



CMS FINANCIAL REPORT

TRANSFORMING HEALTH CARE
FOR ALL AMERICANS

fiscal year
2013



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AT A GLANCE

The Centers for Medicare & Medicaid Services (CMS) is an Operating Division within the Department of Health and Human Services (HHS). The CMS Annual Financial Report for FY 2013 presents the agency's detailed financial information relative to our mission and the stewardship of those resources entrusted to us. This report is organized into the following three sections:

1 Management's Discussion & Analysis:

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

2 Financial Section:

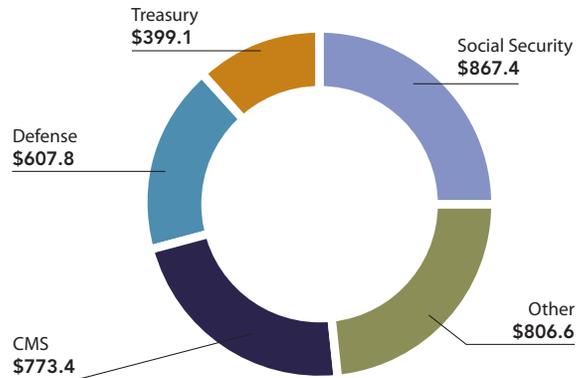
This section contains the message from our Chief Financial Officer, financial statements and notes, required supplementary information, and audit reports.

3 Other 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 Accrediting Organizations, and Clinical Laboratory Improvement Validation Program.

The CMS Annual Financial Reports can be obtained at:

<https://www.cms.gov/CFOReport>



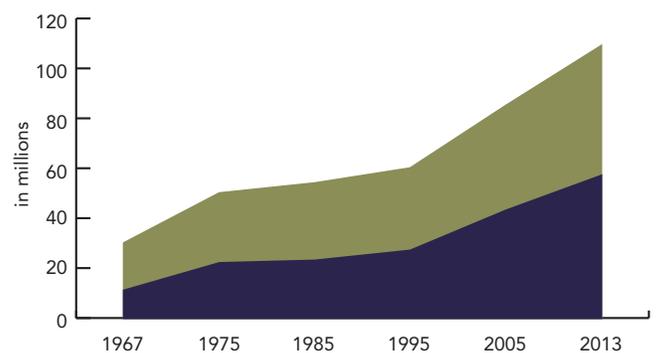
\$ in billions

Source: U.S. Treasury

2013 FEDERAL OUTLAYS

CMS has outlays of approximately \$773.4 billion (net of offsetting receipts and Payments of the Health Care Trust Funds) in fiscal year (FY) 2013, approximately 22 percent of total Federal outlays.

CMS has over 6,000 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.



2013 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 52 million beneficiaries. Medicaid enrollment has increased from 10 million beneficiaries in 1967 to about 57 million beneficiaries.

A MESSAGE FROM THE ADMINISTRATOR

MARILYN TAVENNER



The Centers for Medicare & Medicaid Services (CMS) is committed to strengthening and modernizing the nation's health care system to provide access to high quality care at a lower cost. We are focused on measurably improving care and population health by transforming the United States health care system into an integrated and accountable system that continues to improve care, reduce unnecessary costs, prevent illness and disease progression, and promote public health. We strive to find better ways to ensure that individuals' health care is accessible and delivered efficiently and effectively.

CMS is continuing its implementation of programs and initiatives related to electronic health records (EHRs). Adoption of EHRs makes it easier for physicians, hospitals, and others serving Medicare and Medicaid beneficiaries to assess a patient's medical status and ensure that care is appropriate. They also help to reduce redundant and costly procedures. Through the Medicare and Medicaid EHR Incentive Programs, incentives have been paid to over 325,000 health care providers to promote the adoption and meaningful use of EHRs. In the coming year, many health care providers will begin Stage 2 of the EHR Incentive Programs, which promotes information exchange for better care coordination and online access for patients to their important health information.

Medicare continues to be a strong and thriving program. Because of the Affordable Care Act, out-of-pocket savings on medications for people with Medicare continue to grow. Just this year, 2.8 million people in the Medicare prescription drug coverage gap, known as the "donut hole," have each saved an average of \$834. Over 7.1 million people with Medicare have saved \$8.3 billion on prescription drugs in the Medicare Part D coverage gap since the law was enacted. Medicare beneficiaries in the coverage gap now receive discounts and some coverage when they purchase prescription drugs at a pharmacy or order them through the mail, until they reach the catastrophic coverage phase. The Affordable Care Act, in 2011, began phasing in discounts and coverage for brand-name and generic prescription drugs. The law will continue to provide additional savings each year until the coverage gap is closed in 2020.

CMS is currently partnering with 243 organizations in Medicare accountable care organization (ACO) arrangements that reward health care providers for providing patients with high quality care and lowering the rate of growth in Medicare expenditures. In 2012, CMS launched the initial performance periods of the Medicare Shared Savings Program and the Pioneer ACO Model. The ACOs participating in these initiatives offer care to over 3.8 million beneficiaries. ACOs participating in CMS initiatives are highly diverse and include integrated health systems and networks of individual physician practices offering care in rural and urban areas in 47 states, as well as the District of Columbia and Puerto Rico. Later this year, CMS will announce another group of ACOs with a January 2014 start date for the Medicare Shared Savings Program.

A top priority for the Agency is enhancing program integrity, and we have made important strides in reducing fraud, waste, and improper payments across the government. This past year, CMS continued to use its powerful anti-fraud tools provided by Congress to shift beyond a "pay and chase" approach to preventing fraud. CMS completed its first implementation year of the Fraud Prevention System, the predictive analytic technology that identifies suspect claims before payment, and reported an estimated \$115 million in fraudulent payments that were stopped, prevented, or identified in its first year. We led the first information exchange in the Healthcare Fraud Prevention Partnership, a public-private partnership among the federal government, states, and private health insurance companies and associations, to prevent and detect fraud across the health care industry. CMS expanded the Medicare-Medicaid Data Match Program (Medi-Medi), a

collaborative program to analyze billing trends across the Medicare and Medicaid programs to identify potential fraud, waste, and abuse, to 20 states, which represented 67 percent of Medicaid billing in fiscal year (FY) 2011. CMS is also strengthening our provider and supplier enrollment rules, and reported that, as a result of the targeted screening requirements in the Affordable Care Act and other enrollment activities, the number of provider and supplier revocations has doubled, and in some states revocations have quadrupled, compared to the two-year period prior to the Affordable Care Act. Finally, we imposed the first temporary provider and supplier enrollment moratoria under the Affordable Care Act in three high risk geographic areas of fraud, waste, and abuse.

CMS is continuing its coordination of the Quality Improvement Organization (QIO) program, one of the largest federal programs dedicated to improving the health quality of Medicare beneficiaries at the local level. The QIO program is the keystone initiative of Medicare's national health care quality improvement portfolio. As such, the QIO program serves as CMS's key implementer of its quality improvement goals for Medicare at the grassroots, "bedside" level. Today, CMS holds 53 contracts with entities that serve as QIOs, with the charge to work at the grassroots level of American health care delivery systems in all 50 states, the District of Columbia, and most U.S. territories in order to improve care for Medicare beneficiaries. QIOs represent CMS as change agents and conveners for widespread, significant improvements in the care provided to Medicare beneficiaries. They offer knowledge and resources for improving health quality, efficiency, and value that may also benefit all patients/residents/clients. In 2012, QIOs across the country recruited nearly 5,000 nursing homes (or over 435,000 nursing home residents nationwide) to participate in a first-of-its-kind National Nursing Home Quality Care Collaborative, which launched in early 2013. Preliminary data show that the quality of skilled-nursing care overall is improving among these homes.

On February 7, 2013, CMS published a proposed rule, *Part II—Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction*. The rule, as well as certain regulations under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), reduces burden, both monetary and operationally, for many health care providers and suppliers. This rule follows the original burden reduction rule that was published in FY 2012, which also addressed the regulatory reforms required under the Executive Order 13563. CMS estimates a one-time savings of \$22 million, and an annual recurring savings of \$654 million from

implementation of this second burden reducing rule, while improving safety for patients. Stakeholders have been very supportive of the provisions of this proposed rule. Publication of a final rule is expected in FY 2014.

Medicare beneficiaries continue to show great interest in Medicare Advantage (MA) plans. Access to the MA program remains strong, with 99.6 percent of beneficiaries having access to a plan in 2013. Enrollment in the MA program has increased by 9.3 percent and premiums remain steady in the current year. Since the Affordable Care Act was signed into law in 2010, MA premiums have fallen by 14.3 percent and enrollment has risen by 26.6 percent, while access to supplemental benefits remains steady and beneficiaries' average out-of-pocket spending remains constant. Star Ratings coupled with Quality Bonus Payments are driving improvements in Medicare quality. For the 2014 Star Ratings, there have been significant increases in MA plans' quality relative to the 2013 ratings. Currently, over half of all MA enrollees are in contracts with four or more stars. CMS is continuing to promote enrollment in high quality plans and alert beneficiaries who are enrolled in lower quality plans. Medicare beneficiaries enrolled in consistently low-performing plans now receive notifications to let them know how they can change to a higher quality plan. Additionally, the Plan Finder online enrollment functionality was turned off for consistently low-performing plans beginning in plan year 2013. Our 5-star plans continue to be rewarded by being allowed to continuously market and enroll beneficiaries throughout the year. In 2013, there was a significant increase in the percentage of beneficiaries switching out of MA and Prescription Drug Plan (PDP) contracts with consistently low performance into contracts with higher star ratings (from 17 percent in 2012 to 27 percent in 2013).

Citizens depend on our programs, and I have seen first-hand the important work this Agency produces and the essential services it provides to many in our society. We will continue to meet their needs by continuously striving to provide critically important services as effectively and efficiently as possible. I encourage you to read about the vigorous strides CMS is undertaking to protect the health care of the millions of beneficiaries we serve as described in the 2013 CMS Financial Report.



MARYLYN TAVENNER
CMS Administrator

December 2013

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

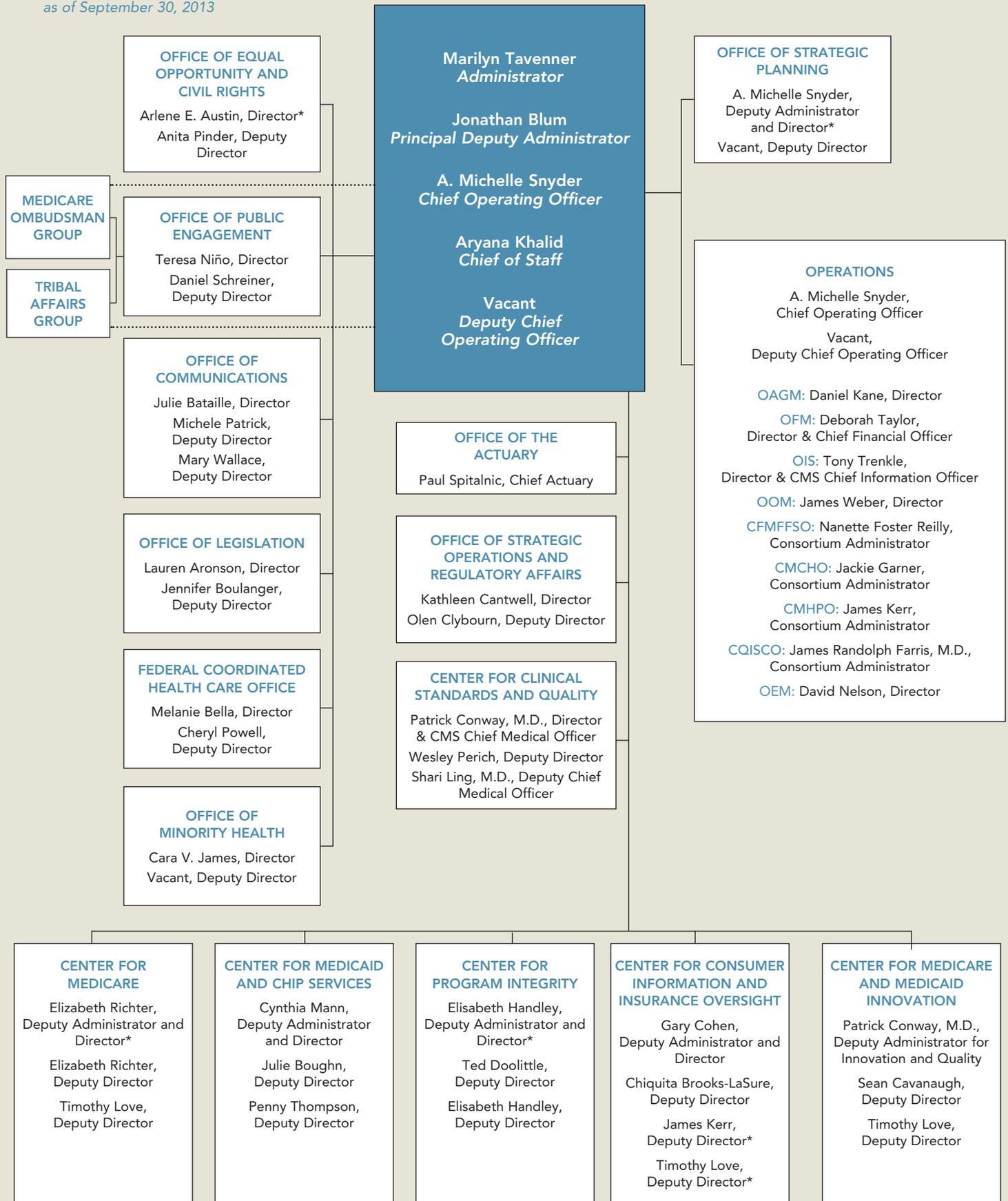
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OUR MISSION: We envision ourselves as a major force and trustworthy partner for continual improvement of health and health care for *all* Americans.

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

APPROVED LEADERSHIP
as of September 30, 2013





MANAGEMENT'S DISCUSSION AND ANALYSIS

1

Overview // Programs // Performance Goals // Financial Accomplishments //

MANAGEMENT'S DISCUSSION AND ANALYSIS

OVERVIEW

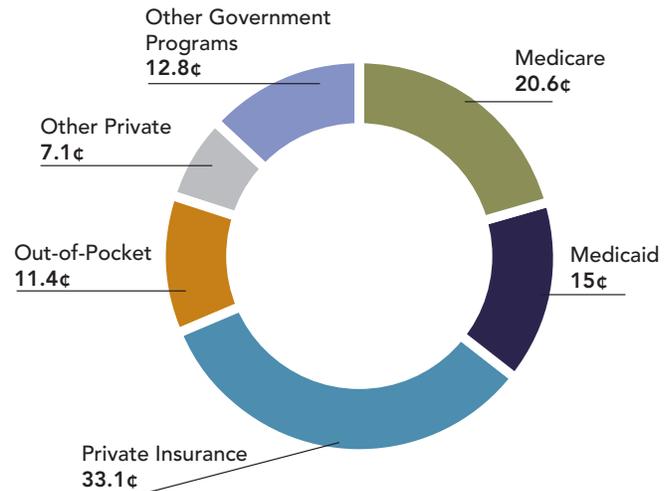
CMS, a component of HHS, administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Clinical Laboratory Improvement Amendments of 1988 (CLIA). With the passage of the Affordable Care Act, CMS' role in the larger health care arena has been further expanded beyond our traditional role of administering the Medicare, Medicaid and CHIP Programs. The Affordable Care Act takes significant steps towards expanding coverage and improving access to health care while also improving the quality and affordability of health care for all Americans.

As the largest purchaser of health care in the world, CMS maintains the Nation's largest collection of health care data. Based on the latest projections, Medicare and Medicaid (including state funding), represent 36 cents of every dollar spent on health care in the United States (U.S.)—or looked at from three different perspectives: 55 cents of every dollar spent on nursing homes, 44 cents of every dollar received by U.S. hospitals, and 32 cents of every dollar spent on physician services. CMS **outlays** totaled approximately \$773.4 billion (net of offsetting collections and receipts) in fiscal year (FY) 2013. Our **expenses** totaled approximately \$849.6 billion, of which \$4.4 billion (or less than one percent) were administrative expenses.

CMS employs over 6,000 Federal employees in Maryland, Washington, DC, and 10 regional offices (ROs) throughout the country. We provide direct services to state agencies, health care providers, beneficiaries, sponsors of group health plans, Medicare health and prescription drug plans, and the general public. Employees also write policies and regulations that establish program eligibility and benefit coverage; set payment rates; safeguard the fiscal integrity of the programs it administers from fraud, waste, and abuse; and develop quality measurement systems to monitor quality, performance, and compliance. CMS also provides technical assistance to Congress, the Executive branch, universities, and other private sector researchers.

Many important activities CMS is responsible for are also handled by third parties. Each state

THE NATION'S HEALTH CARE DOLLAR 2013



Source: U.S. Treasury

administers the Medicaid program and CHIP, as well as inspects hospitals, nursing homes, and other facilities to ensure that health and safety standards are met. The Medicare Administrative Contractors (MACs) process Medicare claims, provide technical assistance to providers and answer beneficiary inquiries. Additionally, Quality Improvement Organizations (QIOs) conduct a wide variety of quality improvement programs to ensure quality of care provided to Medicare beneficiaries.

PROGRAMS

Medicare

Medicare was established in 1965 as title XVIII of the Social Security Act. It was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people aged 65 and over. In 1972, the program was expanded to cover the disabled, people with end-stage renal disease (ESRD) requiring dialysis or kidney transplant, and people age 65 or older that elect Medicare coverage. The Medicare program was further expanded in 2003 to include

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.

a prescription drug benefit. In 2010, the President signed legislation to develop 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 continues to be a significant legislation passed which has had significant impact to CMS.

Medicare processes over one billion fee-for-service (FFS) claims a year, and accounts for approximately 15 percent of the Federal Budget. Medicare is a combination of four programs: Hospital Insurance, Supplementary Medical Insurance, Medicare Advantage, and Medicare Prescription Drug Benefit. Since 1966, Medicare enrollment has increased from 19 million to over 52 million beneficiaries.

Hospital Insurance

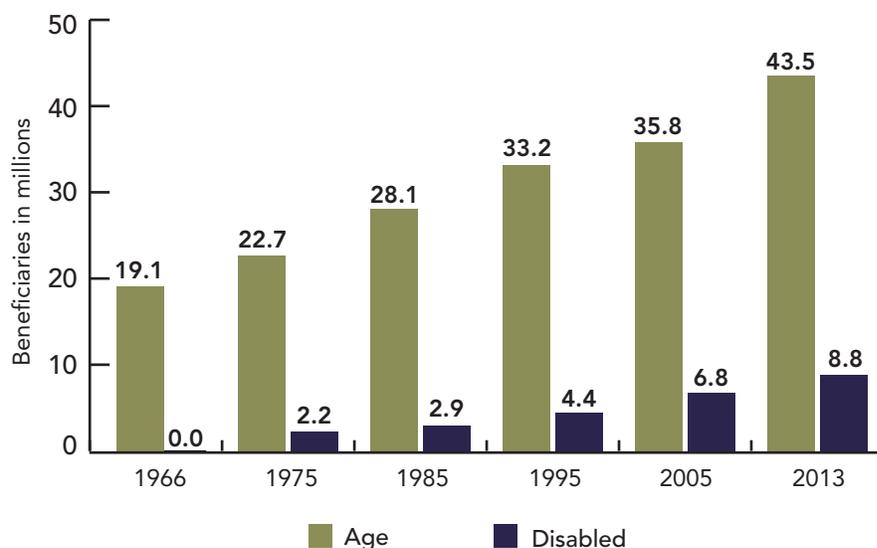
Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. The HI program pays for hospital, 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 2014 President's budget, inpatient hospital spending accounted for 53 percent of HI benefit outlays in FY 2013. Managed care spending comprised 28 percent of total HI outlays. During FY 2013, HI benefit outlays increased by 5.1 percent, and the HI benefit outlays per enrollee were projected to increase by 1.7 percent to \$5,090.

Supplementary Medical Insurance

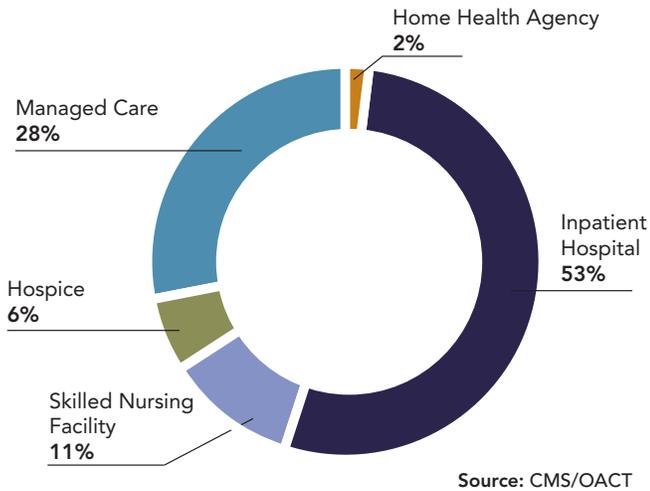
Supplementary Medical Insurance, also known as SMI or Medicare Part B, is voluntary and available to nearly all people aged 65 and over, the disabled, and people with ESRD who are entitled to Part A benefits. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment (DME), designated therapy, some outpatient prescription drugs, and other services not covered by HI. The SMI coverage is optional, and beneficiaries are subject to monthly premium payments. About 92 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.

MEDICARE ENROLLMENT



MANAGEMENT'S DISCUSSION AND ANALYSIS

HI MEDICARE BENEFIT PAYMENTS

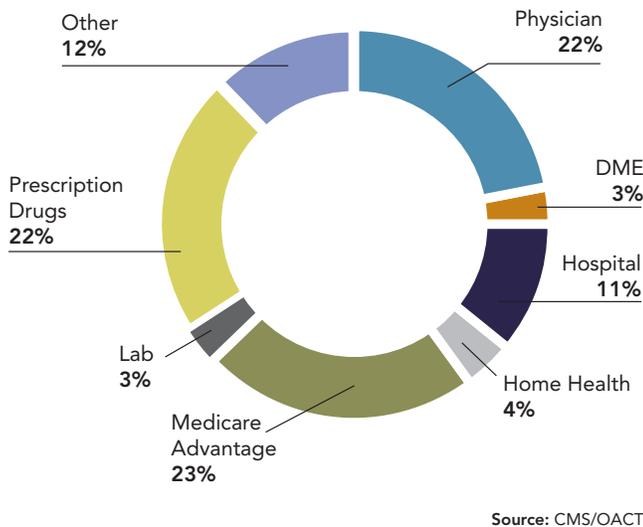


Based on estimates from the Midsession Review of the FY 2014 President's budget, SMI benefit outlays increased by 9.9 percent during FY 2013. Managed care payments, the largest component of SMI, accounted for 23 percent of SMI benefit outlays. During FY 2013, the SMI benefit outlays per enrollee were projected to increase 6.2 percent to \$6,640.

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.

SMI MEDICARE BENEFIT PAYMENTS



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 \$141.5 billion of the total \$561.9 billion in Medicare benefit payment expenses in FY 2013.

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 2013 standard benefits generally have a \$325 deductible and coinsurance of 25 percent after the deductible up to the initial coverage limit of \$2,970 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 \$4,750. 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 2013, it includes 21 percent plan coverage for generic drugs and a 52.5 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.

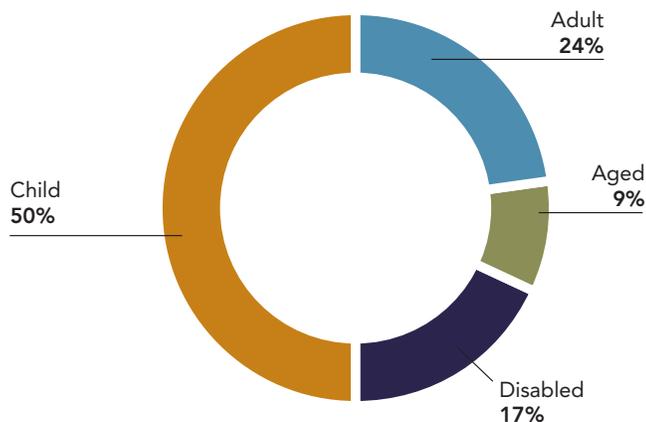
Employer, union, and other Plan Sponsors (PS) of group health plans that offer a prescription drug benefit that is actuarially equivalent to Part D are able to apply for the Retiree Drug Subsidy (RDS) program. A PS may only receive subsidy payments for qualifying covered retirees. All PS that provide 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.

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

FY 2013 MEDICAID ENROLLEES



Source: CMS/OACT

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 2013, about 18 percent of the U.S. population. About 10 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 2013, the basic Federal matching rate for Medicaid program costs among the states according to the formula ranged from 50 to 73.4 percent. The weighted average matching rate for FY 2013 is expected to be 58 percent. Federal matching rates for various state and local administrative costs are set by statute. The Federal government currently pays about 62 percent of these costs. Medicaid payments to states are funded by Federal general revenues provided to CMS through an annual appropriation.

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 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 2013, Medicaid spending for persons with AIDS as well as others infected with the Human Immunodeficiency Virus (HIV) is estimated to be about \$10.5 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 2013, state and Federal ADM gross outlays are estimated at \$23.7 billion, about 5 percent of the gross Medicaid outlays. State and Federal MAP total outlays were \$448.8 billion or 95 percent of total Medicaid outlays, an increase of 9.4 percent over FY 2012. Thus, state and Federal MAP and ADM outlays for FY 2013 totaled \$472.4 billion. CMS' share of Medicaid outlays totaled \$274.8 billion in FY 2013.

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 26 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 Mechanisms 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 and/or state plan options provided by CMS to introduce managed care plans tailored to their state and local needs, and 49 states and territories 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.

4. **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 adults with incomes below 133 percent of the Federal Poverty Level beginning January 1, 2014, at state option. States could also choose 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) and the Health Information Exchange (HIE) 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/HIE is key to CMS' efforts to better measure, monitor and assure the quality of care provided in Medicaid. Finally, 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.

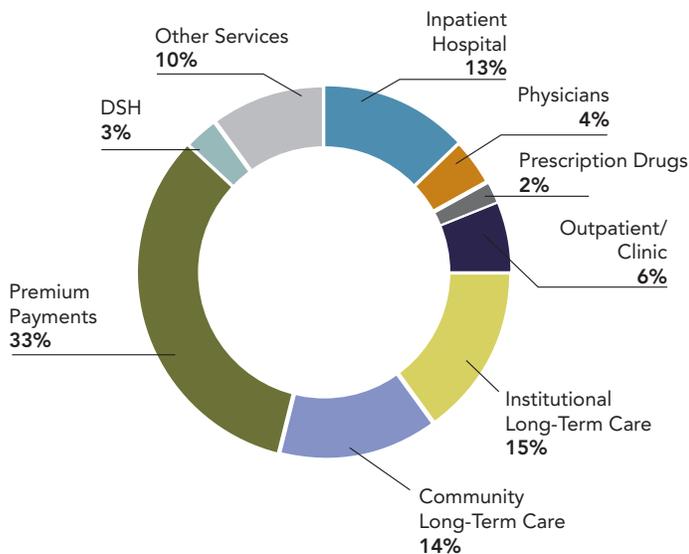
¹ 49 states offer managed care; the number includes DC and PR. AK, NH, VI, and WY do not offer managed care. The July 1, 2011 data is collected from the states and represents that point-in-time. FY 2012 data is not available at this time.

MANAGEMENT'S DISCUSSION AND ANALYSIS

MEDICAL ASSISTANCE PAYMENTS BY AGGREGATE SERVICE CATEGORIES

IN BILLIONS

Total Payments: \$434.3 billion



Source: President's FY 2013 Budget, Mid-session Review

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. The Affordable Care Act² and CHIPRA³ specifically appropriated \$525 million dollars to strengthen the quality of care and health outcomes for children and adults enrolled in Medicaid and CHIP. These initiatives include:

- Establishing an initial core set of child and adult quality performance measures for voluntary reporting by state Medicaid and CHIP programs with annual review and update;
- \$100 million across ten grants (that include 18 states) to test innovative approaches to using performance measures, HIT/HIE, EHR, and provider delivery models to improve the quality of care for children;
- Establishing a model 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;
- Develop 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 Maternal and Infant Health Outcomes Initiative;
- A Children's Oral Health Improvement initiative;
- A Medicaid Prevention Learning Network;
- Improving access, data collection/reporting, and assessment of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services; and
- Demonstration grants across 26 states to measure improvement of quality healthcare for adults in Medicaid.

Federal Medical Assistance Percentages (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

² Public law 111-148 patient protection and affordable care act Subtitle I—Improving the Quality of Medicaid for Patients and Providers, Sect. 2701. Adult Health Quality Measures (\$300 million)

³ Public law 111-3 children's health insurance reauthorization act of 2009 Title IV—Strengthening Quality of Care and Health Outcomes, Sect. 401. Child Health Quality Improvement Activities for Children Enrolled in Medicaid or CHIP (\$225 million).

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 the basis specified by the Secretary of HHS.

Medicaid Home and Community-Based Services

Medicaid affords states with opportunities to provide home and community-based services as an alternative to institutional services. In 2013, 47 states and the District of Columbia operated 314 1915(c) Home and Community-Based Services waivers serving over 1,000,000 individuals. Preliminary reports for 2011 indicate the costs for services and supports nationally were approximately \$36 billion. 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. The Affordable Care Act also implemented the 1915(k) Community First Choice Option, which gives states an additional 6 percentage points of federal match for providing personal attendant care.

CMS works closely with our state partners on an evidence-based, continuous quality improvement process for 1915 (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 states' 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. CMS Central Office and Regional Office staff work closely with the states to ensure that the quality goals and measurements for each individual waiver is embedded in the approved waiver. States report to CMS on the progress of the quality program annually and cumulatively through an Evidentiary Report submitted in the fourth year of the five year waiver cycle. Any changes necessitated by the state or CMS findings are incorporated into the waiver at renewal.

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. The Adult Quality measures requirements in the ACA are also providing for a new Demonstration grant FOA now under review called Testing Experience and Functional Assessment Tools. CMS will offer \$45 million to ten qualified state applicants over four years. The grant program, known as TEFT (Demonstration Grant for Testing Experience and Functional Assessment Tools (TEFT) in Community-Based Long Term Services and Supports) is designed to test quality measurement tools and demonstrate e-health in Medicaid long term services and supports.

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

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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 September 2013, state programs for CHIP included 13 Medicaid expansions (includes District of Columbia and all of the territories), 15 separate children health programs and 28 combination CHIP programs.

Consumer Information and Insurance Oversight

CMS is charged with implementing many of the provisions of the Affordable Care Act that relate to private health insurance. 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 in conjunction with states to ensure compliance with a Patient's Bill of Rights and other market reforms that protect consumers through policies like prohibiting insurers from denying coverage for pre-existing conditions, prohibiting annual and lifetime dollar limits on coverage, and ensuring that issuers are complying with

new rating requirements. CMS also oversees the implementation of rules related to rate review and medical loss ratio.

Health Insurance Rate Review/Medical Loss Ratio

The rate review and medical loss ratio programs are two mechanisms to help ensure that consumers receive a good value for their premium dollar and to make the marketplace more transparent. Between FY 2010 and FY 2013, CMS has awarded \$230.5 million in Health Insurance Rate Review Grants to states, territories and the District of Columbia, to help strengthen and improve their rate review processes. CMS works in conjunction with states to ensure that all proposed rate increases above 10 percent are based on reasonable cost assumptions and solid evidence. Additionally, beginning in 2014, CMS is also responsible for monitoring all rate increases.

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.

Enforcement

CMS is responsible for ensuring that issuers comply with new insurance market reforms included in the Affordable Care Act, the Mental Health Parity and Addiction Equity Act (MHPAEA), the Health Insurance Portability and Accountability Act (HIPAA), the Women's Health and Cancer Rights Act (WHCRA), the Newborns' and Mothers' Health Protection Act, Michelle's Law, and the Genetic Information Nondiscrimination Act (GINA). While states have the authority to enforce these provisions, CMS assumes enforcement authority if a state notifies CMS that it either lacks the authority to or is not otherwise enforcing one or more of these provisions. Enforcement activities can include reviewing issuers' policy forms, conducting market conduct examinations, and conducting other activities to ensure issuers are compliant with the laws listed above.

Consumer Information and Support

CMS has given consumers an unprecedented amount of clear information about their coverage options. Even before the implementation of the Federally-facilitated marketplace, <http://www.healthcare.gov>, housed the Plan Finder, the first central database of health coverage options,

combining information about public programs with information on more than 10,000 private insurance plans. CMS continues to update this data regularly to allow consumers to review all the health insurance options specific to their personal situation and local community. Another way CMS has increased transparency for consumers is by requiring all plans and issuers currently providing health benefits to provide to consumers a Summary of Benefits and Coverage (SBC), including coverage examples which detail how cost sharing mechanisms and benefit limits and exclusions work for distinct treatment scenarios, and a uniform glossary. The SBC and uniform glossary allow consumers to make an “apples to apples” comparison of health insurance products by providing consumers with equivalent information on all available coverage options. CMS further protected consumers by establishing a set of uniform standards for external review. Now, consumers in employer sponsored group health plans and in individual health insurance policies can ask an independent third party to review decisions made by their plans and insurance companies to deny preauthorization or payment for a service.

CMS has direct jurisdictional authority over non-Federal governmental plans and provides some health insurance assistance services to consumers enrolled in such plans. Additionally, to support states' efforts to establish or strengthen programs that provide direct services to consumers with questions about health insurance, CMS provides limited direct assistance and referral services to consumers with Affordable Care Act related questions who reside in states without Consumer Assistance Programs (CAP). In late FY 2012, CMS made additional funds available across the country, and continues to provide technical support to those CAPs, including training on assisting consumers with resolving problems with obtaining premium tax credits in the Marketplaces. Also in late FY 2013, CMS awarded Navigator cooperative agreements to states with a Federally Facilitated Marketplace (FFM) or State Partnership Marketplace (SPM) to conduct public education activities to raise awareness of qualified health plans (QHPs); distribute fair, impartial, and linguistically appropriate information concerning enrollment in QHPs and the availability of premium tax credits; facilitate enrollment in QHPs; and provide referrals for any enrollee with a grievance, complaint or question regarding existing coverage.

Affordable Insurance Marketplaces

CMS is working closely with states to implement the Affordable Insurance Marketplaces. Starting

in 2014, these Affordable Insurance Marketplaces will provide individuals and small businesses with a “one-stop shop” to find and compare affordable, quality health insurance options. Grants may be awarded through December 31, 2014, for all Marketplace models. Grant funds are available for permissible and approved establishment activities, which include expenses for outreach, testing, and necessary improvements during the establishment and start-up year. Funding can also be used to support states that wish to transition from a SPM or FFM to a State-based Marketplace.

CMS has awarded a series of grants over the last three FYs to assist with the construction of State-based Affordable Insurance Marketplaces. In FY 2013, CMS awarded \$2.1 billion in three award cycles to states (final application deadline in FY 2013 was August 15, 2013). To ensure states have the flexibility they need to best serve their residents, CMS proposed the Affordable Insurance Marketplace “Partnership Options” that allows states to perform some functions (for example, plan management and/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 program 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 to 2014 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 40 states and the District of Columbia, while 10 states have chosen to run their own programs. The PCIP program began accepting applications for enrollment July 2010 and will provide coverage to enrollees until 2014. Enrollment in PCIP is now closed. In June 2013, there were 104,996 enrollees in the PCIP program 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)

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between a cost threshold and cost limit. As of July 2013, ERRP has supported the availability of affordable health benefits coverage to early retirees and their families through the disbursement of over \$4.87 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 Marketplace that is responsive to consumer needs. The CO-OP program offers low-interest loans to eligible nonprofit groups to help set up and maintain these new health insurance issuers. 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, 24 CO-OPs were established, 23 of which were subsequently licensed and are now 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 August 2013, CMS has awarded \$2 billion in CO-OP loans with \$635 million disbursed and expects some additional loan funding to be awarded to current loan recipients as requests for additional funding and requests to expand operations into additional states are reviewed in FY 2014.

Other Program Initiatives 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. CMS continues to make progress toward strengthening and modernizing the Nation's health care to provide access to high quality and improved health at lower costs. CMS' strategy outlines the critical work that the Agency conducts in achieving:

1. better care and lower costs;
2. prevention and population health;
3. expanded health care coverage; and
4. enterprise excellence.

Business Transformation

The role of CMS in the American health care system is evolving rapidly. New legislative mandates and changes in the external environment—including budgetary pressures, demographic changes and technological advances—have dramatically expanded CMS' responsibilities and placed new operational demands on the Agency. As a result, CMS must find methods for carrying out its current

activities more efficiently while simultaneously developing a host of new capabilities.

CMS embraces these changes and the expanded responsibilities that come with them as an opportunity to strengthen the U.S. health care system and increase access to affordable, high-quality care. In order to do so, CMS is undertaking a comprehensive, long-term transformation of its business operations. Transformations are defined as high-priority, complex operations initiatives that require coordinated, cross-component management and oversight.

Business transformation lays the foundation for a five-year program that will manage a coordinated, Agency-wide transformation of critical operational capabilities that will enable CMS to:

- Align business operations with the Agency's key strategic objectives;
- Develop new capabilities required to meet the changing demands posed by regulatory requirements and the rapidly evolving health care landscape;
- Guide and prioritize investments;
- Enhance enterprise excellence by improving performance and operational efficiency; and
- Promote increased transparency, collaboration, and agility.

Business transformation in CMS was developed following a comprehensive review of the Agency's internal capabilities and future needs, as well as best practices in transformation programs.

CMS Alliance to Modernize Healthcare (CAMH) Federally Funded Research Development Center (FFRDC)

In September 2012, CMS established the CAMH. The CAMH is sponsored by CMS and is a federally funded research and development center operated by MITRE, a not-for-profit company chartered to work in the public interest. The CAMH FFRDC is an objective, independent advisor for HHS organizations to advance the Nation's progress toward an integrated healthcare system with improved access and quality at a sustainable cost. The following are the capabilities of the CAMH FFRDC:

- Strategic and Tactical Planning and Analysis;
- Conceptual Planning and Proof of Concept;
- Acquisition Assistance;
- Organizational Planning and Relationship Management;

- Continuous Process Improvement;
- Strategic Technology Evaluation; and
- Feasibility Analysis and Design.

Medicare and Medicaid Innovation

CMS continues 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 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 CMS' goals and aims, and has developed a significant online presence, including a website (<http://innovation.cms.gov/>).

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. These activities 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, CMS is continuing to

research and develop new models of care delivery and payment for future testing and evaluation.

Medicare and Medicaid Coordination

Under the Affordable Care Act, CMS brings together Medicare and Medicaid in order to more effectively integrate benefits, and improve the coordination between the Federal Government and states to ensure access to quality services for Medicare-Medicaid enrollees. 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.

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 2013, CMS invested approximately \$10.3 million to support ongoing initiatives in three main areas: Program Alignment; Data and Analytics; and Demonstrations and Models.

Program Alignment. CMS' goals include eliminating regulatory conflicts and cost-shifting between Medicare and Medicaid and among related providers. To foster progress in these goals and better coordinate benefits and services, CMS acts as a catalyst to align laws, rules, requirements and policies among the programs. In May 2011, CMS compiled and categorized a list of opportunities for statutory, regulatory, and policy alignments between Medicare and Medicaid. CMS is continually making progress in addressing these program alignment areas.

Data and Analytics. A major barrier for states in providing integrated care for Medicare-Medicaid enrollees has been lack of access to Medicare data. CMS established a process for states to access Medicare data to support care coordination for Medicare-Medicaid enrollees, while also protecting beneficiary privacy and confidentiality. Twenty-eight states continue to work with CMS to receive and use these data, and with the new integrated data set tool, are better equipped to coordinate benefits and services in a seamless, cost-effective manner.

In addition, CMS made available a new Medicare-Medicaid integrated data set within the Chronic Condition Warehouse that is now available to researchers, states and policymakers. This data set

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provides tools to identify new opportunities for care coordination, including information on eligibility, enrollment, beneficiary conditions, service use and expenditures for both the Medicare and Medicaid programs. The data set will assist researchers, as well as Federal and state policymakers, to better identify regions, populations or necessary interventions to improve the quality, cost, and utilization of care for Medicare-Medicaid enrollees.

As part of our efforts to better coordinate the Medicare and Medicaid programs, CMS has begun releasing a series of analytical reports to help provide policymakers, researchers, and other interested parties with a greater understanding and awareness of the population to foster program improvement. CMS released state profiles, including 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. CMS is continuing to analyze and report on Medicare-Medicaid enrollee 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 is focused on improving quality for Medicare-Medicaid enrollees. To this end, it has worked with the National Quality Forum (NQF) on developing a recommended core set of quality measures, as well as priority gaps in measurement and measure stratification for high leverage areas that are responsive to the unique needs of Medicare-Medicaid enrollees. CMS is incorporating the recommended starter set of measures in each of the Medicare-Medicaid Financial Alignment Demonstrations. CMS is continuing to work with NQF, the National Committee for Quality Assurance, as well as other partners on the development of programs and measures that support quality improvement for the entire Medicare-Medicaid enrollee population.

Demonstrations and Models. The Affordable Care Act gives CMS the ability to test innovative payment and service delivery models that have the potential to improve the coordination and quality of care furnished to beneficiaries while also reducing program expenditures in Medicare and Medicaid. CMS has several initiatives underway utilizing this authority and advancing a well-coordinated, person-centered, more efficient care delivery system.

In 2011, CMS launched the Medicare-Medicaid Financial Alignment Initiative to more effectively integrate the Medicare and Medicaid programs to improve the overall beneficiary experience, as well as both quality and costs of care. Through this work, CMS is partnering with states to test two models—a capitated model and a managed fee-for-service model—to align the service delivery and financing between the Medicare and Medicaid programs while preserving or enhancing the quality of care furnished to Medicare-Medicaid enrollees. CMS has entered memoranda of understanding with California, Illinois, Massachusetts, New York, Ohio, Virginia, and Washington to test these new models to improve health care for Medicare-Medicaid enrollees.

To support this work, CMS has released funding opportunity announcements. First, CMS released a funding opportunity for State Health Insurance Assistance Programs (SHIPs) and/or Aging and Disability Resource Centers (ADRCs) to provide options counseling to Medicare-Medicaid enrollees. CMS also released a funding opportunity for states to develop independent ombudsman programs in states participating in the Financial Alignment Initiative.

CMS is providing ongoing technical assistance to providers to enable them to better integrate care for beneficiaries eligible for both Medicare and Medicaid. This effort is identifying promising provider-led practices that have positively impacted, or have the potential to improve, the care received by Medicare-Medicaid enrollees; developing partnerships with such providers to understand the promising practice and the impact (or potential impact) on Medicare-Medicaid enrollees; and developing 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.

In early 2012, CMS launched the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents where it is partnering with seven organizations to test strategies to reduce avoidable hospitalizations for Medicare and Medicaid enrollees who are long-stay residents of nursing facilities. Selected organizations are partnering with nursing facilities to test evidence-based interventions to accomplish these goals and will implement and operate proposed interventions over a 4-year

period. This demonstration began serving Medicare and Medicaid enrollees in February of 2013.

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 ACOs' 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 ACOs' activity throughout the length of the agreement period.

As part of the final rule, 42 CFR 425, CMS estimated that between 50 and 270 ACOs would participate in the Shared Savings Program and generate \$470 million in net Federal savings between 2012 and 2015. The 220 ACOs currently participating in the Shared Savings Program serve over 3.2 million people with traditional fee-for-service Medicare. The Shared Savings Program accepts applications on an annual basis with the next group scheduled to start January 1, 2014.

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 causes 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 are responsive to and driven by local circumstances, needs and capabilities.

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. QIOs work to improve quality of care, assess medical necessity and appropriateness of care, 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, 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 rates of preventive services, and decreasing avoidable re-hospitalizations have established a foundation for related, future QIO Program Initiatives.

The QIOs 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 QIOs 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. Health care providers who worked with their QIO improved clinical performance and contributed to national progress

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in patient safety, prevention, care transitions, and health disparities.

CMS calls upon the QIOs 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 disseminating and spreading of best practices.

Clinical Laboratory Improvement Amendments (CLIA) Program

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 248,675 facilities as of December 31, 2012. 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 20,500 laboratories on a biennial basis. CMS-approved accrediting organizations conduct onsite surveys of an additional 16,800 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.

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 adopted 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 adopted a new standard for Medicaid pharmacy subrogation. 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 requests 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 electronic funds transfer. In addition, HHS published a proposed rule that, when 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.

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 (HHS) Strategic Plan for fiscal years 2010 through 2015, which can be viewed at <http://www.hhs.gov/secretary/about/priorities/strategicplan2010-2015.pdf>. Consistent with GPRA principles, the CMS FY 2013 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. HHS is developing a new agency Strategic Plan, as required by the GPRA Modernization Act of 2010 (GPRAMA) that will cover FY 2014-2018, and will be released with the FY 2015 President's budget.

Our FY 2013 performance measures track progress in our major program 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

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2013 measures are included in the HHS Online Performance Appendix and can be viewed at http://www.hhs.gov/budget/fy2014/opa_040513.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 GPRAMA, 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 maintains strong financial management operations and continues to improve upon its financial management and reporting processes to provide timely, reliable, and accurate financial information that CMS management and other decision makers use to make timely and accurate program and administrative decisions. CMS' Risk Management and Financial Oversight Committee, which is comprised of members of CMS' senior leadership, is responsible for overseeing financial management issues and budget concerns impacting the day-to-day operations of the Agency, its financial statements and the CFO audit.

During FY 2013, CMS achieved several initiatives that ensured accurate and reliable financial management and reporting, and contributed to the solvency of the Medicare Trust Funds.

Budget Execution

For FY 2013, 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.

Administrative Payments

During FY 2013, we 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 made via ACH.

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. For FY 2013, the total amount of delinquent debt referred by CMS to the Program Support Center to process and transfer to Treasury is approximately \$840 million.

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 all of CMS' programs. All of CMS' core program dollars are accounted for in HIGLAS. During FY 2013, CMS successfully transitioned its internal administrative program accounting functions to HIGLAS. Since May of 2005, when the first contractor transitions to HIGLAS occurred, HIGLAS has processed more than 4.75 billion financial transactions and processed over 181.8 million payments worth \$1.71 trillion. HIGLAS continues to enhance CMS' oversight of Part A/Part B MACs' financial operations, and achieve accurate, reliable, and timely financial accounting and reporting for all of CMS' programs and activities.

Oversight of Medicare Contractor Financial Operations & Reporting

The MACs administer the day-to-day operations of the Medicare FFS program by paying claims, auditing provider cost reports, and establishing and collecting overpayments. As part of these activities, the MACs 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 years and other key initiatives to train staff and review contractor operations has resulted in significant improvements in the MACs' financial management activities and in the oversight of the Agency. 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.

The MACs are subject to various financial management and information technology (IT) security audits and reviews performed by the Office of Inspector General (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 MACs' 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, MACs are required to prepare corrective action plans (CAPs), which define activities to remedy findings and the timeframes for which they will be implemented. CMS also requires all MACs 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 Federal Manager's Financial Integrity Act, OMB Circular A-123 and the 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 2013 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 MACs also continued to contract with independent CPA firms to conduct Statement on Standards for Attestation Engagements No. 16 (SSAE 16) internal control audits. The results of our comprehensive self-assessment are provided in the **Summary of Federal Managers' Financial Integrity Act Report and OMB Circular A-123 Statement of Assurance** section.

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, Medicare Improvements for Patients and Providers Act 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, 2013, CMS has realized a cumulative total of \$221 million in tax levy offsets and \$100 million in non-tax offsets through HIGLAS on behalf of FPLP.

Recovery Audit Contractor Program

Medicare FFS

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. 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. FY 2013 recoveries continued to grow and were 59 percent higher than recoveries in FY 2012. In FY 2013, the Medicare FFS Recovery Audit program demanded approximately \$4.2 billion and recovered \$3.7 billion. The recovery auditors

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continued to focus their reviews on short hospital stays and claims for DME. 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 make continuous improvements to activities, such as, the appeals process, feedback to providers, and system improvements. CMS remains focused on taking the findings identified by the recovery auditors and putting actions into place to prevent future improper payments. In FY 2013, CMS released four Provider Compliance Newsletters that provided detailed information on 30 findings identified by the Recovery Auditors. CMS also implemented local and/or national system edits to automatically prevent improper payments.

The Medicare FFS Recovery Audit Program's 3-year Prepayment Review Demonstration, which was launched in 2012 permits recovery auditors to review claims before they are paid to providers. Claim selection criteria is based on the Medicare Severity Diagnosis Related Groups (MS-DRG) selected by CMS with the highest payment error rate, identified through the Comprehensive Error Rate Testing (CERT). Prepayment reviews are conducted in the seven Health Care Fraud Prevention and Enforcement Action Team (HEAT) states (Florida, California, Michigan, Texas, New York, Louisiana, Illinois) and four states with the highest number of inpatient stays (Pennsylvania, Ohio, North Carolina, Missouri). In FY 2013, the Medicare FFS Recovery Audit Program denied \$22.3 million in claims for the Prepayment Review Demonstration.

In addition, recovery auditors began reviewing therapy claims in April 2013. The American Taxpayer Act of 2012 extended the Medicare Part B Outpatient Therapy Cap Exceptions Process through December 31, 2013. Manual medical record review is completed for services above \$3,700 for Occupational Therapy, and/or \$3,700 for Physical Therapy and Speech Language Pathology services combined. Recovery auditors are completing prepayment therapy review in the demonstration states and immediate post payment review in the remaining states.

CMS has begun procurement preparations for the next contract period and plans to contract with four Recovery Auditors for Parts A/B and one national DME and Home Health & Hospice Recovery

Auditor. A transition plan has been implemented to ensure recovery operations continue while minimizing the impact on providers.

Medicare Parts C and D Recovery Audit Contractors

CMS contracted with a Part D recovery audit contractor in January 2011. During the first year of operation, the Part D recovery audit contractor completed its systems approval requirements and began analysis of contract year 2007 prescription drug event (PDE) data to identify instances where excluded providers either received payment or prescribed drugs that were paid for by Medicare Part D. The appeals process for the 2007 Excluded Provider Audit Review was completed in the beginning of FY 2013 and CMS recovered approximately \$2 million. The Part D recovery audit contractor has now completed its Excluded Provider Review of data for 2008–2011 and notifications totaling \$3.4 million were sent to affected plan sponsors in August of 2013. Additionally, the Part D recovery audit contractor initiated its review of 2009 PDE data to identify potential duplicate payments by the end of FY 2013. The review process is ongoing and will continue through FY 2014. As part of the procurement process to secure a recovery audit contractor for Medicare Part C, CMS published a Request for Information in December 2012. Eight organizations responded with interest. Procurement activities for the Medicare Part C recovery audit contractors are ongoing, and an award is expected in FY 2014.

Medicaid

Section 6411(a) of the Affordable Care Act required states to establish Medicaid recovery audit contractor programs by submitting state plan amendments, attesting that their programs meet the statutory requirements. HHS published a final rule titled, "Medicaid Program: Recovery Audit Contractors" in the Federal Register on September 16, 2011, that implemented section 6411(a) of the Affordable Care Act. The final rule, effective January 1, 2012, required states to implement recovery audit contractor programs in an effort to identify and recover improper payments in their Medicaid programs. The final rule aligns the state Medicaid recovery audit contractor requirements to existing Medicare recovery audit contractor FFS program requirements, where feasible, and provides each state the flexibility to tailor its recovery audit contractor program where appropriate. As of August 1, 2013, 45 states and the District of Columbia have implemented Medicaid recovery

auditor contractor programs. The remaining five states have CMS-approved exceptions.

Medical Review Program

Medicare Administrative Contractors

Consistent with sections 1833(e), 1842(a)(2)(B), and 1862(a)(1) of the Social Security Act, CMS is required to protect the Medicare Trust Fund against inappropriate payments that pose the greatest risk to the trust fund and take corrective actions. To meet this requirement, CMS contracts with Part A and Part B MACs, DME MACs, and others to perform analysis of FFS claims data to identify atypical billing patterns and perform claims review. Medical review is the collection of information and clinical review of medical records to ensure that payment is made only for services that meet all Medicare coverage, coding, and medical necessity requirements. Medical review activities are directed toward areas where data analysis, Comprehensive Error Rate Testing results, Office of Inspector General/Government Accountability Office findings, and Recovery Audit findings indicate questionable billing patterns. CMS continues to enhance medical review efforts and encourage MACs to review more claims than in previous years, while closely monitoring the decisions made by these contractors. The MAC medical review resulted in a projected \$5.6 billion in savings for FY 2013.

Prior Authorization of Power Mobility Devices Demonstration

CMS implemented a prior authorization process for scooters and power wheelchairs (together known as power mobility devices) for people with FFS Medicare who reside in seven states with high populations of fraud- and error-prone providers (California, Illinois, Michigan, New York, North Carolina, Florida and Texas). This demonstration began for orders written on or after September 1, 2012. The CMS believes this demonstration will lead to reductions in improper payments for power mobility devices, which will help ensure the sustainability of the Medicare Trust Funds and protect beneficiaries who depend upon the Medicare program. In addition, this demonstration is designed to develop and demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act.

Since implementation, CMS has observed a decrease in the expenditures for power mobility

devices in the demonstration states and non-demonstration states. Based on claims submitted as of September 30, 2013, monthly expenditures for the power mobility device Healthcare Common Procedure Coding System codes included in the demonstration decreased from \$12 million in September 2012 to \$4 million in August 2013 in the demonstration states and from \$20 million to \$9 million in the non-demonstration states. The prior authorization reviews are being performed timely, industry feedback has been positive, and we have received no complaints from the beneficiaries we serve. We will continue to closely monitor and evaluate the effectiveness of the demonstration and plan to analyze demonstration data to assist in the investigation and prosecution of fraud.

Medicare Secondary Payer (MSP)

CMS' efforts in the MSP area saved the Medicare Trust Funds approximately \$8.93 billion in FY 2013. 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 pursue debts owed the Medicare program. 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

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of October 2013, there were over 1,400 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 approximately \$7 billion per year in FY 2011 and FY 2012 and almost \$9 billion in FY 2013.

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 WCMSA amounts totaling approximately \$1.8 billion in FY 2013. These amounts represent payments that Medicare might otherwise make in terms of beneficiaries’ future medical expenses related to their associated accident, illness, or injury.

Total recoveries by the Medicare Secondary Payer Recovery Contractor (MSPRC) increased from \$548 million in FY 2012 to \$585 million in FY 2013.

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.

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:

1. **Fraud Prevention:** Providing enrollment and screening, engaging Medicare beneficiaries, educating state Medicaid program integrity staff, antifraud marketing, and improving payment accuracy through The National Fraud Prevention Program;



2. **Fraud Detection:** Greatly enhancing data analytics, partnering with providers, law enforcement, Part C and D compliance activities, Medicaid data analytics and audit activities;
3. **Transparency and Accountability:** Increasing coordination with law enforcement, collaborating with the private sector and states; including the Healthcare Fraud Prevention Partnership (HFPP) and the OPEN PAYMENTS (Affordable Care Act section 6002: Physician Payments Sunshine Act) transparency program.
4. **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. During FY 2013, CMS continued its work in revalidating the enrollments of all existing 1.5 million Medicare suppliers and providers. As of September 30, 2013, CMS is approximately 39% through the revalidation process and is on target to fully complete the process by 2015.

CMS also continues to use its authority to suspend payments pending the investigation of a credible allegation of fraud, provider enrollment application fees, and its authority to impose temporary provider enrollment moratoria 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.

CMS also published a final rule in April 2012 that implements the provisions of section 6405 of the Affordable Care Act, "Physicians Who Order Items Or Services Required To Be Medicare Enrolled Physicians Or Eligible Professionals." This rule codified CMS requirements and processes associated with validating that physicians who order or certify the need for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), home health care, and services of independent diagnostic testing facilities and clinical laboratories are enrolled in Medicare or have validly opted out of the Medicare program.

CMS also published the final rule for section 6002 of the Affordable Care Act (commonly referred to as the Physician Payment Sunshine Act) entitled "Transparency Reports and Reporting of Physician Ownership or Investment Interests," which requires annual reporting by applicable manufacturers (defined as manufacturers of drugs, devices, biologicals, or medical supplies covered by Medicare, Medicaid, or CHIP) of payments or other transfers of value to a non-employee physician or a teaching hospital. This increased transparency is intended to help reduce the potential for conflicts of interest that physicians or teaching hospitals could face as a result of their relationships with manufacturers.

The provision also requires reporting by applicable manufacturers and group purchasing organizations of any physician ownership or investment interests in such entities. Further, the provision sets civil money penalties for noncompliance, and the establishment of procedures for reporting and for making the reported information publicly available on the internet. Annual reports to Congress and reports to states are also required and must include aggregate information reported by each applicable manufacturer or group purchasing organization, and any enforcement actions or penalties imposed during the preceding year. Finally, the provision preempts any duplicative state or local laws or regulations. Further information regarding this program can be located at <http://go.cms.gov/openpayments>.

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.

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- **Benefit Integrity (BI):** Benefit Integrity activities identify, detect, and prevent payment of fraudulent or otherwise improper claims. Responsibilities include managing CMS' program integrity contractors (Zone Program Integrity Contractors and Program Safeguard Contractors) and acting as law enforcement liaisons to ensure coordination on crosscutting issues.

Enhancing program integrity is a top priority for the Agency, and we have made important strides in reducing fraud, waste, and improper payments across the government. This past year, CMS has used its 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 reported on the completion of the first implementation year of the Fraud Prevention System, the predictive analytic technology that identified potential fraud before payment, which resulted in an estimated \$115 million in fraudulent payments being stopped, prevented or identified. We led the first information exchange in the Healthcare Fraud Prevention Partnership, a public-private partnership among the federal government, states and private health insurance companies and associations, to prevent and detect fraud across the healthcare industry. CMS expanded the Medicare-Medicaid Data Match Program (Medi-Medi), a program to collaboratively analyze billing trends across the Medicare and Medicaid programs to identify potential fraud, waste, and abuse, to 20 states, which represented 67 percent of Medicaid billing in FY 2011. CMS is also strengthening our provider enrollment rules, and reported that as a result of the targeted screening requirements in the Affordable Care Act and other enrollment activities, the number of provider revocations had doubled compared to the two years prior to the passage of the health law. In 18 states, that number had quadrupled in the same time period. We imposed the first temporary provider enrollment moratoria under the Affordable Care Act in three geographic areas at high risk of fraud, waste and abuse.

The Agency also demonstrated its commitment to being effective financial stewards in FY 2013. We have developed a Unified Program Integrity Contractor strategy, with an overarching goal to integrate the program integrity functions for audits and investigations across Medicare and Medicaid by implementing a contracting strategy that rationalizes our relationships with providers, leverages existing resources, and enhances our cooperative efforts with partners. As a part of that

work, CMS reviewed the contracts that we use to engage Medicaid Integrity Contractors (MICs) that review and audit Medicaid claims, and decided not to renew the options on five Review MIC task orders as they expired over the period from August 2012 to May 2013.

Healthcare Fraud Prevention Partnership (HFPP)

One of the Secretary's key health care fraud prevention initiatives is to establish an ongoing partnership with the private sector to fight fraud across the health care system. Data collected and shared across payers can assist payers in evaluating trends, recognizing patterns consistent with potential fraud, and potentially uncover schemes or bad actors they could not otherwise identify using only their own information. Such collaboration is the purpose of the Healthcare Fraud Prevention Partnership (HFPP).

Several key milestones occurred in FY 2013 including the signing of the official HFPP Charter by the HHS Secretary and the US Attorney General, holding of the first HFPP Executive Board meeting, and convening and establishing frequent meetings within HFPP committees. The HFPP has successfully completed a significant pilot information exchange, in which 11 entities, including CMS, contributed fraud related data for aggregation and analysis. This has led to the discovery of new vulnerabilities and savings for certain partners. Future studies, of both non-identifiable data and identifiable, will significantly expand in complexity and require substantial technologies and infrastructure including relevant contactors and a data exchange partner to serve as a Trusted Third Party. To plan for this function, CMS has invested in a strategic contractor with the objective of defining the requirements for a Trusted Third Party contract, to be procured in FY 2014. CMS added additional partners to the HFPP to bring the total number of partners to 31, and is targeting further expansion of the partnership to include additional willing public and private payers.

Medicare Drug Integrity Contractor (MEDIC)

There are two MEDIC contractors, each with distinct responsibilities related to Medicare Advantage and Part D benefits.

- The **National Benefit Integrity (NBI) MEDIC** is responsible for processing and tracking all Medicare Advantage and Part D complaints, requests for information (RFIs), proactive data analysis, conducting investigations, and referrals to law enforcement.

- The **Outreach and Education (O&E) MEDIC** is responsible for conducting outreach and education activities for Medicare Advantage and Part D stakeholders.

In FY 2013, the NBI MEDIC received approximately 6,651 actionable complaints (within the MEDIC's scope) which is an average of 554 per month; processed an average of 54 and 10 requests for information from OIG and DOJ per month respectively; and referred a total of 391 cases for further investigation, which is an average of 33 cases per month.

The NBI MEDIC also conducted several proactive analyses; two of these analyses targeted improper payments associated with prescribers (e.g. veterinarians, deceased providers). Additionally, the NBI MEDIC conducted a fraud audit of a health plan and performed a crossover drug claim analysis regarding Part D vs. Part A hospice payment. As a result of the NBI MEDIC analyses, Part D Sponsors were informed to correct over \$25 million in total drug cost due to improper payments.

The NBI 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 41 convictions, 38 arrests, and 34 indictments. One particular false claims case in Michigan resulted in 39 individuals indicted, including a pharmacist who owned 26 pharmacies and billed insurers for expensive prescriptions that the pharmacist never intended to give to customers. Of the 26 people originally charged in this case, six individuals were convicted, including the pharmacist who was sentenced to 17 years in prison and ordered to pay nearly \$20 million in restitution. Seventeen additional defendants pled guilty in this case. And later, stemming from the investigations and convictions in this case, an additional 13 people were indicted, bringing the total number of subjects apprehended to 39.

In FY 2013, the O&E MEDIC facilitated the CMS Parts C & D Fraud Work Group (FWG) meetings which offer Medicare Advantage organizations and Prescription Drug plans an opportunity to collaborate and discuss techniques on how to prevent and detect fraud, waste, and abuse in the Medicare Advantage and Part D programs. These FWG meetings are designed to educate Medicare Advantage organization and Prescription Drug plan staff through enhanced collaboration, information sharing, data analytics and communication. FWG meeting stakeholders include Plan Sponsors,

Pharmacy Benefit Managers (PBMs), representatives from law enforcement agencies-- including HHS/OIG, U.S. DOJ, and other state and local law enforcement entities. These FWG meetings provide a forum for stakeholders to learn about the most recent fraud schemes and fraud prevention best practices to assist in developing effective fraud prevention programs.

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 health care fraud in South Florida and has served as a testing ground for efforts that have been expanded to a national level.

Health Care Fraud Prevention and Enforcement Action 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.
- **Supporting 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 seven cities since 2010—Brooklyn, NY; Boston, MA; Chicago, IL; Detroit, MI; Los Angeles, CA; Miami, FL and Philadelphia, PA. The most recent summit was held in Chicago on April 4, 2012 highlighting the new high-tech war against health care fraud being jointly fought by HHS and DOJ. These

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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.

CMS 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 is evaluating how best to leverage tools used in Medicare for opportunities to transfer the knowledge and lessons learned 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 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 as a part of the third implementation year report to Congress. Several initiatives are currently underway in furtherance of this analysis.

National Medicaid Audit Program (NMAP)

In FY 2013, the NMAP continued to work 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 audit

targets. Through this process, CMS has been able to more effectively support a state's program integrity efforts. In addition, the corresponding data for the collaborative audits is in most 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 a cumulative total of 378 collaborative audits assigned 28 states as of July 2013. These 28 states represent 67 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 July 2013, there have been 45 Final Audit Reports related to collaborative audits issued to states valued at roughly \$11.9 million. Overall, a total of \$27.5 million in estimated overpayments has been identified by the efforts of CMS and the Audit Medicaid Integrity Contractors (MICs) as of July 3, 2013.

In FY 2013, all five of the Audit MIC task orders were renewed. However, as a consequence of the NMAP redesign, CMS determined that the nature and volume of collaborative audits did not require the same Review MIC capacity for provider data review. As a result, CMS decided not to renew any of the Review MIC contracts as they expired over the period from August 2012 to May 2013.

Improper Payments

CMS has implemented Executive Order 13520, *Reducing Improper Payments*, which 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. Pre- and post-

intervention measurements are 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 in the area of pharmacy education to measure the extent to which education targeted at physicians with aberrant prescribing practices can reduce the number of prescriptions that exceed recommended dosages. After collection of baseline measures, CMS conducted a targeted education program in three participating states and collected post-intervention data during FY 2013. We are currently analyzing and evaluating the results obtained from the targeted prescriber educational intervention to assess its scalability and applicability to other states. CMS has initiated a second PAIG project aimed at reducing improper payments in the high risk area of home and community based services (HCBS), using the results produced by the FY 2012 PERM program, to determine baseline measures and target the root causes of errors. CMS is preparing educational materials identified in HCBS as having high potential PERM improper payment rates during FY 2013. With the support of states, CMS plans to launch an education program aimed at a targeted audience of physicians, direct care staff, home health agencies, and beneficiaries in FY 2014.

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 2013, CMS has continually offered MII courses and trained over 4,000 state employees and officials from 50 states, the District of Columbia, and Puerto Rico through 91 courses and 6 workgroups 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 2013, as of July 1, the MII conducted 14 courses, with

4 courses scheduled for the remainder of the fiscal year.

In FY 2013, MII began offering a credentialing program for state Medicaid program integrity employees to certify professional qualifications. As of June 2013, 20 state employees in 17 states have received the credential of Certified Program Integrity Professional (CPIP). The MII also supports state access to the DOJ's Regional Information Sharing System—a secure web-based portal where states can exchange documents, tips, and best practices about Medicaid program integrity issues.

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 Medicaid stakeholder 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 outreach to providers at regional conferences and continuing education courses to enhance awareness of program integrity issues.

CMS works to enhance opportunities states have to share ideas and network with peers and other program integrity stakeholders. For example, the Agency provides staff support to the Medicaid Fraud and Abuse Technical Advisory Group, which provides a monthly forum for the exchange of information on Medicaid integrity issues between CMS and representative state program integrity directors. 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. CMS' New York Regional Office also hosts semi-annual regional meetings of program integrity stakeholders from Medicaid, Medicare, and law enforcement to discuss current fraud issues and recent cases.

MANAGEMENT'S DISCUSSION AND ANALYSIS

Support and Assistance to the States

CMS provides substantial oversight of state program integrity activities and effective support and assistance to states to combat Medicaid fraud, waste, and abuse. To gauge states' efforts in this regard, CMS conducts triennial comprehensive reviews of each state's program integrity activities. State Program Integrity Reviews assess each state's regulatory compliance, program integrity best practices, and program integrity vulnerabilities in areas including provider enrollment, provider disclosures, managed care operations, and the interaction between the state's Medicaid agency and its Medicaid Fraud Control Unit. During FY 2013, CMS completed the second cycle of triennial comprehensive reviews of each state, the District of Columbia, and the Commonwealth of Puerto Rico. CMS also conducts follow-up reviews to evaluate the success of the state's corrective actions. Through its reviews, CMS has identified 84 unduplicated program integrity "best practices" that we have publicized to all states through annual summaries of our efforts.

In response to feedback from state Medicaid stakeholders, CMS completed and pilot-tested a redesigned review guide in reviews of six states during FY 2013. The new review guide re-focuses the reviews from an emphasis on regulatory compliance to a more integrative assessment of risk and program vulnerabilities. CMS also developed a new report format that provides a more cohesive organization of findings into areas of risk, such as inadequate attention to fraud and abuse detection, poor program integrity oversight of managed care operations, and ineffective provider enrollment practices and reporting. The review guides have been made available to all states to serve as self-assessment tools to improve their overall program integrity performance.

In addition, each year CMS routinely fulfills hundreds of requests for technical assistance from state employees, attorneys, providers and others in a variety of program integrity-related areas.

In FY 2013, CMS participated in three field projects with the State of Florida - two projects focused on assisted living facilities and one project investing developmentally disabled group homes. 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 provisions and billings were taking place, if services were being provided by qualified staff, and if other quality of care or environmental issues were

present. Florida has reported that the Jacksonville ALF/ACH Review resulted in \$233,000 in fines, 13 prepayment reviews, 38 providers sanctioned, and 2 provider termination requests. In addition, provider education in multiple program areas was developed and conducted.

Additionally, CMS partnered with the New York State Office of the Medicaid Inspector General and the New York City Taxi and Limousine Commission to investigate ambulettes providing non-emergency medical transportation to Medicaid beneficiaries in New York City. Preliminary results from the investigation included issuing 18 summonses and the seizure of improperly licensed ambulettes.

Medicare Advantage and Prescription Drug Financial Oversight

Sections 1857(d)(1) and 1860D-12(b)(c) of the Social Security Act requires the HHS 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 2013, CMS completed 258 audits of MAOs and PDPs for contract year 2010 and awarded contracts for 246 audits for contract year 2011. 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.

In FY 2013, CMS' contractors audited Medicare cost reports for years 2006 through 2011, reducing the backlog of unaudited cost reports. Disallowances resulting from FY 2013 settlement activity saved about \$38 million producing a rate of return of \$18.09 to \$1.

Information Technology (IT)

During FY 2013, CMS continued to make 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. CMS has expanded 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. For example, SharePoint has been implemented to modernize the project management office and improve scheduling and reporting performance. To enhance the performance of SharePoint the Information Infrastructure Architecture was redesigned and built into a Two-Tier environment. The upgrading of the infrastructure has helped to improve performance in the development, validation and production environments.

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 has deployed and continues to enhance a Cyber Forensics and Malware Analysis capability that has broadened the SOC's spectrum of technical capabilities to include monitoring the integrity of the CMS Enterprise and further assisting the OIG and CMS in effective investigations. In addition, in order to comply with current security guidance from the National Institute of Standards and Technology, CMS has established a security penetration testing team to objectively test the security posture of the systems in the CMS Enterprise.
- 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. A monthly EVM Report Card process is in place with the data centers to analyze and manage security performance that will improve our security awareness posture. Over the last year, the EVM program has expanded to encompass additional data centers with in the CMS Enterprise.
- A comprehensive security awareness and training program that provides role-based classroom and computer-based training for all CMS staff

including Managers, Contracting Officer's Representatives, Information System Security Officers, and other CMS personnel that require security training.

- CMS has continued 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 Xpedited Life Cycle (XLC). As part of the RMH development, the Enterprise Information Security Group (EISG) is continuing to establish much needed security policy updates, including standards and procedures for Cloud Computing, Authentication, Incident Handling, and other security program management tasks. In addition, EISG performed a major update to the principle CMS security and privacy policy, the CMS Policy for Information Security and Privacy. This policy update provides the framework for security and privacy policy and programmatic integration throughout the Agency. CMS continues to be a major contributor on a number of Chief Information Officer (CIO) Directives and IT governance documents for the CMS CIO.

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 2013 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.

MANAGEMENT'S DISCUSSION AND ANALYSIS

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 include the OMB Circular A-136⁴, *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, 2013 and 2012, 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 \$370.2 billion. The bulk of these assets are in Investments totaling \$278.3 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 \$76.6 billion, most of which is for Medicaid, Other Health, and CHIP. Liabilities of \$88.3 billion consist primarily of the Entitlement Benefits Due and Payable of \$77.3 billion. CMS' net position totals \$281.9 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, 2013 and 2012. The Statement of Net Cost shows only a single dollar amount: the actual net cost of CMS' operations for the period by program. 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 funds from dedicated collections vs. other fund components of net cost as additional information.

Total Benefit Payments were \$842.1 billion for FY 2013. Administrative Expenses were \$4.4 billion, less than one percent of total net Program/Activity Costs of \$849.6 billion.

The net cost of the Medicare program including benefit payments, QIOs, Medicare Integrity Program spending, and administrative costs, was \$498.6 billion. The HI total costs of \$265.3 billion were offset by \$3.8 billion in revenues. The SMI total costs of \$302.6 billion were offset by premiums and other revenues of \$65.5 billion. Medicaid total costs of \$266.6 billion, represent expenses incurred by the states and territories that were reimbursed by CMS during the FY, plus accrued payables. The CHIP total costs were \$9.6 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, 2013 and 2012. 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. Funds from dedicated collections 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 \$266 billion; \$247.7 billion in transfers from Payments to Health Care Trust Funds to HI and SMI; CHIP appropriations of \$9.5 billion and State Grants and Demonstrations and general fund-financed Program Management appropriations of \$718 million. Medicaid and CHIP are financed by a general fund appropriation provided by Congress.

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.

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 \$212.9 billion. The Federal matching contribution is income to the SMI program from a general fund appropriation (Payments to Health Care Trust Funds) of \$176.9 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, 2013 and 2012. 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 \$1,194 billion (\$305 million in non-budgetary). Obligations of \$1,159.3 billion (\$305 million in non-budgetary) leave unobligated balances of \$34.4 billion (of which \$1.9 billion of budgetary resources is not available). Total outlays, net of collections, were \$1,109.3 billion. When offset by \$335.9 billion relating to collection of premiums and general fund transfers from the Payments to Health Care Trust Funds, as well as refunds of MAC overpayments, the net outlays were \$733.4 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) increased from \$(5.6) trillion, determined as of January 1, 2012, to \$(4.8) trillion, determined as of January 1, 2013.

Including the combined HI and SMI Trust Fund assets increases the present value, as of January 1, 2013, of future cash flow for all current and future participants to \$(4.5) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI Trust Fund assets, is \$(9.4) trillion.

MANAGEMENT'S DISCUSSION AND ANALYSIS

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 134 percent at the beginning of FY 2009 to 85 percent at the beginning of FY 2013.

TRUST FUND RATIO (Beginning of Fiscal Year ⁵)					
	2009	2010	2011	2012	2013
HI	134%	124%	106%	94%	85%

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 2013 Trustees Report indicate that the HI Trust Fund is not adequately financed over the next 10 years. Under the intermediate

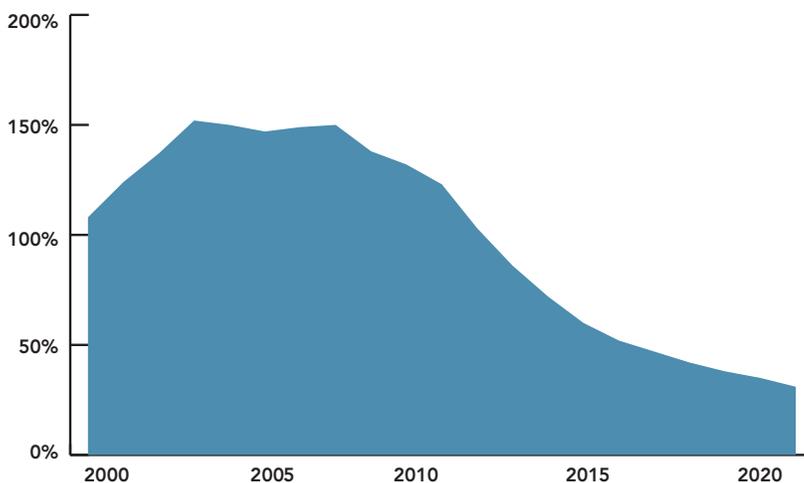
assumptions of the 2013 Trustees Report, the HI Trust Fund ratio is estimated to steadily decline to about 48 percent by the beginning of calendar year 2022. From the end of 2012 to the end of 2022, assets are expected to decline by 13 percent, from \$220 billion to \$192 billion.

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 2026, 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 2026, declining to 73 percent of projected expenditures in 2087.

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 2012 to about 2.1 by 2087. In addition, health care costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is \$4.6 trillion, which is 1.1 percent of taxable payroll and 0.5 percent of Gross Domestic Product (GDP) over the same period.

HI TRUST FUND RATIO



Source: CMS/OACT

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

MANAGEMENT'S DISCUSSION AND ANALYSIS

Significant uncertainty surrounds the estimates for the SOSI. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near-term and ultimate assumptions used in the projections. For more information, please refer to the *Required Supplementary Information: Social Insurance* disclosures required by the Federal Accounting Standards Advisory Board (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 \$(22.5) 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 2012, SMI expenditures were 1.99 percent of GDP. By 2087, SMI expenditures are projected to grow to 4.01 percent of the GDP.

The following table presents key amounts from our basic financial statements for fiscal year 2011 through 2013.

TABLE OF KEY MEASURES⁶			
(Dollars in Billions)			
	2013	2012	2011
Net Position (end of fiscal year)			
Total Assets	\$370.2	\$424.8	\$424.2
Less Total Liabilities	\$88.3	\$80.5	\$87.5
Net Position (assets net of liabilities)	\$281.9	\$344.3	\$336.7
Change in Net Position (end of fiscal year)			
Net Costs	\$779.8	\$737.8	\$754.1
Total Financing Sources	\$756.1	\$710.8	\$730.4
Change in Net Position	\$(23.6)	\$(27.0)	\$(23.7)
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	\$(4,772)	\$(5,581)	\$(3,252)
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	\$(5,581)	\$(3,252)	\$(2,683)
Change in present value	\$809	\$(2,329)	\$(569)

⁶ 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.

MANAGEMENT'S DISCUSSION AND ANALYSIS

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, 2013, would have decreased by \$285 billion due to advancing the valuation date by one year and including the additional year 2087. However, changes in the projection base, demographic assumptions, economic and health care assumptions, and legislation changes increased the present value of future cash flows by \$308 billion, \$724 billion, \$31 billion, and \$31 billion, respectively.

Required Supplementary Information (RSI)

As required by Statement of Federal Financial Accounting Standards (SFFAS) Number 17, Accounting for Social Insurance (as amended by SFFAS Number 37, Social Insurance: Additional Requirements for Management Discussion and Analysis and Basic Financial Statements), CMS has included information about the Medicare Trust Funds—HI and SMI. The RSI presents required long-range cash-flow projections, the long-range projections of the ratio of contributors to beneficiaries (dependency ratio), and the sensitivity analysis illustrating the effect of the changes in the most significant assumptions on the actuarial projections and present values. The SFFAS 37 does

not eliminate or otherwise affect the SFFAS 17 requirements for the supplementary information, except that actuarial projections of annual cash flow in nominal dollars are no longer required; as such, it will not be reported in the RSI. The RSI assesses the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the **2013 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

2

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A MESSAGE FROM THE CHIEF FINANCIAL OFFICER

DEBORAH A. TAYLOR, CPA



The financial statements and the annual Chief Financial Officers' audit are important elements of fiscal integrity over the Centers for Medicare & Medicaid Services' programs. Our commitment to fiscal accountability is exemplified by our unqualified opinion on four out of the six principal financial statements. In addition to the unqualified opinion, the auditors found no material weaknesses in our internal controls; however, they continued to cite significant deficiencies in information systems and financial reporting, systems and oversight. Since the auditors first noted these deficiencies, we have implemented corrective actions to mitigate these issues and also strengthen our control environment. Our corrective actions for some of these issues, especially those surrounding information systems, are multi-year efforts requiring a significant amount of resources.

The uncertainty of the long-range assumptions used in our Statement of Social Insurance (SOSI) continues to cause our auditors to disclaim an opinion. This year, as with previous years, the SOSI has been developed based upon current law in accordance with the standards required by the Federal Accounting Standards Advisory Board. We remain confident that the fiscal year (FY) 2013 SOSI projections in this statement fairly represent the effects of the Affordable Care Act and properly disclose the purpose of the projection.

We have had tremendous success this fiscal year in improving our fiduciary responsibilities while we continually seek innovative ways to deliver financial compliance, accountability and transparency in our Agency's diverse programs. This includes CMS' initiatives to recover improper payments and improve our financial operations to increase the financial stability of our programs. CMS continues to aggressively work towards reducing improper payments, and we have reported error rates for all of our high-risk programs. In reducing the risk of improper payments, our successes have been demonstrated through the following:

- Recovered over \$3.7 billion in improper Medicare payments in FY 2013 through the Medicare Fee-for-Service Recovery Audit Program. This represents an increase in recoveries of 59 percent over FY 2012. We also continued to expand the use of Recovery

Auditors in the Medicare Fee-for-Service program. The Recovery Auditors are now allowed to review certain types of claims that historically have high amounts of improper payments before they are paid, thereby preventing improper payments from being made. This demonstration project began for claims processed on or after September 2012. Through this prepayment demonstration, CMS prevented approximately \$22.3 million in erroneous payments.

- CMS continues to enhance medical review efforts and encourage Medicare Administrative Contractors to review more claims than in previous years, while closely monitoring the decisions made by these contractors. The Medicare Administrative Contractors reported that medical review resulted in \$5.6 billion in savings for FY 2013.
- CMS continues to improve the Medicare Secondary Payment (MSP) processes. By simplifying and enhancing our procedures and systems, the MSP program had Medicare Trust Fund savings of more than \$8.9 billion in FY 2013.
- Successfully implemented a prior authorization demonstration program in seven states aimed at establishing improved methods for issues such as reducing improper payments for power mobility devices (PMDs). The prior authorization reviews are being performed timely, industry

feedback has been positive, and we have received no complaints from the beneficiaries we serve. This demonstration project began on September 2012 and since implementation CMS has observed a decrease in the expenditures for power mobility devices in the demonstration states and non-demonstration states. Overall, spending for PMDs has decreased by \$117 million since the inception of the demonstration. While a portion of the decrease may be due to continuous supplier education and other initiatives to prevent fraud and improper payments, the majority can be attributed to the new prior authorization requirements.

In addition, CMS has made outstanding progress in the following initiatives which have contributed to significant improvements in the financial management area:

- Successfully completed the transition of the Financial Accounting and Control System (FACS) legacy system functionality into the Healthcare Integrated General Ledger Accounting System (HIGLAS). This functionality is also known as the Administrative Program Accounting (APA) functions. Through this accomplishment, all of the APA functions are now performed by HIGLAS—effectively providing one system of record for all financial transactions and financial reporting. With successful implementation of APA functionality, the Agency reached its goal of accounting for 100 percent of CMS' core program dollars in HIGLAS.
- Continued our efforts to improve and streamline the MSP program. We successfully awarded the last of four new contracts under a new MSP contracting strategy that will provide stakeholders with one central point of contact for coordination of benefits and recovery matters. We also reconfigured the MSP section of the CMS website to improve transparency and simplified numerous standard beneficiary letters to ensure clear and concise communications.
- Enhanced our program integrity through additional reviews and audits. CMS began pre-payment Meaningful Use audits for the Electronic Health Record Incentive Program. Over 2,300 pre-payment Meaningful Use audits have been successfully completed, resulting in savings of approximately \$9 million. Also we established a Supplemental Medical Review Contractor to provide support for a variety of tasks that are aimed at lowering the improper payment rate by enhancing medical review efficiencies. One of the Supplemental Medical Review Contractor's primary tasks is evaluating medical records

and related documents to determine whether claims were billed in compliance with Medicare's coverage, coding, and payment rules.

CMS continues to comply with appropriations law and to act in a fiscally responsible manner by minimizing administrative costs and eliminating antiquated and unnecessary practices throughout the Agency. We continue to do everything we can to reduce costs, and we work diligently to identify opportunities to promote efficient and effective spending in order to perform mission-critical functions. CMS issued several policies on conference planning, travel, promotional items and printing to promote and display an aggressive commitment to efficient spending of appropriated funds. As a result of implementing these efficient spending practices coupled with sequestration in FY 2013, CMS reduced its discretionary administrative spending by \$193 million. While we could not eliminate reductions to all workloads, CMS sought to minimize the impact of these cuts to mission-critical activities.

We will continue to enhance our level of corresponding financial management requirements in order to achieve and maintain sound fiscal policies and procedures in support of CMS' missions and programs. Our successes have been shaped by the dedicated CMS employees, internal and external stakeholders, business partners, and most importantly, the millions of beneficiaries we serve. To this end, as the Agency's Chief Financial Officer, I proudly disclose the FY 2013 audited financial statements included in the annual CMS Financial Report.



DEBORAH A. TAYLOR, CPA
CMS Chief Financial Officer

December 2013

FINANCIAL STATEMENTS

CONSOLIDATED BALANCE SHEETS

as of September 30, 2013 and September 30, 2012

(IN MILLIONS)

	FY 2013 Consolidated Totals	FY 2012 Consolidated Totals
ASSETS		
Intragovernmental Assets:		
Fund Balance with Treasury (Note 2)	\$76,609	\$109,006
Investments (Note 3)	278,270	302,904
Accounts Receivable, Net (Note 4)	3,371	505
Other Assets	114	38
Total Intragovernmental Assets	358,364	412,453
Accounts Receivable, Net (Note 4)	10,637	10,569
General Property, Plant and Equipment, Net	369	378
Other Assets (Note 5)	831	1,432
TOTAL ASSETS	\$370,201	\$424,832
LIABILITIES		
Intragovernmental Liabilities:		
Accounts Payable	\$655	\$646
Accrued Payroll and Benefits	1	5
Other Intragovernmental Liabilities	1,472	952
Total Intragovernmental Liabilities	2,128	1,603
Accounts Payable	147	
Federal Employee and Veterans' Benefits	15	12
Entitlement Benefits Due and Payable (Note 6)	77,277	72,493
Accrued Payroll and Benefits	72	106
Contingencies (Note 7)	7,366	5,291
Other Liabilities	1,282	1,054
TOTAL LIABILITIES (Note 8)	\$88,287	\$80,559
NET POSITION		
Unexpended Appropriations-Dedicated Collections	\$4,569	\$20,519
Unexpended Appropriations-Other Funds	37,655	60,417
Total Unexpended Appropriations	42,224	80,936
Cumulative Results of Operations-Dedicated Collections	238,145	261,800
Cumulative Results of Operations-Other Funds	1,545	1,537
Total Cumulative Results of Operations	239,690	263,337
TOTAL NET POSITION	\$281,914	\$344,273
TOTAL LIABILITIES AND NET POSITION	\$370,201	\$424,832

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF NET COST*for the Years Ended September 30, 2013 and September 30, 2012*

(IN MILLIONS)

	FY 2013 Consolidated Totals	FY 2012 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS		
GPRAs Programs		
Medicare (Dedicated Collections)	\$498,576	\$477,687
Medicaid	266,624	247,508
CHIP	9,548	9,260
Net Cost: GPRAs Programs	774,748	734,455
Other Activities		
State Grants and Demonstrations	712	656
Other Health	4,023	2,522
Other	308	190
Net Cost: Other Activities	5,043	3,368
NET COST OF OPERATIONS (Notes 9,13, and 18)	\$779,791	\$737,823

The accompanying notes are an integral part of these statements.

FINANCIAL STATEMENTS

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the Year Ended September 30, 2013

(IN MILLIONS)

	Consolidated Dedicated Collections	Consolidated Other Funds	FY 2013 Consolidated Total
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	\$261,800	\$1,537	\$263,337
Budgetary Financing Sources:			
Appropriations Used	247,684	280,032	527,716
Nonexchange Revenue:			
FICA and SECA Taxes	212,901		212,901
Interest on Investments	11,990	3	11,993
Other Nonexchange Revenue	4,758		4,758
Transfers-in/out Without Reimbursement (Note 10)	(2,448)	1,183	(1,265)
Other Financing Sources (Nonexchange):			
Transfers-in/out Without Reimbursement		(7)	(7)
Imputed Financing	36	12	48
Total Financing Sources	474,921	281,223	756,144
Net Cost of Operations	498,576	281,215	779,791
Net Change	(23,655)	8	(23,647)
CUMULATIVE RESULTS OF OPERATIONS	\$238,145	\$1,545	\$239,690
UNEXPENDED APPROPRIATIONS			
Beginning Balances	\$20,519	\$60,417	\$80,936
Budgetary Financing Sources:			
Appropriations Received	249,300	289,906	539,206
Appropriations Transferred-in/out		(2,981)	(2,981)
Other Adjustments (Note 11)	(17,566)	(29,655)	(47,221)
Appropriations Used	(247,684)	(280,032)	(527,716)
Total Budgetary Financing Sources	(15,950)	(22,762)	(38,712)
Total Unexpended Appropriations	4,569	37,655	42,224
NET POSITION	\$242,714	\$39,200	\$281,914

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 Dedicated Collections	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 10)	(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 11)	(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.

FINANCIAL STATEMENTS

COMBINED STATEMENTS OF BUDGETARY RESOURCES

for the Years Ended September 30, 2013 and September 30, 2012

(IN MILLIONS)

	FY 2013 Combined Totals Budgetary	FY 2013 Non-Budgetary Credit Reform Financing Account	FY 2012 Combined Totals Budgetary	FY 2012 Non-Budgetary Credit Reform Financing Account
BUDGETARY RESOURCES:				
Unobligated balance, brought forward, October 1:	\$72,274	\$3,123	\$41,779	
Recoveries of prior year unpaid obligations	22,295		23,052	
Other changes in unobligated balance	(671)		(3,572)	
Unobligated balance from prior year budget authority, net	93,898	3,123	61,259	
Appropriation	1,083,649		1,078,147	
Borrowing authority		(2,064)		\$3,194
Spending authority from offsetting collections	16,122	(754)	11,647	1,624
TOTAL BUDGETARY RESOURCES	\$1,193,669	\$305	\$1,151,053	\$4,818
STATUS OF BUDGETARY RESOURCES:				
Obligations incurred	\$1,159,282	\$305	\$1,078,779	\$1,695
Unobligated balance, end of year:				
Apportioned	26,084		67,557	3,123
Exempt from apportionment	1,864			
Unapportioned	6,439		4,717	
Total unobligated balance, end of year	34,387		72,274	3,123
TOTAL BUDGETARY RESOURCES	\$1,193,669	\$305	\$1,151,053	\$4,818
CHANGE IN OBLIGATED BALANCE:				
Unpaid obligations:				
Unpaid obligations, brought forward, October 1	\$98,570	\$1,602	\$102,559	
Obligations incurred	1,159,282	305	1,078,779	\$1,695
Outlays (gross)	(1,124,934)	(658)	(1,059,716)	(93)
Recoveries of prior year unpaid obligations	(22,295)		(23,052)	
Unpaid obligations end of year	110,623	1,249	98,570	1,602
Uncollected Payments:				
Uncollected payments, Federal sources, brought forward, October 1	(7,250)	(1,587)	(6,462)	
Change in uncollected payments, Federal sources	(504)	1,051	(788)	(1,587)
Uncollected payments, Federal sources, end of year	(7,754)	(536)	(7,250)	(1,587)
Memorandum entries:				
Obligated start of year, net	91,320	15	96,097	
Obligated balance, end of year, net	\$102,869	\$713	\$91,320	\$15
BUDGETARY AUTHORITY AND OUTLAYS, NET:				
Budget authority, gross	\$1,099,771	\$(2,818)	\$1,089,794	\$4,818
Actual offsetting collections	(15,618)	(296)	(10,859)	(37)
Change in uncollected customer payments from Federal sources	(504)	1,051	(788)	(1,587)
Budget authority, net	1,083,649	(2,063)	1,078,147	3,194
Outlays, gross	1,124,934	658	1,059,716	93
Actual offsetting collections	(15,618)	(296)	(10,859)	(37)
Outlays, net	1,109,316	362	1,048,857	56
Distributed offsetting receipts	(335,935)		(316,656)	

The accompanying notes are an integral part of these statements.

STATEMENT OF SOCIAL INSURANCE

75-Year Projection as of January 1, 2013 and Prior Base Years

(IN BILLIONS)

	Estimates from Prior Years				
	2013 (Unaudited)	2012 (Unaudited)	2011 (Unaudited)	2010 (Unaudited)	2009
<i>Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 15 and 16)</i>					
<i>Current participants who, in the starting year of the projection period:</i>					
Have not yet attained eligibility age					
HI	\$8,147	\$7,929	\$7,581	\$7,216	\$6,348
SMI Part B	15,227	14,431	13,595	12,688	16,323
SMI Part D	5,871	5,866	6,438	6,355	6,144
Have attained eligibility age (age 65 or over)					
HI	301	302	262	248	209
SMI Part B	2,620	2,395	2,122	1,972	1,924
SMI Part D	722	694	695	646	595
Those expected to become participants					
HI	7,744	7,367	7,260	6,944	5,451
SMI Part B	3,530	3,333	3,223	3,077	4,909
SMI Part D	2,617	2,568	2,817	2,714	2,632
All current and future participants					
HI	16,192	15,598	15,104	14,408	12,008
SMI Part B	21,377	20,159	18,940	17,737	23,156
SMI Part D	9,211	9,128	9,950	9,715	9,371
<i>Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 15 and 16)</i>					
<i>Current participants who, in the starting year of the projection period:</i>					
Have not yet attained eligibility age					
HI	14,629	14,919	12,887	12,032	18,147
SMI Part B	15,075	14,303	13,489	12,587	16,342
SMI Part D	5,871	5,866	6,438	6,355	6,144
Have attained eligibility age (age 65 and over)					
HI	3,422	3,369	2,923	2,648	2,958
SMI Part B	2,887	2,646	2,343	2,166	2,142
SMI Part D	722	694	695	646	595
Those expected to become participants					
HI	2,913	2,891	2,546	2,411	4,673
SMI Part B	3,415	3,211	3,108	2,984	4,672
SMI Part D	2,617	2,568	2,817	2,714	2,632
All current and future participants:					
HI	20,963	21,179	18,356	17,090	25,778
SMI Part B	21,377	20,159	18,940	17,737	23,156
SMI Part D	9,211	9,128	9,950	9,715	9,371
<i>Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 15 and 16)</i>					
HI	\$(4,772)	\$(5,581)	\$(3,252)	\$(2,683)	\$(13,770)
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0
ADDITIONAL INFORMATION					
<i>Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 15 and 16)</i>					
HI	\$(4,772)	\$(5,581)	\$(3,252)	\$(2,683)	\$(13,770)
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0
Trust Fund assets at start of period					
HI	220	244	272	304	321
SMI Part B	66	80	71	76	59
SMI Part D	1	1	1	1	1
<i>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 15 and 16)</i>					
HI	\$(4,551)	\$(5,337)	\$(2,980)	\$(2,378)	\$(13,449)
SMI Part B	66	80	71	76	59
SMI Part D	1	1	1	1	1

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

FINANCIAL STATEMENTS

STATEMENT OF SOCIAL INSURANCE (Continued)

75-Year Projection as of January 1, 2013 and Prior Base Years

(IN BILLIONS)

	Estimates from Prior Years				
	2013 (Unaudited)	2012 (Unaudited)	2011 (Unaudited)	2010 (Unaudited)	2009
MEDICARE SOCIAL INSURANCE SUMMARY					
Current Participants:					
<i>Actuarial present value for the 75-year projection period from or on behalf of:</i>					
Those who, in the starting year of the projection period, have attained eligibility age:					
Income (excluding interest)	\$3,643	\$3,391	\$3,079	\$2,866	\$2,729
Expenditures	7,031	6,709	5,961	5,459	5,695
Income less expenditures	(3,388)	(3,319)	(2,882)	(2,593)	(2,967)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	29,244	28,227	27,615	26,259	28,815
Expenditures	35,574	35,088	32,814	30,974	40,634
Income less expenditures	(6,330)	(6,861)	(5,199)	(4,715)	(11,819)
<i>Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)</i>	(9,718)	(10,180)	(8,081)	(7,308)	(14,786)
<i>Combined Medicare Trust Fund assets at start of period</i>	288	325	344	381	381
<i>Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period</i>	(9,430)	(9,855)	(7,737)	(6,927)	(14,405)
Future Participants:					
<i>Actuarial present value for the 75-year projection period:</i>					
Income (excluding interest)	13,891	13,268	13,300	12,735	12,991
Expenditures	8,945	8,669	8,471	8,109	11,976
Income less expenditures	4,946	4,599	4,829	4,626	1,016
Open-Group (all current and future participants):					
<i>Actuarial present value of estimated future income (excluding interest) less expenditures</i>	(4,772)	(5,581)	(3,252)	(2,683)	(13,770)
<i>Combined Medicare Trust Fund assets at start of period</i>	288	325	344	381	381
<i>Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period</i>	\$(4,484)	\$(5,256)	\$(2,908)	\$(2,302)	\$(13,390)

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 17)					
As of January 1, 2012	\$44,885	\$50,467	(\$5,581)	\$325	(\$5,256)
Reasons for change					
Change in the valuation period	1,972	2,257	(285)	(46)	(331)
Change in projection base	(944)	(1,252)	308	9	317
Changes in the demographic assumptions	1,219	495	724	0	724
Changes in economic and health care assumptions	(342)	(374)	31	0	31
Changes in law	(11)	(42)	31	0	31
Net changes	1,893	1,084	809	(37)	772
As of January 1, 2013	\$46,779	\$51,550	\$(4,772)	\$288	\$(4,484)
HI: PART A (Note 17)					
As of January 1, 2012	\$15,598	\$21,179	\$(5,581)	\$244	\$(5,337)
Reasons for change					
Change in the valuation period	631	916	(285)	(29)	(314)
Change in projection base	(258)	(566)	308	5	313
Changes in the demographic assumptions	764	40	724	0	724
Changes in economic and health care assumptions	(544)	(576)	31	0	31
Changes in law	0	(31)	31	0	31
Net changes	593	(216)	809	(24)	786
As of January 1, 2013	\$16,192	\$20,963	\$(4,772)	\$220	\$(4,551)
SMI: PART B (Note 17)					
As of January 1, 2012	20,159	20,159	0	80	80
Reasons for change					
Change in the valuation period	874	874	0	(17)	(17)
Change in projection base	(504)	(504)	0	3	3
Changes in the demographic assumptions	212	212	0	0	0
Changes in economic and health care assumptions	647	647	0	0	0
Changes in law	(12)	(12)	0	0	0
Net changes	1,217	1,217	0	(13)	(13)
As of January 1, 2013	\$21,377	\$21,377	\$0	\$66	\$66
SMI: PART D (Note 17)					
As of January 1, 2012	\$9,128	\$9,128	\$0	\$1	\$1
Reasons for change					
Change in the valuation period	467	467	0	(0)	(0)
Change in projection base	(182)	(182)	0	0	0
Changes in the demographic assumptions	242	242	0	0	0
Changes in economic and health care assumptions	(446)	(446)	0	0	0
Changes in law	1	1	0	0	0
Net changes	83	83	0	0	0
As of January 1, 2013	\$9,211	\$9,211	\$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.

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 17)					
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)	0	(97)
Changes in economic and health care assumptions	24	2,570	(2,546)	0	(2,546)
Changes in law	(66)	(219)	153	0	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 17)					
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)	0	(97)
Changes in economic and health care assumptions	(71)	2,475	(2,546)	0	(2,546)
Changes in law	0	(153)	153	0	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 17)					
As of January 1, 2011	\$18,940	\$18,940	\$0	\$71	\$71
Reasons for change					
Change in the valuation period	845	845	0	6	6
Change in projection base	152	152	0	2	2
Changes in the demographic assumptions	(339)	(339)	0	0	0
Changes in economic and health care assumptions	623	623	0	0	0
Changes in law	(61)	(61)	0	0	0
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 17)					
As of January 1, 2011	\$9,950	\$9,950	\$0	\$1	\$1
Reasons for change					
Change in the valuation period	533	533	0	0	(0)
Change in projection base	(54)	(54)	0	0	0
Changes in the demographic assumptions	(767)	(767)	0	0	0
Changes in economic and health care assumptions	(528)	(528)	0	0	0
Changes in law	(5)	(5)	0	0	0
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.

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 generally accepted accounting principles 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. It also allowed for the establishment of a Center for Consumer Information and Insurance Oversight (CCIIO). The programs under CCIIO include: Pre-existing Condition Insurance Program (PCIP), Early Retiree Reinsurance Programs, Affordable Insurance Marketplaces (the "Marketplaces"), and the Consumer Operated and Oriented Plan (CO-OP) program. A brief description of these programs and their impact on the CMS financial statements is presented below.

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 Marketplaces programs are operational. Congress appropriated \$5 billion for the life of this interim program. This program ends on January 1, 2014.

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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 Marketplaces

Grants have been provided to the states to establish Affordable Insurance Marketplaces. 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. All Marketplaces will launch open enrollment on October 1, 2013.

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. 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.

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

Funds from Dedicated Collections

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

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

The Medicare Funds from dedicated collections include:

Medicare Hospital Insurance Trust Fund — Part A

Section 1817 of the Social Security Act established the Medicare Hospital Insurance (HI) Trust Fund. Medicare contractors are paid by CMS to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI Trust Fund. A portion of CMS payments to Medicare Advantage plans are also charged to this fund. The financial statements include HI Trust Fund activities administered by the Department of the Treasury (Treasury). The HI Trust Fund has permanent indefinite authority. Employment tax revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA). Employees and employers are both required to contribute 1.45

percent of earnings, with no limitation, to the HI Trust Fund. Self-employed individuals contribute the full 2.9 percent of their net income. The Social Security Act requires the transfer of these contributions from the General Fund of Treasury to the HI Trust Fund based on the amount of wages certified by the Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 as the basis for conducting quarterly certification of regular wages. (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 10 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 10 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.

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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. Medicaid also provides funding for the Health Information Technology for Economic and Clinical Health (HITECH) incentive payments made to the states.

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) extended the program through September 2013; the Affordable Care Act extends the program through September 2015. CHIPRA also establishes a Child Enrollment Contingency Fund to cover shortfalls in funding for the states. This fund is invested in interest-bearing Treasury securities.

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

State Grants and Demonstrations

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

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

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

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

Program Management User Fees: Medicare Advantage, Clinical Laboratory Improvement Program, 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 10). 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.

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The cost related to the Program Management Appropriation is allocated among all programs based on the CMS cost allocation system. It is reported in the Medicare and Health columns of the Consolidating Statement of Net Cost in the Supplementary Information section.

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

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

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

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

Trust Fund (Dedicated collections) Investments are investments (plus the accrued interest on investments) held by Treasury. Sections 1817 for HI and 1841 for SMI of the Social Security Act require that trust fund investments not necessary to meet current expenditures be invested in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December) and was adjusted to include an accrual for interest earned from July 1 to September 30. The FASAB SFFAS 27 prescribes certain disclosures concerning dedicated collections investments, such as the fact that cash generated from funds from dedicated collections is used

by the U.S. Treasury for general Government purposes and that, upon redemption of investments to make expenditures, the Treasury will finance those expenditures in the same manner that it finances all other expenditures (see Note 3).

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

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

Unexpended Appropriations include the portion of CMS' 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 2012 balances have been reclassified to conform to FY 2013 financial statement presentations.

Change in Presentation

Effective for FY 2013, changes have been made to the Statement of Budgetary Resources to reflect the new format prescribed by OMB's Circular A-136.

Estimation of Obligations Related to Canceled Appropriations

As of September 30, 2013, CMS has canceled over \$331 million in cumulative obligations related to FY 2008 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 2009 through 2013 related to canceled appropriations, CMS anticipates an additional \$4 million will be paid from current year funds for canceled obligations.

FINANCIAL STATEMENTS

NOTE 2:

FUND BALANCE WITH TREASURY

(DOLLARS IN MILLIONS)

	FY 2013 Consolidated Totals	FY 2012 Consolidated Totals
FUND BALANCES:		
Trust Funds:		
HI Trust Fund (Dedicated collections)	\$1,959	\$1,490
SMI Trust Fund (Dedicated collections)	7,489	21,764
Revolving Funds:		
CO-OP Financing	121	93
General Funds:		
Medicaid	32,150	47,914
CHIP	17,139	16,131
State Grants and Demonstrations	2,246	2,252
Other Health	14,012	18,255
Other		4
Program Management	1,477	1,091
Other Fund Types:		
CMS Deposit/Suspense Accounts	16	12
Total Fund Balances	\$76,609	\$109,006
STATUS OF FUND BALANCES WITH TREASURY:		
Unobligated Balance:		
Available	\$27,948	\$70,680
Unavailable	6,439	4,717
Obligated Balance not yet Disbursed	103,582	91,335
Non-Budgetary FBWT	(61,360)	(57,726)
Total Status of Fund Balances with Treasury	\$76,609	\$109,006

Fund Balances are funds with Treasury that are primarily available to pay current expenditures and liabilities. The Medicaid balance of \$32,150 million (\$47,914 million in FY 2012) includes \$3,772 million (\$5,170 million in FY 2012) of funds for ARRA. The Unobligated Balance Available includes \$12,972 million (\$15,912 million in FY 2012), 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 2013 MEDICARE INVESTMENTS <i>(Dedicated Collections)</i>	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2014	2 3/8%	\$8,841
Bonds	June 2015 to June 2024	3 1/4 – 6 1/2%	197,169
Accrued Interest			2,221
Total HI TF Investments			\$208,231
SMI TF			
Certificates	June 2014	2 3/8%	\$9,147
Bonds	June 2014 to June 2026	1 3/4 – 6 1/2%	58,238
Accrued Interest			557
Total SMI TF Investments			\$67,942
Total Medicare Investments			\$276,173

FY 2012 MEDICARE INVESTMENTS <i>(Dedicated Collections)</i>	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

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

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

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

FINANCIAL STATEMENTS

NOTE 3:

INVESTMENTS (Continued)

(DOLLARS IN MILLIONS)

FY 2013	Maturity Date	Cost	Unamortized Discount	Investments, Net
Treasury Bill	01/09/14	\$2,098	\$1	\$2,097
Total Investments		\$2,098	\$1	\$2,097

FY 2012	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 Investments		\$2,096	\$1	\$2,095

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.

CMS INVESTMENT SUMMARY

(DOLLARS IN MILLIONS)

FY 2013	Medicare (Dedicated Collections)			Non-Dedicated Collections	Consolidated Total
	HI TF	SMI TF	Total	CHIP	
Certificates	\$8,841	\$9,147	\$17,988		\$17,988
Bonds	197,169	58,238	255,407		255,407
Treasury Bills				\$2,097	2,097
Accrued Interest	2,221	557	2,778		2,778
Total Investments	\$208,231	\$67,942	\$276,173	\$2,097	\$278,270

FY 2012	Medicare (Dedicated Collections)			Non-Dedicated Collections	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

Note 4:

ACCOUNTS RECEIVABLE, NET

(DOLLARS IN MILLIONS)

FY 2013	Medicare (Dedicated Collection)		Medicaid	CHIP	Other Health	Other	Consolidated Total
	HI TF	SMI TF					
INTRAGOVERNMENTAL	\$571	\$2,800					\$3,371
WITH THE PUBLIC							
Provider & Beneficiary Overpayments							
Accounts Receivable Principal	\$1,618	\$636				\$46	\$2,300
Less: Allowance for Uncollectible Accounts	(251)	(218)				(20)	(489)
Accounts Receivable, Net	1,367	418				26	1,811
Medicare Secondary Payer (MSP)							
Accounts Receivable Principal	104	66				3	173
Less: Allowance for Uncollectible Accounts	(26)	(22)				(1)	(49)
Accounts Receivable, Net	78	44				2	124
Medicare Prescription Drug							
Accounts Receivable Principal		2,536					2,536
Less: Allowance for Uncollectible Accounts							
Accounts Receivable, Net		2,536					2,536
Medicare Premiums							
Accounts Receivable Principal	332	1,189					1,532
Less: Allowance for Uncollectible Accounts	(73)	(125)					(209)
Accounts Receivable, Net	259	1,064					1,323
State Phased-Down Contributions							
Accounts Receivable Principal		1,354					1,354
Less: Allowance for Uncollectible Accounts							
Accounts Receivable, Net		1,354					1,354
Medicaid/CHIP Overpayments							
Accounts Receivable Principal			\$1,926	\$5			1,931
Less: Allowance for Uncollectible Accounts							
Accounts Receivable, Net			1,926	5			1,931
Audit Disallowances							
Accounts Receivable Principal			2,288	8			2,296
Less: Allowance for Uncollectible Accounts			(842)	(2)			(844)
Accounts Receivable, Net			1,446	6			1,452
Other Accounts Receivables							
Accounts Receivable Principal	529	447	3		\$4	18	1,001
Less: Allowance for Uncollectible Accounts	(456)	(424)			(1)	(14)	(895)
Accounts Receivable, Net	73	23	3		3	4	106
Total Accounts Receivable Principal	\$2,583	\$6,228	\$4,217	\$13	\$4	\$67	\$13,123
Less: Allowance for Uncollectible Accounts Receivable	(806)	(789)	(842)	(2)	(1)	(35)	(2,486)
Total Accounts Receivable, Net	\$1,777	\$5,439	\$3,375	\$11	\$3	\$32	\$10,637

FINANCIAL STATEMENTS

Note 4:

ACCOUNTS RECEIVABLE, NET (Continued)

(DOLLARS IN MILLIONS)

FY 2012	Medicare (Dedicated Collection)		Medicaid	CHIP	Other Health	Other	Consolidated Total
	HI TF	SMI TF					
INTRAGOVERNMENTAL	\$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
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/CHIP 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	448	408	272		\$19	21	1,168
Less: Allowance for Uncollectible Accounts	(404)	(371)	(27)			(17)	(819)
Accounts Receivable, Net	44	37	245		19	4	349
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

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 \$2,536 million (\$3,632 million in FY 2012) consists of amounts due CMS after completion of the Part D payment reconciliation for calendar year (CY) 2012 in the amount of \$1,296 million (\$2,368 million in FY 2012) and the Coverage Gap Discount Program in the amount of \$1,240 million (\$1,264 million in FY 2012).

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).

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Other Accounts Receivables

This represents amounts for activities such as civil monetary penalties and restitutions, fraud and abuse, and managed care.

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:

OTHER ASSETS

(DOLLARS IN MILLIONS)

As of September 30, 2013, CMS has \$831 million (\$1,432 million in FY 2012) in Other Assets. This includes the direct loans for the CO-OP program. At September 30, 2012, we reflected advances of \$1,379 million mainly from Part D plans.

Note 6:

ENTITLEMENT BENEFITS DUE AND PAYABLE

(DOLLARS IN MILLIONS)

	Medicare (Dedicated Collections)			Medicaid	CHIP	Other Health	Other	Consolidated Total
	HI TF	SMI TF	Total					
FY 2013								
Medicare Benefits Payable (1)	\$19,470	\$19,259	\$38,729					\$38,729
Medicare Advantage/Prescription Drug Program (2)	1,335	6,890	8,225					8,225
Retiree Drug Subsidy (3)		1,660	1,660					1,660
Undocumented Aliens							\$19	19
Medicaid/CHIP (4)				\$27,588	\$693			28,281
Other Health						\$363		363
Total Entitlement Benefits Due and Payable	\$20,805	\$27,809	\$48,614	\$27,588	\$693	\$363	\$19	\$77,277

	Medicare (Dedicated Collections)			Medicaid	CHIP	Other Health	Other	Consolidated Total
	HI TF	SMI TF	Total					
FY 2012								
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

(1) Medicare benefits payable consists of a \$38,729 million estimate (\$38,775 million in FY 2012) for Medicare services incurred but not paid as of September 30, 2013. 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 2013 that were paid in 2014 and (e) an estimate of retroactive settlements of cost reports. The September 30, 2013 and 2012 estimate also includes amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals and teaching

hospitals as well as amounts which may be due/owed to hospitals for adjusted prospective payments.

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

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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 \$8,225 million (\$5,292 million in FY 2012) consists of a \$4,500 million estimate (\$2,779 million in FY 2012) for amounts owed to plans relating to risk and other payment related adjustments including the estimate for the first nine months of CY 2013 for the Part D payment reconciliation and \$3,725 million (\$2,513 million in FY 2012) owed to plans after the completion of the Prescription Drug Payment reconciliation.

(3) The Retiree Drug Subsidy (RDS) consists of a \$1,660 million estimate (\$2,369 million in FY 2012) of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2013. 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 \$27,588 million (\$24,955 million in FY 2012) 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, 2013. This estimate incorporates claim activity tracked under ARRA of \$175 million (\$248 million in FY 2012). An estimated CHIP benefits payable of \$693 million has been recorded (\$651 million in FY 2012) for the net Federal share of expenses that have been incurred by the states but not yet reported to CMS as of September 30, 2013.

Note 7:

CONTINGENCIES

The contingencies balance as of September 30, 2013 is \$7,366 million (5,291 million in FY 2012). Additionally, CMS may owe amounts to providers for previous years' disputed cost report adjustments for disproportionate share hospitals. CMS is a party in various administrative proceedings, legal actions, and tort claims which may ultimately result in settlements or decisions adverse to the Federal Government. CMS accrues contingent liabilities where a loss is determined to be probable and the amount can be estimated. Other contingencies exist where losses are reasonably possible, and an estimate can be determined or an estimate of the range of possible liability has been determined. CMS does not record an accrual for a contingent liability if it is not estimable and probable but does disclose those contingencies in the financial statements, if the future settlement could be material to the financial statements.

The Medicaid amount for \$6,066 million (\$3,856 million in FY 2012) consists of Medicaid audit and program disallowances of \$2,978 million (\$1,874 million in FY 2012) and \$3,088 million (\$1,982 million in FY 2012) for reimbursement of state plan amendments. Contingent liabilities have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the states. The funds could have been returned or CMS can decrease the state's authority. CMS will be required to pay these amounts if the appeals are decided in the favor of the states. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a state. There are also outstanding reviews of the state expenditures in which a final determination has not been made. Examples of these reviews are the Office of Inspector General Audits, Focused Financial Management Reviews, and Quarterly Medicaid Statement of Expenditures Report (Form CMS-64) reviews. The appropriate Center for Medicaid and CHIP Services (CMCS) Regional Office staff is responsible for reviewing the findings and recommendations. The monetary effect of these reviews is not known until a final decision is determined and rendered by the Director of CMCS. The outcome of these reviews may result in funds being owed to CMS.

Appeals at the Provider Reimbursement Review Board

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. However, historical cases that have been appealed and settled by the PRRB are considered in the development of the actuarial Medicare IBNR

liability. As of September 30, 2013, 7,124 cases (5,041 in FY 2012) remain on appeal. A total of 3,907 new cases (652 in FY 2012) were filed and 9 cases were reopened (19 in FY 2012). The PRRB rendered decisions on 210 cases (98 in FY 2012) in FY 2013 and additional 1,623 cases (2,215 in FY 2012) were dismissed, withdrawn, or settled prior to an appeal hearing. The PRRB receives no information on the value of these cases that are settled prior to a hearing.

Note 8:

LIABILITIES NOT COVERED BY BUDGETARY RESOURCES

(DOLLARS IN MILLIONS)

FY 2013	Medicare (Dedicated Collections)						Combined Total	Intra-CMS Eliminations	Consolidated Total
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other			
Intragovernmental									
Accrued Payroll and Benefits Other Health	\$1	\$2			\$7		\$3 7		\$3 7
Total Intragovernmental	\$1	\$2			\$7		\$10		\$10
Federal Employee and Veterans' Benefits	\$4	\$8	\$1		\$2		\$15		\$15
Accrued Payroll and Benefits	14	25	2		8	\$2	51		51
Other Health					70		70		70
Contingencies		1,300	6,066				7,366		7,366
Total Liabilities Not Covered by Budgetary Resources	19	1,335	6,069		87	2	7,512		7,512
Total Liabilities Covered by Budgetary Resources	48,824	66,410	27,593	\$694	949	90	144,560	\$(63,785)	80,775
TOTAL LIABILITIES	\$48,843	\$67,745	\$33,662	\$694	\$1,036	\$92	\$152,072	\$(63,785)	\$88,287

FY 2012	Medicare (Dedicated Collections)						Combined Total	Intra-CMS Eliminations	Consolidated Total
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other			
Intragovernmental									
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

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.

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Note 9:

NET COST OF OPERATIONS

(DOLLARS IN MILLIONS)

FY 2013	Medicare (Dedicated Collections)			Health				Consolidated Total
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	
PROGRAM/ACTIVITY COSTS								
Medicare								
Fee for Service	\$190,497	\$172,804	\$363,301					\$363,301
Medicare Advantage/ Managed Care	71,466	70,017	141,483					141,483
Prescription Drug (Part D)		57,170	57,170					57,170
Medicaid/CHIP/State Grants & Demos				\$266,137	\$9,527		\$515	276,179
Other Health						\$4,014		4,014
Total Program/Activity Costs	261,963	299,991	561,954	266,137	9,527	4,014	515	842,147
OPERATING COSTS								
Medicare Integrity Program	\$1,496		\$1,496					\$1,496
Quality Improvement Organizations	388	\$138	526					526
Bad Debt Expense and Writeoffs	156	5	161	\$325	\$2	\$1		489
Reimbursable Expenses	114	251	365	18	2	46	\$13	444
Administrative Expenses	1,106	2,178	3,284	167	21	196	722	4,390
Depreciation and Amortization	12	14	26	(7)	(2)	33	(8)	42
Imputed Cost Subsidies	12	24	36	2		8	2	48
Total Operating Costs	\$3,284	\$2,610	\$5,894	\$505	\$23	\$284	\$729	\$7,435
TOTAL COSTS	\$265,247	\$302,601	\$567,848	\$266,642	\$9,550	\$4,298	\$1,244	\$849,582
Less: Exchange Revenues:								
Medicare Premiums	\$3,656	\$65,253	\$68,909					\$68,909
Other Exchange Revenues	112	251	363	\$18	\$2	\$275	\$224	882
Total Exchange Revenues	\$3,768	\$65,504	\$69,272	\$18	\$2	\$275	\$224	\$69,791
TOTAL NET COST OF OPERATIONS	\$261,479	\$237,097	\$498,576	\$266,624	\$9,548	\$4,023	\$1,020	\$779,791

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FY 2012	Medicare (Dedicated Collections)			Health				Consolidated Total
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	
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
Total Program/Activity Costs	250,969	286,128	537,097	247,305	9,247	2,612	439	796,700
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	585	3,878
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	\$533	\$6,216
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
Other Exchange Revenues	48	113	161	\$6	\$1	\$102	\$126	396
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

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 \$2,380 million (\$2,067 million in FY 2012) 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 2013 Part D expense of \$57,170 million (\$52,251 million in FY 2012) is net of state reimbursements of \$8,758 million (\$8,417 million in FY 2012). The gross expense would have been \$65,928 million in FY 2013 (\$60,668 million in FY 2012).

Of the Medicaid benefit expense of \$266,137 million (\$247,305 million in FY 2012), \$2,857 million were identified under ARRA (\$3,612 million in FY 2012).

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Note 10:

TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT

(DOLLARS IN MILLIONS)

FY 2013 Transfers-in Without Reimbursement	Medicare (Dedicated Collections)						Combined Total	Intra-CMS Eliminations	Consolidated Total
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other			
Medicare Benefit Transfers	\$269,928	\$309,084					\$579,012	\$(579,012)	
Transfers to HCFAC	1,575						1,575	(1,575)	
Federal Matching Contributions		176,940					176,940	(176,940)	
Medicare Part D Benefits		49,900					49,900	(49,900)	
Medicare Part D Administrative		367					367	(367)	
Allocation to CMS Programs	927	2,009	\$146	\$15	\$477	\$68	3,642	(3,642)	
Fraud and Abuse Appropriation	237						237	(237)	
Transfer-Uninsured Coverage	228						228	(228)	
Prog Mngmt Admin. Expense (1)	567						567	(567)	
Income Tax OASDI Benefits (2)	14,310						14,310	(14,310)	
Railroad Retirement Board	643						643		\$643
Criminal Fines	779						779	(779)	
Medicaid Part B Premiums			477				477	(477)	
HITECH	3,656	7,720					11,376	(11,376)	
QIO	338	121					459	(459)	
Interest Adjustments									
Other	1	1					2		2
Total Transfers-in	\$293,189	\$546,142	\$623	\$15	\$477	\$68	\$840,514	\$(839,869)	\$645

FY 2013 Transfers-out Without Reimbursement	Medicare (Dedicated Collections)						Combined Total	Intra-CMS Eliminations	Consolidated Total
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other			
SSA Administrative Expenses	\$(761)	\$(981)					\$(1,742)		\$(1,742)
Medicare Benefit Transfers	(269,928)	(309,084)					(579,012)	\$579,012	
Transfers to HCFAC	(1,575)						(1,575)	1,575	
Federal Matching Contributions		(176,940)					(176,940)	176,940	
Medicare Part D Benefits		(49,900)					(49,900)	49,900	
Medicare Part D Administrative		(367)					(367)	367	
Transfers to Program Management	(1,813)	(1,829)					(3,642)	3,642	
Fraud and Abuse Appropriation	(237)						(237)	237	
Transfer-Uninsured Coverage	(228)						(228)	228	
Prog Mngmt Admin. Expense (1)	(567)						(567)	567	
Income Tax OASDI Benefits (2)	(14,310)						(14,310)	14,310	
Criminal Fines	(779)						(779)	779	
Medicaid Part B Premiums		(477)					(477)	477	
HITECH	(3,366)	(8,010)					(11,376)	11,376	
QIO	(459)						(459)	459	
Office of the Secretary	(34)	(34)					(68)		(68)
Payment Assessment Commission	(6)	(4)					(10)		(10)
AOA/MIPPA Expense	(8)	(8)					(16)		(16)
Transfer to PCORTF	(25)	(27)					(52)		(52)
Railroad Retirement Board		(22)					(22)		(22)
Total Transfers-out	\$(294,096)	\$(547,683)					\$(841,779)	\$839,869	\$(1,910)
Total Transfers-in/out without reimbursement	\$(907)	\$(1,541)	\$623	\$15	\$477	\$68	\$(1,265)		\$(1,265)

Note 10:

TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT

(DOLLARS IN MILLIONS)

FY 2012 Transfers-in Without Reimbursement	Medicare (Dedicated Collections)						Combined Total	Intra-CMS Eliminations	Consolidated Total
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other			
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 (Dedicated Collections)						Combined Total	Intra-CMS Eliminations	Consolidated Total
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other			
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)

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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. As of September 30, 2013, the Payments to the Health Care Trust Funds appropriation paid \$567 million to the HI Trust Fund (\$226 million was paid in FY 2012) 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 \$99.90 from October 2012 through December 31, 2012 and \$104.90 from January 2013 to September 2013. Premiums collected from beneficiaries totaled \$61,770 million (\$57,889 million in FY 2012) and were matched by a \$176,940 million (\$165,254 million in FY 2012) 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, 2013, approximately \$50,267 million has been transferred-in (\$45,254 million in FY 2012) to Part D from the general fund.

Note 11:

BUDGETARY FINANCING SOURCES: OTHER ADJUSTMENTS

(DOLLARS IN MILLIONS)

FY 2013 Unexpended Appropriations	Medicare (Dedicated Collections)		Medicaid	CHIP	Other Health	Other	Consolidated Total
	HI TF	SMI TF					
Withdrawal of Expired or Canceled Year Authority	\$(11)	\$(17,555)		\$(594)		\$(17)	\$(18,177)
Return of Indefinite Authority			\$(19,964)		\$(128)		(20,092)
Rescissions				\$(6,368)	\$(2,279)	\$(200)	(8,847)
Sequestration					\$(65)	\$(40)	\$(105)
Total Other Adjustments	\$(11)	\$(17,555)	\$(19,964)	\$(6,962)	\$(2,472)	\$(257)	\$(47,221)

FY 2012 Unexpended Appropriations	Medicare (Dedicated Collections)		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)

Other adjustments include decreases to Unexpended Appropriations that result from sequestration for 2013. In 2012, the decreases 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.

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Note 12:

FUNDS FROM DEDICATED COLLECTIONS

(DOLLARS IN MILLIONS)

Funds from dedicated collections are financed by specifically identified revenues, often supplemented by other financing sources, which remain available over time. CMS has designated as funds from dedicated collections the Medicare HI and SMI Trust Funds which also include the Payments to the Health Care Trust Funds appropriation and the HCFAC account. In addition, portions of the Program Management appropriation have been allocated to the HI and SMI Trust Funds. Condensed information showing assets, liabilities, gross cost, exchange and nonexchange revenues and changes in net position appears below.

	HI TF	SMI TF	Total Dedicated Collections Funds
<i>Balance Sheet as of September 30, 2013</i>			
ASSETS			
Fund Balance with Treasury	\$1,959	\$7,489	\$9,448
Investments	208,231	67,942	276,173
Other Assets	28,655	45,026	73,681
Total Assets	\$238,845	\$120,457	\$359,302
Entitlement Benefits Due and Payable	\$20,805	\$27,809	\$48,614
Other Liabilities	28,038	39,936	67,974
Total Liabilities	\$48,843	\$67,745	\$116,588
Unexpended Appropriations	\$978	\$3,591	\$4,569
Cumulative Results of Operations	189,024	49,121	238,145
Total Net Position	\$190,002	\$52,712	\$242,714
Total Liabilities and Net Position	\$238,845	\$120,457	\$359,302
<i>Statement of Net Cost For the Year Ended September 30, 2013</i>			
Benefit Expense	\$261,963	\$299,991	\$561,954
Operating Costs	3,284	2,610	5,894
Total Costs	265,247	302,601	567,848
Less Earned Revenues	3,768	65,504	69,272
Net Cost of Operations	\$261,479	\$237,097	\$498,576
<i>Statement of Changes in Net Position For the Year Ended September 30, 2013</i>			
Net Position, Beginning of Period	\$212,261	\$70,058	\$282,319
Taxes and Other Nonexchange Revenue	223,804	5,845	229,649
Other Financing Sources	15,416	213,906	229,322
Less Net Cost of Operations	261,479	237,097	498,576
Change in Net Position	(22,259)	(17,346)	(39,605)
Net Position, End of Period	\$190,002	\$52,712	\$242,714

Note 12:

FUNDS FROM DEDICATED COLLECTIONS (Continued)

(DOLLARS IN MILLIONS)

	HI TF	SMI TF	Total Dedicated Collections Funds
<i>Balance Sheet as of September 30, 2012</i>			
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
<i>Statement of Net Cost For the Year Ended September 30, 2012</i>			
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
<i>Statement of Changes in Net Position For the Year Ended September 30, 2012</i>			
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

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Note 13:

INTRAGOVERNMENTAL COSTS AND EXCHANGE REVENUE

(DOLLARS IN MILLIONS)

	Gross Cost			Less: Exchange Revenue			Consolidated Net Cost of Operations
	Intra-governmental	Public	Total	Intra-governmental	Public	Total	
FY 2013							
PROGRAM/ACTIVITY COSTS							
GPRC Programs							
Medicare (Dedicated Collections)							
HI TF	\$834	\$264,413	\$265,247	\$14	\$3,754	\$3,768	\$261,479
SMI TF	188	302,413	302,601	29	65,475	65,504	237,097
Medicaid	13	266,629	266,642	2	16	18	266,624
CHIP	5	9,545	9,550		2	2	9,548
Subtotal	1,040	843,000	844,040	45	69,247	69,292	774,748
Other Activities							
State Grants and Demonstrations	23	711	734	3	19	22	712
Other Health	150	4,148	4,298	20	255	275	4,023
Other	43	467	510		202	202	308
Subtotal	216	5,326	5,542	23	476	499	5,043
PROGRAM/ACTIVITY TOTALS	\$1,256	\$848,326	\$849,582	\$68	\$69,723	\$69,791	\$779,791

	Gross Cost			Less: Exchange Revenue			Consolidated Net Cost of Operations
	Intra-governmental	Public	Total	Intra-governmental	Public	Total	
FY 2012							
PROGRAM/ACTIVITY COSTS							
GPRC Programs							
Medicare (Dedicated Collections)							
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							
State Grants and Demonstrations	47	528	575		(81)	(81)	656
Other Health	82	2,542	2,624	3	99	102	2,522
Other	49	348	397		207	207	190
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

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 14:

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 2013	Direct	Reimbursable	Combined Totals
Category A	\$13,016	\$207	\$13,223
Category B	601,373	666	602,039
Exempt	544,325		544,325
Total	\$1,158,714	\$873	\$1,159,587

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

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 (SBR). The portion of trust fund receipts collected in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in that fiscal year is precluded by law from being available for obligation. This excess of receipts over obligations is Temporarily Not Available Pursuant to Public Law and is included in the calculation for appropriations on the Statement of Budgetary Resources and, therefore, is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the trust funds and currently become available for obligation as needed. The entire trust fund balances in the amount of \$245,041 million as of September 30, 2013, (\$245,356 million in FY 2012) are included in Investments on the Balance Sheets. The following table presents trust fund activities and balances for FY 2013 and FY 2012 (in millions):

	FY 2013 Combined Balance	FY 2012 Combined Balance
TRUST FUND BALANCE, BEGINNING	\$245,356	\$260,656
Receipts	528,467	476,709
Less Obligations	528,782	492,009
Excess (Shortage) of Receipts Over Obligations	(315)	(15,300)
TRUST FUND BALANCE, ENDING	\$245,041	\$245,356

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EXPLANATIONS OF DIFFERENCES BETWEEN THE STATEMENT OF BUDGETARY RESOURCES AND THE BUDGET OF THE UNITED STATES GOVERNMENT FOR FY 2012

(DOLLARS IN MILLIONS)

FY 2012	Budgetary Resources	Obligations Incurred	Distributed Offsetting Receipts	Net Outlays
Combined Statement of Budgetary Resources	\$1,155,871	\$1,080,474	\$316,656	\$1,048,913
Expired Accounts	(5,116)			
Other	2,591	3,500	(100)	3,944
President's Budget (2012 Actual)	\$1,153,346	\$1,083,974	\$316,556	\$1,052,857

The Other Adjustments Line for Budgetary Resources includes an increase in the amount of \$4,001 million for the amounts reported in the President's Budget but reported on the Centers for Disease Control (CDC) SBR, TAFS for CCIIO assigned to CMS but reported by PSC in the amount of \$5 million; TAFS 75 11 10/12 0035 assigned to CMS but reported under Executive office of the President by OMB in the amount of \$(5) million, backdated warrant for 75 11 1806 processed during the revision window in the amount of \$(22) million, back dated warrant for 75 X 0580 in the amount of \$(100) million, subsidy calculation was changed for 75 X 4418 in the amount of \$(895) million during the revision window, reclass of the 4881 credit balances to 4871 in the amount of \$(375) million) during the revision window and a MAX adjustment for indefinite authority that should have been returned at September 30, 2012 for 75 12 0115 in the amount of \$(18) million.

The Other Adjustments Line for Obligations Incurred includes an increase of \$4,000 million for the amounts reported in the President's Budget but reported on the CDC SBR; back dated warrant for the 75 11 1806 processed during the revision window in the amount of \$(22) million, back dated warrant for 75 X 0580 \$(100) million, TAFS 75 11 10/12 0035 assigned to CMS but reported under Executive Office of the President by OMB in the amount of \$(5) million, reclass of the 4881 credit balances to 4871 in the amount of \$(375) million during the revision window and \$2 million due to rounding.

The Other Adjustments Line for Offsetting Receipts includes the difference resulting from the TAR that captures cash that was actually collected and the SBR that captures the accruals in the amount of \$1 million, back dated 224 reported for 75 X 8005.44 in the amount of \$(100) million and \$(1) million due to rounding.

The Other Adjustments Line for Net Outlays includes an increase to net outlays in the amount of \$3,603 million for the amounts reported in the President's Budget but reported on the CDC SBR; TAFS for CCIIO assigned to CMS but reported by PSC in the amount of \$462 million, back dated warrant for 75 11 1806 processed during the revision window in the amount of \$(22) million, back dated warrant for 75 X 0580 in the amount of \$(100) million and \$1 million due to rounding.

Undelivered Orders at the End of the Period

The amount of budgetary resources obligated for undelivered orders totaled \$19,230 million for Budgetary and \$1,243 million for Non-Budgetary at September 30, 2013 (\$19,626 million in FY 2012).

Non-Budgetary Credit Reform Financing Account

The negative balance for borrowing authority, net of \$2,064 million under the FY 2013 Non-Budgetary Credit Program Financing Account column on the SBR reflects an adjustment occurring in the current year to return 2012

indefinite borrowing authority of \$2,228 million that should have been made at September 30, 2012. In addition, the negative balance of \$754 million for spending authority from offsetting collections under that column represents a reduction to unfilled orders for an \$894 million overstatement at September 30, 2012. These adjustments were determined to be immaterial to the overall financial statements and the error was corrected in the 2013 financial statements.

Note 15:

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 16 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 16 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 May 31, 2013, 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

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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 May 31, 2013. 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 2013 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2013. 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/CFORepor/>.

Table 1:
SIGNIFICANT ASSUMPTIONS AND SUMMARY MEASURES USED FOR THE STATEMENT OF SOCIAL INSURANCE 2013

	Fertility rate ¹	Net immigration ²	Morality rate ³	Real-wage differential ⁴	Annual percentage change in:						Real-interest rate ⁹
					Per beneficiary cost ⁸						
					Wages ⁵	CPI ⁶	Real GDP ⁷	HI	SMI		
								B	D		
2013	1.91	1,155,000	722.2	0.87	2.67	1.80	2.2	-0.9	0.4	0.3	-0.3
2020	2.06	1,255,000	670.2	1.35	4.15	2.80	2.3	3.9	5.3	6.6	2.8
2030	2.03	1,115,000	613.0	1.20	4.00	2.80	2.0	4.7	4.9	5.5	2.9
2040	2.00	1,080,000	564.1	1.15	3.95	2.80	2.2	5.3	4.5	5.3	2.9
2050	2.00	1,065,000	521.1	1.11	3.91	2.80	2.1	4.2	4.1	5.0	2.9
2060	2.00	1,060,000	483.3	1.10	3.90	2.80	2.0	3.9	4.0	4.8	2.9
2070	2.00	1,055,000	449.7	1.10	3.90	2.80	2.1	4.1	4.0	4.7	2.9
2080	2.00	1,055,000	419.8	1.13	3.93	2.80	2.1	3.8	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 service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.

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

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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 2013–2009

	Fertility rate ¹	Net immigration ²	Morality rate ³	Real-wage differential ⁴	Annual percentage change in: Per beneficiary cost ⁸						Real-interest rate ⁹
					Wages ⁵	CPI ⁶	Real GDP ⁷	HI	SMI		
									B	D	
FY 2013	2.0	1,055,000	419.8	1.1	3.93	2.8	2.1	3.8	3.8	4.5	2.9
FY 2012	2.0	1,030,000	446.0	1.1	3.92	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

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

² Includes legal immigration, net of emigration, as well as other, non-legal, immigration. The ultimate level of net legal immigration is 790,000 persons per year and the assumption for annual net other immigration varies throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.

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. The value presented is the average of annual real-wage differentials for the last 65 years of the 75-year projection period, is consistent with the annual differentials shown in table 1, and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.

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

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 soon after the 10th year 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 2013 bid submissions by the private plans offering this coverage, together with actual data on beneficiary enrollment and program spending through 2012, 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 16:

**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 reductions in provider payments 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 25 percent in payment rates for physician services in 2014, as required under current law. If lawmakers act to prevent this decrease, as they have for 2003 through 2013, 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 methodology is explained in more detail in section IV.D of the 2013

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Medicare Trustees Report:

The Panel also recommended the continued use of a supplemental analysis, similar to the illustrative alternative projection in the 2010 through 2012 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 approximate 25 percent reduction in Medicare payment rates for physician services in January 2014, as estimated in the 2013 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

¹The Panel's final report is available at <http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf>.

MEDICARE PRESENT VALUES

(IN BILLIONS)

	Current law (Unaudited)	Alternative Scenario ^{1,2} (Unaudited)
Income		
Part A	\$16,192	\$16,214
Part B	21,377	27,510
Part D	9,211	9,224
Expenditures		
Part A	20,963	25,396
Part B	21,377	27,510
Part D	9,211	9,224
Income less expenditures		
Part A	(4,772)	(9,182)
Part B	0	0
Part D	0	0

¹ These amounts are not presented in the 2013 Trustees' Report.

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

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 out, 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 0.7 percent annual increases through 2022, 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 25 percent higher under the alternative scenario than 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 29 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 17:

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 from the period beginning on January 1, 2012 to the period beginning on January 1, 2013, and the reconciliation from the period beginning on January 1, 2011 to the period beginning on January 1, 2012. 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,

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- 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 15 summarizes these assumptions for the current year.

Period beginning on January 1, 2012 and ending January 1, 2013

Present values as of January 1, 2012 are calculated using interest rates from the intermediate assumptions of the 2012 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2013. 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 2012 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 2013 Trustees Report.

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.

Change in the Valuation Period

Period beginning on January 1, 2012 and ending January 1, 2013

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2012–86) to the current valuation period (2013–87) 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 2012 and replaces it with a much larger negative net cashflow for 2087. 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 2012–86 to 2013–87. 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 2012 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

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.

Change in the Projection Base

Period beginning on January 1, 2012 and ending January 1, 2013

Actual income and expenditures in 2012 were different than what was anticipated when the 2012 Trustees Report projections were prepared. Part A income and expenditures were lower than anticipated, based on actual experience. Part B total income and expenditures were also 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 an increase in the future net cashflow. Actual experience of the Medicare Trust Funds between January 1, 2012 and January 1, 2013 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

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.

Changes in Demographic Assumptions

Period beginning on January 1, 2012 and ending January 1, 2013

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).

For the current valuation (beginning on January 1, 2013), changes in ultimate assumptions and recent data for immigration have significant effects.

- The assumed ultimate annual immigration of “other immigrants”, that is, those entering the country without legal permanent resident (LPR) status, is 1.4 million in the current valuation, compared with 1.5 million assumed for the prior valuation.
- The assumed ultimate annual number of persons attaining LPR status is 1.05 million for the current valuation, compared with 1.03 million assumed for the prior valuation. The distribution of the ultimate number between those entering the country with LPR status and those adjusting status after having already entered the country was also revised.

Otherwise, the ultimate demographic assumptions for the current valuation are the same as those for the prior valuation. However, the starting demographic values, and the way these values transition to the ultimate assumptions, were changed.

- Final mortality data for 2008 and 2009 show substantially larger reductions in death rates for the current valuation than were expected in the prior valuation. The new data show a lower starting level of death rates and a faster rate of decline in death rates over the next 25 years.
- Final fertility (birth) data for 2009 and 2010, and preliminary data for 2011, indicate lower birth rates for these years than were assumed in the prior valuation.
- New historical data for marital status, for the number of new marriages, for “other immigration”, and for the size of the population (based on the 2010 Census) were used in the current valuation.

These changes increased the Part A present values of future expenditures and income. Since overall population projections are higher compared to the prior valuation, these changes increase the Part B and Part D present values of expenditures, and also income because of the financing mechanism in place for both.

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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.

Changes in Economic and Health Care Assumptions

Period beginning on January 1, 2012 and ending January 1, 2013

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

The ultimate economic assumptions for the current valuation (beginning on January 1, 2013) are the same as those for the prior valuation. Other changes include:

- The real interest rate is projected to be lower over the first ten years of the current valuation.
- The starting economic values and near-term economic growth rate assumptions were updated.

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

- Utilization rate and case mix increase assumptions for skilled nursing facilities were decreased.
- Lower projected Medicare Advantage program costs that reflect recent data suggesting that certain provisions of the Affordable Care Act will reduce growth in these costs by more than was previously projected.
- Administrative action that increased Medicare Advantage payment rates beginning in 2014 to reflect assumed future legislative overrides of the physician payment reductions.
- Larger than previously projected impact from patent expiration of several major prescription drugs in 2012.
- Lower projected prescription drug trend for 2013.

The net impact of these changes resulted in a slight increase in the future net cashflow for total Medicare. For Part A, these changes resulted in a decrease to the present value of expenditures and income, with an overall slight increase 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, 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-Affordable Care Act “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 biggest 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.

Changes in Law

Period beginning on January 1, 2012 and ending January 1, 2013

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. The American Taxpayer Relief Act of 2012 included several provisions that had an impact on the Medicare program. These include the extension of the 0 percent physician payment update through 2013, which slightly increases the present value of Part B expenditures; payments for inpatient hospital services in 2014-2017 are reduced in order to recoup \$11 billion in overpayments associated with documentation and coding adjustments during 2008-2010 that were not previously recovered, which lowers the present value of Part A expenditures; reductions to the end-stage renal disease (ESRD) bundled payment rate to reflect changes in the utilization of certain drugs and biological and a delay in the inclusion of oral-only ESRD drugs in the rate, which reduces the present value of Part B expenditures and increases the present value of Part D expenditures; and the coding intensity adjustment used in determining payments to Medicare Advantage plans was revised, which lowers the present value of Part A and Part B expenditures.

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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 zero 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.

Note 18:

RECONCILIATION OF NET COST OF OPERATIONS TO BUDGET

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.

Note 18:

RECONCILIATION OF NET COST OF OPERATIONS TO BUDGET

	FY 2013 Totals	FY 2012 Totals
<i>Resources Used to Finance Activities:</i>		
Budgetary Resources Obligated:		
Obligations incurred	\$1,159,587	\$1,080,474
Less: Spending authority from offsetting collections and recoveries	37,663	36,321
Obligations net of offsetting collections and recoveries	1,121,924	1,044,153
Less: Distributed offsetting receipts	335,935	316,656
Net obligations	785,989	727,497
Other Resources:		
Imputed financing from costs absorbed by others	48	45
Net other resources used to finance activities	48	45
TOTAL RESOURCES USED TO FINANCE ACTIVITIES	\$786,037	\$727,542
<i>Resources Used to Finance Items not Part of the Net Cost of Operations:</i>		
Change in budgetary resources obligated for goods, services and benefits ordered but not yet provided	\$1,019	\$(11,494)
Resources that fund expenses recognized in prior periods	(15)	(3)
Budgetary offsetting collections and receipts that do not affect net cost of operations	(411)	(109)
Resources that finance the acquisition of assets	696	138
Other resources or adjustments to net obligated resources that do not affect net cost of operations	7,310	2,286
Total resources used to finance items not part of the net cost of operations	8,599	\$(9,182)
TOTAL RESOURCES USED TO FINANCE THE NET COST OF OPERATIONS	\$777,438	\$736,724
<i>Components of the Net Cost of Operations that will not Require or Generate Resources in the Current Period:</i>		
Components Requiring or Generating Resources in Future Periods:		
Decrease/(Increase) in annual leave liability	\$(41)	\$50
Decrease/(Increase) in receivables from the public	(274)	15
Other	2,137	1,023
Total components of Net Cost of Operations that will require or generate resources in future periods	1,822	1,088
Components not Requiring or Generating Resources:		
Depreciation and amortization	42	55
Other	489	(44)
Total components of Net Cost of Operations that will not require or generate resources	531	11
Total Cumulative Total components of Net Cost of Operations that will not require or generate resources in the current period	\$2,353	\$1,099
NET COST OF OPERATIONS	\$779,791	\$737,823

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 *2013 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 the sequestration of non-salary Medicare expenditures as required by the Budget Control Act of 2011 (Public Law 112-25, enacted on August 2, 2011), as amended by the American Taxpayer Relief Act of 2012. Under the sequestration, Medicare benefit payments are reduced by an estimated 2 percent and administration expenses are reduced by an estimated 5 percent. The reduction in benefit payments will end on March 31, 2022, and the administrative expense reductions will end on September 30, 2021.

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 benefits, combating fraud and abuse, and initiating a major program of research and development to identify alternative provider payment mechanisms, health care delivery systems,

and other changes intended to improve the quality of health care and reduce costs.

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from provisions of the 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 changes in current health care delivery systems, 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 almost 25 percent is assumed to be implemented beginning in 2014 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 16 in these financial statements, in Appendix C of this year's annual Medicare Trustees Report, and in an auxiliary memorandum prepared by the CMS Office of the Actuary at the request of the Board of Trustees.

Printed copies of the Trustees Report and auxiliary memorandum may be obtained from the CMS Office of the Actuary (410-786-6386) or can be downloaded from <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

In December 2011, the 2010-2011 Medicare Technical Review Panel⁴ unanimously recommended a new approach that builds on the longstanding "GDP plus 1 percent" assumption while incorporating several key refinements.⁵ The methodology involves use of two separate means of establishing long-range growth rates. The first approach is a refinement to the traditional "GDP

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 final report is available at <http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf>.

⁵ For convenience, the assumed increase in Medicare expenditures per beneficiary, before consideration of demographic effects, is referred to as the "Medicare cost growth" and is often expressed in relation to the per capita increase in GDP, with the result characterized simply as "GDP plus X percent."

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plus 1 percent” growth assumption, which better accounts for the magnitude of payment rate updates for Medicare (prior to the Affordable Care Act) compared to private health insurance and other payers of health care. Under this approach, the rate of growth in Medicare prices prior to the provisions of the Affordable Care Act, which was assumed to be the same as the rate of private medical price growth in earlier reports, is now assumed to be 0.4 percent faster. This change results in the long-range pre-Affordable Care Act “baseline” cost growth assumption being “GDP plus 1.4 percent.” The second approach recommended by the Technical Panel is the “factors contributing to growth” model developed by the Office of the Actuary at CMS as a possible replacement for the existing process.

The Technical Panel did not specify a process for how to establish one set of growth rate assumptions from the two separate and independent techniques. For the 2012 report, the Trustees decided (i) to base the average ultimate growth rate on the updated “GDP plus 1.4 percent” baseline assumption and (ii) to use the “factors contributing to growth” model to create the specific, year-by-year declining growth rates during the last 50 years of the projection.

For the 2013 Medicare Trustees Report, the Trustees decided to use the factors model as the basis for determining the long-range Medicare cost growth assumption and to apply the “GDP plus” framework as a reasonableness check. The long-range Medicare cost growth assumptions under current law are established in three steps. Based on the factors model, the Trustees (i) create specific, year-by-year declining national health expenditure (NHE) growth rates over the long-range period and derive the growth in the volume and intensity of NHE services; (ii) assume, consistent with Finding III-2 of the Technical Panel’s report, that the growth in the volume and intensity of Medicare services prior to the effects of the Affordable Care Act is identical to the growth in the volume and intensity of overall NHE services; and (iii) determine the Medicare payment rate updates required by the Affordable Care Act and their estimated effects on increases in the volume and intensity of services. For Medicare services for which the Affordable Care Act permanently reduces the annual increases in Medicare payment rates by the increase in economy-wide productivity, the Trustees adjust the growth rates in the volume and intensity of services by –0.1 percent annually. This assumption is consistent with Recommendation III–3 of the Technical Panel’s report.

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 on average an ultimate growth rate of 4.3 percent or “GDP plus 0.2 percent.” The year-by-year increases for these provider services start at 4.5 percent in 2037, or “GDP plus 0.4 percent,” and gradually decline to 3.6 percent in 2087, or “GDP minus 0.5 percent.”
- 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 on average a long-range growth assumption of 3.5 percent or “GDP minus 0.6 percent.” The corresponding year-by-year growth rates are 3.6 percent in 2037, or “GDP minus 0.5 percent,” declining to 2.8 percent in 2087, or “GDP minus 1.3 percent.”
- iii. Per beneficiary 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 11.0 percent of total Part B expenditures in 2022, have on average a long-range per beneficiary cost growth rate of 5.1 percent, or “GDP plus 1 percent.” The corresponding year-by-year growth rates from the factors model are 5.3 percent in 2037, or “GDP plus 1.2 percent,” declining to 4.4 percent by 2087, or “GDP plus 0.3 percent.”

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.

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”).

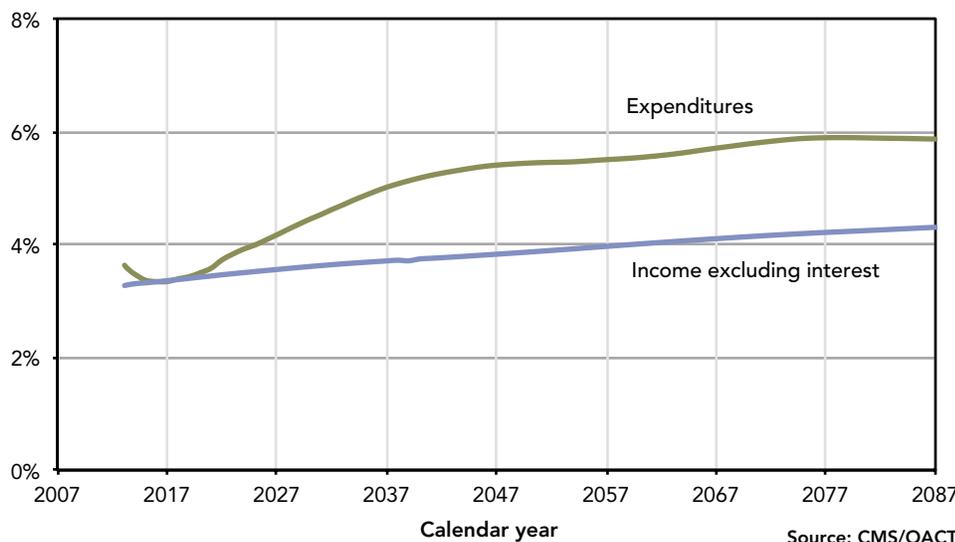
Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected long-range HI cost rates shown in this report are lower than those from the 2012 report. The primary reasons for the difference are (i) lower projected spending for most HI service categories—especially for skilled nursing facilities—to reflect lower-than-expected spending in 2012 and other recent data; (ii) lower projected Medicare Advantage program costs that reflect recent data suggesting that certain provisions of the Affordable Care Act will reduce growth in these costs by more than was previously projected; and (iii) a refinement in projection methods that reduces assumed per beneficiary cost growth during the transition period between the short-range projections and the long-range projections.

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 2013–2022, as required by the Budget Control Act of 2011 and amended by the American Taxpayer Relief Act of 2012. 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

Chart 1
HI EXPENDITURES AND INCOME EXCLUDING INTEREST
AS A PERCENTAGE OF TAXABLE PAYROLL (2013–2087)



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cost growth by an estimated 1.1 percent per year. Under the alternative scenario, if the slower price updates were not feasible in the long range and were phased down during 2020–2034, then the HI cost rate would be 5.2 percent in 2035 and 9.2 percent in 2085. These levels are about 8 percent and 57 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

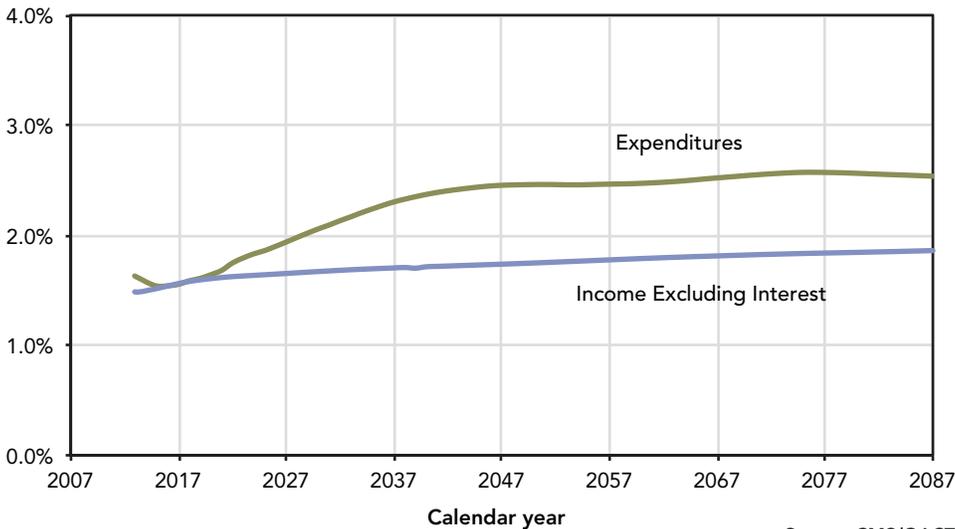
Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2012, the expenditures were \$266.8 billion, which was 1.7 percent of GDP. This percentage is projected to increase steadily through 2046 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative projections,⁶ HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 4.0 percent in 2087.

SMI

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

Chart 2

HI EXPENDITURES AND INCOME EXCLUDING INTEREST AS A PERCENTAGE OF GDP (2013–2087)



⁶ 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 0.7-percent annual increase during 2014-2022 and then gradually rise to the per capita increase in health spending in the US overall by 2037; (ii) the Affordable Care Act reductions in Medicare payment rates are partially phased out from 2020-2034; 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 2013 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 3
SMI EXPENDITURES AND PREMIUMS
AS A PERCENTAGE OF GDP (2013–2087)

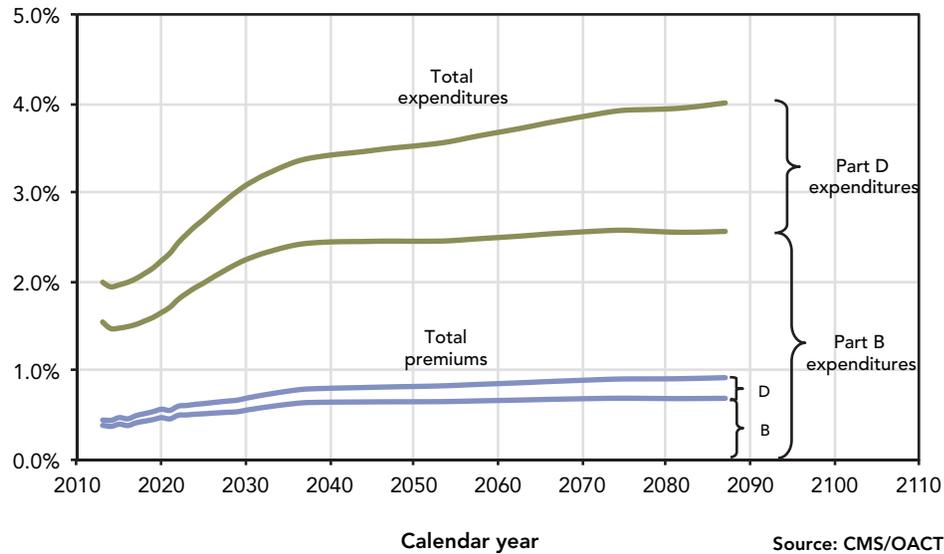


Chart 3 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. The growth rates are estimated year by year for the next 10 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 11 to 25 is assumed to grade smoothly into the long-range assumption described previously.

Under the intermediate assumptions, annual SMI expenditures were \$307.4 billion, or about 2.0 percent of GDP, in 2012. Then, in about 25 years, they would grow to roughly 3.4 percent of GDP and to 4.0 percent by the end of the projection period. Total SMI expenditures in 2087 would be 4.7 percent of GDP if physician payment rates were set as assumed under the illustrative alternative projections. Such costs would represent 5.7 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 2013 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

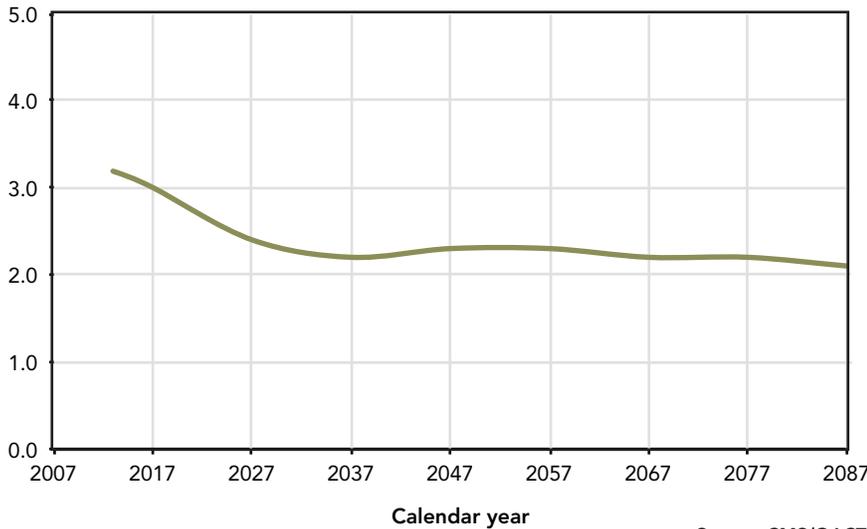
HI

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 2012, 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 2087.

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Chart 4

NUMBER OF COVERED WORKERS PER HI BENEFICIARY (2013–2087)



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.⁷ The assumptions varied are the health care cost factors, real-wage differential, CPI, real-interest rate, fertility rate, and net immigration.⁸

For this analysis, the intermediate economic and demographic assumptions in the *2013 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, 2013 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

⁷ 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.

⁸ 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.

accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

Health Care Cost Factors

Table 1 shows the net present value of 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 \$6,014 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 \$9,580 billion.

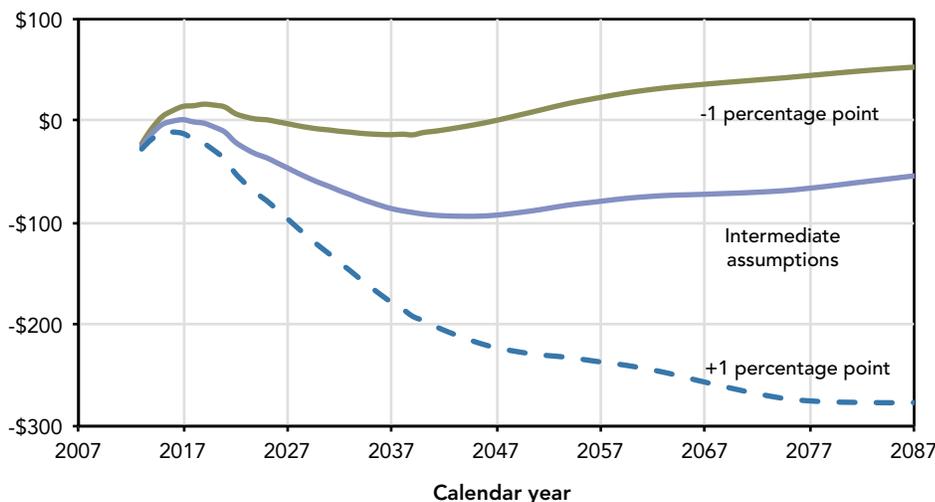
Chart 5 shows projections of the present value of the estimated net cashflow under the three alternative annual growth rate assumptions presented in table 1.

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)	\$1,242	-\$4,772	-\$14,352

Chart 5
PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS HEALTH CARE COST FACTORS (2013–2087)
(IN BILLIONS)



Source: CMS/OACT

REQUIRED SUPPLEMENTARY INFORMATION

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.⁹ 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 \$850 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about \$450 billion.

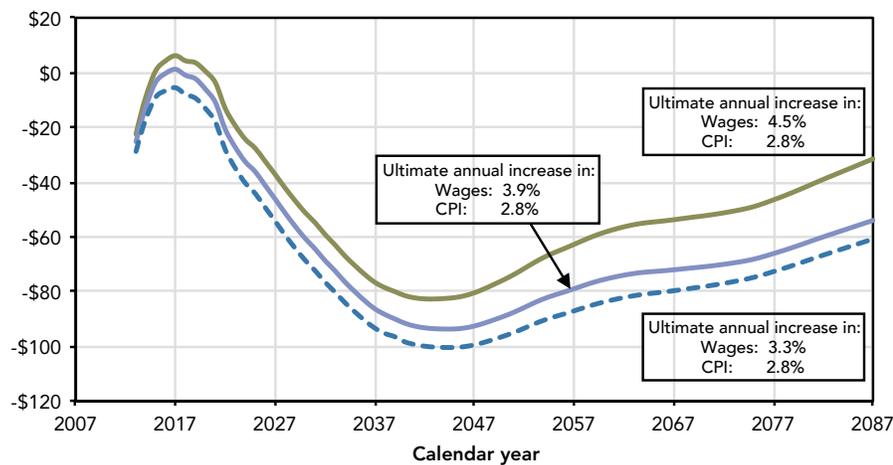
Chart 6 shows projections of the present value of the estimated net cashflow under the three alternative real-wage differential assumptions presented in table 2.

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 on the long-range feasibility of the lower

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)	-\$5,310	-\$4,772	-\$3,753

Chart 6
PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS REAL-WAGE ASSUMPTIONS (2013–2087)
(IN BILLIONS)



⁹ The real-wage differential is the difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.

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 1.1 percent, which yields ultimate percentage increases in average annual wages in covered employment of 2.9, 3.9, and 4.9 percent, respectively.

Table 3 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by \$204 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit decreases by \$224 billion.

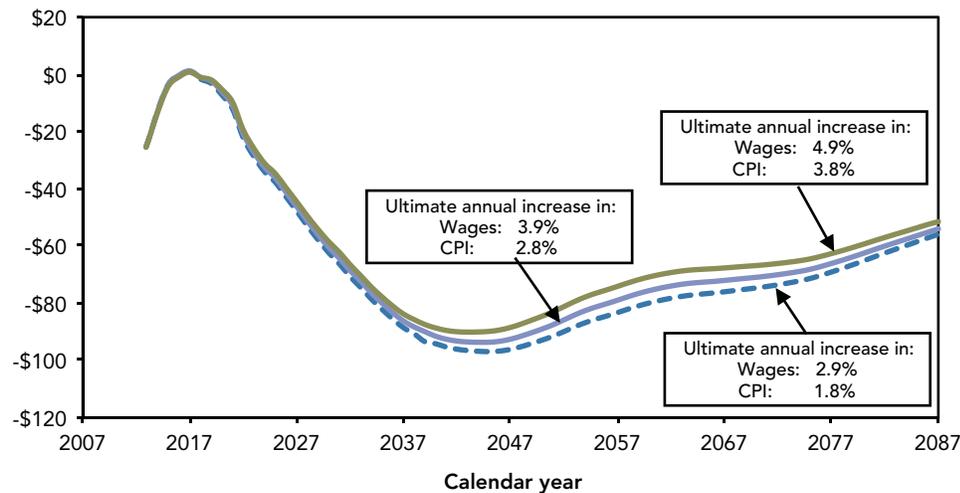
Chart 7 shows projections of the present value of net cashflow under the three alternative CPI rate-of-increase assumptions presented in table 3.

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.

Table 3
PRESENT VALUE OF ESTIMATED HI INCOME LESS EXPENDITURES UNDER VARIOUS CPI—INCREASE ASSUMPTIONS

Ultimate percentage increase in wages – CPI	2.9 – 1.8	3.9 – 2.8	4.9 – 3.8
Income minus expenditures (in billions)	-\$4,976	-\$4,772	-\$4,548

Chart 7
PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS CPI-INCREASE ASSUMPTIONS (2013–2087)
(IN BILLIONS)



Source: CMS/OACT

REQUIRED SUPPLEMENTARY INFORMATION

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: 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 \$185 billion.

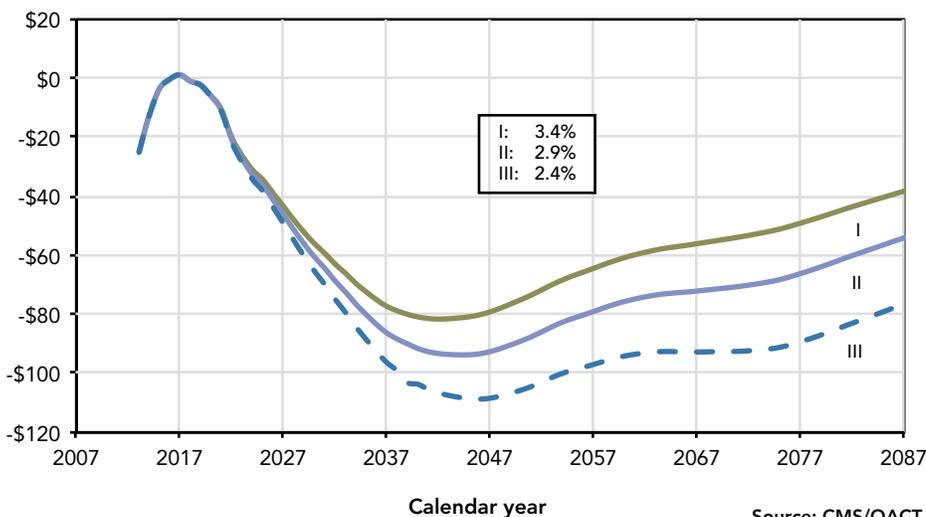
Chart 8 shows projections of the present value of the estimated net cashflow under the three alternative real-interest assumptions presented in table 4.

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 2026. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

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)	-\$5,800	-\$4,772	-\$3,954

Chart 8
PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS REAL-INTEREST RATE ASSUMPTIONS (2013–2087)
(IN BILLIONS)



Source: CMS/OACT

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 \$390 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.

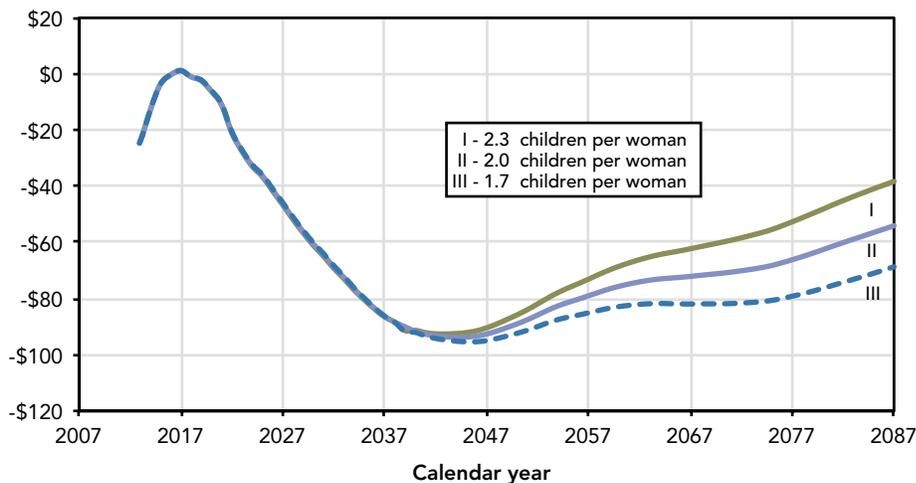
Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, as in past reports, but their impact on future HI taxes will be relatively greater, since many will become subject to the additional HI tax, thereby lowering the deficit proportionately more 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.

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)	-\$5,159	-\$4,772	-\$4,378

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 (2013–2087)
(IN BILLIONS)



Source: CMS/OACT

REQUIRED SUPPLEMENTARY INFORMATION

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: 800,000 persons, 1,095,000 persons, and 1,400,000 persons per year.

As indicated in table 6, if the average annual net immigration assumption is 800,000 persons, the deficit—expressed in present-value dollars—increases by \$76 billion. Conversely, if the assumption is 1,400,000 persons, the deficit decreases by \$41 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.

Trust Fund Finances and Sustainability

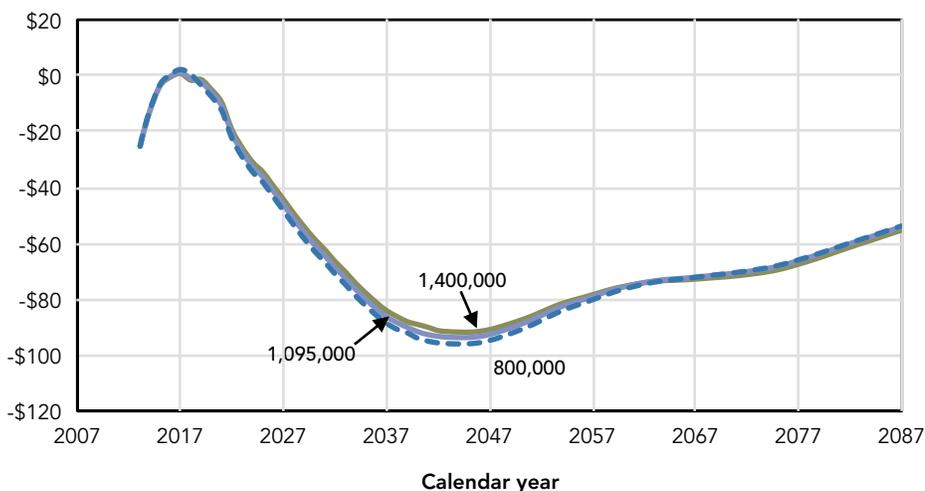
HI

Under the Medicare Trustees' intermediate assumptions, the estimated depletion date for the HI Trust Fund is 2026, 2 years later than in last year's report. As in past years, the Trustees have determined that the fund is not adequately financed over the next 10 years. HI taxable earnings in 2012

Table 6
PRESENT VALUE OF ESTIMATED HI INCOME LESS EXPENDITURES UNDER VARIOUS NET IMMIGRATION ASSUMPTIONS

Average annual net immigration	800,000	1,095,000	1,400,000
Income minus expenditures (in billions)	-\$4,848	-\$4,772	-\$4,731

Chart 10
PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS NET IMMIGRATION ASSUMPTIONS (2013–2087)
(IN BILLIONS) 2013 - 2087



Source: CMS/OACT

were slightly lower than last year's estimate. The projected rate of growth in these earnings is lower in 2013 and 2014 but then exceeds last year's growth assumptions after 2014. HI expenditures in 2012 were slightly lower than the previous estimate, but after 2014, the projected level grows more rapidly than shown in last year's report because of assumed higher payment updates. HI expenditures have exceeded income annually since 2008, and projected amounts continue doing so through 2014. The Trustees then project slight surpluses in 2015 through 2020 with a return to deficits thereafter until the fund becomes depleted in 2026. 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.

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 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 2013 is adequate to cover 2013 expected expenditures and to maintain the financial status of the account in 2013 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 lower than previously estimated. The difference is primarily attributable to the further increase of the market penetration of generic drugs, the larger than previously projected impact from patent expiration of several major drugs in 2012, and a lower projected trend for 2013.

The Part B and Part D accounts in the SMI Trust Fund are adequately financed under current law because premium and general revenue income are reset each year to cover expected costs. Such financing, however, would have to increase faster than the economy to cover expected expenditure growth under current law. A critical issue for the SMI program is the impact of the rapid growth of SMI costs, which places steadily increasing demands on beneficiaries and taxpayers.

REQUIRED SUPPLEMENTARY INFORMATION

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 (2013–2019).¹⁰ This difference is expected to exceed 45 percent of total expenditures in fiscal year 2013, 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 2006–2012 annual reports to Congress. With this eighth 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 depletion 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 cannot be sustained, then these further policy reforms will have to address much larger financial challenges than implied by the current-law projections. In their 2013 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 such reforms should occur in the near future.”

¹⁰ 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, 2013

(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:			\$20,518	\$21,090	\$11,726	\$449	\$13,801	\$4,690	\$72,274	\$3,123
Recoveries of prior year unpaid obligations	\$141	\$97		18,132	414	2,824	313	374	22,295	
Other changes in unobligated balance	(54)	20		9	(594)	(37)	2	(17)	(671)	
Unobligated balance from prior year budget authority, net	87	117	20,518	39,231	11,546	3,236	14,116	5,047	93,898	3,123
Appropriation	276,583	252,305	231,734	245,836	11,086	63,791	(159)	2,473	1,083,649	
Borrowing authority										(2,064)
Spending authority from offsetting collections	439	11	18	528		3,160	223	11,743	16,122	(754)
TOTAL BUDGETARY RESOURCES	\$277,109	\$252,433	\$252,270	\$285,595	\$22,632	\$70,187	\$14,180	\$19,263	\$1,193,669	\$305
STATUS OF BUDGETARY RESOURCES:										
Obligations incurred	\$277,109	\$252,433	\$247,702	\$283,313	\$9,525	\$69,748	\$5,325	\$14,127	\$1,159,282	\$305
Unobligated balance, end of year:										
Apportioned			11	2,282	10,767		8,772	4,252	26,084	
Exempt from apportionment			1,794			70			1,864	
Unapportioned			2,763		2,340	369	83	884	6,439	
Total unobligated balance, end of year			4,568	2,282	13,107	439	8,855	5,136	34,387	
TOTAL BUDGETARY RESOURCES	\$277,109	\$252,433	\$252,270	\$285,595	\$22,632	\$70,187	\$14,180	\$19,263	\$1,193,669	\$305
CHANGE IN OBLIGATED BALANCE:										
Unpaid obligations:										
Unpaid obligations, brought forward, October 1	\$24,209	\$24,404		\$26,837	\$6,500	\$5,607	\$4,454	\$6,559	\$98,570	\$1,602
Obligations incurred	277,109	252,433	\$247,702	283,313	9,525	69,748	5,325	14,127	1,159,282	305
Outlays (gross)	(276,074)	(252,049)	(242,424)	(262,141)	(9,482)	(65,133)	(4,278)	(13,353)	(1,124,934)	(658)
Recoveries of prior year unpaid obligations	(141)	(97)		(18,132)	(414)	(2,824)	(313)	(374)	(22,295)	
Unpaid obligations end of year	25,103	24,691	5,278	29,877	6,129	7,398	5,188	6,959	110,623	1,249
Uncollected Payments:										
Uncollected payments, Federal sources, brought forward, October 1	(1)							(7,249)	(7,250)	(1,587)
Change in uncollected payments, Federal sources	1							(505)	(504)	1,051
Uncollected payments, Federal sources, end of year								(7,754)	(7,754)	(536)
Memorandum entries:										
Obligated balance, start of year, net	24,208	24,404		26,837	6,500	5,607	4,454	(690)	91,320	15
Obligated balance, end of year, net	\$25,103	\$24,691	\$5,278	\$29,877	\$6,129	\$7,398	\$5,188	\$(795)	\$102,869	\$713
BUDGET AUTHORITY AND OUTLAYS, NET:										
Budget authority, gross	\$277,022	\$252,316	\$231,752	\$246,364	\$11,086	\$66,951	\$64	\$14,216	\$1,099,771	\$(2,818)
Actual offsetting collections	(440)	(11)	(18)	(528)		(3,160)	(223)	(11,238)	(15,618)	(296)
Change in uncollected customer payments from Federal sources	1							(505)	(504)	1,051
Budget authority, net	276,583	252,305	231,734	245,836	11,086	63,791	(159)	2,473	1,083,649	(2,063)
Outlays (gross)	276,074	252,049	242,424	262,141	9,482	65,133	4,278	13,353	1,124,934	658
Actual offsetting collections	(440)	(11)	(18)	(528)		(3,160)	(223)	(11,238)	(15,618)	(296)
Outlays, net	275,634	252,038	242,406	261,613	9,482	61,973	4,055	2,115	1,109,316	362
Distributed offsetting receipts	(29,435)	(306,366)			(3)			(131)	(335,935)	
AGENCY OUTLAYS, NET	\$246,199	\$(54,328)	\$242,406	\$261,613	\$9,479	\$61,973	\$4,055	\$1,984	\$773,381	\$362

SUPPLEMENTARY INFORMATION



Consolidating Balance Sheet

Consolidating Statement of Net Cost

Consolidating Statement of Changes in Net Position

CONSOLIDATING BALANCE SHEET

as of September 30, 2013

(IN MILLIONS)

	Medicare (Dedicated Collections)			Health (Other Funds)				Combined Totals	Intra-CMS Eliminations	Consolidated Totals
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other			
ASSETS										
Intragovernmental Assets:										
Fund Balance with Treasury	\$1,959	\$7,489	\$9,448	\$32,150	\$17,139	\$14,133	\$3,739	\$76,609		\$76,609
Investments	208,231	67,942	276,173		2,097			278,270		278,270
Accounts Receivable, Net	26,646	39,381	66,027	123	15	287	704	67,156	\$(63,785)	3,371
Other Assets	113		113			1		114		114
Total Intragovernmental Assets	236,949	114,812	351,761	32,273	19,251	14,421	4,443	422,149	(63,785)	358,364
Accounts Receivable, Net	1,777	5,439	7,216	3,375	11	3	32	10,637		10,637
General Property, Plant & Equipment, Net	113	195	308	14	1	40	6	369		369
Other Assets	6	11	17	2		752	60	831		831
TOTAL ASSETS	\$238,845	\$120,457	\$359,302	\$35,664	\$19,263	\$15,216	\$4,541	\$433,986	\$(63,785)	\$370,201
LIABILITIES										
Intragovernmental Liabilities:										
Accounts Payable	\$27,182	\$37,228	\$64,410	\$1		\$21	\$8	\$64,440	\$(63,785)	\$655
Accrued Payroll and Benefits		1	1					1		1
Other Intragovernmental Liabilities	160	739	899			545	28	1,472		1,472
Total Intragovernmental Liabilities	27,342	37,968	65,310	1		566	36	65,913	(63,785)	2,128
Accounts Payable	38	66	104	3	\$1	25	14	147		147
Federal Employee and Veterans' Benefits	4	8	12	1		2		15		15
Entitlement Benefits Due and Payable	20,805	27,809	48,614	27,588	693	363	19	77,277		77,277
Accrued Payroll and Benefits	20	35	55	3		11	3	72		72
Contingencies		1,300	1,300	6,066				7,366		7,366
Other Liabilities	634	559	1,193			69	20	1,282		1,282
TOTAL LIABILITIES	\$48,843	\$67,745	\$116,588	\$33,662	\$694	\$1,036	\$92	\$152,072	\$(63,785)	\$88,287
NET POSITION										
Unexpended Appropriations-Dedicated Collections	\$978	\$3,591	\$4,569					\$4,569		\$4,569
Unexpended Appropriations-Other Funds				\$1,881	\$18,551	\$13,813	\$3,410	37,655		37,655
Cumulative Results of Operations-Dedicated Collections	189,024	49,121	238,145					238,145		238,145
Cumulative Results of Operations-Other Funds				121	18	367	1,039	1,545		1,545
TOTAL NET POSITION	\$190,002	\$52,712	\$242,714	\$ 2,002	\$18,569	\$14,180	\$4,449	\$281,914		\$281,914
TOTAL LIABILITIES AND NET POSITION	\$238,845	\$120,457	\$359,302	\$35,664	\$19,263	\$15,216	\$4,541	\$433,986	\$(63,785)	\$370,201

SUPPLEMENTARY INFORMATION

CONSOLIDATING STATEMENT OF NET COST

for the year ended September 30, 2013

(IN MILLIONS)

	Medicare (Dedicated Collections)			Health (Other Funds)				Consolidated Total
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	
NET PROGRAM/ACTIVITY COSTS								
GPRA Programs:								
Medicare (Dedicated Collections)	\$261,479	\$237,097	\$498,576					\$498,576
Medicaid				\$266,624				266,624
CHIP					\$9,548			9,548
Net Cost: GPRA Programs	261,479	237,097	498,576	266,624	9,548			774,748
Other Activities:								
State Grants and Demonstrations							\$712	712
Other Health						\$4,023		4,023
Other							308	308
Net Cost: Other Activities						4,023	1,020	5,043
NET COST OF OPERATIONS	\$261,479	\$237,097	\$498,576	\$266,624	\$9,548	\$4,023	\$1,020	\$779,791

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2013

(IN MILLIONS)

	Medicare (Dedicated Collections)			Health (Other Funds)				Consolidated Total
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	
CUMULATIVE RESULTS OF OPERATIONS								
Beginning Balances	\$211,471	\$50,329	\$261,800	\$135	\$19	\$112	\$1,271	\$263,337
Budgetary Financing Sources:								
Appropriations Used	16,123	231,561	247,684	265,985	9,529	3,800	718	527,716
Nonexchange Revenue:								
FICA and SECA Taxes	212,901		212,901					212,901
Interest on Investments	9,565	2,425	11,990		3			11,993
Other Nonexchange Revenue	1,338	3,420	4,758					4,758
Transfers-in/out Without Reimbursement	(907)	(1,541)	(2,448)	623	15	477	68	(1,265)
Other Financing Sources (Nonexchange):								
Transfers-in/out Without Reimbursement						(7)		(7)
Imputed Financing	12	24	36	2		8	2	48
Total Financing Sources	239,032	235,889	474,921	266,610	9,547	4,278	788	756,144
Net Cost of Operations	261,479	237,097	498,576	266,624	9,548	4,023	1,020	779,791
Net Change	(22,447)	(1,208)	(23,655)	(14)	(1)	255	(232)	(23,647)
CUMULATIVE RESULTS OF OPERATIONS	\$189,024	\$49,121	\$238,145	\$121	\$18	\$367	\$1,039	\$239,690
UNEXPENDED APPROPRIATIONS								
Beginning Balances	\$790	\$19,729	\$20,519	\$22,021	\$17,591	\$17,770	\$3,035	\$80,936
Budgetary Financing Sources:								
Appropriations Received	16,322	232,978	249,300	269,405	17,451	2,267	783	539,206
Appropriations Transferred-in/out				(3,596)		48	567	(2,981)
Other Adjustments	(11)	(17,555)	(17,566)	(19,964)	(6,962)	(2,472)	(257)	(47,221)
Appropriations Used	(16,123)	(231,561)	(247,684)	(265,985)	(9,529)	(3,800)	(718)	(527,716)
Total Budgetary Financing Sources	188	(16,138)	(15,950)	(20,140)	960	(3,957)	375	(38,712)
Total Unexpended Appropriations	978	3,591	4,569	1,881	18,551	13,813	3,410	42,224
NET POSITION	\$190,002	\$52,712	\$242,714	\$2,002	\$18,569	\$14,180	\$4,449	\$281,914

AUDIT REPORTS





DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



DEC - 9 2013

TO: Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson
Inspector General *Daniel R. Levinson*

SUBJECT: Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2013 (A-17-13-02013)

This memorandum transmits the independent auditors' reports on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2013 financial statements, conclusions about the effectiveness of internal controls and compliance with laws and other matters. The Chief Financial Officers Act of 1990 (P.L. No. 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the CMS financial statements in support of the U.S. Department of Health and Human Services audit.

We contracted with the independent certified public accounting firm of Ernst & Young, LLP, to audit the CMS (1) consolidated balance sheets as of September 30, 2013 and 2012, 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, 2013, 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 14-02, *Audit Requirements for Federal Financial Statements*.

Results of the Independent Audit

Ernst & Young found that the FY 2013 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 beginning in note 15 to the financial statements, with respect to the estimates for the Statement of Social Insurance as of January 1, 2013, CMS management has noted that actual future costs for Medicare are likely to exceed those projections estimated to implement current law, including the Patient Protection and Affordable Care Act (P.L. No. 111-148). The Medicare Board of Trustees, in their annual

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report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results. As a result, Ernst & Young was unable to obtain sufficient evidential support for the amounts presented in the statements of social insurance as of January 1, 2013, 2012, 2011, and 2010, and the related statements of changes in social insurance amounts as of January 1, 2013 and 2012, to enable them to express an opinion on whether the statements were presented fairly. Ernst & Young provided an unqualified opinion on the statement of social insurance as of January 1, 2009.

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

- *Financial Reporting Processes*—Ernst & Young noted that the Center for Medicaid and CHIP Services needs to strengthen oversight controls for Medicaid that will serve to prevent, detect, and resolve errors in a timely manner and to deter fraud, waste, and abuse in Medicaid. Ernst & Young also reported that during the testing of internal controls, errors were identified that were not detected by the organization's monitoring and review function, and accordingly, the control was not functioning as designed or intended, along with weaknesses in oversight of third-party contractors. Regarding the Statement of Social Insurance projections, Ernst & Young reported control weaknesses and recommended that CMS adhere to established policies and procedures.
- *Information Systems Controls*—Ernst & Young noted that CMS should continually assess CMS's governance and oversight of its organizational units responsible for configuration management and information security for its Medicare systems. However, Ernst & Young noted that a renewed 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, which impact 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 of inadequate segregation of duties. CMS also continues to experience deficiencies in the implementation of computer security policies and regular monitoring of compliance with those policies. The deficiencies found continue to constitute a significant deficiency in internal control.

Also, given the significant changes in CMS programs effective January 1, 2014, related to the ongoing implementation of the provisions of the Patient Protection and Affordable Care Act (P.L. No. 111-148) that include the insurance exchanges, premium subsidies, risk corridors, and reinsurance provisions, Ernst & Young noted the importance of CMS's developing accounting policies and procedures early in FY 2014, including internal controls related to significant processes to ensure that resources are properly utilized. In addition, Ernst & Young also noted that CMS should analyze the impact of those provisions and establish the appropriate accounting treatment in the financial statements.

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, Ernst & Young disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards* and OMB Bulletin 14-02.

Evaluation and Monitoring of Audit Performance

We reviewed the audit of the CMS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the 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 the 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.

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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-17-13-02013.

Attachment

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

Report on the Financial Statements

We have audited the accompanying consolidated balance sheets of the Centers for Medicare and Medicaid Services (CMS) as of September 30, 2013 and 2012, 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, the statement of social insurance as of January 1, 2009, and the related notes to the financial statements. We were engaged to audit the statements of social insurance as of January 1, 2013, 2012, 2011 and 2010, the related statements of changes in social insurance amounts for the periods ended January 1, 2013 and 2012, and the related notes to these financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audits. Except as discussed in the Basis for Disclaimer of Opinion paragraphs with respect to the accompanying statements of social insurance as of January 1, 2013, 2012, 2011 and 2010, the related statements of changes in social insurance amounts for the periods ended January 1, 2013 and 2012, and the related notes to these financial statements, we conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget Bulletin No. 14-02, *Audit Requirements for Federal Financial Statements*. Those standards and bulletin require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.



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

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion on the consolidated balance sheets as of September 30, 2013 and 2012, 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, the statement of social insurance as of January 1, 2009, and the related notes to these financial statements.

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

As discussed in Note 15 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. 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 and issues regarding the sustainability of the underlying assumptions under current law were introduced by the passage of the Patient Protection and Affordable Care Act (ACA).

As further described in Note 16 to the financial statements, with respect to the estimates for the CMS social insurance program presented as of January 1, 2013, 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) indicated in the ACA and reductions in Medicare payment rates for physician services mandated in current law. 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. In addition, legislation mandating reductions in provider payments has in the past 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. As a result of these limitations, we were unable to obtain sufficient audit evidence for the amounts presented in the statements of social insurance as of January 1, 2013, 2012, 2011 and 2010, and the related statements of changes in social insurance amounts for the periods ended January 1, 2013 and 2012.

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

Because of the significance of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the financial condition of the CMS social insurance program as of January 1, 2013, 2012, 2011 and 2010, and the related changes in the social insurance program for the periods ended January 1, 2013 and 2012.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of CMS as of September 30, 2013 and 2012, 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 in conformity with U.S. generally accepted accounting principles.

Required Supplementary Information

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



financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Supplementary and Other Information

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

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

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

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we also have issued our reports dated December 9, 2013 on our consideration of CMS' internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations and other matters. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* in considering CMS' internal control over financial reporting and compliance.

A handwritten signature in black ink that reads 'Ernst & Young LLP'.

December 9, 2013



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

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

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 14-02, *Audit Requirements for Federal Financial Statements*, the financial statements of the Centers for Medicare and Medicaid Services (CMS), which comprise the consolidated balance sheet as of September 30, 2013 and the related consolidated statements of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal year then ended, and the related notes to the financial statements, and we were engaged to audit the statement of social insurance as of January 1, 2013, and the related statement of changes in social insurance amounts for the period ended January 1, 2013, and have issued our report thereon dated December 9, 2013. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2013 and the related statement of changes in social insurance amounts for the period ended January 1, 2013.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether CMS' financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in OMB Bulletin No. 14-02. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. We limited our tests of compliance to these provisions, and we did not test compliance with all laws and regulations applicable to CMS.

The results of our tests of compliance with the laws and regulations described in the second paragraph of this report disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 14-02, and which are described below.



The Improper Payments Information Act of 2002 as amended by the Improper Payments Elimination and Recovery Act of 2010 and the Improper Payments Elimination and Recovery Improvement Act of 2013 (hereinafter the Acts) require federal agencies to identify programs and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. Although CMS has reported error rates for each of its high-risk programs, or components of such programs, it is not in full compliance with the Acts. For example, the Medicare fee-for-service error rate is greater than the statutorily required maximum of 10 percent. In addition, CMS is not in full compliance with Section 6411 of the Affordable Care Act as CMS has not yet implemented recovery activities of the identified improper payments for the Medicare Advantage (Part C) program. To date, CMS has received and analyzed comments related to a Part C recovery audit contractor program, continues to explore implementation options and anticipates executing a contract in fiscal year 2014.

CMS' Response to Findings

CMS' response to the findings identified in our audit are described in their letter dated December 9, 2013. CMS' response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Purpose of this Report

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

A handwritten signature in black ink that reads 'Ernst & Young LLP'.

December 9, 2013



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

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

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 14-02, *Audit Requirements for Federal Financial Statements*, the financial statements of the Centers for Medicare and Medicaid Services (CMS), which comprise the consolidated balance sheet as of September 30, 2013 and the related consolidated statements of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal year then ended, and the related notes to the financial statements, and we were engaged to audit the statement of social insurance as of January 1, 2013, and the related statement of changes in social insurance amounts for the period ended January 1, 2013, and have issued our report thereon dated December 9, 2013. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2013 and the related statement of changes in social insurance amounts for the period ended January 1, 2013.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered CMS' internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of CMS' internal control. Accordingly, we do not express an opinion on the effectiveness of the CMS' internal control. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 14-02. We did not test all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982, such as those controls relevant to ensuring efficient operations.

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



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

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

Significant Deficiencies

Financial Reporting Processes

Financial management in the Federal government requires accountability of financial and program managers for financial results of actions taken, control over the Federal government's financial resources and protection of Federal assets. To enable these requirements to be met, financial management systems and internal controls must be in place to process and record financial events effectively and efficiently and to provide complete, timely, reliable and consistent information for decision-makers and the public.

CMS 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 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 the Department of Health and Human Services (HHS). We noted deficiencies in designing the proper controls, the 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 its financial management systems.



The increasing complexity of implementing and accounting for the provisions of the Affordable Care Act (ACA) 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 within CMS. 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 59 percent. The Center for Medicaid and CHIP Services (CMCS) is responsible for providing the Federal government oversight of the program and executing the internal controls at the Federal level, which includes: approval of the state plans and amendments, which serve as the contract describing how that state administers the program; approval of each state's budget (the authorized amount) on a quarterly or annual basis; reconciling the Federal share of the expenditures to amounts reported by the state; requiring the states to have program audits and performing analytical procedures over program expenditures. The Federal government controls were designed assuming that the states would have their own set of procedures and controls over program costs and that the states would have an incentive 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 weaknesses of their oversight of the program expenditures. As of September 30, 2013, a \$1.9 billion accounts receivable and a \$1.6 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. In FY 2013, CMCS has established a protocol to address negative balances and implemented review procedures to compare the quarterly expenditures, budgeted grant awards and quarterly draws. Although the FY 2012 grant finalizations were performed more consistently and timely for the states in 2013, our analyses of this process still identified the following deficiencies in the Medicaid program:

- There is insufficient analysis of the state Medicaid account balances and related expenditures as part of the quarterly financial statement close process. For example, CMCS does not analyze the changes in the accumulated individual state accounts



receivable and payable balances to identify and monitor the reasonableness of quarterly activity for each state's Payment Management System (PMS) subaccount. Although CMCS performs a weekly analysis of the PMS subaccount balances as part of their monitoring procedures, high-level analyses could identify potential anomalies in the expenditure data that may not be a practical expectation of the regional office review procedures.

- During FY 2013, CMCS implemented a new protocol to encourage states to return funds associated with pending deferrals. The new protocol and efforts resulted in a reduction of certain individual state receivable balances, however it has not prevented or positively impacted the aggregate unsettled balances with the states as they continued to increase from the 2012 levels. The unsettled balances arise because of Medicaid claim deferrals issued by CMS to the states subsequent to a state draw down for the claim and the states not drawing the authorized funds in PMS (based on approved expenditures) timely. CMS does not have the authority to force the payments to the states or require the states to draw those funds. In addition, the review procedures implemented over the status of unsettled amounts are detect controls which do not prevent the states from drawing from the incorrect PMS subaccounts.
- 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 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 process is manually intensive because the states frequently report differing amounts on their Federal Financial Report (FFR) and their CMS-64 Reports. Also, those amounts reported, even if they match between the two reports, do not always exactly match the PMS account balances. 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 those accounts for which CMCS had declared the grant awards finalized.
- Accounts receivable and payable balances are not recorded in detail within a Medicaid receivable or payable subsidiary ledger.

As noted in 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. CMCS followed up on the findings noted in that report in FY 2013 and concluded that the payment rate for those services for that state were based on a payment methodology that relied on inflated costs which caused the state to exceed



the upper payment limit. This will be corrected going forward starting April 1, 2014. 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. At least one expected level of state oversight was missing and additional oversight procedures should have been performed by CMCS. Starting in FY 2014, CMCS will perform a review of the inpatient, outpatient and nursing facility payment methodologies and prepare an executive summary for senior management's review. The states are required to submit an annual report of the upper payment limit for review by the regional offices and CMCS. The results of these reviews are not available at this time as the process/procedures are still being implemented.

CMCS has been working on a multiyear project to define data and analytics to improve their program and financial management. That program is not operational at a level where it currently provides controls supporting program integrity. CMCS should continue to enhance its financial management systems and its related data analyses capability to develop robust analytical procedures and measures against benchmarks to monitor and identify risks associated with the Medicaid program, including outliers and unusual or unexpected results that may identify abnormalities in state-related Medicaid expenditures. 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 2013 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 an 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 questionable expenditures and errors timely and to deter fraud, waste and abuse of Federal government resources. Improvements in the Medicaid program oversight controls is of further importance due to the upcoming Medicaid expansion related to ACA. 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 continue to further enhance its coordination and collaboration within CMS and its data analyses capability.

Analyses Required for an Effective Financial Management System

Critical or new financial 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 and budget matters through a series of white papers. The dispersed nature of the financial management environment and the current process that borrows professionals from other tasks to complete the white papers 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 timely complete the required white papers. The white papers supporting the conclusions on unique, non-routine and critical accounting matters were not prepared timely and not all aspects of the important financial matters were considered. For example, CMS failed to timely record, report and return to Treasury approximately \$2.2 billion in unobligated borrowing authority for the Consumer Operated and Oriented Plan program as of September 30, 2012. Although CMS identified the error in January 2013, the unobligated borrowing authority was not identified and returned to Treasury timely. In addition, the unobligated borrowing authority was not reported correctly in the FACTS II submission to Treasury for fiscal year 2012. In this example, CMS had not implemented appropriate controls around the evaluation of the final amounts of unobligated authority required to be recorded, reported and returned to Treasury. Given the significant changes in programs effective January 1, 2014 related to the continued implementation of the provisions of the ACA (for example the insurance exchanges, premium subsidies, risk corridors, re-insurance provisions), it is important that CMS develops accounting policies and procedures early in FY 2014, including internal controls related to the significant processes to ensure that the resources are properly utilized. In addition, CMS should analyze the impact of those provisions and establish the appropriate accounting treatment in the financial statements.

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. It may be beneficial for CMS to identify a cross-functional working group to perform such analysis, for example: (i) identify and document the reasons behind the changes in program expenditures and (ii) corroborating analysis between the changes in Medicare Part C and Part D beneficiaries and the changes in the monthly plan payments.

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, the final monthly letter of credit report was not used for the February 2013 National Claims History (NCH) validation analysis); (ii) the review or monitoring function was not performed timely (for example, untimely review of the Medicaid/CHIP budget and expenditure regional office reports); and (iii) activity or accounts for which no formal, documented review or monitoring function was established.



Oversight of Third-Party Contractors

CMS relies heavily on third-party contractors as it outsources substantially all the day-to-day operations for its information technology systems, the payment of Medicare fee-for-service and Medicaid claims and certain services related to the Medicare Part C and Part D programs. We continued to identify areas where improvements could be made in the control environment related to the oversight of third-party contractors.

The contracts between CMS and its Medicare fee-for-service contractors include provisions that require the Medicare Administrative Contractors (MACs) to develop 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 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 relating to: (1) the claims completeness validation process between the claims submitted by the providers and the claims received by the MACs; (2) the Medicare Summary Notices, which are returned to the MACs but are not investigated as to why they are returned, as there currently is no existing CMS policy that addresses the actions in this circumstance; (3) the claims outstanding greater than one year as there is no policy or procedure in place to periodic review, track or monitor those aged claims other than those identified as bankruptcy, fraud or abuse; and (4) the provider records as there are no procedures in place to reconcile, review and monitor provider records and eligibility status on a periodic basis to verify that all changes were timely, accurately and completely processed.

The nature and volume of its expenditures present a substantial challenge to CMS in the quantification, evaluation and remediation of improper payments. Health insurance claims represent the vast majority of the CMS payments. These payments are highly complex and involve the evaluation of the program eligibility of both the recipient of the services and of the health provider, oversight of the medical necessity of each covered treatment and concurrence with the cost to be paid some of which is based on very complex financial formulas and/or coding decisions. The fee-for-service portion of the Medicare program alone accounts for more than one billion transactions per year. CMS has developed sophisticated sampling processes for estimating error rates in the various CMS insurance programs. These include the annual Comprehensive Error Rate Testing (CERT) process for Medicare Parts A and B and the Payment



Error Rate Measurement (PERM) process for Medicaid and CHIP. Similar processes are used to monitor improper payments for Medicare Part C and Part D plans.

As part of our audit procedures, we reviewed the error rate estimates and activities performed by management to identify and measure errors and reduce improper payments. Over the past few years, refinements have been made to the error rate estimation processes which can impact the comparability of information on an annual basis. CMS reports that the main purpose of their error rate programs is to report an accurate measure of improper payments for each program. To accomplish this goal they build in time to their study to allow all payments sampled for review sufficient time to allow for appeals of the errors and submission of additional documentation by the claimant. CMS believes that expediting the error rate calculations would result in less time for sampled payments to complete the measurement process allowing errors to be cited solely due to the fact that not enough time was given for things such as appeals or documentation submission. Calling payments in error that were not truly improper payments would lead to a less accurate error rate. Allowing the maximum amount of time for this development causes the study to be completed very near the required annual reporting deadline. Upon completion of the study a thorough analysis linking the results and specific policies and procedures that contribute to the error rate is provided to the administrators of each program. The administrators develop corrective actions that specifically address the drivers of the error rate. We have noted that despite the extensive processes to increase the accuracy of the error rates and the significant programs and process changes instituted each year the error rate remains high in comparison to the Federal Government's stated goals.

Statements of Social Insurance

The Statements of Social Insurance (SOSI) for CMS presents a long-term projection of the present value of the benefits to be paid for the closed and open groups of existing and future participants of the Medicare social insurance programs less the inflows to be received from or on behalf of those same individuals

The SOSI models are complex, 75-year projections that contain a high degree of estimation. The models and their results are heavily reviewed by actuaries and others within CMS. The veracity of the underlying data remains critical to the accuracy of the model. In recognition of the importance of the underlying data, CMS has developed and implemented a change management process over the SOSI model, which applies to significant changes or changes in the methodology of each model. In addition, CMS' policies and procedures require that the input or output data within the SOSI model are documented to properly understand the flow of the data. During our control testing, we noted one significant change made to a model and a few instances where the input and output data within the models were not properly documented in accordance with the policy.



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:

- Perform high-level analysis, including the corroboration of the results, over the Medicaid account balances and related expenditures. In addition, the accounts receivable and payable Medicaid balances should be analyzed and validated through the use of a subsidiary ledger.
- Challenge whether the newly implemented protocol and detect controls address the underlying root cause of why states continue to have negative balances within their PMS subaccounts. Evaluate the current protocol and determine if additional procedures and controls should be implemented to continuously monitor the state Medicaid draws and perform grant oversight activities to ensure that the states deposit the funds back after a deferral is issued and report timely, accurately, and consistently on the funds drawn to both CMS and PMS. In addition, CMS should encourage the states to reconcile the FFR, CMS-64 and PMS subaccounts in a timely manner so that they can perform the grant close-out process timely and consistently within PMS to eliminate any erroneous draws to grant awards with remaining authority.
- 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 \$27.6 billion accrual.
- Establish a policy individual or group to analyze the accounting and reporting of unique, newly implemented, non-routine or significant transactions, enhance the financial reporting process, address or identify transactions that required cross-functional input as well as to develop robust analytical procedures or measures against benchmarks to monitor and mitigate risks associated with the decentralized nature of CMS operations. Enhancement of this process may assist to develop, document and validate the new critical accounting matters, that are identified or implemented during the year and improve the timeliness and completeness of the white papers. In addition, prepare the required presentations and disclosures to ensure adequate time for analysis and feedback from key stakeholders. The internal controls and financial reporting implications of the significant provisions of ACA that commence in fiscal year 2014 require management's



attention and may need to be addressed prior to formalizing further changes to the white paper process.

- Continue to develop and implement policies and procedures within the budget and financial reporting process to ensure that the unobligated authority required to be returned to Treasury is determined and finalized timely.
- Improve the contingent liability process to ensure that sufficient documentation is maintained to support or corroborate management's conclusions and to evidence that the controls are operating effectively and as designed.
- 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.
- Consider expediting the CERT, PERM, Part C and Part D error rate development study time to increase the time allocated to analyze the findings and development of the plans for remediation prior to the required reporting deadline. Additional analysis of the error rate study results may increase observations of specific causes, contributing factors and anomalies to drive investigations of the root causes of the errors and improve prevention, mitigation and recovery plans.
- Continue to adhere to established policies and procedures to ensure that the SOSI model methodology and related calculation and estimates are consistently documented. Adherence to these policies will ensure that the model is evaluated to verify that the input/output data is appropriate based on the expected results of the data and spreadsheet changes and the model is accurate and complete.

Information Systems Controls

The nature, size and complexity of their operations require CMS to manage their programs under a decentralized business model by using numerous geographically dispersed contractors using complex and extensive information systems operations. Several of the Centers and Offices within CMS provide overall direction for its enterprise information systems operations using a variety of oversight methods.

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. 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' agreements with its contractors. Formal monitoring procedures have been developed and implemented by CMS Central Office.

However, in addition to continuing demands on CMS' resources to implement a national system of 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 existing government mandates for enhanced information security processes. In addition, governance of the information systems environment by multiple groups within CMS, when combined with inadequately designed and inconsistent and incomplete implementation of controls over the information systems, resulted in instances of a lack of compliance with intended policies. A renewed focus is required to minimize the risk of current and unresolved prior year deficiencies. Such deficiencies may result in incomplete and inaccurate processing of Medicare 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 governance, operational oversight, and functioning of the Medicare fee-for-service claims processing systems.

CMS' Systems Environment Overview

CMS' Central Office supports a number of Medicare fee-for-service computerized systems that are used by numerous external organizations such as 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 management data processes.

CMS also maintains multiple standard claims processing systems depending on the type of claim. These systems are referred to as shared systems, which are maintained by the SSMs. The maintenance of these shared systems is coordinated by CMS through SSMs and a Single Testing Contractor.

In addition to the Medicare fee-for-service claims systems, several important computerized systems are managed by the CMS Central Office and include the Healthcare Integrated General Ledger Accounting System (HIGLAS), the Medicare Advantage and Prescription Drug System (MARx), the Enrollment Data Base (EDB), the Medicare Beneficiary Data Base (MBD), the Medicaid Budget & Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), and the NCH.

CMS' Information Management Controls Overview

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 could be compromised.

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 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.

In addition to periodic assessments of contractors' financial and information systems controls conducted through reports in accordance with the American Institute of Certified Public Accountant's SSAE 16 and OMB A-123, CMS principally monitors its Medicare fee-for-service contractors' compliance with its information systems control standards through the following processes:

- Annual evaluations of the implementation of information security requirements outlined in Section 912 of the Medicare Modernization Act of 2003; and
- Monitoring procedures performed by CMS including ongoing contractor management assessments and regular reviews of computer security configurations submitted by the MACs and the EDCs.

In addition, annual independent assessments of CMS' compliance with guidance provided by the National Institute of Standards and Technology (NIST) 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)*.

Governance of Information Systems Controls

CMS is challenged in maintaining information systems controls by a number of key factors, including:

- The division of information systems controls oversight responsibilities includes multiple business units within CMS Central Office, such as the Office of Information Services and the Center for Medicare, resulting in potentially varying interpretations of CMS' standards, the degree of monitoring and enforcement, and the translation of Federal security mandates into actual CMS practices. Their decentralized business control structure leads to program executives being 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 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.
- 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 monitoring of compliance with computer security policies, system access, and monitoring of unauthorized system access and the prevention of and monitoring for inconsistencies in access rights allowing a potential lack of segregation of duties in certain areas. These deficiencies extend to both Medicare fee-for-service contractors as well as to the enterprise as a whole.

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 policies 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.

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. In addition, 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.

Controls over System Access and Monitoring of Unauthorized System Access

In part due to inconsistent oversight and monitoring activities, we noted several deficiencies with implementation planning and execution of CMS' overall directives and guidance. These deficiencies may lessen the ability of CMS to provide secure and reliable processing systems. Examples of these deficiencies include:

- 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.
- Secure remote access techniques were not consistently implemented.
- Evidence supporting testing of claims processing software changes was not always retained.



- Network vulnerability assessments were not always communicated to CMS.
- CMS does not have a documented standard process for assessing or confirming computer configuration waiver requests submitted by its Medicare fee-for-service contractors.
- Medicare and financial data backups were not encrypted at two EDCs.

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 across the enterprise.

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

- For two MACs, shared system user accounts had incompatible sensitive access levels that did not have sufficient business justification or documentation.
- At two MACs, two EDCs and one SSM, we found that system software used to implement shared system changes was not configured for adequate segregation of duties.
- 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 at Central Office, several MACs and both EDCs, in some cases without a business justification or monitoring and oversight, resulting in the risk of incorrectly configured user profiles and potentially unauthorized changes to Medicare financial data files and programs.



- Implementation of certain authentication mechanisms was insufficiently documented for system access and had 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 not consistently performed.
- Several vulnerabilities in system configurations, program coding, input validation, and incident response procedures for the Medicare fee-for-service networks.

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

Continued Implementation of the 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 reporting of financial data related to the CMS contractors' standard claims processing systems. HIGLAS is the system of record and CMS is preparing financial statements using HIGLAS, however, the full functionality of HIGLAS may not have been implemented yet. The MACs' accounts receivable balances are recorded at Central Office through the manual journal voucher process. In addition, the creation of the periodic financial statements is largely system dependent; however, there is a need for system interventions to properly categorize the information within the financial statements, as required by OMB A-136.

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 at both the Central Office and the CMS contractors. 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:

- 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.
- 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.

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:

- 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.
- Consistent, current and complete system security plans prepared by all system owners and the Medicare fee-for-service contractors.
- 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 its integrated financial management system for use by CMS and the Medicare fee-for-service contractors to promote consistency and reliability in accounting and financial reporting and assess the capability of and implement the full functionality of HIGLAS.



CMS' Response to Findings

CMS' response to the findings identified in our audit are described in their letter dated December 9, 2013. CMS' response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Purpose of this Report

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

Ernst & Young LLP

December 9, 2013

CMS MANAGEMENT RESPONSE



AUDIT REPORTS

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



December 9, 2013

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

Dear Sir:

CMS has reviewed the Independent Auditor's Report prepared by Ernst & Young, LLP (EY), and we are extremely pleased to receive an unqualified opinion on our Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position and the Combined Statement of Budgetary Resources. As in previous years, EY disclaimed an opinion on the Statement of Social Insurance (SOSI), primarily due to the uncertainty of the long-range assumptions used in the SOSI model. Our belief is the SOSI projections for fiscal year (FY) 2013, as well as 2012 through 2010, appropriately show the effects of the Affordable Care Act. In addition, we have provided sufficient disclosures regarding the nature and uncertainty of these projections. The FY 2013 SOSI and accompanying footnotes are fully consistent with findings and recommendations made by the independent panel of expert actuaries and economists CMS consulted with in prior fiscal years. 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 continue to develop the necessary actions to remediate this issue for the future.

The results of the audit also identified no material weaknesses in our internal controls; however, it continues to cite significant deficiencies in financial reporting and information systems. Upon receiving the notice of these deficiencies, CMS began implementing corrective actions to mitigate these issues and strengthen our controls. We remain committed to determining the causes of the deficiencies noted in the report. CMS acknowledges the findings and descriptions of matters noted and is dedicated to further improving our financial management systems, as well as the transparency of financial information. Some of the issues surrounding information systems are multi-year efforts which require a significant amount of resources; however, the Agency is devoted to seeing the implementation of these efforts achieved.

We recognize that our complex and diverse programs can be challenging and we would like to thank the OIG and EY for the professionalism displayed throughout the audit process.

Sincerely,

A handwritten signature in black ink that reads "Deborah A. Taylor".

Deborah A. Taylor, CPA
Chief Financial Officer



OTHER INFORMATION

3

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

SUMMARY OF FEDERAL MANAGERS' 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) Office of Management and Budget (OMB) Circular A-123, Appendix A self-assessments; (3) assessments of internal control over the acquisition function; (4) Office of Inspector General (OIG) audits, and Government Accountability Office (GAO) audits and High-Risk reports; (5) Statement on Standards for Attestation Engagements (SSAE) 16 internal control audits; (6) evaluations and tests of Medicare contractor controls conducted pursuant to section 912 of the Medicare Modernization Act; (7) the annual Chief Financial Officer (CFO) audit; (8) security assessment and authorization of systems; and (9) the Secretary's Program Integrity Initiative. As of September 30, 2013, the internal controls and financial management systems of CMS provided reasonable assurance that the objectives of the Federal Managers' Financial Integrity Act (FMFIA) were achieved; 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 FMFIA and 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.

Assurance for Internal Control over Financial Reporting

CMS conducted its assessment of the effectiveness of internal controls 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, 2013, were operating effectively and no material weaknesses were found in the design or operation of the internal control over financial reporting.

Assurance for Internal Control over Operations and Compliance

CMS conducted its assessment of internal control over the effectiveness and efficiency of operations and compliance with applicable laws and regulations in accordance with OMB Circular No. A-123. Based on the results of this evaluation, as of September 30, 2013, 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, 2013, we also complied with applicable laws and regulations, except for the two instances of noncompliance noted above.

While the GAO's High-Risk Report as of February 2013 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. Also noted is that like health care spending in general, Medicare spending has grown faster than growth in the economy for many years, and that the continued growth in the number of Medicare beneficiaries and program spending in the coming years will create increasing challenges to sustain the program over the long term while continuing to ensure that beneficiaries have access to appropriate health care. GAO also designated Medicaid as a high-risk program due to its size, growth, diversity of programs, and concerns about the adequacy of fiscal oversight, which is necessary to prevent inappropriate program spending. GAO noted positive agency steps toward reducing improper payments in the Medicare and Medicaid programs and other initiatives, along with additional opportunities for improvement.

Assurance for the Federal Financial Management Improvement Act of 1996

The Federal Financial Management Improvement Act of 1996 (FFMIA) requires agencies to implement and maintain financial management systems that are substantially in compliance with Federal financial management systems requirements, Federal accounting standards, and the United States Government Standard General Ledger at the transaction level. CMS conducted its assessment of financial management systems for compliance with FFMIA. Based on the results of this evaluation, CMS provides reasonable assurance that all CMS financial management and related systems substantially comply with FFMIA as of September 30, 2013.

After becoming substantially compliant with FFMIA in fiscal year (FY) 2010, we have continued our efforts to implement the Healthcare Integrated General Ledger Accounting System (HIGLAS), which integrates the CMS claims administration contractors' shared claims processing systems and replaces 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*. Through the implementation of HIGLAS at the Medicare Administrative Contractors (MACs), and the implementation of administrative program accounting functions at CMS central office, 100 percent of CMS core program dollars (Medicare, Medicaid, and the Children's Health Insurance Program (CHIP)) are accounted for in HIGLAS. HIGLAS will continue to enhance CMS' oversight of claims administration contractor financial operations, and the accounting and reporting of other CMS activities.

Noncompliance—Actions and Accomplishments

In FY 2012, CMS reported an improper rate for CHIP for the first time since FY 2008. While CMS has reported the improper payment rate for CHIP, CMS noncompliance stems from not developing and reporting error rate reduction targets and corrective action plans for CHIP. CMS develops the CHIP corrective action plan based on the state corrective action plans which were submitted after the publication of the FY 2012 CHIP improper payment rates. CMS is pleased that we developed and reported comprehensive CHIP corrective action plans in FY 2013. With respect to CHIP reduction targets, we do not establish reduction targets for a program until we have established the baseline. The

CHIP improper payment baseline will be established when all three cycles of states have completed their measurement over a three-year period (FY 2012 – 2014). CMS will have a CHIP baseline error measurement in FY 2014, and will then establish reduction targets for the program.

For Medicare fee-for-service (FFS), CMS and HHS work together to set aggressive reduction targets in an effort to drive improvement in payment accuracy levels. The downside of setting aggressive targets is that they may not always be met as CMS' noncompliance stems from not meeting the Medicare FFS and Part D improper payment rate reduction target and reporting a Medicare FFS improper payment rate greater than 10 percent. While some corrective actions have been implemented, others are in the early stages of implementation. CMS believes these major undertakings will have a larger impact through time.

The Part C targets set in the FY 2012 AFR have the error rate below 10 percent (and in compliance with IPERA) in FY 2015. The target for FY 2013 is 10.9 percent, FY 2014 is 10.4 percent, and FY 2015 is 9.9 percent. However, it is possible that the error rate will be below 10 percent by either FY 2013 or FY 2014.

CMS has taken, and continues to take a number of actions outlined in the FY 2013 Agency Financial Report (AFR) to reduce error rates in all of its programs, including Medicare FFS and Part C programs. CMS continues its efforts to comply with IPERA and OMB's implementing guidance.

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. CMS anticipates awarding a contract in early FY 2014.

OTHER INFORMATION

IMPROPER PAYMENTS

In July 2010, Congress amended the IPIA¹, with the IPERA to better standardize the way Federal agencies report improper payments in programs they oversee or administer. In January 2013, Congress amended IPERA with the Improper Payments Elimination and Recovery Improvement Act (IPERIA), which emphasizes the importance of not only measuring improper payments, but also recovering and reducing improper payments. 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 2013, CMS complied with the OMB's IPERA reporting guidance and 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 Fee-for-Service (FFS)

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 developed the Comprehensive Error Rate Testing (CERT) program and took responsibility for the error rate program beginning with FY 2003. The 2013 Medicare FFS measurement methodology is the same as the 2012 methodology.

The Medicare FFS compliance rate was 89.9 percent during the FY 2013 report period. That is, Medicare FFS claim payments were made correctly 89.9 percent of the time, which is an estimated \$321.4 billion in proper payments. Automated edits in the claims processing systems detect problems such as duplicate or incorrectly coded claims. Most claims are paid accurately by the systems because required codes and billing information are on the claim. However, supporting medical records which are needed to truly substantiate a claim are not usually submitted along with the claim. For a small portion of claims, Medicare review contractors request the medical records and conduct a full review of the claim and the medical record to determine its appropriateness. The CERT program calculates the Medicare FFS compliance rate by reviewing claims and the supporting medical records. These reviews uncover more complex issues including lack of sufficient information and lack of medical necessity. These issues are not detectable through automated methods. The Agency believes that more can be done to achieve an even greater compliance rate. To do this, CMS must focus the Agency's corrective actions on specific areas that are most vulnerable to improper payments.

Medicare Advantage and Prescription Drugs

CMS has reported a Part C payment error rate since FY 2008. The Part C error rate measures risk adjustment error, improper payments made to Medicare Advantage (MA) plans based on diagnoses submitted by MA plans for payment. A Part C payment error rate of 9.5 percent is reported in the FY 2013 HHS AFR.

FY 2013 GROSS NON-COMPLIANCE PAYMENTS AND ERROR RATES IN THE MEDICARE FFS PROGRAM

..... GROSS			
Overpayments	Underpayments	Non-Compliance Payment Amount (Overpayments + underpayments)	Non-Compliance Rate
\$34.6 B	\$1.4 B	\$36.0 B	10.1%

¹ In January 2013, Congress amended IPERA with the Improper Payments Elimination and Recovery Improvement Act (IPERIA) however OMB implementing guidance has not been released.

Since FY 2011, CMS has reported a composite payment error rate for the Medicare Prescription Drug Benefit, a Medicare benefit effective calendar year 2006. The Part D composite payment error rate combines four component error rates into a single composite measure for total Part D payments: (1) Payment Error Related to Low Income Status (PELS); (2) Payment Error Related to Incorrect Medicaid Status (PEMS); (3) Payment Error Related to Prescription Drug Event (PDE) Data Validation (PEPV); and (4) Payment Error Related to Direct and Indirect Remuneration (PEDIR). A Part D composite payment error rate of 3.7 percent is reported in the FY 2013 HHS AFR.

From FY 2008 to FY 2012, CMS reported the Medicare Advantage Prescription Drug (MARx) Payment Error (MPE) as a component of the Part C and Part D payment error rate measures. MARx is the system used to pay Part C and Part D plans. FY 2012 was the last year for reporting the MPE for both programs, as it declined significantly and steadily since 2008, demonstrating the improved accuracy of the MARx payment system.

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 improper payment rate for Medicaid and CHIP annually, through the Payment Error Rate Measurement (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.

In FY 2013, CMS made two improper payment rate calculation methodology enhancements to improve the accuracy of the Medicaid improper payment rate estimate. These two enhancements include: (1) replacing the three-year weighted average national Medicaid improper payment rate with a single-year rolling national Medicaid improper payment rate and (2) incorporating prior year state-level improper payment rate recalculations.

In the past, CMS reported a three-year weighted average national Medicaid improper payment rate representing the percentage of expenditures improperly paid over the past three years. The three-year rate was calculated by utilizing a weighted average of the PERM cycle error rates from the three most recent years. This methodology was implemented to ensure Medicaid improper payment rate reporting included findings from all states.

CMS is now reporting a single-year rolling national Medicaid improper payment rate, a more precise estimate that represents the percentage of expenditures improperly paid during one fiscal year. The single-year rolling rate is calculated by multiplying each state's most recently observed error rate by that state's expenditures from the fiscal year being reported and dividing by the expenditures for that fiscal year. The single-year rolling rate treats the three most recent PERM cycles as a contiguous sample (as if all states were observed in the fiscal year being reported) which allows CMS to report on findings from all states with improved precision.

The national Medicaid error rate reported for FY 2013 is 5.8 percent, or \$14.4 billion in gross improper payments based on measurements conducted in FY 2011, 2012, and 2013. The national component error rates are as follows: Medicaid FFS: 3.6 percent; Medicaid managed care: 0.3 percent; and Medicaid eligibility: 3.3 percent.

The two Medicaid improper payment rate calculation methodology enhancements described above also apply to the CHIP improper payment rate estimate with one difference. For FY 2013, only two cycles of states have been measured for CHIP requiring a slightly different approach to the single-year CHIP rolling improper payment rate until all three cycles of states have been measured in FY 2014. For FY 2013, the 34 measured states will be treated as a contiguous sample and projected to the 17 states that have not yet been measured. The FY 2013 national CHIP improper payment rate is 7.1 percent or \$0.6 billion in gross improper payments based on measurements conducted in FY 2012 and 2013. The national FY CHIP error component rates are as follows: CHIP FFS: 5.7 percent; CHIP managed care: 0.2 percent; and CHIP eligibility: 5.1 percent.

REVIEW OF MEDICARE'S PROGRAM FOR OVERSIGHT OF ACCREDITING ORGANIZATIONS

Introduction

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"² to demonstrate this compliance through accreditation by a Centers for Medicare & Medicaid Services (CMS)-approved accreditation program of a private, national Accrediting Organization (AO).³ AOs may voluntarily submit for CMS review and approval, provider- and supplier-specific accreditation programs intended to demonstrate compliance with the applicable Medicare standards. AOs charge fees to facilities that seek their accreditation. Generally, AOs offer facilities at least two accreditation options: accreditation alone, or accreditation under a CMS-approved program for the purpose of participating in Medicare. CMS reviews and provides oversight only to those accreditation programs submitted by an AO requesting to have the program recognized as a Medicare accreditation program. Accordingly, this report addresses AO activity only as it relates to CMS-approved Medicare accreditation programs.

CMS has the responsibility for oversight and approval of AO programs used for Medicare certification purposes, and for ensuring that providers or suppliers that are accredited under an approved AO program meet the quality and patient safety standards required by the Medicare

conditions.⁴ A thorough review of each Medicare accreditation program voluntarily submitted by an AO is conducted by CMS, including a review of the equivalency to the Medicare standards of its accreditation requirements, survey processes and procedures, training, oversight of provider entities, and enforcement. Also reviewed are the qualifications of the surveyors, staff, and the AO's financial status. Upon approval, any provider or supplier accredited by the AO's approved program could be "deemed" to have met the applicable Medicare conditions and are referred to as having deemed status.

Section 1875 of the Act requires CMS to submit this annual report to Congress on its oversight of all AO Medicare accreditation programs. CMS has implemented a comprehensive approach to the review and approval of an AO's Medicare 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 and provide ongoing oversight of facilities it accredits.

As of fiscal year (FY) 2012, CMS has approved accreditation programs for the following facility types: hospitals, psychiatric hospitals, critical access hospitals (CAHs), home health agencies (HHAs), hospices, ambulatory surgical centers (ASCs), outpatient physical therapy and speech-language pathology services (OPTs), and rural health clinics (RHCs).⁵ CMS maintains a comprehensive AO Medicare accreditation oversight program and continually strives to strengthen and enhance its ongoing oversight. The program includes:

² 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 durable medical equipment suppliers, which are required to be accredited under section 1834(e), of the Act. Oversight of this accreditation program is administered separately by CMS; this accreditation program is not subject to the section 1875 reporting requirement and is not addressed in this report.

³ Accreditation for provider entities in accordance with section 1865 is voluntary and not required for Medicare participation. Accreditation by an approved national AO Medicare accreditation is an alternative to being subject to assessment of compliance by the applicable State Survey Agency.

⁴ 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.

⁵ 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.

Deeming application review: CMS rigorously reviews each Medicare accreditation program submitted by an AO to ascertain whether the AO can adequately ensure that facilities comply with Medicare requirements;

Electronic reporting systems: CMS builds, implements and updates electronic systems for AO reporting on activities related to deemed facilities;

Performance measurement: CMS develops and implements performance measures which reflect each AO's compliance with administrative reporting requirements;

Validation survey program: CMS has expanded efforts across a growing number of AO programs and types of facilities to measure the effectiveness of the AO survey process in identifying areas of serious non-compliance with Medicare conditions. CMS may include in its validation survey program both traditional "look-back" surveys and mid-cycle validation surveys which focus on specific facility types to address specific issues of concern. No mid-cycle validation surveys were conducted in FY 2012; and FY 2013.

Education: CMS conducts ongoing education for AO staff that includes, but is not limited to, quarterly conference calls, an annual on-site training for all AOs with approved programs at CMS, and provision of an AO resource manual which is periodically updated; and

In FY 2012, CMS continued to work with AOs to expand on these significant enhancements in systems for monitoring AO activities and AO compliance with CMS requirements. Specifically, CMS worked to improve the program by:

- Increasing the total number of validation surveys conducted, as well as the number of 60-day validation surveys conducted for each AO and facility type. This expansion increases the reliability and validity of the analysis.
- Continuing to update the electronic database used to collect, analyze, and manage data regarding the facilities accredited by the AOs; and working to move the database to a web-based platform to improve the accuracy and increase the frequency of data collected.
- Significantly revising the AO performance measures to require continued improvement in the submission of timely, accurate and complete information.

Overview

This report reviews AO activities in FY 2012, compares this activity to past years, and describes the current CMS oversight of approved Medicare accreditation programs as follows:

Section 1: CMS-Approval of Medicare Accreditation Programs. Discusses the process used for CMS approval and renewal of AO Medicare accreditation programs; the types of CMS reviews and decisions; the number of these reviews that were performed and decisions made since FY 2008; the current AOs with approved Medicare accreditation programs; and the most recent CMS approval or review status for each AO Medicare accreditation program.

Section 2: Scope of Medicare AO Accreditation Programs. Presents the current number of deemed status and non-deemed Medicare-certified facilities by program type and discusses the growth in deemed status facilities within the Medicare program since FY 2008.

Section 3: Summary of Medicare AO Accreditation Program Activity. Discusses the overall Medicare accreditation survey activities of each AO in FY 2012, including the number of initial and renewal accreditation surveys performed and the types of accreditation decisions made for each of the AOs' approved accreditation programs.

Section 4: State Survey Validation of AO Surveys Describes the Accreditation Validation Program and presents the number of representative sample validation surveys that have been performed for hospital and non-hospital facilities since FY 2007. The section also describes the components of the analysis of the 60-day validation surveys used in assessing each AO program's ability to ensure compliance with Medicare conditions. The validation performance results for FYs 2008–2012 are presented by facility type for each AO. The FY 2012 AO and SA condition-level citations for each facility type are presented and compared. For hospital accreditation programs, validation performance results separate comparisons are made for short-term acute care and long term care hospitals.

Section 5: AO Performance Measures. Describes AO reporting requirements, and CMS' methods for collecting AO quarterly data on Medicare accreditation program activities. Presents and discusses the FY 2012 AO performance measures and the results for each AO; and compares FYs 2011 and 2012 performance measure results.

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Section 6: CMS Oversight Activities. Describes the various areas in which CMS has executed and improved its program management and oversight activities.

Section 7: AO Self-Reported Program Improvements. Presents each AO's self-report of recent program improvement activities.

SECTION 1: CMS-Approval of Medicare Accreditation Programs

Application and Renewal Process

Approval of a National Accrediting Organization's Medicare Accreditation Program

The process for CMS-approval of a national AO's Medicare accreditation program is applicant-driven. In order to gain approval of an accreditation program for Medicare deemed status purposes, an AO 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 State Agencies (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 Medicare accreditation program application on the AO's:

- Requirements for accreditation meeting or exceeding the Medicare requirements;
- Survey procedures;
- Ability to provide adequate resources for conducting surveys;
- Capacity to furnish information for use by CMS 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 AO's complete application requesting approval of a Medicare accreditation program, a notice which identifies the national AO making the request, describes the nature of the request, and provides 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 request.

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 a Medicare 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 Medicare accreditation program. Approval of an AO's Medicare accreditation program is for a specified time period, with a six-year maximum. Some AOs are given approval on a conditional basis, while CMS reviews and monitors 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 program's performance, including its ability to ensure deemed status facilities' compliance with Medicare conditions, and its ability to comply with CMS' administrative requirements that facilitate ongoing oversight of the AO's CMS-approved accreditation programs. The CMS evaluation process includes the following components:

- Onsite observations:
 - Corporate on-site 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;
 - Electronic data management; and
 - Financial status.

From FY 2008 through FY 2012, CMS completed 32 reviews of renewal and initial applications (which include approvals published in the *Federal Register* as well as initial applications withdrawn by the AO prior to publication).

Other Reviews of AO Medicare Accreditation Programs

CMS performs other reviews which focus on specific issues, including the following categories:

- **Standards and Survey Process Reviews:** Once approved, any subsequent changes in the AO's Medicare accreditation program standards or survey process must also be reviewed and

approved by CMS prior to implementation by the AO, to ensure that the program continues 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). The AO must notify CMS in writing of any proposed changes in its approved Medicare accreditation program at least 30 days in advance of the effective date of the changes. Additionally, when CMS adopts changes to the applicable Medicare requirements, the AO must submit documentation that it has revised its Medicare program 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.

- **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.

- **Performance Review:** CMS reviews AO performance on an ongoing basis in accordance with section 1875(b) of the Act. This includes, but is not limited to, review of the AO's survey activity, analysis of validation surveys, and review of the AO's continued fulfillment of the requirements at 42 CFR 488.4.

From FY 2008 through FY 2012, CMS completed 170 other reviews.

Table 1 below summarizes the initial, renewal and other reviews conducted by CMS.

Approved AO Medicare Accreditation Programs

CMS reviews and approves separately each type of provider or supplier Medicare accreditation program for which an AO seeks CMS approval. AOs currently have CMS-approval for eight provider/supplier program types: hospital, psychiatric hospital, critical access hospital (CAH), home health agency (HHA), hospice, ambulatory surgical center (ASC), outpatient physical therapy and speech-language pathology (OPT), and rural health clinic (RHC). As of September 30, 2012, there were

TABLE 1:

CMS REVIEW OF AO MEDICARE ACCREDITATION PROGRAMS (FYs 2008 – 2012)

TYPE OF REVIEW AND CMS DECISION	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
INITIAL APPLICATIONS					
Decision: Full approval	0	1	1	3	1
Decision: Denied	0	0	0	0	0
Incomplete application	0	0	0	0	2
Application withdrawn	0	1	2	1	1
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
TOTAL REVIEWS OF INITIAL AND RENEWAL APPLICATIONS	3	10	8	4	7
OTHER REVIEWS					
Standards review	7	4	15	18	20
Survey process review	0	4	12	10	5
Issue review and resolution	*	*	*	44	22
Performance review	0	1	2	3	3
TOTAL OTHER REVIEWS	7	9	29	75	50

* Data was not collected for these issues during this timeframe.

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TABLE 2:

AOS WITH APPROVED MEDICARE ACCREDITATION PROGRAMS (FY 2012)

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

TABLE 3:

APPROVED MEDICARE ACCREDITATION PROGRAMS BY AO (FY 2012)

AO	Hospital	Psych Hospital	Critical Access Hospital	Home Health Agency	Hospice	Ambulatory Surgery Center	OPT	Rural Health Clinic	TOTAL
AAAHC						X			1
AAAASF						X	X	X	3
ACHC				X	X				2
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

seven national AOs with 19 approved Medicare accreditation programs. (See Tables 2 and 3)

The number of CMS-approved Medicare accreditation programs has grown steadily, from 13 in FY 2008 to 19 in FY 2012. Since 2008, CMS has approved six new Medicare accreditation programs, including two from a new AO (DNVHC):

- Three for facility types that already had one or more approved programs (ACHC hospice program, DNVHC hospital program and DNVHC CAH program); and
- Three for facility types that previously did not have a CMS-approved accreditation program (JC psychiatric hospital program, AAAASF OPT program, and AAAASF RHC program).

Approval of Medicare Accreditation Programs

Below is information regarding the initial CMS-approval and the most recent approval or review status for each approved Medicare accreditation program:

ACCREDITATION ASSOCIATION FOR AMBULATORY HEALTH CARE (AAAHC)

Ambulatory Surgery Center

AAAHC's ASC Medicare accreditation program was initially approved on December 19, 1996. Most recently, AAAHC's ASC program 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>.

AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY SURGERY FACILITIES (AAAASF)

Ambulatory Surgery Center

AAAASF's ASC Medicare accreditation program was initially approved on December 2, 1998. Most recently AAAASF received a three-year term of approval, effective November 27, 2009 through November 27, 2012. The final notice announcing this decision was published in the *Federal Register* on August 20, 2010 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 Medicare 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's RHC Medicare accreditation program 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>.

ACCREDITATION COMMISSION FOR HEALTH CARE (ACHC)

Home Health Agency

ACHC's HHA Medicare accreditation program was initially approved 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>.

Performance Review: CMS opened a deeming review of ACHC's HHA accreditation program in February 2011. 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 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 were 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. CMS completed its formal review in September, 2012, and determined that ACHC had fully addressed and resolved all concerns.

Hospice

ACHC's hospice Medicare accreditation program was initially approved for 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>.

AMERICAN OSTEOPATHIC ASSOCIATION / HEALTHCARE FACILITIES ACCREDITATION PROGRAM (AOA/HFAP)

Hospital

AOA/HFAP has had an approved hospital Medicare 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>.

Performance Review: 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 hospital Medicare 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

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assurance that AOA/HFAP's revised policies, procedures and program-wide changes were 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. To confirm compliance, CMS completed its review and conducted a follow-up corporate onsite visit in June 2012 and determined that AOA/HFAP had fully addressed and resolved the identified concerns.

Critical Access Hospital

AOA/HFAP's CAH Medicare accreditation program was initially approved 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's ASC Medicare accreditation program was initially approved January 30, 2003. More recently, AOA/HFAP received approval for a four-year renewal term, 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://www.gpo.gov/fdsys/pkg/FR-2012-09-28/pdf/2012-23996.pdf>.

Performance Review: 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 ASC Medicare 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 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 were 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. To confirm compliance, CMS completed its review and conducted a follow-up corporate onsite visit in June 2012 and determined that AOA/HFAP had fully addressed and resolved the identified concerns.

COMMUNITY HEALTH ACCREDITATION PROGRAM (CHAP)

Home Health Agency

CHAP's HHA Medicare accreditation program was initially approved August 27, 1992. Most recently, CHAP received approval of 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's hospice Medicare accreditation program was initially approved April 20, 1999. More recently, CHAP received an approval of a six-year renewal term, effective November 20, 2012 through November 20, 2018. The final notice announcing this decision was published in the *Federal Register* on October 19, 2012 and can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2012-10-19/pdf/2012-25467.pdf>.

DET NORSE VERITAS HEALTH CARE (DNVHC)**Hospital**

DNVHC's hospital Medicare accreditation program was initially approved September 29, 2008. More recently, CMS approved a six-year renewal term, effective September 26, 2012 through September 26, 2018. The final notice announcing this decision was published on August 24, 2012 and can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2012-08-24/pdf/2012-20199.pdf>.

Critical Access Hospital

DNVHC's CAH Medicare accreditation program was initially approved December 23, 2010 and is effective through December 23, 2014. The final notice announcing this decision was published on November 15, 2010 in the *Federal Register* and can be accessed at <http://edocket.access.gpo.gov/2010/pdf/2010-28666.pdf>.

THE JOINT COMMISSION (JC)**Hospital**

The JC's hospital Medicare accreditation program was initially approved July 15, 2010, effective through July 15, 2014. Prior to July 15, 2010, the JC's hospital accreditation program had statutory status and did not require CMS review and approval. The final notice announcing this decision was published in the *Federal Register* on November 27, 2009, and can be accessed at <http://edocket.access.gpo.gov/2009/pdf/E9-27973.pdf>.

Psychiatric Hospital

The JC's psychiatric hospital Medicare accreditation program was initially approved February 25, 2011 for a four-year period through February 25, 2015. The final notice announcing this decision was published in the *Federal Register* on February 25, 2011, and can be accessed at <http://edocket.access.gpo.gov/2011/pdf/2011-4294.pdf>.

Critical Access Hospital

The JC's CAH Medicare accreditation program was initially approved November 21, 2002. More recently, CMS approved a six year renewal term, effective November 21, 2011 through November 21, 2017. The final notice announcing this decision was published in the *Federal Register* on September 23, 2011 and can be accessed at <http://www.gpo.gov/fdsys/pkg/FR-2011-09-23/pdf/2011-24496.pdf>.

Home Health Agency

The JC's HHA Medicare accreditation program was initially approved September 28, 1993. More recently, CMS approved a six-year renewal term, 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's hospice Medicare accreditation program was initially approved June 18, 1999. More recently, CMS approved a six-year renewal term, 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 ASC Medicare accreditation program was initially approved December 19, 1996. More recently, the CMS approved a six-year renewal term, 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>.

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SECTION 2: Scope of Medicare AO Accreditation Programs

Medicare-Certified Facilities by Program Type

In FY 2012, CMS approved the first RHC accreditation program. With this additional program, AOs were responsible for assuring compliance with Medicare conditions for 36 percent of all Medicare-certified facilities in the eight program types for which there was an approved AO program. (See Table 4)

In FY 2012, the AOs with CMS-approved Medicare accreditation programs continued to be responsible for monitoring compliance with health and safety standards for varying percentages of the total number of Medicare-participating facilities for each program type, ranging from a high of 88 percent for hospitals to a low of less than one percent for RHC facilities. The Hospital category continues to have the largest percentage of facilities participating in Medicare via deemed status.

Growth in Medicare Deemed Facilities

The total number of Medicare-participating certified health care facilities across all program types has increased from 24,752 in FY 2008 to 34,590 in FY 2012. This represents a 40 percent increase. Since FY 2008 the majority of the newly-participating facilities enrolled and certified in the Medicare program have had deemed status.

The growth in the number of deemed facilities is likely attributable, in part, to CMS' priorities for

SAs' workload. The long-standing CMS 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 Medicare accreditation programs to demonstrate their compliance with Medicare requirements, to facilitate a faster enrollment and certification process.

Five AO accreditation program types, including hospital, CAH, HHA, hospice and ASC, have been operational prior to FY 2008. The OPT and psychiatric hospital accreditation program types became operational in FY 2011. No CMS-approved psychiatric hospital accreditation program existed prior to FY 2011. Historically, psychiatric hospitals were included with the hospital program. The RHC program was newly-operational in FY 2012.

Graphs 1 and 2 on the next page show the number of facilities certified each year by CMS by virtue of a CMS-recognized Medicare accreditation program, and the percentage of all Medicare-certified facilities that these deemed facilities represent. These graphs represent the seven program types for which there is currently more than one year of data (the RHC AO program is excluded for this reason).

TABLE 4:

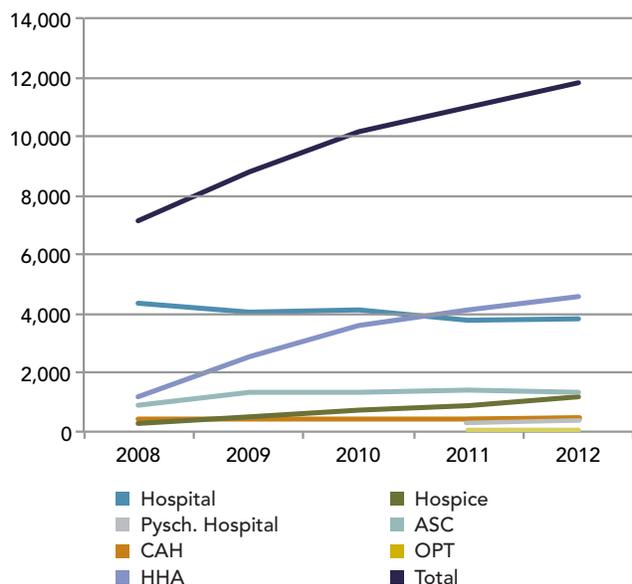
DEEMED & NON-DEEMED MEDICARE-CERTIFIED FACILITIES PROGRAM TYPES WITH A MEDICARE ACCREDITATION PROGRAM OPTION (FY 2012)

Program Type	Deemed* (percentage)	Non-Deemed** (percentage)	Total
Hospital	3,815 (88)	545 (12)	4,360
Psychiatric Hospital	409 (77)	120 (23)	529
CAH	432 (32)	903 (68)	1,335
HHA	4,608 (36)	8,058 (64)	12,666
Hospice	1,157 (31)	2,620 (69)	3,777
ASC	1,358 (25)	4,086 (75)	5,444
OPT	36 (2)	2,335 (98)	2,371
RHC	3 (<1)	4,105 (>99)	4,108
TOTAL	11,818 (34)	22,772 (66)	34,590

* As reported by AOs.

** Surveyed by a SA for compliance with Medicare conditions

GRAPH 1
Number of Deemed Facilities by Program Type
(FYs 2008–2012)



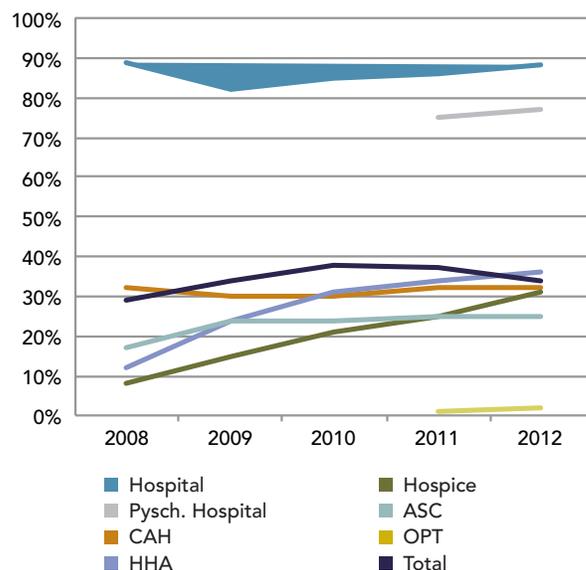
Total: For the five Medicare accreditation program types which have been operational from FY 2008 through FY 2012, and for the OPT and psychiatric hospital programs which have been operational since FY 2011, the number of Medicare-certified facilities increased from 24,752 in FY 2008 to 30,482 in FY 2012. This represents an increase of 23 percent. However, the growth in deemed facilities during that same period has been much larger.

- The number of facilities participating in Medicare via deemed status increased from 7,128 in FY 2008 to 11,815 in FY 2012 (excluding RHCs), a 66 percent increase.
- While SAs continue to survey the majority of facilities requiring certification, the proportion of all certified facilities in these categories represented by deemed status facilities grew from 29 percent to 34 percent.

Hospital: The number of Medicare-certified hospitals was largely unchanged between FYs 2008 and 2012. The hospital and psychiatric hospital programs are the only categories in which the majority of facilities participate in Medicare by virtue of accreditation under an approved Medicare accreditation program.

- The number of deemed hospitals decreased from 4,381 in FY 2008 to 3,815 in FY 2012, a reduction of four percent. Please note: this decrease in percentage is adjusted based on the separate reporting of 409 deemed psychiatric hospitals.
- The proportion of all Medicare-certified hospitals that were deemed decreased slightly from 89 percent to 88 percent during this period.

GRAPH 2:
Deemed Facilities as Percentage of Medicare Certified
Facilities by Program Type (FYs 2008–2012)



Psychiatric Hospital: The number of Medicare-certified psychiatric hospitals increased slightly from 516 in FY 2011 to 529 in FY 2012, a three percent increase.

- The number of deemed psychiatric hospitals increased from 388 in FY 2011 to 409 in FY 2012, a five percent increase.
- The proportion of all Medicare-certified psychiatric hospitals which were deemed increased from 75 percent to 77 percent during the same time period.

CAH: The number of Medicare-certified CAHs increased slightly from 1,310 in FY 2008 to 1,335 in FY 2012, a two percent increase.

- The number of deemed CAHs increased from 415 in FY 2008 to 432 in FY 2012, a four percent increase.
- The proportion of all Medicare-certified CAHs that were deemed remained at 32 percent.

HHA: The number of Medicare-certified HHAs increased from 9,893 in FY 2008 to 12,666 in FY 2012, a 28 percent increase.

- The number of deemed HHAs increased from 1,161 in FY 2008 to 4,608 in FY 2012, a 297 percent increase.
- The proportion of all Medicare-certified HHAs which were deemed increased from 12 percent to 36 percent.

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Hospice: The number of Medicare-certified hospices increased from 3,388 in FY 2008 to 3,777 in FY 2012, an 11 percent increase.

- The numbers of deemed hospices increased from 278 in FY 2008 to 1,157 in FY 2012, a 316 percent increase.
- The proportion of all Medicare-certified hospices which were deemed increased from eight percent to 31 percent during the same time period.

ASC: The number of Medicare-certified ASCs increased from 5,217 in FY 2008 to 5,444 in FY 2012, a four percent increase.

- The number of deemed ASCs increased from 893 in FY 2008 to 1,358 in FY 2012, a 52 percent increase.
- The proportion of all Medicare-certified ASCs which were deemed increased from 17 percent to 25 percent during the same time period.

OPT: The number of Medicare-certified OPTs decreased slightly from 2,471 in FY 2011 to 2,371 in FY 2012, a four percent decrease.

- The number of deemed OPTs increased from 13 in FY 2011 to 36 in FY 2012, a 177 percent increase.
- The proportion of all Medicare-certified OPTs which were deemed increased from one percent to two percent during the same time period.

SECTION 3: Summary of AO Medicare Accreditation Program Activity

Medicare Accreditation Program Survey Activity

An AO with a CMS-recognized Medicare accreditation program 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 evaluation performed by the AO includes, but is not limited to, observation and review of the following: care processes in the facility, the physical environment, administrative and patient medical records, and staff qualifications. The AO performs an initial survey for a facility that is being reviewed by the AO for the first time. Initial surveys include surveys of facilities that are seeking new Medicare certification as well as those of facilities previously overseen by a SA or another AO. The AO may award accreditation under a Medicare accreditation program for up to three

years. A renewal survey must be completed prior to the expiration date of the facility's Medicare accreditation, to ensure that the facility remains in compliance with CMS requirements.

In FY 2012, the AOs reported having performed 1,491 initial surveys and 3,369 renewal surveys. The total number of deemed status facilities in FY 2012 was 11,818. (See Table 5)

Summary of Survey Activity for Each AO with CMS-Approved Medicare Accreditation Program(s)

Below are summaries of all types of Medicare accreditation surveys performed, and all types of accreditation decisions made by each AO for each of their Medicare accreditation programs in FY 2012. The various accreditation decisions are also presented as a percentage of the total surveys performed by each AO for each of their Medicare accreditation programs.

AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY SURGERY FACILITIES (AAAASF)

Program Type	Total Deemed	Initial Surveys	Renewal Surveys
ASC	123	42	28
OPT	36	54	0*
RHC	3	23	0*
TOTAL	162	119	28

* The first accreditation program for OPT received initial approval in FY 2011. The first accreditation program for RHC received initial approval in FY 2012. Therefore, no renewal surveys were due to be performed in FY 2012. Although AAAASF conducted 54 initial OPT surveys and awarded accreditation to 52 OPTs, and conducted 23 initial RHC surveys and awarded accreditation to 22 RHCs in FY 2012, CMS awarded deemed status to many of these facilities in early FY 2013. Therefore, they are not reflected in the total number of deemed OPTs And RHCs.

AAAASF awarded full accreditation to 81 percent of the total ASCs surveyed, 96 percent of the total OPTs surveyed and 96 percent of the total RHCs surveyed.

Accreditation Decisions	ASCs (percent)	OPT (percent)	RHC (percent)
Full Accreditation	55 (81)	52 (96)	22 (96)
Denial	12 (18)	2 (4)	1 (4)
Pending	1 (1)	0	0
TOTAL SURVEYS*	68 (100)	54 (100)	23 (100)

* Note: Two facilities were granted "Conditional" accreditation and are not included in the above table.

TABLE 5

TOTAL NUMBER OF DEEMED FACILITIES INITIAL SURVEYS AND RENEWAL SURVEYS BY AO ACCREDITATION PROGRAM (FY 2012)

PROGRAM TYPE/ ACCREDITATION ORGANIZATIONS	TOTAL DEEMED FACILITIES	INITIAL SURVEYS	RENEWAL SURVEYS
Hospital			
AOA/HFAP	177	3	45
DNVHC	219	50	49
JC	3,419	43	1,169
Psychiatric Hospital			
JC	409	22	124
Critical Access Hospital			
AOA/HFAP	33	2	12
DNVHC	34	11	0*
JC	365	7	138
Home Health Agency			
ACHC	624	130	152
CHAP	2,000	385	540
JC	1,984	281	486
Hospice			
ACHC	77	34	3
CHAP	605	100	197
JC	475	104	88
Ambulatory Surgery Center			
AAAHC	789	126	245
AAAASF	123	42	28
AOA/HFAP	26	5	7
JC	420	69	86
Outpatient Physical Therapy			
AAAASF	36	54	0*
Rural Health Clinic			
AAAASF	3	23	0**
TOTAL	11,818	1,491	3,369

Source: As reported by AOs.

* The DNVHC CAH and AAAASF OPT accreditation programs received initial approval in FY 2011. Therefore, no renewal surveys were due to be conducted in FY 2012. Although AAAASF conducted 54 initial OPT surveys and awarded accreditation to 52 OPTs in FY 2012, CMS awarded deemed status to some of these facilities in early FY 2013. Therefore, they are not reflected in the total number of deemed OPTs.

**The AAAASF RHC accreditation program received initial approval in FY 2012. Although AAAASF conducted 23 initial surveys and awarded accreditation to 22 RHCs in FY 2012, CMS awarded deemed status to the majority of these facilities in early FY 2013. Therefore, they are not reflected in the total number of deemed RHCs.

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ACCREDITATION ASSOCIATION FOR AMBULATORY HEALTH CARE (AAAHC)

Program Type	Total Deemed	Initial Surveys	Renewal Surveys
ASC	789	126	245

AAAHC awarded full accreditation to 96 percent of the total ASCs surveyed.

Accreditation Decisions	ASCs (percent)
Full Accreditation	355 (96)
Denial	11 (3)
Pending	5 (1)
TOTAL SURVEYS	371 (100)

ACCREDITATION COMMISSION FOR HEALTH CARE (ACHC)

Program Type	Total Deemed	Initial Surveys	Renewal Surveys
HHA	624	130	152
Hospice	77	34	3
TOTAL	701	164	155

ACHC awarded full accreditation to 90 percent of the total HHAs surveyed and 92 percent of the total hospice facilities surveyed.

Accreditation Decisions	HHAs (percent)	Hospice (percent)
Full Accreditation	254 (90)	34 (92)
Denial	22 (8)	2 (5)
Pending	6 (2)	1 (3)
TOTAL SURVEYS	282 (100)	37 (100)

AMERICAN OSTEOPATHIC ASSOCIATION/ HEALTHCARE FACILITIES ACCREDITATION PROGRAM (AOA/HFAP)

Program Type	Total Deemed	Initial Surveys	Renewal Surveys
ASC	26	5	7
CAH	33	2	12
Hospital	177	3	45
TOTAL	236	10	64

AOA/HFAP awarded full accreditation to 75 percent of the total ASCs surveyed, 93 percent of the total CAHs surveyed and 100 percent of the total hospitals surveyed.

Accreditation Decisions	ASCs (percent)	CAH (percent)	Hospital (percent)
Full Accreditation	9 (75)	13 (93)	48 (100)
Denial	3 (25)	1 (7)	0 (0)
Pending	0 (0)	0 (0)	0 (0)
TOTAL SURVEYS*	12 (100)	14 (100)	48 (100)

COMMUNITY HEALTH ACCREDITATION PROGRAM (CHAP)

Program Type	Total Deemed	Initial Surveys	Renewal Surveys
HHA	2,000	385	540
Hospice	605	100	197
TOTAL	2,605	485	737

CHAP awarded full accreditation to 98 percent of the total HHAs surveyed and 99 percent of the total hospice facilities surveyed.

Accreditation Decisions	HHAs (percent)	Hospice (percent)
Full Accreditation	905 (98)	295 (99)
Denial	7 (1)	0 (0)
Pending	13 (1)	2 (1)
TOTAL SURVEYS	925 (100)	297 (100)

DET NORSKE VERITAS HEALTH CARE (DNVHC)

Program Type	Total Deemed	Initial Surveys	Renewal Surveys
CAH	34	11	0*
Hospital	219	50	49
TOTAL	253	61	49

* The DNVHC CAH accreditation program received initial approval in FY 2011. Therefore, no renewal surveys were due to be performed in FY 2012.

DNVHC awarded full accreditation to 100 percent of the total CAHs surveyed and 99 percent of the total hospitals surveyed.

Accreditation Decisions	CAH (percent)	Hospital (percent)
Full Accreditation	11 (100)	98 (99)
Denial	0 (0)	0 (0)
Pending	0 (0)	1 (1)
TOTAL SURVEYS	11 (100)	99 (100)

THE JOINT COMMISSION (JC)

Program Type	Total Deemed	Initial Surveys	Renewal Surveys
ASC	420	69	86
CAH	365	7	138
HHA	1,984	281	486
Hospice	475	104	88
Hospital	3,419	43	1,169
Psychiatric Hospital	409	22	124
TOTAL	7,072	526	2,091

The JC awarded full accreditation to:

- 97 percent of the total ASCs surveyed;
- 97 percent of the total CAHs surveyed;
- 92 percent of the total HHAs surveyed;
- 93 percent of the total hospice facilities surveyed;
- 97 percent of the total hospitals surveyed; and
- 94 percent of the total psychiatric hospitals surveyed.

Accreditation Decisions	ASC (percent)	CAH (percent)	HHA (percent)	Hospice (percent)	Hospital (percent)	Psychiatric Hospital (percent)
Full Accreditation	150 (97)	140 (97)	708 (92)	179 (93)	1,175 (97)	137 (94)
Denial	0 (0)	0 (0)	27 (4)	1 (1)	2 (<1)	1 (1)
Pending	5 (3)	5 (3)	32 (4)	12 (6)	35 (3)	8 (5)
TOTAL SURVEYS	155 (100)	145 (100)	767 (100)	192 (100)	1,212 (100)	146 (100)

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SECTION 4: State Survey Validation of AO Surveys

Accreditation Validation Program

Section 1864(c) of the Act permits SA validation surveys of provider and supplier types deemed for Medicare participation under section 1865(a) of the Act as a means of validating the AOs' accreditation processes. A facility certified on the basis of being "deemed" to meet the Medicare conditions, based on accreditation under a CMS-approved Medicare accreditation program and recommendation for deemed status by the AO, is not subject to routine surveys by SAs to determine compliance with all applicable Medicare conditions. However, these deemed status facilities may be subject to validation surveys authorized by CMS and generally conducted by a SA.

The Accreditation Validation Program is a significant component of CMS' oversight of AOs with approved Medicare accreditation programs, and consists of two types of validation surveys:

- **Substantial allegation surveys (also called "complaint surveys"):** these are focused surveys based on complaints which, if substantiated, could indicate serious noncompliance with one or more Medicare conditions; and
- **Representative sample validation surveys:** these are full surveys are routinely performed

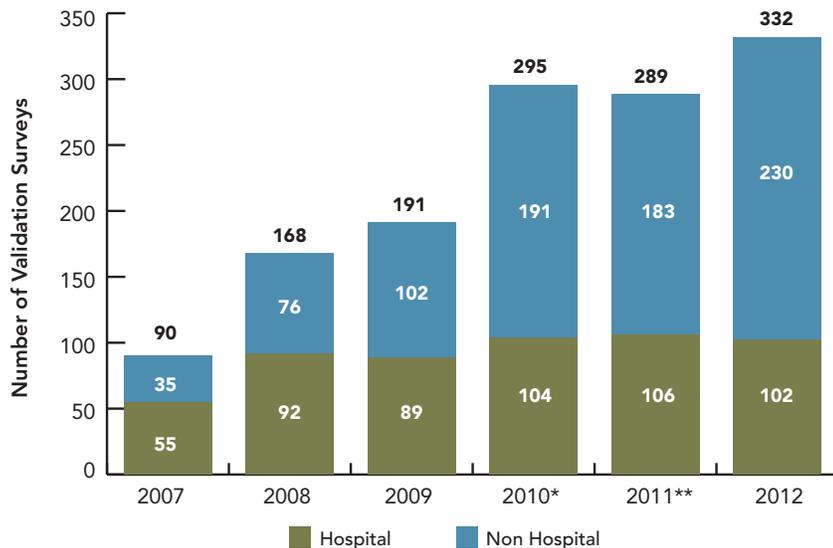
for a representative sample of deemed facilities as part of the annual CMS AO representative sample validation survey program. These surveys, generally, must be completed by the SA no more than 60 days after an AO full accreditation survey of the same facility. In some cases, representative sample "mid-cycle validation surveys" may be conducted independent of a preceding AO survey.

Note: The discussion in this section of the methodology for and results of CMS validation of the AOs' Medicare accreditation programs is based only upon analysis of 60-day representative sample validation surveys.

Prior to 2009, section 1875 of the Act required CMS to report to Congress annually only on the Joint Commission's hospital program. Nevertheless, in FY 2007, CMS began conducting 60-day representative sample validation surveys for selected non-hospital facility types (CAHs, HHAs, and ASCs), in addition to those already being performed for deemed status hospitals. In FY 2010, hospice 60-day validation surveys were added, and in FY 2011, psychiatric hospital 60-day validation surveys. In FY 2012, CMS conducted a total of 332 representative sample 60-day validation surveys for eight facility types across seven AOs. This total was comprised of 102 hospital and 230 non-hospital validation surveys. (See Graph 3)

GRAPH 3:

NUMBER OF REPRESENTATIVE SAMPLE VALIDATION SURVEYS FOR BOTH HOSPITAL AND NON-HOSPITAL FACILITIES (FY 2007 – 2012)*



* FY 2010: The non-hospital total of 191 includes 72 mid-cycle ASC validation surveys.

** FY 2011: The hospital total of 106 includes 33 mid-cycle LTCH validation surveys.

Since 2007, CMS has worked to strengthen oversight of accrediting organizations. The number of validation surveys conducted has expanded significantly as more attention and Federal resources have been made available to this priority area. Below is the recent history of validation surveys.

- **2007:** 55 hospital and 35 non-hospital surveys totaling 90 surveys.
- **2008:** 92 hospital and 76 non-hospital surveys totaling 168 surveys.
- **2009:** 89 hospital and 102 non-hospital surveys totaling 191 surveys.
- **2010:** 104 hospital and 191 non-hospital surveys, including 72 ASC mid-cycle surveys, totaling 295 surveys.
- **2011:** 106 hospital surveys, including 33 LTCH mid-cycle surveys, and 183 non-hospital surveys totaling 289 surveys.
- **2012:** 102 hospital and 230 non-hospital surveys totaling 332 surveys.

These numbers represent a 269 percent increase in the overall number of validation surveys conducted, from 90 in FY 2007 to 332 in FY 2012. During the same time period, the number of non-hospital validation surveys conducted increased by 557 percent, from 35 surveys in FY 2007 to 230 surveys in FY 2012. The number of hospital validation surveys conducted increased by 85 percent, from 55 surveys in FY 2007 to 102 surveys in FY 2012.

60-Day Validation Surveys

The purpose of 60-day validation surveys is to assess the AO's ability to ensure compliance with Medicare conditions. These validation surveys are on-site full surveys completed by SA surveyors no later than 60 days after the end date of an AO's Medicare accreditation program survey. The SA performs these surveys without any knowledge of the findings of the AO's accreditation survey.

The composition of the validation sample is driven by a number of factors, including the total number of Medicare accreditation surveys scheduled by the AO and reported on monthly survey schedules furnished to CMS, the accuracy of those schedules, and individual state validation survey volume targets. 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.

Proportion of Deemed Facilities Receiving Validation Surveys

The proportion of 60-day validation surveys completed for deemed facilities is calculated by dividing the number of 60-day validation surveys conducted by the total number of deemed facilities. (See Figure 1)

FIGURE 1:

PROPORTION OF DEEMED FACILITIES RECEIVING VALIDATION SURVEYS

$$\frac{\text{Number of 60-day validation surveys}}{\text{Number of Deemed facilities}} = \text{Proportion of deemed facilities receiving validation surveys}$$

The proportion of facilities that received a 60-day validation survey in FY 2012 is as follows:

- **Hospitals:** Three percent of deemed hospitals received a validation survey in FY 2012 [102 validation surveys conducted out of 3,815 deemed facilities].
- **Psychiatric Hospitals:** Two percent of deemed facilities received a validation survey in FY 2012 [eight validation surveys conducted out of 409 deemed facilities].
- **CAHs:** Eight percent of deemed CAHs received a validation survey in FY 2012 [33 validation surveys conducted out of 432 deemed facilities].
- **HHAs:** Two percent of deemed HHAs received a survey in FY 2012 [102 validation surveys conducted out of 4,608 deemed facilities].
- **Hospices:** Two percent of deemed hospices received a validation survey in FY 2012 [21 validation surveys conducted out of 1,157 deemed facilities]. Hospice has been included in the validation program since FY 2010.
- **ASCs:** Five percent of deemed ASCs received a validation survey in FY 2012 [66 validation surveys conducted out of 1,358 deemed facilities].

Note: No validation surveys were targeted for OPTs or RHCs in FY 2012 due to the small numbers of deemed facilities in these recently approved Medicare accreditation programs (approved in FYs 2011 and 2012 respectively).

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Validation Analysis

Condition-Level Deficiencies and Disparity Rate

Once the 60-day validation surveys are completed, CMS performs a validation analysis and compares the “condition-level deficiencies” (i.e., serious deficiencies) cited by the SA with deficiencies cited by the AO on its Medicare accreditation survey. The goal of this validation analysis 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 Medicare accreditation survey, and should also have been cited by the AO.

When the SA finds a condition-level deficiency in a deemed status facility, CMS removes its deemed status and places it under the jurisdiction of the SA until the facility comes into substantial compliance. If the facility is unable to demonstrate substantial compliance in a timely manner, 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.

When the SA cites a condition-level deficiency for which the AO has cited no comparable deficiency, the deficiency is considered by CMS to have been “missed” by the AO and is a factor in determining the AO’s “disparity rate” for each facility type. (See Figure 2)

FIGURE 2:

DISPARITY RATE CALCULATION

$$\frac{\text{Number of AO surveys with missed condition-level deficiency findings}}{\text{Number of 60-day validation surveys}^*} = \text{Disparity Rate}$$

* The number of 60-day validation surveys includes the total number of 60-day validation surveys conducted regardless of whether or not the SA cited condition-level deficiencies.

The methodology for the disparity rate is set by regulation at 42 CFR 488.1. 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 total number of surveys in the 60-day representative 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. For example, if there were 77 60-day validation surveys conducted, and the AO missed 12 condition-level deficiencies that were cited by the SA, the disparity rate would be 16 percent (12 divided by 77). A lower disparity rate indicates better AO performance. The regulations at 42 CFR 488.8(d) require that CMS identify any AO with a disparity rate exceeding 20 percent.

Sampling Fraction

The sampling fraction is the proportion of AO surveys during the fiscal year for which a representative sample 60-day validation survey was completed. (See Figure 3)

FIGURE 3:

SAMPLING FRACTION CALCULATION

$$\frac{\text{Number of 60-day validation surveys completed by the SA}}{\text{Number of accreditation surveys completed by the AO}} = \text{Sampling Fraction}$$

For example, if the number of FY 2012 60-day validation surveys conducted by the SA is 33 and the overall number of accreditation surveys conducted by the AO over the same time period is 638, then the sampling fraction would be 33 divided by 638—which is five percent (.051). CMS has worked to increase this sampling 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 Medicare accreditation surveys completed by the AO.

Validation Performance Results: Each Facility Type

The table below presents the results of the 60-day validation surveys for all AOs from FY 2008 through FY 2012 by facility type. (See Table 6)

In FY 2012, with the exception of Hospice and HHA, the disparity rate score for each facility type

TABLE 6:

60-DAY VALIDATION SURVEY RESULTS FOR EACH FACILITY TYPE (FYs 2008 THROUGH 2012)

Facility Type/Validation Survey Analysis	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
HOSPITAL					
60-day Validation Sample	92	89	104	73	102
SA: Condition-level Deficiencies	43	39	47	36	50
Missed by AO	30	32	40	32	45
Disparity Rate	33%	36%	38%	44%	44%
Sampling Fraction	.06	.06	.07	.05	.08
PSYCHIATRIC HOSPITAL					
60-day Validation Sample*	-	-	-	-	8
SA: Condition-level Deficiencies	-	-	-	-	6
Missed by AO	-	-	-	-	6
Disparity Rate	-	-	-	-	75%
Sampling Fraction	-	-	-	-	.05
CAH					
60-day Validation Sample	17	22	23	20	33
SA: Condition-level Deficiencies	9	16	16	11	15
Missed by AO	7	15	15	9	12
Disparity Rate	41%	68%	65%	45%	36%
Sampling Fraction	.15	.14	.16	.14	.13
HHA					
60-day Validation Sample	21	51	76	77	102
SA: Condition-level Deficiencies	5	9	15	15	30
Missed by AO	3	8	11	12	19
Disparity Rate	14%	16%	14%	16%	19%
Sampling Fraction	.03	.03	.05	.05	.05
HOSPICE					
60-day Validation Sample**	0	0	20	20	21
SA: Condition-level Deficiencies	NA	NA	5	3	2
Missed by AO	NA	NA	5	1	2
Disparity Rate	NA	NA	25%	5%	10%
Sampling Fraction	NA	NA	.06	.07	.04
ASC					
60-day Validation Sample***	38	29	0	66	66
SA: Condition-level Deficiencies	17	12	NA	34	25
Missed by AO	16	12	NA	30	21
Disparity Rate	42%	41%	NA	45%	32%
Sampling Fraction	.06	.05	NA	.11	.11

* Not part of the validation program as a separate program type until FY 2012. The psychiatric hospital accreditation program received initial CMS-approval in FY 2011.

**Validation program did not include hospice in FY 2008 and FY 2009.

***No 60-day ASC validation surveys were performed in FY 2010. Instead, mid-cycle validation surveys were performed.

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exceeded the 20 percent threshold established in the regulation. In cases where the disparity rate for the AO's Medicare accreditation program exceeded the 20 percent threshold, CMS notified the AO of the finding.

Note: The Hospice and HHA disparity rates are significantly different than the other facility types due to the lower percentage of surveys with condition-level deficiencies cited by SAs in the 60-day validation samples for both hospice and HHA for FYs 2010-2012. This lower deficiency rate is primarily due to these facility types not having deficiencies related to physical environment conditions. There is no physical environment condition for HHAs since these services are provided in the patient's home. Although hospices do have a physical environment condition, a number of hospice services are provided in the patient's home as well. This finding is discussed in more detail later in this section.

In FY 2012, while the disparity rate for ASCs was 32 percent, which still exceeds the 20 percent threshold, it was reduced significantly from the disparity rates in preceding years exceeding 40 percent rate.

Validation Performance Results: Individual AOs

Each AO receives feedback on the results of CMS' analysis of 60-day validation surveys for its deemed status facilities. The series of tables below, presents the results of the 60-day validation surveys by facility type for each of the AO Medicare accreditation programs from FYs 2008–2012. (See Tables 7–12)

When the number of 60-day validation surveys completed by the SA is less than five surveys, the disparity rate is not presented. The small 60-day

validation sample sizes limited the analysis of some AO programs. Since 2008, CMS has significantly increased the number of 60-day validation samples. With minimal exception, the sample size for every AO program was either maintained or increased from FY 2011 to FY 2012. CMS hopes to maintain this larger sample size in the future based on the availability of Federal funds. While this expansion is taking place, the presentation of validation results for several time periods provides a more complete examination of the consistency of individual AO performance. Therefore, the results for the FYs 2008–2011 60-day validation surveys for individual AOs have been combined in the tables below to provide a more robust and reliable estimate of the disparity rates.

As was true for the national disparity rates for each facility type, the disparity rates between FYs 2008 and 2012 for each of the individual AO programs that received 60-day validation surveys consistently exceeded 20 percent, with the same exceptions of AO hospice and HHA programs. As stated earlier, this is largely due to having a large portion of hospice and all HHA services being provided in the patient's home.

Hospital

The AOs with hospital programs in FY 2012 were the JC, AOA/HFAP and DNVHC. (See Table 7)

JC: In FY 2012, the disparity rate was 45 percent based on the completion of 86 validation surveys. The number of validation surveys conducted represents a seven percent sample of surveys conducted by the JC. The FY 2012 disparity rate is higher than the disparity rate of 36 percent for combined FYs 2008–2011 which was also based on a seven percent sample of JC surveys conducted during that period.

TABLE 7:

HOSPITAL 60-DAY VALIDATION SURVEY RESULTS BY AO (FYs 2008–2012)

Validation Survey Analysis	JC		AOA/HFAP		DNVHC		Total	
	FYs 2008–2011	FY 2012	FYs 2008–2011	FY 2012	FYs 2009–2011*	FY 2012	FYs 2008–2011	FY 2012
60-Day Validation Sample	334	86	10	7	7	9	351	102
SA: Condition-level Deficiencies	151	44	8	2	3	4	162	50
Missed by AO	120	39	8	2	3	4	131	45
Disparity Rate	36%	45%	80%	29%	43%	44%	37%	44%
Sampling Fraction	.07	.07	.04	.02	.04	.09	.05	.04

*DNVHC hospital accreditation program received initial CMS-approval September 2008.

AOA: In FY 2012, the disparity rate was 29 percent based on the completion of seven validation surveys. The number of validation surveys conducted represents a two percent sample of the surveys conducted by AOA. The FY 2012 disparity rate is a significant improvement compared to the disparity rate of 80 percent for combined FYs 2008–2011, which was based on a four percent sample of the surveys conducted during that period.

DNVHC: In FY 2012, the disparity rate was 44 percent based on the completion of nine validation surveys. The number of validation surveys conducted represents a nine percent sample of the surveys conducted by DNVHC. The FY 2012 disparity rate is relatively consistent with the disparity rate of 43 percent for combined FYs 2008–2011 which was based on a four percent sample of the surveys conducted during that period.

Psychiatric Hospital

The only AO with a CMS-approved psychiatric hospital Medicare accreditation program in FY 2012 was the JC. The psychiatric hospital program was initially approved by CMS in FY 2011. (See Table 8)

JC: In FY 2012, the disparity rate was 75 percent based on eight validation surveys completed. The number of validation surveys completed represents a five percent sample of the surveys conducted by the JC.

TABLE 8:

PSYCHIATRIC HOSPITAL 60-DAY VALIDATION SURVEY RESULTS BY AO (FY 2012)

Validation Survey Analysis	JC
	FY 2012
60-Day Validation Sample	8
SA: Condition-level Deficiencies	6
Missed by AO	6
Disparity Rate	75%
Sampling Fraction	.05

Critical Access Hospital

The AOs with CAH accreditation programs in FY 2012 were the JC, AOA/HFAP and DNVHC. (See Table 9)

JC: In FY 2012, the disparity rate was 36 percent based on the completion of 28 validation surveys. The number of validation surveys completed represents a 19 percent sample of the surveys conducted by the JC. The FY 2012 disparity rate is a significant improvement compared to the disparity rate of 55 percent for combined FYs 2008–2011, which was based on a 15 percent sample of surveys conducted during that period.

AOA: In FY 2012, no disparity rate was calculated due to the small validation survey sample size.

DNVHC: In FYs 2011 and 2012, no disparity rate was calculated due to the small validation survey sample size.

TABLE 9:

CRITICAL ACCESS HOSPITAL 60-DAY VALIDATION SURVEY RESULTS BY AO (FYs 2008–2012)

Validation Survey Analysis	JC		AOA/HFAP		DNVHC		Total	
	FYs 2008–2011	FY 2012	FYs 2008–2011	FY 2012	FY 2011*	FY 2012	FYs 2008–2011	FY 2012
60-Day Validation Sample	73	28	8	2	1	3	82	33
SA: Condition-level Deficiencies	46	13	6	0	0	2	52	15
Missed by AO	40	10	6	NA	NA	NA	46	12
Disparity Rate	55%	36%	75%	NA	NA	NA	56%	36%
Sampling Fraction	.15	.19	.21	.14	.04	.03	.15	.19

NA: Not applicable due to sample size less than five or SAs cited no condition-level deficiencies.

* DNVHC accreditation program received initial CMS-approval November FY 2011.

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Home Health Agency

The AOs with HHA accreditation programs in FY 2012 were the JC, ACHC and CHAP. (See Table 10)

JC: In FY 2012, the disparity rate was 19 percent based on the completion of 27 validation surveys. The number of validation surveys completed represents a four percent sample of the surveys conducted by the JC. The FY 2012 disparity rate represents improvement compared to the disparity rate of 22 percent for combined FYs 2008–2011, which was also based on a four percent sample of the surveys conducted during that period.

ACHC: In FY 2012, the disparity rate was 12 percent based on the completion of 25 validation surveys. The number of validation surveys completed represents a nine percent sample of surveys conducted by ACHC. The FY 2012 disparity rate is higher than the disparity rate of 10 percent for combined FYs 2008–2011 which was based on a three percent sample of surveys conducted during that period.

CHAP: In FY 2012, the disparity rate was 22 percent based on the completion of 50 validation surveys. The number of validation surveys completed represents a five percent sample of the surveys conducted by CHAP. The FY 2012 disparity rate is significantly higher than the disparity rate of 11 percent for combined FYs 2008–2011, which was also based on a five percent sample of the surveys conducted during that time.

Hospice

The AOs with hospice accreditation programs in FY 2012 were the JC, CHAP and ACHC. Hospice validation surveys were initiated in FY 2010. (See Table 11)

JC: In FY 2012, the disparity rate was 0 percent as there were no condition-level deficiencies cited by the SA. In combined FYs 2010–2011, the disparity rate was five percent. This disparity rate was based on the completion of 21 validation surveys which represents eight percent of the surveys conducted by the JC during that period.

TABLE 10:

HOME HEALTH AGENCY 60-DAY VALIDATION SURVEY RESULTS BY AO (FYs 2008–2012)

Validation Survey Analysis	JC		ACHC		CHAP		Total	
	FYs 2008–2011	FY 2012						
60-Day Validation Sample	86	27	31	25	108	50	225	102
SA: Condition-level Deficiencies	25	7	4	6	15	17	44	30
Missed by AO	19	5	3	3	12	11	34	19
Disparity Rate	22%	19%	10%	12%	11%	22%	15%	19%
Sampling Fraction	.04	.04	.03	.09	.05	.05	.04	.05

TABLE 11:

HOSPICE 60-DAY VALIDATION SURVEY RESULTS BY AO (FYs 2010–2012)

Validation Survey Analysis	JC		CHAP		ACHC	Total	
	FY 2010–2011	FY 2012	FY 2010–2011	FY 2012	FY 2012*	FYs 2010–2011	FY 2012
60-Day Validation Sample	21	10	19	10	1	40	21
SA: Condition-level Deficiencies	2	0	6	2	0	8	2
Missed by AO	1	0	5	2	NA	6	2
Disparity Rate	5%	0	26%	20%	NA	15%	10%
Sampling Fraction	.08	.05	.06	.03	.03	.07	.04

* ACHC hospice accreditation program received initial CMS-approval in FY 2010.

NA: Not applicable since SAs cited no condition-level deficiencies or survey sample size was less than five so the disparity rate was not calculated.

CHAP: In FY 2012, the disparity rate was 20 percent based on the completion of 10 validation surveys. The number of validation surveys completed represents a three percent sample of the surveys performed by CHAP. The FY 2012 disparity rate is an improvement compared to the disparity rate of 26 percent for combined FYs 2010–2011, which was based on a six percent sample of the surveys conducted during that period.

ACHC: In FY 2012, no disparity rate was calculated due to the small validation survey sample size.

Ambulatory Surgery Center

The AOs with ASC accreditation programs in FY 2012 were the JC, AAAHC and AAAASF. (See Table 12)

JC: In FY 2012, the disparity rate was 41 percent based on the completion of 17 validation surveys. The number of validation surveys completed represents an 11 percent sample of the surveys performed by the JC. The FY 2012 disparity rate was a modest improvement compared to the disparity rate of 44 percent for combined FYs 2008–2011, which was based on a seven percent sample of surveys conducted during that period.

AAAHC: In FY 2012, the disparity rate was 25 percent based on the completion of 44 validation surveys. The number of validation surveys completed represents a twelve percent sample of the surveys performed by AAAHC. The FY 2012 disparity rate was a significant improvement compared to the disparity rate of 42 percent for combined FYs 2008–2011, which was based on an eight percent sample of surveys conducted during that period.

AAAASF: In FY 2012, the disparity rate was 60 percent based on the completion of five validation surveys. The number of completed validation surveys represents a seven percent sample of the surveys performed by AAAASF. The FY 2012 disparity rate was an improvement compared to the disparity rate of 71 percent for combined FYs 2008–2011, which was also based on a seven percent sample of the surveys conducted during that period.

Validation Performance Results: Physical Environment vs. Other Health 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. CMS uses two approaches for this analysis: (1) a review of the types of condition-level citations identified by SAs and the comparable AO deficiency findings; and (2) a comparison of the number of surveys with physical environment condition-level deficiencies and the number of surveys with other types of condition-level deficiencies. Both approaches highlight the same conclusion: SAs identify more physical environment condition-level deficiencies than any other type of deficiency on validation surveys; and AOs miss a significant number of these physical environment deficiencies. These findings are consistent with validation analysis results for the past several years.

TABLE 12:

AMBULATORY SURGERY CENTER 60-DAY VALIDATION SURVEY RESULTS BY AO (FYs 2008–2012)

Validation Survey Analysis	JC		AAAHC		AAAASF		Total	
	FYs 2008–2011*	FY 2012	FYs 2008–2011*	FY 2012	FYs 2008–2011*	FY 2012	FYs 2008–2011	FY 2012
60-Day Validation Sample	25	17	101	44	7	5	133	66
SA: Condition-level Deficiencies	12	8	46	14	5	3	63	25
Missed by AO	11	7	42	11	5	3	58	21
Disparity Rate	44%	41%	42%	25%	71%	60%	44%	32%
Sampling Fraction	.07	.11	.08	.12	.07	.07	.08	.11

* No 60-day ASC validation surveys were performed in FY 2010. Instead, mid-cycle validation surveys were performed.

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Comparison of SA and AO Condition-Level Citation Findings

The first analysis yields the number of facilities cited by SAs for specific condition-level deficiencies and the number of surveys where the AOs missed citing comparable deficiencies. These results are discussed below by each specific facility type. (See Tables 13–18)

In FY 2012, the hospital sample consisted of 102 validation surveys. In this sample, 50 facilities were cited at the condition-level by the SAs. Physical Environment was the most prevalent condition-level deficiency cited by the SAs with 33 SA condition-level citations. The AOs missed 30 comparable deficiencies for Physical Environment. The findings regarding Physical Environment were similar in FYs 2010 and 2011.

In FY 2012, the next most frequently SA-cited conditions were: Patient Rights and Infection Control, each with eight SA condition-level citations. The AOs missed eight comparable deficiencies for Patient Rights and four comparable deficiencies for Infection Control.

The first psychiatric hospital accreditation program was approved in FY 2011. Therefore, FY 2012 was the first year validation surveys were conducted for this program. In FY 2012, the psychiatric hospital

sample consisted of eight validation surveys. In this sample, six facilities were cited at the condition-level by the SAs. Physical Environment was the most prevalent condition-level deficiency cited by the SAs with four SA condition-level citations. The AO missed four comparable deficiencies for Physical Environment.

In FY 2012, the psychiatric hospitals surveyed were also cited at the condition-level by the SAs one time for each of six other health conditions: Governing Body, Patient Rights, Nursing Services, Food and Dietetic Services, Infection Control, and Special Medical Requirements for Psychiatric Hospitals. Four of these condition-level deficiencies cited by the SA were also missed by the AO. The AOs cited comparable condition-level deficiencies for Nursing Services and Special Medical Requirements for Psychiatric Hospitals.

In FY 2012, the CAH sample consisted of 33 validation surveys. In this sample, 15 facilities were cited at the condition-level by the SAs. Physical Environment was the most prevalent condition-level deficiency cited by the SAs with 10 SA condition-level citations. The AO missed nine comparable deficiencies for Physical Environment. Physical Environment was also the most frequently cited condition in FYs 2010 and 2011.

TABLE 13:

NUMBER AND TYPE OF CONDITION-LEVEL DEFICIENCIES CITED ON 60-DAY VALIDATION SURVEYS HOSPITAL (FY 2012)

Medicare Conditions	Cited by State Agency	Missed by Accrediting Organization
Sample Size: 102		
Governing Body	13	9
Patient Rights	8	8
QAPI	7	5
Medical Staff	2	1
Nursing Services	5	5
Medical Record Services	2	2
Pharmaceutical Services	4	2
Food and Dietetic Services	6	6
Physical Environment	33	30
Infection Control	8	4
Discharge Planning	1	1
Surgical Services	3	2
Anesthesia Services	1	1
Outpatient Services	1	0
Rehab Services	1	1

In FY 2012, the next most frequently SA-cited condition for CAHs was for Surgical Services with five SA condition-level citations and four comparable deficiencies missed by the AO.

In FY 2012, the HHA sample consisted of 102 validation surveys. In this sample 30 facilities were cited for condition-level deficiencies by the SAs. The most frequently cited conditions were: Organization, Services, and Administration, with 12 SA condition-level citations and four comparable deficiencies missed by the AO, and Acceptance of Patients, Plan of Care & Medical Supervision, also with 12 condition-level SA citations but with eight comparable deficiencies missed by the AO.

In FY 2012, the next most frequently cited condition was Skilled Nursing Services, with 10 SA condition-level citations and five comparable deficiencies missed by the AO. Patterns were similar in FY 2011 for Skilled Nursing Services, with eight condition-

level SA citations and four comparable deficiencies missed by the AO.

In FY 2012, the Hospice sample consisted of 21 validation surveys. In this sample, two facilities were cited for condition-level deficiencies by the SAs. Quality Assessment and Home Aide & Homemaker Services were each cited at the condition-level once by the SAs and both were missed by the AO. There is no comparable data for FY 2011 as the sample size was less than five and, therefore, not reported.

In FY 2012, the ASC sample consisted of 66 validation surveys. In this sample 25 facilities were cited for condition-level deficiencies by the SAs. The most frequently cited condition was Physical Environment, with 14 SA condition-level citations. The AOs missed 11 comparable deficiencies for Physical Environment. Physical Environment was also the most prevalent SA condition-level deficiency for ACSs in FYs 2008, 2009 and 2011.

TABLE 14:

NUMBER AND TYPE OF CONDITION-LEVEL DEFICIENCIES CITED ON 60-DAY VALIDATION SURVEYS PSYCHIATRIC HOSPITAL (FY 2012)

Medicare Conditions	Cited by State Agency	Missed by Accrediting Organization
Sample Size: 8		
Governing Body	1	1
Patient Rights	1	1
Nursing Services	1	0
Food and Dietetic Services	1	1
Physical Environment	4	4
Infection Control	1	1
Special Medical Requirements for Psychiatric Hospitals	1	0

TABLE 15:

NUMBER AND TYPE OF CONDITION-LEVEL DEFICIENCIES CITED ON 60-DAY VALIDATION SURVEYS CRITICAL ACCESS HOSPITAL (FY 2012)

Medicare Conditions	Cited by State Agency	Missed by Accrediting Organization
Sample Size: 33		
Number of Beds and Length of Stay	1	1
Physical Plant and Environment	10	9
Organizational Structure	4	2
Provision of Services	3	1
Clinical Records	2	1
Surgical Services	5	4
Periodic Evaluation and Quality Assurance	2	0

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TABLE 16:

NUMBER AND TYPE OF CONDITION-LEVEL DEFICIENCIES CITED ON 60-DAY VALIDATION SURVEYS HOME HEALTH AGENCY (FY 2012)

Medicare Conditions	Cited by State Agency	Missed by Accrediting Organization
Sample Size: 102		
Patient Rights	3	1
Release of Patient Identifiable Oasis Information	1	1
Compliance with Federal, State and Local Laws	1	1
Organization, Services, and Administration	12	4
Group of Professional Personnel	4	1
Acceptance of Patients, Plan of Care & Medical Supervision	12	8
Skilled Nursing Services	10	5
Home Health Aide Services	6	0
Clinical Records	4	2
Evaluation of the Agency's Program	5	2
Comprehensive Patient Assessment	8	4

TABLE 17:

NUMBER AND TYPE OF CONDITION-LEVEL DEFICIENCIES CITED ON 60-DAY VALIDATION SURVEYS HOSPICE (FY 2012)

Medicare Conditions	Cited by State Agency	Missed by Accrediting Organization
Sample Size: 21		
Quality Assessment	1	1
Home Aide & Homemaker Services	1	1

TABLE 18:

NUMBER AND TYPE OF CONDITION-LEVEL DEFICIENCIES CITED ON 60-DAY VALIDATION SURVEYS AMBULATORY SURGERY CENTER (FY 2012)

Medicare Conditions	Cited by State Agency	Missed by Accrediting Organization
Sample Size: 66		
ASC Definition	1	0
Basic Requirements	1	1
Compliance with State Licensure	1	1
Governing Body and Management	7	5
Surgical Services	2	1
Quality Assessment and Performance Improvement	3	3
Physical Environment	14	11
Medical Staff	1	1
Nursing Services	1	1
Medical Records	1	0
Pharmaceutical Services	4	4
Infection Control	5	5

The FY 2010 60-day validation sample did not include ASCs. The next most frequently cited conditions were Governing Body and Management, cited 7 times by SAs and missed 5 times by AOs, and Infection Control, cited 5 times by SAs, all of which were missed by AOs. Pharmaceutical Services was cited 4 times and Quality Assessment and Performance Improvement 3 times, and in both cases all citations were missed by the AOs.

Comparison of Deficiencies for Physical Environment and Other Health Conditions

The second analysis compares the validation results for condition-level deficiencies for Physical Environment conditions with the results for condition-level deficiencies for all other conditions and yields two disparity rates for each type of facility. (See Tables 19 and 20)

In FY 2012, Physical Environment continued to have a significant impact on each facility type's overall disparity rate. The FY 2012 results continue to show that the Physical Environment condition is still the single largest driver of the disparity rate for hospitals, psychiatric hospitals, CAHs, and ASCs. For all facility types in Table 20, the range of disparity rates based on the Physical Environment condition are between one and 25 percentage points higher than the disparity rates calculated based on all other health and safety conditions. Physical Environment is an extremely significant driver of the disparity rate for psychiatric hospitals, yielding a 25 percentage point difference between the Physical Environment and All Other Conditions disparity rates. There is a six percent point difference for hospitals and CAHs, and a one percentage point difference for ASCs.

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. In March 2011, they presented actionable information to assist the AOs in strengthening their National Fire Protection Association (NFPA) Life Safety Code (LSC) survey processes. The majority of the physical environment disparity consists of LSC deficiencies, and the CMS engineers identified the top 10 disparate LSC deficiencies cited by the SA, but not cited by the AO. These top 10 deficiencies are consistent with the findings from FYs 2011 and 2012 validation surveys as well.

The AOs have had specific difficulty missing conditions that SAs have cited related to the LSC

2000 edition requirements that CMS has adopted as part of its health and safety standards. Fire safety requirements are statutorily mandated for hospitals. CMS has been working with all AOs to provide guidance on the source of this problem and possible ways to improve performance. CMS has continued to discuss with the AOs their concerns as well as their performance in the area of evaluating health care facility safety from fire. CMS is also weighing the possible benefits and appropriateness of updating Federal regulations to reflect the NFPA's most recent version of the LSC, i.e., the 2012 version. While we do not believe that the difference in LSC editions accounts for AOs' problems in identifying LSC deficiencies, this is an issue that AOs, as well as the hospital industry, has raised and which could affect the survey process.

Comparison of Deficiencies and Disparity Rates for Long Term Care Hospitals (LTCHs) and All Other Hospital Subtypes

In 2010, CMS became concerned about the quality of care provided in LTCHs based on available SA survey findings. In last year's report to Congress, CMS reported on the analysis of mid-cycle validation surveys for 33 LTCHs. The Government Accountability Office (GAO) recommended in a 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.⁶ (See Tables 21 and 22) We attempted to increase the LTCH sample size for 60-day representative sample surveys, but are limited in our ability to do so by the scheduling of LTCH Medicare accreditation surveys by the AOs, as well as the concentration of LTCHs in certain states. The fixed surveyor capacity of SAs makes it impractical for SAs in those states to conduct a larger number of validation surveys.

There is little difference between the overall disparity rates in LTCHs and all other hospital subtypes. However, when comparing the drivers of the disparity rate, Physical Environment is a bigger driver of the disparity rate in non-LTCH hospitals. In contrast, the other health and safety requirements are bigger drivers of the disparity rate in LTCHs. Excluding Physical Environment, the most frequent disparate condition-level deficiencies for all other hospital subtypes are Patient Rights, Governing Body, Food and Dietetic Services, and QAPI. Governing Body, Infection Control, and Nursing Services are the most frequent disparate condition-level deficiencies for LTCHs.

⁶ "Long-Term Care Hospitals: CMS Oversight is Limited and Should be Strengthened," Government Accountability Office, GAO-11-810, September, 2011.

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TABLE 19:

NUMBER OF 60-DAY VALIDATION SURVEYS FOR FACILITY TYPES WITH LSC REQUIREMENTS (FY 2012)

Validation Survey Analysis	Hospital	Psych Hospital	Critical Access Hospital	Ambulatory Surgery Center
60-Day Validation Surveys	102	8	33	66

TABLE 20:

NUMBER OF 60-DAY VALIDATION SURVEYS FOR FACILITY TYPES WITH LSC REQUIREMENTS (FY 2012)

Validation Survey Analysis	Hospital All Other CoPs	Hospital PE	Psych Hospital All Other CoPs	Psych Hospital PE	CAH All Other CoPs	CAH PE	ASC All Other CoPs	ASC PE
SA: Condition-level Deficiencies	26	33	3	4	9	10	14	13
Missed by AO	23	30	2	4	7	9	11	12
Disparity Rate	23%	29%	25%	50%	21%	27%	17%	18%

TABLE 21:

NUMBER OF 60-DAY VALIDATION SURVEYS AND OVERALL DISPARITY RATE LONG TERM CARE HOSPITALS AND ALL OTHER HOSPITAL SUBTYPES (FY 2012)

Validation Survey Analysis	LTCHs	All Other Hospitals
60-Day Validation Surveys	11	91
Overall Disparity Rate	45%	45%

TABLE 22:

COMPARISON OF 60-DAY HEALTH AND PHYSICAL ENVIRONMENT VALIDATION SURVEY RESULTS FOR LONG TERM CARE HOSPITALS AND ALL OTHER HOSPITAL SUBTYPES (FY 2012)

Validation Survey Analysis	LTCHs	All Other Hospitals	LTCHs	All Other Hospitals
SA: Condition-level Deficiencies	4	3	22	30
Missed by AO	4	3	19	27
Disparity Rate	36%	27%	21%	30%

SECTION 5: AO Performance Measures

AO Reporting Requirements

A major focus of CMS' ongoing work with each AO is monitoring and improving the AO's ability to provide CMS with complete, timely, and accurate information regarding deemed status facilities, as required at 42 CFR 488.4. It is important that AOs and CMS be able to accurately determine a facility's Medicare accreditation status on an ongoing basis. This information is vital for CMS to identify which facilities have deemed status and are, therefore, subject to AO versus SA oversight. Additionally, when an AO makes an adverse Medicare accreditation program decision based on a 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 to effectively implement the validation program. To this end, AOs must submit to CMS:

- Monthly survey schedules which document the surveys that were completed for the previous month, and those scheduled for the current and following months;
- A quarterly report of all data pertaining to all Medicare accreditation and enforcement activity for the quarter;
- Facility notification letters for all Medicare accreditation program actions and any follow-up communication associated with those facility notification letters; and
- Responses to any formal correspondence from CMS.

CMS employs several methods to facilitate obtaining this information.

In addition to the provision and ongoing improvement of ASSURE, CMS provides AOs with:

- Information on the essential elements that must be included in an AO facility notification letter regarding a facility's Medicare accreditation status, to facilitate AO communication with CMS;
- Dedicated electronic mailboxes for AO submission of copies of facility notification letters concerning their Medicare accreditation program status; and
- Comparative analysis and feedback on the accuracy and completeness of AO notification letters and deemed facility data contained in ASSURE. This includes whether the facilities in ASSURE could be matched to certified facilities in CMS' national Medicare certification database,

SPOTLIGHT



SPOTLIGHT ON PROGRAM IMPROVEMENT INSTITUTING AND UPDATING ASSURE

CMS instituted the Accrediting Organization System for Storing User Recorded Experiences (ASSURE) in FY 2010. This electronic Medicare accreditation database facilitates timely, accurate, and complete AO quarterly reporting on their Medicare accreditation program activities. The ASSURE application provides CMS with a system for collecting, analyzing, and managing data regarding the facilities accredited by the AOs. In FY 2012, CMS continued work to transition ASSURE from a desktop to a web-based platform. This new platform will increase the accuracy of the ASSURE data by consolidating multiple databases and reducing the opportunities for error. Web-ASSURE was implemented May 2013. Monthly AO data submissions are now required. Thus, data lag time has been reduced.

and whether the data is consistent with information provided in the notification letters.

AO Performance Measures and Scoring

In FY 2009, CMS instituted performance measures for AOs and reviews and updates measures annually. The measures provide CMS with a method of assessing each AO's ability to provide CMS with timely, accurate and complete information regarding the various aspects of their work to survey and monitor facilities, and to enable CMS to determine the Medicare accreditation status of certified health care facilities.

Each performance measure is scored on a quarterly basis. For survey schedule measures, the quarterly score is calculated based on monthly scores. Annual scores are the average of all four quarterly scores. Measures are scored as a percentage of correct submissions for a specific month/quarter.

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FY 2012 AO Performance Measures

In FY 2012, AOs were scored on their performance on 13 measures in four key performance focus areas: ASSURE Database; Facility Notification Letters; Survey Schedule; and Formal Correspondence. (See Table 23)

TABLE 23:

FY 2012 AO PERFORMANCE MEASURES

ASSURE DATA BASE

AOs are required to use the ASSURE electronic database to record all AO Medicare accreditation program activity, including enforcement activity and to submit to CMS a quarterly export file of this ASSURE data. Performance in this area was based on:

- The accuracy and completeness of deemed facility data in ASSURE as measured by:
 - The number of CMS Certification Number (CCNs) present (not missing >180 days)
 - The number of pending surveys (not >180 days)
- The timeliness of conducting triennial (renewal) surveys

FACILITY NOTIFICATION LETTERS:

AOs are required to electronically submit facility notification letters to CMS for all Medicare accreditation program actions in CMS-approved programs. Performance in this area was based on:

- The accuracy and completeness of the letters submitted as measured by:
 - All required attachments are included
 - Only required notifications are included
 - Do not contain duplicate notices
 - Contain all information requested by CMS
- Whether the ASSURE facility list is updated with information consistent with facility notification letters
- Whether data is corrected in ASSURE to address CMS-identified deficiencies from the previous quarter

SURVEY SCHEDULE:

AOs are required to submit a monthly schedule which documents surveys completed in the past month as well as scheduled surveys for the current and next two months. Performance in this area is based on:

- The accuracy of monthly survey schedules (specifically, 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)
- The timeliness of reporting changes in the survey schedule and incorporating these changes in the next survey schedule submission (and in the proper format)
- The accuracy of the data in ASSURE regarding number of surveys reported as completed for the quarter and the number of surveys actually completed each quarter

FORMAL CORRESPONDENCE:

AOs are required to submit a monthly schedule which documents surveys completed in the past month as well as scheduled surveys for the current and next two months. Performance in this area is based on:

- The timely responses to formal correspondence (on or before the specified due date)

Significant Changes for FY 2012 AO Performance Measures

Retired FY 2011 Performance Measures

CMS retired 11 of the FY 2011 performance measures in three key performance focus areas. After conducting a thorough review and evaluation of past performance, CMS determined that the AOs had consistently scored at 100 percent on these measures for the previous two years.

1. ASSURE DATABASE

- Timeliness of providing ASSURE Export File
- Error free ASSURE Export file
- Data includes deemed facilities only

2. FACILITY NOTIFICATION LETTERS

Electronic submission of facility notification letters:

- Are forwarded on an ongoing basis
- Are submitted for every deemed program
- Have a complete subject line

3. SURVEY SCHEDULES

- Timeliness of submission
- Consistent formatting
- Forwarded survey schedule for all deemed programs includes both prospective and retrospective surveys
- Include information for all deemed programs
- Do not include surveys scheduled for non-deemed providers or suppliers, or surveys other than initial or reaccreditation surveys

Expanded FY 2011 Performance Measure in FY 2012

CMS expanded one FY 2011 performance measure in one key performance focus area.

1. ASSURE DATABASE

The measure regarding accuracy and completeness of deemed facility data in ASSURE required a CMS Certification Number (CCN) for every facility. It was expanded in FY 2012 to measure:

- The number of CCNs present (not missing >180 days)
- The number of pending surveys (not > 180 days)

New FY 2012 Performance Measures

CMS added four new performance measures in two key performance focus areas.

1. FACILITY NOTIFICATION LETTERS

Electronic submission of facility notification letters:

SPOTLIGHT



SPOTLIGHT ON PROGRAM IMPROVEMENT UPDATING AO PERFORMANCE MEASURES

CMS reviews and updates the specific AO performance measures annually. This results in a dynamic set of measures that allows CMS to update its assessment of AOs based on areas that AOs have consistently demonstrated achievement or continued opportunity for improvement, and as CMS may change programmatic or operational requirements that impact AOs. In FY 2012, CMS made significant changes to the measures previously used. Many measures were retired that were initially used to ensure that data was being submitted in what was then the newly instituted desktop ASSURE database. Additionally, in FY 2012, several new performance measures were added and a new category of measurement was instituted regarding AO response to formal correspondence from CMS.

- Includes all required attachments
- Includes only required notifications
- Does not contain duplicate notices

2. FORMAL CORRESPONDENCE

(which is also a new key performance focus area)

- Timely responses to formal correspondence

Performance Measure Results

The FY 2012 performance data for each AO is presented below in two tables. The first table presents results for performance measures that were monitored in both FYs 2011 and 2012. A comparison is presented by AO for these two fiscal years. The second table presents results for performance measures specific to FY 2012 due to the addition of new measures for this fiscal year or the modification of measures from the previous year. Therefore, the data in the second table cannot be directly compared to the FY 2011 performance measures results and are presented independently. Both tables present the performance measures according to the key focus areas. All results include quarterly

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averages utilizing standard rounding rules. The data represent the percent frequency with which the task required by the measure was performed in an

accurate, timely, complete manner. (See Tables 24 and 25) A discussion of the performance measure scoring and results follows the tables.

TABLE 24:

PERFORMANCE MEASURE RESULTS (PERCENTAGE) BY AO COMPARABLE MEASURES FOR FYs 2011 AND 2012

	AAAHC		AAAASF		ACHC		AOA / HFAP		CHAP		DNVHC		JC		All AOs	
	FY11	FY12	FY11	FY12	FY11	FY12	FY11	FY12	FY11	FY12	FY11	FY12	FY11	FY12	FY11	FY12
ASSURE Database																
Timely triennial surveys	100	100	100	100	99	99	91	97	100	100	100	99	100	99	98	99
Facility Notification Letters																
ASSURE updates are consistent with letters*	93	96	47	40	70	100	57	60	87	79	100	90	78	66	76	76

* Measure calculated for the last two quarters of FY 2012.

TABLE 25:

PERFORMANCE MEASURE RESULTS (PERCENTAGE) BY AO FY 2012 (Not Comparable to FY 2011 Measures)

Performance Measures	AAAHC	AAAASF	ACHC	AOA / HFAP	CHAP	DNVHC	JC	All AOs
ASSURE Database								
Number of CCNs present (not missing >180 days)	97	100	98	100	99	100	96	99
Number of pending surveys (not > 180 days)	100	100	100	100	100	100	100	100
Facility Notification Letters								
Letters submitted with attachments	97	100	100	100	98	100	100	99
Only required notifications submitted	100	100	100	100	100	100	96	99
No duplicate notices submitted	100	100	100	100	100	100	100	100
Contain all required information	94	97	100	100	98	100	98	98
ASSURE data corrected according to CMS-identified deficiencies from previous quarter*	N/A	48	63	10	0	0	28	25
Survey Schedule								
AO conducted survey as reported on survey schedule	100	92	100	100	100	100	100	99
Timely submission of schedule changes and proper incorporation into the next monthly schedule.	100	100	100	92	100	100	100	99
Number of surveys performed matches number reported in ASSURE	97	74	93	35	100	97	92	84
Formal Correspondence								
Responses to CMS on or before specified due date	100	100	100	96	100	89	100	98

N/A: No discrepancies to correct

* Measure calculated for the last two quarters of FY 2012.

Scoring:

- “Performed well” means a 100 percent score.
- “Substantial improvement” means improved by at least nine percent in FY 2012 compared to the previous year.
- “Opportunity for improvement” means any score below 90 percent in FY 2012.
- “Lower score” means a decrease of at least nine percent in FY 2012 compared to the previous year.

Highlights**1. ASSURE DATA BASE**

- All AO scored 100 percent for the measure “Number of pending surveys (not > 180 days)
- All AOs scored at the 96 percent level or higher on every measure

2. FACILITY NOTIFICATION LETTERS

- All AOs scored 100 percent with no duplicate notices being submitted in the electronic submission of facility notification letters.
- All but one AO scored 100 percent in the measure “only required notifications submitted” with the overall score impacted by this one AO.
- The measure “ASSURE updates are consistent with letters,” had mixed results with several AOs showing opportunity for improvement while several others scored 90 percent or above.
- All AOs showed significant opportunity for improvement on the measure, “ASSURE data corrected according to CMS-identified deficiencies from previous quarter.

3. SURVEY SCHEDULE

- All but one AO achieved a 100 percent score on two of the three measures
- The measure “number of surveys performed matches the number reported in ASSURE” shows the opportunity for improvement for most AOs.

4. FORMAL CMS CORRESPONDENCE

- A new performance measure for FY 2012, the average score for all AOs was 98 percent. The majority of AOs scored 100 percent with the overall score largely affected by one AO.

CMS continues to work closely with AOs to improve performance in areas that need improvement as well as to 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

to ensure that AOs are effectively managing their Medicare accreditation programs and communicating vital program information to CMS.

AO Specific Discussion

AAHC: For the performance measures that can be compared to FY 2011 scores, AAHC once again performed well with regard to timely triennial surveys and showed a slight improvement in updating ASSURE consistent with facility notification letters. In summary, AAHC reached the 100 percent level on eight of 13 measures in FY 2012.

AAAASF: For the performance measures that can be compared to FY 2011 scores, AAAASF once again performed well with regard to timely triennial surveys and scored somewhat lower in FY 2012 in updating ASSURE consistent with facility notification letters. In summary, AAAASF reached the 100 percent level on eight of 13 measures in FY 2012.

ACHC: For the performance measures that can be compared to FY 2011 scores, ACHC received the same high score with regard to timely triennial surveys and showed substantial improvement in updating ASSURE consistent with facility notification letters reaching the 100 percent performance level on this measure. In summary, ACHC reached the 100 percent level on nine of 13 measures in FY 2012.

AOA/HFAP: For the performance measures that can be compared to FY 2011 scores, AOA scored higher with regard to timely triennial surveys and once again has opportunity for improvement in updating ASSURE consistent with facility notification letters. In summary, AOA/HFAP reached the 100 percent level on seven of 13 measures in FY 2012.

CHAP: For the performance measures that can be compared to FY 2011 scores, CHAP once again performed well with regard to timely triennial surveys and once again has opportunity for improvement in updating ASSURE consistent with facility notification letters. In summary, CHAP reached the 100 percent level on eight of 13 measures in FY 2012.

DNVHC: For the performance measures that can be compared to FY 2011 scores, DNVHC had a slightly decreased level of performance with regard to timely triennial surveys and a lower score in updating ASSURE consistent with facility notification letters. In summary, DNVHC reached the 100 percent level on eight of 13 measures in FY 2012.

JC: For the performance measures that can be compared to FY 2011 scores, the JC had a slightly

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decreased level of performance with regard to timely triennial surveys and a lower score in updating ASSURE consistent with facility notification letters that once again shows opportunity for improvement. In summary, the JC reached the 100 percent level on six of 13 measures in FY 2012.

SECTION 6: CMS Oversight Activities

The number of CMS-approved Medicare accreditation program options for health care facilities has grown significantly since 2007. By FY 2012, there were seven CMS-recognized AOs and 19 approved Medicare accreditation programs covering eight facility types. The volume of facilities that participate in the Medicare programs through accreditation by a CMS-approved accreditation program continued to grow in FY 2012. Currently, 36 percent of all Medicare-participating facilities with an approved Medicare accreditation program option, more than 12,000 facilities, demonstrate compliance with the Medicare requirements and participate in the Medicare program via deemed status.

CMS has continued to strengthen its program oversight. CMS has worked to enhance systems and processes to ensure the completeness and accuracy of the data exchange between AOs and CMS regarding deemed status facilities to facilitate the management and analysis of that data. In FY 2012, CMS focused on a number of key areas in order to continue to refine and maintain an effective oversight infrastructure:

- CMS/AO Communication and Relationship Building
- AO Education
- AO Performance Management
- Deemed Status Facility Data
- CMS Program Updates

CMS/AO Communication and Relationship Building

Communications

CMS continues its periodic meetings with AOs with approved Medicare accreditation programs, 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 status 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 e-mail or telephone, to address a wide variety of issues related to deemed status facilities, operations, surveys, requirements, interpretation of regulations, and data exchange.

Consultation

CMS has 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.

AO Education

CMS affords AO staff 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 meetings continue to include breakout sessions by program type and interactive sessions. In FY 2012, CMS provided a comprehensive update to the AO resource manual. This manual contains a wide variety of information on CMS requirements and expectations of AO Medicare accreditation program performance.

AO Performance Management

Deeming Application, Standards, and Survey Process Reviews

Deeming application, standards, and survey process 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 Medicare accreditation program 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 2012, the team completed seven deeming application reviews (two applications were considered incomplete and one was withdrawn prior to publication). Other deeming program review activity included three performance reviews, 20 standards reviews, and five survey process and surveyor guidance revisions. CMS also identified

and addressed 22 issues outside an application review that arose in case-specific instances which suggested problems with the manner in which an AO implemented its Medicare accreditation program. Through this case-based process, CMS facilitated resolution of issues, and improved AO performance and oversight of deemed status facilities. (See Section 1 for discussion of CMS review of AO Medicare accreditation programs.)

AO Performance Measures

CMS continues to refine and improve the current methods for measuring AO performance in assuring compliance with the Medicare requirements. Measures are calculated and shared with individual AOs on a quarterly basis. Measures are reviewed, evaluated and updated on an annual basis.

CMS works to ensure the AOs receive education and guidance regarding the use and analysis of the measures. At the CMS-AO meeting in FY 2012, AO staff 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 and data issues, as well as how to improve their documentation.

CMS also strives to ensure the performance measures appropriately challenge the AOs to achieve and improve their performance. For FY 2012, CMS made significant changes to the measures, including retiring numerous measures, adding new and expanded measures, and adding a new key performance focus area. These changes are part of CMS' ongoing effort to ensure AO accountability, continuous improvement and higher levels of achievement. (See Section 5 for discussion of FY 2012 AO Performance Measures and the retired or expanded FY 2011 measures.)

Deemed Status Facility Data

CMS continues to focus on obtaining complete, accurate and timely data from AOs on facilities accredited under their CMS-approved Medicare accreditation 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 status facilities to CMS on a quarterly basis. The ASSURE database provides both CMS and the AOs with the means to collect, analyze, and manage information regarding deemed status facilities, and supports CMS oversight of the AOs and their Medicare accreditation programs. We note that data in the

ASSURE database has increasingly been of interest to the GAO and the Office of Inspector General when they conduct studies related to deemed status facilities.

In FY 2012, CMS made significant progress in improving the functionality of the ASSURE database. This progress included significant progress in transitioning ASSURE from a desktop to web-based application, as transition which was completed in FY 2013. This transition to a web-based application will provide increased functionality, enhanced data base integrity and security, improve processing times, and increase accessibility. The database will be more adaptable by providing the capability for more timely reporting of vital program information further enhancing program oversight. (See Section 5 for discussion of instituting and updating the ASSURE database).

CMS Program Updates

ASC Conditions for Coverage

In FY 2012, CMS published two final rules that revised the ASC CfCs. The first final rule entitled "Changes to the Ambulatory Surgical Centers Patient Rights Conditions for Coverage," released October 24, 2011, contained revisions to the ASC patient rights CfCs (76 FR 65886). The second final rule entitled "Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction," released May 16, 2012, contained revision to the ASC emergency equipment and infection control CfCs (77 FR 29002). In accordance with the requirements at § 488.4(b)(3)(iv), CMS requested and reviewed AAAASF's, AAAHC's, AOA/HFAP's and the JC's revised Medicare ASC accreditation program standards, surveyor tools, and documents, and relevant surveyor training to ensure their standards continued to meet or exceed those of Medicare.

Hospital and CAH Conditions of Participation

The final rule entitled "Reform of Hospital and Critical Access Hospital Conditions of Participation," released May 16, 2012, contained revisions to the Hospital Governing Body, Patient Rights, Medical Staff, Nursing, Medical Records and Outpatient Services, and, Infection Control, as well as clarifying changes to the Pharmaceutical and Surgical Services and Personnel Qualifications. It also contained revisions to the CAH conditions related to Definitions, Physical Plant and Environment, Provision of Services and Surgical Services. (77 FR 29034) CoPs. In accordance with the requirements at § 488.4(b)(3)(iv), CMS requested and reviewed

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AOA/HFAP's, DNVHC's, and the JC's revised hospital and CAH Medicare accreditation program standards, surveyor tools, and documents, and relevant surveyor training to ensure their standards continued to meet or exceed those of Medicare.

Validation Program Sample Size

In FY 2012, 332 representative sample validation surveys were conducted across all deemed status providers and suppliers, with the exception of RHCs and OPTs. This represents a 36 percent increase since FY 2007, when only 90 validation surveys were performed. Not only has the total number of representative sample validation 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. (See Section 4 for discussion of the Accreditation Validation Program and the increase in the number of validation surveys from FYs 2007 to 2012.)

SECTION 7: AO Self-Reported Program Improvements

Accreditation Association for Ambulatory Health Care (AAAHC)

Process Improvements

AAAHC shifted to a single term of accreditation model in 2012. Every accredited organization now receives a three-year term of accreditation. With this single term of accreditation, AAAHC created a method of oversight that incorporates the plan of correction and includes follow-up activity as necessary. When deficiencies are cited through the AAAHC/Medicare Deemed Status survey, an ASC is required to submit an acceptable plan of correction. Depending on the severity of the deficiencies, an ASC may also be required to undergo an interim survey.

Performance Measures

AAAHC is proud of its record of consistently high scores. With respect to complete data for CCNs, AAAHC has regularly scored 95 percent to 99 percent. AAAHC continues to confirm CCNs with the CMS Regional Offices, in addition to communicating directly with the ASCs. AAAHC strives for a rating of 100 percent for all performance measures and will continue to work with CMS to ensure that all data is accurate and timely.

Education

AAAHC maintains resources to assist ASCs in understanding and meeting CMS requirements. We communicate to ASCs through newsletters, e-mail blasts, and website links. The AAAHC website allows for web-based resources to be easily and continually updated. AAAHC continues to provide quarterly face-to-face education programs with focused sessions on issues related to the CfCs. AAAHC surveyors are provided access to the resources for ASCs, as well as to surveyor-specific resources and educational tools that provide in-depth information on CMS requirements. Weekly e-mail communications and online training provide updates on CMS requirements, as needed.

Disparity Rate Analysis

AAAHC conducts ongoing, in-depth analysis of validation and accreditation/deemed status survey findings. The analysis compares data received from validation surveys conducted by regional authorities with AAAHC survey documents. Through this analysis, AAAHC continues to identify opportunities to reduce disparities and improve survey processes and education.

The American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

AAAASF Growth

AAAASF is very proud of the growth of all three of its CMS-approved accreditation programs, particularly the Outpatient Physical Therapy (OPT) and Rural Health Clinic (RHC) programs. By the close of FY 2012, these programs included 55 and 18 facilities nearing deemed status after only 17 and six months of existence respectively. The AAAASF Board of Directors' commitment to patient safety is evident in the care that AAAASF has taken in implementing these new programs as well as in its commitment to constantly improving the performance of the ASC accreditation program. During FY 2012, AAAASF added two dedicated staff members to its Medicare Accreditation Department and restructured the Medicare Accreditation team to include a Medicare Accreditation Manager. The new size and organization of the Medicare Accreditation Department creates sufficient capacity to accommodate continued growth while ensuring daily and detailed oversight at a management level. Finally, AAAASF has added a Director level staff member to focus on the rapid development in the OPT and RHC programs. This organization

has established a reputation of fair but stringent application of the standards and conditions for coverage that is now serving the OPT and RHC communities in addition to ASC providers.

The Importance of Peer Review

AAAASF continues to work to incorporate the OPT Medicare Accreditation Program into our nationally recognized Peer Review Patient Data System and will begin to do the same with the RHC program. Over the past decade, AAAASF has captured pertinent patient safety data on over eight million patient procedures conducted in accredited facilities. This data, collated by specialty provides vital statistical information to public agencies, academia, and private institutions to inform vital patient safety and outcomes discussions and drive the revision of standards. Going into the future, AAAASF will continue to collect this data by specialty areas for all of our approved Medicare-deemed programs, maintaining AAAASF's unique position of strength as a clearinghouse for data related to outpatient care. In 2012, AAAASF and its partners undertook efforts to create the next generation of the Peer Review system, which will carry data collection and patient safety analysis to a new level of sophistication.

Data Tracking Systems

AAAASF has improved the automation of several ASSURE reporting fields and has experienced a dramatic improvement in performance measures related to ASSURE reporting. The AAAASF staff has continued dialogue with CMS contact personnel to maintain continuity in the data reporting relationships and to improve compliance with performance measures related to notification letters, survey scheduling, and data matching between CMS and AAAASF internal databases. AAAASF staff interacted and collaborated with Regional Office staff on data transfer and reporting with a higher frequency than ever before.

The AAAASF performance scores continue their annual improvement due in large part to internal upgrades. AAAASF recently updated all data synchronization processes with the ASSURE system and has taken considerable steps to ensure the validity and accuracy of its data in preparation of the migration to the web-based ASSURE platform. Information technology staff concentrated on improving the flexibility of the AAAASF data systems to accommodate the disparate information related to the various deemed programs and to improve the ability of the organization to accommodate new programs in the future.

AAAASF has standardized many internally generated forms and letters in an effort to provide more consistency to the regional and state offices with which the organization interacts. AAAASF has also made strides to formalize and improve internal reporting structures and audit functions to achieve more reliable real-time monitoring of all aspects of the accreditation programs including facility resurvey schedules, common citations, surveyor performance, and compliance issues. This internal performance focus contributed to the decision to add a full-time staff member to serve as the Manager of Data Analysis. This team member is dedicated to fostering the improvement of the accreditation process and administration of accreditation programs through the aggregation and analysis of collected data.

Surveyor Education

Surveyor Training New Programs and ASC

Update: AAAASF has developed two new surveyor training courses for the OPT and RHC program with format that includes interactive training segments on critical surveyor skill sets including "Record Review" and "Principles of Documentation." The training course incorporates in-depth, interactive training segments as well as lecture segments with a complete review of CMS regulatory requirements and AAAASF OPT and RHC Medicare Program Standards. A competency examination is administered at the conclusion of the course. To complete the certification process, 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. The ASC surveyor training program has been updated with the latest regulatory changes released in 2012.

Web Academy New Programs and ASC Update

AAAASF launched the Surveyor Web Institute for Facilitated Training (SWIFT) web-based education platform in 2011. The training site is updated periodically and currently contains modules for the Medicare ASC 2012 regulatory changes, OPT and RHC programs. 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 on-site surveys. The SWIFT web-based platform is used by the Director of

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Education and the Education and Quality Assurance Committee Chairs to 'track' surveyors' compliance with continuing education requirements necessary to maintain surveyor certification. This technology allows AAAASF to deliver educational content in an expeditious manner.

OPT Program Accreditation Essentials Course

A new OPT Accreditation course has been developed by AAAASF and was presented in October 2012. The content was created with dual purposes—first, to give prospective surveyors an overview of the accreditation health survey process and, secondly, to provide AAAASF Medicare OPT facilities with the information essential for successfully achieving accreditation and 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 various reporting systems. In addition to the existing surveyor educational compliance measures, the committee has published revised scoring tools to collect survey team performance data from surveyed facilities. The Committee has also implemented tools to assess the performance and responsiveness of individual survey team members and to collect feedback from survey observers and validation teams. The Committee oversees and reviews all compliments, comments and complaints received by AAAASF staff concerning surveyors, and manages surveyor retraining accordingly. With improved measurement tools and reporting, the Committee is better equipped to assess the performance of AAAASF surveyors and the consistency of AAAASF's Surveys.

Electronic Resources

The AAAASF website has been redesigned and enhanced to allow easy access to our Medicare program materials and other programs. AAAASF has updated and improved an internet user's ability to download needed forms and documents from the Web. The AAAASF Resource Guide is available online 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. AAAASF has committed to improving its electronic resources and has begun to evaluate various system upgrades.

Future Focus

The AAAASF Board of Directors steadfastly continues to support its aggressive five-year Strategic Plan for continued growth in partnership with the Medicare sector. AAAASF has dedicated many staff and resources to educate the provider groups in new program areas about the concepts related to utilizing a deeming authority. It is a goal of AAAASF to ensure a seamless transition from state administration while creating a collaborative environment with the various state Agencies, Regional Offices, and Central Office staff.

Accreditation Commission for Health Care (ACHC)

ACHC inspires excellence in health care 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 on-site 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, sustaining fiscal growth and improving market presence.

Improved Surveyor Education

ACHC conducts an interactive format for annual training which provides an engaging experience for surveyors.

Provider Education

This year, ACHC has concentrated on educating agencies about 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 of Participation. 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 comprehensive.

The American Osteopathic Association/ Healthcare Facilities Accreditation Program (AOA/HFAP)

Staffing and Resources

Account Manager Position Created: The primary responsibility of the Account Manager is to interact with customers during the entire accreditation process, to assure timely and accurate submissions of applications; plans of corrections; and interim progress reports.

Standards Interpretation Staff (SIS): HFAP added staff, with extensive accreditation standards background, specifically dedicated to standards interpretation, to ensure consistency in information being released by HFAP to our accredited facilities and surveyors, educating our facilities, and conducting on-site presentations, providing answers to FAQs submitted by accredited facilities.

Life Safety Code Surveyor Expert: HFAP contracted with a consultant to assist with surveyor training on Life Safety Code (LSC) for all programs, as well as updating LSC policies and procedures.

Accreditation Manual Improvements

HFAP updated the standard scoring options in the accreditation manuals for Acute Care Hospitals, Critical Access Hospitals and Ambulatory Surgical Centers:

- 1 = Compliant
- 2 = Not Compliant
- 3 = Not Applicable

Implementation of the Electronic Application:

HFAP notified our customers that starting January 1, 2012, we would only accept applications for accreditation and certification electronically through our website <http://www.hfap.org/>. This would result in faster, more efficient service to our facilities, as well as a quicker way for HFAP staff to process their information.

Implementation of Standardized Tools for Facility Responses

Interim Progress Report (IPR) Instructions and Template: Facilities that are required to submit IPRs will now be provided an Interim Progress Report Template, which must be completed. This template will lend consistency to the submission of IPRs and the contents contained in the IPR to demonstrate sustained/continued compliance with specific standards identified by the Executive Committee of the AOA Bureau of Healthcare Facilities Accreditation (BHFA).

Plan of Correction Instructions and Template. HFAP developed and implemented a clearly delineated method for responding to requests for Plan(s) of Correction (POCs) to demonstrate compliance with HFAP standards. HFAP has introduced specific instructions as to how information must be submitted to the HFAP Central Office and now requires that facilities use a formatted template to document their response.

Accreditation Surveys

HFAP implemented the policy to conduct extension surveys when an accredited facility acquires a new service, program or site.

Post Survey

Implementation of the "10 and 10" Methodology for Granting Accreditation: This process now requires facilities to respond to all citations within 10 calendar days. This change requires a POC for all deficiencies within this timeframe. Once a POC has been accepted by HFAP, the facility will be required to submit IPRs in order to demonstrate continued movement toward compliance and/or sustained compliance, as outlined by the written process for IPRs. Benefits of this change include:

- An HFAP program more closely aligned to the requirements put forth by CMS;
- A more realistic expectation of the correction of deficiencies cited;
- A decrease in the turn-around time for making accreditation decisions; and
- A more long-term and robust approach to assuring that POCs are actually implemented by the facility.

Restructuring the Executive Committee

HFAP restructured the entire method for how accreditation/certification decisions are rendered by its Executive Committee of the BHFA.

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Complaint Process

During January 2012, policies and procedures were reviewed and revised to ensure a robust Complaint Committee was established.

Internal Quality Audit Process: Monthly audits are completed by clinical staff and account managers to ensure quality and accuracy of processes. Improvements are driven by information derived from the audit process. Audits include:

- QI-01 Clinical Deficiency Audit 2012 v1.
- QI-02 Complaint Process Audit 2012 v1.
- QI-03 PoC and IPR Process Audit 2012 v1.
- QI-04 Review Process Audit 2012 v1.

Community Health Accreditation Program (CHAP)

Training and Education

- Provided training to Site Visitors to increase inter-rater reliability including training on: survey techniques, use of CHAP's accreditation software, standards interpretation and application, and review and analysis of deficiencies and condition-level findings.
- Performed regular in-service orientation training for new Site Visitors.
- Conducted a series of provider education trainings focused on the accreditation process and requirements related to compliance.
- Conducted in-service training with CHAP internal staff on CMS-related policies and processes, including timeframes for follow-up reviews and documentation, and reporting to state and federal authorities.

Performance Measurement

- Analyzed validation survey findings and disparate survey findings.
- Leveraged key data to understand trends in organizational performance.
- Utilized performance metrics on CHAP's processes to better serve our customers, including data on customer service, timeliness and accuracy.

Infrastructure Development

- Continued development of the second generation of CHAP's accreditation software, including tools to enhance the application, scheduling, and site visit review process, as well as to enhance data analysis and reporting.
- Enhanced the CHAP website to support improved provider education and to disseminate

regular updates regarding standards and policies and procedures.

Det Norske Veritas Health Care (DNVHC)

Training Portfolio

We revised our training programs to focus on an approach consistent with the implementation of an effective quality management system in the hospital. This training program ties directly to our accreditation program to encompass the requirements of ISO 9001 which must be demonstrated by the hospital at the time of their re-accreditation under DNVHC. This includes understanding the relationship between the hospital's Healthcare Quality Management System and its leadership, ISO9001 requirements, and applicable DNVHC NAIHO accreditation requirements.

Surveyor Education

We have developed a program to provide cross-training for our surveyors to give them a more in-depth understanding of each discipline, particularly as this relates to the aspects of the Physical Environment. All of the full-time Generalist surveyors have successfully completed this training which includes the Life Safety Code (LSC) and National Fire Protection Association (NFPA) requirements.

Comprehensive Stroke Center Certification/Launch

Stroke Center Certifications, though non-mandatory from a national regulatory perspective, are an increasingly important way to demonstrate a stroke center's expertise and leadership within its peer group. In some states, such as Texas, the level of certification determines where trauma and EMS services will transport patients for the most appropriate reimbursable care within state health department guidelines. DNVHC has now developed a Comprehensive Stroke Center Certification Program that incorporates elements from our NIAHO® hospital accreditation standards, as well as requirements from the guidelines of the Brain Attack Coalition, and recommendations of the American Stroke Association.

The emphasis these programs place on deploying a disciplined management system, combined with the relevant clinical best practices, sets DNVHC stroke certifications apart from other programs.

Hospitals seeking and maintaining a Stroke Center Certification must participate in the Medicare

program and be in compliance with the CoPs which may be demonstrated by maintaining accreditation with DNVHC or another approved CMS-approved accreditation organization.

Collaborative Agreements with State Agencies—States of New York and Oregon

To better facilitate the accreditation and survey process with the state agencies, DNVHC has entered into Collaborative Agreements with the States of New York and Oregon. These agreements allow each state DNVHC accreditation in lieu of a state licensure survey. Not only will this better facilitate current accreditation surveys, but it will also improve the handling of the complaint process.

Re-Approval of Deeming Authority

DNVHC completed the rigorous review process for continued recognition as a national accrediting organization for hospitals that wish to participate in the Medicare or Medicaid programs. We have formally completed all of the requirements for the renewal of our deeming authority approval by CMS. DNVHC received a six-year re-approval for our deeming authority to accredit acute care hospitals. A six-year approval is the maximum allowable by law and a remarkable achievement for DNVHC.

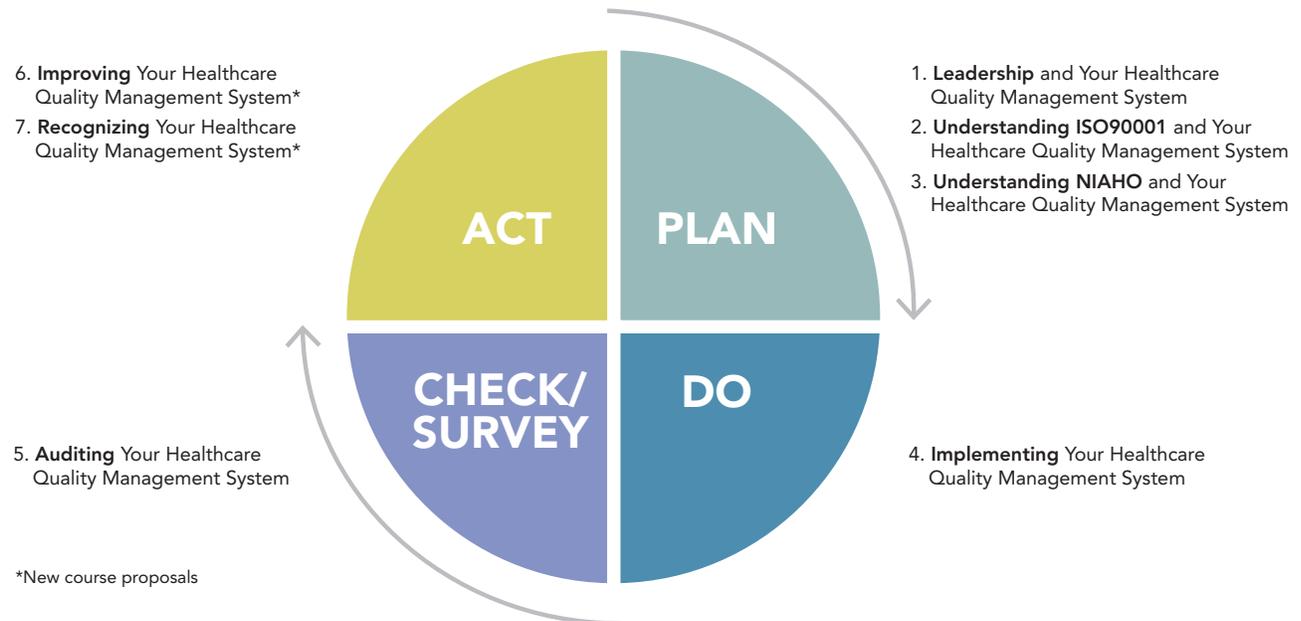
Managing Infection Risk

DNVHC developed the 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, DNVHC has developed a Managing Infection Risk Management Standard to provide a framework to help hospitals improve their management of infection risks and also to serve as a benchmark for stakeholders in setting requirements for the health care 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 DNVHC, directly ties in with the CMS Partnership for Patients initiative.

Ventricular Assist Devices—Application to CMS for Approval

On November 29, 2011, DNVHC submitted a request to CMS for reconsideration of the National Coverage Determination (NCD) for ventricular assist devices (§20.9 of NCD Manual 100.03) to include the DNVHC Mechanical Circulatory Support Certification Program as an acceptable credential as one of the criteria for facilities qualifying under this NCD. The request was accepted by CMS and the review initiated on February 7, 2013. The Proposed Decision Memo due date is August 7, 2013.

DNV BUSINESS ASSURANCE TRAINING FOR HEALTHCARE



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Strengthened Condition-Level Assessment

We have received the validation survey analyses (2567 forms) from the respective CMS Regional Offices which has led us to increase the scrutiny for applying the condition-level findings and subsequent follow-up surveys. By comparison, we have similar findings requiring plans of correction but, perhaps, categorize these differently under our nonconformities handling process. To apply more consistency to this process, we have further refined our criteria under our procedures for condition-level findings and methods for handling these under the survey process. As demonstrated in the ASSURE database, there has been a substantial increase in the number of condition-level findings in FY 2012.

Refined Complaint Handling Process

The significant increase in the number of DNV-accredited hospitals has required us to refine our complaint handling process to preserve the integrity of our program and accountability of the hospitals we accredit. We have improved the intake process and now manage it through our internal systems. This ensures that we follow up on complaints and address them with the on-site surveys and subsequent required follow-up.

Created Director of Accreditation

As we have substantially increased the number of hospitals attracted to DNVHC, it has been extremely important that we have a management structure in place to help facilitate our operations, and manage our growth. Recognizing the talent within our current staff, we have appointed one of our Team Leaders to the role of Director of Accreditation. Doing so has helped to facilitate the survey process and interaction with the surveyors and accreditation group.

Complete a Corporate Audit, ISO Internal Audit and CMS Corporate On-Site Visit

During FY 2012, DNVHC underwent a number of audits both internally and externally. In line with the similar approach and scrutiny we apply to our hospitals, we also subject ourselves to this same level of scrutiny to ensure that we have effective processes and practices in place to maintain the integrity of our accreditation program. We will similarly develop corrective/preventive action plans to address any shortcomings identified under our processes to ensure we continually improve. CMS has done this third-party review as a part of our re-approval process and through this we have demonstrated our capability and have instilled, in CMS, confidence in our accreditation process.

DNVHC continues to improve its internal processes based on communication and feedback from The Centers for Medicare and Medicaid Survey & Certification Group. The CMS Central and Regional Offices provide copies of the reports (Form 2567) for Validation Surveys completed of DNV-accredited hospitals. This in turn is provided 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 to continue meeting the expectations of CMS.

The Joint Commission (JC)

The Joint Commission is pleased to provide information on the various initiatives implemented during the past year to enhance the effectiveness of the Joint Commission's accreditation process and improve patient safety and quality. These initiatives are:

Continued recognition of the Top Performer on Key Quality Measures™ Program for hospitals and critical access hospitals that attain and sustain excellence in accountability measure performance

Almost all of the Joint Commission's accountability measures have been recognized for inclusion in the CMS' Value-Based Purchasing program. In the Joint Commission's 2012 Annual Report on Quality and Safety, 620 (18 percent) Joint Commission-accredited hospitals were identified as attaining and sustaining excellence in accountability measure performance for the previous year, 2011. This represents an increase of 50 percent from 2010 in terms of the total number of hospitals achieving this distinction, including a total of 244 hospitals that achieved the distinction for a second straight year.

Integration of performance expectations on accountability measures into accreditation standards

Joint Commission-accredited hospitals are now expected to meet a new performance improvement requirement (Standard PI.02.01.03, Element of Performance 1) that establishes an 85 percent composite compliance target rate for performance on ORYX® accountability measures. The new requirement is intended to help improve performance on ORYX core measures of patient care.

Development of updated Leadership standards that emphasize the importance of patient flow in hospitals, in particular the patient flow through the emergency department

Although overcrowding and patient boarding in the emergency department have drawn widespread attention, the revised standards make clear that the flow of patients must be managed systematically throughout the entire hospital. The new and revised requirements enhance patient safety by addressing: the use of data and metrics to better manage patient flow as a hospital-wide concern; the safe provision of care for patients should boarding occur; and mitigating risks experienced by patients with psychiatric emergencies who are boarded in the emergency department.

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. The Center introduced two new projects in 2012: 1) reducing sepsis mortality, and 2) reducing insulin-related medication errors. Early detection and appropriate treatment of sepsis can decrease mortality, improve patient outcomes and decrease the length of stay in hospitals. This project will work to address the barriers to consistent, successful implementation of treatment. Insulin errors have been associated with the highest risk of injury to patients and are identified as one of the top high-alert medications by the Institute for Safe Medication Practices (ISMP). Safe use of insulin to achieve optimal blood glucose has been directly associated with improved patient outcomes. The occurrence of these preventable adverse drug reactions and events can be reduced and insulin can be used safely to achieve optimal glycemic control for hospitalized patients. Additional resources are provided to Joint Commission customers via the Targeted Solutions Tool™, which allows facilities to share their successful practices and experiences, and helps them evaluate their own unique concerns and solutions.

Initiation of a three-year initiative to define methods for achieving improvement in the effectiveness of the transitions of patients between health care organizations, which provide for the continuation of safe, quality care for patients in all settings

All three components of The Joint Commission enterprise (The Joint Commission, Joint Commission Resources, and the Center for Transforming Healthcare) will offer various interventions and resources that are designed collectively to improve transitions of care. The interventions would apply to The Joint Commission's accreditation programs for hospitals, critical access hospitals, behavioral health care, home care, long term care, and ambulatory care settings.

Release of Targeted Solutions Tool (TST)™ by The Joint Commission Center for Transforming Healthcare for Hand-off Communications

This is a customizable tool that measures the effectiveness of hand-offs within an organization or to another facility, and provides proven solutions. The TST provides a tested and validated measurement system that produces data that support and drive the need for improving the current hand-off communication processes. The solutions are based on the work of the original 10 participating health care organizations working with the Center's Hand-off Communications Project. The problem-solving resources and interventions from the project were pilot tested at several other organizations and in a variety of care settings, and produced measurable improvement in the ability to effectively care for patients as they transition from one care setting to another.

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Introduction of Sentinel Event Alert #49: Safe Use of Opioids in Hospitals

The Joint Commission developed this complimentary publication to help health care organizations and health care professionals identify specific types of sentinel events, describe their common underlying causes, and suggest steps to prevent occurrences in the future. Opioid analgesics rank among the drugs most frequently associated with adverse drug events. Of the opioid-related adverse drug events—including deaths—that occurred in hospitals and were reported to The Joint Commission's Sentinel Event database (2004–2011), 47 percent were wrong dose medication errors, 29 percent were related to improper monitoring of the patient, and 11 percent were related to other factors, including excessive dosing, medication interactions and adverse drug reactions. These reports underscore the need for the judicious and safe prescribing and administration of opioids, and the need for appropriate monitoring of patients.

Continuing to raise awareness of the issue of surgical fire prevention

The Joint Commission participates in FDA's Surgical Fire Prevention Work Group to help identify and disseminate tools to help hospitals and ambulatory surgery centers prevent the occurrence of surgical fires when the elements of the "fire triangle" (fuel, ignition source, and oxygen) come together. Additionally, The Joint Commission has published both a Sentinel Event Alert (Issue 29—Preventing Surgical Fires) and an article in the Environment of Care News® publication to provide to the field additional guidance on surgical fire prevention.

Participation on the CDC's National Institute for Occupational Safety and Health (NIOSH), National Occupational Research Agenda (NORA), Healthcare and Social Assistance Sector Council

With support from the NORA program (contract no. 212-2010-M-35609), The Joint Commission undertook a project to develop an educational monograph entitled "Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation." The goal of the project was to stimulate greater awareness of the potential synergies between patient and worker health and safety activities. Since its release in November 2012, more than 8,700 copies have been downloaded. It is also available on the OSHA website and has stimulated additional interest in understanding the important role of worker safety in efforts to achieve patient safety in high reliability health care organizations.

Clinical Laboratory Improvement Validation Program

Introduction

This report on the Clinical Laboratory Improvement Validation Program covers the evaluations of fiscal year (FY) 2012 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 requirements⁷, 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 more than 16,000 accredited laboratories received a validation survey in 2012. 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,

⁷ 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.

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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 2012, approximately 220 laboratories used their AABB accreditation for CLIA program purposes. Validation surveys were conducted in 10 AABB-accredited laboratories. Condition-level deficiencies were cited in one of the validation surveys, and the AABB inspection report noted comparable findings, thus there was no disparity. We commend the AABB for its history of zero disparity in 14 out of the past 17 validation reviews.

American Osteopathic Association

Rate of disparity: zero percent

For CLIA purposes, approximately 80 laboratories used their AOA accreditation. Nine validation surveys were conducted. One survey was removed from the review pool for administrative reasons. Of the remaining eight validation surveys, one laboratory was cited with CLIA condition-level deficiencies. The AOA noted comparable findings, thus there was no disparity. We commend the AOA for its history of zero disparity in 14 out of the past 17 validation reviews.

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 two ASHI-accredited laboratories. No condition-level deficiencies were cited in either 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. We commend the ASHI for its history of zero percent disparity in 16 out of the past 17 validation reviews.

COLA

Rate of disparity: 10 percent

A total of 202 validation surveys were conducted in COLA-accredited laboratories. Twenty-eight laboratories were cited with condition-level deficiencies. In seven of those laboratories, COLA findings were comparable to all of the CLIA condition-level deficiencies cited. In the remaining 21 laboratories, however, COLA noted comparable findings to only some or none of the CLIA condition-level deficiencies cited; thus, there were 21 disparate cases yielding a disparity rate of 10 percent.

College of American Pathologists

Rate of disparity: 11 percent

A total of 91 validation surveys were conducted in CAP-accredited laboratories. Two surveys were removed from the review pool for administrative reasons. Of the remaining 89 cases, 13 laboratories were cited with CLIA condition-level deficiencies. In three of those laboratories, the College noted comparable findings to all of the CLIA condition-level deficiencies cited. In the remaining 10 laboratories, however, the College noted comparable findings to only some or none of the CLIA condition-level deficiencies cited; thus, there were 10 disparate cases for a disparity rate of 11 percent.

The Joint Commission

Rate of disparity: 12 percent

During this validation period, a total of 70 validation surveys were conducted in JC-accredited laboratories. One survey was removed from the validation review pool for administrative reasons. Of the remaining 69 validation surveys, 11 laboratories were cited with CLIA condition-level deficiencies. In three of those laboratories, the JC findings were comparable to all of the CLIA condition-level deficiencies cited. In the other 8 laboratories, however, the JC noted comparable findings to only some or none of the CLIA condition-level deficiencies cited; thus, there were 8 disparate cases yielding a disparity rate of 12 percent.

Conclusion

CMS has performed this statutorily-mandated validation review in order to evaluate and report to Congress 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 the energy sector.

B

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

Beneficiary: A person entitled under the law to receive Medicare or Medicaid benefits (also referred to as an enrollee).

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

C

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 require the development and maintenance of agency financial management systems that comply with: applicable accounting principles, standards, and requirements; internal control standards; and requirements of the Office of Management and Budget (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 (CAP): 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

The Debt Collection Improvement Act of 1996 (DCIA of 1996): The DCIA requires Federal agencies to refer delinquent non-tax debts to the Department of Treasury's Financial Management Service (FMS) for purposes of collection by offset of non-tax payments. Non-tax payments include vendor, Federal retirement, Federal salary, and Social Security benefits.

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.

GLOSSARY

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 process 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.

Electronic Health Record (EHR): An EHR is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users.

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.

G

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

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

H

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

Health Information Exchange (HIE): The electronic sharing of health-related information among organizations.

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

Health Information Technology for Economic and Clinical Health Act (HITECH): The American Recovery and Reinvestment Act of 2009 (ARRA) includes the "HITECH Act," which established programs under Medicare and Medicaid to 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: 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.

GLOSSARY

Medicaid: A joint Federal and state program that helps with medical costs for persons with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if one qualifies for both Medicare and Medicaid.

Medical Review/Utilization Review (MR/UR): Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

Medicare: Medicare is the Federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

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

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

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

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

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA): Legislation passed that established a new program in Medicare to provide a prescription drug benefit, Medicare Part D, which became available on January 1, 2006. Additionally, MMA sets forth numerous changes to existing programs, including a revised managed care program, certain payment reforms, rural health care improvements, and other changes involving administrative improvements, regulatory reduction, administrative appeals, and contracting reform.

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

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

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

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.

Pre-Existing Condition Insurance Plan (PCIP):

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

Program 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).

Retiree Drug Subsidy Program: The retiree drug subsidy (RDS) is one of several options available under Medicare that enables employers and unions to continue assisting their Medicare eligible retirees in obtaining more generous drug coverage.

Revenue: The recognition of income earned and the use of appropriated capital from the rendering of services in the current period.

GLOSSARY

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 also referred to as Part B.

T

Tax Relief and Health Care Act: Legislation that required HHS to implement the Medicare FFS Recovery Audit Program in all 50 states no later than January 1, 2010.

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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CMS welcomes comments and suggestions on both the content and presentation of this report.

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