contractors (MICs) collaborate on the development and refinement of algorithms and other data-mining techniques to help identify providers with billing patterns that may warrant audits by the Audit MICs. In 2011, CMS evaluated the current process for data analytics and audit target selection which had been in place but was not leading to high success outcomes for audits. As a result of the evaluation, CMS identified areas for improvement including developing ways to overcome the data limitations of Medicaid Statistical Information System (MSIS) data, our main Medicaid data source.

At the same time, CMS is evaluating many of the tools used in Medicare for opportunities to transfer the knowledge and lessons learned to the Medicaid program. Specifically, CMS is evaluating the use of new predictive analytic tools being used in the Medicare program on state data. CMS is also actively pursuing ways to apply advanced data analytics technology, including predictive analytics, to the Medicaid program. CMS is required, under the Small Business Jobs Act of 2010, to complete an analysis of the cost-effectiveness and feasibility of expanding predictive analytics technology to Medicaid and the CHIP after the third

implementation year of such tools in the Medicare program. Based on this analysis, the law requires CMS to expand predictive analytics to Medicaid and CHIP by April 1, 2015.

National Medicaid Audit Program (NMAP)

In FY 2012, the NMAP completed its shift to work more collaboratively with states in the development of audits. The collaborative approach allows CMS to work alongside states in identifying areas that warrant further investigation and to develop the audit targets. Through this process, CMS can more effectively support a state's program integrity efforts. In addition, the corresponding data for the collaborative audits is in many cases provided or supplemented by the states, making the data more complete and thus increasing the accuracy of audit findings. The number of collaborative audits has progressively increased since the first collaborative audits were assigned in January 2010, resulting in 175 collaborative audits with 19 states as of August 2012. These 19 states represent 59 percent of all Medicaid expenditures. Areas of collaboration have included hospice, Medicaid credit balances, emergency services to non-citizens, and several audits of mental health services provided by a Tribe. As of August 2012, there have been seven Final Audit Reports related to collaborative audits issued to states valued at roughly $4.6 million. Overall, a total of $20.6 million in estimated overpayments has been identified by the efforts of CMS and the Audit MICs as of July 31, 2012.

In FY 2012, all five of the Audit MIC task orders were renewed. CMS awarded two of the five task order renewals for the Review MICs in FY 2012, and redesigned the contract work to ensure that all CMS regions are supported. The Review MICs will use national and regional analysis to detect vulnerabilities and focus analytics, while moving away from conducting solely linear state-specific algorithms based on MSIS data. The Review MICs will also be more integrally involved in collaborative audits and other collaborative projects with states, including collaborative discussions focusing on improving the quality of Medicaid data for CMS needs.

Improper Payments

CMS has implemented Executive Order 13520, Reducing Improper Payments, which was issued November 23, 2009. This Executive Order requires Federal agencies with high-priority programs to establish annual or semi-annual measurements for reducing improper payments, or if the programs already reported an annual measurement, agencies were required to develop supplemental measures. Medicaid is designated a high-priority program and currently measures improper payments annually through the Payment Error Rate Measurement (PERM) program. CMS is required to develop the supplemental measures for the Medicaid program, and CMS is collaborating with states on the development and reporting of these supplemental measures.

The supplemental measures will be calculated based on the results of state Payment Accuracy Improvement Groups (PAIG). A PAIG is a group of states with a shared, identified Medicaid program integrity vulnerability and has a common approach or intervention that will be evaluated to assess how well it addresses the problem. A pre- and post-intervention measurement is taken to determine the effectiveness of the approach and the results are shared with the other states. This facilitates the implementation of best practice interventions by providing states information on tested approaches to reducing the error rate. CMS launched the first PAIG project to measure improper payments in the area of pharmacy claims in FY 2010. After data collection, we calculated the baseline measures for this project in late 2011. During FY 2012, CMS finalized and approved educational materials on five drug classes identified as having high potential improper payment rates, launching a targeted education program with the first state in June of 2012. Final results from data collected after the educational intervention are expected in FY 2013.

Education for States

To address Medicaid's structure as a Federal-state partnership, CMS has developed initiatives specifically designed to assist states in strengthening their own efforts to combat fraud, waste, and abuse. The Medicaid Integrity Institute (MII) is one of CMS' most significant achievements in Medicaid program integrity. The MII provides for the continuing education of state program integrity employees, including specific coursework focused on predictive analytics. At the MII, CMS has a unique opportunity to offer substantive training, technical assistance, and support to states in a structured learning environment. From its inception in 2008 through June 2012, CMS has continually offered MII courses and trained 3,098 state employees and officials from 50 states, the District of Columbia, and Puerto Rico through 76 courses at no cost to the states. These state employees are able to learn and share information with program integrity staff from other states on topics such as emerging trends in

Medicaid fraud, data collection, and fraud detection skills, along with other helpful topics. In FY 2012, as of August 1, the MII conducted 20 courses, with 4 more scheduled in the remainder of the fiscal year. These included a Data Experts Symposium in July 2012 which proved extremely effective in bringing together state Medicaid data experts to exchange ideas about predictive analytics, including algorithm development and trend analysis. Twenty-two courses are scheduled for FY 2013. CMS is developing systematic methods of calculating the return on investment from the training it provides states.

The Education MIC is responsible for promoting the integrity of Medicaid programs by developing education and training for Medicaid service providers, Managed Care Organizations, Medicaid recipients and State agencies regarding Medicaid payment integrity and quality of care. Current topics include managed care compliance, dental professional compliance, provider medical identity theft, drug diversion prevention, and beneficiary card sharing. Products such as webinars, train-the-trainer activities, fact sheets, resource handouts, and referral guidelines were developed in collaboration with key stakeholders, including some states.

Through the Education MIC, CMS presents its program integrity materials at national conferences and state training activities. CMS offers training for state staff to utilize the presentation materials with provider and beneficiary audiences. CMS has created educational products which states may customize and distribute to key stakeholders. CMS also offers continuing education courses to enhance the provider's awareness of program integrity issues.

At the close of FY 2011, CMS published the first Medicaid Program Integrity Manual for the benefit of states throughout FY 2012. The purpose of this manual is to promote the continuity and consistency of the MIP by providing a comprehensive guide to its overall operations. This internet-based resource serves as a ready reference tool to assist state Medicaid stakeholders in (1) understanding the goals and objectives of the MIP; (2) improving the communication and transparency of the MIP; and (3) educating outside entities of the evolving functions of the MIP.

States also have many opportunities to share ideas and network with peers through national and regional conference calls and meetings sponsored by CMS. The Medicaid Fraud and Abuse Technical Advisory Group meets monthly to provide information to states and to support CMS' program integrity efforts. In addition, CMS' Medicaid Integrity Group sponsors quarterly calls for the Program Integrity Directors of each region as well as monthly calls for the Program Integrity Directors from the 14 smallest state Medicaid programs.

Technical Assistance to the States

CMS provides substantial oversight of state program integrity activities and technical assistance to states and others. To provide effective support and assistance to states to combat Medicaid fraud, waste, and abuse, and to gauge states' efforts in this regard, CMS conducts triennial comprehensive reviews of each state's program integrity activities. We use the State Program Integrity Reviews to identify and disseminate best practices. The review areas include provider enrollment, provider disclosures, program integrity, managed care operations, and the interaction between the state's Medicaid agency and its Medicaid Fraud Control Unit (MFCU). CMS also conducts follow-up reviews to evaluate the success of the state's corrective actions. Through its reviews, CMS has identified 52 unduplicated program integrity "best practices" that we have publicized to all states through annual summaries of our efforts.

At the end of FY 2012, CMS will have conducted 18 comprehensive program integrity reviews which identified regulatory non-compliance, program integrity best practices and program integrity vulnerabilities in every state reviewed. CMS published its annual review of state best practices in June 2011. Also, CMS released its fifth Report to Congress for FY 2010 on the MIP in June 2011.

CMS publishes an annual State Program Integrity Assessment which provides valuable information on each state's program integrity efforts, including staffing, expenditures and recoveries of overpayments. In FY 2012, through second quarter, CMS fulfilled 312 requests for technical assistance from state employees, attorneys, providers and others in a variety of program integrity-related areas.

In FY 2012, CMS participated in two field projects with the State of Florida. These involved site visits to 191 assisted living facilities (ALFs) serving vulnerable Medicaid populations in South Florida. In each investigation, state and Federal staff worked side by side reviewing medical, licensure, and employee records in facilities serving vulnerable Medicaid populations to determine if appropriate service provision and billings were taking place, if services were being provided by qualified staff, and if other quality of care or environmental issues were present. The two ALF investigations resulted in

$0.8 million in fines, $0.1 million in paid claims reversals, and over 200 other sanctions taken against facilities where problems were found.

Since FY 2007, CMS has participated in a total of 12 joint field investigations, 10 with Florida and 1 each with California and New York. While cost avoidance data for the post-2010 reviews is not available, the investigations conducted before 2011 saved the Medicaid program roughly $40 million in improper billings. This calculation was based on an analysis of claims submissions for the periods six months before and after each investigation. The investigations have also resulted in nearly 900 total sanctions being taken against providers and facilities, including:

- Fines,
- Suspensions,
- Licensing referrals,
- Fraud referrals to law enforcement, and
- Education letters.

Medicare Advantage and Prescription Drug Financial Oversight

Sections 1857(d)(1) and 1860D-12(b)(c) of the Social Security Act require the Secretary to provide for the annual audit of financial records of at least one-third of the Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs). The one-third financial audit program is designed to examine the health plans financial records, data relating to costs, Medicare utilization, and the computation of the bids. During FY 2012, CMS completed 251 audits of MAOs and PDPs for contract year 2009 and awarded contracts for 258 audits for contract year 2010. In addition, through our ROs, CMS conducts audits of the MAOs and PDPs—outside of the one-third audit requirement—to further improve oversight of both Part C and Part D sponsors.

CMS worked to reduce the number of backlogged unsettled managed care cost reports in FY 2012. Through September 2012 disallowances resulting from FY 2012 settlement activity saved about $22 million producing a rate of return of $21.32 to $1. The remaining backlog still represents a challenge and requires CMS to resolve numerous critical issues related to the managed care program.

Information Technology (IT)

During FY 2012, CMS made great strides to strengthen IT internal controls, particularly its oversight of the implementation of those controls. The management approach featured a strategy to leverage information security processes and technologies to improve the overall security posture of the CMS Enterprise. In the last year, CMS' information security program has undergone, and continues to undergo, significant change that extends security oversight, continuous monitoring, and vulnerability management to the CMS Enterprise. The Office of the Chief Information Security Officer (OCISO)'s oversight of information security has continued to move CMS from a distributed model for governing information security, where business components fully manage security oversight, to a hybrid model, where OCISO plays a much more active oversight role. CMS has established several programs to enhance continuous monitoring to help drive real-time enterprise-level situational awareness, increase the efficiency of the CMS system authorization process, and drive ongoing communications with business stakeholders. Additionally, CMS continues to implement and enhance the following information security initiatives:

- A Security Operations Center (SOC) that provides an enterprise view of the overall security posture at CMS, and is a key component in driving oversight, monitoring compliance, and identifying misuse or fraudulent use of CMS Enterprise resources. Overall development activities continue with Secure Enclave tool implementations at the CMS data centers. CMS also plans to deploy a Cyber Forensics capability that will broaden the SOC's spectrum of technical capabilities to include monitoring the integrity of the CMS Enterprise and further assisting the OIG and the Center for Program Integrity (CPI) in effective investigations.
- An Enterprise Vulnerability Management (EVM) program at CMS provides a near-real-time profile of vulnerabilities in the CMS enterprise and enhances the continuous monitoring process by providing management with information about CMS systems' ongoing vulnerabilities.
- CMS has began centralizing all CMS Security and Risk Management Framework practices, procedures, standards, and guidelines into a comprehensive three-volume CMS Risk Management Handbook (RMH). This document details the integration of information security into the CMS IT Investment & System Life Cycle Framework (ILC). As part of the RMH development, the OCISO established much needed security policy updates, including policies for Cloud Computing and Authentication. CMS continues to be a major contributor on a number of directives and IT governance documents for the CMS Chief Information Officer.

CMS is dedicated to protecting information and information systems with a comprehensive Information Security program that continues to integrate operational security and information security programs monitored by performance metrics that are continually improving. The program goal for FY 2012 focused on improvements to the information security awareness and training programs and the continued development and implementation of improved metrics for managing and reporting on the performance of the Information Security program.

Oversight of Medicare Contractor Financial Operations & Reporting

Medicare contractors administer the day-to-day operations of the Medicare FFS program by paying claims, auditing provider cost reports, and establishing and collecting overpayments. In addition, to performing these activities, Medicare contractors are required to maintain a vast array of financial data. With the availability of real time financial data provided by HIGLAS, CMS' implementation of new and/or revised policies over the past several years and other key initiatives to train staff and review contractor operations has resulted in significant improvements in the contractors' financial management activities and in the oversight of the Agency. The CMS continues to enhance its analytical tools to provide the steps to identify potential errors, unusual variances, system weaknesses, or inappropriate patterns of financial data accumulation. Some examples of these analytical tools are the HIGLAS monthly Financial Integrity Reconciliation and the HIGLAS monthly Detailed Accounts Payable Schedules.

On a monthly basis, HIGLAS Medicare contractors perform a financial reconciliation of their daily activity to the CMS Treasury Report on Receivables and Summary 2 Trial Balance. HIGLAS Medicare contractors are required to submit detailed accounts payable schedules monthly and maintain supporting documentation to ensure proper reporting of specific accounts payable balances. In addition, HIGLAS Medicare contractors are required to complete the HIGLAS Contractor's Monthly Bank Reconciliation Worksheet. The worksheet is designed to provide a monthly reconciliation of the Medicare Contractor's benefit account activity to the cash balances reported on CMS Monthly Balance Sheet and Summary 2 Trial Balance. The non-HIGLAS Medicare contractors perform a monthly reconciliation of their Form CMS-1522 Funds Expended Report to their paid claims or system reports. Furthermore, to ensure accounts receivable balances reported are reasonable.

Medicare contractors are required to perform trend analysis on a quarterly basis. The CMS central and regional offices review the Medicare contractors' quarterly trend analysis and their monthly cash reconciliations.

The Medicare contractors are subject to various financial management and IT security audits and reviews performed by the OIG, Government Accountability Office (GAO), independent CPA firms, and CMS staff to provide reasonable assurance that they have developed and implemented sound internal controls. The results of these audits and reviews indicate whether the contractors' internal controls have significant design or operational deficiencies. Audit resolution is a top priority at CMS and correcting these deficiencies is essential to improving financial management. Therefore, Medicare contractors are required to prepare corrective action plans (CAPs), which describe activities to correct findings and the timeframes for which they will be implemented. The initial CAP reports, which have been prepared using standardized formats, consolidate the findings and facilitate our monitoring responsibilities. Quarterly updates to the CAPs are required and CMS reviews all CAP submissions for adequacy. The CMS also requires all Medicare contractors to submit an annual Certification Package for Internal Controls (CPIC). In the CPIC, contractors are required to report any material weaknesses and significant deficiencies identified during the FY, along with CAPs to remedy the weaknesses. The CPIC provides CMS with assurance that contractors are in compliance with FMFIA, OMB Circular A-123 and CFO Act of 1990.

Office of Management and Budget (OMB) Circular A-123

CMS continued to build upon our success in implementing OMB's revisions to Circular A-123, *Management's Responsibility for Internal Control*. The Agency again procured an independent CPA firm in FY 2012 to assist in performing management's self-assessment in support of the assurance statement regarding internal control over financial reporting as of June 30. The scope of the review included CMS central office, four regional offices, and 19 major IT applications. In addition, the CPA firm conducted Circular A-123, Appendix A Internal Control over Financial Reporting (ICOFR) reviews at Medicare contractors (the Retiree Drug Subsidy and the MSPRC), five data centers, three shared system maintainers, and the Single Testing Contractor (STC) for the shared systems.

The MACs continued to contract with independent CPA firms to conduct Statement on Standards for Attestation Engagements (SSAE) Number 16 (SSAE 16) internal control audits. As a result, 14 SSAE 16 audit reports were leveraged for the FY 2012 ICOFR review. Also, we conducted CAP follow-up reviews related to Statement on Auditing Standards 70 (SAS 70) internal control audits and other reviews conducted in previous years. To implement the requirements under Appendix A of OMB Circular A-123, CMS: (1) planned and scoped the evaluation, (2) documented controls and evaluated the design of the controls, (3) tested operating effectiveness, (4) identified and corrected deficiencies, and (5) reported on internal controls. CMS provided an assurance statement as of June 30 and updated it as of September 30. The results of our self-assessment are provided in the ***Summary of Federal Managers' Financial Integrity Act Report and OMB Circular A-123 Statement of Assurance*** section.

The Risk Management and Financial Oversight Committee continued to play a key role in the A-123 assessment process. Moreover, managers and staff were trained on internal controls and OMB Circular A-123, which included an online training session, entitled: "Internal Controls and You!"

Financial Statements Introduction & Highlights

Introduction

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 included the OMB Circular A-136[4], 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 notes.

Consolidated Balance Sheets

The Consolidated Balance Sheets present as of September 30, 2012 and 2011, 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' Consolidated Balance Sheet has reported assets of $424.8 billion. The bulk of these assets are in Investments totaling $302.9 billion, which are invested in U.S. 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 $109 billion, most of which is for Medicaid, Other Health, and CHIP. Liabilities of $80.5 billion consist primarily of the Entitlement Benefits Due and Payable of $72.5 billion. CMS' net position totals $344.3 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 net cost of operations for the years ended September 30, 2012 and 2011. The Statement of Net Cost shows only a single dollar amount: the actual net cost of CMS' operations for the period by program. Under the *Government Performance and Results Act (GPRA)*, CMS is required to identify the mission of the agency and develop a strategic plan and performance measures to show that desired outcomes are being met. The three major programs that CMS administers are: Medicare, Medicaid, and CHIP. The bulk of CMS' 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: CLIA, State Grants and Demonstrations, Other Health, and Other. A Consolidating Statement of Net Cost is provided to show the earmarked vs. non-earmarked components of net cost as additional information.

Total Benefit Payments were $796.9 billion for FY 2012. Administrative Expenses were $3.7 billion, less than one percent of total net Program/Activity Costs of $737.8 billion.

The net cost of the Medicare program including benefit payments, QIOs, Medicare Integrity Program spending, and administrative costs, was $477.7 billion. The HI total costs of $254.1 billion were offset by $3.7 billion in revenues. The SMI total costs of $288.4 billion were offset by premiums and other revenues of $61.1 billion. Medicaid total costs of $247.5 billion, represent expenses incurred by the

[4] On October 27, 2011, OMB issued a revised Circular No. 136, establishing a reference for all Federal financial reporting guidance for Executive Branch departments, agencies, and entities required to submit audited financial statements.

states and territories that were reimbursed by CMS during the FY, plus accrued payables. The CHIP total costs were $9.3 billion.

Consolidated Statements of Changes in Net Position

The Consolidated Statements of Changes in Net Position present the change in net position for the years ended September 30, 2012 and 2011. The Statement of Changes in Net Position (SCNP) reports the change in net position during the FY that occurred in the two components of net position: Cumulative Results of Operations and Unexpended Appropriations. Earmarked funds are shown in a separate column from other funds. A Consolidating Statement of Changes in Net Position is provided to present the change in net position by major programs as additional information.

The line, Appropriations Used, represents the Medicaid appropriations used of $246.8 billion; $231.5 billion in transfers from Payments to Health Care Trust Funds to HI and SMI; CHIP appropriations of $9.2 billion and State Grants and Demonstrations and general fund-financed Program Management appropriations of $672 million. 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 (FICA) and Self Employment Contributions Act (SECA) for the HI Trust Fund, and totaled $204.8 billion. The Federal matching contribution is income to the SMI program from a general fund appropriation (Payments to Health Care Trust Funds) of $165.3 billion, which matches monthly premiums paid by beneficiaries.

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, 2012 and 2011. 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 $1,151.1 billion ($4.8 billion in non-budgetary). Obligations of $1,078.8 billion ($1.7 billion in non-budgetary) leave unobligated balances of $72.3 billion—$3.1 billion in non-budgetary—(of which $4.7 billion of budgetary resources is not available). Total outlays, net of collections, were $1,048.9 billion. When offset by $316.7 billion relating to collection of premiums and general fund transfers from the Payments to Health Care Trust Funds, as well as refunds of Medicare contractor overpayments, the net outlays were $732.2 billion.

Statement of Social Insurance (SOSI)

The 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 from the formulas specified in current law 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 under current law are not included in the Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position, or Combined Statement of Budgetary Resources.

The SOSI presents the following estimates:

- The present value of future income (income excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income to be received from or on behalf of current participants who have not yet attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income less future cost for the closed group, which represents all current participants who attain age 15 or older in the first year of the projection period, *plus* the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period;
- The present value of income to be received from or on behalf of future participants and the cost of providing benefits to those same individuals;
- The present value of future income less future cost for the open group, which represents all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program, *plus* the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period; and
- The present value of future cash flows for all current and future participants over the next 75 years (open group measure) decreased from $(3.3) trillion, determined as of January 1, 2011, to $(5.6) trillion, determined as of January 1, 2012.

Including the combined HI and SMI Trust Fund assets increases the present value, as of January 1, 2012, of future cashflow for all current and future participants to $(5.3) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI Trust Fund assets, is $(9.9) 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 139 percent at the beginning of FY 2008 to 94 percent at the beginning of FY 2012.

TRUST FUND RATIO
(Beginning of Fiscal Year[5])

	2008	2009	2010	2011	2012
HI	139%	134%	124%	106%	94%

Short-Term Financing

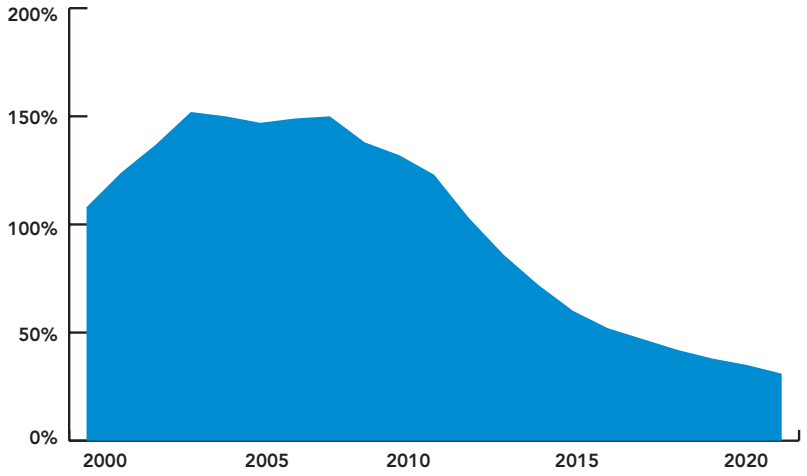
The HI Trust Fund is deemed adequately financed for the short term when actuarial estimates of Trust Fund assets for the beginning of each calendar year are at least as large as program obligations for the year. Estimates in the 2012 Trustees Report indicate that the HI Trust Fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2012 Trustees Report, the HI Trust Fund ratio is estimated to steadily decline to about 32 percent by the beginning of calendar year 2021. From the end of 2011 to the end of 2021, assets are expected to decline by 50 percent, from $244 billion to $119 billion.

Long-Term Financing

HI financing is not projected to be sustainable over the long term with the tax rates and expenditure levels projected in current law. Program cost will exceed total income in all years of the 75-year projection period. In 2024, the HI Trust Fund will be exhausted according to the projections by the CMS Office of the Actuary. Under current law, when the HI Trust Fund is exhausted, full benefits cannot be paid on a timely basis. Tax revenues are projected to be sufficient to support 87 percent of projected expenditures after the HI Trust Fund exhaustion in 2024, declining to 69 percent of projected expenditures in 2086.

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 3.43 in 2011 to about 2.1 by 2086. In addition, health care costs

HI TRUST FUND RATIO



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

continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $5.5 trillion, which is 1.4 percent of taxable payroll and 0.6 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 FASAB.

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, their program benefits are quite different in nature, and there is no provision for transferring assets.

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, Part D has a flexible general revenue appropriation, which means that general revenues cover the remaining cost of providing Part D benefits, thereby eliminating the need to maintain a normal contingency reserve.

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 expenditures less income for the 75-year projection period is $(21.6) trillion.

Even though from a program perspective, the unfunded liability is $ 0, there is concern over the rapid cost of the SMI program as a percent of GDP. In 2011, SMI expenditures were 1.97 percent of GDP. By 2086, SMI expenditures are projected to grow to 4.02 percent of the GDP.

The following table presents key amounts from our basic financial statements for fiscal year 2010 through 2012.

TABLE OF KEY MEASURES[7]
(Dollars in Billions)

	2012	2011	2010
Net Position (end of fiscal year)			
Assets	$424.8	$424.2	$430.7
Less Total Liabilities	$80.5	$87.5	$80.5
Net Position (assets net of liabilities)	$344.3	$336.7	$350.2
Change in Net Position (end of fiscal year)			
Net Costs	$737.8	$754.1	$728.7
Total Financing Sources	$710.8	$730.4	$709.5
Change in Net Position	$(27.0)	$(23.7)	$(19.2)
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	$(5,581)	$(3,252)	$(2,683)
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	$(3,252)	$(2,683)	$(13,770)
Change in present value	$(2,329)	$(569)	$11,087

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

Statement of Changes in Social Insurance Amounts (SCSIA)

The SCSIA reconciles the change (between the current valuation period and the prior valuation period) in the present value of future tax income less future cost for current and future participants (the open group measure) over the next 75 years. This reconciliation identifies those components of the change that are significant and provides reasons for the changes.

The present value as of January 1, 2012, would have decreased by $125 billion due to advancing the valuation date by one year and including the additional year 2086. Similarly, changes in the demographic, and economic and health care assumptions further decreased the present value of future cash flows by $97 billion and $2,546 billion, respectively. However, projection base and legislative changes, increased the present value of future cash flows by $286 billion and $153 billion, respectively (please refer to Note 19, *Statement of Changes in Social Insurance Amounts* for further explanation).

Required Supplementary Information (RSI)

As required by SFFAS Number 17 (as amended by SFFAS Number 37), CMS has included information about the Medicare trust funds—HI and SMI. The RSI presents required long-range cash-flow projections, the long-range projections of the ratio of contributors to beneficiaries (dependency ratio), and the sensitivity analysis illustrating the effect of the changes in the most significant assumptions on the actuarial projections and present values. The SFFAS 37 does not eliminate or otherwise affect the SFFAS 17 requirements for the supplementary information, except that actuarial projections of annual cash flow in nominal dollars are no longer required; as such, it will not be reported in the RSI. The RSI assesses the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the ***2012 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.

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

DEBORAH A. TAYLOR, CPA

As the Agency's Chief Financial Officer, it is with great pleasure that I present the fiscal year (FY) 2012 CMS Financial Report, including the audited financial statements with related program and financial information. In FY 2012, we continued to demonstrate a strong fiscal prudence and discipline over the programs we manage. We received an unqualified opinion on four out of the six principal financial statements, however Ernst & Young did not again, express an opinion on the Statement of Social Insurance (SOSI), mainly due to the uncertainty of the long-range assumptions used in the model. This year and in previous years, the SOSI has been developed based upon current law, in accordance with standards required by the Federal Accounting Standards Advisory Board. We remain confident that the FY 2012 SOSI projections in this statement fairly represent the effects of the Affordable Care Act and properly disclose the purpose of the projection.

In addition to the unqualified opinion, the auditors found no material weaknesses in our internal controls; however, they continued to cite on-going significant deficiencies in information systems and financial reporting, systems and oversight. Since the auditors first noted these deficiencies, we have worked diligently at correcting these issues while strengthening our control environment and mitigating any risks. Our corrective actions for some of these issues, especially those surrounding information systems, are multi-year efforts requiring dedicated resources. CMS has already implemented or is in the process of implementing the corrective actions to address those findings.

We are proud of the many initiatives and activities we have undertaken and achieved this year that have greatly improved CMS' financial management posture. The culmination of our efforts to successfully transition all of our Medicare Administrative Contractors (MACs) to the Healthcare Integrated General Ledger Accounting System (HIGLAS) was a huge accomplishment this year. In the upcoming months, we will be moving one step closer to transitioning CMS' programmatic and administrative accounting functions to HIGLAS. With the availability of "real time" financial data provided by HIGLAS, CMS will have even greater ability to be transparent in its financial management activities, and thus, improving the overall financial stability of the Agency.

CMS has worked tirelessly to ensure relevant, reliable and timely information is available to all of its stakeholders, all while improving our internal controls, ensuring accountability, and decreasing the risk of financial fraud and errors. During FY 2012, CMS expanded the recovery audit programs to include not only Medicare fee-for-service (FFS), but also Medicaid. The recovery audit programs are key initiatives in protecting the funds invested in Medicare and Medicaid. The Medicare FFS recovery audit program recovered over $2.2 billion in Medicare payments in FY 2012. This represents an increase in recoveries of 187 percent over FY 2011.

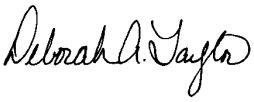
CMS continues to make great strides in implementing the requirements of the Improper Payment Information Act of 2002, which was amended in FY 2010, by the Improper Payments Elimination and Recovery Act. CMS reported error rates for all of our high-risk programs and continued efforts to reduce improper payments. This year's reporting also includes the Children's Health Insurance Program (CHIP).

"We are proud of the many projects and activities we have undertaken and achieved this year that have greatly improved CMS' financial management posture."

Reducing these error rates continues to be one of CMS' top priorities. During FY 2012, we implemented three demonstration projects that we believe will reduce the risk of improper payments.

- In January 2012, we began a demonstration project that allows hospitals to resubmit claims for 90 percent of allowable Part B payments when a Medicare Administrative Contractor, Recovery Auditor, Comprehensive Error Rate Testing Contractor, or the hospital finds that it incorrectly billed for a Medicare patient who met the requirements for Part B outpatient services but did not meet the requirements for a Part A inpatient stay. This demonstration could provide a model for the future on how to best allow rebilling.
- In September 2012, we began a demonstration project which allows Medicare Recovery Auditors to review claims before they are paid to ensure that the provider complied with all Medicare payment and coverage rules. These reviews focus on certain states with high populations of fraud and error-prone providers. It also focuses on states with high claims volumes for short inpatient hospital stays. We expect this demonstration will help lower the error rate by preventing improper payments before they occur, rather than the traditional "pay and chase" methods of looking for improper payments after they have been made.
- In September 2012, we also began a demonstration project that implements a prior authorization requirement for scooters and power wheelchairs for all people with Medicare who reside in certain states with high populations of fraud and error-prone providers. This demonstration will help ensure that a beneficiary's medical condition warrants the necessity for medical equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary's ability to receive quality products from accredited suppliers.

While we have just begun implementing many of our initiatives, CMS' programs continue to rapidly evolve and grow. Although our programs are complex, diverse and extremely challenging, we will continue to enhance our level of corresponding financial management requirements in order to successfully achieve and maintain sound fiscal policies and procedures. We would not have, nor could we continue our achievements without the hard work and dedication of CMS' employees and the internal and external stakeholders that work with us to achieve our goals. We do all of this in order to support CMS' mission, programs, systems, business partners, and most importantly, the millions of beneficiaries we serve.



DEBORAH A. TAYLOR, CPA
CMS Chief Financial Officer

November 2012

CONSOLIDATED BALANCE SHEETS

as of September 30, 2012 and 2011

(IN MILLIONS)

	FY 2012 Consolidated Totals	FY 2011 Consolidated Totals
ASSETS		
Intragovernmental Assets:		
Fund Balance with Treasury *(Note 2)*	$109,006	$74,517
Investments *(Note 3)*	302,904	322,065
Accounts Receivable, Net *(Note 4)*	505	516
Other Assets	38	91
Total Intragovernmental Assets	**412,453**	**397,189**
Accounts Receivable, Net *(Note 4)*	10,569	10,527
Direct Loans, Net *(Note 5)*	53	
General Property, Plant and Equipment, Net	378	389
Other Assets *(Note 6)*	1,379	16,083
TOTAL ASSETS	**$424,832**	**$424,188**
LIABILITIES		
Intragovernmental Liabilities:		
Accounts Payable	$646	$651
Debt *(Note 7)*	150	
Accrued Payroll and Benefits	5	4
Other Intragovernmental Liabilities	802	878
Total Intragovernmental Liabilities	**1,603**	**1,533**
Federal Employee and Veterans' Benefits	12	13
Entitlement Benefits Due and Payable *(Note 8)*	72,493	80,882
Accrued Payroll and Benefits	106	54
Contingencies *(Note 9)*	5,291	3,016
Other Liabilities	1,054	1,947
TOTAL LIABILITIES *(Note 10)*	**$80,559**	**$87,445**
NET POSITION		
Unexpended Appropriations-earmarked funds	$20,519	$4,335
Unexpended Appropriations-other funds	60,417	42,093
Total Unexpended Appropriations	**80,936**	**46,428**
Cumulative Results of Operations-earmarked funds	261,800	288,862
Cumulative Results of Operations-other funds	1,537	1,453
Total Cumulative Results of Operations	**263,337**	**290,315**
TOTAL NET POSITION	**$344,273**	**$336,743**
TOTAL LIABILITIES AND NET POSITION	**$424,832**	**$424,188**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF NET COST

for the years ended September 30, 2012 and 2011

(IN MILLIONS)

	FY 2012 Consolidated Totals	FY 2011 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS		
GPRA Programs		
Medicare (Earmarked)	$477,687	$474,005
Medicaid	247,508	268,116
CHIP	9,260	8,689
Net Cost: GPRA Programs	734,455	750,810
Other Activities		
CLIA	225	101
State Grants and Demonstrations	656	679
Other Health	2,522	2,418
Other	(35)	137
Net Cost: Other Activities	3,368	3,335
NET COST OF OPERATIONS *(Notes 11,15, and 20)*	$737,823	$754,145

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2012

(IN MILLIONS)

	Consolidated Earmarked Funds	Consolidated Other Funds	FY 2012 Consolidated Total
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	$288,862	$1,453	$290,315
Budgetary Financing Sources:			
Appropriations Used	231,489	258,984	490,473
Nonexchange Revenue:			
FICA and SECA Taxes	204,752		204,752
Interest on Investments	13,823	2	13,825
Other Nonexchange Revenue	3,412		3,412
Transfers-in/out Without Reimbursement *(Note 12)*	(2,886)	1,224	(1,662)
Other Financing Sources (Nonexchange):			
Imputed Financing	35	10	45
Total Financing Sources	**450,625**	**260,220**	**710,845**
Net Cost of Operations	**477,687**	**260,136**	**737,823**
Net Change	**(27,062)**	**84**	**(26,978)**
CUMULATIVE RESULTS OF OPERATIONS	**$261,800**	**$1,537**	**$263,337**
UNEXPENDED APPROPRIATIONS			
Beginning Balances	$4,335	$42,093	$46,428
Budgetary Financing Sources:			
Appropriations Received	251,066	288,098	539,164
Appropriations Transferred-in/out		(3,966)	(3,966)
Other Adjustments *(Note 13)*	(3,393)	(6,824)	(10,217)
Appropriations Used	(231,489)	(258,984)	(490,473)
Total Budgetary Financing Sources	**16,184**	**18,324**	**34,508**
Total Unexpended Appropriations	**20,519**	**60,417**	**80,936**
NET POSITION	**$282,319**	**$61,954**	**$344,273**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2011

(IN MILLIONS)

	Consolidated Earmarked Funds	Consolidated Other Funds	FY 2011 Consolidated Total
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	$313,447	$609	$314,056
Budgetary Financing Sources:			
Appropriations Used	242,152	279,539	521,691
Nonexchange Revenue:			
FICA and SECA Taxes	192,063		192,063
Interest on Investments	15,651	5	15,656
Other Nonexchange Revenue	2,455		2,455
Transfers-in/out Without Reimbursement *(Note 12)*	(2,942)	1,437	(1,505)
Other Financing Sources (Nonexchange):			
Imputed Financing	41	3	44
Total Financing Sources	**449,420**	**280,984**	**730,404**
Net Cost of Operations	**474,005**	**280,140**	**754,145**
Net Change	**(24,585)**	**844**	**(23,741)**
CUMULATIVE RESULTS OF OPERATIONS	**$288,862**	**$1,453**	**$290,315**
UNEXPENDED APPROPRIATIONS			
Beginning Balances	$1,776	$34,377	$36,153
Budgetary Financing Sources:			
Appropriations Received	245,949	310,168	556,117
Appropriations Transferred-in/out		3,779	3,779
Other Adjustments *(Note 13)*	(1,238)	(26,692)	(27,930)
Appropriations Used	(242,152)	(279,539)	(521,691)
Total Budgetary Financing Sources	**2,559**	**7,716**	**10,275**
Total Unexpended Appropriations	**4,335**	**42,093**	**46,428**
NET POSITION	**$293,197**	**$43,546**	**$336,743**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENTS OF BUDGETARY RESOURCES

for the years ended September 30, 2012 and 2011

(IN MILLIONS)

	FY 2012 Combined Totals Budgetary	FY 2012 Non-Budgetary Credit Reform Financing Account	FY 2011 Combined Totals Budgetary
Budgetary Resources:			
Unobligated balance, brought forward, October 1:	$41,779		$30,770
Recoveries of prior year unpaid obligations	23,052		22,733
Other changes in unobligated balance	(3,572)		(319)
Unobligated balance from prior year budget authority, net	61,259		53,184
Appropriation	1,078,147		1,110,233
Borrowing authority		$3,194	
Spending authority from offsetting collections	11,647	1,624	11,751
TOTAL BUDGETARY RESOURCES	**$1,151,053**	**$4,818**	**$1,175,168**
Status of Budgetary Resources:			
Obligations incurred *(Note 16)*:	$1,078,779	$1,695	$1,133,389
Unobligated balance:			
Apportioned	67,557	3,123	37,674
Exempt from apportionment			136
Unapportioned	4,717		3,969
Total unobligated balance, end of year	72,274	3,123	41,779
TOTAL BUDGETARY RESOURCES	**$1,151,053**	**$4,818**	**$1,175,168**
Change in Obligated Balance:			
Obligated balance, net:			
Unpaid obligations, brought forward, October 1 (gross)	$102,559		$89,406
Uncollected customer payments from Federal sources, brought forward, October 1	(6,462)		(2,868)
Obligated Balance start of year (net)	96,097		86,538
Obligations incurred	1,078,779	$1,695	1,133,389
Outlays (gross)	(1,059,716)	(93)	(1,097,503)
Change in uncollected customer payments from Federal sources	(788)	(1,587)	(3,594)
Recoveries of prior year unpaid obligations	(23,052)		(22,733)
Obligated balance, net, end of period:			
Unpaid Obligations	98,570	1,602	102,559
Uncollected customer payments from Federal sources	(7,250)	(1,587)	(6,462)
OBLIGATED BALANCE, END OF YEAR (NET)	**$91,320**	**$15**	**$96,097**
Obligated balance, end of year Net:			
Budget authority, gross	$1,089,794	$4,818	$1,121,984
Actual Offsetting collections	(10,859)	(37)	(8,157)
Change in uncollected customer payments from Federal sources	(788)	(1,587)	(3,594)
BUDGET AUTHORITY, NET	**1,078,147**	**3,194**	**1,110,233**
Outlays, gross	1,059,716	93	1,097,503
Actual offsetting collections	(10,859)	(37)	(8,157)
Outlays, net	1,048,857	56	1,089,346
Less: Distributed offsetting receipts	(316,656)		(321,925)
AGENCY OUTLAYS, NET	**$732,201**	**$56**	**$767,421**

The accompanying notes are an integral part of these statements.

STATEMENT OF SOCIAL INSURANCE

75-Year Projection as of January 1, 2012 and Prior Base Years

(IN BILLIONS)

		Estimates from Prior Years			
	2012 (Unaudited)	2011 (Unaudited)	2010 (Unaudited)	2009	2008
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 17 and 18)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$7,929	$7,581	$7,216	$6,348	$6,320
SMI Part B	14,431	13,595	12,688	16,323	14,932
SMI Part D	5,866	6,438	6,355	6,144	6,527
Have attained eligibility age (age 65 or over)					
HI	302	262	248	209	202
SMI Part B	2,395	2,122	1,972	1,924	1,785
SMI Part D	694	695	646	595	581
Those expected to become participants					
HI	7,367	7,260	6,944	5,451	5,361
SMI Part B	3,333	3,223	3,077	4,909	4,480
SMI Part D	2,568	2,817	2,714	2,632	2,856
All current and future participants					
HI	15,598	15,104	14,408	12,008	11,883
SMI Part B	20,159	18,940	17,737	23,156	21,197
SMI Part D	9,128	9,950	9,715	9,371	9,964
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 17 and 18)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	14,919	12,887	12,032	18,147	17,365
SMI Part B	14,303	13,489	12,587	16,342	14,949
SMI Part D	5,866	6,438	6,355	6,144	6,527
Have attained eligibility age (age 65 and over)					
HI	3,369	2,923	2,648	2,958	2,747
SMI Part B	2,646	2,343	2,166	2,142	1,986
SMI Part D	694	695	646	595	581
Those expected to become participants					
HI	2,891	2,546	2,411	4,673	4,506
SMI Part B	3,211	3,108	2,984	4,672	4,262
SMI Part D	2,568	2,817	2,714	2,632	2,856
All current and future participants:					
HI	21,179	18,356	17,090	25,778	24,619
SMI Part B	20,159	18,940	17,737	23,156	21,197
SMI Part D	9,128	9,950	9,715	9,371	9,964
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 17 and 18)					
HI	($5,581)	$(3,252)	$(2,683)	$(13,770)	$(12,737)
SMI Part B					
SMI Part D					
ADDITIONAL INFORMATION					
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 17 and 18)					
HI	($5,581)	$(3,252)	$(2,683)	$(13,770)	$(12,737)
SMI Part B					
SMI Part D					
Trust Fund assets at start of period					
HI	244	272	304	321	312
SMI Part B	80	71	76	59	53
SMI Part D	1	1	1	1	3
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 17 and 18)					
HI	($5,337)	$(2,980)	$(2,378)	$(13,449)	$(12,425)
SMI Part B	80	71	76	59	53
SMI Part D	1	1	1	1	3

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, 2012 and Prior Base Years

(IN BILLIONS)

		Estimates from Prior Years			
	2012 (Unaudited)	2011 (Unaudited)	2010 (Unaudited)	2009	2008
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)	$3,391	$3,079	$2,866	$2,729	$2,568
Expenditures	6,709	5,961	5,459	5,695	5,315
Income less expenditures	(3,319)	(2,882)	(2,593)	(2,967)	(2,746)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	28,227	27,615	26,259	28,815	27,778
Expenditures	35,088	32,814	30,974	40,634	38,841
Income less expenditures	(6,861)	(5,199)	(4,715)	(11,819)	(11,063)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(10,180)	(8,081)	(7,308)	(14,786)	(13,809)
Combined Medicare Trust Fund assets at start of period	325	344	381	381	368
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(9,855)	(7,737)	(6,927)	(14,405)	(13,441)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	13,268	13,300	12,735	12,991	12,698
Expenditures	8,669	8,471	8,109	11,976	11,625
Income less expenditures	4,599	4,829	4,626	1,016	1,073
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(5,581)	(3,252)	(2,683)	(13,770)	(12,737)
Combined Medicare Trust Fund assets at start of period	325	344	381	381	368
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	($5,256)	$(2,908)	$(2,302)	$(13,390)	$(12,369)

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

(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 19)*					
As of January 1, 2011	$43,993	$47,245	($3,252)	$344	($2,908)
Reasons for change					
Change in the valuation period	2,011	2,136	(125)	(28)	(153)
Change in projection base	113	(173)	286	9	295
Changes in the demographic assumptions	(1,189)	(1,092)	(97)		(97)
Changes in economic and health care assumptions	24	2,570	(2,546)		(2,546)
Changes in law	(66)	(219)	153		153
Net changes	892	3,221	(2,329)	(19)	(2,348)
As of January 1, 2012	$44,885	$50,467	($5,581)	$325	($5,256)
HI: PART A *(Note 19)*					
As of January 1, 2011	$15,104	$18,356	($3,252)	$272	($2,980)
Reasons for change					
Change in the valuation period	634	759	(125)	(34)	(159)
Change in projection base	15	(271)	286	6	292
Changes in the demographic assumptions	(84)	13	(97)		(97)
Changes in economic and health care assumptions	(71)	2,475	(2,546)		(2,546)
Changes in law	0	(153)	153		153
Net changes	494	2,824	(2,329)	(28)	(2,357)
As of January 1, 2012	$15,598	$21,179	($5,581)	$244	($5,337)
SMI: PART B *(Note 19)*					
As of January 1, 2011	$18,940	$18,940	$0	$71	$71
Reasons for change					
Change in the valuation period	845	845		6	6
Change in projection base	152	152		2	2
Changes in the demographic assumptions	(339)	(339)			
Changes in economic and health care assumptions	623	623			
Changes in law	(61)	(61)			
Net changes	1,220	1,220	0	8	8
As of January 1, 2012	$20,159	$20,159	$0	$80	$80
SMI: PART D *(Note 19)*					
As of January 1, 2011	$9,950	$9,950	$0	$1	$1
Reasons for change					
Change in the valuation period	533	533			(0)
Change in projection base	(54)	(54)			
Changes in the demographic assumptions	(767)	(767)			
Changes in economic and health care assumptions	(528)	(528)			
Changes in law	(5)	(5)			
Net changes	(822)	(822)	0	0	0
As of January 1, 2012	$9,128	$9,128	$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)

(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 19)*					
As of January 1, 2010	$41,860	$44,543	$(2,683)	$381	$(2,302)
Reasons for change					
Change in the valuation period	1,952	2,063	(112)	(49)	(160)
Change in projection base	(1,069)	(538)	(531)	11	(519)
Changes in the demographic assumptions	(67)	44	(112)		(112)
Changes in economic and health care assumptions	1,299	1,115	185		185
Changes in law	19	19		1	1
Net changes	2,134	2,703	(569)	(37)	(606)
As of January 1, 2011	$43,993	$47,245	$(3,252)	$344	$(2,908)
HI: PART A *(Note 19)*					
As of January 1, 2010	$14,408	$17,090	$(2,683)	$304	$(2,378)
Reasons for change					
Change in the valuation period	611	723	(112)	(32)	(143)
Change in projection base	(427)	103	(531)	(1)	(531)
Changes in the demographic assumptions	(151)	(40)	(112)		(112)
Changes in economic and health care assumptions	664	479	185		185
Changes in law					
Net changes	696	1,265	(569)	(32)	(602)
As of January 1, 2011	$15,104	$18,356	$(3,252)	$272	$(2,980)
SMI: PART B *(Note 19)*					
As of January 1, 2010	$17,737	$17,737	$0	$76	$76
Reasons for change					
Change in the valuation period	807	807		(16)	(16)
Change in projection base	(552)	(552)		12	12
Changes in the demographic assumptions	123	123			
Changes in economic and health care assumptions	806	806			
Changes in law	19	19		1	1
Net changes	1,203	1,203	0	(4)	(4)
As of January 1, 2011	$18,940	$18,940	$0	$71	$71
SMI: PART D *(Note 19)*					
As of January 1, 2010	$9,715	$9,715	$0	$1	$1
Reasons for change					
Change in the valuation period	534	534		(1)	(1)
Change in projection base	(90)	(90)			
Changes in the demographic assumptions	(39)	(39)			
Changes in economic and health care assumptions	(170)	(170)			
Changes in law					
Net changes	234	234	0	(0)	(0)
As of January 1, 2011	$9,950	$9,950	$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.

The financial statements were prepared from CMS' 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 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.

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. During FY 2011, operational responsibility for several programs established by the Affordable Care Act was transferred from the HHS Office of the Secretary to CMS, as of April 1, 2011. These programs include: the Pre-existing Condition Insurance Plan Program (PCIP), Early Retiree Reinsurance Programs, Affordable Insurance Exchanges (the "Exchanges"), and the Consumer Operated and Oriented Plan (CO-OP) Program, and are administered by CMS' Center for Consumer Information and Insurance Oversight (CCIIO). Obligations on or after April 1, 2011, were executed by CMS and will continue to be accounted for by CMS. The HHS Office of the Secretary will continue to account for obligations recorded prior to April 1, 2011 until expended or de-obligated. A brief description of these programs and their impact on the CMS financial statements is presented below.

Pre-existing Condition Insurance Plan Program

This plan offers coverage to uninsured Americans who have been unable to obtain health coverage because of a pre-existing health condition. Plans are administered through two processes: supporting State-run programs, or providing insurance coverage directly to individuals in States where States do not run their own programs. This program was established to enable coverage until the Exchanges programs are operational. Congress appropriated $5 billion for the life of this interim program. This program ends on January 1, 2014.

Early Retiree Reinsurance Program

Under the Affordable Care Act, a temporary reinsurance program was established to

reimburse a portion of the employer cost of providing health insurance coverage for early retirees. Congress appropriated $5 billion for the life of this program. The Act authorizes the HHS Secretary to stop taking applications for participation in the program based on the availability of funding. On June 29, 2010, HHS began accepting applications from employers. The program permits approved applicants to submit for reimbursement expenses incurred after June 1, 2010. The program is scheduled to terminate on January 1, 2014.

Affordable Insurance Exchanges

Grants have been provided to the States to establish Affordable Insurance Exchanges. The initial grants were made by the 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.

Consumer Operated and Oriented Plan (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. These CO-OPs will operate a strong consumer focus and provide consumers with greater plan choice. Under this program, assistance is 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. In FY 2012, CMS awarded the first loan agreements for both start-up and solvency requirements; however, disbursements have been made for only the start-up costs. The loans are accounted for as receivables after funds have been disbursed. See Note 5 for additional information on the issuance of the CO-OP loans.

Congress originally appropriated $6 billion to carry out this assistance program under the Affordable Care Act. The Department of Defense and Full-Year Continuing Appropriations Act of 2011 and the Department of Labor, Health and Human Services, Education, and Related Agencies Appropriation Act of 2012 included a $2.2 billion and $400 million rescission, respectively, that reduced CO-OP budget authority to $3.4 billion.

The following is a description of each of the major funds under CMS controls and method of accounting.

Earmarked Funds

Earmarked funds are financed by specifically identified revenues, often supplemented by other financing sources, which remain available over time. Earmarked funds meet the following criteria:

- A statute committing the Federal Government to use specifically identified revenues and other financing sources only for designated activities, benefits or purposes;
- Explicit authority for the earmarked 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 earmarked fund from the Government's general revenues.

The Medicare **Earmarked** funds 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. (See "Payments to the Health Care Trust Funds Appropriation" and "Permanent Appropriations" below for additional descriptions of revenues and financing sources for the HI trust fund.)

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, 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 by monthly premiums paid by Medicare beneficiaries and 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. (See Note 12 for descriptions of revenues and financing sources for the SMI trust fund.)

Medicare Supplementary Medical Insurance Trust Fund – Part D

The Medicare Prescription Drug Benefit – Part D, established by the Medicare Modernization Act of 2003 (MMA), became effective January 1, 2006. 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. (See "Payments to the Health Care Trust Funds Appropriation" below as well as Note 12 for descriptions of revenues and financing sources for the SMI trust fund.)

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, *Public Law No. 104-191. § 202)* 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, *Public Law No. 109-171. § 6034)*, 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 (appropriated funds to provide for Federal matching of SMI premium collections) and HI (for the Uninsured and Federal Uninsured Payments). The MMA 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 Payments to the Health Care Trust Funds to the SMI trust fund. HIPAA 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 through permanent appropriations of the Payments to the Health Care Trust Funds as well as payments to support FBI activities related to health care fraud and abuse activities. In addition, funds are provided by this appropriation to cover CMS' 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 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989. The Social Security Amendments of 1994, provided for additional tax payments from Social Security OASDI benefits and Tier 1 Railroad Retirement beneficiaries.

The HIPAA prescribes that criminal fines and civil monetary penalties arising from health care cases be appropriated to the HCFAC account of the HI trust fund. 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.

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.

The American Recovery and Reinvestment Act of 2009 (ARRA) provided additional federal funding for the States through a temporary increase in the Federal Medical Assistance Percentages (FMAP) from the first quarter of FY 2009 through the first quarter of FY 2011. In August 2010, Congress acted, through the Education Jobs and Medicaid Assistance Act, to extend the ARRA FMAP increases at phased down levels through the third quarter of FY 2011.

Children's Health Insurance Program (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) extends the program through September 2013. 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 MMA appropriated funds annually, from FY 2005 through FY 2009, for the Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens. 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, 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. CMS and the Public Health Service share responsibility for the CLIA program, with CMS having the lead responsibility for financial management. Fees for registration, certificates, and compliance determination of all U.S. clinical laboratories are collected to finance the program. 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 (see Note 12). 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 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 (Earmarked) 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 earmarked investments, such as the fact that cash generated from earmarked funds 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).

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

Direct Loans consists of loans issued for the CO-OP program.

Debt includes amounts borrowed from and owed to Treasury to finance a portion of the loans issued under the CO-OP program.

Unexpended Appropriations include the portion of CMS' 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. This subsection 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.

Premiums Collected are used to finance SMI benefits and administrative expenses. Monthly 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.

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 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 Appropriation. The Social Security Amendments of 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989.
- ***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.

Reclassifications

Certain FY 2011 balances have been reclassified to conform to FY 2012 financial statement presentations.

Change in Presentation

Effective for FY 2012, changes have been made to the Statement of Budgetary Resources to reflect the new format prescribed by OMB's Circular A-136 and credit program financing due to CO-OP loans.

Estimation of Obligations Related to Canceled Appropriations

As of September 30, 2012, CMS has canceled over $318 million in cumulative obligations related to FY 2007 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 2008 through 2012 related to canceled appropriations, CMS anticipates an additional $4 million will be paid from current year funds for canceled obligations.

NOTE 2:

FUND BALANCE WITH TREASURY

(DOLLARS IN MILLIONS)

	FY 2012 Consolidated Totals	FY 2011 Consolidated Totals
FUND BALANCES:		
Trust Funds:		
HI Trust Fund (Earmarked)	$1,490	$443
SMI Trust Fund (Earmarked)	21,764	5,687
Revolving Funds:		
CLIA	275	402
General Funds:		
Medicaid	47,914	28,230
CHIP	16,131	16,571
State Grants and Demonstrations	2,252	2,232
Other Health	18,348	20,370
Other	4	3
Program Management	816	572
Other Fund Types:		
CMS Deposit/Suspense Accounts	12	7
Total Fund Balances	$109,006	$74,517
STATUS OF FUND BALANCES WITH TREASURY:		
Unobligated Balance:		
Available	$70,680	$37,810
Unavailable	4,717	3,969
Obligated Balance not yet Disbursed	91,335	96,097
Non-Budgetary FBWT	(57,726)	(63,359)
Total Status of Fund Balances with Treasury	$109,006	$74,517

Fund Balances are funds with Treasury that are primarily available to pay current expenditures and liabilities. The Medicaid balance of $47,914 million ($28,230 million in FY 2011) includes $5,170 million ($3,238 million in FY 2011) of funds for ARRA. The Unobligated Balance Available includes $15,912 million ($18,955 million in FY 2011), 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 2012 MEDICARE INVESTMENTS *(Earmarked)*	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2013	1 1/4%	$8,098
Bonds	June 2014 to June 2024	3 1/4 – 6 1/2%	220,194
Accrued Interest			2,544
Total HI TF Investments			$230,836
SMI TF			
Certificates	June 2013	1 1/4%	$3,906
Bonds	June 2014 to June 2026	2 1/2 – 6 1/2%	65,418
Accrued Interest			649
Total SMI TF Investments			$69,973
Total Medicare Investments			$300,809

FY 2011 MEDICARE INVESTMENTS *(Earmarked)*	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2012	1 7/8%	$1,145
Bonds	June 2013 to June 2024	3 1/4 – 6 1/2%	244,794
Accrued Interest			2,879
Total HI TF Investments			$248,818
SMI TF			
Bonds	June 2013 to June 2026	2 1/2 – 6 1/2%	$70,446
Accrued Interest			708
Total SMI TF Investments			$71,154
Total Medicare Investments			**$319,972**

Trust Fund (Earmarked) 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 an earmarked fund are deposited in the U.S. Treasury, which uses the cash for general government purposes. Treasury securities are issued to the HI and SMI trust funds as evidence of their receipts. Treasury securities are an asset to the HI and SMI trust funds and a liability to the U.S. Treasury. Because the HI and SMI trust funds and the U.S. Treasury are both parts of the Federal government, these assets and liabilities offset each other from the standpoint of the Federal government as a whole. For this reason, they do not represent an asset or a liability in the U.S. government-wide financial statements.

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

NOTE 3:

INVESTMENTS *(Continued)*

(DOLLARS IN MILLIONS)

FY 2012 MEDICARE INVESTMENTS *(Non-Earmarked)*	Maturity Date	Cost	Unamortized Discount	Investments, Net
Treasury Bill	02/07/13	$7		$7
Treasury Bill	02/07/13	2,089	$1	2,088
Total Non-earmarked Investments		$2,096	$1	$2,095

FY 2011 MEDICARE INVESTMENTS *(Non-Earmarked)*	Maturity Date	Cost	Unamortized Discount	Investments, Net
Treasury Bill	02/09/12	$2,092		$2,092
Treasury Bill	02/09/12	1		1
Total Non-earmarked Investments		$2,093		$2,093

Non-earmarked 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.

FY 2012 CMS INVESTMENT SUMMARY	Medicare (Earmarked)			Non-earmarked	Consolidated Total
	HI TF	SMI TF	Total	CHIP	
Certificates	$8,098	$3,906	$12,004		$12,004
Bonds	220,194	65,418	285,612		285,612
Treasury Bills				$2,095	2,095
Accrued Interest	2,544	649	3,193		3,193
Total Investments	$230,836	$69,973	$300,809	$2,095	$302,904

FY 2011 CMS INVESTMENT SUMMARY	Medicare (Earmarked)			Non-earmarked	Consolidated Total
	HI TF	SMI TF	Total	CHIP	
Certificates	$1,145		$1,145		$1,145
Bonds	244,794	$70,446	315,240		315,240
Treasury Bills				$2,093	2,093
Accrued Interest	2,879	708	3,587		3,587
Total Investments	$248,818	$71,154	$319,972	$2,093	$322,065

Note 4:

ACCOUNTS RECEIVABLE, NET

(DOLLARS IN MILLIONS)

FY 2012	Medicare (earmarked)		Medicaid	CHIP	Other Health	Other	Consolidated Total
	HI TF	SMI TF					
INTRAGOVERNMENTAL							
Railroad Retirement Board Principal	$505						$505
WITH THE PUBLIC							
Provider & Beneficiary Overpayments							
Accounts Receivable Principal	$1,022	$726				$44	$1,792
Less: Allowance for Uncollectible Accounts	(143)	(267)				(26)	(436)
Accounts Receivable, Net	879	459				18	1,356
Medicare Secondary Payer (MSP)							
Accounts Receivable Principal	126	81				5	212
Less: Allowance for Uncollectible Accounts	(32)	(20)				(2)	(54)
Accounts Receivable, Net	94	61				3	158
Medicare Prescription Drug							
Accounts Receivable Principal		3,632					3,632
Less: Allowance for Uncollectible Accounts							
Accounts Receivable, Net		3,632					3,632
CMPs & Other Restitutions							
Accounts Receivable Principal	241	49					290
Less: Allowance for Uncollectible Accounts	(201)	(36)					(237)
Accounts Receivable, Net	40	13					53
Fraud & Abuse							
Accounts Receivable Principal	203	307	$272				782
Less: Allowance for Uncollectible Accounts	(202)	(300)	(27)				(529)
Accounts Receivable, Net	1	7	245				253
Medicare Advantage							
Accounts Receivable Principal	2	50				5	57
Less: Allowance for Uncollectible Accounts	(1)	(35)				(5)	(41)
Accounts Receivable, Net	1	15					16
Medicare Premiums							
Accounts Receivable Principal	311	998					1,309
Less: Allowance for Uncollectible Accounts	(66)	(105)					(171)
Accounts Receivable, Net	245	893					1,138
State Phased-Down Contributions							
Accounts Receivable Principal		1,262					1,262
Less: Allowance for Uncollectible Accounts							
Accounts Receivable, Net		1,262					1,262
Medicaid Overpayments							
Accounts Receivable Principal			944	$10			954
Less: Allowance for Uncollectible Accounts							
Accounts Receivable, Net			944	10			954
Audit Disallowances							
Accounts Receivable Principal			2,204	5			2,209
Less: Allowance for Uncollectible Accounts			(489)				(489)
Accounts Receivable, Net			1,715	5			1,720
Others Accounts Receivable							
Accounts Receivable Principal	2	2			$19	16	39
Less: Allowance for Uncollectible Accounts						(12)	(12)
Accounts Receivable, Net	2	2			19	4	27
Total Accounts Receivable Principal	$1,907	$7,107	$3,420	$15	$19	$70	$12,538
Less: Allowance for Uncollectible Accounts Receivable	(645)	(763)	(516)			(45)	(1,969)
Total Accounts Receivable, Net	$1,262	$6,344	$2,904	$15	$19	$25	$10,569

Note 4:

ACCOUNTS RECEIVABLE, NET *(Continued)*

(DOLLARS IN MILLIONS)

FY 2011	Medicare (earmarked)		Medicaid	CHIP	Other Health	Other	Consolidated Total
	HI TF	SMI TF					
INTRAGOVERNMENTAL							
Railroad Retirement Board Principal	$516						$516
WITH THE PUBLIC							
Provider & Beneficiary Overpayments							
Accounts Receivable Principal	$723	$795				$30	$1,548
Less: Allowance for Uncollectible Accounts	(128)	(391)				(17)	(536)
Accounts Receivable, Net	595	404				13	1,012
Medicare Secondary Payer (MSP)							
Accounts Receivable Principal	121	85				3	209
Less: Allowance for Uncollectible Accounts	(20)	(24)				(2)	(46)
Accounts Receivable, Net	101	61				1	163
Medicare Prescription Drug							
Accounts Receivable Principal		3,844					3,844
Less: Allowance for Uncollectible Accounts							
Accounts Receivable, Net		3,844					3,844
CMPs & Other Restitutions							
Accounts Receivable Principal	283	144					427
Less: Allowance for Uncollectible Accounts	(240)	(138)					(378)
Accounts Receivable, Net	43	6					49
Fraud & Abuse							
Accounts Receivable Principal	104	210	$310				624
Less: Allowance for Uncollectible Accounts	(104)	(205)	(19)				(328)
Accounts Receivable, Net		5	291				296
Medicare Advantage							
Accounts Receivable Principal	1	38				4	43
Less: Allowance for Uncollectible Accounts	(1)	(7)				(3)	(11)
Accounts Receivable, Net		31				1	32
Medicare Premiums							
Accounts Receivable Principal	293	1,104					1,397
Less: Allowance for Uncollectible Accounts	(62)	(112)					(174)
Accounts Receivable, Net	231	992					1,223
State Phased-Down Contributions							
Accounts Receivable Principal		1,170					1,170
Less: Allowance for Uncollectible Accounts							
Accounts Receivable, Net		1,170					1,170
Medicaid Overpayments							
Accounts Receivable Principal			1,293				1,293
Less: Allowance for Uncollectible Accounts							
Accounts Receivable, Net			1,293				1,293
Audit Disallowances							
Accounts Receivable Principal			1,863	$3			1,866
Less: Allowance for Uncollectible Accounts			(430)	(1)			(431)
Accounts Receivable, Net			1,433	2			1,435
Others Accounts Receivable							
Accounts Receivable Principal	2	1			$3	17	23
Less: Allowance for Uncollectible Accounts						(13)	(13)
Accounts Receivable, Net	2	1			3	4	10
Total Accounts Receivable Principal	$1,527	$7,391	$3,466	$3	$3	$54	$12,444
Less: Allowance for Uncollectible Accounts Receivable	(555)	(877)	(449)	(1)		(35)	(1,917)
Total Accounts Receivable, Net	$972	$6,514	$3,017	$2	$3	$19	$10,527

Intragovernmental Accounts Receivable

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.

Accounts Receivable with the Public

Accounts receivable with the public are composed of various program related overpayments and other recoverable payments. The major accounts receivable components are as follows:

Provider & Beneficiary Overpayments

Overpayments (accounts receivable) represent amounts owed by health care providers, insurers, third party administrators, beneficiaries, employers, and other government agencies due to overestimated paid claims or duplicate payments.

Medicare Secondary Payer (MSP)

MSP results when Medicare makes primary payments for services furnished to beneficiaries that should have been the primary payment responsibility of a group health plan or other insurer or beneficiary. MSP accounts receivable are recorded on the financial statements as of the date the MSP recovery demand letter is issued. However, the MSP accounts receivable ending balance reflects an adjustment for expected reductions to group health plan accounts receivable for situations where CMS receives valid documented defenses to its recovery demands.

Medicare Prescription Drug

The Medicare Prescription Drug accounts receivable of $3,632 million ($3,844 million in FY 2011) consists of amounts due CMS after completion of the Part D payment reconciliation for calendar year (CY) 2011 in the amount of $2,368 million ($2,195 million in FY 2011) and the Coverage Gap Discount Program in the amount of $1,264 million ($1,649 million in FY 2011). The estimate for the first nine months of CY 2012 is reported as an advance of $1,188 million ($1,052 million in 2011) in "Other Assets" on the Balance Sheet. The estimated advance is caused by the fact that CMS payments to the plans are made evenly throughout the year while payments made by the plans are more heavily weighted towards the fourth calendar quarter. This advance will be liquidated as claims are incurred and submitted to the plans during the first quarter of FY 2013. As a result, CMS management believes the Part D accrual estimate will become a liability by the end of CY 2012.

Civil Monetary Penalties (CMPs) & Other Restitutions

CMP accounts receivable result from penalties assessed against individuals or entities that commit fraud against the Medicare program. CMPs are imposed on a skilled nursing facility and/or a nursing facility under section 1819 (h) and/or 1919 (h) of the Social Security Act when the facility is determined to be non-compliant with established Medicare policies and procedures and for other reasons, as allowed under current law. CMS' 10 Regional Offices (ROs) are responsible for ensuring that annual site surveys are performed and the survey summary is reviewed. ROs utilize the Automated Survey Processing Environment (ASPEN) and Quality Improvement & Evaluation Systems (QIES) database to maintain all health care provider information.

Medicare Premiums

The accounts receivable for the standard Part A and Part B premiums as well as Medicare Advantage and Part D premiums are billed to beneficiaries, states, and other third party groups, which establish the Medicare premium accounts receivable. CMS utilizes two computer systems: Direct Billing System (DBS), and Third Party System (TPS) to bill Medicare premiums.

State Phased-Down Contributions

The MMA requires that States contribute toward the costs of prescription drugs for beneficiaries eligible for both Medicare and Medicaid. The receivable represents the State's share of drug costs based on an actuarial calculation. The State contribution for each enrolled beneficiary starts at 90% of the State's share of the projected drug costs in 2006 and is reduced each subsequent year by equal amounts to 75% of the calculated per capita amount in 2015 where it remains thereafter. No allowance has been established for this receivable as grant awards can be offset for amounts not collected.

Medicaid Overpayments
The Medicaid overpayments consist of those states where advances exceeded approved expenditures. Those states that had a remaining advance balance after processing approved expenditures have been reclassified as a receivable.

Audit Disallowances
Transactions under the Medicaid accounts receivable section occur because of disallowances or deferrals initiated by the RO from audits by the Office of Inspector General (OIG), from OMB Circular A-133 (Single Audits), from focused Financial Management Reports (FMRs), and quarterly reviews. Disallowance letters are sent to the state when it is determined that a claim is unallowable.

For disallowances of claims for which CMS has reimbursed the state, the state can elect to retain the funds while the disputed claims are resolved (CMS records a contingent liability in its financial statements). The anticipated recoveries are reported at gross amounts with an accompanying allowance while contingent liabilities are reported net of an allowance for uncollectible accounts. Both allowances are based on historical percentages of monetary settlement in CMS' favor. A description of these activities, which includes both the CO and the ROs, follows Disallowance process (42 Code of Federal Regulations (CFR) 430.42).

Write Offs and Adjustments
CMS' financial reporting reflected additional adjustments, resulting from the validation and reconciliation efforts performed, revised policies and supplemental guidance provided by CMS to the Medicare contractors. The accounts receivable ending balance continues to reflect adjustments for accounts receivable which have been reclassified as Currently Not Reportable debt.

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. Such disallowances are not considered bad debts; the States elect to retain the funds until final resolution.

Currently Not Reportable/Currently Not Collectible Debt
CMS has a number of policies for the reporting of delinquent accounts receivable. Provisions within the OMB Circular A-129, *Managing Federal Credit Programs*, allow an agency to move certain uncollectible delinquent debts into memorandum entries, which removes the receivable from the financial statements. The policy provides for certain debts to be written off, closed without any further collection activity, or reclassified as Currently Not Reportable. (This is also referred to as Currently Not Reportable/ Collectible.) This category of debt will continue to be referred for collection and litigation, but will not be reported on the financial statements because of the unlikelihood of collecting it. While these debts are not reported on the financial statements, the Currently Not Reportable/ Collectible process permits and requires the use of collection tools of the Debt Collection Improvement Act of 1996. This allows delinquent debt to be worked until the end of its statutory collection life cycle.

Note 5:

DIRECT LOANS, NET

(DOLLARS IN MILLIONS)

Discussion of Credit Programs and Characteristics

CMS start-up and solvency loans are made to approved organizations to encourage the establishment of member operated, qualified non-profit health insurance issuers within each state and the District of Columbia. The program provides start-up loans (repayable in 5 years) to finance start-up costs and solvency loans (repayable in 15 years) to finance the applicable state reserve and solvency requirements to support the development of Consumer Operated and Orientated Plans (CO-OPs). The CO-OPs will offer non-profit qualified health plans in the individual and small group markets.

PROGRAM CHARACTERISTIC – DIRECT LOANS

FY 2012

CO-OP Programs	Repayment Period	Interest Rate	Unique Servicing Option
Start-up	Maximum 5 years from each draw down date	Fixed Rate set at time of award as Treasury minus 1%	
Solvency	Maximum 15 years from each drawn down date	Fixed Rate set at time of award as Treasury minus 2%	May be structured as a surplus note — 10 % contingency funding included in loan

Direct Loans

Direct loan obligations, and the resulting direct loan, are governed by the Federal Credit Reform Act of 1990, as amended. The Act requires agencies to estimate the cost of direct loans at net present value for the budget. A direct loan is a disbursement of funds by the Government to a non-Federal borrower under a contract that requires the repayment of such funds with or without interest. The net present value of the subsidy costs (i.e., interest rate differentials, interest subsidies, delinquencies and defaults, fee offsets, and other cash flows) associated with direct loans are recognized as a cost in the year the loan is disbursed.

Direct loan obligations are reported at net present value. Under the present value method, the nominal amount of direct loans is reduced by an allowance equal to the difference between the nominal amount and the present value of the expected net cash flows from the loans. The net present value of loans at any point in time is the amount of the gross loans less the net present value of the subsidy at that time. The net present value of loans receivable is not necessarily representative of the proceeds that might be expected if these loans were sold on the open market.

A modification is any government action different from the baseline assumptions that affects the subsidy cost, such as a change in the terms of the loan contract. This includes the sale of loan assets. This also includes any action resulting from new legislation, or from the exercise of administrative discretion under existing law, that directly or indirectly alters the estimated cost of outstanding direct loans or direct loan obligations. The cost of a modification is the difference between the net present value of the cash flows before and after the modification. No loan modifications have occurred at this time.

Subsidy Rates and Reestimates

The Federal Credit Reform Act of 1990, as amended, and OMB Circular A-11 governs the proprietary and budgetary accounting treatment of direct loans. The estimated long-term cost to the government for direct loans is referred to as "subsidy cost." Under the Act, subsidy costs for loans obligated beginning in FY 1992 are recognized at the net present value of projected lifetime costs in the year the direct loan is disbursed. Subsidy costs are estimated annually. Components of the subsidy cost include interest subsidies, defaults, fee offsets, and other cash flows. Reestimates are revisions of the subsidy cost estimate for a cohort (or risk category) based on information about the actual performance and/or estimated changes in future cash flows of the cohort (or risk category).

Reestimates using projected fiscal year activity were recorded in the current fiscal year.

CMS' cash flow models are tailored for this program based on unique program characteristics. Specific models developed and utilized include a direct start-up loan and a direct solvency loan model.

Direct Loan Obligations

Direct loan obligations are binding agreements by a Federal agency to make a direct loan when specified conditions are fulfilled by the borrower. **Table 1** illustrates the overall composition of the CO-OP loan portfolio by loan program for FY 2012. Direct loans receivable, net balances at the end of FY 2012 are $53 million. No loans were issued in FY 2011.

Table 1:

TOTAL CREDIT PROGRAM RECEIVABLES (FY 2012)

	Loans Receivable, Gross	Interest Receivable	Present Value Allowance	Value of Assets
CO-OP Start-Up Loans	$90		$37	$53
CO-OP Solvency Loans				
Total Loans Receivable	**$90**		**$37**	**$53**

Loans disbursed in FY 2012 bear zero percent interest as such no interest is accrued as of September 30, 2012.

Subsidy Cost Allowance

During the fiscal year, the gross outstanding balance of the direct loans obligated is adjusted by the value of the subsidy cost allowance held against those loans. **Table 2** shows the reconciliation of subsidy cost allowance balances in FY 2012.

Table 2:

SCHEDULE FOR RECONCILING SUBSIDY COST ALLOWANCE BALANCES (FY 2012)

Beginning Balance of the Subsidy Cost Allowance	$0
Add subsidy expense for direct loans disbursed during the year by component:	
Interest rate differential costs	$5
Default costs (net of recoveries)	$29
Fees and other collections	
Other subsidy costs	
Total of the above subsidy expense component	**$34**
Adjustments:	
Loan modifications	
Fees received	
Loans written off	
Subsidy Allowance amortization	
Other	
Ending Balance of the subsidy cost allowance before reestimates	$34
Add or subtract reestimates by component:	
Interest rate reestimates	
Technical/default reestimates	$3
Total of the above reestimate components	**$3**
Ending Balance of the Subsidy Cost Allowance	**$37**

Direct loan subsidy expense is a component of the subsidy cost allowance. The total direct loan subsidy expense for FY 2012 is a combination of subsidy expense for new direct loans disbursed in the current year, and interest rate and technical reestimates to existing loans. **Table 3** illustrates the composition of total subsidy expense, including reestimates, for FY 2012 by program. Total direct loan subsidy expense in FY 2012 was $37 million.

Table 3:

DIRECT LOAN SUBSIDY BY PROGRAM

Subsidy Expense for New Direct Loans Disbursed

Direct Loan Program	Interest Differential	Defaults	Fees and Other Collections	Total Subsidy Expense
CO-OP Start-Up Loans	$5	$29		$34
CO-OP Solvency Loans				
Total Subsidy Expense	**$5**	**$29**		**$34**

Modifications and Reestimates

Direct Loan Program	Total Modifications	Interest Rate Reestimates	Technical Reestimates	Total Reestimates
CO-OP Start-Up Loans			$3	$3
CO-OP Solvency Loans				
Total Subsidy Expense			**$3**	**$3**

Total Direct Loan Subsidy Expense

Direct Loan Program	FY 2012
CO-OP Start-Up Loans	$37
CO-OP Solvency Loans	
Total Subsidy Expense	**$37**

Direct Loans Disbursed

Loan distribution between programs is shown in **Table 4**. The amounts of the direct loans disbursed were $90 million in FY 2012. To date, no disbursements have been made for solvency loans.

Table 4:

TOTAL AMOUNT OF DIRECT LOANS DISBURSED

Direct Loan Program	FY 2012
CO-OP Start-Up Loans	$90
CO-OP Solvency Loans	
Total Subsidy Expense	**$90**

Subsidy Rates for Direct Loans

Subsidy rates are used to compute each year's subsidy expense. **Table 5** has the direct loan subsidy rates for FY 2012. The subsidy rates disclosed in **Table 5** pertain only to the FY 2012 cohorts. These rates cannot be applied to the direct loans disbursed during the current reporting year to yield the subsidy expense.

Table 5:

SUBSIDY RATES FOR DIRECT LOANS (FY 2012)

PERCENTAGE

	Interest Differential	Defaults	Fees and Other Collections	Other	Total
CO-OP Start-Up Loans	5.95%	31.56%			37.51%
CO-OP Solvency Loans	22.41%	21.58%			43.99%

Analysis of Direct Loans

As of the end of the fiscal year, only start-up loans for cohort year 2012 have been disbursed and have been reestimated. The cohort had an upward reestimate of about $3 million due primarily to the increased spread between the cost of borrowing from Treasury and the borrower interest rate.

Administrative Expense

Administrative expense for the CO-OP program was $4 million in FY 2012.

Note 6:

OTHER ASSETS

(DOLLARS IN MILLIONS)

As of September 30, 2012 CMS has $1,379 million ($16,083 million in FY 2011) in Other Assets: $1,188 million ($1,052 million in FY 2011) representing the estimated advance paid to Part D plans during the first nine months of calendar year 2012 (see Note 4) and $191 million ($142 million in FY 2011) representing advances to grantees for other Health and Program Management Allocation. At September 30, 2011, Medicare Advantage and Prescription Drug plans were issued advance payments in the amount of $14,889 million for services that were provided in October 2011.

Note 7:

DEBT

(DOLLARS IN MILLIONS)

FY 2012	Beginning Balance	Net Borrowing	Ending Balance
Debt to the Treasury		$150	$150
Total Debt		**$150**	**$150**
Classification of Debt:			
Intragovernmental Debt			**$150**

CMS borrowed from Treasury $150 million to disburse start-up and solvency loans for the CO-OP program for FY 2012 (see Note 5). CMS incurred and paid interest expense on the borrowed funds in the amount of $3 million.

Borrowing Authority

Requirements for Repayments of Borrowings
For the year ended September 30, 2012, CMS had borrowing authority available of $3 billion.

Borrowings are repaid on nonexpenditure transfers as maturity dates become due. For financing accounts, maturity dates are based on the period of time used in the subsidy calculation, not the contractual term of the loans. There has been no repayment of debt in FY 2012.

Financing Sources for Repayments of Borrowings
CMS will use interest received as well as principal repayments on direct loans to repay debt in the non-budgetary direct loan program financing accounts. CMS will also use residual unobligated balances, where applicable, as another source for repayment.

Other Terms of Borrowing Authority Used
In general, borrowings are for periods of between one year and approximately fifty years depending upon the loan program/cohort. Interest rates on borrowings in the financing accounts are assigned on the basis of the Treasury rate in effect during the period of loan disbursements. Some individual loans are disbursed over several quarters or years. Consequently, several interest rates can be applicable to an individual loan. Thus, a single weighted average interest rate is maintained for each cohort and is adjusted each year until the disbursements for the cohort have been made. Each year, the current average annual interest rate is weighted by current year disbursements and merged with the prior year's weighted average to calculate a new weighted average.

Note 8:

ENTITLEMENT BENEFITS DUE AND PAYABLE

(DOLLARS IN MILLIONS)

	Medicare (Earmarked)							
FY 2012	**HI TF**	**SMI TF**	**Total**	**Medicaid**	**CHIP**	**Other Health**	**Other**	**Consolidated Total**
Medicare Benefits Payable (1)	$18,950	$19,825	$38,775					$38,775
Medicare Advantage/Prescription Drug Program (2)	1,241	4,051	5,292					5,292
Retiree Drug Subsidy (3)		2,369	2,369					2,369
Undocumented Aliens							$18	18
Medicaid/CHIP (4)				$24,955	$651			25,606
Other Health						$433		433
Total Entitlement Benefits Due and Payable	$20,191	$26,245	$46,436	$24,955	$651	$433	$18	$72,493

	Medicare (Earmarked)							
FY 2011	**HI TF**	**SMI TF**	**Total**	**Medicaid**	**CHIP**	**Other Health**	**Other**	**Consolidated Total**
Medicare Benefits Payable (1)	$27,755	$19,944	$47,699					$47,699
Medicare Advantage/Prescription Drug Program (2)	873	3,146	4,019					4,019
Retiree Drug Subsidy (3)		2,574	2,574					2,574
Undocumented Aliens							$64	64
Medicaid/CHIP (4)				$26,069	$457			26,526
Total Entitlement Benefits Due and Payable	$28,628	$25,664	$54,292	$26,069	$457		$64	$80,882

(1) Medicare benefits payable consists of a $38,775 million estimate ($47,699 million in FY 2011) for Medicare services incurred but not paid as of September 30, 2012. This actuarial liability 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 2012 that were paid in 2013 and (e) an estimate of retroactive settlements of cost reports. The September 30, 2012 and 2011 estimate also includes amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals and amounts which may be due/owed to hospitals for adjusted prospective payments.

Medicare benefits payable include estimates of our obligations for medical care services that have been rendered on behalf of insured consumers but for which CMS has either not yet received or processed claims, and for liabilities for physician, hospital, and other medical cost disputes. CMS develops estimates for medical costs incurred but not reported using an actuarial process that is consistently applied, centrally controlled, and automated. The actuarial models consider factors such as time from date of service to claim receipt, claim backlogs, medical care professional contract rate changes, medical care consumption, and other medical cost trends. CMS estimates liabilities for physician, hospital, and other medical cost disputes based upon an analysis of potential outcomes, assuming a combination of litigation and settlement strategies. Each period, CMS re-examines previously established medical costs payable estimates based on actual claim submissions and other changes in facts and circumstances. As the liability estimates recorded in prior periods become more exact, CMS adjusts the amount of the estimates, and includes the changes in estimates in medical costs in the period in which the change is identified. In every reporting period, CMS operating results include the effects of more completely developed Medicare benefits payable estimates associated with previously reported periods.

(2) Medicare Advantage and Prescription Drug Program benefits payable of $5,292 million ($4,019 million in FY 2011) consists of a $2,779 million estimate ($1,887 million in FY 2011) for amounts owed to plans relating to risk and other payment related adjustments and $2,513 million ($2,132 million in FY 2011) owed to plans after the completion of the Prescription Drug Payment reconciliation.

(3) The Retiree Drug Subsidy (RDS) consists of a $2,369 million estimate ($2,574 million in FY 2011) of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2012. As part of MMA (incorporated in Section 1860D-22 of the Social Security Act), the RDS program makes subsidy payments available to sponsors of retiree prescription drug coverage. The program is designed to strengthen health care coverage for Medicare-eligible retirees by encouraging the retention of private, employer- and union-based retiree prescription drug plans.

(4) Medicaid benefits payable of $24,955 million ($26,069 million in FY 2011) is an estimate of the net Federal share of expenses that have been incurred by the States but not yet reported to CMS as of September 30, 2012. This estimate incorporates claim activity tracked under ARRA of $248 million ($1,068 million in FY 2011). An estimated CHIP benefits payable of $651 million has been recorded ($457 million in FY 2011) for the net Federal share of expenses that have been incurred by the States but not yet reported to CMS as of September 30, 2012.

Note 9:

CONTINGENCIES

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.

The Medicaid amount for $3,856 million ($3,016 million in FY 2011) consists of Medicaid audit and program disallowances of $1,874 million ($1,056 million in FY 2011) and $1,982 million ($1,960 million in FY 2011) for reimbursement of state plan amendments. The CHIP is reporting a contingent liability of $1 million. 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 is that CMS could be owed funds.

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, 2012, 5,041 cases (6,683 in FY 2011) remain on appeal. A total of 652 new cases (821 in FY 2011) were filed and 19 cases were reopened (14 in FY 2011). The PRRB rendered decisions on 98 cases (122 in FY 2011) in FY 2012 and 2,215 additional cases (1,863 in FY 2011) 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 10:

LIABILITIES NOT COVERED BY BUDGETARY RESOURCES

(DOLLARS IN MILLIONS)

FY 2012 Intragovernmental	Medicare (Earmarked)								
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
Accrued Payroll and Benefits	$1	$2					$3		$3
Total Intragovernmental	$1	$2					$3		$3
Federal Employee and Veterans' Benefits	$3	$7	$1			$1	$12		$12
Accrued Payroll and Benefits	13	70	2		$2	6	93		93
Other Health					21		21		21
Contingencies		1,434	3,856	1			5,291		5,291
Total Liabilities Not Covered by Budgetary Resources	17	1,513	3,859	1	23	7	5,420		5,420
Total Liabilities Covered by Budgetary Resources	46,484	58,120	24,957	651	586	80	130,878	$(55,739)	75,139
TOTAL LIABILITIES	$46,501	$59,633	$28,816	$652	$609	$87	$136,298	$(55,739)	$80,559

FY 2011 Intragovernmental	Medicare (Earmarked)								
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
Accrued Payroll and Benefits	$1	$2					$3		$3
Total Intragovernmental	$1	$2					$3		$3
Federal Employee and Veterans' Benefits	$4	$9					$13		$13
Accrued Payroll and Benefits	12	26	$1		$1	$2	42		42
Unfunded Liabilities					1,272		1,272		1,272
Contingencies			3,016				3,016		3,016
Total Liabilities Not Covered by Budgetary Resources	17	37	3,017		1,273	2	4,346		4,346
Total Liabilities Covered by Budgetary Resources	62,861	56,486	26,071	$457		116	145,991	$(62,892)	83,099
TOTAL LIABILITIES	$62,878	$56,523	$29,088	$457	$1,273	$118	$150,337	$(62,892)	$87,445

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.

Note 11:

NET COST OF OPERATIONS

(DOLLARS IN MILLIONS)

FY 2012	Medicare (Earmarked)			Health				
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	Consolidated Total
PROGRAM/ACTIVITY COSTS								
Medicare								
Fee for Service	$181,915	$169,454	$351,369					$351,369
Medicare Advantage/ Managed Care	69,054	64,423	133,477					133,477
Prescription Drug (Part D)		52,251	52,251					52,251
Medicaid/CHIP/State Grants & Demos				$247,305	$9,247		$439	256,991
Other Health						$2,612		2,612
CLIA							223	223
Total Program/Activity Costs	250,969	286,128	537,097	247,305	9,247	2,612	662	796,923
OPERATING COSTS								
Medicare Integrity Program	$1,551		$1,551					$1,551
Quality Improvement Organizations	374	$83	457					457
Bad Debt Expense and Writeoffs	87	(107)	(20)	$67	$(1)		$(90)	(44)
Reimbursable Expenses	72	170	242	11	1		20	274
Administrative Expenses	1,039	2,109	3,148	124	11	$10	362	3,655
Depreciation and Amortization	15	20	35	5	3		12	55
Imputed Cost Subsidies	12	23	35	2		2	6	45
Total Operating Costs	$3,150	$2,298	$5,448	$209	$14	$12	$310	$5,993
TOTAL COSTS	**$254,119**	**$288,426**	**$542,545**	**$247,514**	**$9,261**	**$2,624**	**$972**	**$802,916**
Less: Exchange Revenues:								
Medicare Premiums	$3,639	$61,058	$64,697					$64,697
CLIA Revenues							$(2)	(2)
Other Exchange Revenues	48	113	161	$6	$1	$102	128	398
Total Exchange Revenues	$3,687	$61,171	$64,858	$6	$1	$102	$126	$65,093
TOTAL NET COST OF OPERATIONS	**$250,432**	**$227,255**	**$477,687**	**$247,508**	**$9,260**	**$2,522**	**$846**	**$737,823**

Note 11:

NET COST OF OPERATIONS *(Continued)*

(DOLLARS IN MILLIONS)

FY 2011	Medicare (Earmarked)			Health				
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	Consolidated Total
PROGRAM/ACTIVITY COSTS								
Medicare								
Fee for Service	$193,594	$164,412	$358,006					$358,006
Medicare Advantage/ Managed Care	63,568	57,667	121,235					121,235
Prescription Drug (Part D)		53,302	53,302					53,302
Medicaid/CHIP/State Grants & Demos				$268,267	$8,673		$625	277,565
Other Health						$2,436		2,436
CLIA							267	267
Total Program/Activity Costs	$257,162	$275,381	$532,543	$268,267	$8,673	$2,436	$892	$812,811
OPERATING COSTS								
Medicare Integrity Program	$1,270		$1,270					$1,270
Quality Improvement Organizations	278	$54	332					332
Bad Debt Expense and Writeoffs	(30)	27	(3)	$(273)	$1		$17	(258)
Reimbursable Expenses	37	84	121	5	1		2	129
Administrative Expenses	1,113	2,047	3,160	119	15		189	3,483
Depreciation and Amortization	11	23	34	3				37
Imputed Cost Subsidies	13	28	41	1			2	44
Total Operating Costs	$2,692	$2,263	$4,955	$(145)	$17		$210	$5,037
TOTAL COSTS	**$259,854**	**$277,644**	**$537,498**	**$268,122**	**$8,690**	**$2,436**	**$1,102**	**$817,848**
Less: Exchange Revenues:								
Medicare Premiums	$3,495	$59,858	$63,353					$63,353
CLIA Revenues							$166	166
Other Exchange Revenues	43	97	140	$6	$1	$18	19	184
Total Exchange Revenues	$3,538	$59,955	$63,493	$6	$1	$18	$185	$63,703
TOTAL NET COST OF OPERATIONS	**$256,316**	**$217,689**	**$474,005**	**$268,116**	**$8,689**	**$2,418**	**$917**	**$754,145**

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 the Medicare, Medicaid, CHIP, and State Grants and Demonstrations programs based on the CMS cost allocation system. Administrative costs allocated to the Medicare program include $2,067 million ($1,983 million in FY 2011) paid to Medicare contractors to carry out their responsibilities as CMS' 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 2012 Part D expense of $52,251 million ($53,302 million in FY 2011) is net of State reimbursements of $8,417 million ($6,897 million in FY 2011). The gross expense would have been $60,668 million in FY 2012 ($60,199 million in FY 2011).

Of the Medicaid benefit expense of $247,305 million ($268,267 million in FY 2011), $3,612 million were identified under ARRA ($10,492 million in FY 2011).

Note 12:

TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT

(DOLLARS IN MILLIONS)

FY 2012 Transfers-in Without Reimbursement	Medicare (Earmarked)								
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
Medicare Benefit Transfers	$250,656	$287,049					$537,705	$(537,705)	
Transfers to HCFAC	1,573						1,573	(1,573)	
Federal Matching Contributions		165,254					165,254	(165,254)	
Medicare Part D Benefits		44,874					44,874	(44,874)	
Medicare Part D Administrative		380					380	(380)	
Allocation to CMS Programs	974	2,250	$154	$17		$451	3,846	(3,846)	
Fraud and Abuse Appropriation	400						400	(400)	
Transfer-Uninsured Coverage	262						262	(262)	
Prog Mngmt Admin. Expense *(1)*	226						226	(226)	
Income Tax OASDI Benefits *(2)*	18,643						18,643	(18,643)	
Railroad Retirement Board	502						502		$502
Criminal Fines	1,450						1,450	(1,450)	
Medicaid Part B Premiums			602				602	(602)	
HITECH	1,741	1,850					3,591	(3,591)	
QIO	419	93					512	(512)	
Interest Adjustments		(1)					(1)		(1)
Other	1	1					2		2
Total Transfers-in	$276,847	$501,750	$756	$17		$451	$779,821	$(779,318)	$503

FY 2012 Transfers-out Without Reimbursement	Medicare (Earmarked)								
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
SSA Administrative Expenses	$(930)	$(1,140)					$(2,070)		$(2,070)
Medicare Benefit Transfers	(250,656)	(287,049)					(537,705)	$537,705	
Transfers to HCFAC	(1,573)						(1,573)	1,573	
Federal Matching Contributions		(165,254)					(165,254)	165,254	
Medicare Part D Benefits		(44,874)					(44,874)	44,874	
Medicare Part D Administrative		(380)					(380)	380	
Transfers to Program Management	(1,405)	(2,441)					(3,846)	3,846	
Fraud and Abuse Appropriation	(400)						(400)	400	
Transfer-Uninsured Coverage	(262)						(262)	262	
Prog Mngmt Admin. Expense *(1)*	(226)						(226)	226	
Income Tax OASDI Benefits *(2)*	(18,643)						(18,643)	18,643	
Criminal Fines	(1,450)						(1,450)	1,450	
Medicaid Part B Premiums		(602)					(602)	602	
HITECH	(2,135)	(1,456)					(3,591)	3,591	
QIO	(419)	(93)					(512)	512	
Office of the Secretary	(36)	(36)					(72)		(72)
Payment Assessment Commission	(7)	(5)					(12)		(12)
Railroad Retirement Board		(11)					(11)		(11)
Total Transfers-out	$(278,142)	$(503,341)					$(781,483)	$779,318	$(2,165)
Total Transfers-in/out without reimbursement	$(1,295)	$(1,591)	$756	$17		$451	$(1,662)		$(1,662)

Note 12:

TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT *(Continued)*

(DOLLARS IN MILLIONS)

FY 2011 Transfers-in Without Reimbursement	Medicare (Earmarked)								
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
Medicare Benefit Transfers	$267,249	$299,428					$566,677	$(566,677)	
Transfers to HCFAC	1,685						1,685	(1,685)	
Federal Matching Contributions		168,849					168,849	(168,849)	
Medicare Part D Benefits		55,929					55,929	(55,929)	
Medicare Part D Administrative		400					400	(400)	
Allocation to CMS Programs	925	2,291	$114	$14		$606	3,950	(3,950)	
Fraud and Abuse Appropriation	128						128	(128)	
Transfer-Uninsured Coverage	275						275	(275)	
Prog Mngmt Admin. Expense *(1)*	214						214	(214)	
Income Tax OASDI Benefits *(2)*	15,143						15,143	(15,143)	
Railroad Retirement Board	498						498		$498
Criminal Fines	1,214						1,214	(1,214)	
Medicaid Part B Premiums			703				703	(703)	
HITECH	1,621	490					2,111	(2,111)	
QIO	833	186					1,019	(1,019)	
Interest Adjustments	(2)						(2)		(2)
Miscellaneous	1	2					3		3
Total Transfers-in	$289,784	$527,575	$817	$14		$606	$818,796	$(818,297)	$499

FY 2011 Transfers-out Without Reimbursement	Medicare (Earmarked)								
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
SSA Administrative Expenses	$(863)	$(1,040)					$(1,903)		$(1,903)
Medicare Benefit Transfers	(267,249)	(299,428)					(566,677)	$566,677	
Transfers to HCFAC	(1,685)						(1,685)	1,685	
Federal Matching Contributions		(168,849)					(168,849)	168,849	
Medicare Part D Benefits		(55,929)					(55,929)	55,929	
Medicare Part D Administrative		(400)					(400)	400	
Transfers to Program Management	(1,457)	(2,493)					(3,950)	3,950	
Fraud and Abuse Appropriation	(128)						(128)	128	
Transfer-Uninsured Coverage	(275)						(275)	275	
Prog Mngmt Admin. Expense *(1)*	(214)						(214)	214	
Income Tax OASDI Benefits *(2)*	(15,143)						(15,143)	15,143	
Criminal Fines	(1,214)						(1,214)	1,214	
Medicaid Part B Premiums		(703)					(703)	703	
HITECH	(1,621)	(490)					(2,111)	2,111	
QIO	(833)	(186)					(1,019)	1,019	
Office of the Secretary	(41)	(39)					(80)		(80)
Payment Assessment Commission	(7)	(5)					(12)		(12)
Railroad Retirement Board		(9)					(9)		(9)
Total Transfers-out	$(290,730)	$(529,571)					$(820,301)	$818,297	$(2,004)
Total Transfers-in/out without reimbursement	$(946)	$(1,996)	$817	$14		$606	$(1,505)		$(1,505)

CMS Transfers-in/Transfers-out Without Reimbursement between or within Federal agencies are either nonexpenditure or expenditure transfers that do not represent payments for goods and services, but serve only to adjust amounts available in accounts. Transfers between trust funds or within a trust fund are nonexpenditure transfers. CMS finances its HI and SMI trust fund allocation accounts (which record Medicare benefit expenses) via nonexpenditure transfers from the Treasury Bureau of Public Debt's HI and SMI trust fund corpus accounts. Expenditure transfers take place between a general fund and a trust fund. Transfers from CMS' Payments to the Health Care Trust Funds to the HI and SMI trust funds are expenditure transfers. (There is an exception: transfers between the HI and SMI trust funds and the Social Security Administration's Limitation on Administrative Expenses (LAE) trust fund are considered expenditure transfers.) Intra-CMS transfers are eliminated; transfers to or from outside Federal agencies are not.

(1) During FY 2012, the Payments to the Health Care Trust Funds appropriation paid the HI trust fund $226 million ($214 million in FY 2011) to cover the Medicaid, CHIP, and State Grants and Demonstrations programs' share of CMS' administrative costs.

(2) The Omnibus Budget Reconciliation Act of 1993 increased the maximum percentage of OASDI benefits that are subject to Federal income taxation under certain circumstances from 50 percent to 85 percent. The revenues, resulting from this increase, are transferred to the HI trust fund.

Federal Matching Contributions

SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and 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. The monthly SMI premium per beneficiary was $115.40 from October 2011 through December 31, 2011 and $99.90 from January 2012 to September 2012. Premiums collected from beneficiaries totaled $57,889 million ($57,027 million in FY 2011) and were matched by a $165,254 million ($168,849 million in FY 2011) contribution from the Federal government.

Part D Transfers-In

Part D benefits and administrative expenses are financed by the general fund appropriation, Payments to the Health Care Trust Funds. As of September 30, 2012, approximately $45,254 million has been transferred-in ($56,329 million in FY 2011) to Part D from the general fund.

Note 13:

BUDGETARY FINANCING SOURCES: OTHER ADJUSTMENTS

(DOLLARS IN MILLIONS)

FY 2012 Unexpended Appropriations	Medicare (Earmarked)		Medicaid	CHIP	Other Health	Other	Consolidated Total
	HI TF	SMI TF					
Withdrawal of Expired or Canceled Year Authority		$(3,393)				$(22)	$(3,415)
Return of Indefinite Authority				$(34)			(34)
Rescissions				$(6,368)	$(400)		(6,768)
Total Other Adjustments		$(3,393)		$(6,402)	$(400)	$(22)	$(10,217)

FY 2011 Unexpended Appropriations	Medicare (Earmarked)		Medicaid	CHIP	Other Health	Other	Consolidated Total
	HI TF	SMI TF					
Withdrawal of Expired or Canceled Year Authority	$(192)	$(1,046)				$(12)	$(1,250)
Return of Indefinite Authority			$(26,680)				(26,680)
Total Other Adjustments	$(192)	$(1,046)	$(26,680)			$(12)	$(27,930)

Other adjustments include increases or decreases to Unexpended Appropriations that result from transactions other than the receipt of appropriations, transfers in or out of appropriated authority, or the expenditure of appropriations. Such transactions include the return to the Treasury general fund of expired or canceled year authority, rescissions, return of indefinite authority, or other adjustments.

Note 14:

EARMARKED FUNDS

(DOLLARS IN MILLIONS)

Earmarked funds are financed by specifically identified revenues, often supplemented by other financing sources, which remain available over time. CMS has designated as earmarked funds 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 non-exchange revenues and changes in net position appears below.

	HI TF	SMI TF	Total Earmarked Funds
Balance Sheet as of September 30, 2012			
ASSETS			
Fund Balance with Treasury	$1,490	$21,764	$23,254
Investments	230,836	69,973	300,809
Other Assets	26,436	37,954	64,390
Total Assets	$258,762	$129,691	$388,453
Entitlement Benefits Due and Payable	$20,191	$26,245	$46,436
Other Liabilities	26,310	33,388	59,698
Total Liabilities	$46,501	$59,633	$106,134
Unexpended Appropriations	$790	$19,729	$20,519
Cumulative Results of Operations	211,471	50,329	261,800
Total Net Position	$212,261	$70,058	$282,319
Total Liabilities and Net Position	$258,762	$129,691	$388,453
Statement of Net Cost For the Year Ended September 30, 2012			
Benefit Expense	$250,969	$286,128	$537,097
Operating Costs	3,150	2,298	5,448
Total Costs	254,119	288,426	542,545
Less Earned Revenues	3,687	61,171	64,858
Net Cost of Operations	$250,432	$227,255	$477,687
Statement of Changes in Net Position For the Year Ended September 30, 2012			
Net Position, Beginning of Period	$226,752	$66,445	$293,197
Taxes and Other Nonexchange Revenue	216,289	5,698	221,987
Other Financing Sources	19,652	225,170	244,822
Less Net Cost of Operations	250,432	227,255	477,687
Change in Net Position	(14,491)	3,613	(10,878)
Net Position, End of Period	$212,261	$70,058	$282,319

Note 14:

EARMARKED FUNDS *(Continued)*

(DOLLARS IN MILLIONS)

	HI TF	SMI TF	Total Earmarked Funds
Balance Sheet as of September 30, 2011			
ASSETS			
Fund Balance with Treasury	$443	$5,687	$6,130
Investments	248,818	71,154	319,972
Other Assets	40,369	46,127	86,496
Total Assets	$289,630	$122,968	$412,598
Entitlement Benefits Due and Payable	$28,628	$25,664	$54,292
Other Liabilities	34,250	30,859	65,109
Total Liabilities	$62,878	$56,523	$119,401
Unexpended Appropriations	$836	$3,499	$4,335
Cumulative Results of Operations	225,916	62,946	288,862
Total Net Position	$226,752	$66,445	$293,197
Total Liabilities and Net Position	$289,630	$122,968	$412,598
Statement of Net Cost For the Year Ended September 30, 2011			
Benefit Expense	$257,162	$275,381	$532,543
Operating Costs	2,692	2,263	4,955
Total Costs	259,854	277,644	537,498
Less Earned Revenues	3,538	59,955	63,493
Net Cost of Operations	$256,316	$217,689	$474,005
Statement of Changes in Net Position For the Year Ended September 30, 2011			
Net Position, Beginning of Period	$261,814	$53,409	$315,223
Taxes and Other Nonexchange Revenue	205,080	5,089	210,169
Other Financing Sources	16,174	225,636	241,810
Less Net Cost of Operations	256,316	217,689	474,005
Change in Net Position	(35,062)	13,036	(22,026)
Net Position, End of Period	$226,752	$66,445	$293,197

Note 15:

INTRAGOVERNMENTAL COSTS AND EXCHANGE REVENUE

(DOLLARS IN MILLIONS)

FY 2012	Gross Cost			Less: Exchange Revenue			
	Intra-governmental	Public	Total	Intra-governmental	Public	Total	Consolidated Net Cost of Operations
PROGRAM/ACTIVITY COSTS							
GPRA Programs							
Medicare (Earmarked)							
HI TF	$805	$253,314	$254,119	$6	$3,681	$3,687	$250,432
SMI TF	208	288,218	288,426	13	61,158	61,171	227,255
Medicaid	14	247,500	247,514		6	6	247,508
CHIP	2	9,259	9,261		1	1	9,260
Subtotal	1,029	798,291	799,320	19	64,846	64,865	734,455
Other Activities							
CLIA	33	190	223		(2)	(2)	225
State Grants and Demonstrations	47	528	575		(81)	(81)	656
Other Health	82	2,542	2,624	3	99	102	2,522
Other	16	158	174		209	209	(35)
Subtotal	178	3,418	3,596	3	225	228	3,368
PROGRAM/ ACTIVITY TOTALS	$1,207	$801,709	$802,916	$22	$65,071	$65,093	$737,823

FY 2011	Gross Cost			Less: Exchange Revenue			
	Intra-governmental	Public	Total	Intra-governmental	Public	Total	Consolidated Net Cost of Operations
PROGRAM/ACTIVITY COSTS							
GPRA Programs							
Medicare (Earmarked)							
HI TF	$650	$259,204	$259,854	$6	$3,532	$3,538	$256,316
SMI TF	218	277,426	277,644	12	59,943	59,955	217,689
Medicaid	12	268,110	268,122	1	5	6	268,116
CHIP	8	8,682	8,690		1	1	8,689
Subtotal	888	813,422	814,310	19	63,481	63,500	750,810
Other Activities							
CLIA	50	217	267		166	166	101
State Grants and Demonstrations	16	682	698		19	19	679
Other Health	3	2,433	2,436		18	18	2,418
Other	22	115	137				137
Subtotal	91	3,447	3,538		203	203	3,335
PROGRAM/ ACTIVITY TOTALS	$979	$816,869	$817,848	$19	$63,684	$63,703	$754,145

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 16:

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 2012	Direct	Reimbursable	Combined Totals
Category A	$13,194	$286	$13,480
Category B	553,805	329	554,134
Exempt	512,860		512,860
Total	$1,079,859	$615	$1,080,474

FY 2011	Direct	Reimbursable	Combined Totals
Category A	$12,094	$290	$12,384
Category B	594,272	19	594,291
Exempt	526,714		526,714
Total	$1,133,080	$309	$1,133,389

Legal Arrangements Affecting Use of Unobligated Balances

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Statement of Budgetary Resources. 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 $245,356 million as of September 30, 2012, ($260,656 million in FY 2011) are included in Investments on the Balance Sheets. The following table presents trust fund activities and balances for FY 2012 and FY 2011 (in millions):

	FY 2012 Combined Balance	FY 2011 Combined Balance
TRUST FUND BALANCE, BEGINNING	$260,656	$300,470
Receipts	476,709	468,579
Less Obligations	492,009	508,393
Shortage of Receipts Over Obligations	(15,300)	(39,814)
TRUST FUND BALANCE, ENDING	$245,356	$260,656

EXPLANATIONS OF DIFFERENCES BETWEEN THE STATEMENT OF BUDGETARY RESOURCES AND THE BUDGET OF THE UNITED STATES GOVERNMENT FOR FY 2011

	Budgetary Resources	Obligations Incurred	Offsetting Receipts	Net Outlays
Statement of Budgetary Resources	$1,175,168	$1,133,389	$321,925	$1,089,346
Unobligated Balances Not Available	(3,142)			
Other Adjustments	3,531	3,976		3,804
CCIIO Adjustments	2,750	2,750		2,280
President's Budget (actual)	$1,178,307	$1,140,115	$321,925	$1,095,430

The Other Adjustments Line for Budgetary Resources includes an increase in the amount of $3,957 million for the amounts reported in the President's Budget but reported on the Centers for Disease Control (CDC) SBR; amounts that are appropriately reported on the SBR but not included as new budgetary resources in the President's Budget (obligations incurred line for expired accounts) in the amount of ($338) million; accounts for CCIIO assigned to CMS but reported by PSC in the amount of $2,750 million; an account assigned to CMS but reported under Executive Office of the President by OMB in the amount of ($3) million; a back dated warrant processed during the revision window in the amount of $22 million; and a negative warrant processed during the revision window in the amount of ($107) million.

The Other Adjustments Line for Obligations Incurred includes an increase of $3,953 million for the amounts reported in the President's Budget but reported on the CDC SBR; accounts for CCIIO assigned to CMS but reported by PSC in the amount of $2,750 million; a back dated warrant processed during the revision window in the amount of $22 and $1 million due to rounding.

The Other Adjustments Line for Net Outlays includes an increase to net outlays in the amount of $3,779 million for the amounts reported in the President's Budget but reported on the CDC SBR; accounts for CCIIO assigned to CMS but reported by PSC in the amount of $2,280 million; a back dated warrant processed during the revision window in the amount of $22 and $3 million due to rounding.

Undelivered Orders at the End of the Period

The amount of budgetary resources obligated for undelivered orders totaled $19,626 million at September 30, 2012 ($14,636 million in FY 2011).

Note 17:

STATEMENT OF SOCIAL INSURANCE (Unaudited)

The Statement of Social Insurance (SOSI) presents the projected 75-year actuarial present values of the income and expenditures of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds. Future expenditures are expected to arise from the health care payment provisions specified in current law for current and future program participants and from associated administrative expenses. Actuarial present values are computed on the basis of the intermediate set of assumptions specified in the *Annual Report of the Medicare Board of Trustees*. These assumptions represent the Trustees' best estimate of likely future economic, demographic, and health care-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. Please see note 18 below for further information on this panel ("the Panel").

The SOSI projections are based on current law, and reflect the effects of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, which is referred to collectively as the "Affordable Care Act." The Affordable Care Act improves the financial outlook for Medicare substantially; however, the full effects of some of the law's provisions on Medicare are not known at this time, with the result that the projections are very uncertain, especially in the long-range future. It is important to note that the substantially

improved results for HI and SMI Part B depend in part on the long-range feasibility of lower increases in Medicare payment rates to most categories of providers, as mandated by the Affordable Care Act. Without fundamental change in the current delivery system, these adjustments would probably not be viable indefinitely. Please see note 18 below for further information on the impact of the Affordable Care Act.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. The Trustees' projections are based on the current Medicare laws, regulations, and policies in effect on April 23, 2012, 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 as well as 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, 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 made on behalf of beneficiaries. 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.

The Part A present values in the SOSI exclude 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 primary purpose of the SOSI is to compare the projected future costs of Medicare with the program's scheduled revenues. Since costs for the uninsured are separately funded either through general revenue appropriations or through premium payments, the exclusion of such amounts does not materially affect the financial balance of Part A. In addition, such individuals are granted coverage outside of the social insurance framework underlying Medicare Part A. For these reasons, it is appropriate to exclude their income and expenditures from the statement of social insurance.

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 participating 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 future expenditures from the actuarial present value of 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 problems 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" of participants 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 future income over 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 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 factors that are inherently uncertain. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and such actual cost could differ materially from the projections shown in the SOSI. Moreover, these differences could affect the long-term sustainability of this social insurance program. Please see note 18 below for important information on the further uncertainty, resulting from the provisions in the Affordable Care Act, associated with the current-law projections presented in the SOSI. In order to make projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the trust funds will continue to operate under the law in effect on April 23, 2012. In addition, the estimates depend on many economic, demographic, and health care-specific assumptions, including changes in per beneficiary health care cost, 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 most significant underlying assumptions, based on current law, used in the projections of Medicare spending displayed in this section, are included in the following table. The assumptions underlying the 2012 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2012. 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. Detailed information, similar to that denoted within table 1, for the prior years is publicly available on the CMS website at: http://www.cms.hhs.gov/CFOReport/.

Table 1:

SIGNIFICANT ASSUMPTIONS AND SUMMARY MEASURES

Used for the Statement of Social Insurance 2012

					Annual percentage change in:						
								Per beneficiary cost[8]			
	Fertility rate[1]	Net immigration[2]	Morality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI		Real-interest rate[9]
									B	D	
2012	2.04	960,000	759.3	1.74	3.75	2.01	2.6	-0.1	3.9	2.1	0.4
2020	2.04	1,205,000	708.6	1.26	4.07	2.81	2.2	3.8	5.3	6.2	2.7
2030	2.02	1,125,000	650.4	1.13	3.93	2.80	2.0	4.9	4.8	5.5	2.9
2040	2.00	1,075,000	598.8	1.17	3.97	2.80	2.2	5.4	4.5	5.3	2.9
2050	2.00	1,050,000	553.3	1.11	3.91	2.80	2.1	4.1	4.1	5.0	2.9
2060	2.00	1,040,000	513.2	1.10	3.90	2.80	2.1	4.0	4.1	4.8	2.9
2070	2.00	1,035,000	477.7	1.09	3.89	2.80	2.1	4.1	3.9	4.6	2.9
2080	2.00	1,030,000	446.0	1.12	3.92	2.80	2.0	3.7	3.8	4.5	2.9

[1] Average number of children per woman.
[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, 2000, 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 services provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.
[9] Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

The projections presented in the Statement of Social Insurance 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. These ultimate values assumed for the current year and the prior four years are summarized in table 2 below. They are based on the intermediate assumptions of the respective Medicare Trustees Reports.

Table 2:

SIGNIFICANT ULTIMATE ASSUMPTIONS

Used for the Statement of Social Insurance, FY 2012–2008

					Annual percentage change in:						
								Per beneficiary cost[8]			
	Fertility rate[1]	Net immigration[2]	Morality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI		Real-interest rate[9]
									B	D	
FY 2012	2.0	1,030,000	446.0	1.1	3.9	2.8	2.0	3.7	3.8	4.5	2.9
FY 2011	2.0	1,030,000	443.2	1.2	4.0	2.8	2.1	3.3	3.7	4.4	2.9
FY 2010	2.0	1,025,000	446.1	1.2	4.0	2.8	2.1	3.3	3.8	4.4	2.9
FY 2009	2.0	1,025,000	458.2	1.1	3.9	2.8	2.1	4.4	4.3	4.3	2.9
FY 2008	2.0	1,025,000	476.8	1.1	3.9	2.8	2.1	4.4	4.3	4.4	2.9

[1] Average number of children per woman. The ultimate fertility rate is assumed to be reached in the 25-year of the projection period.

[2] Includes legal immigration, net of emigration, as well as other, non-legal, immigration. For 2008–2011, the ultimate level of net legal immigration was increased from 600,000 to 750,000 persons per year. In addition, the method for projecting annual net other immigration was changed and it now varies throughout the projection period. So for 2008–2011, the assumption presented is the value assumed in the year 2080. For 2007, the ultimate assumption is displayed and is reached by the 20th year of each projection period.

[3] The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.

[4] Difference between percentage increases in wages and the CPI. Except for minor fluctuations, the ultimate assumption is reached within the first 10 years of the projection period.

[5] Average annual wage in covered employment. Except for minor fluctuations, the ultimate assumption is reached within the first 10 years of the projection period.

[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. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.

[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. The annual rate of growth declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.

[9] Average rate of interest earned on new trust fund securities, above and beyond rate of inflation. The ultimate assumption is reached within the first 10 years of each projection period.

Part D Projections

In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the Part D program is still relatively new (having begun operations in January 2006), with relatively little actual program data currently available. The actual 2006 through 2012 bid submissions by the private plans offering this coverage, together with actual data on beneficiary enrollment and program spending through 2011, have been used in the current projections. Nevertheless, there remains a high level of uncertainty surrounding these cost projections, pending the availability of sufficient data on actual Part D expenditures to establish a trend baseline.

Note 18:

AFFORDABLE CARE ACT AND SMI PART B PHYSICIAN PAYMENT UPDATE FACTOR (Unaudited)

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from provisions of the Affordable Care Act. It is important to note, however, that these improved results for HI and SMI Part B since 2010 depend in part on the long-range feasibility of the various cost-saving measures in the Affordable Care Act—in particular, the 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 possible

that health care 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.

A transformation of health care in the U.S., affecting both the means of delivery and the method of paying for care, is also a possibility. The Affordable Care Act takes important steps in this direction by initiating programs of research into innovative payment and service delivery models, such as accountable care organizations, patient-centered "medical homes," improvement in care coordination for individuals with multiple chronic health conditions, improvement in coordination of post-acute care, payment bundling, "pay for performance," and assistance for individuals in making informed health choices. If researchers and policy makers can demonstrate that the new approaches developed through these initiatives will improve the quality of health care and/or reduce costs, then the Secretary of Health and Human Services can adopt them for Medicare without further legislation. Such changes have the potential to reduce health care costs and cost growth rates and could, as a result, help lower Medicare cost growth rates to levels compatible with the lower price updates payable under current law.

The ability of new delivery and payment methods to significantly lower cost growth rates is uncertain at this time, since specific changes have not yet been designed, tested, or evaluated. Hopes for success are high, but at this time there is insufficient evidence to support an assumption that improvements in efficiency can occur of the magnitude needed to align with the statutory Medicare price updates.

The reduction in provider payment updates, if implemented for all future years as required under current law, could have secondary impacts on provider participation, beneficiary access to care; quality of services; and other factors. These possible impacts are very speculative, and at present there is no consensus among experts as to their potential scope. Further research and analysis will help to better inform this issue and may enable the development of specific projections of secondary effects under current law in the future.

In addition, the Medicare Part B projections reflect a reduction of almost 31 percent in payment rates for physician services in 2013, as required under current law. If lawmakers act to prevent this decrease, as they have for 2003 through 2012, then actual Part B and total SMI costs will significantly exceed the projections shown in this report.

Because knowledge of the potential long-range effects of the productivity adjustments, delivery and payment innovations, and certain other aspects of the Affordable Care Act is so limited, in August 2010 the Secretary of the Department of Health and Human Services, working on behalf of the Board of Trustees, established an independent group of expert actuaries and economists to review the assumptions and methods used by the Trustees to make projections of the financial status of the trust funds. The members of the Panel began their deliberations in November 2010 and were asked to focus their immediate attention on the long-range Medicare cost growth assumptions. In December 2011, the panel members unanimously recommended a new approach that builds on the longstanding "GDP plus 1 percent" assumption while incorporating several key refinements. Both the Office of the Actuary at CMS and the Board of Trustees support these recommendations, and they form the basis for the long-range cost growth assumptions used in this annual report. The new methodology is explained in more detail in section IV.D of the 2012 Medicare Trustees Report.

The Panel also recommended the continued use of a supplemental analysis, similar to the illustrative alternative projection in the 2010 and 2011 Trustees Reports, for the purpose of illustrating the higher Medicare costs that would result if the reduction in physician payment rates and the productivity adjustments to most other provider payment updates are not fully implemented as required under current law.[1]

The SOSI projections must be based on current law. Therefore, the productivity adjustments are assumed to occur in all future years, as required by the Affordable Care Act. In addition, an

[1] *The Interim Report of the Technical Review Panel on the Medicare Trustees Report* is available at http://aspe.hhs.gov/health/medpanel/2010/interim1103.shtml. Once it is completed, the final report will be available at http://aspe.hhs.gov/health/medpanel/2010/.

approximate 31 percent reduction in Medicare payment rates for physician services in January 2013, as estimated in the 2012 Trustees Report, is assumed to be implemented as required under current law, despite the virtual certainty that Congress will continue to override this reduction. Therefore, it is important to note that the actual future costs for Medicare are likely to exceed those shown by these current-law projections.

Illustrative Scenario

The Medicare Board of Trustees, in their annual report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results. This alternative scenario assumes that the productivity adjustments are gradually phased down during 2020 to 2034 and that the physician fee reductions are overridden. These examples were developed for illustrative purposes only; the calculations have not been audited; no endorsement of the illustrative alternative to current law 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 payments under Medicare and of the broad range of uncertainty associated with such impacts. The table below contains a comparison of the Medicare 75-year present values of income and expenditures under current law with those under the alternative scenario illustration.

As expected, the differences between the current-law projections and the illustrative alternative are substantial, although both represent a sizable improvement in the financial outlook for Medicare compared to the laws in effect prior to the Affordable Care Act. This difference in outlook serves as a compelling reminder of the importance of developing and implementing further means of reducing health care cost growth in the coming years. All Part A fee-for-service providers are affected by the productivity adjustments, so the current law projections reflect an estimated 1.1 percent reduction in annual Part A cost growth each year. If the productivity adjustments were gradually phased down, as illustrated under the alternative scenario, the present value of Part A expenditures is estimated to be roughly 20 percent higher than the current-law projection. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario.

The Part B expenditure projections are significantly higher under the alternative scenario than under current law, both because of the assumed gradual phase-out of the productivity adjustments and the assumption that the scheduled physician fee reductions would be overridden and based on 1 percent annual increases through 2021, based on a recommendation by the 2010-2011 Medicare Technical Review Panel. The productivity adjustments are assumed to affect more than half of Part B expenditures at the time their phase-out is assumed to begin. Similarly, physician fee schedule services are assumed to be roughly 30 percent higher under the alternative scenario than

MEDICARE PRESENT VALUES

(IN BILLIONS)

	Current law (Unaudited)	Alternative Scenario[1,2] (Unaudited)
Income		
Part A	$15,598	$15,600
Part B	20,159	28,007
Part D	9,128	9,129
Expenditures		
Part A	21,179	25,494
Part B	20,159	28,007
Part D	9,128	9,129
Income less expenditures		
Part A	(5,581)	(9,895)
Part B	0	0
Part D	0	0

[1] These amounts are not presented in the 2011 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 differ from current law. No endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred.

under current law at that time. The combined effect of these two factors results in a present value of Part B expenditures under the alternative scenario that is approximately 39 percent higher than the current-law projection.

The Part D projections are basically unaffected under the alternative projection because the services are not impacted by the productivity adjustments or the physician fee schedule reductions. The very minor impact is the result of 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 current-law amounts due to changes to the productivity adjustments and physician payments depends on both the specific changes that might be legislated and on whether Congress would pass further provisions to help offset such costs. As noted, these examples only reflect hypothetical changes to provider payment rates.

It is likely that in the coming years Congress will consider, and pass, numerous other legislative proposals affecting Medicare. Many of these will likely be designed to reduce costs in an effort to make the program more affordable. In practice, it is not possible to anticipate what actions Congress might take, either in the near term or over longer periods.

Note 19:

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 future income (excluding interest) for current and future participants; (2) present value of future expenditures for current and future participants; (3) present value of future noninterest income less 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 future noninterest income less future expenditures for current and future participants over the next 75 years plus the assets of the combined Medicare Trust Funds. The Statement of Changes shows the reconciliation changing from the period beginning on 1/1/2011 to the period beginning on 1/1/2012, and the reconciliation changing from the period beginning on 1/1/2010 to the period beginning on 1/1/2011. 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 expenditures has the same effect on estimated total income, and vice versa. Therefore, any change has no impact on the future net cashflow. In order to enhance the presentation, the changes in the present values of income and 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 the projection base,
- changes in 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.

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 17 summarizes these assumptions for the current year.

Period beginning on January 1, 2011 and ending January 1, 2012

Present values as of January 1, 2011 are calculated using interest rates from the intermediate assumptions of the 2011 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2012. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are

determined using the interest rates under the intermediate assumptions of the 2011 Trustees Report. Since interest rates are economic assumptions, the estimates of the present values of changes in economic assumptions are presented using the interest rates under the intermediate assumptions of the 2012 Trustees Report.

Period beginning on January 1, 2010 and ending January 1, 2011

Present values as of January 1, 2010 are calculated using interest rates from the intermediate assumptions of the 2010 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2011. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are determined using the interest rates under the intermediate assumptions of the 2010 Trustees Report. Since interest rates are economic assumptions, the estimates of the present values of changes in economic assumptions are presented using the interest rates under the intermediate assumptions of the 2011 Trustees Report.

Change in the Valuation Period

Period beginning on January 1, 2011 and ending January 1, 2012

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2011–85) to the current valuation period (2012–86) 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 cashflow for 2011 and replaces it with a much larger negative net cashflow for 2086. The present value of future net cashflow (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 2011-85 to 2012-86. 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 2011 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

Period beginning on January 1, 2010 and ending January 1, 2011

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2010–84) to the current valuation period (2011–85) 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 cashflow for 2010 and replaces it with a much larger negative net cashflow for 2085. The present value of future net cashflow (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 2010-84 to 2011-85. 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 2010 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

Change in the Projection Base

Period beginning on January 1, 2011 and ending January 1, 2012

Actual income and expenditures in 2011 were different than what was anticipated when the 2011 Trustees Report projections were prepared. Part A income was slightly higher than estimated and Part A expenditures were lower than anticipated, based on actual experience. Part B total income and expenditures were higher than estimated based on actual experience. For Part D, actual income and expenditures were both slightly lower than prior estimates. The net impact of the Part A, B, and D projection base changes is an increase in the future net cashflow. Actual experience of the Medicare Trust Funds between January 1, 2011 and January 1, 2012 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

Period beginning on January 1, 2010 and ending January 1, 2011

Actual income and expenditures in 2010 were different than what was anticipated when the 2010 Trustees Report projections were prepared. Part A income was lower than estimated and Part A expenditures were higher than anticipated, due to the impacts of

the economic recession. Part B total income and expenditures were lower than estimated based on actual experience. For Part D, actual income and expenditures were both slightly lower than prior estimates. The net impact of the Part A, B, and D projection base changes is a slight decrease in the future net cashflow. Actual experience of the Medicare Trust Funds between January 1, 2010 and January 1, 2011 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

Changes in Demographic Assumptions

Period beginning on January 1, 2011 and ending January 1, 2012

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 period are the same as those for the prior valuation period. However, the starting demographic values were changed.

- Preliminary birth rate data for 2009 and 2010 are lower than were expected in the prior valuation. During the period of transition to their ultimate values, the birth rates in the current valuation are generally lower than they were in the prior valuation.
- The current valuation incorporates final data on legal immigration levels for 2010. The levels are slightly lower than the estimates used in the prior valuation.
- Updated starting population levels and the interaction of these levels with the changes in the fertility and immigration assumptions result in higher ratios of retirement age population to working age population than in the prior valuation.

These changes have little impact on the Part A present values of future expenditures and income. However, since overall population projections are lower compared to the prior valuation, these changes lower the Part B and Part D present values of expenditures, and also income because of the financing mechanism in place for both.

Period beginning on January 1, 2010 and ending January 1, 2011

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 period are the same as those for the prior valuation period. However, the starting demographic values were changed.

- The inclusion of final mortality data for 2007 results in lower starting death rates and faster near-term declines in death rates at older ages for the current valuation period.
- Revised historical estimates of net other immigration and final data on legal immigration for 2009 are also used in the current valuation. Based on estimates from the Department of Homeland Security for 2007 and 2008 and due to the weak U.S. economy since 2008, net other immigration levels for 2007–10 are assumed negative for the current valuation period. These levels are significantly lower than the positive estimates used in the prior valuation period.
- Birth rates projected through 2026 are slightly lower in the current valuation; preliminary birth data for 2008 and 2009 was lower than was expected for the prior valuation.

These changes have little impact on the present values of future expenditures and income.

Changes in Economic and Health Care Assumptions

Period beginning on January 1, 2011 and ending January 1, 2012

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

The ultimate economic assumptions for the current valuation period are the same as those for the prior valuation period. However, the starting economic values and near-term economic growth rate assumptions were changed. The

economic recovery has been slower than was assumed for the prior valuation period.

- For the current valuation period, HI taxable earnings are considerably lower for the starting year, 2011, than were projected for the prior valuation period. The projected level of taxable earnings grows more slowly through 2017 for the current valuation period.
- Price inflation in 2011 was higher than expected, with the cost-of-living adjustment in December 2011 being 2.9 percentage points higher than was assumed in the prior valuation.
- The real interest rate is projected to be lower over the first ten years of the current valuation period.

Inclusion of each of these economic revisions decreases the present value of future net cashflow.

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

- Case mix growth assumptions for inpatient hospitals were lowered.
- Utilization rate and case mix increase assumptions for skilled nursing facilities and home health agencies were increased.
- Growth in hospice services was increased.
- Increase in average pre-ACA "baseline" growth rate from GDP+1% to GDP+1.4% to better account for the level of payment rate updates for Medicare (prior to the ACA) compared to private health insurance and other payers of health insurance in the U.S.
- Use of the "factors contributing to growth" model, developed by the Office of the Actuary at CMS, for year-by-year growth rate assumptions in long range. The impact of this change, in association with the baseline growth rate assumption described just above, has the largest effect on the change in the net present value of income less expenditures. It resulted in an increase in the present value of Part A and Part B expenditures of roughly $1 trillion and $570 billion, respectively. Since the present value of Part A income is unaffected by these changes and the present value of Part B income is also higher by $570 billion, the net present value of income less expenditures is lower by about $1 trillion. Therefore, approximately $1 trillion of the $2.3 trillion is due to these changes.
- Lower assumed growth rate for prescription drug expenditures in the U.S. overall.
- Explicit projection of Part B services indexed by the CPI (e.g., ASC, lab, and DME services). The impact of this change lowers the present value of Part B expenditures and income by roughly $570 billion, and has no effect on the net present value of income over expenditures.

The net impact of these changes resulted in a decrease in the future net cashflow for total Medicare. For Part A, these changes resulted in an increase to the present value of expenditures and a very slight decrease on the present value of income, with an overall decrease in the future net cashflow. For Part B, these changes increased the present value of expenditures (and also income). On the other hand, the above-mentioned changes lowered the present value of expenditures (and also income) for Part D.

Period beginning on January 1, 2010 and ending January 1, 2011

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

The ultimate economic assumptions for the current valuation period are the same as those for the prior valuation period. However, the starting economic values and near-term economic growth rate assumptions were changed. The economic recovery has been slower than was assumed for the prior valuation period.

- For the current valuation period, HI taxable earnings are considerably lower for the starting year, 2010, than were projected for the prior valuation period. The projected level of taxable earnings grows more slowly through 2017 for the current valuation period.
- Unemployment rates are slightly higher over first few years of the projection for the current valuation period.
- The interest rates assumed in the short-range period are lower for the current valuation period.

Inclusion of each of these economic revisions decreases the present value of future net cashflow.

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

- Utilization rates for certain hospitals were lowered.
- Components of price updates for hospitals were increased.
- Components of price updates for home health agency services were lowered.
- Slightly lower residual assumptions for certain Part B services in the short-range period.
- Slight refinement in the Part B application of the ACA multifactor productivity adjustments in the long range period, which lowers expenditures.
- The utilization assumed for beneficiaries assumed to switch from Medicare Advantage to fee-for-service was lowered.
- The utilization assumed for beneficiaries assumed to switch from fee-for-service to Medicare Advantage was increased.
- Assumed utilization of skilled nursing facility and home health agency services was increased.
- Reduction in the projected growth in prescription drug spending in the U.S.

These changes had a net positive impact on the future net cashflow for total Medicare. For Part A, these changes resulted in a net increase to the present value of both income and expenditures, with an overall increase on the future net cashflow. For Part B, these changes increased the present value of expenditures (and also income). On the other hand, the above-mentioned changes lowered the present value of expenditures (and also income) for Part D.

Changes in Law

Period beginning on January 1, 2011 and ending January 1, 2012

Although Medicare legislation was enacted since the prior valuation date, many of the provisions have a negligible impact on the present value of the 75-year income, expenditures, and net cashflow. However, there were three specific provisions enacted that had a fairly substantial impact on the Medicare program. These include the 2 percent sequestration of expenditures in February 2013 through January 2022 required by the Budget Control Act of 2011, which reduces the present value of expenditures for Medicare; the extension of the 0 percent physician payment update through 2012 required by the Temporary Payroll Tax Cut Continuation Act of 2011 and the Middle Class Tax Relief and Job Creation Act of 2012, which slightly increases the present value of Part B expenditures; and the reduction in bad debt payments required by the Middle Class Tax Relief and Job Creation Act of 2012, which reduces the present value of Part A and Part B expenditures.

Period beginning on January 1, 2010 and ending January 1, 2011

Although Medicare legislation was enacted since the prior valuation date, most of the provisions have a negligible impact on the present value of the 75-year income, expenditures, and net cashflow. However, the enacted changes to the physician payment update very slightly increased the present value of both income and expenditures, but had no effect on the 75-year present value of future net cashflow.

Note 20:

RECONCILIATION OF NET COST OF OPERATIONS TO BUDGET

	FY 2012 Consolidated Totals	FY 2011 Consolidated Totals
Resources Used to Finance Activities:		
Budgetary Resources Obligated:		
Obligations incurred	$1,080,474	$1,133,389
Less: Spending authority from offsetting collections and recoveries	36,321	34,484
Obligations net of offsetting collections and recoveries	1,044,153	1,098,905
Less: Distributed offsetting receipts	316,656	321,925
Net obligations	727,497	776,980
Other Resources:		
Imputed financing from costs absorbed by others	45	44
Net other resources used to finance activities	45	44
Total resources used to finance activities	$727,542	$777,024
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	$(11,494)	$16,486
Resources that fund expenses recognized in prior periods	(3)	
Budgetary offsetting collections and receipts that do not affect net cost of operations	(109)	(73)
Resources that finance the acquisition of assets	138	28
Other resources or adjustments to net obligated resources that do not affect net cost of operations	2,286	2,366
Total resources used to finance items not part of the net cost of operations	$(9,182)	$18,807
Total resources used to finance the net cost of operations	$736,724	$758,217
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	$50	
Decrease/(Increase) in receivables from the public	15	$(2,748)
Other	1,023	(1,103)
Total components of Net Cost of Operations that will require or generate resources in future periods	1,088	(3,851)
Components not Requiring or Generating Resources:		
Depreciation and amortization	55	37
Other	(44)	(258)
Total components of Net Cost of Operations that will not require or generate resources	11	(221)
Total components of Net Cost of Operations that will not require or generate resources in the current period	$1,099	$(4,072)
Net Cost of Operations	$737,823	$754,145

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' 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 almost 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 based on current law and 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 *2012 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 report incorporate a provision of the Budget Control Act of 2011 (Public Law 112-25, enacted on August 2, 2011) that affects Medicare expenditures. Under this provision, a Joint Select Committee on Deficit Reduction was established, tasked with developing recommendations to reduce the deficit over 10 years, and required to report to Congress. This provision also required a sequestration process to be put into effect government-wide to reduce Federal outlays should the Joint Committee fail to refer legislation or not meet the required savings threshold. Since the Joint Committee did not report recommendations for deficit reduction, the sequestration process will automatically start, effective February 2013, unless Congress acts to address the budget deficit before then. Medicare benefit payments are subject to a maximum 2-percent reduction through the sequestration process, as provided for in the Budget Control Act. The sequestration of Federal outlays would end on January 31, 2022.

As was the case with the prior two reports, the projections shown here 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", contained roughly 165 provisions affecting the Medicare program by reducing costs, increasing revenues, improving certain 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 its costs to Medicare.

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from provisions of the Affordable Care Act. These improved results for HI and SMI Part B depend in part on the long-range feasibility of the various cost-saving measures in the Affordable Care Act—in particular, the lower increases in Medicare payment rates to most categories of health care providers. It is possible that providers can improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. Whether these provisions of current law can be sustained is debatable due to substantial uncertainty about the adequacy of future Medicare payment rates. Without fundamental change in the current delivery system, these adjustments would probably not be viable indefinitely. For these reasons, the estimates shown under current law should be used cautiously in evaluating the overall financial obligation created by Medicare and in assessing the financial status of the individual trust fund accounts. However, the effects of some of the law's provisions on Medicare are not known at this time, with the result that the projections are very uncertain, especially in the longer-range future.

As stated previously, the projections in this section are drawn from the annual Medicare Trustees report, which must be based on current law. In addition, the FASAB rules governing the Statement of Social Insurance also require use of projections based on current law. Accordingly, the permanent payment update reductions are assumed to occur in all future years, as required by the Affordable Care Act. In addition, a reduction in Medicare payment rates for physician services of more than 30 percent is assumed to be implemented beginning in 2013 as required under current law, despite the virtual certainty that Congress will override the reduction, as they have every year since 2003.

As will be discussed in more detail later, the long-range Medicare cost growth assumptions under current law take into consideration the recommendations by the 2010–2011 Technical Review Panel on the Medicare Trustees Report. These recommendations were designed to build upon the long-range assumptions used in the 2011 and prior Trustees Reports, but they incorporated a more refined analysis of the factors behind those assumptions, most notably for the increases in the price, volume, and intensity of health care services overall.

In view of the factors described above, it is important to note that the actual future costs for Medicare are likely to exceed those shown by the current-law projections. Therefore, the Medicare Board of Trustees, in their annual report to Congress, reference two alternative scenarios to illustrate where possible the potential understatement of Medicare costs and projection results. At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare trust fund projections under hypothetical modifications to current law. No endorsement of the illustrative alternatives by the Trustees, CMS, or the Office of the Actuary should be inferred. Additional information on the hypothetical alternatives to current law is provided in Note 18 in these financial statements, in Appendix C of this years' 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 http://www.cms.hhs.gov/ReportsTrustFunds/.

ACTUARIAL PROJECTIONS

Long-Range Medicare Cost Growth Assumptions

The assumed long-range rate of growth in annual Medicare expenditures per beneficiary is one of the most critical determinants of the projected cost of Medicare-covered health care services in the more distant future. Starting with the 2001 Medicare Trustees Report, the assumed average increase in expenditures per beneficiary for the 25th through 75th years of the projection has been based in whole or in part on the growth in per capita GDP

plus 1 percentage point.[1] This assumption was recommended by the 2000 Medicare Technical Review Panel and confirmed as reasonable by the 2004 panel. Beginning with the 2006 report, the Trustees adopted a slight refinement of the long-range growth assumption that provided a more gradual transition from current health cost growth rates, which had been roughly 2 to 3 percentage points above the level of GDP growth, to the ultimate assumed level of GDP plus zero percent just after the 75th year and for the indefinite future.[2]

Following enactment of the Affordable Care Act, the long-range Medicare cost growth assumptions for the 2010 and 2011 Medicare Trustees Reports continued to use this same methodology to establish a pre-Affordable Care Act "baseline" set of annual growth rates. The Trustees then reduced these growth rates for most categories of Medicare expenditures by the 10-year moving average increase in private, non-farm business multifactor productivity, as required under the Affordable Care Act.[3]

For the 2012 Medicare Trustees Report, based on the recommendations of the 2010-2011 Medicare Technical Review Panel,[4] the Board of Trustees adopted a long-range pre-Affordable Care Act baseline cost growth assumption of "GDP plus 1.4 percent" and a "factors contributing to growth" model, which creates specific, year-by-year declining growth rates during the last 50 years of the projection period. As noted previously, the Affordable Care Act permanently reduces the annual increases in Medicare payment rates for most categories of health service providers by the increase in economy-wide productivity. Thus, the long-range cost growth rate for affected providers is set equal to the pre-Affordable Care Act baseline growth assumptions, minus the increase in economy-wide multifactor productivity (1.1 percent). In addition, the Medicare Technical Panel concluded that the slower payment updates would have a small, net downward effect on growth in the volume and intensity of services. Based on this conclusion, the growth rates are further adjusted by −0.1 percent annually.

The different provisions for updating payment rates require separate long-range cost growth assumptions for the different categories of providers:

i. All HI, and some SMI Part B (primarily outpatient hospital, home health, and dialysis), services that are updated annually by provider input price increases, less the increase in economy-wide productivity, have an ultimate growth rate of "GDP plus 0.2 percent" or 4.3 percent on average. Based on the factors model, the year-by-year increases start at "GDP plus 0.4 percent" in 2036 and gradually decline to "GDP minus 0.5 percent" in 2086.

ii. Certain SMI Part B services—such as durable medical equipment, laboratory tests, care at ambulatory surgical centers, ambulance services, and medical supplies that are updated annually by the Consumer Price Index (CPI) increase, less the increase in productivity—have a long-range growth assumption of "GDP minus 0.6 percent" or 3.5 percent on average. The corresponding year-by-year growth rates are "GDP minus 0.5 percent" in 2036, declining to "GDP minus 1.3 percent" in 2086.

iii. Expenditures for services payable under the physician fee schedule are increased at approximately the rate of per capita GDP growth, as required by the sustainable growth rate formula in current law.

iv. All other Part B outlays, which constitute an estimated 12.0 percent of total Part B expenditures in 2021, have an assumed average growth rate of per capita GDP plus 1 percent or 5.1 percent on average. The corresponding year-by-year growth rates from the factors model are "GDP plus 1.2 percent" in 2036, declining to "GDP plus 0.3 percent" by 2086.

After combining the rates of growth from the four long-range assumptions, the weighted average growth rate for Part B is 4.1 percent per year for the last 50 years of the projection period, or "GDP plus 0 percent," on average. When Parts A, B, and D are combined, the weighted average growth rate for Medicare is 4.3 percent over this same period.

[1] This assumed increase in the expenditures per beneficiary excludes the impacts of the aging of the population and changes in the gender composition of the Medicare population, which are estimated and applied separately.

[2] The year-by-year growth assumptions were based on a simplified economic model and were determined in a way such that the 75-year actuarial balance for the HI trust fund was consistent with that generated by the constant "GDP plus 1 percent" assumption.

[3] "Multifactor productivity" is a measure of real output per combined unit of labor and capital, reflecting the contributions of all factors of production.

[4] The Panel's interim report is available at http://aspe.hhs.gov/health/medpanel/2010/interim1103.shtml. Once it is completed, the final report will be available at http://aspe.hhs.gov/health/medpanel/2010/.

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 long-range HI cost rates shown in this report are significantly higher than those from the 2011 report. The primary reason for the difference is the faster assumed long-range growth in the volume and intensity of HI services, as recommended by the 2010-2011 Medicare Technical Review Panel.

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. Under the Affordable Care Act, however, high-income workers will 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) in 2013 and later. 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 will initially decline due to the expected economic recovery, the savings provisions of the Affordable Care Act, and the 2-percent reduction in all Medicare expenditures for 2013-2021, as required by the Budget Control Act of 2011. Subsequently, the cost rate will increase significantly due to retirements of those in the baby boom generation and continuing health services cost growth. The effect of these factors will be largely offset in 2045 and later under current law by the accumulating effect of the reduction in provider price updates, which will reduce annual HI cost growth by an estimated 1.1 percent per year. Under the illustrative alternative, if the slower price updates were not feasible in the long range and were phased down during 2020-2035, then the HI cost rate would be 5.5 percent in 2035 and 9.9 percent in 2085. These levels are about 10 percent and 60 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 2011, the expenditures were $256.7 billion, which was 1.7 percent of GDP. This percentage is projected to increase steadily through 2046 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative projections,[5] HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 4.3 percent in 2086.

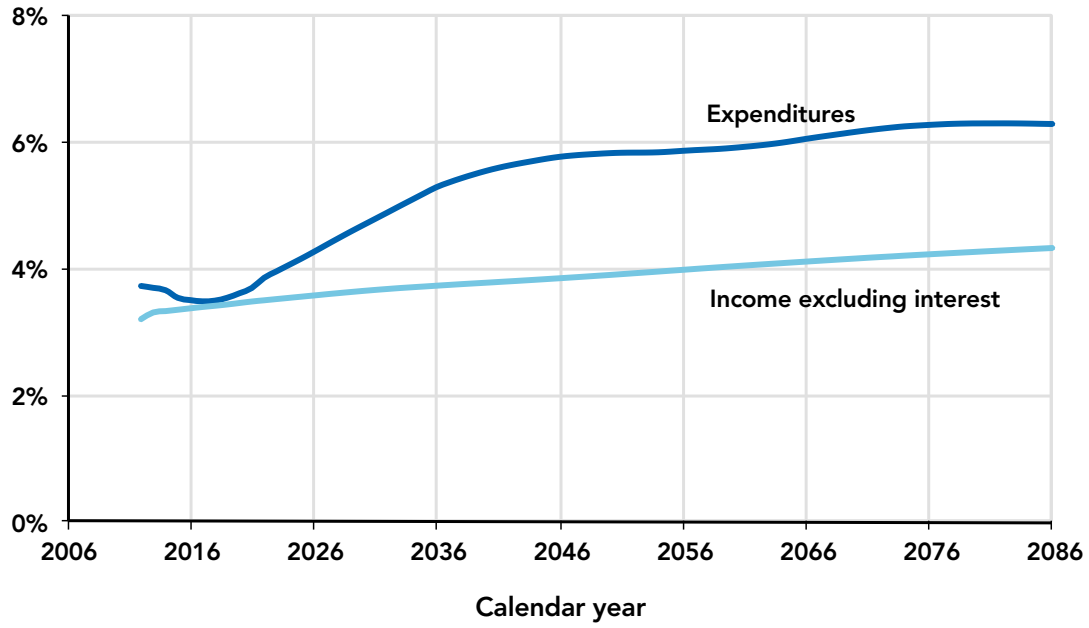
SMI

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.

[5] At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare trust fund projections under hypothetical alternatives to current law, which assumes that (i) the SGR-mandated physician fee schedule payment reductions are replaced with a 1-percent annual increase during 2013-2021 and then gradually transition to the per capita increase in health spending in the US overall; (ii) the productivity adjustments are gradually phased down over 2020-2035; and (iii) the Independent Payment Advisory Board requirements are not implemented. A summary of the illustrative alternative projections is contained in appendix V.C. of the 2012 Trustees Report. No endorsement of the illustrative alternatives to current law by the Trustees, CMS, or the Office of the Actuary should be inferred.

Chart 1

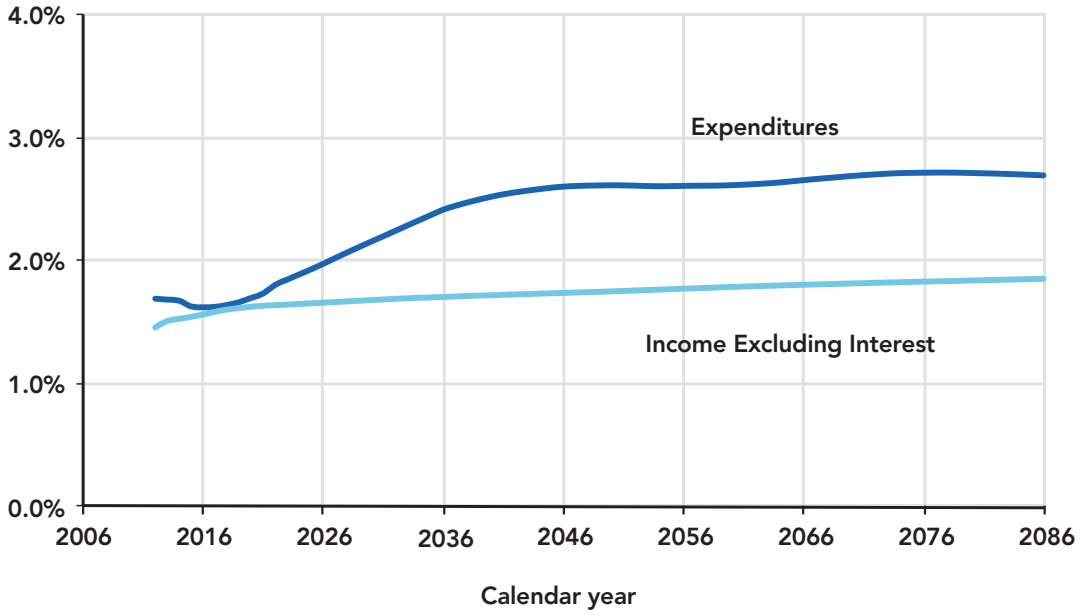
HI EXPENDITURES AND INCOME EXCLUDING INTEREST AS A PERCENTAGE OF TAXABLE PAYROLL (2012–2086)



Source: CMS/OACT

Chart 2

HI EXPENDITURES AND INCOME EXCLUDING INTEREST AS A PERCENTAGE OF GDP (2012–2086)



Source: CMS/OACT

Chart 3 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. As in the projections for HI, the assumed long-range increase in average expenditures per beneficiary incorporates the effects of the Affordable Care Act. 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.

Under the intermediate assumptions, annual SMI expenditures were $292.5 billion, or about 1.9 percent of GDP, in 2011. Then, in about 25 years, they would grow to roughly 3.4 percent of GDP and to more than 4.0 percent by the end of the projection period. Total SMI expenditures in 2086 would be 5.2 percent of GDP if physician payment rates were set as assumed under the illustrative alternative projections. Such costs would represent more than 6.0 percent of GDP under the full illustration, including larger payment updates for most other categories of Part B providers.

To match the faster growth rates for SMI expenditures, under current law, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time. In fact, average per-beneficiary costs for Part B and Part D benefits are projected to increase after 2012 by about 4.4 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate. The special State payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the State payments are also expected to increase faster than GDP.

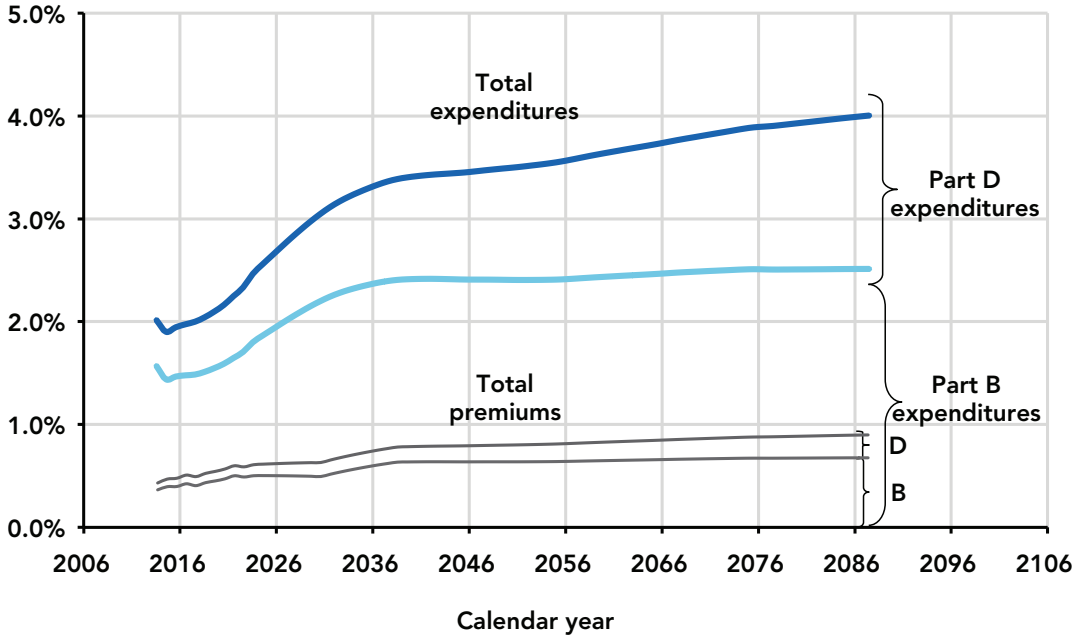
Worker-to-Beneficiary Ratio

HI

Another way to evaluate the long-range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 4 illustrates this ratio over the next 75 years. For the most part, current benefits are paid for by current workers. The retirement of the baby boom generation will therefore be financed by the relatively smaller number of persons born after the baby boom. In 2011, every beneficiary had 3.3 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.3 workers per beneficiary. The projected ratio continues to decline until there are just 2.1 workers per beneficiary by 2086.

Chart 3

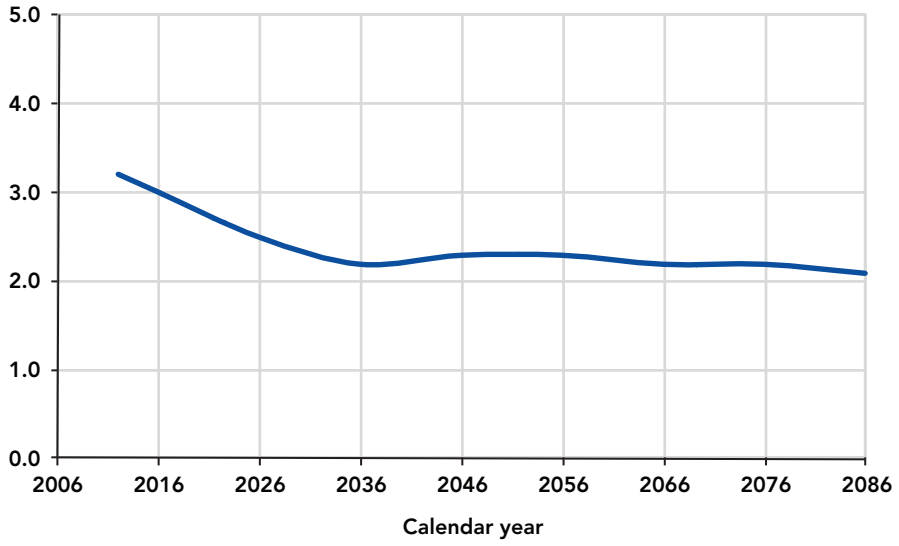
SMI EXPENDITURES AND PREMIUMS AS A PERCENTAGE OF GDP (2012–2086)



Source: CMS/OACT

Chart 4

NUMBER OF COVERED WORKERS PER HI BENEFICIARY (2012–2086)



Source: CMS/OACT

SENSITIVITY ANALYSIS

In order to make 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.[6] The assumptions varied are the health care cost factors, real-wage differential, CPI, real interest rate, fertility rate, and net immigration.[7]

For this analysis, the intermediate economic and demographic assumptions in the *2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2012 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 cashflow for each assumption varied. Generally, under all three scenarios, the present values initially increase, as the effects of the Affordable Care Act result in trust fund surpluses, and then decrease until about 2045 when they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process used for computing present values, which is used to help interpret the net cashflow 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

[6] 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 cashflow, since the change would affect income and expenditures equally.

[7] 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.

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 cashflow 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 that which was 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 $6,114 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 $9,751 billion.

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

This assumption has a dramatic impact on projected HI cashflow. The present value of the net cashflow under the ultimate growth rate assumption of 1 percentage point lower than the intermediate assumption actually becomes a surplus and remains positive throughout the entire period, due to the improved financial outlook for the HI trust fund as a result of the Affordable Care Act. 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.

Table 1

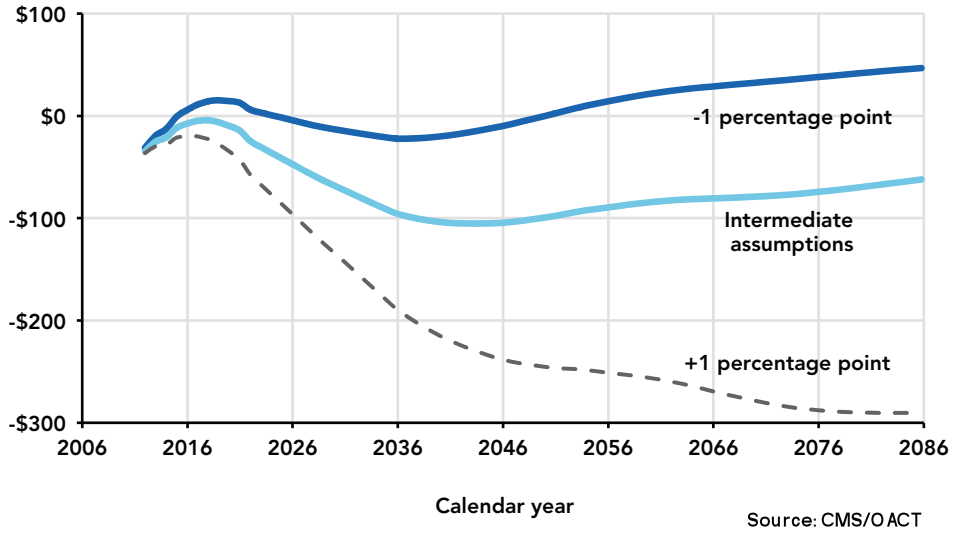
PRESENT VALUE OF ESTIMATED HI INCOME LESS EXPENDITURES UNDER VARIOUS HEALTH CARE COST GROWTH RATE ASSUMPTIONS

Annual cost/payroll relative growth rate	–1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures *(in billions)*	$533	$(5,581)	$(15,332)

Chart 5

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS HEALTH CARE COST FACTORS (2012–2086)

(IN BILLIONS)



Source: CMS/OACT

Real-Wage Differential

Table 2 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.5, 1.1, and 1.7 percentage points.[8] In each case, the assumed ultimate annual increase in the CPI is 2.8 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 3.3, 3.9, and 4.5 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 $620 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $230 billion.

Chart 6 shows projections of the present value of the estimated net cashflow 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 cashflow 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 Affordable Care Act depends critically

Table 2

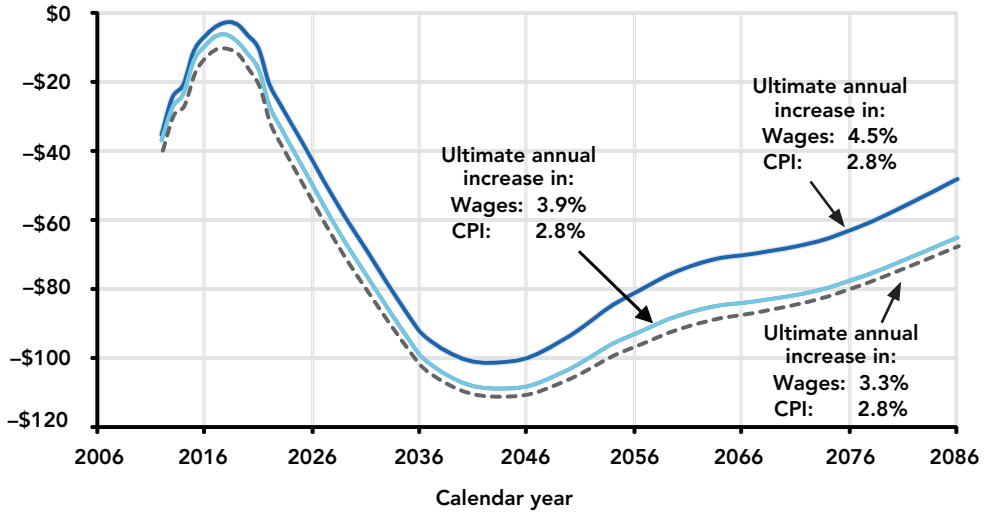
PRESENT VALUE OF ESTIMATED HI INCOME LESS EXPENDITURES UNDER VARIOUS REAL-WAGE ASSUMPTIONS

Ultimate percentage increase in wages – CPI	3.3 – 2.8	3.9 – 2.8	4.5 – 2.8
Ultimate percentage increase in real-wage differential	0.5	1.1	1.7
Income minus expenditures *(in billions)*	$(5,860)	$(5,581)	$(4,839)

Chart 6

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS REAL-WAGE ASSUMPTIONS (2012–2086)

(IN BILLIONS)



Source: CMS/OACT

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

on the long-range feasibility of the lower Medicare price updates for hospitals and other HI providers. There is a strong likelihood that certain of these changes will not be viable in the long range.

Consumer Price Index

Table 3 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 1.8, 2.8, and 3.8 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 3.0, 4.0, and 5.0 percent, respectively.

Table 3 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by $231 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit decreases by $265 billion.

Chart 7 shows projections of the present value of net cashflow 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 cashflow is expressed as present values. The relative insensitivity of the projected present values of HI cashflow to different levels of general inflation occurs because inflation tends to 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 Affordable Care Act 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 cashflow during the 75-year projection period under three alternative ultimate annual real-interest assumptions:

Table 3

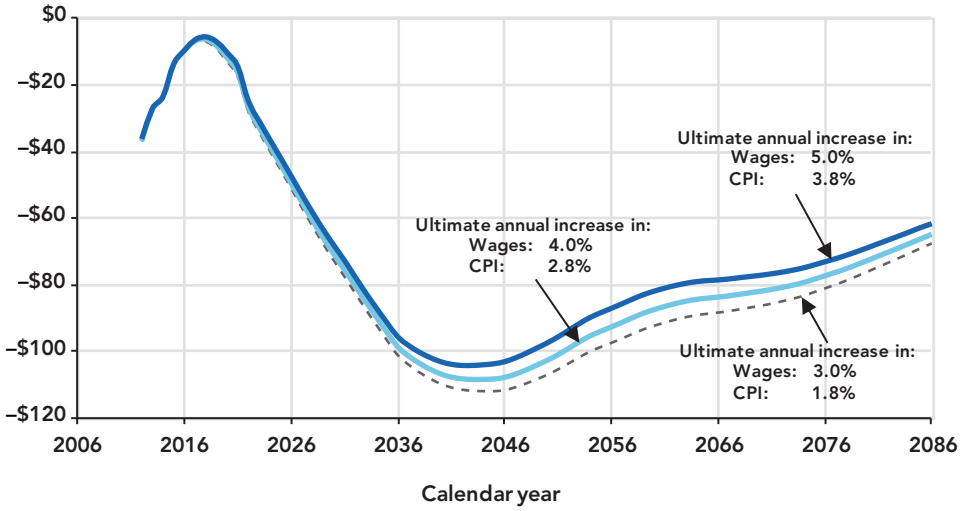
PRESENT VALUE OF ESTIMATED HI INCOME LESS EXPENDITURES UNDER VARIOUS CPI—INCREASE ASSUMPTIONS

Ultimate percentage increase in wages – CPI	3.0 – 1.8	4.0 – 2.8	5.0 – 3.8
Income minus expenditures *(in billions)*	$(5,812)	$(5,581)	$(5,316)

Chart 7

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS CPI-INCREASE ASSUMPTIONS (2012–2086)

(IN BILLIONS)



Source: CMS/OACT

2.4, 2.9, and 3.4 percent. In each case, the assumed ultimate annual increase in the CPI is 2.8 percent, which results in ultimate annual yields of 5.2, 5.7, and 6.2 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 $215 billion.

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

As shown in chart 8, the projected HI cashflow 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 2024. 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 cashflow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.7, 2.0, and 2.3 children per woman.

As table 5 demonstrates, for an increase of 0.3 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $370 billion.

Chart 9 shows projections of the present value of the net cashflow under the three alternative fertility rate assumptions presented in table 5.

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

Table 4

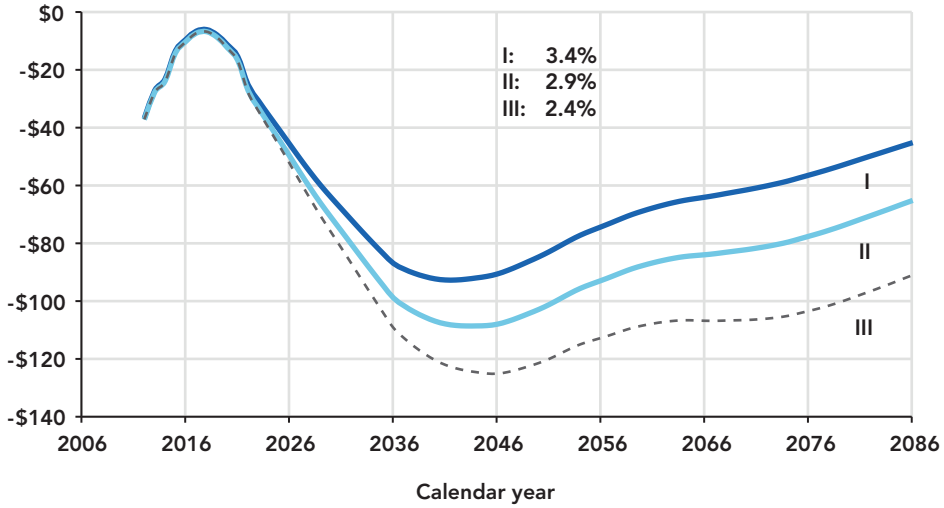
PRESENT VALUE OF ESTIMATED HI INCOME LESS EXPENDITURES UNDER VARIOUS REAL-INTEREST ASSUMPTIONS

Ultimate real-interest rate	2.4 percent	2.9 percent	3.4 percent
Income minus expenditures *(in billions)*	$(6,713)	$(5,581)	$(4,558)

Chart 8

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS REAL-INTEREST RATE ASSUMPTIONS (2012–2086)

(IN BILLIONS)



Source: CMS/OACT

Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, as in past reports, but their impact on future HI taxes will be relatively greater, since many will become subject to the additional HI tax, thereby lowering the deficit proportionately more on a present-value-dollar basis. Under the lower fertility rate assumptions, on the other hand, 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 cashflow during the 75-year projection period under three alternative average annual net immigration assumptions: 790,000 persons, 1,080,000 persons, and 1,375,000 persons per year.

As indicated in table 6, if the average annual net immigration assumption is 790,000 persons, the deficit—expressed in present-value dollars—increases by $82 billion. Conversely, if the assumption is 1,375,000 persons, the deficit decreases by $72 billion.

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

Higher net immigration results in smaller HI cashflow 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.

Table 5

PRESENT VALUE OF ESTIMATED HI INCOME LESS EXPENDITURES UNDER VARIOUS FERTILITY RATE ASSUMPTIONS

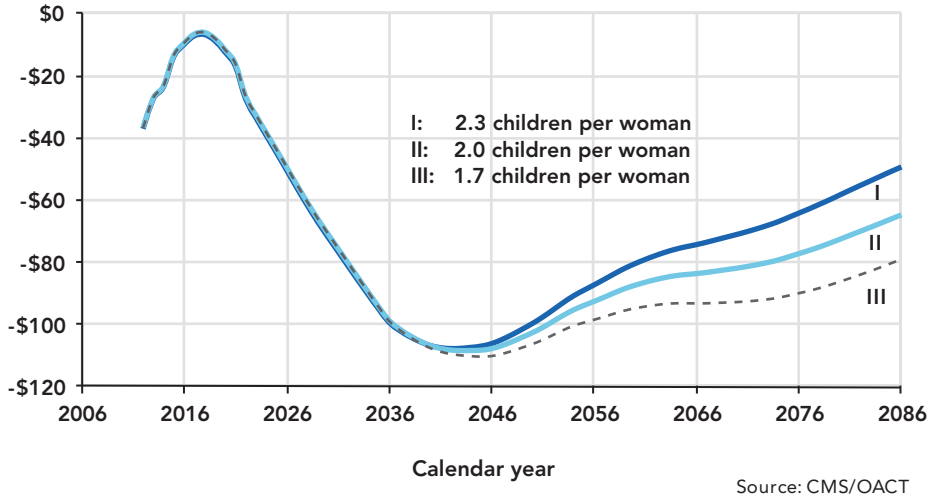
Ultimate fertility rate[1]	1.7	2.0	2.3
Income minus expenditures *(in billions)*	$(5,947)	$(5,581)	$(5,199)

[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.

Chart 9

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS ULTIMATE FERTILITY RATE ASSUMPTIONS (2012–2086)

(IN BILLIONS)



Source: CMS/OACT

Trust Fund Finances and Sustainability

HI

Under the Medicare Trustees' intermediate assumptions, the HI trust fund is projected to be exhausted in 2024, the same as 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 taxable earnings in 2011 were about equal to last year's estimate. However, the projected rate of growth in these earnings is lower in 2012 through 2014 but then exceeds last year's growth assumptions after 2014. HI expenditures in 2011 were lower than the previous estimate, but the projected level grows more rapidly than shown in last year's report because of changes in HI provider assumptions and the projected faster growth in earnings after 2014. Most of this faster growth is offset by the expected 2-percent reduction in HI outlays under the Budget Control Act of 2011 for fiscal years 2013 through 2021. HI expenditures have exceeded income annually since 2008 and are projected to continue to do so through the short-range period until the fund becomes exhausted in 2024. The shortfalls can be met with increasing reliance on the redemption of trust fund assets, thereby adding to the draw on the Federal Budget. In the absence of corrective legislation, a depleted HI trust fund would initially produce payment delays but would very quickly lead to a curtailment of health care services to beneficiaries. In practice, Congress has never allowed a Medicare or Social Security trust fund to become fully depleted.

It is important to note that the improved outlook for the HI trust fund, relative to pre-Affordable Care Act, depends in part on the feasibility of the provider payment update reductions. There is a significant likelihood, however, that these providers would not be able to reduce their cost growth rates sufficiently during this period to match the slower increases in Medicare payments per service, and in this case they would eventually become unable to continue providing health care services to Medicare beneficiaries. If such a situation occurred, and Congress overrode the payment update reductions, then actual costs would be higher, and the HI trust fund would be depleted somewhat sooner.

Table 6

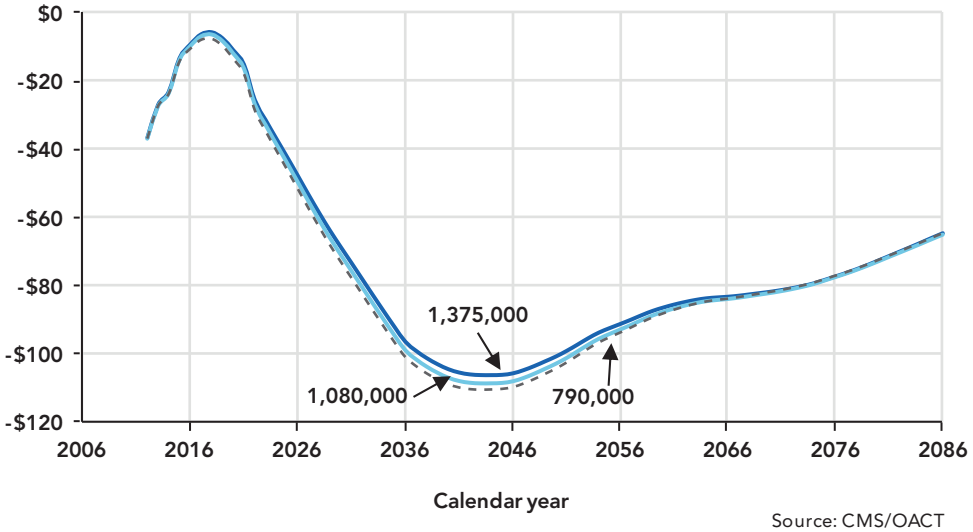
PRESENT VALUE OF ESTIMATED HI INCOME LESS EXPENDITURES UNDER VARIOUS NET IMMIGRATION ASSUMPTIONS

Average annual net immigration	790,000	1,080,000	1,375,000
Income minus expenditures *(in billions)*	$(5,663)	$(5,581)	$(5,509)

Chart 10

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS NET IMMIGRATION ASSUMPTIONS (2012–2086)

(IN BILLIONS)



Source: CMS/OACT

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. These changes are needed partially as a result of the impending retirement of the baby boom generation. If the reductions to HI provider price updates could not be continued in the long run, then the actuarial deficit would be much greater.

SMI

Under current law, 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 authority to transfer 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 2012 is adequate to cover 2012 expected expenditures and to maintain the financial status of the account in 2012 at a satisfactory level. The Part B cost projections are understated as a result of the substantial reductions in physician payments that would be required under current law and are further understated if the reductions in future price updates for most other Part B providers are not viable. Actual future Part B costs will depend on the steps that Congress might choose to take to address these situations.

No financial imbalance is anticipated for the Part D account, since the general revenue subsidy for this benefit is drawn on a daily, as-needed basis. The projected Part D costs shown in this section are somewhat lower than previously estimated, mostly due to the lower assumed growth rates for prescription drug expenditures for the next 10 years.

For both the Part B and Part D accounts, beneficiary premiums and general revenue transfers will be set to meet expected costs each year. Such financing, however, would have to increase faster than the economy to match expected expenditure growth under current law. A critical issue for the SMI trust fund continues to be the impact of the past and expected rapid growth of SMI costs, which place gradually increasing demands on beneficiaries, the Federal Budget, and society at large.

Medicare Overall

The Medicare Modernization Act requires the Board of Trustees to determine whether the difference between Medicare outlays and "dedicated financing sources" is projected to exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2012–2018).[9] This difference is expected to exceed 45 percent of total expenditures in fiscal year 2012, which is the first year of the 7-year test period. Consequently, the Trustees issued a determination of projected "excess general revenue Medicare funding," as required by law. Similar determinations were made in their 2006–2011 annual reports to Congress. With this seventh consecutive finding, another "Medicare funding warning" is triggered this year, indicating that the general revenues provided to Medicare under current law are becoming a substantial proportion of total program costs. This finding requires the President to submit to Congress, within 15 days after the release of the next budget, proposed legislation to respond to the warning. Congress is then required to consider this legislation on an expedited basis. This requirement helps to call attention to Medicare's impact on the Federal Budget. To date, elected officials have not enacted legislation responding to these funding warnings.

The projections shown in this section continue to demonstrate the need for timely and effective action to address the remaining financial challenges facing Medicare—including the projected exhaustion of the HI trust fund, this fund's long-range financial imbalance, and the issue of rapid growth in Medicare expenditures. Furthermore, if the lower prices payable for health services under Medicare could not be sustained, then these further policy reforms would have to address much larger financial challenges than implied by the current-law projections. In their 2012 annual report to Congress, the Medicare Boards 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…further reforms should occur in the near future."

[9] Dedicated Medicare financing sources include HI payroll taxes; income from taxation of Social Security benefits; State transfers for the prescription drug benefit; premiums paid under Parts A, B, and D; fees allocated to Part B related to brand-name prescription drugs; and any gifts received by the Medicare trust funds

COMBINING STATEMENT OF BUDGETARY RESOURCES

for the year ended September 30, 2012

(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:			$4,334	$512	$11,536	$572	$19,760	$5,065	$41,779	
Recoveries of prior year unpaid obligations	$436	$117		20,560	1,144	441	16	338	23,052	
Other changes in unobligated balance	(84)	(77)	(3,393)				28	(46)	(3,572)	
Unobligated balance from prior year budget authority, net	**352**	**40**	**941**	**21,072**	**12,680**	**1,013**	**19,804**	**5,357**	**61,259**	
Appropriation	255,815	236,355	251,066	266,620	8,625	56,012	1,273	2,381	1,078,147	
Borrowing authority										$3,194
Spending authority from offsetting collections	138	17	15	687		2,216	97	8,477	11,647	1,624
TOTAL BUDGETARY RESOURCES	**$256,305**	**$236,412**	**$252,022**	**$288,379**	**$21,305**	**$59,241**	**$21,174**	**$16,215**	**$1,151,053**	**$4,818**
Status of Budgetary Resources:										
Obligations incurred	$256,305	$236,412	$231,504	$267,289	$9,579	$58,792	$7,373	$11,525	$1,078,779	$1,695
Unobligated balance:										
Apportioned			19,734	21,032	8,962		13,774	4,055	67,557	3,123
Exempt from apportionment			784	58	2,764	449	27	635	4,717	
Total unobligated balance, end of year			**20,518**	**21,090**	**11,726**	**449**	**13,801**	**4,690**	**72,274**	**3,123**
TOTAL BUDGETARY RESOURCES	**$256,305**	**$236,412**	**$252,022**	**$288,379**	**$21,305**	**$59,241**	**$21,174**	**$16,215**	**$1,151,053**	**$4,818**
Change in Obligated Balance:										
Unpaid obligations, brought forward, October 1	$32,194	$24,063		$27,726	$7,130	$5,216	$610	$5,620	$102,559	
Uncollected customer payments from Federal sources, brought forward, October 1	(1)							(6,461)	(6,462)	
Obligated balance start of year (net)	**32,193**	**24,063**		**27,726**	**7,130**	**5,216**	**610**	**(841)**	**96,097**	
Obligations incurred	256,305	236,412	$231,504	267,289	9,579	58,792	7,373	11,525	1,078,779	$1,695
Outlays (gross)	(263,854)	(235,954)	(231,504)	(247,618)	(9,065)	(57,960)	(3,513)	(10,248)	(1,059,716)	(93)
Change in uncollected customer payments from Federal sources								(788)	(788)	(1,587)
Recoveries of prior year unpaid obligations	(436)	(117)		(20,560)	(1,144)	(441)	(16)	(338)	(23,052)	
Obligated balance, net, end of period:										
Unpaid obligations, end of year (gross)	24,209	24,404		26,837	6,500	5,607	4,454	6,559	98,570	1,601
Uncollected customer payments from Federal sources, end of year	(1)							(7,249)	(7,250)	(1,586)
Obligated balance, end of year (net)	**$24,208**	**$24,404**		**$26,837**	**$6,500**	**$5,607**	**$4,454**	**$(690)**	**$91,320**	**$15**
Budget Authority and Outlays, Net:										
Budget authority, gross	$255,953	$236,372	$251,081	$267,307	$8,625	$58,228	$1,370	$10,858	$1,089,794	$4,818
Actual offsetting collections	(138)	(17)	(15)	(687)		(2,216)	(97)	(7,689)	(10,859)	(37)
Change in uncollected customer payments from Federal sources								(788)	(788)	(1,587)
BUDGET AUTHORITY, NET	**255,815**	**236,355**	**251,066**	**266,620**	**8,625**	**56,012**	**1,273**	**2,381**	**1,078,147**	**3,194**
Outlays, gross	263,854	235,954	231,504	247,618	9,065	57,960	3,513	10,248	1,059,716	93
Actual offsetting collections	(138)	(17)	(15)	(687)		(2,216)	(97)	(7,689)	(10,859)	(37)
Outlays, net	263,716	235,937	231,489	246,931	9,065	55,744	3,416	2,559	1,048,857	56
Distributed offsetting receipts	(31,709)	(284,875)						(72)	(316,656)	
AGENCY OUTLAYS, NET	**$232,007**	**$(48,938)**	**$231,489**	**$246,931**	**$9,065**	**$55,744**	**$3,416**	**$2,487**	**$732,201**	**$56**

CONSOLIDATING BALANCE SHEET

as of September 30, 2012

(IN MILLIONS)

	Medicare (Earmarked)			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	$1,490	$21,764	$23,254	$47,914	$16,131	$18,348	$3,359	$109,006		$109,006
Investments	230,836	69,973	300,809		2,095			302,904		302,904
Accounts Receivable, Net	25,004	30,147	55,151	129	16	3	945	56,244	$(55,739)	505
Other Assets	22	9	31	1	1	1	4	38		38
Total Intragovernmental Assets	**257,352**	**121,893**	**379,245**	**48,044**	**18,243**	**18,352**	**4,308**	**468,192**	**(55,739)**	**412,453**
Accounts Receivable, Net	1,262	6,344	7,606	2,904	15	19	25	10,569		10,569
Direct Loans, Net						53		53		53
General Property, Plant & Equipment, Net	129	222	351	21	4		2	378		378
Other Assets	19	1,232	1,251	3		67	58	1,379		1,379
TOTAL ASSETS	**$258,762**	**$129,691**	**$388,453**	**$50,972**	**$18,262**	**$18,491**	**$4,393**	**$480,571**	**$(55,739)**	**$424,832**
LIABILITIES										
Intragovernmental Liabilities:										
Accounts Payable	$25,529	$30,852	$56,381			$3	$1	$56,385	$(55,739)	$646
Debt						150		150		150
Accrued Payroll and Benefits	1	3	4				1	5		5
Other Intragovernmental Liabilities	190	566	756	$2			44	802		802
Total Intragovernmental Liabilities	**25,720**	**31,421**	**57,141**	**2**		**153**	**46**	**57,342**	**(55,739)**	**1,603**
Federal Employee and Veterans' Benefits	3	7	10	1			1	12		12
Entitlement Benefits Due and Payable	20,191	26,245	46,436	24,955	$651	433	18	72,493		72,493
Accrued Payroll and Benefits	17	77	94	2		3	7	106		106
Contingencies		1,434	1,434	3,856	1			5,291		5,291
Other Liabilities	570	449	1,019			20	15	1,054		1,054
TOTAL LIABILITIES	**$46,501**	**$59,633**	**$106,134**	**$28,816**	**$652**	**$609**	**$87**	**$136,298**	**$(55,739)**	**$80,559**
NET POSITION										
Unexpended Appropriations-earmarked funds	$790	$19,729	$20,519					$20,519		$20,519
Unexpended Appropriations-other funds				$22,021	$17,591	$17,770	$3,035	60,417		60,417
Cumulative Results of Operations-earmarked funds	211,471	50,329	261,800					261,800		261,800
Cumulative Results of Operations-other funds				135	19	112	1,271	1,537		1,537
TOTAL NET POSITION	**$212,261**	**$70,058**	**$282,319**	**$22,156**	**$17,610**	**$17,882**	**$4,306**	**$344,273**		**$344,273**
TOTAL LIABILITIES AND NET POSITION	**$258,762**	**$129,691**	**$388,453**	**$50,972**	**$18,262**	**$18,491**	**$4,393**	**$480,571**	**$(55,739)**	**$424,832**

CONSOLIDATING STATEMENT OF NET COST

for the year ended September 30, 2012

(IN MILLIONS)

	Medicare (Earmarked)			Health (Other Funds)				Consolidated Total
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	
NET PROGRAM/ACTIVITY COSTS								
GPRA Programs:								
Medicare (Earmarked)	$250,432	$227,255	$477,687					$477,687
Medicaid				$247,508				247,508
CHIP					$9,260			9,260
Net Cost: GPRA Programs	**250,432**	**227,255**	**477,687**	**247,508**	**9,260**			**734,455**
Other Activities:								
CLIA							$225	225
State Grants and Demonstrations							656	656
Other Health						$2,522		2,522
Other							(35)	(35)
Net Cost: Other Activities						**2,522**	**846**	**3,368**
NET COST OF OPERATIONS	**$250,432**	**$227,255**	**$477,687**	**$247,508**	**$9,260**	**$2,522**	**$846**	**$737,823**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2012

(IN MILLIONS)

	Medicare (Earmarked)			Health (Other Funds)				Consolidated Total
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	
CUMULATIVE RESULTS OF OPERATIONS								
Beginning Balances	$225,916	$62,946	$288,862	$115	$14	$336	$988	$290,315
Budgetary Financing Sources:								
Appropriations Used	20,981	210,508	231,489	246,770	9,246	2,296	672	490,473
Nonexchange Revenue:								
FICA and SECA Taxes	204,752		204,752					204,752
Interest on Investments	10,934	2,889	13,823		2			13,825
Other Nonexchange Revenue	603	2,809	3,412					3,412
Transfers-in/out Without	(1,295)	(1,591)	(2,886)	756	17		451	(1,662)
Other Financing Sources (Nonexchange):								
Imputed Financing	12	23	35	2		2	6	45
Total Financing Sources	**235,987**	**214,638**	**450,625**	**247,528**	**9,265**	**2,298**	**1,129**	**710,845**
Net Cost of Operations	**250,432**	**227,255**	**477,687**	**247,508**	**9,260**	**2,522**	**846**	**737,823**
Net Change	**(14,445)**	**(12,617)**	**(27,062)**	**20**	**5**	**(224)**	**283**	**(26,978)**
CUMULATIVE RESULTS OF OPERATIONS	**$211,471**	**$50,329**	**$261,800**	**$135**	**$19**	**$112**	**$1,271**	**$263,337**
UNEXPENDED APPROPRIATIONS								
Beginning Balances	$836	$3,499	$4,335	$2,171	$18,212	$18,765	$2,945	$46,428
Budgetary Financing Sources:								
Appropriations Received	20,935	230,131	251,066	270,617	15,027	1,673	781	539,164
Appropriations Transferred-in/out				(3,997)		28	3	(3,966)
Other Adjustments *(Note 10)*		(3,393)	(3,393)		(6,402)	(400)	(22)	(10,217)
Appropriations Used	(20,981)	(210,508)	(231,489)	(246,770)	(9,246)	(2,296)	(672)	(490,473)
Total Budgetary Financing Sources	**(46)**	**16,230**	**16,184**	**19,850**	**(621)**	**(995)**	**90**	**34,508**
Total Unexpended Appropriations	**790**	**19,729**	**20,519**	**22,021**	**17,591**	**17,770**	**3,035**	**80,936**
NET POSITION	**$212,261**	**$70,058**	**$282,319**	**$22,156**	**$17,610**	**$17,882**	**$4,306**	**$344,273**

AUDIT REPORTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

NOV - 9 2012

TO: Marilyn Tavenner
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 2012 (A-17-12-02012)

This memorandum transmits the independent auditors' reports on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2012 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 (Ernst & Young), to audit the CMS (1) consolidated balance sheets as of September 30, 2012 and 2011, 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, 2012, 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 the *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 07-04, *Audit Requirements for Federal Financial Statements*.

Results of the Independent Audit

Ernst & Young found that the FY 2012 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. As presented in notes to the financial statements, with respect to the estimates for the Statement of Social

Page 2 – Marilyn Tavenner

Insurance as of January 1, 2012 and 2011, management has noted that actual future costs for Medicare are likely to exceed those projections estimated under the Patient Protection and Affordable Care Act (P.L. No. 111-148) and other current laws. As a result, Ernst & Young was unable to obtain sufficient evidential matter for the amounts presented in the statements of social insurance as of January 1, 2012, 2011, and 2010, and the related statements of changes in social insurance amounts for the periods ending January 1, 2012 and 2011, to enable them to express an opinion on whether the statements were presented fairly. Ernst & Young provided unqualified opinions on the statements of social insurance as of January 1, 2009 and 2008.

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 process and information systems controls:

- *Financial Reporting Process*—Ernst & Young noted that CMS needs to strengthen Medicaid oversight controls that will serve to prevent, detect, and resolve errors in a timely manner and to deter fraud, waste, and abuse of Federal Government resources. In addition, Ernst & Young noted that steps have been taken that have improved the financial reporting processes, but CMS's financial reporting process could still be improved. During FY 2012, Ernst & Young noted audit errors that were not detected by CMS's monitoring and review function, and so, accordingly, the monitoring and review control was not functioning as designed or intended. Ernst & Young identified weaknesses in financial reporting oversight. There continues to be a degree of uncertainty regarding the Statement of Social Insurance projections, and as a result, we were unable to assess whether the presentation of the Statement of Social Insurance was fairly presented and fully useful for its intended purpose.

- *Information Systems Controls*—Ernst & Young noted that CMS has made efforts to address the existing needs for governance, processes and practices, and the security of information technology application configuration integrity for its systems. However, Ernst & Young noted that additional focus is required to minimize the risk of current and unresolved prior-year deficiencies. These conditions may result in incomplete and inaccurate processing of transactions, impacting the integrity and completeness of data used to prepare CMS's financial statements. CMS continues to experience difficulties in implementing its policy of least privilege access, preventing and monitoring for inconsistencies in access rights to various systems, and mitigating the potential impact on adequate segregation of duties. CMS also continues to experience deficiencies in the implementation and regular monitoring of compliance with its computer security policies. These deficiencies continue to constitute a significant deficiency in internal control.

Page 3 – Marilyn Tavenner

Exclusive of the Improper Payment Elimination and Recovery Act of 2010 (P.L. No. 111-204) and section 6411 of the Patient Protection and Affordable Care Act (P.L. No. 111-148) Ernst & Young disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards* and OMB Bulletin 07-04.

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 audits;
- 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," and "Supplementary 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-17-12-02012.

Attachment

Page 4 – Marilyn Tavenner

cc:
Ellen Murray
Assistant Secretary for Financial Resources
and Chief Financial Officer

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

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Report of Independent Auditors

The Administrator 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 the accompanying consolidated balance sheets of the Centers for Medicare and Medicaid Services (CMS) as of September 30, 2012 and 2011, 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 statements of social insurance as of January 1, 2009 and 2008. We were engaged to audit the statements of social insurance as of January 1, 2012, 2011 and 2010 and the related statements of changes in social insurance amounts for the periods ended January 1, 2012 and 2011. These financial statements are the responsibility of CMS' management. Our responsibility is to express an opinion on these financial statements based on our audits.

Except as discussed in the following paragraphs with respect to the accompanying statements of social insurance as of January 1, 2012, 2011 and 2010 and the related statements of changes in social insurance amounts for the periods ended January 1, 2012 and 2011, we conducted our audits in accordance with auditing standards generally accepted in the United States, 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. 07-04*, Audit Requirements for Federal Financial Statements*, as amended. 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. We were not engaged to perform an audit of CMS' internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of CMS' internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As discussed in Note 17 to the financial statements, the statement of social insurance presents the actuarial present value of the CMS' 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. However, 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, the SMI Part D projections have an added uncertainty in that they were prepared using very little program data upon which to base the estimates, and as discussed below, significant additional variability has been introduced by the passage of recent legislation as well as issues regarding the sustainability of the underlying assumptions under current law.

As further described in Note 18 to the financial statements, with respect to the estimates for the CMS social insurance program presented as of January 1, 2012, 2011 and 2010, management has reflected in the projections of the program the direct impact, but has not fully reflected the secondary impacts of productivity adjustments (reductions in anticipated rates of increase) and reductions in Medicare payment rates for physician services mandated in the Patient Protection and Affordable Care Act (ACA) and current law. Prior legislation mandating reductions in provider payments has been overridden in whole or in part by new legislation, including frequent adjustments to scheduled reductions in physician payments and to prior efforts to adjust payments for inpatient hospital services. Management has noted that actual future costs for Medicare are likely to exceed those shown by the current-law projections, and has developed illustrative alternative scenarios and projections intended to provide additional context to users of the actuarial estimates regarding the long-term sustainability of the social insurance program. As a result of these limitations, we were unable to obtain sufficient evidential support for the amounts presented in the statements of social insurance as of January 1, 2012, 2011 and 2010 and the related statements of changes in social insurance amounts for the periods ended January 1, 2012 and 2011.

Because of the matters discussed in the preceding paragraph, 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, 2012, 2011 and 2010 and the related changes in the social insurance program for the periods ended January 1, 2012 and 2011.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of CMS as of September 30, 2012 and 2011, and its net cost, changes in net position, and budgetary resources for the years then ended, and the financial condition of its social insurance program as of January 1, 2009 and 2008 in conformity with US generally accepted accounting principles.

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 9, 2012 on our consideration of CMS' internal control over financial reporting and on our tests of its compliance with certain provisions of laws and 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* and should be considered in assessing the results of our audit.

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

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

Ernst + Young LLP

November 9, 2012

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

The Administrator 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 the financial statements of the Centers for Medicare and Medicaid Services (CMS) as of and for the year ended September 30, 2012, and we were engaged to audit the statement of social insurance as of January 1, 2012 and the related statement of changes in social insurance amounts for the period ended January 1, 2012, and have issued our Report of Independent Auditors thereon dated November 9, 2012. That report states that because of the matters discussed therein, 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, 2012 and the related statement of changes in social insurance amounts for the period ended January 1, 2012. Except for the matters discussed in the fourth paragraph of the Report of Independent Auditors, we conducted our audit in accordance with auditing standards generally accepted in the United States, 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. 07-04, *Audit Requirements for Federal Financial Statements,* as amended.

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 and 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. 07-04, as amended. However, providing an opinion on compliance with certain provisions of laws and regulations 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 an instance of noncompliance with laws and regulations or other matters that is required to be reported under *Government Auditing Standards* and OMB Bulletin No. 07-04, as amended, as described below.

The Improper Payments Information Act (IPIA) and Improper Payment Eliminations and Recovery Act (IPERA) (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 error rates for each of its high-risk

programs, or components of such programs, it is not in full compliance with the Acts. In addition, CMS is not in full compliance with Section 6411 of the Affordable Care Act.

It is our understanding that management agrees with the facts as presented and that relevant comments from CMS' management responsible for addressing the noncompliance are provided in their letter dated November 9, 2012. We did not audit management's comments and, accordingly, we express no opinion on it.

This report is intended solely for the information and use of management of CMS and the Department of Health and Human Services, the Office of Inspector General of the Department of Health and Human Services, OMB, and Congress. This report is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

November 9, 2012

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

The Administrator 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 the financial statements of the Centers for Medicare and Medicaid Services (CMS) as of and for the year ended September 30, 2012, and we were engaged to audit the statement of social insurance as of January 1, 2012, and the related statement of changes in social insurance amounts for the period ended January 1, 2012, and have issued our Report of Independent Auditors thereon dated November 9, 2012. That report states that because of the matters discussed therein, 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, 2012 and the related statement of changes in social insurance amounts for the period ended January 1, 2012. Except for the matters discussed in the fourth paragraph of the Report of Independent Auditors, we conducted our audit in accordance with auditing standards generally accepted in the United States, 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. 07-04, *Audit Requirements for Federal Financial Statements*, as amended.

Management of CMS is responsible for establishing and maintaining effective internal control over financial reporting. In planning and performing our audit, we considered CMS' internal control over financial reporting as a basis for designing our auditing procedures 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 over financial reporting. Accordingly, we do not express an opinion on the effectiveness of CMS' internal control over financial reporting. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 07-04, as amended. We did not test all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982 (FMFIA), such as those controls relevant to ensuring efficient operations.

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

Our consideration of internal control over financial reporting was for the limited purpose described in the second paragraph and was not designed to identify all deficiencies in internal control that might be deficiencies, significant deficiencies or material weaknesses. We did not identify any deficiencies in internal control that we consider to be material weaknesses, as defined above. However, we identified certain deficiencies in internal control over financial reporting, as discussed below, that we consider to be significant deficiencies in internal control over financial reporting.

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. We consider the deficiencies related to Financial Reporting Processes and Information Systems Controls 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 relies on a decentralized organization and complex financial management systems to operate and accumulate data for financial reporting. This structure is comprised of a significant number of users (more than 10,000) and contracted organizations (more than 500) that have access to the CMS systems and the related sensitive data. The business owners and users are located at the contracted organizations, providers, regional offices, Centers and Offices outside of the Office of Financial Management (OFM). Providing strong oversight to this organization requires a common set of accounting and reporting standards, proper execution of those standards/policies, an integrated financial system, a sufficient number of properly trained personnel and close coordination and meaningful collaboration within CMS and with Department of Health and Human Services (HHS). We noted deficiencies in designing the proper controls, timely execution and monitoring of the established policies and procedures, and at times, a lack of coordination and collaboration within the organization to resolve either the symptoms of or the broader organizational findings. To ultimately prevent and/or detect and resolve errors and irregularities in a timely manner, deter fraud, waste and abuse of Federal government resources and facilitate efficient and effective delivery of designated programs, 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 the financial management systems.

Recent legislation enacted not only requires close coordination and meaningful collaboration within CMS, and with HHS, but provides opportunities to challenge and continuously transform the financial management processes. As CMS continues its efforts to enhance internal controls, the following items noted in the current year audit merit continued focus on the oversight of the Medicaid program and the financial reporting systems and processes. Additional focus is required to minimize the risk of current and unresolved prior year deficiencies.

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. In general, states pay for the health benefits provided, and the Federal government in turn matches qualified state expenditures based on the Federal medical assistance percentage. On average, the Federal government expects to match state costs at a rate of approximately 58 percent. 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 assuming that the states would have their own set of procedures and controls over program costs and that the states would be incented to enforce compliance with their procedures and controls to protect the integrity of their own program costs as well as the expenditures shared by the Federal government.

In recent years, as CMCS has separately identified and reconciled the states' annual funds, there has been an increase in the number of adjustments, which have become more difficult to resolve timely, highlighting the weaknesses of their oversight of the program expenditures. As of September 30, 2012, a $950 million accounts receivable and a $1.4 billion accounts payable balance were recorded in the CMS financial statements related to the Medicaid program, some of which dates back to FY 2009 and prior. Although the FY 2011 grant finalizations were performed more consistently and timely for the states in 2012, our analyses of this process still identified the following deficiencies in the Medicaid program:

- In the first quarter of FY 2012, CMCS did not have the appropriate funding in one Treasury account to fund specific grant awards. Although the funding was available in the other Medicaid Treasury account, steps required to make the funds available were not executed in a timely fashion due to insufficient communications within CMS, a miscalculation for carryforward and recovery amounts for the Medicaid budget authority and inadequate controls to timely identify the need for the funding. As a result, on

November 30, 2011, specific states were notified of the lack of funding and negative grant awards were issued for $720 million to deobligate the funds. On December 5, 2011, after the corrections in funding had been made, funds were reobligated, and grant awards of $720 million were issued, to the states. Our testing indicated that there are not adequate prevent controls established to validate the budgeted amounts requested by the states and there is no effective monitoring of the state's draws compared to the related expenditures until the grant award is finalized.

- There is not a timely settlement of the receivables and payables with the state after the annual grant award has been finalized, as certain amounts recorded in the prior year have yet to be resolved (either collected or paid). The states make adjustments and/or transfers within their Payment Management System (PMS) accounts and appropriate documentation is not provided to CMCS to validate and authorize the changes.

- The grant close out process within the PMS is not performed timely nor are the grants simultaneously closed out within PMS when finalized. The states have two years to report the Medicaid claims expenditures. In certain cases, the balances have remained outstanding or unresolved for three years. The states have access to draw or transfer funds from open PMS accounts, even the accounts that CMCS has finalized the grant awards.

- Accounts receivable and payable balances were not identified timely in finalizing actual state certified expenditures nor are these balances recorded in detail within a Medicaid receivable or payable subsidiary ledger.

- CMCS does not analyze the changes in the accounts receivable and payable balances to identify and monitor the current period activity nor are the impacts of the issued deferrals on the balances identified, documented or resolved timely. Some deferral balances have been outstanding for more than three years.

During FY 2012, an Office of Inspector General (OIG) report was issued related to a state that may have overcharged the Federal government for care at institutions for the developmentally disabled for a number of years. This report demonstrates another broad deficiency in the design of CMCS' controls over the program. The design of the program controls rely upon the states provision of oversight for the providers of the required services to the beneficiaries. In certain cases, as was the case studied in the OIG report, the state was providing the services itself. In such an example, at least one expected level of state oversight was missing and additional oversight procedures should have been performed by CMCS.

CMCS has been working on a project to define data and analytics to improve their program and financial management. That program is not operational at a level that 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. In addition, 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 2012 financial statements. 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 (which is based on using a historical three-year average) to record the Medicaid EBDP without the ability to confirm the reasonableness of its methodology.

CMCS needs to strengthen the Medicaid program oversight controls that will serve to prevent, detect and resolve errors timely and to deter fraud, waste and abuse of Federal government resources. Strong oversight of the Medicaid program will facilitate an efficient and effective delivery of the program and allow continued focus on the mission of the Medicaid program. In strengthening the oversight and monitoring of the program, CMCS should further enhance its coordination and collaboration within CMS and its data analyses capability.

Analyses Required for an Effective Financial Management System

Critical or new accounting matters identified within CMS require a robust analysis and review process, including close coordination and meaningful collaboration with Centers and Offices, timely summarization of considerations and conclusions and documentation of the significant accounting matters through a series of white papers. The white papers supporting the conclusions on several critical accounting matters were not prepared timely, not all aspects of the accounting matters were considered or whether conclusions on prior year matters remain appropriate. The dispersed nature of the environment leaves CMS vulnerable to delays in the financial management implications of issues being recognized and addressed and creates a challenge to gather and analyze the information from across the organization to complete the required white papers timely.

Consistent with the prior years, CMS does not ensure that the legal accrual is recorded in accordance with generally accepted accounting principles in the United States. As CMS continues to enhance its data analyses capability, further improvement can be made by developing robust analytical procedures or measures against benchmarks to monitor and mitigate risks associated with the decentralized nature of CMS operations. To the extent more robust analysis occurs within Centers and Offices, identifying, evaluating and reviewing such analysis would assist in ensuring that a perspective that incorporates a financial reporting point of view is captured and considered.

During the internal control tests, errors were noted, consistent with the prior year, that were not detected by the organization's monitoring and review function, and accordingly, the 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, including an example for each category, as follows: (i) review or monitoring function was established but was not performed or effective or the policies and procedures are not properly designed and implemented (for example, a $126 million difference identified during the audit of the State Plan Amendment accrual); (ii) the review or monitoring function was not performed timely (for example, untimely review of the Medicare FFS and Medicaid/CHIP regional office reports); and (iii) activity or accounts for which no formal, documented review or monitoring function was established (for example, lack of segregation of duties maintaining the accounts receivable subsidiary ledger and preparing the reconciliation).

A strong control environment not only ensures accountability but provides oversight and reasonable assurance over the financial reporting process. Improvements can be made in the way the Centers and Offices coordinate, collaborate and communicate with OFM to understand the impact of their program transactions and ultimately corroborate the impact is properly reflected in the financial statements.

Business Partner Risk Management

CMS administers an extensive internal control program to protect the Agency's resources from fraud, waste and mismanagement. CMS relies heavily on third-party contractors as it outsources substantially all the day-to-day operations for its information technology systems, the payment of Medicare fee-for-service and Medicaid claims and certain services related to the Part C and Part D programs. In the current year we continued to identify areas where improvements could be made in the overall control environment. This is especially true of CMS' relationships with its 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 and follow objectives established by CMS. Through the established procedures, the MACs are required to a) periodically certify to the completeness and accuracy of the financial information transmitted; b) document specific objectives and maintain supporting documentation for review and audit; and c) provide monthly shared system reports and related support for recorded amounts. Through its OMB Circular No. A-123, *Management's Responsibility for Internal Control* (A-123), Statement on Standards for Attestation Engagements No. 16, *Reporting on Controls at a Service Organization* (SSAE 16), and regional office processes, CMS tests and monitors the MACs' compliance with its policies and procedures, established controls and the accuracy of financial reporting.

While this approach to financial integrity supports monitoring of the MACs' financial controls, the oversight/monitoring process 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. During our audit activities, we identified deficiencies in financial reporting oversight, including the following examples.

- Undelivered Medicare Summary Notices (MSNs) returned to the MACs are not being investigated, as there is no existing CMS policy that addresses the actions in this circumstance. The result of the beneficiary not being able to review the MSN and notifying CMS of unusual services or charges may lead to improper payments going undetected.

- CMS provided guidance to the MACs to review and investigate the detailed transactions for certain ancillary accounts (for example, refunds payable). Although the reconciliation process for these accounts has improved in the second half of this fiscal year, there has not been a consistent application of the guidance.

The processes designed to prevent errors should be supplemented by controls and analyses that highlight any material errors that may or could occur. In this regard, errors or abuses within the Medicare claim data, if material, should be detected in the annual Comprehensive Error Rate Testing (CERT) process for Medicare Parts A and B and in the Payment Error Rate Measurement (PERM) process for Medicaid and CHIP. Similar processes are used to monitor improper payments for Part C and Part D plans. The timeliness of finalizing the error rates continues to be a challenge, which is critical to the Agency's efforts to provide transparency and accountability to the public.

We reviewed the error analyses and these analyses quantify the overall challenges that CMS has regarding improper payments. Our audit procedures also consider the activities performed by OIG and others for Part C, Part D and other programs. Findings, such as the timeliness of the plan audits and the accumulation of the Prescription Drug Event (PDE) data, are inherent risks of the programs. The error rate review processes, methodologies and calculations continue to evolve and changes implemented may impact comparability of information on an annual basis and the transparency and accountability of the process. In addition, ensuring that a fully reconciled population of claims is subject to testing is an important starting point in the development of PERM error rates and the reconciliation of such populations continue to be an area of focus.

Statements of Social Insurance

The Statements of Social Insurance (SOSI) for CMS presents a long-term projection of the present value of the benefits to be paid for the closed and open groups of existing and future participants of the Medicare social insurance programs less the inflows to be received from or on behalf of those same individuals. The presentation assumes the Medicare programs will continue in their current form under current law, albeit with certain economic assumptions that serve to constrain growth of the programs and imply refinements in response to the burden of the programs on economic activity.

In FY 2010, the passage of the ACA significantly impacted the projections embodied in the Trustees Report and SOSI. The application of the current law formulation to development of the SOSI projection created significant challenges in applying this legislation. The degree of uncertainty experienced in FY 2010 regarding the projections continued through FY 2012, and as a result, we were unable to assess whether the presentation of the SOSI was fairly presented and fully useful for its intended purpose. Management has noted that the effects of some of ACA's provisions on Medicare are not known and the long-range feasibility of certain of the provisions is doubtful. The Trustees Report and related Actuarial Opinion reflect uncertainty regarding the projections and reflect concerns that certain current law provisions are not sustainable or will, based on prior patterns, likely be modified. The extent to which the current law SOSI projections, as presented, are subject to ongoing uncertainty this year and may not reflect management's reasonable estimate of the ultimate cash flows of the social insurance program, is discussed in the footnotes to the FY 2012 SOSI.

Developing auditable estimates for SOSI that fairly present the financial condition of the Trust Funds may require revisiting provisions of Federal accounting standards and potentially reformulating the assumptions used in SOSI and the Trustees Report to help improve the usefulness of the estimates provided. Certain efforts have been taken within CMS that will assist in narrowing areas of concern, including the appointment of a panel of advisors to assist in reviewing the projections and related assumptions. Although the work of the panel of advisors was not completed timely for the FY 2012 SOSI presentation and Trustees Report development, certain recommendations made by the panel of advisors regarding the economic model were implemented by OACT in the FY 2012 SOSI. As the panel of advisors finalizes its report and recommendations, the completed set of measures may assist CMS during the refinement of future projections and in considering the appropriate response to concerns about the sustainability of current law provisions over the projection period. The investment made by the Office of the Actuary in formulating alternative illustrative scenarios, coupled with recent activities by the Federal Accounting Standards Advisory Board, may help inform the process and facilitate developing appropriate responses to the unique challenges faced by CMS in developing SOSI projections.

Recommendations

We recommend that CMS continue to develop and refine 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:

- Efforts to continuously monitor the state Medicaid draws and perform grant oversight activities should be improved to ensure that the states do not overdraw funds. CMS should perform the grant close out process timely and consistently within PMS to eliminate any erroneous draws to grant awards with remaining authority. In addition, the accounts receivable and payable Medicaid balances should be analyzed and validated through the use of a subsidiary ledger.

- CMCS should strengthen the Medicaid program oversight controls that will serve to prevent, detect and resolve errors timely and to deter fraud, waste and abuse of Federal government resources. With respect to state-operated programs, CMCS should perform additional oversight and analysis procedures related to the state costs.

- 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 $25 billion accrual.

- Delegate to and ensure that the Centers or Offices prepare robust analytical analyses on a periodic basis that would be reviewed and used by OFM in connection with the preparation of the quarterly CMS financial reports and available for use throughout the organization.

- Further enhance its process to develop, document and validate the new critical accounting matters that are identified during the year, including timeliness, accuracy and completeness of the white papers. Prepare required presentations and disclosures to ensure adequate time for analysis and feedback from key stakeholders.

- Ensure that the legal accrual is recorded in accordance with generally accepted accounting principles in the United States.

- Establish a periodic organizational-wide financial statement review process to enhance the financial reporting process, address or identify transactions that require cross-functional input and ensure financial statements are accurate and complete.

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

- Continue to utilize the results and enhance the benefits of the CERT, PERM, Part C and Part D error rate development and analysis tools. Error rate results should be developed at a sufficient level of detail to analyze, scrutinize and identify anomalies to begin investigations of the root causes of the errors and prevention, mitigation and recovery plans. Continue efforts to further develop the eligibility process to ensure only appropriate parties participate. In addition, track or continue to track the resulting error rate reduction plans/corrective action plans at a sufficient level to determine the impact to the respective error rates.

- Developing SOSI projections representing management's reasonable estimate of the cash flows for the programs over a 75-year projection period, will continue to be a challenge. In pursuing the ultimate resolution, CMS should obtain and implement the complete set

of recommendations made by the panel of advisors to assist in addressing the challenges presented by the passage of ACA. In addition, continue and broaden discussions with key stakeholders and standard setting bodies, including the Federal Accounting Standards Advisory Board, to co-develop appropriate recommendations for potential revisions to the approaches used in presenting projections for the programs in the Trustees Report and standards applicable to presentation of the SOSI to aid in ensuring that the SOSI projection is meaningful and presents fairly the financial condition of the Trust Funds.

Information Systems Controls

The nature, size and complexity of their operations require CMS to manage their programs under a decentralized business model by geographically dispersed contractors using complex and extensive information systems operations. CMS manages national health care related programs, of which Medicare fee-for-service is the largest; other significant programs include Medicare Advantage (Part C), the Prescription Drug (Part D), Medicaid, and the Children's Health Insurance Program (CHIP). CMS' Central Office provides overall direction for these programs using a variety of complex decentralized and networked information systems. Internal controls over these operations are essential to manage the integrity, confidentiality, and reliability of these programs and application systems and to reduce the risk of errors, fraud or other illegal acts.

CMS' operations support a number of Medicare fee-for-service application systems that are intended to assure consistency in administering the Medicare fee-for-service activities, in addition to processing, accounting for, and reporting Medicare fee-for-service expenditures and related assets and liabilities. These systems are used by numerous user communities within the Fiscal Intermediaries (FIs), Carriers, MACs, Standard Systems Maintainers (SSMs) and Enterprise Data Centers (EDCs), collectively referred to as Medicare fee-for-service contractors, to administer Medicare fee-for-service claims and related beneficiary, provider, payment, and financial data processes. Additional information systems at the Central Office are used to accumulate the Medicare claims and other related transactions for financial management and reporting processes.

To manage the operational and financial risk presented by these information systems, CMS has developed 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 Central Office systems and also are incorporated by reference in CMS' contracts with its business partners. Formal monitoring procedures have been implemented by CMS Central Office. Generally, the Medicare fee-for-service contractors have implemented more consistent monitoring of system configurations, segregations of duties and related reporting to CMS in recent years.

However, in addition to increasing demands on CMS to continue to provide affordable health care, monitoring and validation activities have not kept pace with the increased volume of activity at the Medicare fee-for-service contractors and new government mandates for enhanced information security processes. When combined with inadequately designed controls over monitoring and oversight, these factors may result in unauthorized system access, inconsistencies in access rights allowing a potential lack of segregation of duties, and a lack of compliance with intended policies. Additional focus is required to minimize the risk of current and unresolved prior year deficiencies. These conditions may result in incomplete and inaccurate processing of transactions, impacting the integrity and completeness of data used to prepare CMS' financial statements. The following sections provide more specifics about our information systems control findings related to the oversight and operation of the Medicare fee-for-service claims processing systems.

CMS' Systems Environment Overview

CMS maintains multiple Medicare fee-for-service claims processing systems depending on the type of claim. These systems include the Fiscal Intermediary Standard System (FISS), the Multi-Carrier System (MCS), the ViPS Medicare System (VMS), and the Common Working File (CWF). Collectively, these systems are referred to as shared systems and each of these is maintained by the SSMs. The maintenance of these systems is coordinated by CMS through a Single Testing Contractor (STC).

In addition to the Medicare fee-for-service systems previously noted, the important financial systems managed by the CMS Central Office include the Healthcare Integrated General Ledger Accounting System (HIGLAS), the Financial Accounting and Control System (FACS), the Medicare Advantage and Prescription Drug System (MARx), the Medicaid Budget & Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), and the National Claims History (NCH).

CMS maintains a Business Partners Systems Security Manual (BPSSM) based on Federal guidelines to direct the information security and assurance activities at the Medicare fee-for-service contractors. Monitoring compliance with the BPSSM is accomplished through CMS' ongoing Security Authorization program. Each contractor is required to maintain a System Security Plan developed in accordance with the BPSSM that outlines the contractor's plan for maintaining a secure environment for CMS' systems.

CMS principally monitors its Medicare fee-for-service contractors' compliance with its standards through the following processes:

- Reports issued annually on the controls MACs placed in operation and tested to conclude on the operating effectiveness issued by independent auditors in accordance with the American Institute of Certified Public Accountant's SSAE 16;

- Annual evaluations of the implementation of information security requirements outlined in Section 912 of the Medicare Modernization Act of 2003;

- Annual reviews are performed to meet the requirements of OMB A-123, which provide updated internal control standards and specific requirements for conducting management's assessment of the effectiveness of internal control over financial reporting and financial systems;

- Additional monitoring procedures performed by CMS including ongoing contractor management assessments and regular reviews of computer security configurations submitted by the MACs and the EDCs; and

- CMS is subject to various Federal information security and application software management guidelines. Primary guidance is provided by the National Institute of Standards and Technology (NIST). An independent assessment of CMS' compliance with the NIST guidance is in part accomplished through the performance of an annual review conducted by the HHS OIG under the *Federal Information Security Management Act of 2002 (FISMA).*

Information Management Controls

Information management security and configuration controls are fundamental to the integrity of all information systems. Such controls, including properly authorized, designed and implemented controls, and active monitoring of security events for proper assessment and timely remediation, can help manage risks such as unauthorized access and changes to critical data. These controls include physical and logical access restrictions to protect against unauthorized usage of CMS information resources, including programs and data files. Without maintaining an appropriate level of segregation of duties through robust information management security and configuration controls, the integrity of CMS' information resources cannot be assured.

Configuration management is the process used to ensure that the information systems applications used by CMS operate as intended. Configuration management depends on the consistent application of program change management policies to ensure the continued integrity, security and reliability of financial and claims data.

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 that use the shared systems 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.

Because of the complexity and size of the shared systems, the SSMs perform the initial program design and coding. 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 EDCs, 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.

CMS has implemented configuration and change control processes for its Central Office systems that affect the Medicare fee-for-service, Part C, Part D, Medicaid, and CHIP programs. These processes include the use of structured system development methodologies, change control boards, and configuration management software to help ensure the integrity of program code.

CMS is challenged in maintaining computer security by a number of key factors, including:

- The very large number of users required to have access to CMS systems to process claims and to support beneficiaries in a timely and effective manner.
- Their decentralized business control structure wherein program executives are tasked with the responsibility to manage the operations and controls over many business functions including compliance with information security and assurance standards designed by the enterprise information security office at CMS Central Office.
- The use and reliance upon contractors to accomplish most business functions, including operation of the computer systems. In many cases, the degree of computer security is dependent upon a contractor's interpretation of and adherence to CMS security policies.

Improvements are necessary in the controls over system access and monitoring of unauthorized system access, the prevention of and monitoring for inconsistencies in access rights allowing a potential lack of segregation of duties in certain areas and monitoring of compliance with computer security policies. These deficiencies extend to both Medicare fee-for-service contractors as well as to the enterprise as a whole.

Controls over System Access and Monitoring of Unauthorized System Access

CMS has developed policies that are designed to comply with and are consistent with Federal information security standards. However, the implementation of these policies is affected by the size and complexity of the environment and availability of resources to ensure policies are properly implemented. As a result, inconsistent implementation planning and execution of CMS' overall directives and guidance was observed. These deficiencies may lessen the ability of CMS to provide secure and reliable processing systems. Examples of these deficiencies include:

Medicare Fee-for-Service Contractors:

- System security plans were incomplete and not always current.
- Authorization for connecting Medicare contractor systems to the CMS network was not always obtained or current.

Enterprise-Wide

- Interconnection security agreements between the Medicare contractors and its business partners did not follow all CMS guidelines and were inconsistently documented.
- CMS does not require user acceptance testing of all claims processing software changes.
- The Part A claims processing application has some functional limitations, which resulted in inappropriate access.
- CMS does not have a documented standard process for assessing or confirming computer configuration waiver requests submitted by its Medicare fee-for-service contractors.

Appropriate consideration of the design of controls is essential to provide a suitable framework for subsequent implementation and operation of the controls.

Prevention of and Monitoring for Inconsistencies in Access Rights Allowing a Potential Lack of Segregation of Duties

CMS continues to experience difficulties in implementing its policy of least privilege access, preventing and monitoring for inconsistencies in access rights to various systems, and mitigating the potential impact on adequate segregation of duties. We found several deficiencies that may result in a potential lack of segregation of duties at both the Medicare fee-for-service contractors and the CMS Central Office.

Medicare Fee-for-Service Contractors

CMS system user access rights were not adequately maintained or monitored. Examples of deficiencies that we found include:

- Users had the ability to directly update Medicare fee-for-service data without a business justification for such access. In addition, direct data access to alter Medicare fee-for-service data was granted to users who were designated as application developers and outside subcontractors.

- For one MAC, shared system user accounts had incompatible sensitive access levels that did not have sufficient business justification.

- Reviews of access rights of user accounts for propriety were not performed or not documented at the STC and one MAC.

- Inappropriate access was shared between users at several MACs and users at both the SSMs and EDCs.

At two MACs and one EDC, we found that system software used to implement shared system changes was not configured for adequate segregation of duties.

Enterprise-Wide

CMS Central Office is responsible for providing governance and oversight for the programs and data that are used to manage the Medicare programs. However, the complex nature of the systems impacts the ability to implement adequate information security controls. Examples of these deficiencies that we found at the Central Office include:

- Some Central Office applications did not have adequate segregation of duties as it relates to implementing new program code. In addition, the documentation for authorization, testing and approval of changes was not retained.

- Business users for one key application were able to increase their access capabilities, such as maintaining system codes and the system configuration files.

- Inconsistent and inappropriate access was granted to certain users for several key applications, in some cases without a business justification, resulting in the risk of incorrectly configured user profiles and potentially unauthorized changes to Medicare data files and programs.

- Implementation of authentication mechanisms has not been completed for a key application that is used for controlling system access.
- Oversight of periodic access reviews for key applications was not performed as required or consistently.
- Inappropriate privileged access granted to selected users and a lack of monitoring and oversight, resulting in a risk of unauthorized changes to system applications, data and programs.

The CMS systems continue to evolve using networks to permit more efficient data transport for financial and operations management purposes. However, several vulnerabilities in system configurations, program coding, input validation, and incident response procedures for the Medicare fee-for-service networks and the Central Office were identified. Evidence that vulnerability scans were performed and remedial actions were taken was not retained at one contractor.

Without adequate controls over managing segregation of duties, the risk of errors, fraud or other illegal acts is increased.

Monitoring of Compliance with Computer Security Policies

CMS continues to experience deficiencies in the implementation and regular monitoring of compliance with its defined computer security polices at both the Medicare fee-for-service contractors and the Central Office. Some of these deficiencies are a result of a compressed schedule to implement numerous required change requests across the broad range of claims systems and are indicative of the complexity faced by CMS in its daily business activities and the need for assigning priorities to tasks.

Medicare Fee-for-Service Contractors

The Medicare fee-for-service contractors are subject to regular audits as part of the overall oversight by CMS. Reports from these audits are used to remediate identified deficiencies. However, we noted that information security and configuration management-related findings identified by these audits remained unresolved.

We found that adequate monitoring policies needed improvement at two MACs. The information assurance program did not support effective continuous monitoring and compliance reporting to enable the timely compliance with CMS' configuration requirements and removal of obsolete security and configuration settings.

We also found deficiencies related to compliance with CMS' configuration management policies:

- Testing of shared system change requests by the STC was neither complete nor successful, but the changes were implemented.
- Modifications to Medicare fee-for-service programs to address short-term fixes did not follow a standard process for all affected systems.
- Local changes to Medicare fee-for-service data edits made by a MAC were not always documented or approved by CMS.

Enterprise-Wide

- CMS has developed a process requiring Interface Control Documents (ICDs) for its major applications, but these are not standardized in content, are not used by all relevant programming groups and have not been inventoried.

As a result of these deficiencies, CMS may not be able to ensure the accuracy, completeness or overall integrity of its Medicare systems and other enterprise-wide systems.

Transition to an Integrated Financial Management System

Federal agencies are required to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, processes (manual and automated), controls and data necessary to carry out the financial management functions, manage the financial operations and report the financial status.

CMS continues their efforts to implement a web-based accounting system, HIGLAS, which will integrate the CMS contractors' standard claims processing system and replace FACS (currently, HIGLAS has been placed "on top" of FACS). Although CMS is preparing financial statements using HIGLAS, the majority of the financial transactions and journal vouchers are recorded within the current mainframe-based financial system. As a result, full functionality of HIGLAS has not been implemented; however CMS will transition and further implement HIGLAS in fiscal year 2013. CMS will need to fully implement HIGLAS to consolidate the financial data from the Medicare contractors and Central Office. In addition, there is no letter of credit or cash management module that currently exists within HIGLAS at Central Office that monitors the MACs' draws. The MACs' accounts receivable balances are recorded at Central Office through the manual journal voucher process.

There are a number of system interventions and manual adjustments or reconciliations to properly categorize the information within the financial statements, as required by OMB A-136. The creation of the periodic financial statements is largely system dependent. The information

security controls over FACS are weak, primarily due to the lack of segregation of duties that continue to exist between the business and information security administration functions within OFM. OFM has assigned personnel the function of system and security administrators, and these personnel also are able to grant access to the FACS application to perform and process business transactions. Adequate information security controls are fundamental to the integrity of any information system to protect against unauthorized usage of financial data. CMS is aware of the noted shortcomings within FACS but does not plan to make changes to this system, as it will be decommissioned in fiscal year 2013.

All MACs have implemented HIGLAS, except for the Durable Medical Equipment (DME) 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.

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. Such an approach will require continued and active communication and integration of efforts by the OFM, the Office of Information Services and the Center for Medicare.

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:

- Ensuring that systems are appropriately and timely certified, related system security plans are complete, and documentation of all interconnections between Medicare contractors is consistently prepared.

- Reviewing and evaluating identified deficiencies and instances of noncompliance with stated CMS policies, including the documentation of conclusions and evaluating their impact on the financial statements.

Specific to the implementation of a governance-based model at CMS consisting of separate but related control activities relative to configuration management and information security, we recommend that:

- Consistent, current and complete system security plans prepared by all system owners and the Medicare fee-for-service contractors.

- Appropriate segregation of duties should be established for all systems that support CMS' programs, including Medicare fee-for-service claims and related financial processing at

the FIs, Carriers, MACs and EDCs to prevent excessive or inappropriate access. In addition, access to all systems should be periodically assessed to ensure that access remains appropriate and no incompatible duties exist.

- Continued implementation of additional system security management activities at the Central Office and the Medicare fee-for-service contractors in accordance with CMS' policies, related monitoring procedures, and timely remediation of identified deficiencies.

- All application changes and interfaces to CMS systems, including the Medicare fee-for-service shared systems, and related support systems managed by the Central Office, are documented, and tested timely, adequately and completely.

- System interfaces are identified and ICDs are consistently completed and used for all of CMS' significant systems.

- Relevant NIST guidance should be applied in the review and approval of all changes. Documentation should be prepared for all phases of the change management process.

In addition, CMS should continue to implement an 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 while working toward decommissioning FACS.

We have reviewed our findings and recommendations with CMS management. CMS' response to our findings and recommendations is included in their letter dated November 9, 2012. Management will provide a corrective action plan to the Office of Inspector General in accordance with applicable Agency directives. We did not audit CMS' response and, accordingly, we express no opinion on it.

This report is intended solely for the information and use of management of CMS and the Department of Health and Human Services, the Office of Inspector General of the Department of Health and Human Services, OMB and Congress. This report is not intended to be and should not be used by anyone other than these specified parties.

Ernst + Young LLP

November 9, 2012

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

November 9, 2012

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

Dear Sir:

Thank you for your audit report on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2012 financial statements. CMS has reviewed the report prepared by Ernst & Young, LLP (E&Y) and we are pleased that the result of the audit is an unqualified opinion on our Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position and the Combined Statement of Budgetary Resources. However, this year, E&Y did not express an opinion on the Statement of Social Insurance (SOSI). We continue to believe that the FY 2012 SOSI projections appropriately show the effects of the Affordable Care Act and that we provide sufficient disclosures regarding the nature and uncertainty of the projections. We believe the independent panel of expert actuaries and economists we consulted with to review the assumptions and methods used by the Medicare Board of Trustees to make the projections reflected in the Medicare SOSI since the passage of the Affordable Care Act in 2010 support our position. While their final report has not been issued, we believe our FY 2012 SOSI and accompanying footnotes are fully consistent with their interim findings and recommendations. The Medicare Trustees will continue their efforts, taking into consideration the recommendations of the panel, to develop possible improvements to the long-range assumptions underlying the SOSI projections, and we will continue to work closely with the panel, you, and our partners in the Office of the Inspector General (OIG) to develop the necessary actions to remediate this issue for the future.

Your review also identified no material weaknesses, and two instances of non-compliance with laws and regulations. CMS generally concurs with the findings and descriptions of the matters noted in your Reports on Internal Controls over Financial Reporting and Compliance and Other Matters. CMS will continue to focus its efforts on addressing the root causes of the deficiencies and non-compliance, and is committed to resolving these matters by developing and implementing corrective action plans to address the audit issues identified in your reports. It is the Agency's top priority to assess and resolve these matters as quickly as possible.

Finally, we would like to confirm CMS' commitment to further improve our financial management systems, as well as the production of accurate and reliable financial information. CMS would like to thank the OIG and the E&Y audit team for the professionalism exhibited throughout the audit process.

Sincerely,

Deborah A. Taylor, CPA
Chief Financial Officer

OTHER ACCOMPANYING INFORMATION

- Summary of Federal Manager's Financial Integrity Act
- OMB Circular A-123 Statement of Assurance
- Improper Payments
- Review of Medicare's Program for Oversight for Accreditation Organizations
- Clinical Laboratory Improvement Validation Program

SUMMARY OF FEDERAL MANAGER'S FINANCIAL INTEGRITY ACT REPORT AND OMB CIRCULAR NO. A-123 STATEMENT OF ASSURANCE

CMS assesses its internal controls through: (1) management self-assessments, including annual tests of security controls, (2) OMB Circular A-123, Appendix A self-assessment, (3) assessment of internal control over the acquisition function, (4) OIG audits and Government Accountability Office (GAO) audits and High-Risk reports, (5) 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) audit, and (8) certification and accreditation of systems. As of September 30, 2012, the internal controls and financial management systems of CMS provided reasonable assurance that the objectives of FMFIA were achieved; however, two instances of noncompliance were identified.

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 the Federal Managers' Financial Integrity Act (FMFIA) and Office of Management and Budget (OMB) Circular No. A-123, *Management's Responsibility for Internal Control*, dated December 21, 2004. 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, CMS provided a qualified statement of reasonable assurance that its internal controls and financial management systems met the objectives of FMFIA due to its noncompliance with the Improper Payments Elimination and Recovery Act (IPERA), and Section 6411 of the Affordable Care Act.

After becoming substantially compliant with the Federal Financial Management Improvement Act (FFMIA) in FY 2010, we have continued our efforts to implement the Healthcare Integrated General Ledger Accounting System (HIGLAS), which will integrate the CMS claims administration contractors' shared claims processing system and replace the CMS mainframe-based financial system with a web-based accounting system. CMS considers our financial systems to be integrated in accordance with OMB Circular A-127, *Financial Management Systems*. The HIGLAS has, as of September 2012, 99.49 percent of total program payments accounted for in HIGLAS. The HIGLAS will continue to enhance CMS' oversight of claims administration contractor financial operations, and the accounting and reporting of other CMS activities.

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, 2012, 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, 2012, we also complied with applicable laws and regulations, except for the two instances of noncompliance noted above. While the GAO High-Risk Report continues to include the Medicare and Medicaid programs as high risk, we do not believe that they constitute a material weakness. GAO designated Medicare as a high-risk program with serious management challenges because of its size, complexity, and susceptibility to improper payments. GAO also designated Medicaid as a high-risk program in part due to concerns about the adequacy of fiscal oversight, which is necessary to prevent inappropriate program spending. GAO noted new laws, directives, and agency efforts as positive steps toward reducing improper payments in the Medicare and Medicaid programs and improving transparency.

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, 2012, were operating effectively and no material weaknesses were found in the design or operation of the internal control over financial reporting.

Noncompliance

During FY 2012, we continued our overall efforts to reduce improper payments and plan to again report a composite payment error measure for the Part D Prescription Drug program. The Part D composite payment error rate was first reported in FY 2011. CMS also plans to report an error rate for the Part C program, as it has since FY 2008. While CMS has developed and reported error rates for each of its high risk programs, or components of such programs (i.e., Medicare fee-for-service (FFS), Medicaid, Children's Health Insurance Program (CHIP), Part C Medicare Advantage, and Part D Prescription Drug programs), CMS' non-compliance stems from the reporting of a Part C Medicare Advantage composite error rate that is greater than 10 percent. CMS continues its efforts to comply with IPERA and OMB's implementing regulation.

Regarding compliance with Section 6411 of the Affordable Care Act, CMS published a solicitation of comments regarding the development of the Medicare Part C Recovery Audit Contractor (RAC) program in December 2010. To date, CMS has received and analyzed comments related to a Part C RAC program, and continues to explore implementation options.

IMPROPER PAYMENTS

In July 2010, Congress amended the IPIA, with the IPERA to better standardize 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. During FY 2011, CMS has fully complied with the OMB's IPERA guidance and has implemented 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

The identification and reporting of improper payments has been in place for Medicare FFS since FY 1996 as a part of CMS' financial reporting. The OIG estimated the Medicare FFS rate from 1996 through 2002. With the passage of the IPIA, CMS took responsibility for the error rate program beginning with FY 2003. IPIA required a change in use of gross improper payment figures. The gross improper payment figure is calculated by adding together the absolute value of underpayments and overpayments. From FY 1996–FY 2003, CMS reported the Medicare FFS estimate of improper payments as a net number (where underpayments were subtracted from overpayments). In FY 2004 and forward, Medicare FFS estimates comply with the IPIA requirement to report gross numbers.

CMS' newly modified estimate for FY 2012 indicated that the paid claims gross error rate was 8.5 percent or $29.6 billion in gross improper payments. This change in estimate provides a more accurate estimate of improper payments in the Medicare FFS program.

Under current Medicare policy, hospitals that submit a claim for Part A inpatient services that should have been provided on an outpatient basis under Part B are not permitted to re-submit a claim for such payment. In the past year, the

FY 2012 GROSS IMPROPER PAYMENTS AND ERROR RATES IN THE MEDICARE FFS PROGRAM

		GROSS	
Overpayments	Underpayments	Improper Payment Amount (Overpayments + underpayments)	Error Rate
$28.5 B	$1.1 B	$29.6 B	8.5%

Administrative Law Judges and the Departmental Appeal Board, which represent the third and fourth levels of Medicare claim appeals (respectively), have concluded that, contrary to HHS's longstanding policy and interpretation of certain Medicare manuals, policy statements in the manuals support Part B rebilling in these circumstances. As a result, Medicare has been directed to provide payment to hospitals for all Part B services that they provided after their Part A inpatient claim was denied. In consultation with the Department of Health and Human Services and the Office of Management and Budget, CMS refined the improper payment methodology to account for the impact of rebilling denied Part A inpatient claims for allowable services under Part B. Incorporating this impact into the modified report period methodology results in a final FY 2012 improper payment rate of 8.5 percent.

Medicare Advantage and Prescription Drugs

CMS has reported a Part C composite payment error rate since FY 2008. The Part C composite payment error rate combines two component error rates into a single composite measure for total Part C payments: (1) the Medicare Advantage and Prescription Drug System (MARx) system payment error (MPE) rate for Part C; and (2) the Part C risk adjustment error (RAE) rate. A Part C composite payment error rate of 11.4 percent is reported in the FY 2012 HHS Agency Financial Report (AFR).

Since FY 2011, CMS has reported a composite payment error rate for the Medicare Prescription Drug Benefit, a Medicare benefit effective CY 2006. The Part D composite payment error rate combines five component error rates into a single composite measure for total Part D payments: (1) the Medicare Advantage and Prescription Drug (MARx) system payment error (MPE); (2) Payment Error Related to Low Income Status (PELS); (3) Payment Error Related to Incorrect Medicaid Status (PEMS); (4) Payment Error Related to Prescription Drug Event (PDE) Data Validation (PEPV) and (5) Payment Error Related to Direct and Indirect Remuneration (PEDIR). A Part D composite payment error rate of 3.1 percent is reported in the FY 2012 HHS AFR

Medicaid and CHIP

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

CMS measures the national payment error rate for Medicaid and CHIP annually, through the PERM program. Through the PERM, CMS measures three areas of Medicaid and CHIP: FFS claims, managed care claims, and eligibility cases. Using CMS' guidelines, the states lead the effort in measuring errors in the eligibility cases. A sample of 17 states is measured each year to produce and report national program error rates.

The national Medicaid error rate reported for FY 2012 is 7.1 percent, or $19.2 billion in gross improper payments, which reflects a three-year weighted average national error rate including data from 2010, 2011, and 2012. The weighted national error component rates are as follows: Medicaid FFS: 3.0 percent; Medicaid managed care: 0.3 percent; and Medicaid eligibility: 4.9 percent.

As required under section 601 of the CHIPRA, CMS published a final rule on August 11, 2010, which revised the PERM eligibility review to be consistent with state policies for eligibility validation. For the FY 2011 error rate, eligibility reviews were conducted under the new PERM final rule. Section 601 of CHIPRA prohibited HHS from calculating or publishing any national or state-specific error rates for CHIP until six months after a new PERM final rule has been in effect. The new final rule for PERM was effective on September 10, 2010 and section 205(c) of the Medicare and Medicaid Extenders Act of 2010, exempts CMS from completing a 2011 CHIP error rate. CMS will report a CHIP error rate in the FY 2012 HHS AFR. CMS calculated and is reporting the single-year FY 2012 national improper payment rate. The FY 2012 national CHIP improper payment rate is 8.2 percent or $0.7 billion.

The national component improper payment rates are as follows: CHIP FFS: 6.9 percent; CHIP managed care: 0.1 percent; and CHIP eligibility: 5.8 percent.

REVIEW OF MEDICARE'S PROGRAM FOR OVERSIGHT OF ACCREDITATION ORGANIZATIONS

Section 1: Overview

In order to be eligible to receive Medicare reimbursement, certain types of health care facilities must demonstrate compliance with Medicare conditions of participation (CoPs), conditions for coverage (CfCs), or conditions for certification. Section 1865 of the Social Security Act (the Act) allows health care facilities that are "provider entities"[1] to demonstrate this compliance through accreditation by an approved, private national Accreditation Organization (AO).[2] The Centers for Medicare & Medicaid Services (CMS) has the responsibility for oversight and approval of the AOs' programs, and for ensuring that providers or suppliers that are accredited by an approved AO meet the quality and patient safety standards required by the Medicare conditions.[3] A thorough review of each AO program is conducted by CMS, including equivalency of their accreditation requirements, survey processes and procedures, training, oversight, and enforcement. Also reviewed are the qualifications of the surveyors, staff, and the AO's fiscal fitness. Upon approval, any provider or supplier accredited by the AO's approved program would be deemed to meet the Medicare conditions. Section 1875 of the Act requires CMS to submit this annual report to Congress on its oversight of all AO programs. CMS has a comprehensive approach to the review and approval of an AO's accreditation program and its ongoing oversight of AO activities. The primary goal of this review is to ensure that the AO's standards meet or exceed the Medicare conditions for each program type and that the organization has the capacity to adequately administer the program. Currently, CMS has approved accreditation programs for the following facility types: hospitals, critical access hospitals (CAHs), home health agencies (HHAs), hospices, ambulatory surgical centers (ASCs), psychiatric hospitals, outpatient physical therapy and speech-language pathology services (OPTs), and rural health clinics (RHCs).[4] During the past several years, CMS has implemented a comprehensive program to strengthen and enhance ongoing oversight of AOs, including:

- Rigorous review of the AO's programs to ascertain whether the AO can adequately ensure that facilities comply with Medicare requirements (deeming application reviews);
- Building and implementing electronic systems for AO reporting on their activities related to deemed facilities;
- Implementing measures which reflect each AO's compliance with administrative reporting requirements (performance measures);
- Expanding the validation survey program; this measures the effectiveness of the AO survey process in identifying areas of serious non-compliance with Medicare conditions;
- Conducting ongoing education for AO staff and developing an AO resource manual; and,
- Developing special validation studies which focus on specific facility types in response to policy questions.

During the last year, CMS has continued to work with AOs to expand on these significant enhancements in systems for monitoring AO activities and AO compliance with CMS requirements.

This report reviews AO activities and describes the current CMS oversight of recognized accreditation programs as follows:

- **Scope of AO activities (Section 2):** Describes the role of AOs in Medicare's health care facility certification process.

[1] Section 1865 of the Act defines "provider entity" to include a provider of services, supplier, facility, clinic, agency, or laboratory. Section 1861(d) defines a "supplier" to mean a physician or other practitioner, a facility or other entity other than a provider. Section 1861(u) defines a "provider" to mean a hospital, CAH, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency or hospice program. Note that "provider entities" does not include imaging centers or durable medical equipment suppliers, which are required to be accredited under Section 1834(a)(2) and Section 1834(e), respectively, of the Act. Oversight of these accreditation programs is administered separately by CMS; these accreditation programs are not subject to the Section 1875 reporting requirement and are not addressed in this report.

[2] Accreditation for provider entities in accordance with Section 1865 is voluntary and not required for Medicare participation. Accreditation by an approved, national AO is an alternative to being subject to assessment of compliance by the State Survey Agency.

[3] Conditions of participation apply to providers; conditions for coverage apply to suppliers; and, conditions for certification apply to rural health clinics. In this report, the term "facility" is used to cover all types of institutional health care providers which require certification in order to participate in Medicare and "Medicare conditions" is used to cover both conditions of participation, conditions for coverage, and conditions for certification.

[4] Note that other types of facilities may also participate in Medicare via an approved accreditation program, but to date no AO has sought and received approval for any of these additional facility types.

- **CMS approval of accreditation programs (Section 3):** Describes the process for CMS review and approval of AO accreditation programs, and the number and types of reviews completed in the past four years.
- **AO survey activities and assessment of compliance (Section 4):** Describes the FY 2011 survey activities of each AO, the most recent application review by CMS for each AO program, as well as AO scores on administrative performance measures for FYs 2010 and 2011. The results indicate that performance on these administrative measures has continued to improve since performance reporting was initiated in FY 2009. While performance is at or near the 100 percent level for many measures, there is room for improvement for the remaining measures.
- **State Survey Agency (SA) validation of AO surveys (Section 5):** Describes the CMS program for SA validation of AO survey findings within 60 days of the AO survey and gives performance results for FYs 2008 - 2011 for each AO. Analysis of the results over several years continues to raise issues about the effectiveness of AO surveys in identifying areas of serious non-compliance for hospitals, CAHs and ASCs.
- **Validation surveys for Long Term Care Hospitals (Section 6):** Describes special, mid-cycle validation surveys that were undertaken in deemed Long Term Care Hospitals (LTCHs) in FY 2011 to assess their compliance with CMS requirements. The results suggest that a high percentage of the sampled deemed LTCHs had serious quality problems and appear to be more likely to have serious problems than other types of hospitals.
- **Program improvements as reported by the AOs (Section 7):** Presents each AO's self-report of its recent program improvement activities.
- **CMS' management and oversight of AOs (Section 8):** Describes the changes CMS has made in its AO oversight activities.

Section 2: Scope of Accreditation Organization Medicare Deeming Programs

CMS reviews and approves separately each program type (hospital, psychiatric hospital, CAH, HHA, hospice, ASC, OPT, and RHC) for which an AO seeks CMS recognition. Currently, there are seven recognized AOs with 19 approved accreditation programs, as described in Table 1. Some AOs focus on one or two accreditation programs while others have a range of programs.

Table 1:
APPROVED ACCREDITATION ORGANIZATION PROGRAMS (FY 2011)

	Hospital	Psych Hospital	Critical Access Hospital	Home Health Agency	Hospice	Ambulatory Surgery Center	OPT*	Rural Health Clinic	TOTAL
AAAHC						X			1
ACHC				X	X				2
AAAASF						X	X	X	3
AOA/HFAP	X		X			X			3
CHAP				X	X				2
DNVHC	X		X						2
JC	X	X	X	X	X	X			6
TOTAL	3	1	3	3	3	4	1	1	19

* Outpatient physical therapy and speech-language pathology services

AAAHC: Accreditation Association for Ambulatory Health Care
ACHC: Accreditation Commission for Health Care
AAAASF: American Association for Accreditation of Ambulatory Surgery Facilities
AOA/HFAP: American Osteopathic Association/ Healthcare Facilities Accreditation Program
CHAP: Community Health Accreditation Program
DNVHC: Det Norske Veritas Health Care
JC: The Joint Commission

CMS approved the first accreditation program for psychiatric hospitals in FY 2011. To participate in the Medicare program, psychiatric hospitals must demonstrate compliance with the hospital conditions as well as additional special psychiatric hospital conditions. Prior to approval of the Joint Commission's psychiatric hospital accreditation program in FY 2011, a combination approach was employed to certify a psychiatric hospital's compliance with the requisite Medicare conditions. A psychiatric hospital had the option to employ the services of a CMS-approved AO hospital accreditation program to perform a survey of the hospital to evaluate compliance with the hospital accreditation program requirements, including the Medicare conditions. Once the psychiatric hospital demonstrated full compliance and was awarded accreditation, the AO would recommend that CMS grant the facility deemed status. CMS would then direct a CMS psychiatric hospital survey team to evaluate compliance with the special psychiatric hospital conditions. Once the psychiatric hospital demonstrated full compliance with the hospital and special psychiatric hospital conditions, the facility could be certified as a psychiatric hospital. Since approval of the Joint Commission psychiatric hospital accreditation program, psychiatric hospitals can now be fully certified for participation in Medicare based on this accreditation. However, currently certified psychiatric hospitals accredited by one of the other two CMS-approved AO hospital accreditation programs, DNVHC or AOA/HFAP, may continue to use the combined approach.

As described in Table 2, AOs are responsible for assuring compliance with Medicare conditions for 37 percent of all Medicare-certified facilities in the six provider/supplier categories for which there was an approved AO program in FY 2011. (The first CMS-approved accreditation program for RHCs was approved in FY 2012 and, therefore, is not reflected in Table 2 or in subsequent tables and graphs in this report.) The AOs are responsible for monitoring compliance with health and safety standards for varying percentages of total Medicare-participating facilities for each facility type, ranging from a high of 85 percent for hospitals to a low of one percent for OPT facilities, for which the first accreditation program was approved in FY 2011.

The total number of Medicare-participating certified healthcare facilities in the six categories presented in Table 2 has increased from 27,581 in FY 2008 to 29,958 in FY 2011, a nine percent increase. The majority of the new Medicare-participating facilities have been certified by CMS by virtue of their accreditation from a CMS-recognized AO.

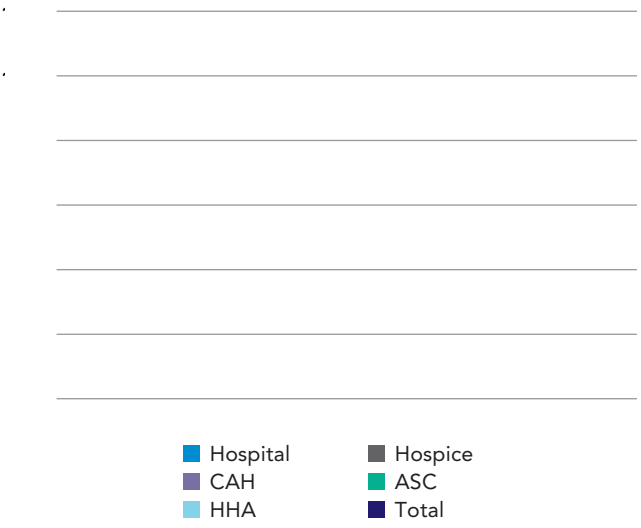
Considering the five AO program types which were operational between FY 2008 and FY 2011 (Hospital, CAH, HHA, hospice and ASC), Graph 1 presents the number of deemed facilities and Graph 2 presents the percentage of facilities certified by CMS by virtue of their accreditation by a CMS-recognized AO for each year:

Table 2:
MEDICARE CERTIFIED FACILITY PROVIDERS/SUPPLIERS (FY 2011)

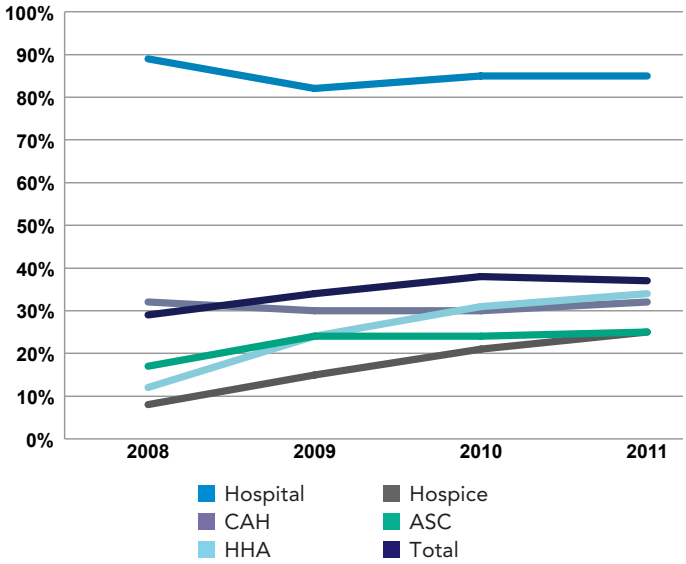
	Deemed* (percentage)	Non-Deemed** (percentage)	TOTAL
Hospital***	4,159 (85)	730 (15)	4,889
CAH	428 (32)	903 (68)	1,331
HHA	4,117 (34)	8,058 (66)	12,175
Hospice	914 (25)	2,718 (75)	3,632
ASC	1,371 (25)	4,089 (75)	5,460
OPT	13 (1)	2,458 (99)	2,471
TOTAL	11,002 (37)	18,956 (63)	29,958

*As reported by AOs.
**Surveyed by a SA for compliance with Medicare conditions.
***Includes 388 deemed psychiatric hospitals for the purposes of trending the growth of deemed facilities.

Graph 1:
NUMBER OF DEEMED FACILITIES FOR EACH PROGRAM TYPE (FYS 2008–2011)



Graph 2:
PERCENT OF DEEMED FACILITIES FOR EACH PROGRAM TYPE (FYs 2008–2011)



- **Total:** For the five AO program types which have been operational over the period from FY 2008 through FY 2011 (OPTs excluded since AO program was newly operational in FY 2011), the number of Medicare-certified facilities increased by 11 percent. However, the growth in deemed facilities has been much larger.
  - The number of facilities participating in Medicare via their deemed status increased from 7,128 to 10,989, a 54 percent increase.
  - While the majority of facilities requiring certification are surveyed by a SAs, the proportion of deemed facilities grew from 29 percent to 40 percent of Medicare-certified facilities during this period.
- **HHAs:** The majority of the growth in Medicare-certified facilities has been in HHAs, which increased by 23 percent between FY 2008 and FY 2011.
  - The number of deemed HHAs increased from 1,161 to 4,117, a 255 percent increase.
  - The proportion of all Medicare-certified HHAs which were deemed increased from 12 percent to 34 percent.
- **Hospices:** The number of Medicare certified hospices increased by seven percent between FY 2008 and FY 2011.
  - The numbers of deemed hospices increased from 278 facilities in FY 2008 to 914 in FY 2011, a 229 percent increase.
  - The proportion of all Medicare-certified hospices which were deemed increased from 8 percent to 25 percent during the same time period.
- **ASCs:** Medicare certified ASCs increased by five percent between FY 2008 and FY 2011.
  - The number of deemed ASCs increased from 893 facilities to 1,371 facilities, a 54 percent increase.
  - The proportion of all Medicare-certified ASCs which were deemed increased from 17 percent to 25 percent during the same time period.
- **Hospitals and CAHs:** The number of Medicare-certified hospitals and CAHs was largely unchanged between FY 2008 and FY 2011. Hospitals are the only category where the majority of facilities participate in Medicare by virtue of their accreditation from a CMS-recognized AO.
  - The number of deemed hospitals decreased from 4,381 to 4,159 (a five percent decrease) and the number of deemed CAHs increased from 415 to 428 (a three percent increase).
  - The proportion of all Medicare-certified hospitals that were deemed decreased from 89 percent to 85 percent and the proportion of all Medicare-certified CAHs that were deemed remained at 32 percent.

The growth in the number of deemed facilities is likely attributable in part to CMS' priorities for SAs' workload. CMS' long-standing policy for SAs has been that initial surveys for newly enrolling facilities with an approved accreditation option have a lower priority as compared to statutorily mandated recertification surveys of already participating nursing homes and HHAs, validation surveys, complaint investigations, other recertification surveys, and initial surveys of new applicants for which no accreditation option exists. As a result, an increasing number of facilities seeking initial Medicare participation have used CMS-approved AO accreditation programs to demonstrate their compliance with Medicare requirements, to facilitate a faster enrollment and certification process.

The AOs charge fees to facilities that seek their accreditation, and generally offer facilities two accreditation options, accreditation alone or accreditation for the purpose of participating in Medicare. CMS reviews, and approves or denies recognition of an accreditation program only for an AO's Medicare accreditation programs. Accordingly, this report addresses AO activity as it relates to CMS-approved Medicare accreditation programs only.

A facility certified on the basis of being "deemed" to meet the Medicare conditions, based on accreditation and recommendation for deemed status by an approved AO, is not subject to routine surveys by CMS to determine compliance with all applicable Medicare conditions. However, these deemed facilities may be subject to validation surveys authorized by CMS and generally conducted by a SA. There are two types of validation surveys: a full survey as part of the annual CMS AO representative sample validation survey program; or a focused survey in response to a complaint allegation which, if true, could indicate serious noncompliance with one or more Medicare conditions. Subsection 1864(c) of the Act authorizes the Secretary to enter into an agreement with SAs to perform such validation surveys. When the SA finds a condition-level, i.e., serious, deficiency in a deemed facility, CMS removes its deemed status and places it under the jurisdiction of the SA until the facility comes into substantial compliance, or, if it is unable to demonstrate timely compliance, the facility's participation in Medicare is terminated. If compliance is demonstrated, CMS restores the facility's deemed status and returns the facility to the AO's jurisdiction.

Section 3: CMS Approval of Accreditation Organization Deeming Programs

The process for CMS approval of a national AO's accreditation programs is applicant-driven. In order to be approved as a recognized national AO, an organization must demonstrate the ability to effectively evaluate a facility using accreditation standards which meet or exceed the applicable Medicare conditions, as well as survey processes comparable to those outlined in the State Operations Manual (SOM). Among other things, the SOM contains CMS' instructions to SAs on how to conduct survey activities on behalf of CMS. Section 1865 of the Act requires that CMS shall base approval of an AO's accreditation program application on the AO's:

- Requirements for accreditation;
- Survey procedures;
- Ability to provide adequate resources for conducting surveys;
- Capacity to furnish information for use in enforcement activities;
- Monitoring procedures for providers or suppliers found out of compliance with conditions or requirements; and
- Ability to provide the necessary data for validation to CMS.

Section 1865(a)(3)(A) of the Act further requires that CMS publish in the *Federal Register*, within 60 days of receipt of an organization's complete application, a notice identifying the national accreditation body making the request, describing the nature of the request, and providing at least a 30-day public comment period. CMS has 210 days from receipt of a complete application to publish a *Federal Register* notice of approval or denial of the application.

The regulations at 42 CFR 488.4 and 488.8 set forth the detailed requirements an AO must satisfy in order to receive and maintain CMS recognition and approval of an accreditation program, as well as the procedures CMS follows in reviewing AO applications. Renewal applications are subject to the same criteria and scrutiny as initial applications for approval of an AO's accreditation program. Approval of an AO's accreditation program is for a specified time period, with a six-year maximum. Some AOs are given approval on a conditional basis, and CMS will review and monitor the accreditation program during a probationary period to determine if the program continues to meet or exceed Medicare requirements.

The application and renewal process provides the opportunity for a comprehensive evaluation of an AO's performance, its ability to ensure accredited deemed facilities' compliance with Medicare conditions, and its ability to comply with CMS' administrative requirements that facilitate ongoing oversight of the AO's deeming program. CMS evaluation process includes the following components:

- On-site observations:
  - Corporate onsite review; and
  - Survey observation.
- Comparability review between AO standards and Medicare Conditions.
- Comprehensive review of the AO's:
  - Policies and procedures;
  - Adequacy of resources to perform required surveys;
  - Survey processes and enforcement;
  - Surveyor evaluation and training; and
  - Electronic data management.

Once approved, any subsequent changes in the AO's program standards or survey process must also be reviewed and approved by CMS prior to implementation, to ensure that the accreditation program continues to meet or exceed Medicare requirements. The AO must notify CMS in writing of any proposed changes in its approved accreditation program at least 30 days in advance of the effective date of the changes. Additionally, when CMS adopts changes to the applicable Medicare conditions, or to its survey processes, the AO must submit documentation that it has revised its standards and/or survey process to comply with the new requirement(s) within 30 days of CMS' notification to the AO of the change(s). During this review process, an AO may be required to make changes in its accreditation program in order to maintain CMS-approval.

The number of CMS-approved AO accreditation programs has grown steadily, from 13 in FY 2008 to 19 in FY 2012. During this time, CMS has approved one new AO (DNVHC) and six new accreditation programs, including three for facility types with existing approved programs (ACHC hospice program, DNVHC hospital program and DNVHC CAH program), and three for facility types that previously did not have a deeming option (JC psychiatric hospital accreditation program, AAAASF OPT accreditation program, and AAAASF RHC accreditation program).

From FY 2008 through FY 2012, CMS completed 30 reviews of renewal and initial applications covering all 19 currently approved accreditation programs. This includes approvals published in the *Federal Register* as well as initial applications withdrawn by the AO prior to publication. Table 3 reviews the specific activities related to the CMS review of accreditation programs over the past five years, including full reviews of accreditation programs (both initial and renewal applications) as well as the other reviews which focus on specific issues. The other reviews include the following categories:

- **Standard and survey process reviews:** Conducted to ensure that the AO accreditation standards and survey process continue to meet or exceed Medicare requirements. Such reviews are conducted in accordance with 42 CFR 488.4(b)(3)(iii) when an AO notifies CMS of any proposed changes in accreditation requirements, and when AO requirements are revised in response to changes in CMS requirements at 42 CFR 488.4(b)(3)(iv).
- **Issue review and resolution:** AOs must demonstrate that their standards and review processes meet or exceed all applicable conditions of Section 1865 of the Act. CMS works with AOs if issues are identified related to this compliance.
- **Performance Review:** CMS reviews AO performance on an on-going basis in accordance with section 1875(b) of the Act. This includes, but is not limited to, review of the AO's survey activity (discussed in Section 4), analysis of validation surveys (discussed in Section 5), and review of the AO's continued fulfillment of the requirements at 42 CRF 488.4.

Table 3:
CMS REVIEW OF AO APPLICATIONS AND REQUESTS (FYs 2008 – 2012)

TYPE OF REVIEW AND CMS DECISION	2008	2009	2010	2011	2012
RENEWAL APPLICATIONS					
Decision: Full approval	3	6	1	0	3
Decision: Denied	0	0	0	0	0
Decision: Conditional approval	0	1	2	0	0
Decision: Final approval removing conditional status	0	1	2	0	0
INITIAL APPLICATIONS					
Decision: Full approval	0	1	1	3	1
Decision: Denied	0	0	0	0	0
Incomplete Application	0	0	0	0	0
Application withdrawn prior to publication	0	1	2	1	1
TOTAL REVIEWS OF RENEWAL AND INITIAL APPLICATIONS	**3**	**10**	**8**	**4**	**5**
OTHER REVIEWS					
Standards review	7	4	15	18	18
Survey process review	0	4	12	10	6
Issue review and resolution	*	*	*	44	15
Performance review	0	1	2	3	3
TOTAL OTHER REVIEWS	**7**	**9**	**29**	**75**	**42****

* Data was not collected for these issues during this timeframe.
**Partial year data as of July 2012.

Section 4: Review of Accreditation Organization Survey Activities and Performance

Section 4 reviews AO activities with primary emphasis on survey activities and measures of AO performance. The initial sections summarize the Medicare accreditation survey activity and performance measure results across all AOs, followed by a section presenting the performance of individual AOs including:

- **AO Medicare Accreditation Activities:** A review of each AO's CMS-approved Medicare accreditation program's survey activities and decisions during FY 2011.
- **Performance Measures:** Performance of each AO in key focus areas for FYs 2010 and 2011.
- **Review of Accreditation Programs:** Information on the initial CMS approval and most recent approval for each AO accreditation program.

Overview: Medicare Accreditation Survey Activity

The AO is responsible for evaluating a facility through an on-site survey to determine whether the facility complies with the health care quality and patient safety standards required by the Medicare conditions. The AO may award accreditation from a CMS-approved accreditation program for up to three years. The evaluation performed by the AO includes, but is not limited to: observation and review of the care processes in the facility, the physical environment, administrative and patient medical records, and staff qualifications. Table 4 presents a summary of the number of deemed facilities by AO in FY 2011, as well as the number of initial and renewal surveys completed during the same year, as reported by the AOs. An initial survey indicates a facility which is being reviewed by this AO for the first time (either a facility which is seeking new Medicare certification or changing from oversight by a SA or another AO).

All AOs experienced growth in the number of deemed facilities between FYs 2008 and 2011, largely due to increases in the numbers of HHA, hospice and ASC facilities. As described in Section 2, this reflects the national growth in

these Medicare-participating facilities and CMS priorities for SA workload, which resulted in facilities obtaining initial Medicare certification based upon accreditation by a CMS-recognized AO accreditation program.

Overview: Performance Measures

A major focus of CMS' work with each AO has been and continues to be the AO's ability to provide CMS with complete, timely, and accurate information regarding deemed facilities, as required at 42 CFR 488.4. It is important for the AO, the facility, and CMS to know a facility's current Medicare accreditation status in order to accurately identify on an ongoing basis which facilities are deemed and therefore subject to AO oversight. Additionally, when an AO makes an adverse accreditation decision based on the facility's failure to satisfy the AO's health and safety standards, it is imperative that CMS be notified promptly in order to take appropriate follow-up enforcement action. It is also essential for CMS to have information concerning upcoming AO survey schedules, in order to implement its validation program for AO surveys.

Methods employed to facilitate obtaining timely, accurate, and complete information from AOs, include:

- The Accrediting Organization System for Storing User Recorded Experiences (ASSURE) beginning in October 2009. This electronic Medicare accreditation data base facilitates timely, accurate, and complete AO quarterly reporting on their Medicare accreditation program activities. The ASSURE application provides a means to collect, analyze, and manage data

Table 4:

NUMBER OF DEEMED FACILITIES, INITIAL, AND RENEWAL SURVEYS FOR EACH ACCREDITATION ORGANIZATION BY PROGRAM TYPE (FY 2011)

PROGRAMS	ACCREDITATION ORGANIZATION	TOTAL DEEMED FACILITIES	INITIAL SURVEYS	RENEWAL SURVEYS
Hospital	AOA/HFAP	185	14	74
	DNVHC	176	63	4
	JC	3,410	36	1,143
Critical Access Hospital	AOA/HFAP	32	3	7
	DNVHC	26	26	0*
	JC	370	8	101
Home Health Agency	ACHC	615	185	128
	CHAP	1,768	353	285
	JC	1,734	318	326
Hospice	ACHC	42	35	0*
	CHAP	546	82	79
	JC	326	67	77
Ambulatory Surgery Center	AAAHC	876	127	241
	AAAASF	120	40	22
	AOA/HFAP	25	4	7
	JC	350	77	80
OPT	AAAASF	13	13	0*
Psychiatric Hospital	JC	388	3	51**
TOTAL		11,002	1,454	2,625

Source: As reported by AOs.

* The DNVHC CAH, ACHC hospice, and AAAASF OPT accreditation programs received recent initial approval; therefore, no renewal surveys were due in FY 2011.

**The JC psychiatric hospital accreditation program was recently approved. The time-frame for renewal surveys was determined jointly by CMS and JC based on a number of factors, including: existing hospital accreditations; most recent survey of the Special Psychiatric Hospital conditions; and, facility compliance history. Effective July 2011, the Joint Commission assumed full responsibility for oversight of their psychiatric hospitals and has been conducting integrated surveys of these facilities. These integrated surveys include evaluation of compliance with all Medicare psychiatric hospital conditions, including both the hospital and special psychiatric hospital conditions.

regarding the facilities accredited by the AOs. Work is underway to move this application from a desk top to a web based application;

- Dedicated electronic mailboxes for AOs to submit to CMS copies of AO notification letters to facilities concerning their accreditation status;
- Monthly submission of AO survey schedules to CMS;
- CMS-developed template AO notification letters to facilitate AO communication to CMS of all essential elements regarding a facility's Medicare accreditation status; and
- Comparative analysis and feedback to AOs on the accuracy and completeness of their notification letters and deemed facility data contained in ASSURE, including whether the facilities in ASSURE could be matched to certified facilities in CMS' national Medicare certification data base, and whether the data is consistent with information provided in the notification letters.

AO performance measures related to the above activities were implemented in FY 2009 (October 2008) and subsequently modified annually. The FY 2011 performance measures are presented in Table 5.

Each measure is scored on a quarterly basis. For survey schedule measures, the quarterly score is calculated based on monthly scores. Measures are scored as a percentage of correct submissions for a specific month/quarter. Table 6 presents the performance data for FYs 2010 (October 2009-September 2010) and 2011 (October 2010-September 2011). This is somewhat different from the approach used for the FY 2011 annual report to Congress, where the quarters from different fiscal years were combined to allow comparisons.

AO performance on most measures has shown considerable improvement since performance measurement was initiated in FY 2009. Most or

Table 5:
PERFORMANCE MEASURES

ASSURE DATA BASE
AOs are required to use the ASSURE electronic data base to submit a record of AO accreditation and enforcement activity.

- **Timeliness** of ASSURE export file submission
- **Accuracy and Completeness** of ASSURE export file
- **Deemed Facility Data** used to populate ASSURE is accurate and in last quarter of FY 2011 whether CMS discrepancies are addressed
- **Timely Triennial Surveys** are conducted

FACILITY NOTIFICATION LETTERS
AOs are required to electronically submit facility notification letters to CMS for all accreditation actions in CMS-approved programs.

- **Electronic** mailbox used for submission of letters for all programs on an ongoing basis
- **Updating** ASSURE facility list with information consistent with facility notification letters
- **Accuracy and Completeness** of letters submitted including: contain all information requested by CMS, effective dates of actions taken and follow-up actions, and no CMS follow-up required to clarify information

SURVEY SCHEDULE
AOs are required to submit a monthly schedule which documents surveys completed in the past month as well as planned surveys for the next two months.

- **Timeliness** of monthly survey schedule report submission
- **Formatting** used for the survey schedule report
- **Accuracy and Completeness** of survey schedule report including: schedule for current month, one prospective month and one past month; reporting changes in the survey schedule; inclusion of all CMS-approved accreditation programs and exclusion of information for non-deemed providers/suppliers; no instances of arrival of the SA to conduct a validation survey and being informed that the accreditation survey had not been conducted as indicated on the survey schedule; whether the survey schedules changes are submitted on an ongoing basis and included in next survey schedule submission; and agreement between number of surveys reported for the month and completed surveys in ASSURE

all AOs scored at the 100 percent level in both FYs 2010 and 2011 for several ASSURE measures (timeliness and accuracy), electronic submission of facility notification letters, and two survey schedule measures (timeliness and formatting). When comparing the FYs 2010 and 2011 scores for all AOs, improvement is particularly evident for the ASSURE measure for timely triennial surveys (from 90 percent to 98 percent), updating ASSURE consistent with facility notification letters (from 52 percent to 76 percent), and the accuracy of facility notification letters (from 83 to 91 percent). However, there continue to be opportunities for improvement on several measures, including updating ASSURE consistent with facility notification letters, which is the only measure below 90 percent.

Lower scores in FY 2011 as compared to FY 2010 are sometimes due to a decline in performance during one quarter or for only one component of the measure. For the last quarter of FY 2011, CMS added a component (correcting discrepancies found by CMS) to the ASSURE measure for deemed facility data. Some AOs did not score well on this new measure and, as a result, their FY 2011 overall deemed facility data average score was reduced. Several AOs had lower scores in FY 2011 for the timeliness of survey schedule submissions. Further, all AOs have lower scores on one component of the accuracy of survey schedule submission measure, i.e. matching the number of surveys they report having conducted to the survey data they report in ASSURE. Other components of the survey schedule accuracy measure are at 100 percent. CMS continues to work closely with AOs to improve performance in these areas as well as maintain high levels of performance in other areas. The goal is for all AOs to consistently score at or near 100 percent on all measures so that AOs can effectively manage their own operations in these areas.

Table 6:
PERFORMANCE MEASURE RESULTS (PERCENTAGE) BY AO (FYs 2010 AND 2011)

	AAAHC		ACHC		AAAASF		AOA/HFAP		CHAP		DNVHC		JC		All AOs	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
ASSURE Data Base																
Timeliness	100	100	100	100	100	100	100	100	100	100	100	100	75	100	96	100
Accuracy	100	100	100	100	100	100	100	83	100	100	100	100	100	100	100	98
Deemed Facility Data	95	98	88	82	93	94	100	95	95	99	98	99	93	86	95	93
Timely Triennial Surveys	93	100	99	99	87	100	79	91	97	100	NA	100	88	100	91	99
Facility Notification Letters																
Electronic	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Updating	55	93	40	70	50	47	20	57	55	87	94	100	47	78	52	76
Accuracy	60	94	65	93	93	83	80	100	89	90	98	100	94	77	83	91
Survey Schedules																
Timeliness	100	100	100	100	100	92	92	66	100	100	100	100	92	100	98	94
Formatting	100	100	100	100	75	100	100	100	100	100	100	100	100	100	96	100
Accuracy	*	99	*	98	*	95	*	82	*	99	*	96	*	96	*	95

NA: Since DNVHC received recent approval for its accreditation program, no triennial surveys were due in FY 2010.

* FY 2010 scores for Survey Schedule Accuracy are not included since the calculation method was changed in FY 2011.

In the following discussion for each AO, the definitions used to describe AO performance are as follows: "performed well" means a 100 percent score; "substantial improvement" means improved by at least nine percent in FY 2011 compared to the previous year; opportunity for improvement" means any score below 90 percent in FY 2011 and "lower score" means a decrease of at least nine percent in FY 2011 compared to FY 2010.

Individual Accreditation Organization Summaries

1. Accreditation Association for Ambulatory Health Care (AAAHC)

Accreditation Activity (Table 4): AAAHC has a CMS-approved accreditation program for ASCs and was responsible for 876 deemed facilities in FY 2011. During that year, AAAHC reported completing a total of 368 surveys. Of these, 127 (35 percent) were initial surveys and 241 (65 percent) were re-accreditation surveys.

AAAHC recommended full accreditation for 92 percent of the 368 ASCs surveyed in FY 2011.

Accreditation Decisions	ASCs (percentage)
Total ASCs Surveys	368
Full Accreditation	339 (92)
Denial	16 (4)
Pending	13 (4)

Performance Measures (Table 6): In FYs 2010 and 2011, AAAHC performed well on two measures related to ASSURE data base submission (timeliness and accuracy), electronic submission of facility notification letters and some survey schedule measures (timeliness and formatting). In FY 2011, AAAHC also achieved a 100 percent score for timely triennial surveys. In comparison to last year's annual report, AAAHC has achieved substantial improvement for two facility notification letter measures (updating ASSURE and accuracy). In summary, the AO scored at the 100 percent level for six out of ten measures in FY 2011.

Approval of Accreditation Programs: AAAHC initially received CMS recognition as a national AO for ASCs December 19, 1996. Most recently, AAAHC received approval of a four-year renewal term, effective December 20, 2008 through December 20, 2012. The final notice announcing this decision was published in the *Federal Register* on November 14, 2008, and can be accessed at http://edocket.access.gpo.gov/2008/pdf/E8-27122.pdf.

2. Accreditation Commission for Health Care (ACHC)

Accreditation Activity (Table 4): ACHC has CMS-approved accreditation programs for HHAs and hospices. In FY 2011, ACHC had responsibility for 615 deemed HHAs and for 42 hospices. ACHC reported completing a total of 313 surveys for HHAs, with 185 (59 percent) initial and 128 (41 percent) re-accreditation surveys. For the hospice program, ACHC completed 35 surveys in FY 2011; all of these were initial surveys.

ACHC awarded full accreditation for 80 percent of the 313 HHAs surveyed in FY 2011. Full accreditation was awarded to 74 percent of the 35 hospice facilities surveyed in the same year.

Accreditation Decisions	HHAs (percentage)	Hospices (percentage)
Total Surveys	313	35
Full Accreditation	249 (80)	26 (74)
Denial	61 (19)	8 (23)
Pending	3 (1)	1 (3)

Performance Measures (Table 6): For both FYs 2010 and 2011, ACHC performed well on measures related to the ASSURE data base (timeliness and accuracy), electronic submission of facility notification letters and some survey schedule submission measures (timeliness and formatting). In comparison to FY 2010, ACHC has achieved substantial improvement in several facility notification letters measures (updating ASSURE and accuracy). Additional opportunities for improvement exist for the ASSURE measures for deemed facility data and updating ASSURE for facility notification letters. The lower performance on the ASSURE measure for deemed facility data was due to the low score on the new component of that measure (correcting for discrepancies found by CMS). In summary, the AO scored at the 100 percent level for five out of ten measures in FY 2011.

Approval of Accreditation Programs:

HOME HEALTH AGENCY

ACHC initially received recognition as a national AO for HHAs February 24, 2006. Most recently, ACHC received a six-year renewal term, effective February 24, 2009 through February 24, 2015. The final notice announcing this decision was published in the *Federal Register* on January 23, 2009, and can be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-684.pdf.

On December 20, 2010, senior leadership from ACHC met with CMS staff to disclose serious and pervasive issues discovered during the course of a comprehensive internal audit of its entire CMS-approved HHA accreditation program. As a result of ACHC's self- identified failures, CMS opened a deeming review of ACHC's HHA accreditation program in early February 2011. ACHC was provided 180 days to implement corrective actions and resolve identified issues. CMS conducted a follow-up corporate onsite visit in July 2011 to validate correction of identified issues and ensure comparability with CMS requirements. Although ACHC had made considerable improvements in several areas, more time was necessary for ACHC to provide CMS with reasonable assurance that its revised policies, procedures and program wide changes are fully implemented and sustainable over time.

In accordance with the regulations at § 488.8(f)(2)(i), *"if CMS determines, following the deeming authority review, that the accreditation organization has failed to adopt requirements comparable to CMS's or submit new requirements timely, the accreditation organization may be given conditional approval of its deeming authority during a probationary period of up to one year."*

Based on this regulatory authority, CMS provided ACHC one year to correct identified areas of noncompliance and adopt comparable requirements. To confirm compliance, CMS will conduct a corporate onsite visit after the probationary year. Within 60 days following the end of the probationary period, CMS will make a final determination as to whether or not ACHC's HHA accreditation program is comparable to the CMS requirements. The follow-up corporate onsite visit will be conducted during fall 2012. As a result of that visit, CMS will make a final determination regarding the status of this program.

HOSPICE

ACHC submitted an application for initial certification as a hospice program and was awarded a four-year term effective November 27, 2009 through November 27, 2013. The notice appeared in the *Federal Register* on November 27, 2009, and may be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-28010.pdf.

3. American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

Accreditation Activity (Table 4): AAAASF has CMS-approved accreditation programs for ASCs, OPTs, and RHCs. The RHC program was approved in FY 2012. AAAASF was responsible for 120 deemed ASCs in FY 2011 and performed a total of 62 surveys in that year. Of these, 40 (65 percent) were initial surveys and 22 (35 percent) were re-accreditation surveys. During the initial year of operation, the AAAASF OPT program was responsible for 13 deemed facilities based on 13 surveys.

In FY 2011, AAAASF awarded full accreditation to 84 percent of the 62 ASCs surveyed and 100 percent of the 13 OPTs surveyed.

Accreditation Decisions	HHAs (percentage)	Hospices (percentage)
Total Surveys	62	13
Full Accreditation	52 (84)	13 (100)
Denial	7 (11)	0
Pending	3 (5)	0

Performance Measures (Table 6): For both FYs 2010 and 2011, AAAASF performed well on some ASSURE measures (timeliness, accuracy) and electronic submission of facility notification letters. In addition, the AAAASF achieved 100 percent scores in FY 2011 on timely triennial surveys and formatting survey schedules, a substantial improvement over FY 2010. Scores for several measures were lower in FY 2011 than FY 2010. Opportunities for improvement remain for several facility notification letter measures (updating ASSURE and accuracy). In summary, the AO reached the 100 percent performance level for five out of ten measures in FY 2011.

Approval of Accreditation Programs:

AMBULATORY SURGERY CENTER

AAAASF initially received recognition as a national AO for ASCs on December 2, 1998. AAAASF submitted a renewal application in March 2009. CMS reviewed that application and awarded a three-year conditional approval with a 180-day probationary period. The final notice appeared in the *Federal Register* on November 27, 2009, and may be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-28048.pdf. AAAASF made the necessary revisions to its program and successfully implemented new requirements to ensure AAAASF's accreditation program for ASCs meets or exceeds the Medicare requirements. On August 20, 2010, CMS

published its decision in the *Federal Register* to approve AAAASF's ASC program without condition. This final notice of approval is effective November 27, 2009 through November 27, 2012, and can be accessed at http://edocket.access.gpo.gov/2010/pdf/2010-19888.pdf.

OUTPATIENT PHYSICAL THERAPY AND SPEECH-LANGUAGE SERVICES

AAAASF's OPT accreditation program was granted initial approval with a four-year term effective April 22, 2011 through April 22, 2015. The final notice appeared in the *Federal Register* on April 22, 2011, and may be accessed at http://edocket.access.gpo.gov/2011/pdf/2011-9176.pdf.

RURAL HEALTH CLINIC

AAAASF submitted an application for a RHC accreditation program which was granted approval with a four-year term effective May 23, 2012 to May 23, 2016. The final notice appeared in the *Federal Register* on May 23, 2012 and may be accessed at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6331.pdf.

4. American Osteopathic Association/Healthcare Facilities Accreditation Program (AOA/HFAP)

Accreditation Activities (Table 4): AOA/HFAP has CMS-approved accreditation programs for hospitals, CAHs and ASCs. In FY 2011, AOA/HFAP was responsible for the following deemed facilities: 185 hospitals, 32 CAHs, and 25 ASCs. During that year, AOA/HFAP performed:

- 88 hospital surveys including 14 (16 percent) initial and 74 (84 percent) re-accreditation surveys;
- 10 surveys for CAHs including 3 (30 percent) initial and 7 (70 percent) re-accreditation surveys; and
- 11 surveys for ASCs including 4 (36 percent) initial and 7 (64 percent) re-accreditation surveys.

AOA/HFAP awarded full accreditation for 98 percent of the 88 hospitals surveyed, 100 percent of the 10 CAHs reviewed and 100 percent of the 11 ASCs reviewed.

Accreditation Decisions	Hospitals (percentage)	CAHs (percentage)	ASCs (percentage)
Total Surveys	88	10	11
Full Accreditation	86 (98)	10 (100)	11 (100)
Denial	0	0	0
Full Accreditation	2 (2)	0	0

Performance Measures (Table 6): During FYs 2010 and 2011, AOA/HFAP performs well on the ASSURE measures for timeliness, electronic submission of facility notification letters, and formatting survey schedule submissions. In comparison to FY 2010, AOA/HFAP achieved substantial improvement for timely triennial surveys, two facility notification letter measures (updating ASSURE and accuracy) reaching the 100 percent level of performance on this last measure. Several scores were lower in FY 2011 as compared to FY 2010. Opportunities for improvement exist for accuracy of ASSURE submissions, updating ASSURE for facility notification letters, and two survey schedule submission measures (timeliness and accuracy). In summary, the AO reached the 100 percent performance level for four out of ten measures in FY 2011.

Approval of Accreditation Programs:

HOSPITAL

AOA/HFAP has had an approved hospital accreditation program since 1965. Although its hospital program is mentioned by name in the Act, it is also explicitly subject to the Secretary's review and approval. Most recently, AOA/HFAP received a four-year renewal term, effective September 25, 2009 through September 25, 2013. The final notice announcing this decision was published in the *Federal Register* on August 28, 2009, and can be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-20203.pdf.

To verify AOA/HFAP's continued compliance with the provisions of this final notice, CMS conducted a follow-up corporate onsite visit in August 2010, and found that problems previously identified remained uncorrected. Subsequently, CMS opened a deeming review of AOA/HFAP's CMS-approved hospital accreditation program in October 2010 for this and other reasons. AOA/HFAP was provided 180 days to implement corrective actions and resolve identified issues. CMS conducted another corporate onsite visit in May 2011 to validate correction of identified issues and ensure comparability with CMS requirements. Although AOA/HFAP had made improvements in several areas, more time was necessary to provide CMS with reasonable assurance that AOA/HFAP's revised policies, procedures and program-wide changes are fully implemented and sustainable over time.

In accordance with the regulations at § 488.8(f)(2)(i), "*if CMS determines, following the deeming authority review, that the*

accreditation organization has failed to adopt requirements comparable to CMS's or submit new requirements timely, the accreditation organization may be given conditional approval of its deeming authority during a probationary period of up to one year."

Based on this regulatory authority, CMS provided AOA/HFAP one year to correct identified areas of noncompliance and adopt comparable requirements. CMS conducted a follow-up corporate onsite visit within 60 days of the end of the probationary year to confirm compliance. CMS completed its review and conducted the follow-up corporate onsite visit June 2012 and determined that AOA/HFAP had fully addressed and resolved the concerns. AOA/HFAP's hospital accreditation program meets or exceeds the Medicare requirements.

CRITICAL ACCESS HOSPITAL

AOA/HFAP first received CMS approval of its CAH accreditation program on December 27, 2001. More recently, AOA/HFAP received approval for a six-year renewal term, effective December 28, 2007 through December 28, 2013. The final notice *announcing this approval was published in the Federal Register* on November 23, 2007, and can be accessed at http://edocket.access.gpo.gov/2007/pdf/E7-22628.pdf.

AMBULATORY SURGERY CENTER

AOA/HFAP received initial recognition by CMS as a national AO for ASCs on January 30, 2003. More recently, AOA/HFAP received approval for renewal of its ASC deeming program effective October 23, 2009 through October 23, 2013. The final notice announcing this approval was published in the *Federal Register* on September 25, 2009, and can be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-22956.pdf.

To verify AOA/HFAP's continued compliance with the provisions of this final notice, CMS conducted a follow-up corporate onsite visit in August 2010 and found that problems previously identified remained uncorrected. Subsequently, CMS opened a deeming review of AOA/HFAP's CMS-approved ASC accreditation program for this and other reasons. AOA/HFAP was provided 180 days to implement corrective actions and resolve identified issues. CMS conducted a corporate onsite visit in May 2011, to validate correction of identified issues and ensure comparability with CMS requirements. Although AOA/HFAP had made improvements in several areas, more time was necessary to provide CMS with reasonable assurance that AOA/HFAP's revised policies, procedures and program wide changes are fully implemented and sustainable over time.

In accordance with the regulations at § 488.8(f)(2)(i), *"if CMS determines, following the deeming authority review, that the accreditation organization has failed to adopt requirements comparable to CMS's or submit new requirements timely, the accreditation organization may be given conditional approval of its deeming authority during a probationary period of up to one year."*

Based on this regulatory authority, CMS provided AOA/HFAP one year to correct identified areas of noncompliance and adopt comparable requirements. CMS conducted a follow-up corporate onsite visit within 60 days of the end of the probationary year to confirm compliance. CMS completed its review and conducted the follow-up corporate onsite visit June 2012 and determined that AOA/HFAP had fully addressed and resolved the concerns. AOA/HFAP's ASC accreditation program meets or exceeds the Medicare requirements.

5. Community Health Accreditation Program (CHAP)

Accreditation Activity (Table 4): CHAP has CMS-approved accreditation programs for HHAs and hospices. In FY 2011, CHAP was responsible for 1,768 deemed HHAs and 546 hospices. In the same year, CHAP conducted a total of 638 HHA surveys. Of these, 353 (55 percent) were initial surveys and 285 (45 percent) were re-accreditation surveys. In FY 2011, CHAP conducted a total of 161 hospice surveys. Of these, 82 (51 percent) were initial and 79 (49 percent) were re-accreditation surveys.

CHAP awarded accreditation for 98 percent of the 638 HHAs and 99 percent of the 161 hospices surveyed.

Accreditation Decisions	HHAs (percentage)	Hospices (percentage)
Total Surveys	638	161
Full Accreditation	623 (98)	159 (99)
Denial	1 (0)	0
Pending	14 (2)	2 (1)

Performance Measures (Table 6): For FYs 2010 and 2011, CHAP performed well on several ASSURE measures (timeliness and accuracy), electronic submission of facility notification letters, and several survey schedule measures (timeliness and formatting). During FY 2011, performance on timely triennial surveys also improves to the 100 percent level. There was substantial improvement for the accuracy of survey schedule submissions and updating ASSURE for facility notification letters; however, this last measure still provides opportunities for improvement. In summary, the AO reached the 100 percent performance level for six out of ten measures.

Approval of Accreditation Programs:

HOME HEALTH AGENCY

CHAP initially received CMS recognition as a national AO for HHAs on August 27, 1992. Most recently, CHAP received a six-year renewal term, effective March 31, 2012 through March 31, 2018. The final notice announcing this decision was published in the *Federal Register* on March 23, 2012 and can be accessed at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6598.pdf.

HOSPICE

CHAP received initial recognition from CMS as a national AO for hospices April 20, 1999. More recently, CHAP submitted a renewal application for the hospice program in April 2009. CMS reviewed that application and awarded a three-year conditional approval with a 180-day probationary period. The final notice appeared in the *Federal Register* on October 23, 2009, and may be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-25072.pdf. During the 180-day probationary period, CHAP made the necessary revisions to its program and successfully implemented new requirements to ensure CHAP's accreditation program for hospices meets or exceeds the Medicare requirements. On July 16, 2010, CMS published the decision to approve CHAP's hospice program without condition. This final notice of approval is effective November 20, 2009 through November 20, 2012, and can be accessed at http://edocket.access.gpo.gov/2010/pdf/2010-17405.pdf.

6. Det Norske Veritas Health Care (DNVHC)

Accreditation Activities (Table 4): DNVHC received initial recognition as a national AO for its hospital accreditation program in FY 2008 and initial approval for its CAH program in FY 2011. The hospital program was responsible for 176 deemed hospitals in FY 2011. DNVHC conducted 63 (94 percent) initial surveys and 4 (six percent) renewal surveys. During its initial year of operation, the DNVHC CAH accreditation was responsible for 26 deemed facilities based on 26 initial surveys.

DNVHC awarded full accreditation to 99 percent of the 67 hospitals surveyed and 100 percent of the 26 CAHs surveyed.

Accreditation Decisions	Hospitals (percentage)	CAHs (percentage)
Total Surveys	67	26
Full Accreditation	66 (99)	26 (100)
Denial	0	0
Pending	1 (1)	0

Performance Measures (Table 6): For FYs 2010 and 2011, DNVHC performed well on several ASSURE measures (timeliness and accuracy), electronic submission of facility notification letters and several survey schedule submissions (timeliness and formatting). Performance also reaches the 100 percent level in FY 2011 for timely triennial surveys and two facility notification letters measures (updating assure and accuracy). In summary, DNVHC scores at the 100 percent level for eight out of ten measures in FY 2011.

Approval of Accreditation Programs:

HOSPITAL

DNVHC received initial recognition by CMS as a national AO for hospitals on September 29, 2008. A four-year term of approval was awarded, effective September 26, 2008 through September 26, 2012. More recently, CMS published the decision to approve the DNVHC's hospital program in the *Federal Register* on August 24, 2012. The final notice of approval is effective September 26, 2012 through September 26, 2018.

CRITICAL ACCESS HOSPITAL

DNV received initial approval for its CAH program for a four-year term effective December 23, 2010 through December 23, 2014. The final notice appeared in the *Federal Register* on November 15, 2010, and can be accessed at http://edocket.access.gpo.gov/2010/pdf/2010-28666.pdf.

7. The Joint Commission (JC)

Accreditation Activities (Table 4): The JC has CMS-approved accreditation programs for hospitals, psychiatric hospitals, CAHs, HHAs, hospices and ASCs. During FY 2011, the JC was responsible for 3,410 hospitals, 388 psychiatric hospitals, 370 CAHs, 1,734 HHAs, 326 hospices and 350 ASCs. During FY 2011, the JC performed:

- 1,179 hospital surveys with 36 (3 percent) initial and 1,143 (97 percent) re-accreditation surveys;
- 109 CAH surveys with 8 (7 percent) initial and 101 (93 percent) re-accreditation surveys;
- 644 HHA surveys with 318 (49 percent) initial and 326 (51 percent) re-accreditation surveys;
- 144 surveys for hospice with 67 (47 percent) initial and 77 (53 percent) re-accreditation surveys;
- 157 surveys for ASCs with 77 (49 percent) initial and 80 (51 percent) re-accreditation surveys; and
- 54 surveys for psychiatric hospitals with 3 (six percent) and 51 (94 percent) re-accreditation surveys.

The JC accreditation decisions for FY 2011 were as follows:

- 1,179 hospital surveys with 82 percent receiving full accreditation;
- 109 CAH surveys with 81 percent receiving full accreditation;
- 644 HHA surveys with 88 percent approved for full accreditation;
- 144 hospice surveys with 87 percent awarded full accreditation;
- 157 ASC surveys with 94 percent awarded full accreditation: and
- 54 psychiatric hospital surveys with 94 percent resulting in full accreditation.

Performance Measures (Table 6): For FYs 2010 and 2011, the JC performed well on measures for the accuracy of ASSURE submissions, electronic submission of facility notification letters and formatting survey schedules. In FY 2011, the JC achieved substantial improvement for the timeliness of ASSURE submissions, timely triennial surveys and timeliness of surveys schedule submissions reaching 100 percent performance for these measures. The JC also made substantial improvement for updating ASSURE for facility notification letters where there is still opportunity for improvement. There were lower scores in FY 2011 for the accuracy of facility notification letters which represent improvement opportunities. In summary, the AO achieved 100 percent performance on six out of ten measures in FY 2011.

Approval of Accreditation Programs:

HOSPITAL

The JC initially received CMS approval as a national AO for hospitals effective July 15, 2010 through July 15, 2014. Prior to July 15, 2010, the JC's hospital accreditation program had statutory status and did not require CMS-approval. The notice of approval appeared in the *Federal Register* on November 27, 2009, and may be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-27973.pdf. To insure compliance with provisions of that notice, CMS conducted a follow-up onsite visit and survey observation in September 2010. Results of this follow-up visit demonstrated that the JC has adopted and implemented requirements comparable to CMS requirements.

PSYCHIATRIC HOSPITAL

The JC received initial approval of its psychiatric hospital accreditation program for a four-year period effective February 25, 2011 through February 25, 2015. The final notice appeared in the *Federal Register* on February 25, 2011, and may be accessed at http://edocket.access.gpo.gov/2011/pdf/2011-4294.pdf.

CRITICAL ACCESS HOSPITAL

The JC first received CMS recognition as a national AO for CAHs November 21, 2002. More recently, CMS published the decision to approve the JC's CAH program in the *Federal Register* on September 23, 2011. The final notice of approval was effective on November 21, 2011 through November 21, 2017, and can be accessed at http://www.gpo.gov/fdsys/pkg/FR-2011-09-23/pdf/2011-24496.pdf.

HOME HEALTH AGENCY

The JC initially received CMS recognition as a national AO for HHAs September 28, 1993. More recently, the JC received a six-year renewal effective March 31, 2008 through March 31, 2014. The final notice announcing this decision was published in the *Federal Register* on March 28, 2008, and can be accessed at http://edocket.access.gpo.gov/2008/pdf/E8-5074.pdf.

HOSPICE

The JC initially received CMS recognition as a national AO for hospices on June 18, 1999. More recently, the JC received a six-year renewal effective June 18, 2009 through June 18, 2015. The final notice announcing this decision was published in the *Federal Register* on March 27,

2009, and can be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-6775.pdf.

AMBULATORY SURGERY CENTER

The JC initially received CMS recognition as a national AO for ASCs on December 19, 1996. More recently, the JC received a six-year renewal effective December 20, 2008 through December 20, 2014. The final notice announcing this decision was published in the *Federal Register* on November 14, 2008, and can be accessed at http://edocket.access.gpo.gov/2008/pdf/E8-27120.pdf.

Section 5: Accreditation Representative Sample Validation Program

Section 1865(d) of the Act permits validation surveys of all provider and supplier types that may be deemed for Medicare participation under Section 1865(a) of the Act. Section 1864 of the Act authorizes the SAs to conduct validation surveys on behalf of CMS in accredited facilities participating in Medicare, as a means of validating the AOs' accreditation processes. The Accreditation Validation Program is a significant component of CMS' oversight of AOs and consists of two types of validation surveys: (1) substantial allegation surveys, i.e., focused surveys based on complaints which, if substantiated, would suggest serious noncompliance with Medicare conditions; and, (2) full surveys of a representative sample of deemed facilities. Representative sample validation surveys generally must be completed by the SA no more than 60 days after an AO survey of the same facility. This section discusses both the methodology and the results for the CMS validation of the AOs' Medicare accreditation programs through the 60-day validation surveys. In some cases, representative sample mid-cycle validation surveys may be conducted independent of a preceding AO survey. During FY 2011, SAs conducted mid-cycle validation surveys for a sample of Long Term Care Hospitals (LTCHs) to further explore the quality of care provided by these facilities. The results of these validation surveys will be discussed separately in Section 6. The purpose of 60-day validation surveys is to assess the AO's ability to ensure compliance with Medicare conditions. These validation surveys are onsite full surveys completed by SA surveyors no later than 60 days after the end date of an AO's full accreditation survey. The SA performs the survey without any knowledge of the findings of the AO's accreditation survey.

CMS validation analysis presented in this section compares the condition-level deficiencies (i.e., serious deficiencies) cited by the SA with the deficiencies cited by the AO on its accreditation survey. The goal is to determine whether the AOs are able to accurately identify serious problems in a facility. The premise of the analysis is that condition-level deficiencies cited by the SA during the 60-day validation survey would also have been present 60 days prior, during the AO's accreditation survey and should also have been cited by the AO.

Methodology: Sample Selection Process and Issues

CMS has increased the number of validation surveys conducted in the last several years. Until recently, Federal budget constraints have placed significant limits on the CMS representative sample validation program. Graph 3 presents the number of representative sample validation surveys performed by SAs over the past 14 years. The largest number of 60-day validation surveys was conducted in 1999, when 235 60-day validation surveys were conducted for the JC hospital program. In FY 2007, CMS began conducting 60-day representative sample validation surveys for non-hospital facilities (i.e., CAHs, HHAs, and ASCs) in addition to the hospital validation surveys. Hospice 60-day validation surveys were added in FY 2010.

In recent years, more Federal resources have been made available for validation surveys. As a result, the total number of validation surveys conducted has increased; however, validation surveys are now spread across multiple facility types and AOs. (Prior to FY 2009, Section 1875 of the Act required CMS to report annually to Congress only on the JC's hospital program.) Nevertheless, the validation program has expanded significantly since FY 2007, with a 221 percent increase in the overall number of validation surveys conducted, from 90 in FY 2007 to 289 in FY 2011, including both 60-day validation surveys and special, mid-cycle LTCH validations. During the same time period, the number of non-hospital validation surveys conducted increased by 423 percent, from 35 surveys in FY 2007 to 183 surveys in FY 2011. The number of hospital validation surveys conducted increased by 93 percent, from 55 surveys in FY 2007 to 106 surveys in FY 2011 including 73 60-day validation surveys and 33 mid-cycle LTCH surveys. However, the hospital component of the 60-day validation program still remains less than a third if the 1999 level.

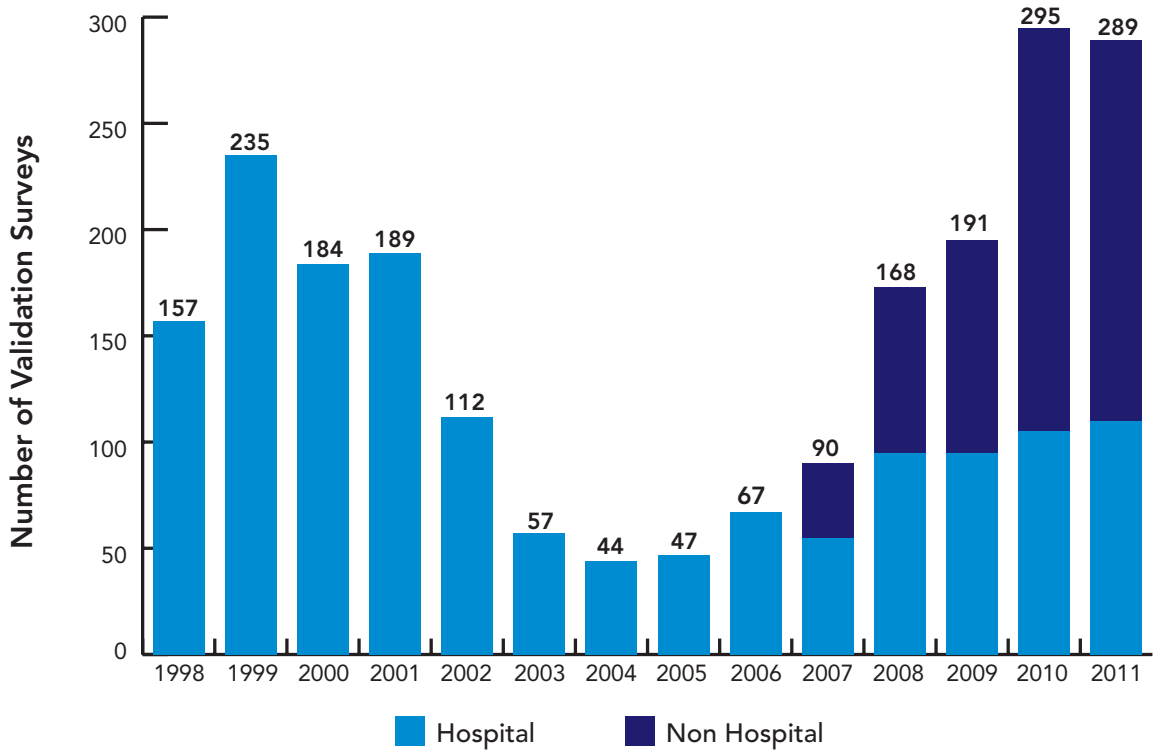
In FYs 2007 through 2010, CMS selected a representative sample of facilities within each of the following categories: hospitals, CAHs, HHAs, and ASCs for 60-day validation surveys. In FY 2010, CMS added hospices in the 60-day validation surveys but all ASC validation surveys were mid-cycle surveys, as previously noted. In FY 2011, CMS selected a representative sample of hospitals, CAHs, HHAs, hospices and ASCs for 60-day surveys and a sample of LTCHs were selected to receive mid-cycle surveys. CMS determines the number of validation surveys to perform for each AO based on the number of facilities the AO surveys each month, as well as the overall budgeted targets, by state and facility type, for validation surveys. CMS then attempts to build a representative national sample for individual accreditation programs. The validation sample is driven by a number of factors, including the total number of accreditation surveys conducted by the AO and reported on the monthly survey schedules furnished to CMS, the accuracy of those schedules, and individual State validation survey volume targets.

Figure 1 provides the calculation for the proportion of 60-day validation surveys completed for deemed facilities. The proportions of deemed facilities receiving a 60-day validation survey during FYs 2008 through 2011 are as follows:

- **Hospitals:** Two percent of deemed hospitals received a validation survey in FY 2011. A total of nine percent of deemed hospitals received a validation survey over the four-year FY 2008 through FY 2011 period.
- **CAHs:** Five percent of CAHs received a validation survey in FY 2011. A total of 21 percent of the deemed CAHs received a validation survey over the four-year period.
- **HHAs:** Two percent of deemed HHAs received a survey in FY 2011 for a total of eight percent over the FY 2008 through FY 2011 period.
- **Hospices:** Three percent of deemed hospices received a validation survey in FY 2011. This was the second year in which hospices had been included in the validation program. Five percent of hospices received a validation survey during FYs 2010 and 2011.

Graph 3:

NUMBER OF REPRESENTATIVE SAMPLE VALIDATION SURVEYS FOR BOTH HOSPITAL AND NON-HOSPITAL FACILITIES (FY 1998-2011)*



*Includes 33 mid-cycle LTCH validation surveys in FY 2011 and 72 mid-cycle ACS validation surveys in FY 2010.

Figure 1:
PROPORTION OF DEEMED FACILITIES RECEIVING VALIDATION SURVEYS

$$\frac{\text{Number of 60-day validation surveys}}{\text{Number of Deemed facilities}} = \text{Proportion of deemed facilities receiving validation surveys}$$

Figure 2:
DISPARITY RATE CALCULATION

$$\frac{\text{Number of AO surveys with missed condition-level deficiency findings}}{\text{Number of 60-day validation surveys*}} = \text{Disparity Rate}$$

* Number of 60-day validation surveys includes those with or without condition-level deficiency findings by the SA.

- **ASCs:** Five percent of deemed ASCs received a survey in FY 2011. Sixty-day validation surveys were not conducted for ASCs during FY 2010; instead all ASC validation surveys were mid-cycle surveys. Eleven percent of deemed ASCs received a 60-day validation survey in the FY 2008 through FY 2011 period.

Validation Analysis Methodology

Each AO received feedback on the results of CMS' analysis of 60-day validation surveys for its deemed facilities conducted during FYs 2007 through 2011. The JC has received feedback on the results of the analysis of 60-day validation surveys conducted for its accredited hospitals since the beginning of the validation program in FY 1998. Tables 7 through 14 and Graph 4 use the following measures to review the survey results:

- **Disparity Rate:** A lower disparity rate indicates better AO performance. The methodology for the disparity rate is set by regulation at 42 CFR 488.1 and presented in Figure 2. The numerator is the number of surveys where the AO did not cite a comparable serious (condition-level) deficiency cited by the SA. The denominator is the number of surveys in the 60-day validation sample. The result is the percentage of 60-day validation surveys where the AO did not cite a comparable serious deficiency cited by the SA. If the AO missed at least one serious deficiency in a third of the 60-day validation surveys, the disparity rate would be 33 percent.
- **Sampling Fraction:** The sampling fraction, illustrated in Figure 3, is the proportion of AO surveys during the FY for which a representative sample 60-day validation survey was completed. For example, the FY 2011 sampling fraction for CHAP's accreditation program for HHAs is five percent, which is the number of FY 2011 surveys (33 validation surveys) divided by the number of HHA surveys CHAP conducted over the same time period (638 surveys). CMS has worked to increase this fraction for each AO and to include a minimum of five 60-day validation surveys per year for each AO program, no matter how small the program.

In summary, the *disparity rate* focuses on the number of 60-day validation surveys where the AO did not cite comparable condition-level deficiencies cited by SAs in relation to the total number of validation surveys completed by the SA. The *sampling fraction* is the proportion of 60-day validation surveys completed by the SA in relation to the number of accreditation surveys completed by the AO.

When the number of 60-day validation surveys completed by the SA is less than five surveys, the disparity rates are not presented. The small 60-day validation sample sizes limited the analysis of some AO programs. However, the results for FYs 2008 through 2010 60-day validation surveys for individual AOs in Tables 8 through 12 have been combined to provide a more robust estimate of the disparity rates. Also, survey results for FY 2011, the most recent validation surveys, are included separately. The presentation of validation results for several time periods allows more opportunity to examine the consistency of individual AO performance. This approach, coupled with the increase in 60-day validation samples over the past several years, has improved the representativeness of the 60-day validation samples for individual AOs. CMS hopes to further expand 60-day validation samples in future years to ensure better estimates of these rates for all AO programs.

Validation Performance Results: All AOs

Table 7 presents the results of the 60-day validation surveys for all AOs during the FYs 2008 through 2011 by facility type. Graph 4 presents the highlights of the validation program results across the four FYs.

Figure 3:
SAMPLING FRACTION CALCULATION

$$\frac{\text{Number of 60-day validation surveys completed by the SA}}{\text{Number of accreditation surveys completed by the AO}} = \text{Sampling Fraction}$$

As shown in Table 7 and Graph 4, with the exception of HHAs for all years and hospices in FY 2011, the disparity rate score for each facility type exceeds the 20 percent threshold established in the regulation for all four FYs. For example, a disparity rate of 44 percent in FY 2011 for hospitals means that the AOs did not cite comparable serious deficiencies as did the SA for almost half of the hospitals surveyed. Similarly, based on disparity rates for FY 2011, the AOs missed comparable serious deficiencies for 45 percent of CAHs and ASCs. The disparity rates for hospitals increased from 33 percent to 44 percent between FYs 2008 and 2011; the disparity rates for HHAs and ASCs are similar over the time period. The disparity rates for CAHs increased between FYs 2008 and 2009, and remained at that higher level in FY 2010 but decreased in FY 2011.

For FY 2011, SAs cited a lower percentage of surveys with condition-level deficiencies in the 60-day validation sample for HHAs (19 percent) as compared to other types of facilities (49 percent of validation sample hospitals, 55 percent of sample CAHs, and 52 percent of sample ASCs). The lower rate of condition-level deficiencies cited in HHAs is consistent across the four FYs presented in Table 7. For hospices, the percentage of condition-level deficiency citations is also low (15 percent) for FY 2011 with similar findings for FY 2010. The higher percentage of condition-level deficiencies is primarily related to the condition for physical environment, which is largely restricted to hospitals, CAHs, and ASCs. There is no physical environment CoP for HHAs, since these services are provided in the patient's home. In addition, a number of hospice services are provided in the patient's home. This finding will be discussed in more detail later in this section.

Validation Performance Results: Individual AOs
Tables 8 through 12 present the results of the 60-day validation surveys for individual AO programs in FYs 2008 through 2011. The FYs 2008 through 2010 results are combined and presented in comparison to FY 2011 validation results. Except for HHAs and hospices, the disparity rates for all AO programs are above the 20 percent threshold for the combined performance for FYs 2008 through 2010 and FY 2011. The regulations at 42 CFR 488.8(d) require that CMS identify any AO with a disparity rate exceeding 20 percent. In cases where the disparity rate for the AO's accreditation program exceeded the 20 percent threshold, CMS notified the AO of the finding.

Results of the 60-day validation surveys raise significant concerns about the effectiveness of certain aspects of the AOs' survey processes. In particular, the data identify difficulty on the part of most AOs in identifying physical environment deficiencies and other aspects of the life safety code (LSC). This finding is reviewed in more detail later in this section with the review of validation performance on specific Medicare conditions.

Below is a more detailed discussion of the results of the 60-day validation surveys by facility type and AO:

- **Hospital:** As shown in Table 8, the hospital disparity rates for each AO were consistently over the twenty percent threshold for the time periods covered; disparity rates were between 34 percent and 80 percent. The disparity rate for all AOs was 36 percent over the FYs 2008 through 2010 period and increased to 44 percent for FY 2011.

  JC: For FY 2011, the disparity rate is 44 percent based on 66 validation surveys. The JC did not cite comparable findings for 29 of the 33 surveys which cited for condition-level deficiencies by the SAs. The validation sample was six percent of surveys conducted by the JC in FY 2011. The disparity rate for FYs 2008 through 2010 was 34 percent based on a seven percent sample of the surveys conducted.

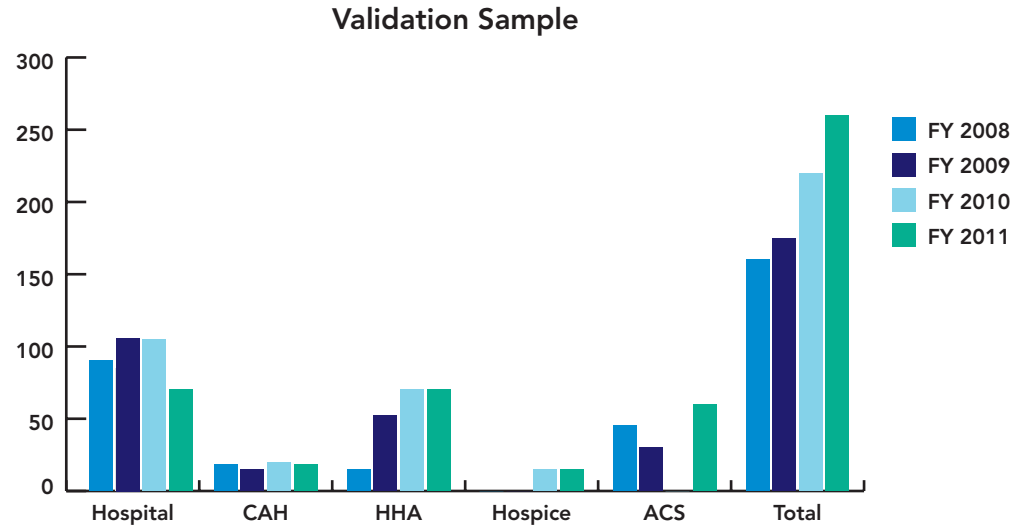
  AOA/HFAP: The validation sample for FY 2011 included three hospitals and was a three percent sample of the surveys conducted by AOA/HFAP. The disparity rate is not reported due to the low sample size. For the FYs 2008 through 2010 period, the disparity rate was 80 percent based on six percent sample of the surveys conducted during this period.

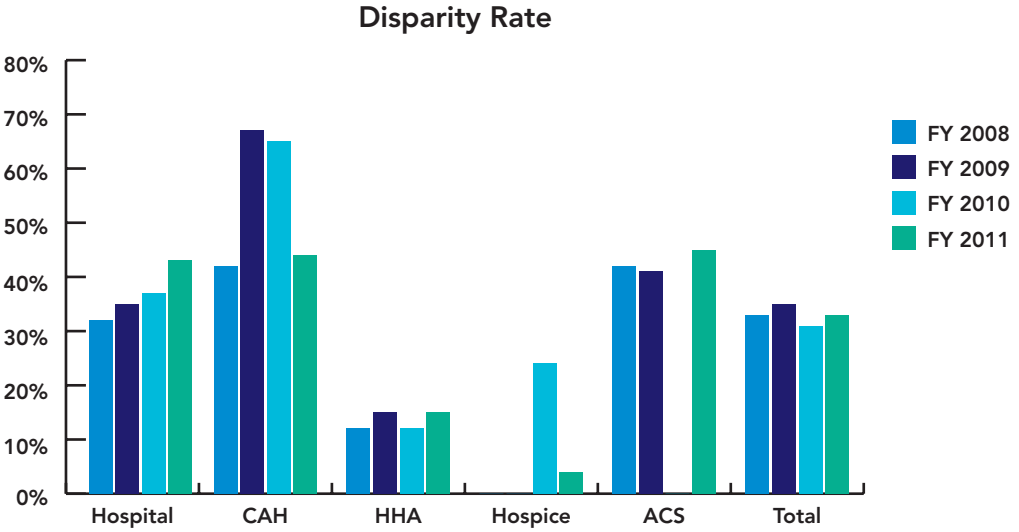
Table 7:
60-DAY VALIDATION SURVEY RESULTS FOR EACH FACILITY TYPE (FYs 2008 THROUGH 2011)

	FY 2008	FY 2009	FY 2010	FY 2011
HOSPITAL				
60-day Validation Surveys	92	89	104	73
SA: Condition-level Deficiencies	43	39	47	36
Missed by AO	30	32	40	32
Disparity Rate	33%	36%	38%	44%
CAH				
60-day Validation Surveys	17	22	23	20
SA: Condition-level Deficiencies	9	16	16	11
Missed by AO	7	15	15	9
Disparity Rate	41%	68%	65%	45%
HHA				
60-day Validation Surveys	21	51	76	77
SA: Condition-level Deficiencies	5	9	15	15
Missed by AO	3	8	11	12
Disparity Rate	14%	16%	14%	16%
HOSPICE				
60-day Validation Surveys	0	0	20	20
SA: Condition-level Deficiencies	NA	NA	5	3
Missed by AO	NA	NA	5	1
Disparity Rate	NA	NA	25%	5%
ASC				
60-day Validation Surveys	38	29	0	66
SA: Condition-level Deficiencies	17	12	NA	34
Missed by AO	16	12	NA	30
Disparity Rate	42%	41%	NA	45%

NA: Not applicable since 60-day validation surveys were not conducted.

Graph 4:
HIGHLIGHTS OF 60-DAY VALIDATION SURVEY RESULTS FOR EACH FACILITY TYPE (FYs 2008 THROUGH 2011)





DNVHC: The SAs did not cite any condition-level deficiencies for the four hospitals included in the validation sample for FY 2011. Therefore, the disparity rate could not be calculated. The validation sample was six percent of the surveys conducted in FY 2011. The disparity rate for the FY 2009–2010 period was 43 percent based on a six percent sample of the surveys conducted. The DNVHC hospital program was not CMS-approved in FY 2008 and, therefore, was not included in the validation analysis for that year.

- **CAH:** As shown in Table 9, the CAH disparity rates for each AO were consistently over the 20 percent threshold for the time periods shown; the disparity rates were between 44 percent and 71 percent. The disparity rate for all AOs was 60 percent over the FYs 2008 through 2010 period and 45 percent in FY 2011.

  JC: The disparity rate for FY 2011 is 44 percent based on 18 validation surveys, a 17 percent sample of the surveys performed. The SAs cited condition-level deficiencies in 10 facilities and the AO cited similar deficiencies in 2 facilities. The disparity rate for the FYs 2008 through 2010 period was 58 percent based on a 14 percent sample of surveys conducted.

  AOA/HFAP: The validation sample for FY 2011 included one survey, a ten percent sample of the surveys performed. Since the sample was small, the validation rate was not calculated. The disparity rate for FYs 2008 through 2010 was 71 percent based on a 24 percent sample of the surveys done.

  DNVHC: The validation sample for FY 2011 included one facility and the SA did not find any condition level deficiencies; therefore, no further analysis was done. DNVHC's CAH accreditation program received initial CMS-approval in November 2010.

Table 8:
HOSPITAL 60-DAY VALIDATION SURVEY RESULTS BY AO (FYs 2008 THROUGH 2011)

Hospital								
	JC		AOA/HFAP		DNVHC*		Total	
	FYs 2008–2010	FY 2011	FYs 2008–2010	FY 2011	FYs 2009–2010	FY 2011	FYs 2008–2010	FY 2011
60-Day Validation Sample	268	66	10	3	7	4	285	73
SA: Condition-level Deficiencies	118	33	8	3	3	0	129	36
Missed by AO	91	29	8	3	3	NA	102	32
Disparity Rate	34%	44%	80%	NA	43%	NA	36%	44%
Sampling Fraction	.07	.06	.06	.03	.06	.06	.06	.05

NA: Not applicable due to sample size less than five or since SAs cited no condition-level deficiencies.
* DNVHC hospital accreditation program received initial CMS-approval September 2008.

Table 9:
CRITICAL ACCESS HOSPITAL 60-DAY VALIDATION SURVEY RESULTS BY AO (FYs 2008 THROUGH 2011)

Critical Access Hospital							
	JC		AOA/HFAP		DNVHC*	Total	
	FYs 2008–2010	FY 2011	FYs 2008–2010	FY 2011	FY 2011	FYs 2008–2010	FY 2011
60-Day Validation Sample	55	18	7	1	1	62	20
SA: Condition-level Deficiencies	36	10	5	1	0	41	11
Missed by AO	32	8	5	1	NA	37	9
Disparity Rate	58%	44%	71%	NA	NA	60%	45%
Sampling Fraction	.14	.17	.24	.10	.04	.15	.14

NA: Not applicable due to sample size less than five or since SAs cited no condition-level deficiencies.
* DNVHC CAH accreditation program received initial CMS-approval November 2010.

- ***HHA:*** As shown in Table 10, the HHA disparity rates for each AO were between 11 percent and 24 percent for the time periods shown but were largely below the twenty percent threshold. The disparity rate for all AOs was 15 percent over the FY 2008 through FY 2010 period and was essentially the same in FY 2011, 16 percent.

  JC: The disparity rate for FY 2011 is 18 percent based on 28 validation surveys, a four percent sample of the surveys performed. The SAs found five condition-level deficiencies and the AO did not find any HHAs with similar deficiencies. The disparity rate for FY 2008 through 2010 was 24 percent based on a four percent sample of the surveys performed.

  ACHC: The disparity rate for FY 2011 is 19 percent based on 16 validation surveys, a five percent sample. The SAs found four HHAs with condition-level deficiencies while the AO found one facility with a similar level deficiency. The SAs did not find any condition-level deficiencies for the 15 surveys performed for the FY 2008 through FY 2010 period; therefore, no further analysis was done.

  CHAP: In FY 2011, the disparity rate is 12 percent based on 33 surveys, a five percent sample of the surveys performed. The SA found six HHAs with condition-level deficiencies while the AOs found two similar deficiencies. The disparity rate for the FY 2008 through FY 2010 period was 11 percent based on 75 surveys, a five percent sample of the surveys performed.

Hospice: As shown in Table 11, the hospice disparity rates for each AO were between zero and 50 percent for the time periods shown but were largely below the 20 percent threshold. Hospice validation surveys were initiated in FY 2010; therefore, results are available for only two years. The disparity rate for all AOs was 25 percent in FY 2010 and decreased to 5 percent in FY 2011.

Table 10:
HOME HEALTH AGENCY 60-DAY VALIDATION SURVEY RESULTS BY AO (FYs 2008 THROUGH 2011)

Home Health Agency								
	JC		ACHC		CHAP		Total	
	FYs 2008–2010	FY 2011	FYs 2008–2010	FY 2011	FYs 2008–2010	FY 2011	FYs 2008–2010	FY 2011
60-Day Validation Sample	58	28	15	16	75	33	148	77
SA: Condition-level Deficiencies	20	5	0	4	9	6	29	15
Missed by AO	14	5	NA	3	8	4	22	12
Disparity Rate	24%	18%	NA	19%	11%	12%	15%	16%
Sampling Fraction	.04	.04	.02	.05	.05	.05	.04	.05

NA: Not applicable since SAs cited no condition-level deficiencies.

Table 11:
HOSPICE 60-DAY VALIDATION SURVEY RESULTS BY AO (FYs 2010 & 2011)

Hospice						
	JC		CHAP		Total	
	FY 2010	FY 2011	FY 2010	FY 2011	FY 2010	FY 2011
60-Day Validation Sample	10	11	10	9	20	20
SA: Condition-level Deficiencies	0	2	5	1	5	3
Missed by AO	NA	1	5	0	5	1
Disparity Rate	NA	9%	50%	0	25%	5%
Sampling Fraction	.08	.08	.06	.06	.07	.07

NA: Not applicable since SAs cited no condition-level deficiencies.

JC: The validation sample included 11 facilities in FY 2011, an eight percent sample of the surveys performed. The SAs cited two condition-level deficiencies and the AO cited one similar deficiency for a nine percent disparity rate. The SAs did not cite any condition-level deficiencies in FY 2010; therefore no further analysis was done.

CHAP: The validation sample for FY 2011 included nine surveys which was a six percent sample of the surveys performed. The SAs cited condition-level deficiencies in one facility. The AO cited comparable deficiencies for a disparity rate of zero.

- **ASC:** As shown in Table 12, the ASC validation rates for each AO were consistently over the 20 percent threshold and were between 38 and 60 percent for the time periods covered. No 60-day validation surveys were performed in FY 2010. The disparity rate for all AOs was 42 percent over the FY 2008 to FY 2009 period and remained at a similar level, 45 percent, in FY 2011.

  JC: The validation sample for FY 2011 included 12 surveys, an eight percent sample of the surveys conducted. The SAs cited condition-level deficiencies in seven ASCs. The JC did not cite comparable deficiencies for six ASCs for a disparity rate of 50 percent. The disparity rate for FYs 2008 and 2009 was 38 percent based on a seven percent sample of the surveys conducted.

  AAAHC: The validation sample for FY 2011 included 49 surveys. SAs cited condition-level deficiencies in 24 ASCs. The AO did not cite comparable deficiencies for 21 ASCs, resulting in a disparity rate of 43 percent based on 13 percent sample of the surveys completed. This was very similar to the 40 percent disparity rate for FYs 2008 and 2009.

  AAAASF: The validation sample for FY 2011 included five surveys, an eight percent sample of the surveys conducted. The SAs cited condition-level deficiencies for three ASCs and the AO did not cite comparable deficiencies for a disparity 60 percent disparity rate. The disparity rate for the FYs 2008 and 2009 was not calculated since the sample size was small.

Validation Performance Results: Physical Environment and Other Conditions Cited

Examining the specific condition-level deficiencies cited by the SAs across all 60-day validation surveys provides an indication of the types of quality problems that exist in these facility types as well as the relationship between SA and AO citations for specific conditions. Two approaches are used for this analysis: (1) a review of the types of condition-level citations identified by SAs and the comparable AO deficiency findings in Table 13; and (2) a comparison of the number of surveys with physical environment condition-level deficiencies and the number of surveys with other types of deficiencies in Table 14. Both approaches highlight the same conclusion: SAs identify more physical environment condition-level deficiencies on validation surveys; AOs miss a significant number of these deficiencies. These findings are consistent with validation results for previous years.

Table 12:
AMBULATORY SURGERY CENTER 60-DAY VALIDATION SURVEY RESULTS BY AO (FYs 2008, 2009 & 2011*)

Ambulatory Surgery Center								
	JC		AAAHC		AAAASF		Total	
	FYs 2008–2010	FY 2011	FYs 2008–2010	FY 2011	FYs 2008–2010	FY 2011	FYs 2008–2010	FY 2011
60-Day Validation Sample	13	12	52	49	2	5	67	66
SA: Condition-level Deficiencies	5	7	22	24	2	3	29	34
Missed by AO	5	6	21	21	2	3	28	30
Disparity Rate	38%	50%	40%	43%	NA	60%	42%	45%
Sampling Fraction	.07	.08	.06	.13	.06	.08	.06	.11

NA: Not applicable due to sample size less than five.

*No 60-day validation surveys were performed in FY 2010.

Table 13 presents the number of facilities cited by SAs for specific condition-level deficiencies and the number of surveys where the AOs missed citing comparable deficiencies. The following are results for specific facility types:

- **Hospital:** As with the previous three years, physical environment was the most prevalent condition-level deficiency cited by the SAs in FY 2011 (deficiency cited for 28 of the 73 hospitals in the sample). Comparable deficiencies were not cited by the AO for 26 of the 28 hospitals. In FY 2010, the AO findings were similar for the physical environment condition. Physical environment was cited in 39 of 104 validation surveys, with the AOs missing a somewhat smaller percentage of deficiencies (32 facilities out of 39 deficiencies cited by SAs). In FY 2011, the next most frequently cited conditions cited by the SAs were: governing body; patient rights; quality assurance and performance improvement; and infection control. Patterns for the past several years were similar.
- **CAH:** The SAs cited condition-level deficiencies for physical environment in 10 out of 20 CAHs in FY 2011 with no comparable AO deficiency citations in eight CAHs. The pattern was similar for FY 2010, when physical environment was cited in 16 out of 23 facilities with the AOs had no comparable deficiency citations in 15 facilities. Physical environment was also the most frequently cited condition in FYs 2008 and 2009.
- **HHA:** The skilled nursing services condition was cited by the SAs for eight of the 77 HHAs in the FY 2011 validation sample. Comparable AO deficiencies were not cited in four HHAs. Other SA condition-level citations were: acceptance of patients, plan of care and medical supervision; comprehensive patient assessment; and organization services/administration. Patterns were similar in FY 2010 when skilled nursing services was also the most frequently cited deficiency.
- **Hospice:** Analysis of the condition-level deficiencies for hospices is not presented in Table 13 due to the small sample size and the small number of deficiencies cited.

Table 13:
NUMBER AND TYPE OF CONDITION-LEVEL DEFICIENCIES CITED ON 60-DAY VALIDATION SURVEYS (FY 2011)

MEDICARE CONDITIONS	CITED BY STATE AGENCY	MISSED BY ACCREDITATION ORGANIZATION
Hospital Sample: 73		
Physical Environment	28	26
Governing Body	6	6
Patient Rights	6	4
Quality Assurance	5	5
Infection Controls	5	1
Other Conditions	12	9
TOTAL	**62**	**51**
Home Health Agency Sample: 77		
Skilled Nursing Services	8	4
Acceptance of Patients, Plan of Care	7	2
Comprehensive Patient Assessment	7	5
Organization Services	5	3
Other Conditions	17	10
TOTAL	**44**	**24**

MEDICARE CONDITIONS	CITED BY STATE AGENCY	MISSED BY ACCREDITATION ORGANIZATION
Critical Access Hospital Sample: 20		
Physical Environment	10	8
Other Conditions	3	3
TOTAL	**13**	**11**
Ambulatory Surgery Center Sample: 66		
Physical Environment	17	16
Infection Control	12	10
Governing Body	12	8
Quality Assessment	9	3
Medical Staff	6	4
Surgical Services	6	4
Laboratory	5	4
Other Conditions	17	14
TOTAL	**84**	**63**

- **ASC:** Physical environment was the most frequently cited deficiency in FY 2011. SAs found deficiencies in 17 of the 66 sample surveys. The AOs did not cite comparable deficiencies for 16 ASCs. The FY 2010 60-day validation sample did not include ASCs. However, physical environment deficiencies were cited most frequently in FYs 2008 and 2009. In FY 2011, the next most frequently cited deficiencies were: infection control; governing body; quality assessment and performance improvement; medical staff; surgical services; and, laboratory/radiological services. In comparison to the other facility types, SAs identified more condition-level citations in ASCs. In addition, SAs tended to cite multiple condition-level deficiencies versus a single condition-level deficiency for an individual facility. This is likely due, in large part, to the extensive work that CMS has done in collaboration with the SAs over the last few years to strengthen the ASC survey process and improve the ability of surveyors to identify problems in infection control practices. AOs (JC and AAAHC) with a disparity rate of > 20 percent related to the infection control condition have conducted a root cause analysis, and identified and submitted strategies to CMS designed to positively impact this area of disparity in their accreditation program.

Table 14 takes a different approach and compares the validation results for health conditions with the results for physical environment conditions. The health conditions include all the non-physical environment conditions (primarily conditions related to clinical services, patient evaluation and administration). Only facility types which have physical environment conditions are included (i.e., hospitals, CAHs and ASCs). For both hospitals and CAHs, the SAs found a higher percentage of physical environment deficiencies than the other deficiencies. These deficiencies were not found by AOs during their surveys. This finding did not hold for ASCs despite the fact that the physical environment condition leads to the highest number of deficiencies. But the combined impact of the health conditions listed in Table 13 was large. As was previously noted in the discussion of Table 7, SAs find much fewer conditions out of compliance for HHAs and hospices, which do not have substantial physical environment conditions, leading to lower disparity rates.

The physical environment condition continues to be the largest driver of the disparity rate. This issue was initially identified when the 60-day validation surveys included only the JC's hospital program; but the finding has been consistent for all AOs and facility types with a physical environment condition. The AOs do not cite deficiencies comparable to SA condition-level deficiency citations for the physical environment condition, and more specifically, to the National Fire Protection Association LSC requirements that CMS has adopted as part of its health and safety standards. CMS has been working with all AOs to provide guidance on the source of the problem and possible ways to improve performance.

As was mentioned in the FY 2011 report, in FY 2010, CMS Life Safety engineers completed an analysis of SA and AO physical environment findings for 60-day validation surveys conducted in hospitals in FYs 2006 through 2009 and in March 2011, presented actionable information to assist the AOs in strengthening their LSC survey processes. The majority of the physical environment disparity consists of LSC deficiencies, and the CMS engineers identified the top ten disparate LSC deficiencies cited by the SA, but not cited by the AO. These top 10 deficiencies held true for FY 2011 validation surveys as well. In addition, a gap in the average number of onsite life safety surveyor hours per survey provided by the AO versus the SA was identified. As the disparity in LSC citations has persisted despite AOs' efforts to address it, more recently the JC has taken issue with the application

Table 14:
60-DAY HEALTH AND PHYSICAL ENVIRONMENT VALIDATION SURVEY RESULTS FOR FACILITY TYPES WITH LSC REQUIREMENTS (FY 2011)

	Hospital		Critical Access Hospital		Ambulatory Surgery Center	
60-Day Validation Surveys	73		20		66	
Deficiency Type	Health	Physical Environment	Health	Physical Environment	Health	Physical Environment
SA: Condition-level Deficiencies	19	28	3	10	23	17
Missed by AO	16	26	3	8	20	16
Disparity Rate	22%	36%	15%	40%	30%	24%

of CMS' standard citation practices when evaluating LSC compliance, and has also raised questions about what it considers to be disproportionate use of SA survey resources for the LSC portion of the survey, suggesting that a cost-effective survey process focuses on other areas which the JC believes are more important for patient safety. CMS notes that fire safety requirements are statutorily required for hospitals but will continue to discuss with the JC and other AOs their concerns as well as their performance in the area of evaluating health care facility safety from fire.

Section 6: Long Term Care Hospital (LTCH) Mid-cycle Validation Surveys

LTCHs are hospitals that are primarily engaged in providing inpatient services to patients whose medically complex conditions require a long hospital stay, averaging more than 25 days. In FY 2011, there were 441 LTCHs participating in Medicare. Like all types of Medicare-participating hospitals, LTCHs are required to demonstrate compliance with Medicare health and safety standards, the hospital CoPs. Although LTCHs may not offer the full range of services offered by a short-term acute care hospital, they are held to the same standards and must comply with all applicable CoPs. Compliance is assessed during routine surveys and validation surveys.

LTCHs have the option of choosing to demonstrate their compliance with the CoPs through surveys conducted by a SA or by an AO with a CMS approved hospital accreditation program. The process is the same for all facility types with CMS approved accreditation programs as described in earlier sections of this report. CMS became concerned in 2010, based on available SA survey findings, with the quality of care provided in LTCHs, particularly when compared to survey findings for short-term acute care hospitals. At the same time, CMS realized that most SA surveys were the result of substantial allegations or complaints alleging substantial non-compliance in a specific facility, and therefore, may not be representative of LTCHs in general. In order to review the quality of care provided by LTCHs, it was necessary for SAs to survey a representative sample of LTCHs to determine whether they have a disproportionate number of serious deficiencies when compared to short-term acute care hospitals.

Approximately 80 percent of all Medicare-participating LTCHs are accredited by a CMS-approved hospital accreditation program, mostly through the JC. This is consistent with the overall percentage of all types of Medicare-participating hospitals that are deemed to meet the CoPs on the basis of their accreditation. Therefore, examining the issue of LTCH quality through SA surveys in a representative sample of LTCHs required surveying a significant number of accredited, deemed LTCHs. To accomplish this, in 2010, CMS decided to construct a stratified random sample of 33 LTCHs in the FY 2011 hospital representative sample validation program which is described in Section 5 of this report. In order to construct a LTCH sample of this size, it was not possible to conduct traditional look-back validation surveys conducted within 60 days of an AO survey. The starting point in making look-back survey assignments is always the survey schedule provided by AOs, from which CMS makes assignments, taking into consideration each SA's budgeted validation survey workload. In past years, the 60-day validation surveys have included no more than eight LTCHs per year utilizing this methodology. In order to achieve a larger LTCH sample, therefore, CMS decided to have SAs conduct mid-cycle validation surveys, which are independent of the timing of any AO survey. Although this method increases the sample size, it does not allow direct comparison between SA and AO findings in specific hospitals, resulting in the calculation of a disparity rate. This creates a separate set of challenges and limitations in analysis of the results, but achieving a larger sample size in one year warrants this approach.

At the same time that CMS was developing this plan for surveying LTCHs, the Government Accountability Office (GAO) also began examining the quality of care delivered in LTCHs, focusing on the oversight of LTCHs by the JC and CMS oversight of the JC and other AOs. The GAO recommended in its September 2011, report that CMS strengthen oversight of LTCHs by, among other things, increasing the number of LTCH representative validation surveys and calculating a separate disparity rate for them.[5]

Methodology: Sample Selection and Analysis

A stratified random sample of 33 deemed LTCHs was selected for mid-cycle validation survey by SAs. CMS first identified the states in which validation surveys would take place, as well as the number of surveys per state. CMS then randomly selected deemed LTCHs in each such state to develop the sample. The resulting sample represents

[5] *"Long-Term Care Hospitals: CMS Oversight is Limited and Should be Strengthened,"* Government Accountability Office, GAO-11-810, September, 2011.

Table 15:
NUMBER AND PERCENTAGE OF CONDITION-LEVEL DEFICIENCIES CITED NON-ACCREDITED LTCH, LTCH MID-CYCLE, 60-DAY HOSPITAL VALIDATION SURVEYS, AND NON-ACCREDITED SHORT-TERM ACUTE CARE HOSPITAL SURVEYS (FY 2011)

	LTCH Mid-cycle Validation Surveys	60-Day Hospital Validation Surveys	Non-Accredited LTCH Surveys	Non-Accredited STAC Surveys
Total number of Surveys	33	77	16	105
Surveys with Condition-level Deficiencies	20	36	7	36
Percentage of Surveys with Condition-level Deficiencies	61%	47%	44%	34%

approximately ten percent of the 338 LTCHs that were deemed in FY 2011. All deemed LTCHs selected were accredited by the JC.

This analysis reviews the condition-level deficiencies (i.e., serious deficiencies) identified by the SA in this sample of deemed LTCHs and makes comparisons based on other groups of SA surveys.

In addition to comparing LTCH validation results to those for other types of hospitals subjected to validation surveys in FY 2011, the analysis also reviewed FY 2010 and FY 2011 results of SA surveys of LTCHs and short-term acute care hospitals, both deemed and non-deemed, in an effort to determine:

- How the FY 2011 mid-cycle LTCH validation results compared to prior LTCH survey results;
- Whether there were differences among deemed and non-accredited LTCHs surveyed by SAs; and, if so,
- Whether differences between deemed and non-accredited LTCHs were comparable to differences, if any, between deemed and non-accredited short-term acute care hospitals surveyed by SAs.

FY 2010 and FY 2011 results included were only from standard surveys, i.e., those surveys assessing compliance with all CoPs. For deemed hospitals surveyed in 2010 and for deemed short-term acute care hospitals surveyed in FY 2011, standard surveys included both representative sample validation surveys and standard surveys conducted after a prior complaint survey by the SA found condition-level noncompliance. More narrowly focused complaint surveys were eliminated from the analysis.

Comparison of FY 2011 Mid-cycle LTCH Validation Surveys with Other FY 2011 Hospital Surveys

As shown in Table 15, SAs cited condition-level non-compliance on 20 of the 33 LTCH mid-cycle validation surveys, i.e., 61 percent of the deemed LTCHs surveyed. This compares to 47 percent of the other types of hospitals surveyed in FY 2011 using 60-day validation surveys. It also compares to SAs citing condition-level deficiencies in 44 percent of non-accredited LTCHs and in 34 percent of short-term acute care (STAC) hospitals in FY 2011.

Comparison between FY 2011 LTCH Mid-cycle Validation Surveys and All FY 2010 LTCH Surveys

It must be noted that the number of LTCH surveys in FY 2011, particularly for non-accredited LTCHs, is small and therefore potentially subject to large variations. Therefore, CMS also reviewed FY 2010 data to see whether the FY 2011 results might be atypical. Table 16 presents a comparison between the FY 2011 LTCH mid-cycle validation surveys of deemed LTCHs conducted by SAs and all FY 2010 standard surveys of deemed and non-deemed LTCHs.

Condition-level deficiencies were cited in 61 percent of the mid-cycle validation LTCH surveys performed by SAs in FY 2011, compared to 36 percent of the LTCHs which the SAs surveyed in FY 2010.

Table 16:
NUMBER AND PERCENTAGE OF CONDITION-LEVEL DEFICIENCIES CITED ON FY 2011 LTCH MID-CYCLE VALIDATION SURVEYS AND ALL FY 2010 STANDARD LTCH SURVEYS

	LTCH Mid-cycle Validation Surveys (FY 2011)	LTCH Standard Surveys (FY 2010)
Total Number of Surveys	33	47
Surveys with Condition-level Deficiencies	20	17
Percentage of Surveys with Condition-level Deficiencies	61%	36%

Table 17:
NUMBER AND PERCENTAGE OF CONDITION-LEVEL DEFICIENCIES CITED ON NON-ACCREDITED AND DEEMED LTCH SURVEYS (FY 2010)

	Non-Accredited LTCHs	Deemed LTCHs
Total Number of Surveys	17	29
Surveys with Condition-level Deficiencies	4	13
Percentage of Surveys with Condition-level Deficiencies	24%	45%

Comparison of FY 2010 Non-Accredited and Deemed LTCHs

The FY 2010 LTCH SA survey results presented in Table 16 were disaggregated based on whether the hospitals had deemed status, in order to compare survey results for deemed and non-deemed facilities. All deemed LTCHs surveyed by the SAs in FY 2010 were accredited by the JC. The non-deemed LTCHs surveyed by SAs were likely surveyed as part of their periodic recertification, whereas the majority of deemed LTCHs surveyed were surveyed as a result of the SA finding serious deficiencies on a prior complaint survey. Therefore, the deemed LTCHs in this group are not necessarily representative of all deemed LTCHs.

Table 17 presents the results of the comparison between condition-level deficiencies cited during FY 2010 SA surveys of non-accredited LTCHs and deemed LTCHs.

Condition-level deficiencies were cited by SAs in 24 percent of the non-accredited LTCHs surveyed, compared to 45 percent of the deemed LTCHs. However, in a similarly small number of non-accredited LTCHs surveyed in FY 2011, condition-level deficiencies were found in 44 percent illustrating how subject to wide variation small numbers are and how difficult it is to draw definitive conclusions from them.

For the larger numbers of deemed LTCHs surveyed, the percentage found to have serious deficiencies in FY 2010 was 16 percentage points lower than in the more representative sample of deemed LTCHs in FY 2011. However, it may be worth noting that many of the deemed LTCHs surveyed in FY 2010, may have undertaken anticipatory corrective actions prior to the survey, because they had a prior complaint survey with serious findings and had been put on notice by CMS that they would be subjected to a standard survey shortly thereafter.

Comparison of FY 2010 & FY 2011 Non-Accredited and Deemed Short Care Acute Hospitals ad LTCHs

This analysis compared the percentage of condition-level deficiencies cited by SAs in FY 2010 with those cited in FY 2011 for non-accredited and deemed short-term acute care hospitals compared to non-accredited and deemed LTCHs. Table 18 presents the number and percentage of condition-level deficiencies cited on FY 2010 and FY 2011 surveys for both short-term acute care hospitals and LTCHs, disaggregating both hospital types into deemed and non-accredited hospitals. The data suggest the following:

- In both FYs 2010 and 2011, a higher proportion of LTCH surveys by SAs resulted in condition-level deficiencies than did SA surveys of short-term acute care hospitals: 37 percent and 55 percent respectively for LTCHs compared to 27 percent in both years for short-term acute care hospitals.
- In both FYs 2010 and 2011, SAs found more serious deficiencies in non-accredited short-term acute care hospitals than they did in deemed hospitals of this type: 30 percent vs. 26 percent in FY 2010 and 34 percent vs. 24 percent in FY 2011. Conversely, in both years SAs found more serious deficiencies in deemed LTCHs than they did in nondeemed LTCHs: 45 percent versus 24 percent in FY 2010, and 61 percent vs. 44 percent in FY 2011.
- The overall proportion of serious deficiencies identified in SA surveys of short-term acute care hospitals, both deemed and non-accredited, was the same in FYs 2010 and 2011, 27 percent, but the proportion of LTCH surveys with serious deficiencies grew substantially, for both deemed and non-deemed LTCHs in FY 2011, from an overall rate of 37 percent to 55 percent.

Table 18:
NUMBER AND PERCENTAGE OF CONDITION-LEVEL DEFICIENCIES CITED ON NON-ACCREDITED AND DEEMED LTCHS AND SHORT-TERM ACUTE CARE HOSPITAL SURVEYS (FY 2010 & FY 2011)

	Non-Accredited LTCHs		Deemed LTCHs		Total LTCHs		Non-Accredited Short-term Acute Care Hospitals		Deemed Short-term Acute Care Hospitals		Total Short-Term Acute Care Hospitals	
	FY10	FY11	FY10	FY11	FY10	FY11	FY10	FY11	FY10	FY11	FY10	FY11
Total Number of Surveys	17	16	29	33	46	49	106	105	283	282	389	387
Surveys with Condition-level Deficiencies	4	7	13	20	17	27	32	36	73	69	105	105
Percentage of Surveys with Condition-level Deficiencies	24%	44%	45%	61%	37%	55%	30%	34%	26%	24%	27%	27%

* Data is from the CMS national survey and certification data base, with the exception of FY 11 deemed LTCH data, which presents the mid-cycle validation survey results. Number of surveys does not add up to those in Table 16 due to missing deemed status data.

Conclusion

Data from FYs 2010 and 2011 SA hospital surveys suggest that LTCHs are more likely to have serious quality problems than both deemed and non-accredited short-term acute care hospitals. Given the more limited number of LTCHs overall, the sample size for the LTCH data in both FYs is necessarily small, and the differences identified are therefore suggestive rather than statistically significant, Nevertheless, these results are a source of concern to CMS. A preliminary draft of this analysis was shared with the JC and they were invited to comment. The JC responded that the draft report was fundamentally flawed, detailing a variety of methodological concerns, including a lack of any identifiable measure of statistical significance. In the view of the JC, "…the results do not appear to say anything about the accuracy of the Joint Commission surveys." Subsequent to receiving the JC's comments CMS was able to incorporate into the analysis FY 2011 data which showed that SA surveys of non-accredited LTCHs also showed a growth in serious deficiencies between FY 2010 and FY 2011, suggesting that improvement efforts need to focus on all LTCHs, not just deemed LTCHs. In both years SAs found a higher percentage of serious problems with deemed LTCHs than with non-accredited LTCHs, but we acknowledge the JC's concerns that the overall LTCH survey numbers are very small, limiting the analysis. Nevertheless, since most LTCHs are deemed by the JC, CMS has asked the JC for its insights on why LTCHs appear to have more serious quality issues and what can be done to address them.

Section 7: Accreditation Organization Improvement Efforts

There is ongoing communication between CMS and the AOs regarding oversight activities, expectations, AO reporting, validation surveys and other requirements. As a continuation of that process, CMS requested that the AOs submit a summary of their activities to improve the operations of their CMS-approved accreditation programs for inclusion in this annual report. The following is the information as provided by all seven CMS-recognized AOs:

1. Accreditation Association for Ambulatory Health Care (AAAHC)

The AAAHC appreciates the opportunity to provide comments for the report to Congress about its rating on performance measures and has prepared the following comments.

PERFORMANCE MEASURES

The AAAHC is proud of its record of consistently attaining high scores, and points out that 14 of 15 performance measures were scored 100 percent at the end of FY 2011. With respect to complete data for CMS Certification Numbers (CCNs), AAAHC has consistently scored 95 percent to 99 percent. AAAHC continues to communicate with the CMS Regional Offices to confirm CCNs, as well as follow-up directly with the ASCs. The AAAHC continues to strive for a monthly rating of 100 percent for all performance measures and will continue to work with CMS to ensure all data are accurate, timely.

EDUCATION

AAAHC maintains resources to assist organizations understand and meet CMS requirements. There are frequent communications to organizations through newsletters, email blasts, and website links. AAAHC introduced a newly designed website, enabling organizations to more easily access information. The new website allows for the web-based resources to be easily and continually updated. AAAHC has re-vamped its quarterly education programs with focused sessions on issues related to the CMS CfCs.

Surveyors are provided access to the same resources as organizations, as well as surveyor specific resources and educational tools that provide in-depth information on CMS requirements. Updates to CMS requirements are provided on an ongoing basis through weekly email communications.

DISPARITY RATE ANALYSIS

AAAHC conducts an in-depth analysis of validation and accreditation/deemed status survey findings. The analysis is ongoing and incorporates data received from regional authorities from validation surveys conducted. Through this analysis, AAAHC will seek to identify opportunities to reduce disparities.

2. Accreditation Commission for Health Care (ACHC)

ACHC seeks to inspire excellence in healthcare through a comprehensive accreditation approach. Enhancements have been made this year to ensure that the entire accreditation process is collaborative, educational and genuinely patient-focused.

Ongoing Compliance and Certification ISO 9001:2008: ACHC's Quality Management System (QMS) promotes accuracy and consistency throughout all organizational operations. The QMS is audited through onsite visits annually by an outside registrar. The ISO quality policy statement commits ACHC to developing and improving health care accreditation programs and services, meeting customer and regulatory requirements, enhancing employee skills and efficiencies, continual improvement of quality management systems/processes, sustained fiscal growth and improved market presence.

LSC Inspections: Working in collaboration with the CMS Life Safety Engineer, ACHC refined the electronic data collection tool used for the LSC inspections for inpatient hospice facilities.

Improved Surveyor Education: ACHC replaced lectures with an interactive format for annual training providing an engaging experience for surveyors.

Provider Education: ACHC has concentrated this year on educating agencies on the comprehensive completion of Plans of Correction (POC). A video presentation is sent to all providers at the time they receive their survey findings. This instructional video and personal coaching from Clinical Review Specialists has dramatically improved the accuracy of POC completion.

Home Health Standards: The home health standards were revised to clearly articulate specific verbiage contained in the Medicare conditions. This fosters clear understanding of both the accreditation and regulatory requirements.

Data Collection Tools and Scoring: A redesign of the on-site data collection tools and scoring methodology refined the survey process. Reports submitted to providers are more comprehensive.

3. American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

AAAASF'S GROWTH

AAAASF is very proud to have earned initial CMS-approval of its OPT and RHC accreditation programs in addition to our current ASC program. The AAAASF Board of Director's vision is that AAAASF can be a stronger more fiscally sound organization with the development of these new programs. In an age when there is so much volatility in medicine, it is critical that AAAASF business not be solely dependent on a limited number of medical specialties.

THE IMPORTANCE OF PEER REVIEW

An equally important area at AAAASF is the incorporation of its new OPT and RHC CMS-approved Accreditation Programs into our nationally recognized Peer Review Patient Data System. Over the past decade, AAAASF has captured pertinent patient AAAASF to provide and share vital statistical information to the Centers for Disease Prevention & Control (CDC), CMS, insurance companies and the Government Accountability Office (GAO) in the fight for infection control, and other vital patient safety areas. AAAASF will continue to collect this data by specialty areas going into the future for all of our approved Medicare-deemed programs, maintaining AAAASF in an unrivaled and unbiased patient safety data clearinghouse position.

DATA TRACKING SYSTEMS

AAAASF has improved the automation of several ASSURE reporting fields and has experienced a significant improvement in performance measures related to ASSURE reporting. The AAAASF staff has continued dialogue with Medicare personnel to improve compliance with performance measures related to notification letters, survey scheduling, and data matching between CMS and AAAASF internal databases. These performance scores have also improved over last year. As CMS continues to release patches and revisions to ASSURE, AAAASF responds as quickly as possible with compatible programming to accommodate the changing data needs. Collaboration has been positive and continues to produce tangible improvements to the reporting process. With the recent CMS-approval of its RHC accreditation program, AAAASF is now including all three programs into the ASSURE and CMS-related reporting systems. AAAASF continues to work closely with CMS to insure a greater collaboration between data systems.

AAAASF is continuing its work on our in house software systems to improve our scores on Medicare's performance measures. A key component of these upgrades is to directly address the disparity rates as identified by CMS.

SURVEYOR EDUCATION

New Surveyor Training Course: AAAASF has developed a new surveyor training course format which includes interactive training segments on critical surveyor skill sets including Record Review, Case Tracer Methodology, and Principles of Documentation. The training course incorporates two DVD segments which give in-depth instruction on how to perform the health survey and the Case Tracer Methodology as well as lecture segments with a complete review of CMS regulatory requirements through AAAASF Medicare Standards. A competency examination is administered at the conclusion of the course. The surveyor is then required to complete a performance evaluation during a site survey with a certified survey team and pass a final review of credentialing/training components by the Quality Assurance Committee to complete the certification process.

Web Academy: AAAASF launched the Surveyor Web Institute for Facilitated Training (SWIFT) web based education platform in 2011. The training site has been operational for several months and currently contains eight modules for the Medicare ASC and RHC programs with modules being developed for the OPT program. Modules containing CMS regulatory requirements and changes are uploaded to conform to timeframes for implementation when CMS issues a Survey and Certification notice. The modules are designed to educate surveyors on new requirements, assist them in maintaining certification and serve as a resource when performing surveys onsite. The SWIFT web based platform will contain surveyor training components for all AAAASF Medicare deemed programs while allowing the Director of Education, Education and Quality Assurance Committee Chairs to 'track' surveyor's compliance for continuing education requirements to maintain surveyor certification. AAAASF is exploring other technology including "Smart Board" platforms as a way to deliver educational content in an expeditious manner.

Medicare Surveyor's DVD: A new DVD/CD Medicare Accreditation Assistant set produced by AAAASF was released in summer 2011. The inclusive set was created with dual purposes, one to give surveyors a visual walk through of the health survey process and case tracer methodology, and to provide the added word documents that assist AAAASF Medicare facilities successfully achieve accreditation to be recommended to CMS for deeming status.

QUALITY ASSURANCE

AAAASF's Quality Assurance and Surveyor's Oversight Committee continues to monitor the progress of our surveyors via reporting systems in place such as surveyor educational compliance, and performance surveys received from surveyed facilities. The Committee oversees and reviews all compliments, comments and complaints received by AAAASF staff concerning surveyors, and manages surveyor retraining accordingly.

ELECTRONIC RESOURCES

The AAAASF web site has been redesigned and enhanced to allow easy access to their Medicare program materials and other programs. Prospective applicants to our three Medicare accreditation programs can download our free application materials including current standards, CMS Interpretive Guidelines and other helpful resources to assist in their practice.

The AAAASF Resource Guide is available on line to provide hundreds of valuable links to third party resources which can be useful to promote quality of care and improve a center's practice. Also available on our web site are sample clips of

our new Medicare Accreditation Assistant videos, product information and order form.

On our web site, patient safety is emphasized with important content and links to other resources to assist prospective patients who may be looking for qualified professionals and accredited ambulatory centers and clinics.

FUTURE FOCUS

AAAASF's Board of Directors continues to actively support their approved and aggressive five-year Strategic Plan for continued growth in partnership with the Medicare sector to fund and support the adding of additional medical specialties for AAAASF and planned applications for CMS-approval of accreditation programs now and into the future.

4. American Osteopathic Association/Healthcare Facilities Accreditation Program (AOA/HFAP) Statement

AOA/HFAP remains the oldest continuous healthcare accreditation organization in the U.S. having begun accreditation of hospitals in 1945. It also remains the oldest CMS-recognized accreditation organization having applied for and received CMS-approval in 1965. Despite its history and longevity, AOA/HFAP has made significant improvements in its operation to ensure it remains contemporary, comprehensive, compliant with CMS, and responsive to feedback from CMS and responsive to its accredited organizations.

Leadership: Significant leadership changes have been made to ensure AOA/HFAP is guided by the most experienced accreditation professionals available. A new Chief Operating Officer and a new Director of Accreditation Services, both with significant accreditation experience, have been added to the staff.

Staffing: Additional staff has been added and will continue to be added to ensure the highest level of compliance with CMS requirements and to provide accredited organizations with exemplary service. The addition of staff supports AOA/HFAP's commitment to continuous improvement, the development of new programs, and to manage a growing customer base.

Surveyor Education: The launch of the Survey Portal provides surveyors with the ability to login and receive streaming education modules, webinars, and other active and passive training developed to assist them in maintaining their competency and developing their proficiency. In addition, monthly newsletters from the Chief Operating Officer are specifically dedicated to surveyor development issues. Mandatory quarterly conference calls are held with the surveyor cadre as another means of interactive exchange.

Monthly Audits: AOA/HFAP continues to conduct monthly audits of its entire accreditation process to assure timeliness and efficiency of all processes. These audits review the competency standards for surveyor performance, the complaint processing system, all timelines for conducting surveys and receiving reports from accredited organizations, as well as the efficacy of new all processes and programs.

Adaptive Survey Agenda: AOA/HFAP permits and encourages the survey team captain to adjust the survey agenda onsite when team members identify a need for greater duration or depth of evaluation is required to adequately address an individual program or process.

Executive Committee Functions: The Executive Committee of the Bureau of Healthcare Facilities Accreditation (AOA/HFAP's governing body) began meeting monthly by conference call in late 2011. The Executive Committee meets to interactively discuss organizations' survey reports and Interim Progress Reports, rendering accreditation decisions on a timely basis. The Executive Committee is also available to provide guidance and approval of the operational changes necessary for AOA/HFAP to adapt to an ever-changing healthcare accreditation and certification environment.

ASSURE: HFAP has done an extensive review of facility and survey information in its primary database and compared it to the data in ASSURE to maintain accuracy and integrity of the data. Processes have been modified to ensure that data updates are timely, complete, and accurately entered in the ASSURE database.

On-Line Manual: AOA/HFAP Accreditation manuals are generated electronically on-line and are interactive allowing facilities to keep notes and track compliance with the standards.

5. Community Health Accreditation Program (CHAP)

During this year, CHAP continued its focus on performance monitoring and improvement. All deemed surveys continue to be performed timely, with timely reporting to CMS using the ASSURE database. CHAP worked closely with CMS Central

Office staff on improving our use of ASSURE and improving our results in compliance to requirements measured through CMS AO performance measures. CHAP received approval for six additional years of deeming authority for home health, and filed a renewal application for deeming authority for hospice, and attended the Annual AO training.

Key Activities:

- Analyzed validation survey findings and disparate survey findings;
- Provided Site Visitor training based on data collection trends from validation disparity report;
- Increased knowledge and understanding of state agency application of the Medicare conditions for home health and hospice;
- Enhanced and updated our Home Health and Hospice Standards of Excellence cross-walk comparing the Medicare conditions for Home Health and Hospice with the CHAP Standards of Excellence;
- Provided additional Site Visitor training on the cross-walks to enhance consistent application;
- Provided coaching to Site Visitors on survey techniques including the review and analysis of deficiencies, determination of appropriate citations, with special emphasis on condition level and immediate jeopardy determinations;
- Contributed to CMS data reconciliation project by research and improvement of our deemed provider record accuracy;
- Continued our work on development of our second generation accreditation software. Planned for launch in calendar 2012, the system will further enhance the accuracy and timeliness of our deemed organization oversight and reporting; and
- Continued our series of provider education offerings regarding the most frequently cited deficient standards, including information of expectations and requirements of compliance.

6. Det Norske Veritas Health Care (DNVHC)

The following describes the actions and other measures taken to further develop the effectiveness of the DNVHC accreditation program:

NIAHO Implementation Training: Client organizations have taken advantage of a NIAHO training course designed to assist organizations learn the concepts and methodology for implementation of the infrastructure of a quality management system that complements accreditation requirement. Based on the feedback from client organizations, DNVHC has designed this course in line with adoption of the ISO quality management system requirements and how this ties into the DNV accreditation requirements consistent with the CMS conditions. This training course further supports compliance and development of the quality management system for the hospital.

Surveyor Education: DNVHC has developed a program to provide cross-training for our surveyors to have a more in depth understanding of each discipline, particularly as this relates to the aspects of the physical environment. Several of the surveyors have successfully completed this training which includes the LSC and NFPA requirements.

Managing Infection Risk: Developed first and only management standard on Biorisk – CWA 15793, sponsored by 24 countries (co-shared with U.S. Department of Agriculture). Based on this standard, DNV has developed a Managing Infection Risk Management Standard to provide a framework to help hospitals improve their management of infection risks and also serve as a benchmark for stakeholders in setting requirements for the healthcare facilities. It also provides organizations with a means for both internal audits and third party certifications, which in turn can provide assurance to regulators, funding bodies, patients and the community that adequate measures are in place to responsibly manage infection risks. This program developed by DNV ties in directly with the CMS Partnership for Patients initiative.

Research & Innovation: As an independent foundation, DNV Research and Innovation conducts strategic research programs and projects to acquire new knowledge and competence, to develop new services to create value for DNV and our customers, as well as to enhance DNV's recognition as a technology leader in selected areas. DNVHC is currently working with Research and Innovation for development of initiatives in Risk Management, Infection Control and Patient Safety. DNV Research and Innovation has also prepared a detailed paper, Technology Outlook 2020, which outlines six megatrends that will influence the development and uptake of technologies within the healthcare sector.

DNVHC continues to improve its internal processes based on communication and feedback from the CMS Survey & Certification Group. CMS Central and Regional Offices provide copies of the reports (Form 2567) for Validation Surveys completed of DNVHC accredited hospitals. These survey reports, in turn, are used as a means to educate and inform our surveyor cadre to improve the consistency of the survey process. This process has been very beneficial to improve our methods for reporting

and receiving information to further improve our accreditation process and continue meeting the expectations of CMS.

7. The Joint Commission (JC)
The JC is pleased to provide information on the various initiatives implemented during the past year to enhance the effectiveness of the JC's accreditation process and improve patient safety and quality. These initiatives are:

Establishment of the *Top Performer on Key Quality Measures™* Program: The *Top Performer* program recognizes hospitals and CAHs that attain and sustain excellence in accountability measure performance. Almost all of the JC's accountability measures have been recognized for inclusion in the CMS' Value-Based Purchasing program. In the JC's 2011 Annual Report on Quality and Safety, 405 (14 percent) JC-accredited hospitals were identified as attaining and sustaining excellence in accountability measure performance for the previous year, 2010.

Increased focus on issues related to LSC: The JC has created a dedicated position to provide ongoing education to LSC surveyors; this position complements the dedicated clinical educator position that has been in place for three years which oversees the ongoing education provided to JC clinical surveyors. Additionally, the JC publishes monthly articles in its newsletter, *Perspectives*, on Life Safety areas that through the years have generated compliance issues with both the conditions and JC requirements, such as door and barrier maintenance, clutter and storage in the corridors or egress maintenance, timing and frequency of fire drills, and waste storage.

Continued development of surveyor education and in the evolution of the tracer methodology: The current tracer methodology process focuses on areas most important to patient safety and quality. In 2012, the areas of Clinical Information Systems and Therapeutic Radiation have received enhanced focus. Further, there is continued ongoing training for surveyors on CMS requirements and the conditions, including an increased focus at their annual conference and throughout the year via distance learning and their newsletter.

Additional attention given to CMS compliance and quality metrics: The JC has established a strong infrastructure to support compliance with CMS' performance measures for AOs, including the allocation of an additional staff person and the development of a "dashboard" to assist in the monitoring of requirements. The JC has also implemented a re-designed application for JC accreditation which collects enhanced information about the organization being surveyed to ensure that the JC can determine survey duration and scope appropriately and meet CMS reporting requirements.

Emphasis on finding solutions to health care's most critical safety and quality problems: Since its establishment in 2009, the Joint Commission Center for Transforming Healthcare has launched seven projects in collaboration with hospitals and health systems that include hand hygiene compliance, wrong site surgery prevention, hand-off communication, surgical site infection reduction, avoidable heart failure hospitalization prevention, safety culture improvement, and the prevention of falls with injury. Additional work has been initiated to address sepsis mortality and medication safety. Additional resources are provided to JC customers via the Targeted Solutions Tool™, which allows facilities to share best practices, experiences, and helps them evaluate their own unique concerns and solutions.

Implementation of activities and resources aimed reducing the incidence of preventable readmissions and healthcare acquired conditions: The JC has introduced a portal on its website dedicated to consolidating solutions and resources addressing health care-associated infections and implemented a new National Patient Safety Goal aimed at reducing catheter-associated urinary tract infections thru the use of clinical guidelines and best practices.

Participating in activities related to discharge planning and transitions of care: The JC's not-for-profit, Joint Commission Resources (JCR), was awarded a contract by the CMS Center for Medicare and Medicaid Innovation and is participating in Project RED (Re-Engineered Discharge), an intervention initiative that improves patient safety through the redesigning of the discharge workflow process. JCR has provided educational programs and resources to hospital project teams in hopes of decreasing avoidable hospital readmissions. To date, more than half of the 270 participating hospitals recruited by JCR have launched pilot projects and/or moved beyond pilots to spread RED interventions to other patient populations in their hospitals.

Section 8: Centers for Medicare & Medicaid Services Oversight

Improvement

The volume of facilities that participate in the Medicare programs through accreditation by a CMS-approved accreditation program continued to grow in FY 2011. Currently, 37 percent of all Medicare-participating facilities that have an approved accreditation program option, over 11,000 facilities, demonstrate compliance with the Medicare requirements and participate in the Medicare program via their deemed status. There are currently seven CMS-recognized AOs and 19 approved programs. CMS continues to strengthen its oversight as the number of CMS-recognized AOs, CMS-approved accreditation programs, and deemed facilities increases. CMS continues to focus on refining and maintaining an effective oversight infrastructure, including enhancing systems and processes, data exchange between AOs and CMS regarding deemed facilities, data management and analysis, CMS–AO communication and relationship building, AO education, performance management, and assisting the AOs to utilize the data which they have entered into the ASSURE database for continuous performance improvement and self-monitoring.

- **Deeming Application Reviews:** Deeming application and standards reviews are conducted by a team of trained analysts to ensure consistent application of a standardized rigorous review methodology. All findings are subject to detailed supervisory review to enhance reliability and consistency. As a result, AO applications, standards, and survey process are reviewed comprehensively and consistently, and areas for improvement are being identified and communicated to the AOs for correction before applications may be approved. In FY 2011, the team completed four deeming application reviews (one of which was withdrawn prior to publication). Other deeming program review activity included three 180-day performance reviews, 18 standards reviews, and 10 survey process and surveyor guidance revisions. CMS also identified and addressed 44 issues outside an application review that arose in case-specific instances and which suggested problems in the manner in which an AO implements its CMS-approved accreditation program. Through this case-based process, CMS facilitates resolution of issues and improved AO performance.
- **Accrediting Organization Reporting on Deemed Facilities:** CMS continues to focus on obtaining complete, accurate and timely data from AOs on facilities accredited under their approved Medicare programs. This has been a major challenge for both CMS and the AOs. ASSURE, a CMS electronic database to inventory and track AO actions that affect the deemed status of a facility, enables the AOs to provide demographic and survey activity information for deemed facilities to CMS on a quarterly basis. It provides both CMS and the AOs with the means to collect, analyze, and manage data regarding deemed facilities, and supports CMS oversight of the AOs and their CMS-approved accreditation programs. Work is underway to transition ASSURE to a web-based system which will provide increased functionality, enhanced data base integrity and security, faster processing times, increased accessibility and adaptability, and the capability for more frequent AO reporting, should CMS decide as a matter of policy that this would be needed.
- **Ongoing Communications with Accreditation Organizations:** CMS continues its periodic meetings with recognized national AOs, including quarterly teleconferences and an annual face-to-face meeting. These meetings serve to foster communication between the AOs and CMS, and serve as a forum to: discuss any issues as they arise; better assure ongoing deemed facility compliance with Medicare conditions; and, provide information and education for AO staff. CMS and individual AOs communicate on a weekly, if not daily, basis, either by email or telephone, to address a wide variety of issues related to: deemed facilities, operations, surveys, and data.
- **Ongoing Education and Support of Accreditation Organizations:** AO staff is afforded many opportunities for education. CMS provides detailed, written and verbal feedback to the AOs as part of the deeming application and data review processes. This feedback includes specific reference to Medicare regulatory requirements as well as SOM references and attachments. Formal education is provided at the annual CMS-AO meeting as well as periodically at the request of individual AOs. AOs are also provided the opportunity to send representatives to State Agency Surveyor Training. CMS-AO annual meeting continues to include breakout sessions by program type and interactive sessions.

- **Methodological Changes to Improve Oversight:** The CMS continues to refine and improve the current methods for measuring AO performance in assuring compliance with the Medicare requirements. FY 2011 AO performance measures are summarized in Table 5. Measures are calculated and shared with individual AOs on a quarterly basis. Measures are reviewed, evaluated and updated on an annual basis. At the CMS-AO meeting in 2012, AO staff again participated in a table-top exercise to calculate selected performance measures based on their AO's data. Through these exercises AOs are better able to understand their data, data issues, as well as how to improve their documentation.
- **Validation Program Sample Size:** In FY 2011, 289 validation surveys were conducted across deemed providers and suppliers. This represents an increase since FY 2007, when 90 validation surveys were performed, of 221 percent, including 33 special, mid-cycle LTCH validations. Not only has the total number of validations surveys conducted increased, but the number of 60-day validation surveys conducted for each AO and facility type has also increased. As sample sizes increase, so does the reliability and validity of the analysis.
- **Quality Assessment and Performance Improvement:** In FYs 2007 through 2009, CMS added requirements to its conditions for hospices, transplant hospitals, dialysis facilities, and ASCs that these facilities have an effectively working, internal quality assessment and performance improvement (QAPI) system. As part of the Department of Health and Human Services *Partnership for Patients: Better Care, Lower Costs* initiative launched in April 2011, CMS continues its focus on reducing hospital readmissions and healthcare acquired conditions. One aspect of CMS' efforts in this area targets strengthening the survey process, revising surveyor guidance, and developing and testing surveyor tools related to the evaluation of a hospital's compliance with the CoPs for QAPI, Infection Control and Discharge Planning. CMS' working assumption is that hospitals in full compliance with these Medicare CoPs will be in a better position to reduce hospital-acquired conditions, including healthcare-associated infections, and preventable hospital readmissions. To this end, CMS developed and is pilot-testing three surveyor worksheets that are intended to aid surveyors in assessing hospital compliance with these Medicare CoPs. AOs with approved hospital accreditation programs participate and have partnered with CMS in this initiative by providing input into the development and testing of these surveyor tools, and encouraging their accredited hospitals to use these tools to self-assess, monitor, and improve their own practices related to QAPI, infection control, and discharge planning.
- **Consultation:** CMS increased opportunities for AOs as well as other stakeholders to provide input into the development of sub-regulatory guidance concerning Medicare standards and survey processes. CMS has committed to ongoing consultation in an effort to improve the resulting guidance.
- **Physical Environment:** In FY 2010, CMS Life Safety Engineers completed an analysis of AO and SA physical environment findings for validation surveys conducted in FYs 2006 through 2009 and identified the top ten disparate deficiencies for LSC cited by the SA, but not cited by the AO. These ten deficiencies account for more than half of all LSC deficiencies. These top ten deficiencies held true for FY 2011 validations surveys as well. CMS Engineers presented the results of this analysis to all AOs at the CMS-AO annual meetings in March 2010 and 2011. All AOs are encouraged to utilize this information to strengthen their ability to evaluate compliance with the physical environment CoP and reduce disparity in this area. As discussed by several AOs in the summary of their improvements efforts (Section 7 of this report), AOs are increasingly focused on LSC surveyor training, developing data collection tools used for the LSC portion of a survey, and enhancing their survey process for physical environment and LSC.

CLINICAL LABORATORY IMPROVEMENT VALIDATION PROGRAM

Introduction

This report on the Clinical Laboratory Improvement Validation Program covers the evaluations of fiscal year (FY) 2011 performance by the six accreditation organizations approved under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The six organizations are as follows:

- AABB
- American Osteopathic Association (AOA)
- American Society for Histocompatibility and Immunogenetics (ASHI)
- COLA
- College of American Pathologists (the College)
- The Joint Commission (JC)

CMS appreciates the cooperation of all of the organizations in providing their inspection schedules and results. While an annual performance evaluation of each approved accreditation organization is required by law, we see this as an opportunity to present information about, and dialogue with, each organization as part of our mutual interest in improving the quality of testing performed by clinical laboratories across the Nation.

Legislative Authority and Mandate

Section 353 of the Public Health Service Act, as amended by CLIA, requires any laboratory that performs testing on human specimens to meet the requirements established by HHS and have in effect an applicable certificate. Section 353 further provides that a laboratory meeting the standards of an approved accreditation organization may obtain a CLIA Certificate of Accreditation. Under the CLIA Certificate of Accreditation, the laboratory is not routinely subject to direct Federal oversight by CMS. Instead, the laboratory receives an inspection by the accreditation organization in the course of maintaining its accreditation, and by virtue of this accreditation, is "deemed" to meet the CLIA requirements. The CLIA requirements pertain to quality assurance and quality control programs, records, equipment, personnel, proficiency testing, and others to assure accurate and reliable laboratory examinations and procedures.

In section 353(e) (2) (D), the Secretary is required to evaluate each approved accreditation organization by inspecting a sample of the laboratories they accredit and "such other means as the Secretary determines appropriate." In addition, section 353(e) (3) requires the Secretary to submit to Congress an annual report on the results of the evaluation. This report is submitted to satisfy that requirement.

Regulations implementing section 353 are contained in 42CFR part 493 Laboratory Requirements. Subpart E of part 493 contains the requirements for validation inspections, which are conducted by CMS or its agent to ascertain whether the laboratory is in compliance with the applicable CLIA requirements. Validation inspections are conducted no more than 90 days after the accreditation organization's inspection, on a representative sample basis or in response to a complaint.

The results of these validation inspections or "surveys" provide:

- on a laboratory-specific basis, insight into the effectiveness of the accreditation organization's standards and accreditation process; and
- in the aggregate, an indication of the organization's capability to assure laboratory performance equal to or more stringent than that required by CLIA.

The CLIA regulations, in section 493.575 of subpart E, provide that if the validation inspection results over a one-year period indicate a rate of disparity of 20 percent or more between the findings in the accreditation organization's results and the findings of the CLIA validation surveys, CMS will re-evaluate whether the accreditation organization continues to meet the criteria for an approved accreditation organization (also called "deeming authority"). Section 493.575 further provides that CMS has the discretion to conduct a review of an accreditation organization program if validation review findings, irrespective of the rate of disparity, indicate such widespread or systematic problems in the organization's accreditation process that the requirements are no longer equivalent to CLIA requirements.

Validation Reviews

The validation review methodology focuses on the actual implementation of an organization's accreditation program described in its request for approval. The accreditation organization's standards, as a whole, were approved by CMS as being equivalent to or more stringent than, the CLIA condition-level requirements[6], as a whole. This equivalency is the basis for granting deeming authority.

In evaluating an organization's performance, it is important to examine whether the organization's inspection findings are similar to the CLIA validation survey findings. It is also important to examine whether the organization's inspection process sufficiently identifies, brings about correction, and monitors for sustained correction, laboratory practices and outcomes that do not meet their accreditation standards, so that equivalency of the accreditation program is maintained.

The organization's inspection findings are compared, case-by-case for each laboratory in the sample, to the CLIA validation survey findings at the condition level. If it is reasonable to conclude that one or more of those condition-level deficiencies were present in the laboratory's operations at the time of the organization's inspection, yet the inspection results did not note them, the case is a disparity. When all of the cases in each sample have been reviewed, the "rate of disparity" for each organization is calculated by dividing the number of disparate cases by the total number of validation surveys, in the manner prescribed by section 493.2 of the CLIA regulations.

Number of Validation Surveys Performed

As directed by the CLIA statute, the number of validation surveys should be sufficient to "allow a reasonable estimate of the performance" of each accreditation organization. A representative sample of the approximately 16,000 accredited laboratories received a validation survey in 2011. Laboratories seek and relinquish accreditation on an ongoing basis, so the number of laboratories accredited by an organization during any given year fluctuates. Moreover, many laboratories are accredited by more than one organization. Each laboratory holding a Certificate of Accreditation, however, is subject to only one validation survey for the accreditation organization it designates for CLIA compliance, irrespective of the number of accreditations it attains.

Nationwide, fewer than 500 of the accredited laboratories used AABB, AOA, or ASHI accreditation for CLIA purposes. Given these proportions, very few validation surveys were performed in laboratories accredited by those organizations. The overwhelming majority of accredited laboratories in the CLIA program used their accreditation by COLA, the College or the JC, thus the sample sizes for these organizations were larger. The sample sizes are roughly proportionate to each organization's representation in the universe of accredited laboratories; however, true proportionality is not always possible due to the complexities of scheduling.

The number of validation surveys performed for each organization is specified below in the summary findings for the organization.

Results of the Validation Reviews of Each Accreditation Organization

AABB

Rate of disparity: zero percent

In FY 2011, approximately 220 laboratories used their AABB accreditation for CLIA program purposes. Validation surveys were conducted in 12 AABB-accredited laboratories. Condition-level deficiencies were cited in two of the validation surveys and the AABB inspection reports noted comparable findings for both laboratories. The AABB is to be commended for this outcome.

AMERICAN OSTEOPATHIC ASSOCIATION

Rate of disparity: zero percent

For CLIA purposes, approximately 80 laboratories used their AOA accreditation. Six validation surveys were conducted. No condition-level deficiencies were cited in any of the validation surveys. When each validation survey results in compliance with the CLIA condition-level requirements, as is the case with the AOA accredited laboratories this year, disparity is precluded.

AMERICAN SOCIETY FOR HISTOCOMPATIBILITY AND IMMUNOGENETICS

Rate of disparity: zero percent

Approximately 120 laboratories used their ASHI accreditation for CLIA purposes. Validation surveys were conducted in five ASHI-accredited

[6] A condition-level requirement pertains to the significant, comprehensive requirements of CLIA, as opposed to a standard-level requirement, which is more detailed, and more specific. A condition-level deficiency is an inadequacy in the laboratory's quality of services that adversely affects, or has the potential to adversely affect, the accuracy and reliability of patient test results.

laboratories. No condition-level deficiencies were cited in any of the validation surveys. When each validation survey results in compliance with the CLIA condition-level requirements, as is the case with the ASHI accredited laboratories this year, disparity is precluded.

The ASHI is to be commended for its history of zero percent disparity in 15 out of the past 16 years of validation reviews.

COLA

Rate of disparity: 7 percent

A total of 177 validation surveys were conducted in COLA-accredited laboratories. Four surveys were removed from the review pool for administrative reasons. Of the remaining 173 surveys, 24 laboratories were cited with condition-level deficiencies. In 12 of those laboratories, COLA noted findings comparable to all of the CLIA condition-level deficiencies cited. In the other 12 laboratories, however, COLA noted comparable findings to only some or none of the CLIA condition-level deficiencies cited; thus, there were 12 disparate cases. The disparity rate this year (7 percent) is an improvement compared to the results of the previous two years (18 percent and 12 percent) respectively.

COLLEGE OF AMERICAN PATHOLOGISTS

Rate of disparity: 11 percent

A total of 101 validation surveys were conducted in CAP-accredited laboratories. One survey was removed from the review pool for administrative reasons. Of the remaining 100 surveys, 15 laboratories were cited with CLIA condition-level deficiencies. In four of those laboratories, the College noted comparable findings to all of the CLIA condition-level deficiencies cited. In the other 11 laboratories, the College noted comparable findings to only some or none of the CLIA condition-level deficiencies cited; thus, there were 11 disparate cases for a disparity rate of 11 percent.

THE JOINT COMMISSION

Rate of disparity: 16 percent

During this validation period, a total of 77 validation surveys were conducted in JC-accredited laboratories. Three surveys were removed from the validation review pool for administrative reasons. Of the remaining 74 validation surveys, 16 laboratories were cited with CLIA condition-level deficiencies. In four of those laboratories, the JC noted findings comparable to all of the CLIA condition-level deficiencies cited. In the other 12 laboratories, the JC noted comparable findings to only some or none of the CLIA condition-level deficiencies cited; thus, there were 12 disparate cases yielding a disparity rate of 16%, similar to the 14% rate found for the previous year.

Conclusion

CMS has performed this validation review in order to evaluate and report to Congress as required by statue on the performance of the six laboratory accreditation organizations approved under CLIA. This endeavor is two-fold: to verify each organization's capability to assure laboratory performance equal to, or more stringent than, that required by CLIA ("equivalency"); and to gain insight into the effectiveness of the accreditation organization's standards and accreditation process on a laboratory-specific basis.

CMS recognizes that similarity of accreditation organization findings to CLIA validation survey findings is an important measure of the organization's capability to ensure equivalency and effectiveness of oversight. Another important measure is an organization's capability to sustain equivalency and effectiveness of oversight. When an accredited laboratory's practices and outcomes fail to conform fully to the accreditation standards, it is important that the accreditation organization's inspection protocol sufficiently identifies the deficiencies, brings about correction and monitors for sustained compliance, so that the laboratory is again in full conformance with the accreditation standards and equivalency is sustained.

In the interest of furthering the mutual goal of promoting quality testing in clinical laboratories and furthering the goal of sustained equivalency, CMS has formed the Partners in Laboratory Oversight group. The group includes the six accreditation organizations. It meets regularly to discuss and resolve issues of mutual interest and to share best practices. The group endeavors to improve their overall consistency in application of laboratory standards, coordination, collaboration and communication in both routine and emergent situations. Through these efforts we hope to further improve the level of laboratory oversight.

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.

Actuarial Soundness: A measure of the adequacy of Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) financing as determined by the difference between trust fund assets and liabilities for specified periods.

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.

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 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

Carrier: A private business, typically an insurance company, that contracts with CMS to receive, review, and pay physician and supplier claims. Carriers have been largely replaced by Medicare Administrative Contractors.

Cash Basis Accounting: A basis of accounting that tracks outlays or new expenditures during the current period regardless of the fiscal year the service was provided or the expenditure was incurred.

Chief Financial Officers Act of 1990 (CFO): The CFO Act of 1990 established a leadership structure, provided for long range planning, required audited financial statements, and strengthened accountability reporting. The aim of the CFO Act is to improve financial management systems and information, and requires the development and maintenance of agency financial management systems that comply with: applicable accounting principles, standards, and requirements; internal control standards; and requirements of OMB, the Department of the Treasury, and others.

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.

Common Working File (CWF): A pre-payment claims validation and Medicare Part A/Part B benefit coordination system, which uses localized databases, maintained by a host contractor.

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: The detailed actions that are taken 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.

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.

Discretionary Spending: Outlays of funds subject to the Federal appropriations process.

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 hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

Durable Medical Equipment Medicare Administrative Contractors (DME MACS): In an effort to provide greater efficiency in the Medicare program as it applies to Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), CMS awarded contracts to four health care contractors which cover a specific geographic region of the country and only processes Medicare claims for DMEPOS items.

E

Early Retiree Reinsurance Program (ERRP): The ERRP provides reimbursement to employer and union sponsors of participating employment-based plans for a portion of the cost of health benefits for early retirees and their spouses, surviving spouses and dependents.

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.

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): A program that identifies management inefficiencies and areas vulnerable to fraud and abuse so that such weaknesses can be corrected with improved internal controls.

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

Fiscal Intermediary (FI): A private business—typically an insurance company—that contracts with CMS to process hospital and other institutional provider benefit claims. FIs have been largely replaced by Medicare Administrative Contractors.

Fiscal Intermediary Shared System (FISS): The shared claims adjudication system for Part A Medicare claims.

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 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 provide incentive payments to eligible professionals (EPs), hospitals, and critical access hospitals for the "meaningful use" of certified EHR technology.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Major provisions include portability provisions for group and individual health insurance, established the Medicare Integrity Program, and provides for standardization of health data and privacy of health records.

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 (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: Are 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

Mandatory Spending: Outlays for entitlement programs such as Medicaid and Medicare benefits.

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.

Medical Review/Utilization Review (MR/UR): Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

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 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 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.

Multi-Carrier System (MCS): The shared claims adjudication system for Part B Medicare claims.

N

National Institute of Standards and Technology (NIST): A non-regulatory Federal agency within the U.S. Department of Commerce. The NIST mission is to promote U.S. innovation and industrial competitiveness by advancing measurement science, standards, and technology in ways that enhance economic security and improve our quality of life.

O

Obligation: Budgeted funds committed to be spent.

Office of Management and Budget (OMB) Circular A-123: 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."

Part C: Medicare Advantage Program.

Part D: Medicare Prescription Drug Benefit.

Patient Protection and Affordable Care Act (Affordable Care Act) (P.l. 111–148): In FY 2010, Congress passed, and the President signed into law, the Affordable Care Act which puts in place comprehensive health insurance reforms that will hold insurance companies more accountable, lower the deficit, provide more health care choices, and enhance the quality of health care for all Americans. Once fully implemented, the Affordable Care Act will provide Americans with access to affordable health coverage by setting up a new competitive private health insurance market, holding insurance companies accountable by keeping premiums down and preventing many types of insurance industry abuses and denials of care, and ending discrimination against Americans with pre-existing conditions.

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

Program 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: Medicare contractors, survey and certification, research, and administrative costs.

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

Q

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).

Revenue: The recognition of income earned and the use of appropriated capital from the rendering of services in the current period.

Risk-Based Health Maintenance Organization (HMO)/Competitive Medical Plan (CMP): A type of managed care organization. After any applicable deductible or co-payment, all of an enrollee/member's medical care costs are paid for in return for a monthly premium. However, due to the "lock-in" provision, all of the enrollee/member's services (except for out-of-area emergency services) must be arranged for by the risk HMO. Should the Medicare enrollee/member choose to obtain service not arranged for by the plan, he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for services from providers that are not part of the HMO's health care system/network.

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 control deficiency, or a combination of deficiencies, that adversely affects the ability to initiate, authorize, record, process, or report external financial data reliability in accordance with accounting principles such that there is a more than remote likelihood that a misstatement of the financial statements will not be prevented or detected.

State Certification: Inspections of Medicare provider facilities to ensure compliance with Federal health, safety, and program standards.

Statement on Standards for Attestation Engagements (SSAE) Number 16 (SSAE 16): A report issued by an independent public accountant in accordance with standards promulgated by the American Institute of Certified Public Accountants (AICPA) on the internal controls of a servicing organization. The AICPA SSAE 16 defines the professional standard used by a service organization's auditor to assess the internal controls at a service organization.

Supplementary Medical Insurance (SMI) (Part B): The part of Medicare that pays physician and supplier claims.

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.

V

ViPS Medicare System (VMS): The standard claims adjudication system for Medicare Durable Medical Equipment (DME) claims.

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