CMS
CENTERS for MEDICARE & MEDICAID SERVICES

CMS FINANCIAL REPORT

fiscal year
2011

Continually improving the health
and health care for all Americans.

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 2011 presents the agency's detailed financial information relative to our mission and the stewardship of those resources entrusted to us.

This report is organized into the following major sections:

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

FINANCIAL SECTION:
This section contains the message from our Chief Financial Officer, financial statements and notes, and required supplementary information. This section also contains the audit reports and management's response to those reports on the independent financial statement audit.

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

The CMS Annual Financial Reports can be obtained at:
https://www.cms.gov/CFOReport

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2011 PROGRAM ENROLLMENT

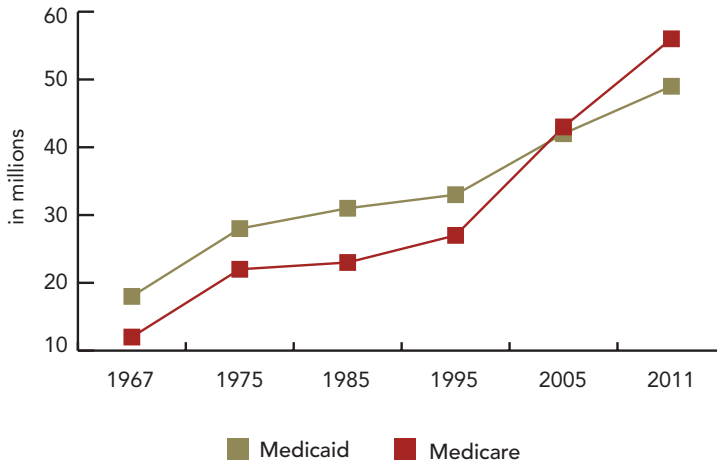
CMS is one of the largest purchasers of health care in the world. Medicare, Medicaid, and Children's Health Insurance Program (CHIP) provide health care for one in four Americans. Medicare enrollment has increased from 19 million beneficiaries in 1966 to 49 million beneficiaries. Medicaid enrollment has increased from 10 million beneficiaries in 1967 to over 56 million beneficiaries.

2011 FEDERAL OUTLAYS

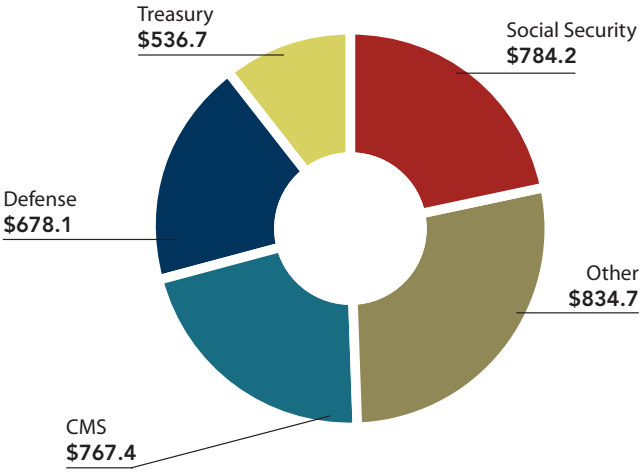
CMS has outlays of approximately $767.4 billion (net of offsetting collections and receipts) in fiscal year (FY) 2011, approximately 21 percent of total Federal outlays.

CMS has over 5,000 Federal employees, but does most of its work through third parties. CMS and its contractors process over one billion Medicare claims annually, monitor quality of care, provide the states with matching funds for Medicaid and CHIP 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.

2011 PROGRAM ENROLLMENT



2011 FEDERAL OUTLAYS



$ in billions

Source: U.S. Treasury

a message from the

ADMINISTRATOR

DONALD M. BERWICK, M.D.

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) Financial Report for fiscal year (FY) 2011.

This year, I have urged my colleagues to think of our agency as not just a payer, but a part of the larger health care system that must find opportunities to provide better care and lower costs not just to Medicare beneficiaries, but to all Americans. This has led to our vision as a major force and a trustworthy partner for the continual improvement of health and health care for all Americans. This vision along with the Three-Part Aim—better care, better health, and lower cost through improvement—will guide our work at CMS now and in the future.

"...creating a bright and vibrant future for health and health care in our Nation."

We are one-and-a-half years into implementation of the Affordable Care Act, and Medicare beneficiaries are already seeing the benefits of the law via better access to care, improved benefits, and lower costs for Americans. As part of the Affordable Care Act's step-by-step efforts to close the Medicare Part D prescription drug coverage gap, eligible beneficiaries who fall in the "donut hole" will receive a 50 percent discount on their brand name prescription drugs when they hit the donut hole. Already through September of this year, 2.2 million Medicare beneficiaries have received prescription drug cost relief. The total value of discounts to eligible Medicare beneficiaries is over $1 billion through September, with an average savings of $550 per beneficiary.

Closing the donut hole is just one of the ways Medicare beneficiaries benefit from the Affordable Care Act. In addition, the average 2012 Medicare prescription drug plan premiums will remain similar to rates beneficiaries are currently paying this year. This, coupled with new discounts for brand-name drugs, will help make medications more affordable for Medicare beneficiaries in 2012 and beyond.

Seniors and other Medicare beneficiaries also have access to expanded preventive services this

year. Under the Affordable Care Act, people with traditional Medicare can receive recommended preventive benefits and a new Annual Wellness Visit without paying a co-payment or any cost-sharing. Through August, over 18 million people enrolled in traditional Medicare have received preventive services this year at no cost to them. Many of these services will help prevent chronic diseases; saving lives and reducing billions in costs to Medicare. In addition, more than 1.2 million Americans with traditional Medicare have taken advantage of the new Annual Wellness Visit.

The Affordable Care Act will also provide CMS more tools and resources to actively and aggressively fight waste, fraud and abuse in Medicare and Medicaid. Just recently, a new rule for the Medicaid Recovery Audit Contractor program, a waste cutting program created by the Affordable Care Act, was issued. The new program is based on the successful Medicare Recovery Audit Contractor program, which has already recovered hundreds of millions of dollars of overpayments in 2011. CMS projects the Medicaid Recovery Audit Contractor program will save $2.1 billion over the next five years, of which $900 million will be returned to the states.

CMS has already implemented a wide array of improvements aimed at laying the foundation for broad reform of our health care delivery system. These include tying payment to quality standards, investing in patient safety, and offering new incentives for providers who deliver high-quality, coordinated care. These efforts are expected to yield significant savings for Medicare over the next five years.

In partnership with the states and other Federal agencies, CMS is also working to establish Affordable Insurance Exchanges – state-based competitive marketplaces where individuals and small businesses will be able to purchase affordable private health insurance. Already, over half of all states have taken actions to build an Affordable Insurance Exchange, and 16 states including the District of Columbia have received $220 million to help them along the way. As a part of this effort, CMS is laying the foundation for the expansion in Medicaid eligibility in 2014, and a simple, seamless system of affordable coverage by coordinating Medicaid and Children's Health Insurance Program (CHIP) with the new Affordable Insurance Exchanges.

CMS has dedicated itself to continually doing our part to make the Medicare, Medicaid, and CHIP programs more affordable and effective for the millions of Americans who rely on them for their health care. Our initiatives demonstrate our commitment and we take pride in the many achievements we have accomplished in FY 2011. We will continue to work together with our partners, stakeholders, and other key sectors of the health care community, to implement those initiatives and to further identify new opportunities for improvement. As we look ahead, we will continue implementing the provisions of the Affordable Care Act. Our work under the Affordable Care Act, combined with our other ongoing efforts, will extend the life of the Medicare trust funds for future generations—thus, creating a bright and vibrant future for health and health care in our Nation.

DONALD M. BERWICK, M.D.
CMS Administrator

November 2011

FINANCING *of* CMS PROGRAMS AND OPERATIONS

FUNDS FLOW FROM →	THROUGH →	TO FINANCE
Payroll Taxes	Medicare Trust Funds	Medicare Benefits
Medicare Premiums		Quality Improvement Organizations
Investment Interest Earnings		Medicare Integrity Program
Federal Taxes		Program Management
Other Federal Taxes	General Fund Appreciation	Medicaid Integrity Program
		Medicaid
		Children's Health Insurance Program (CHIP)
User Fees		Clinical Laboratory Improvements Amendments (CLIA)
		Medicare Advantage

TABLE *of* CONTENTS

A Message from the Administrator ii

Financing of CMS Programs and Operations iv

Agency Organization vi

Management's Discussion and Analysis 1
- Overview 2
- Programs 3
- Performance Goals 19
- Financial Accomplishments 20

Financial Section 35
- A Message from the Chief Financial Officer 36
- Financial Statements 38
- Notes to the Financial Statements 46
- Required Supplementary Information 83
- Supplementary Information 99
- Audit Reports 102

Other Accompanying Information 132
- Summary of Federal Manager's Financial Integrity Act 133
- OMB Circular A-123 Statement of Assurance 133
- Improper Payments 134
- Review of Medicare's Program for Oversight for Accreditation Organizations 136
- Clinical Laboratory Improvement Validation Program 173

Glossary 177

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

APPROVED LEADERSHIP
as of September 2011

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Chief of Staff

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Senior Advisor

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MEDICARE OMBUDSMAN GROUP

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Deputy Chief Operating Officer

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OESS: Robert Tagalicod, Director
OFM: Deborah Taylor, Director & Chief Financial Officer
OIS: Tony Trenkle, Director & CMS Chief Information Officer
OOM: James Weber, Director
CFMFFSO: Nanette Foster Reilly, Consortium Administrator
CMCHO: Jackie Garner, Consortium Administrator
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Penny Thompson
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Deputy Director*
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Deputy Administrator and Director
Timothy Hill
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* Acting

MANAGEMENT'S DISCUSSION *and* ANALYSIS

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

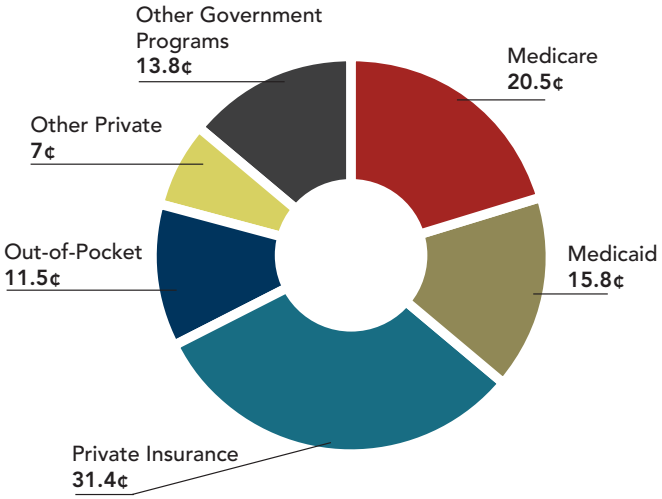
OVERVIEW

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

CMS establishes policies for program eligibility and benefit coverage, processes over one billion Medicare claims annually, matches state expenditures with funds for Medicaid and CHIP, and ensures quality of health care for beneficiaries, and safeguards funds from fraud, waste, and abuse. CMS is one of the largest purchasers of health care in the world and maintains the Nation's largest collection of health care data. Based on the latest projections, Medicare and Medicaid (including state funding), represent 36 cents of every dollar spent on health care in the United States (U.S.)—or looked at from three different perspectives, 53 cents of every dollar spent on nursing homes, 49 cents of every dollar received by U.S. hospitals, and 31 cents of every dollar spent on physician services. CMS **outlays** totaled approximately $767.4 billion (net of offsetting collections and receipts) in FY 2011. Our **expenses** totaled approximately $817.8 billion, of which $3.5 billion (less than one percent) were administrative expenses.

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

THE NATION'S HEALTH CARE DOLLAR 2011



Source: U.S. Treasury

a *closer* look:

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.

CMS is one of the *largest purchasers* of health care in the world.

Many important activities are also handled by third parties. The states administer the Medicaid program and CHIP, as well as inspect hospitals, nursing homes, and other facilities to ensure that health and safety standards are met. The Medicare contractors process Medicare claims, provide technical assistance to providers and answer beneficiary inquiries. Additionally, Quality Improvement Organizations (QIOs) conduct a wide variety of quality improvement programs to ensure quality of care provided to Medicare beneficiaries.

PROGRAMS

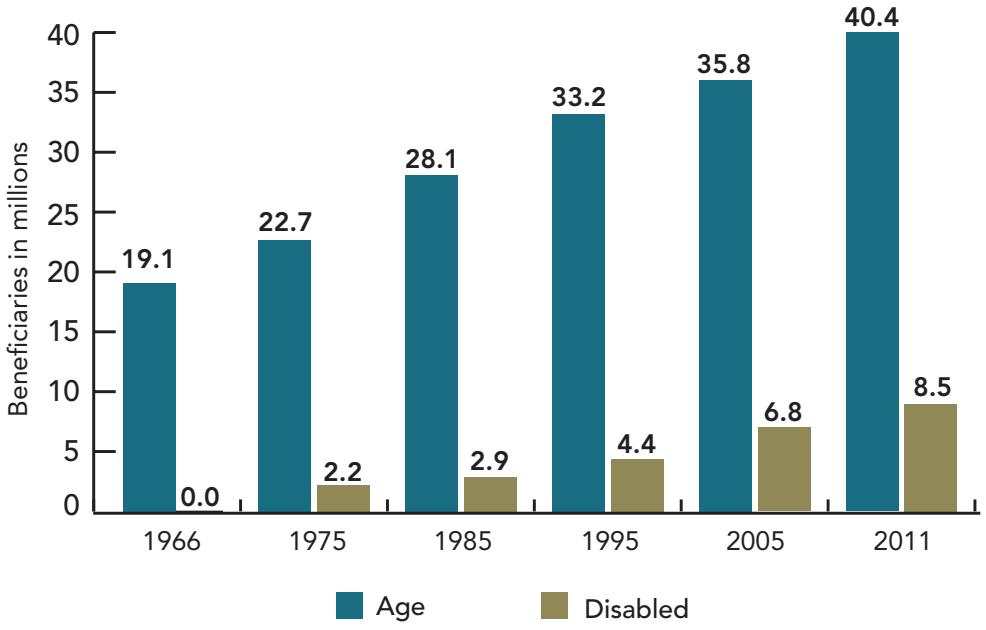
Medicare

Introduction

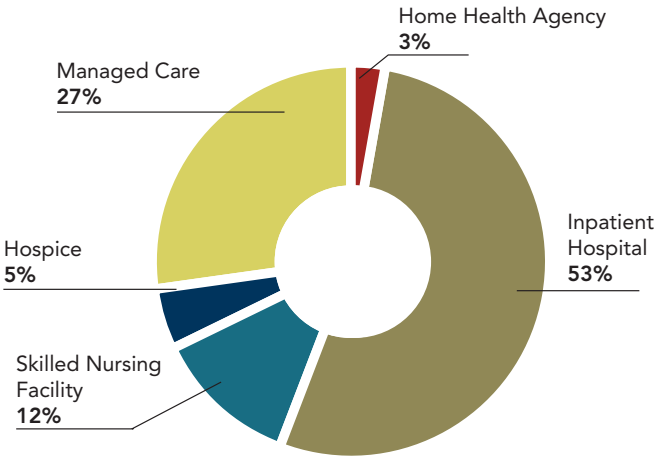
Medicare was established in 1965 as title XVIII of the Social Security Act. It was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people aged 65 and over. In 1972, the program was expanded to cover the disabled, people with End-Stage Renal Disease (ESRD) requiring dialysis or kidney transplant, and people age 65 or older that elect Medicare coverage. In 2003, the Medicare program was further expanded to include a drug benefit. In 2010, the President signed legislation to place comprehensive reforms that strengthen the Medicare program—the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act, collectively referred to as the *Affordable Care Act*. The Affordable Care Act is the most recent legislation passed which has had significant impact to CMS.

Medicare processes over one billion fee-for-service (FFS) claims a year, is the Nation's largest purchaser of managed care, and accounts for approximately 21 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 approximately 49 million beneficiaries.

MEDICARE ENROLLMENT



HI MEDICARE BENEFIT PAYMENTS

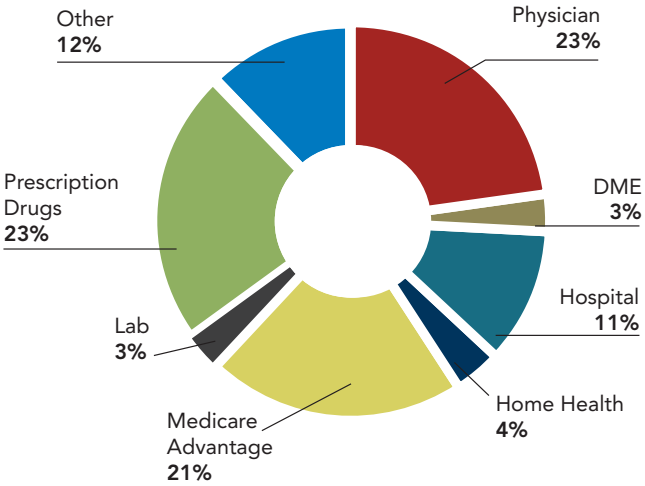


Source: CMS/OACT

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 2012 President's budget, inpatient hospital spending accounted for 53 percent of HI benefit outlays in FY 2011. Managed care spending comprised 27 percent of total HI outlays. During FY 2011, HI benefit outlays grew by 5.4 percent and the HI benefit outlays per enrollee were projected to increase by 2.3 percent to $5,320.

SMI MEDICARE BENEFIT PAYMENTS



Source: CMS/OACT

Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI or Medicare Part B and Medicare Part D, is voluntary and available to nearly all people aged 65 and over, the disabled, and people with ESRD who are entitled to Part A benefits. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy, outpatient prescription drugs, and other services not covered by HI. The SMI coverage is optional and beneficiaries are subject to monthly premium payments. About 93 percent of HI enrollees elect to enroll in SMI to receive Part B benefits. The SMI program is financed primarily by transfers from the general fund of the U.S. Treasury and by monthly premiums paid by beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the SMI trust fund and invested in U.S. Treasury securities.

Also based on estimates from the Midsession Review of the FY 2012 President's budget, SMI benefit outlays grew by 9.9 percent during FY 2011. Physician services, the largest component of SMI, accounted for 23 percent of SMI benefit outlays. During FY 2011, the SMI benefit outlays per enrollee were projected to increase 7.0 percent to $6,590.

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 plans currently serve Medicare beneficiaries through coordinated care plans, which include HMOs, point-of-service (POS) plans offered by HMOs, PPOs, PSOs, and PFFS. MA demonstration projects, as well as cost plans and Health Care Prepayment Plans (HCPPs), also exist.

All MA plans are currently paid a per capita premium, and must provide certain Medicare covered services. MA plans assume full financial risk for care provided to their Medicare enrollees. Many MA plans offer additional services such as prescription drugs, vision, and dental benefits to beneficiaries. In contrast, cost contractors are paid a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the budget. Cost plans must provide all Medicare-covered services, but do not always provide the additional services that some risk MA plans offer. Cost plan enrollees may receive services through the plan's network or through Original Medicare. The HCPPs are paid in a manner similar to cost contractors, but cover only non-institutional Part B Medicare services. There can be no new section 1876 cost based contractors.

Managed care expenses were approximately $121.2 billion of the total $532.5 billion in Medicare benefit payment expenses in FY 2011.

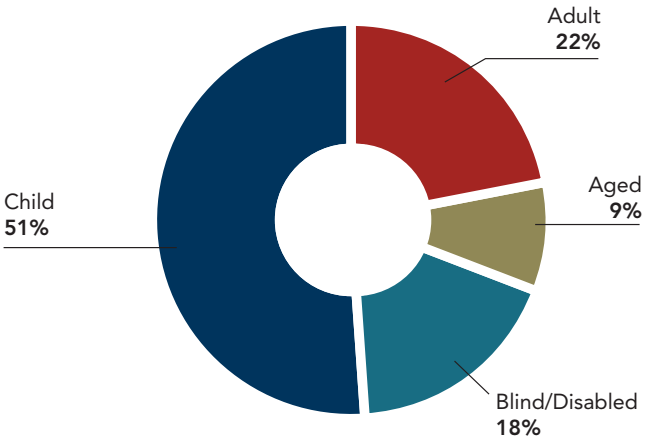
Medicare Prescription Drug Benefit

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 and Part B. Beneficiaries who qualify for both Medicare and Medicaid (full-benefit dual-eligibles) automatically receive the Medicare drug benefit. 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 2011 standard benefits generally have a $310 deductible and coinsurance of 25 percent after the deductible up to the initial coverage limit of $2,840 in total drug spending. This is followed by a coverage gap for which beneficiaries pay 100 percent to an out-of-pocket spending limit of $4,550. 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. The Affordable Care Act added gap coverage for prescription drugs starting in January 2011, which includes a seven percent plan coverage for generic drugs and a 50 percent discount on brand name drugs. PDPs and MA PDs submit annual bids to CMS reflecting expected benefit payments plus administrative costs after a deduction for expected

FY 2011 MEDICAID ENROLLEES



Source: CMS/OACT

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 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 56 million in FY 2011, about 18 percent of the U.S. population. About 8.6 million people are dually eligible, that is, covered by both Medicare and Medicaid.

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

The American Recovery and Reinvestment Act of 2009 (ARRA) directly affected the Medicaid Program under title XIX of the Social Security Act. The ARRA provisions provided Medicaid programs with temporarily increased Federal match rates

and considerable new resources to promote and expand the use of health information technology (HIT) in the health care system. The law provides incentives to encourage the use of electronic health records (EHR) for exchanging information across the health care system. This investment in HIT is key to CMS efforts to better measure, monitor and assure the quality of care provided in Medicaid. Finally, CHIPRA established a new foundation for building a comprehensive, high quality system of care for children by addressing key components essential to accessing coverage and implementing quality improvement strategies related to health care.

Medicaid Quality Improvement Initiatives

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

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

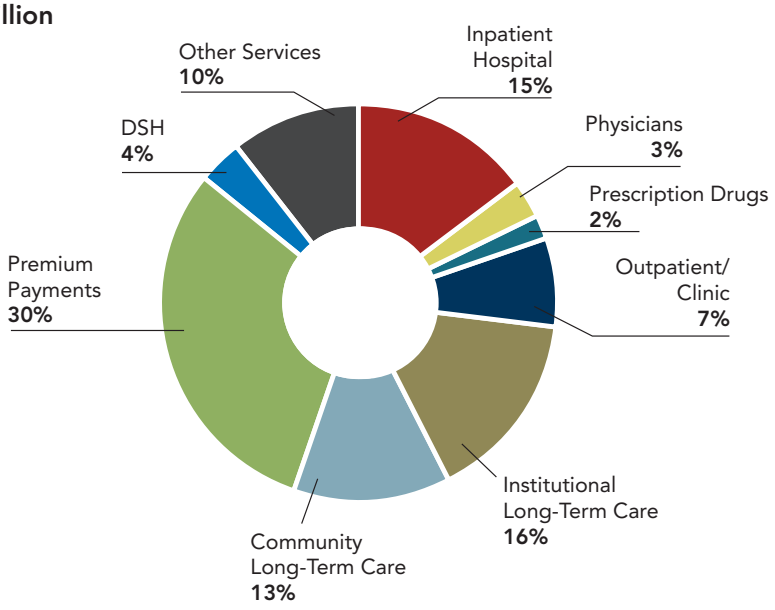
Additionally, CMS is in the early stages of partnering with states to implement several national Medicaid and CHIP quality improvement initiatives:

- A Neonatal Outcomes Improvement Project based on evidence-based clinical intervention strategies;
- A Children's Oral Health Improvement initiative; and

MEDICAL ASSISTANCE PAYMENTS BY AGGREGATE SERVICE CATEGORIES

IN BILLIONS

Total Payments: $398 billion



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

- Improving access, data collection/reporting, and assessment of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Temporary Federal Medical Assistance Percentage (FMAP) Increase for States

ARRA provided a temporary increase to state FMAP rates for the 50 states, the District of Columbia, and options for increased funding for the territories during the current recession. Section 5001(a) and (b) of ARRA provide for maintenance of FMAPs for FY 2009 through the first quarter of FY 2011, and a general across-the-board increase of 6.2 percent for each of such fiscal years. Section 5001(c) provides for a further increase to the FMAPs for those states that have especially high unemployment rates. In August 2010, Congress extended, P.L. 111–226, the ARRA FMAP increases through the third quarter of FY 2011, reducing the across-the-board increases to 3.2 percent and 1.2 percent for the second and third quarters for FY 2011, respectively.

FMAP Increases for Territories

Under section 5001 of ARRA, each territory elected to receive a 30 percent increase in its cap on Federal funds provided under section 1108(f) and (g) of the Social Security Act through June 30, 2011. In accordance with section 1935(e) of the Act, the section 1108 cap is also comprised of amounts intended for the purpose of matching certain drugs provided to Part D eligible individuals. Accordingly, the component of the section 1008 cap related to the amount of the 1108 cap, as adjusted in accordance with section 1935(e) of the Act, would then be increased under the ARRA by 30 percent. The increase in the 1108 cap does not change the existing requirement that in order for the jurisdictions to access these funds they must have actual expenditures for which the funds are available.

Under section 1905 (b) of the Social Security Act, as amended, the FMAP for the territories was increased from 50% to 55% effective July 1, 2011. The Affordable Care Act also provided for a total increase to the territories of $6.3 billion for the period July 1, 2011 through September 30, 2019, to be allocated among the territories on the basis of their Section 1108 caps as available on the date of enactment of the Affordable Care Act. Section 1323 of the Affordable Care Act, also provided for $1 billion in funding for the territories to be available either to increase the territories' Section 1108 cap or to provide for premium and cost-sharing assistance to the residents of the territories who obtain health insurance coverage through

an Affordable Insurance Exchange. Under that provision, $925 million of the $1 billion is allocated to Puerto Rico and the remaining $75 million is allocated to the other 4 territories in accordance with basis specified by the Secretary of HHS.

Medicaid Disproportionate Share Hospital (DSH) Payments

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 2011, the basic Federal matching rate for Medicaid program costs among the states according to the formula ranged from 50 to 75 percent. However, the ARRA provides states with additional Federal matching funds. As a result, the weighted average matching rate for FY 2011 was about 63 percent. Federal matching rates for various state and local administrative costs are set by statute. The Federal government currently pays about 55 percent of these costs. Medicaid payments to states are funded by Federal general revenues provided to CMS through an annual appropriation. There is no cap on Federal matching payments to the states, except with respect to the DSH payments, payments for Part B premiums for Qualifying Individuals (QI), and payments to territories.

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

Medicaid is the largest single source of payment for health care services for persons with Acquired Immune Deficiency Syndrome (AIDS). Medicaid now serves over 50 percent of all AIDS patients and pays for the health care costs of most of the children and infants with AIDS. In FY 2011, Medicaid spending for persons with AIDS as well as others infected with the Human Immunodeficiency Virus (HIV) is estimated to be about $9.2 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 2011, state and Federal ADM gross outlays are estimated at $23.4 billion, about 5 percent of the gross Medicaid outlays. State and Federal MAP total outlays were $410.5 billion or 95 percent of total Medicaid outlays, an increase of 6.1 percent over FY 2010. Thus, state and Federal MAP and ADM outlays for FY 2011 totaled $433.9 billion. CMS share of Medicaid outlays totaled $273.9 billion in FY 2011.

Enrollees

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

Service Delivery Options

Many states are pursuing managed care as an alternative to the FFS system for their Medicaid programs. Managed health care provides several advantages for Medicaid beneficiaries, such as enhanced continuity of care, improved preventive care, and prevention of duplicative and contradictory treatments and/or medications. Most states have taken advantage of waivers provided by CMS to introduce managed care plans tailored to their state and local needs, and 49 states now offer a form of managed care. The number of Medicaid beneficiaries enrolled in managed care has grown from 40 percent in 1996 to 71 percent in 2010.[1]

[1] 49 states offer managed care; the number includes DC and PR. AK, NH, VI, and WY do not offer managed care. For MS, we counted them as having managed care because they have a capitated transportation program. The July 1, 2010 data is collected from the states and represents that point-in-time.

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

1) **Medicaid waivers**—section 1115 of the Social Security Act provides discretion to waive certain provisions of Medicaid law for experimental, pilot, or demonstration projects. Many of the pioneering efforts to develop Medicaid managed care were authorized as section 1115 demonstrations and states continue to use this authority to develop innovative programs.

2) **Freedom of choice waivers**—section 1915(b) of the Social Security Act allows certain provisions of Medicaid law to be waived to allow the states to develop innovative managed health care delivery systems.

3) **Other state plan options to implement managed care**—section 1932(a) of the Social Security Act allows the states to mandate managed care enrollment for certain groups of Medicaid beneficiaries. Certain populations—including dual eligibles, children receiving SSI, children with special health care needs, and American Indians—are exempted from the state plan option. For these groups, the states require waivers to mandate enrollment into managed care.

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

Medicaid Home and Community-Based Services Quality Improvement

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

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

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

Children's Health Insurance Program (CHIP)

The 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, the CHIPRA was enacted and further extended CHIP through September 30, 2013, and appropriated funds for the purposes of providing allotments to the states for their CHIP programs. The 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 by further extending CHIP through September 30, 2015.

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

Title XXI of the Social Security Act outlines the program's structure, and establishes a partnership between the Federal and state governments. States are given broad flexibility in designing their programs. States can create or expand their own separate insurance programs, expand Medicaid, or combine both approaches. States can choose among benchmark benefit packages, develop a benefit package that is actuarially equivalent to one of the benchmark plans, use the Medicaid benefit package, use existing comprehensive state-based coverage, or provide coverage approved by the Secretary of HHS.

States also set their own eligibility criteria regarding age, income, and residency within broad Federal guidelines. The Federal role is to ensure that state programs meet statutory requirements that are designed to ensure meaningful coverage under the program. The DRA and CHIPRA prohibit the use of Federal CHIP funds to provide health benefits coverage to nonpregnant childless adults. States that submit a section 1115 demonstration application on or after October 1, 2005, are not eligible to receive title XXI funds to provide coverage for nonpregnant childless adults. The CHIPRA expands on this provision by stating that renewal applications for a waiver, experimental, pilot, or demonstration project for nonpregnant childless adults may be approved on or after February 4, 2009 (date of the enactment of CHIPRA).

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 30, 2011, state programs for CHIP included 13 Medicaid expansions (includes District of Columbia and all of the territories), 17 separate children health programs and 26 combination CHIP programs.

Other Programs and Activities

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

Center for Consumer Information and Insurance Oversight (CCIIO)

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

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

Health Insurance Rate Review. In FY 2011, CMS issued $157 million in Health Insurance Rate Review Grants to states, territories and the District of Columbia, to help strengthen and improve their rate review processes. The Affordable Care Act requires insurance companies in every state to publicly justify their actions if they want to raise rates by 10 percent or more. CMS recently posted the first set of justifications from insurance companies on www.healthcare.gov, and will update the site regularly. Concurrently, independent experts review the submissions for non-effective rate review states to determine whether or not the proposed increase is reasonable.

CMS is also charged with enforcing compliance with a federal minimum medical loss ratio (MLR) requiring that issuers spend at least 80 percent (for individuals or small groups) or 85 percent (for large group markets) of premium dollars on patient care or refund the difference to enrollees. CMS recognizes states' capacity to assist in enforcement and will accept the findings of a state audit of MLR compliance if they are based on the MLR requirements set forth in Federal law and regulations.

Consumer Information Support. CMS has given consumers an unprecedented amount of clear information about their coverage options. In FY 2010, CCIIO established www.healthcare.gov, the first central database of health coverage options, combining information about public programs with information on more than 8,000 private insurance products. CMS updates this data regularly to allow consumers to review options specific to their personal situation and local community. Additionally, in FY 2011, CMS administered almost $30 million in Consumer Assistance Program grants to support states efforts to establish or strengthen programs that provide direct services to consumers with questions about health insurance. CMS also provides limited direct assistance and referral services to consumers with Affordable Care Act related questions who reside in states without Consumer Assistance Programs. Additionally, CMS has direct jurisdictional authority over non-Federal governmental plans and provides some health insurance assistance services to consumers enrolled in such plans.

Affordable Insurance Exchanges. CMS is working closely with states to implement the Affordable Insurance Exchanges. Starting in 2014, these Affordable Insurance Exchanges will provide individuals and small business with a "one-stop shop" to find and compare affordable, quality health insurance options. In FY2011, CMS awarded a series of grants to assist with the construction of state-based Affordable Insurance Exchanges, including: up to $1 million for Affordable Insurance Exchange Planning to forty-nine states, four territories and the District of Columbia; $241 million for "Early Innovator" model IT development to six states and a multi-state consortium; and over $220 million for Affordable Insurance Exchange Establishment to 16 states and the District of Columbia. To ensure states have the flexibility they need to best serve their residents, CMS proposed the Affordable Insurance Exchange "Partnership Options" Opportunities initiative that allows states to perform some functions (for example, plan management or consumer assistance) and let the Federal government perform others for them.

Access to Affordable Insurance. To help increase consumer access to affordable insurance options today, CMS oversees the Pre-Existing Condition Insurance Plan (PCIP) program and the Early Retiree Reinsurance Program (ERRP). The PCIP makes health insurance available to Americans who are uninsured and have a pre-existing condition. The temporary program covers a broad range of health benefits and is designed as a bridge for people with pre-existing conditions who cannot obtain health insurance coverage in today's private insurance market. CMS directly administers the PCIP program on behalf of 23 states and the District of Columbia, while 27 states have chosen to run their own programs. The PCIP program began accepting applications for enrollment July 2010. As of July 2011, the state-run and federally-run PCIP programs collectively have enrolled approximately 30,000 individuals.

The ERRP provides reimbursement to sponsors of employer-based health plans for a portion of the cost of health benefits for early retirees and their spouses, surviving spouses and dependents. ERRP provides reimbursement equal to 80 percent of the actual cost of health expenses paid by or on behalf of an individual between a cost threshold and cost ceiling to participating sponsors of qualified plans providing health benefits to early retirees, their spouses, and surviving spouses and dependents. As of August 2011, ERRP disbursed approximately, $2.7 billion in payments to approved plan sponsors.

Federal Coordinated Health Care Office

Under the Affordable Care Act, CMS established the Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) in December 2010. The Medicare-Medicaid Coordination Office is charged with better integrating Medicare and Medicaid services, improving health care quality and coordination of care, reducing costs, and improving the beneficiary experience for Medicare-Medicaid enrollees. To date, CMS has implemented a number of initiatives to assure it meets the statutory goals and responsibilities in section 2602 of the Affordable Care Act since its creation. In FY 2011, CMS invested approximately $5.9 million to support ongoing initiatives.

Through the Initiative to Align Medicare and Medicaid Programs (Alignment Initiative), CMS is identifying and implementing solutions that advance better care for individuals, better health for populations, and reduced costs through improvement. The objective is to engage and obtain input from stakeholders in an open and transparent manner to help improve care and the care experience for dual eligible beneficiaries. CMS will use this input to inform its alignment efforts and strategies.

CMS established The Integrated Care Resource Center to support states in developing and implementing coordinated health care models for beneficiaries with chronic conditions and/ or eligibility for both the Medicare and Medicaid programs. This resource will provide technical assistance to states at all levels of readiness to better serve beneficiaries, improve quality and reduce costs.

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

A major barrier for states in providing integrated care for Medicare-Medicaid enrollees has been lack of access to Medicare data. In May 2011, CMS announced the availability of timely Medicare A, B, and D claims/event data to state Medicaid Agencies to support care coordination efforts for Medicare-Medicaid enrollees. This long-awaited announcement provided states with new, valuable information to allow them to fully understand all of the health care needs utilization patterns for Medicare-Medicaid enrollees, thus supporting efforts to better coordinate care across the full spectrum of care needs. CMS is working to assure states are aware of this new resource and assisting states in accessing it. As of today, CMS has actively engaged and begun to work with many states on accessing Medicare data and creating new state pathways to better integrate care for Medicare-Medicaid enrollees.

In 2008, 9.2 million beneficiaries were eligible for both Medicare and Medicaid benefits (dual eligible beneficiaries).[2] These dual eligible beneficiaries have significant health needs and account for a disproportionate share of Medicare and Medicaid expenditures—the 16 percent of Medicare beneficiaries who are dual eligible beneficiaries account for 27 percent[3] of Medicare spending, and the 15 percent of Medicaid beneficiaries who are also eligible for Medicare account for 39 percent of Medicaid program expenditures. Improved care coordination for this population could dramatically improve health outcomes for many dually-eligible beneficiaries, but the current lack of alignment between the two programs creates barriers to better care coordination, improved quality and lower costs.

Also, CMS has awarded design contracts to 15 states to design new approaches to better coordinate care for dual eligible individuals. The goal is to identify and validate delivery system and payment models that can be rapidly tested, and, upon successful demonstration, replicated in other states. The following states were selected and are currently implementing the design portion of the contract: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin. As a foundation to achieve this goal, CMS is in the process of preparing state profiles to identify characteristics of the dual eligible population and subpopulations, including demographics, service utilization, and availability of benefits.

CMS is also working to leverage existing CMS databases to provide necessary tools for CMS, State Medicaid Agencies, and other relevant entities to complete comprehensive analyses aligning Medicare and Medicaid data for dual eligible beneficiaries. This work specifically involves enhancing CMS systems by expanding the existing data to include high prevalence conditions among dual eligible beneficiaries, such as serious mental illness.

CMS is charged with improving the quality of health and long term care services and supports for Medicare-Medicaid enrollees. CMS has begun a review of potential options for subsetting existing measures as well as developing new measures specific to Medicare-Medicaid enrollees within the overall framework of health care quality measurement. To accomplish this, CMS is partnering

[2] Data based on CMS Enrollment Database, Provider Enrollment, Economic and Attributes Report, provided by CMS Office of Research, Development and Information, July 2010.

[3] Report to the Congress: Aligning Incentives in Medicare. MedPAC, June 2010.

with HHS, as well as with external stakeholders, such as the National Quality Forum and National Committee for Quality Assurance, to ensure this initiative aligns with and informs quality initiatives already underway within Medicare and Medicaid as well as other health care improvement projects.

Center for Medicare and Medicaid Innovation (CMMI)

The CMMI was created to test innovative payment and service delivery models that 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. The Innovation Center, along with other transformation 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.

The CMS vision is a people-centered health care system where individuals receive the right care, in the right setting, at the right time—all the time; where health dollars are diffused rapidly. With the help of the Innovation Center, CMS is working to transform a claims payer in a fragmented care system into a partner that helps achieve better value for our health care dollars.

The Innovation Center communicates and consults with a wide array of stakeholders. The Innovation Center's strategy for communicating with and engaging stakeholders has included extensive outreach to gather input, both through sessions with broader audiences—including Open Door Forums and participation in conferences—and through listening sessions with targeted groups such as insurers, academic medical systems, beacon communities, and State Medicaid Directors. The Innovation Center has sought proactively to partner with professional societies, provider education and news media, and other organizations to spread knowledge about and enlist support for the three part aim—better health care and better health at reduced cost through improvement. The Innovation Center has also sponsored numerous events, including over 50 designed to raise awareness about the Partnership for Patients and an Innovation Summit in partnership with Kaiser Permanente and Vangent that drew leaders in health care innovation from across the country. In addition, the Innovation Center has developed a rapidly growing online presence, including a new website (http://innovations.cms.gov/) launched in April 2011.

CMS has launched a number of projects including State Demonstration to integrate Care for Dual Eligible Individuals, Partnership for Patients, Bundled Payments for Care Improvement, Pioneer Accountable Care Organizations (ACO), Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration, the Comprehensive Primary Care Initiative, and Reducing Preventable Hospitalizations among Nursing Facility Residents. Finally, CMS provides support and oversight for other Medicare and multi-payer demonstrations that do not use section 3021 funding. This includes other demonstrations and evaluations authorized by the Affordable Care Act, as well as demonstrations taking place under longstanding CMS waiver authority. These include:

- Multi-Payer Advanced Primary Care Practice Demonstrations;
- Evaluation and Plan for Community-Based Wellness and Prevention Programs for Medicare Beneficiaries;
- Graduate Nurse Education Demonstration; and
- Independence at Home Demonstration.

These initial programs offer significant opportunities to advance the aim of providing better health care, better health, and reduced cost. The Innovation Center's portfolio of models for improvements in health care will be refreshed as compelling ideas are surfaced and validated.

Survey and Certification Program

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

Certification staff oversee compliance with Medicare health and safety standards in approximately 296,746 currently active medical facilities of different types, including hospitals, laboratories, nursing homes, home health agencies, hospices, rural health clinics, ambulatory surgical centers, organ transplant centers, and ESRD facilities.

Clinical Laboratory Improvement Amendments Program (CLIA)

The CLIA legislation expanded survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing specimens from the human body 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 233,829 facilities. Moderate and high complexity testing is subject to onsite surveys. In partnership with the states, we certify and inspect approximately 20,383 laboratories on a biennial basis. The CMS-approved accrediting organizations conduct onsite surveys of an additional 17,000 laboratories each year, on average. 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, coordinates Clinical Laboratory Improvement Amendments Committee (CLIAC) and (3) the Food and Drug Administration performs test categorization.

Health Care Quality Improvement

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

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

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

Medicare and Quality Improvement Organizations (QIO)

One of CMS' resources and the largest Federal program dedicated to improving health quality at the state and local levels is the QIO Program. Created by Congress in 1982, QIOs provide a nationwide network of health organizations aimed at helping practitioners and providers improve healthcare quality. As Medicare contractors, QIOs, work to improve quality of care, assess medical necessity and appropriateness of care, and review beneficiary and hospital appeals of discharge decisions and review beneficiary complaints. The QIOs are authorized to work to improve services to Medicare beneficiaries with a focus

on effectiveness, efficiency, economy and quality. CMS administers the program through a national network of 53 independent QIO contractors located in each of the 50 states, the District of Columbia, Puerto Rico and the Virgin Islands.

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

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

- **Patient Safety:** More than 1,250 nursing homes virtually eliminated the use of physical restraints and decreased pressure ulcer rates by 22.2%. Hundreds of hospitals reduced surgical complications and more than 450 began reporting information about hospital-acquired infections to the Centers for Disease Control and Prevention.

- **Prevention:** More than 1700 primary care physicians used the capabilities of their electronic health record system to coordinate preventive care, leading to increased rated of screening mammograms, colorectal screening, and influenza and pneumonia vaccination.

- **Care Transitions:** More than 1,125,500 Medicare beneficiaries were affected by community-based initiatives to reduce avoidable hospital readmissions in 14 states. In total, participating communities reduced admissions per 1,000 beneficiaries by 5.6%, compared to a 3.4% reduction in 52 peer communities.

- **Health Disparities:** Through community-based initiatives in seven states, more than 8,600 disadvantaged Medicare beneficiaries with diabetes completed self-management education that equipped them to better control their disease and live a healthier life.

- **Chronic Kidney Disease (CKD):** National and local partners, like the Renal Physicians Association, National Kidney Foundation and their affiliates, participated in work in 11 states to help primary care providers identify CKD in earlier stages and slow the progression of renal failure.

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

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

The QIO shall work on the following in the 10th SOW:

C.6 Beneficiary and Family Centered Care
- Case Review
- Patient and Family Engagement Activities

C.7 Improving Individual Patient Care
- Reduction of Health-Care Acquired Conditions
- Reduction of Adverse Drug Events
- Quality Reporting and Improvement

C.8 Integrating Care for Populations and Communities
- Improving Care Transitions Leading to the Reduction of Readmissions

C.9 Improving Health for Populations and Communities
- Promotion of Immunizations and Screenings
- Cardiovascular Health Campaign

Medicare and the End-Stage Renal Disease Quality Initiative

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

CMS' Quality Incentive Program (QIP), required by Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) encourages the continuous improvement of quality in dialysis facilities by tying a portion of a facility's payments to their performance on specific measures of quality. The Quality Incentive Program is currently being implemented and the first dialysis facility payment impact will occur starting January 1, 2012. CMS also collects data for Quality Measurement that facilities use to gauge their own quality, ESRD Networks use to target interventions, and CMS can use to assess state of dialysis care in the nation.

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

Coverage Policy

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

Insurance Oversight and Data Standards

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

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

personal health information be maintained securely while being stored or transmitted.

In January 2009, CMS published two final rules to update the HIPAA code set and transactions standards. The first rule adopts the updated X12 standard (Version 5010) and the National Council for Prescription Drug Programs standard (Version D.0) for electronic transactions, such as health care claims. It also adopts a new standard for Medicaid pharmacy subrogation. The compliance date for these changes will take place on January 1, 2012. The second rule adopts the ICD-10 code set for diagnosis and inpatient hospital procedure coding as of October 1, 2013. During FY 2010, CMS conducted outreach activities and worked closely with industry stakeholders on version 5010/ICD-10, planning, messaging, and monitoring to promote industry readiness by compliance dates.

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. The regulations will be written in the next 12 months to adopt a national Health Plan Identifier (HPID) and operating rules for two of the standard transactions. Over the next three years, four to five more regulations will be released adopting additional 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 Strategic Plan for Fiscal Years 2010 through 2015, which can be viewed at http://www.hhs.gov/secretary/about/priorities.html. Consistent with GPRA principles, the CMS FY 2011 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: Transform Health Care and Goal 4: Increase Efficiency, Transparency, and Accountability of its programs.

Our FY 2011 performance measures track progress in our major programs areas. We track program integrity in Medicare, Medicaid and the CHIP through measuring error rates. In addition, we measure quality improvement initiatives geared toward elderly, disabled and child populations as they are served by the Medicare, Medicaid, CHIP and the QIO programs. We have also begun to develop metrics to track progress of health reform efforts as we work to make affordable health insurance available to all Americans. Detailed information and available results about the FY 2011 measures are included in the Online Performance Appendix and can be viewed at http://www.cms.gov/PerformanceBudget/. Progress on our measures will be reported through the FY 2013 President's Budget request process.

Our future plans will be revised to reflect the requirements of the GPRA Modernization Act of 2010, which retains and amplifies some aspects of the original 1993 law. Performance measurement results provide valuable information about the success of CMS' programs and activities. CMS uses performance information to identify opportunities for improvement and to shape its programs. The use of our performance measures also provides a method of clear communication of CMS programmatic objectives to our partners, such as states and national professional organizations. Performance data are extremely useful in shaping policy and management choices in both the short and long term. We look forward to the challenges represented by our performance goals and are optimistic about our ability to meet them.

FINANCIAL ACCOMPLISHMENTS

CMS has maintained a strong financial management operation, by implementing many initiatives throughout the Agency for FY 2011. Although all may not be discussed in detail below, CMS continues to improve CMS' financial management and reporting processes in order to provide timely, reliable, and accurate financial information to allow CMS management, and other decision makers to make timely and accurate program and administrative decisions.

Financial Management and Reporting

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

Healthcare Integrated General Ledger Accounting System

CMS is still in the process of standardizing and centralizing Federal financial accounting by developing and implementing an integrated dual-entry accounting system. This accounting system, the Healthcare Integrated General Ledger Accounting System (HIGLAS), will replace the existing accounting system for Medicare and Medicaid. The need for HIGLAS initially started with the Medicare contractor community. The Medicare contractors' claims processing systems are operating effectively in adjudicating healthcare claims; however, they were not designed to meet the requirements of a dual entry general ledger accounting system. As a result, they did not meet the provisions of the Federal Financial Management Improvement Act of 1996 (FFMIA). Following the guidance of the Office of Management and Budget (OMB) Circular A-130, ***Management of Federal Information Resources***, CMS acquired a commercial off-the-shelf (COTS) product. As of FY 2010, CMS was substantially compliant with the Federal Financial Management Improvement Act (FFMIA) and considers our financial systems to be integrated in accordance with OMB Circular A-127, Financial Management Systems. As of September 2011, 96 percent of total Medicare program payments are accounted for in HIGLAS. Since going "live" in May of 2005, HIGLAS has processed more than 2.7 billion claims and processed over 106.7 million payments worth $1.07 trillion, as of September 2011. HIGLAS will continue to enhance CMS' oversight of claims administration contractor financial operations and the accounting and reporting of other CMS activities as well as, provide high quality, timely data for decision making and performance measurement.

Federal Payment Levy Program

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

CMS began participating in the FPLP in October 2008, for Medicare FFS payments made through HIGLAS. Specifically, the MIPPA legislation requires that Medicare FFS payments to providers will be offset by a maximum of 15 percent to satisfy payment of delinquent Federal tax debt and 100 percent to satisfy payment of Administrative Offsets for Federal non-tax debt. Non-tax debts include unpaid loans, overpayments or duplicate payments to Federal salary or benefit payment receipts, misused grant funds and fines, penalties, or fees assessed by Federal agencies. All (100 percent) of Medicare FFS payments will be subject to FPLP by 2012. As of September 2011, CMS has realized a cumulative total of $130.9 million in tax levy offsets and $39.1 million in non-tax offsets through HIGLAS on behalf of FPLP.

Communication & Financial Reporting

During FY 2011, CMS continued to improve its communication through the Risk Management and Financial Oversight Committee, which is comprised of members of CMS' senior leadership. The Risk Management and Financial Oversight Committee acts as the conduit for discussing financial management issues impacting the Agency and its financial statements. This committee ensures effective communication and a coordinated process among cross-functional areas within CMS. The Office of Financial Management (OFM) also meets monthly with upper-level management from various program centers/offices to discuss financial and budget concerns that could impact the CFO audit and day-to-day operations.

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

generally accepted accounting principles and Federal Financial Accounting Standards.

Recovery Audit Contractor Program

Medicare

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

In FY 2011, the Medicare FFS Recovery Audit program demanded approximately $961.3 million and recovered $797.4 million. FY 2011 recoveries were 958 percent higher than recoveries in the implementation years of FY 2009 and FY 2010. The Recovery Auditors focused their reviews on short hospital stays and claims for Durable Medical Equipment. This is consistent with CMS' focus to lower the Medicare error rate. CMS expects that implementation of certain corrective actions will lower collections for some types of claims; however, collections will remain stable or increase slightly as Recovery Auditors continue to expand their reviews to other claim types. CMS continues to monitor the Recovery Audit Program and makes continuous improvements to activities, such as, the appeals process, feedback to providers, and system improvements. CMS is also focused on taking the findings identified by the Recovery Auditors and putting actions into place to prevent future improper payments. For example, in FY 2011, CMS released four Provider Compliance Newsletters that provided detailed information on 31 findings identified by the Recovery Auditors. CMS also implemented local and/or national system edits to automatically prevent improper payments.

Medicaid

Section 6411 of the Affordable Care Act required the expansion of the Recovery Audit Contractor (RAC) program to Medicaid. CMS published a final rule in September 2011 that established the requirements for the state RACs. This final rule aligned the Medicaid RAC requirements to existing Medicare requirements where feasible, and provided state flexibility to tailor the programs where appropriate.

Debt Management

The Debt Collection Improvement Act of 1996 (DCIA), CMS is mandated to refer all eligible debt over 180 days delinquent to Treasury—via the HHS Program Support Center (PSC), which serves as a Debt Collection Center (DCC)—for collection. Treasury uses a variety of collection tools, including sending additional demand letters, referring debts to the Treasury Offset Program (TOP), referring debts to private collection agencies, negotiating repayment agreements, and referring some debts to the Department of Justice (DOJ) for litigation. As of September 2011, the total amount of delinquent debt referred by CMS to the PSC to process and transfer to Treasury is approximately $812 million.

Administrative Payments

To date in FY 2011, we have continued to make all of our payments on-time in accordance with the Prompt Payment Act. We also continue to have more than 99 percent of our vendor payments made via Automated Clearing House (ACH) and nearly 100 percent of our travel payments via ACH.

Budget Execution

For FY 2011, CMS' budget execution function continues to be a major strength. The CMS Chief Operating Officer works closely with the Chief Financial Officer to ensure that an Administrator approved operating plan is developed timely and supports CMS' priorities. Strong fund control procedures ensure resources are only used for those activities in the operating plan that has been approved by the Administrator. CMS closely monitors available resources throughout the year to ensure the Anti-Deficiency Act is not violated, while at the same time meeting reasonable but aggressive lapse targets.

Medicare Secondary Payer (MSP)

CMS efforts in the MSP area saved the Medicare trust funds approximately $7.49 billion through the first ten months of FY 2011. CMS continues to expand and improve its coordination of benefits activities to ensure that fewer mistaken payments are made while, at the same time, continuing to actively pursue delinquent debts owed the Medicare program in compliance with DCIA. CMS is confident that savings attributable to the MSP Program will continue to 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 CHIP 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 all will be required to fully report in January 2012.

To date, GHP data submitted under section 111 has quickly become the primary source of new MSP information for CMS, representing as much as 95 percent of new MSP records being posted to CMS' systems. Most significantly, with the dramatic increase in the number of insurers reporting data today, the volume of GHP 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 GHP insurers. As of August 2011, there was an excess of 1,500 GHP 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. 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.

In addition, CMS continues to contract for the financial and medical review of proposed Workers' Compensation Medicare Set-aside Arrangement (WCMSA) amounts that represent monies earmarked in a workers' compensation settlement for future medical services/items that would otherwise be payable by the Medicare program. As a result, CMS has calculated and approved WCMSA amounts totaling approximately $1.439 billion over the period October 1, 2010 through July 31, 2011 (payments that Medicare might otherwise erroneously make in terms of beneficiaries' future medical expenses related to their associated accident, illness, or injury).

Finally, with CMS' recovery functions for all new MSP GHP and Non-GHP debt being consolidated into one Medicare Secondary Payer Recovery Contractor (the MSPRC), CMS recoveries realized under the MSPRC have gradually increased each year. Total savings from recoveries were $1,425 million for the first ten months of FY 2011. This equates to a projected annual recovery amount of $1.546 billion for all of FY 2011.

Program Integrity

Program Integrity (PI) encompasses the operations and oversight necessary to ensure that accurate payments are made to legitimate providers for appropriate and reasonable services for eligible beneficiaries of the Medicare, Medicaid, and CHIP programs. It spans a range of underlying causes of improper payments, including errors, fraud, waste, and abuse. The Center for Program Integrity (CPI) was created in April 2010, to align the Medicare and Medicaid PI groups and strengthen existing PI activities. In February 2011, CPI further realigned activities to add three new groups: Data Analytics, Provider Enrollment, and a PI enforcement group to support the Center's strategic direction.

Strategic Direction

CMS has six key strategies. 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. CMS is also committed to becoming more transparent and accountable, which complements the fifth strategy of meaningfully engaging our public and private partners. Finally, CMS is dedicated to continuing to coordinate and integrate the Medicare and Medicaid strategy to become more effective while reducing burden on the legitimate provider and supplier community.

The four major areas and approaches CMS undertakes focus on these key anti-fraud activities:

- **Fraud Prevention:** the National Fraud Prevention Program, engaging Medicare beneficiaries, educating state Medicaid program integrity staff, antifraud marketing, and improving payment accuracy;

- **Fraud Detection:** Partnering with providers, Part C and D compliance activities, Medicaid data analytics and audit activities;
- **Transparency and Accountability:** Increasing coordination with law enforcement, collaborating with the private sector and states; and
- **Recovery:** Collaborating with law enforcement (HEAT) and implementation of the Medicaid and Medicare Part C/D RACs.

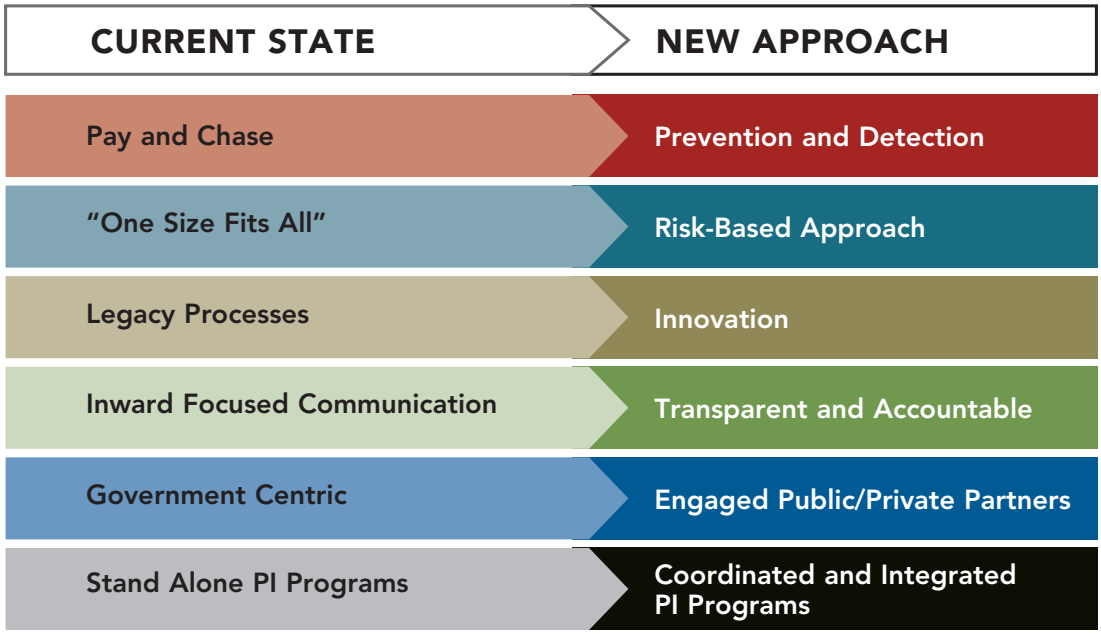
The Affordable Care Act

CMS has implemented many of the important PI provisions included in the Affordable Care Act that is helping to move the PI strategy beyond "pay and chase," as well as aligning Medicare and Medicaid program integrity requirements. CMS published a final rule with comment titled, "Medicare, Medicaid and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions, and Compliance Plans for Providers and Suppliers" in February 2011. This final rule established risk-based provider enrollment screening requirements that are parallel between Medicare and Medicaid, and permits states to rely on the results of Medicare screening for providers who participate in both programs. The final rule also established CMS' authority to suspend payments pending the investigation of a credible allegation of fraud, provider enrollment application fees, and for the first time, authority to impose temporary provider enrollment moratoriums when the Secretary of HHS determines there is a risk of fraud. The Affordable Care Act also requires the termination of providers from Medicaid if they have been terminated for cause from Medicare or any other Medicaid program; and enables CMS to terminate from Medicare if the provider has been terminated from any Medicaid program.

Medicare Program Integrity

The Medicare Program Integrity functions include the detection and deterrence of fraudulent billing in the Medicare program. This is accomplished through the use of enhanced provider enrollment activities, proactive data analysis, and the investigation of complaints from various sources, provider on-site visits, and beneficiary interviews.

- **Provider and Supplier Enrollment:** This function serves to ensure that only eligible providers and suppliers that meet the Medicare enrollment criteria furnish, order, refer or certify services for Medicare beneficiaries. This function prevents "bad" providers and suppliers from program entry while also helping to ensure the quality of services provided to Medicare beneficiaries.
- **Benefit Integrity (BI):** BI functions to identify, detect, and prevent fraudulent or abusive behavior against the Medicare program. To protect the Trust Fund, BI constantly monitors



program trends. Administratively, BI may require corrective action plans, or impose administrative actions such as payment suspensions, overpayment collections, and referrals to law enforcement or sanctions. Other additional BI responsibilities include acting as law enforcement liaisons to ensure coordination on crosscutting issues.

CMS is significantly enhancing its approach to fraud and abuse oversight activities of the Medicare Program. CMS has developed a dual approach to claims processing and enrollment screening as part of its new National Fraud Prevention Program. The program is leveraging sophisticated analytic tools to identify fraudulent claims and, ultimately, the providers who submit such claims, to ensure they are quickly and permanently removed from Medicare, Medicaid, and CHIP. The strategy coordinates the two key PI activities, provider enrollment and benefit integrity, so that the program is stronger and more efficient than a stand-alone project.

CMS is also strengthening provider enrollment operations by streamlining several key processes. First, CMS has issued a solicitation for a National Site Verification Contractor to support the new screening requirements included in the Affordable Care Act. CMS is also awarding an Automated Provider Enrollment Screening contract that will provide continuous monitoring of key enrollment requirements such as licensure. Both contracts are targeted for full implementation in early 2012.

CMS implemented a National Fraud Prevention System (FPS) in June 2011, as required by the Small Business Jobs Act of 2010. The FPS is an innovative risk scoring technology that applies proven predictive models to nationwide Medicare FFS claims on a pre-payment basis. The risk-scores identify highly suspect claims, and help target resources to the areas of Medicare's greatest risk. The FPS was designed based on proven technology that has demonstrated effectiveness against fraud to support volumes increasing by a factor of 10 while operational resources were reduced to less than half in the private sector.

CMS has awarded five of the seven contracts required to complete the realignment of the Zone Program Integrity Contractors (ZIPICs) with the MACs. The seven zones were created to target fraud "hot spots" in the United States. This new risk-based strategy has allowed for a more efficient and effective contracting model and enhances collaboration between the ZPICs so that they share information on fraudulent schemes on an ongoing basis. Additionally, CMS has been able to fund projects directed at new vulnerabilities, improve the infrastructure required for the data analysis that is the foundation of all PI work, and address the numerous administrative and congressional priorities. Our PI contractors continue to produce savings for Medicare Parts A and B by identifying overpayments, referring cases to law enforcement, and by taking an aggressive approach with other administrative actions such as payment suspensions, prepaid claims edit denials, auto denial edits, and revocations.

Finally, CMS is expanding the scope and character of data analysis to enhance ongoing detection efforts. One instance is the use of a geospatial toolset to create a national "heat map" of beneficiary calls with a fraud reference. The technology has the ability to track such calls to identify changing trends and new hot spots just as they are emerging. Using existing data in this innovative way also enables CMS to target providers and suppliers with multiple beneficiary complaints for further investigation.

Medicare Drug Integrity Contractor

CMS continued its efforts in combating fraud, waste, and abuse in the Medicare Part C and Part D programs through the use of the Medicare Drug Integrity Contractor (MEDIC) program. In FY 2011, the national benefit integrity MEDIC received approximately 342 actionable complaints (within the MEDIC's scope) per month; processed 34 requests for information from law enforcement per month; and referred an average of 36 cases per month. The national benefit integrity MEDIC was responsible for assisting the Office of the Inspector General (OIG) and the DOJ (through data analysis and investigative case development) in achieving four guilty pleas, seven arrests, and eight indictments. A particular case produced a 34-count indictment and included a group of 25 individuals and 26 pharmacies owned by one individual in the Detroit area, involving approximately $38 million dollars in Medicare funds. The national benefit integrity MEDIC has also been a key participant in a Part D drug scheme that originated in West Hollywood, CA. Many case referrals have resulted from this project and there is potential for multiple future indictments.

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. CMS has also recently instituted a number of targeted efforts in Houston, which is a high vulnerability area with a large number of beneficiaries and providers/suppliers.

The Miami FO has implemented a comprehensive, multipronged approach to address all aspects of healthcare fraud in South Florida and has served as a testing ground for efforts that may eventually be expanded to a national level. A key Miami FO's initiative has been a more intensive provider enrollment screening process. The intensive screening is coupled with the complementary strategy that uses the results from a dedicated fraud hotline to target follow-up site visits or other activities for providers and suppliers on the watch list.

The New York FO initiated the DME Stop Gap Plan in 2009 to address the continued growth in DME payments and the number of Durable Medical Equipment Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers. This two-year project used data analysis to identify seven "high risk" DME areas (New York, North Carolina, Michigan, California, Texas, Florida, and Illinois). The project targets the highest billing DME suppliers, highest ordering physicians, highest utilizing beneficiaries, and highest risk types of equipment and supplies for a closer look. The project has been extremely effective; over the past two years, workgroup members have completed 5,230 site visits/interviews of high risk providers, suppliers and beneficiaries, denied $34.9 million in claims, requested $66.2 million in overpayments, opened 1,200 new investigations, and revoked or deactivated 469 DME suppliers.

The Compromised Number Checklist (CNC) is both a repository and searchable database of all compromised Medicare beneficiary identification numbers (Health Insurance Claim Numbers (HICNs)) and provider identification numbers (National Provider Identifiers) used to bill or order Medicare services. The creation of the CNC has facilitated data analysis for fraud detection and prevention by consolidating compromised numbers into one location for the first time. To date, the CNC has identified 5,134 compromised providers/suppliers and approximately 284,152 compromised HICNs. This information is then used by the ZPICs to evaluate suspect claims, open investigations and refer to law enforcement or take administrative action, as appropriate.

Health Care Fraud Prevention and Enforcement Team (HEAT)

CMS continues to be 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:

- **Continued coordination of nationwide takedowns:** CMS most recently played a key role in a multi-state takedown of fraudulent providers, resulting in the arrest of 91 individuals responsible for $295 million in false Medicare billings, as announced by HHS and DOJ in September 2011.

- **Expanding the Medicare Fraud Strike Forces:** The Strike Forces are a key component of the HEAT strategy designed to reduce Medicare fraud. The Strike Forces combine data analysis capabilities of CMS and the investigative resources of the Federal Bureau of Investigation (FBI) and HHS/OIG with the prosecutorial resources of the DOJ Criminal Division, Fraud Section and the United States Attorney Offices. There are currently nine Strike Force cities and additional cities are planned by the end of 2012, as budget resources permit.

- **Health Care Fraud Prevention Summits:** CMS partnered with the DOJ to host Health Care Fraud Prevention Summits in four cities during FY 2011—Brooklyn, NY; Boston, MA; Detroit, MI; and Philadelphia, PA. These summits bring together a wide array of federal, state and local partners, beneficiaries, and providers to discuss innovative ways to eliminate fraud across the U.S. health care system. The summits are part of the larger joint effort of the DOJ and HHS through the HEAT.

Medicaid Program Integrity

The Deficit Reduction Act of 2005 established the Medicaid Integrity Program in section 1936 of the Social Security Act and represents a substantial milestone in CMS' first national strategy to detect

and prevent Medicaid fraud and abuse. This program offers a unique opportunity to identify, recover, and prevent inappropriate Medicaid payments. It will also support the program integrity efforts of state Medicaid agencies through a combination of oversight and technical assistance.

The Medicaid Integrity Group (MIG) within CPI leads the significant progress that has been made in developing a strong, effective, and sustainable program to combat Medicaid provider fraud, waste, and abuse. Specifically, the MIG has implemented the following four major functions to accomplish the requirements of the statute: (1) Procurement and oversight of Medicaid Integrity Contractors who conduct reviews, audits and education; (2) Field operations to provide effective support and assistance to state program integrity efforts through oversight reviews, training, and technical assistance; (3) Fraud research and detection to provide statistical data support, identify emerging fraud trends and conduct special studies; and (4) Development of the annual Report to Congress and the Comprehensive Medicaid Integrity Plan in consultation with internal and external partners to guide CMS' efforts.

National Medicaid Audit Program

In FY 2011, the National Medicaid Audit Program continued to evolve. CMS awarded task orders in all regions for contractors to review provider claims, conduct provider audits, and initiate provider education activities. In addition to this traditional audit work, CMS partnered with states to develop collaborative audits in areas such as hospice, drug diversion and Part D. These efforts resulted in roughly 60 audits with seven states.

Improper Payments

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

The supplemental measures will be calculated based on the results of State Payment Accuracy Improvement Groups (PAIG). A PAIG is a group of states with a shared, identified Medicaid program integrity vulnerability and has a common approach or intervention that will be evaluated to assess how well it addresses the problem. A pre- and post-intervention measurement is taken to determine the effectiveness of the approach and the results are shared with the other states. This facilitates the implementation of best practice interventions by providing states information on tested approaches to reducing the error rate. CMS launched the first PAIG project to measure improper payments in July 2010. We anticipate publishing the baseline data for this project in the late 2011, with final results expected by early 2013.

Education for States

CMS continues to offer training to state Medicaid program officials through the Medicaid Integrity Institute (MII). The MII provides a unique opportunity for HHS to offer substantive training, technical assistance, and support to states in a structured learning environment. As of June 2011, the MII provided training to 461 state employees/officials from 47 states, the District of Columbia and Puerto Rico, through 11 courses. An additional eight courses were conducted through September 2011. Nineteen courses are scheduled for FY 2012. In addition in FY 2011, CMS sponsored six state training courses on its own, for the states of California, Florida, Illinois, Georgia, New York, and Texas, in either Medical Records Auditing or Current Procedural Technology (CPT) coding. CMS is developing systematic methods of calculating the return on investment from the training it provides states.

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

States also have many opportunities to share ideas and network with peers through national and regional conference calls and meetings sponsored by CMS. The Medicaid Fraud and Abuse Technical

Advisory Group (TAG) meets monthly to provide information to states and to support CMS' program integrity efforts. In addition, CMS sponsors regional calls ranging from monthly to quarterly.

Technical Assistance to the States

CMS provides substantial oversight of state program integrity activities and technical assistance to states and others. In FY 2011, CMS conducted 16 comprehensive program integrity reviews which identified regulatory non-compliance, program integrity best practices and program integrity vulnerabilities in every state reviewed. CMS published its annual review of state best practices in June 2011. Also, CMS released its fifth Report to Congress for FY 2010 on the MIP in June 2011.

CMS publishes an annual State Program Integrity Assessment which provides valuable information on each state's program integrity efforts, including staffing, expenditures and recoveries of overpayments. In FY 2011, through third quarter, CMS fulfilled 397 requests for technical assistance from state employees, attorneys, providers and others in a variety of program integrity-related areas.

In FY 2011, CMS participated in three field projects with the State of Florida. In each, state and Federal staff worked side by side to interview prescribers, providers and beneficiaries whose Medicaid claims had been flagged for additional review. In total, since FY 2007, CMS has participated in eight such projects with Florida Medicaid. The projects have been responsible, in part, for an estimated $32.2 million reduction in overall home health expenditures in eight selected Florida counties. A total of 654 prescribers, 43 home health agencies and DME suppliers, and 1,150 beneficiaries have been interviewed in all field projects, including one each in California and New York. Approximately 400 actions have also been taken against providers and suppliers, including fines, suspensions, licensing referrals, fraud referrals and education letters.

Medicare Advantage and Prescription Drug Financial Oversight

CMS continued its implementation of the financial and audit program examinations of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs). The financial audit program is designed to examine the health plans' financial records, data relating to costs, Medicare utilization, and the computation of the bids. CMS awarded contracts for 234 audits for contract year 2008. During FY 2011, CMS completed all of remaining audits for 2008. Furthermore, CMS completed the desk reviews and audits of the Risk Sharing Reconciliations for the Regional Preferred Provider Organizations (RPPOs) for contract years 2006 and 2007. In order to satisfy the annual one-third audit requirement, CMS awarded contracts for 252 audits for contract year 2009. Through our ROs, CMS conducts audits of the MAOs and PDPs—outside of the one-third audit requirement—to further improve oversight of both Part C and Part D sponsors.

CMS has also reduced the number of backlogged unsettled managed care cost reports in FY 2011. Disallowances resulting from FY 2011 settlement activity amounted to about $21.8 million. For FY 2011, CMS had a rate of return of $23.47 to $1. The remaining backlog still represents a challenge to CMS because these cost reports have critical issues that must be resolved with managed care organizations.

Information Technology (IT)

During FY 2011, CMS made great strides to strengthen IT internal controls, particularly its oversight of the implementation of those controls. The management approach featured a strategy to leverage information security processes and technologies to improve the overall security posture of the CMS Enterprise. In the last year, CMS' information security program has undergone, and continues to undergo, significant change that extends security oversight, continuous monitoring, and vulnerability management to the CMS Enterprise. The Office of the Chief Information Security Officer (OCISO)'s oversight of information security has continued to move CMS from a distributed model for governing information security, where business components fully manage security oversight, to a hybrid model, where OCISO plays a much more active oversight role. CMS has established several programs to enhance continuous monitoring to help drive real-time enterprise-level situational awareness, increase the efficiency of the CMS system authorization process, and drive ongoing communications with business stakeholders. Additionally, CMS continues to implement and enhance the following information security initiatives:

- A Security Operations Center (SOC) that provides an enterprise view of the overall security posture at CMS, and is a key component in driving oversight, monitoring compliance, and identifying misuse or fraudulent

use of CMS Enterprise resources. Overall development activities continue with Secure Enclave tool implementations at CMS data centers. CMS also plans to deploy a Cyber Forensics capability that will broaden the SOC's spectrum of technical capabilities to include monitoring the integrity of the CMS Enterprise and further assisting the OIG and the Center for Program Integrity (CPI) in effective investigations.

- An Enterprise Vulnerability Management (EVM) program at CMS provides a near-real-time profile of vulnerabilities in the CMS enterprise and enhances the continuous monitoring process by providing management with information about CMS systems' ongoing vulnerabilities.

- CMS has began centralizing all CMS Security and Risk Management Framework practices, procedures, standards, and guidelines into a comprehensive three-volume *CMS Risk Management Handbook (RMH)*. This document details the integration of information security into the CMS IT Investment & System Life Cycle Framework (ILC). As part of the RMH development, the OCISO established much needed security policy updates, including policies for Cloud Computing and Authentication. CMS continues to be a major contributor on a number of directives and IT governance documents for the CMS Chief Information Officer.

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

Oversight of Medicare Contractor Financial Operations & Reporting

Medicare contractors administer the day-to-day operations of the Medicare FFS program by paying claims, auditing provider cost reports, and establishing and collecting overpayments. While performing these activities, Medicare contractors are required to maintain a vast array of financial data. With the availability of real time financial data provided by HIGLAS, CMS' implementation of new and/or revised policies over the past several years and other key initiatives to train staff and review contractor operations has resulted in significant improvements in the contractors' financial management activities and in the oversight of the Agency. 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. One example of these analytical tools is the HIGLAS monthly Financial Integrity Reconciliation.

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

The Medicare contractors are subject to various financial management and IT security audits and reviews performed by the OIG, Government Accountability Office (GAO), independent CPA firms, and CMS staff to provide reasonable assurance that they have developed and implemented sound internal controls. The results of these audits indicate if the contractors' internal controls have significant design or operational deficiencies. Audit resolution is a top priority at CMS and correcting these deficiencies is essential to improving financial management. Therefore, Medicare contractors are required to prepare corrective action plans (CAPs), which describe activities to correct findings and the timeframes for which they will be implemented. The initial CAP reports, which have been prepared using standardized formats, consolidate the findings and facilitate our monitoring responsibilities. Quarterly updates to the CAPs are required and CMS

reviews all CAP submissions for adequacy. CMS also requires all Medicare contractors to submit an annual Certification Package for Internal Controls (CPIC). In the CPIC, contractors are required to report any material weaknesses and significant deficiencies identified during the FY, along with CAPs to remedy the weaknesses.

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 2011 to assist in performing management's self-assessment in support of the assurance statement regarding internal controls over financial reporting as of June 30. The scope of the review included CMS central office, four regional offices, and 19 major IT applications. In addition, the CPA firm conducted Circular A-123, Appendix A Internal Control over Financial Reporting (ICOFR) reviews at eight Medicare contractors (including the Retiree Drug Subsidy and the MSPRC), seven data centers, four shared system maintainers, and the Single Testing Contractor (STC) for the shared systems.

The MACs continued to contract with independent CPA firms to conduct Statement on Auditing Standards 70 (SAS 70) internal control audits. As a result, 12 SAS 70 audit reports were leveraged for the FY 2011 ICOFR review. Also, we conducted CAP follow-up reviews related to SAS 70 internal control audits and other reviews conducted in previous years. To implement the requirements under Appendix A of OMB Circular A-123, CMS: (1) planned and scoped the evaluation, (2) documented controls and evaluated the design of the controls, (3) tested operating effectiveness, (4) identified and corrected deficiencies, and (5) reported on internal controls. CMS provided an assurance statement as of June 30 and updated it as of September 30. The results of our self-assessment are provided in the ***Summary of Federal Managers' Financial Integrity Act Report and OMB Circular A-123 Statement of Assurance*** section.

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

Financial Statements Introduction and Highlights

Introduction

The basic financial statements in this report are prepared pursuant to the requirements of the *Government Management Reform Act* of 1994 and the *Chief Financial Officer's Act of 1990*. Other requirements included the OMB Circular A-136[4], *Financial Reporting Requirements*. The responsibility for the integrity of the financial information included in these statements rests with management of CMS. The OIG selects an independent certified public accounting firm to audit the CMS financial statements and notes.

Consolidated Balance Sheets

The Consolidated Balance Sheets present as of September 30, 2011 and 2010, amounts of future economic benefits owned or managed by CMS (assets), amounts owed (liabilities), and amounts that comprise the difference (net position). A Consolidating Balance Sheet by Major Program is provided as additional information. CMS' Consolidated Balance Sheet has reported assets of $424.2 billion. The bulk of these assets are in the Earmarked Investments totaling $320.0 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 $74.5 billion, most of which is for Medicaid, Other Health, and CHIP. Liabilities of $87.5 billion consist primarily of the Entitlement Benefits Due and Payable of $80.9 billion. CMS net position totals $336.7 billion and reflects primarily the cumulative results of operations for the Medicare Trust Funds and the unexpended balances for Medicaid and CHIP.

[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.

Consolidated Statements of Net Cost

The Consolidated Statements of Net Cost present the net cost of operations for the years ended September 30, 2011 and 2010. The Statement of Net Cost shows only a single dollar amount: the actual net cost of CMS' operations for the period by program. Under the *Government Performance and Results Act (GPRA)*, CMS is required to identify the mission of the agency and develop a strategic plan and performance measures to show that desired outcomes are being met. The three major programs that CMS administers are: Medicare, Medicaid, and CHIP. The bulk of CMS' expenses are allocated to these programs. Both Medicare and Medicaid program integrity funding are included under the HI trust fund. The costs related to the Program Management Appropriation are cost-allocated to all three major components. The net cost of operations under "Other Activities" include: CLIA, State Grants and Demonstrations, Other Health, and Other. A Consolidating Statement of Net Cost is provided to show the earmarked vs. non-earmarked components of net cost as additional information.

Total Benefit Payments were $812.8 billion for FY 2011. Administrative Expenses were $3.5 billion, less than one percent of total net Program/Activity Costs of $754.1 billion.

The net cost of the Medicare program including benefit payments, QIOs, Medicare Integrity Program spending, and administrative costs, was $474 billion. The HI total costs of $259.9 billion were offset by $3.5 billion in revenues. The SMI total costs of $277.6 billion were offset by premiums and other revenues of $60 billion. Medicaid total costs of $268.1 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 $8.7 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, 2011 and 2010. The Statement of Changes in Net Position (SCNP) reports the change in net position during the FY that occurred in the two components of net position: Cumulative Results of Operations and Unexpended Appropriations. Earmarked funds are shown in a separate column from other funds. A Consolidating Statement of Changes in Net Position is provided to present the change in net position by major programs as additional information.

The line, Appropriations Used, represents the Medicaid appropriations used of $267.3 billion; $242.2 billion in transfers from Payments to Health Care Trust Funds to HI and SMI; CHIP appropriations of $8.7 billion and State Grants and Demonstrations and general fund-financed Program Management appropriations of $830 million. Medicaid and CHIP are financed by a general fund appropriation provided by Congress. Employment tax revenue is Medicare's portion of payroll and self employment taxes collected under the Federal Insurance Contributions Act (FICA) and Self Employment Contributions Act (SECA) for the HI Trust Fund, and totaled $192.1 billion. The Federal matching contribution is income to the SMI program from a general fund appropriation (Payments to Health Care Trust Funds) of $168.8 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, 2011 and 2010. 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 $1,175.2 billion. Obligations of $1,133.4 billion leave unobligated balances of $41.8 billion (of which $4 billion is not available). Total outlays, net of collections, were $1,089.3 billion. When offset by $321.9 billion relating to collection of premiums and general fund transfers from the Payments to Health Care Trust Funds, as well as refunds of Medicare contractor overpayments, the net outlays were $767.4 billion.

Statement of Social Insurance (SOSI)

Effective FY 2011, CMS has adopted the new provisions for the Federal Accounting Standards Advisory Board (FASAB) SFFAS Number 37 – *Social Insurance: Additional Requirements for Management Discussion and Analysis (MD&A) and Basic Financial Statements.*[5] 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 as of January 1, 2011) decreased from $(2.7) trillion, determined as of January 1, 2010, to $(3.3) trillion, determined as of January 1, 2011.

[5] On April 5, 2010, FASAB issued SFFAS 37, which was an amendment to SFFAS 17, Accounting for Social Insurance, to provide more accurate and transparent financial reporting information to the public.

Including the combined HI and SMI Trust Fund assets increases the present value, as of January 1, 2011, of future cashflow for all current and future participants to $(2.9) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI Trust Fund assets, is $(7.7) trillion.

HI TRUST FUND SOLVENCY

Pay-as-you-go Financing

The HI Trust Fund is deemed to be solvent as long as assets are sufficient to finance program obligations. Such solvency is indicated, for any point in time, by the maintenance of positive Trust Fund assets. In recent years, current expenditures have exceeded program income for the HI program, and thus, the HI Trust Fund assets have been declining. The following table shows that HI Trust Fund assets, expressed as a ratio of the assets at the beginning of the fiscal year to the expenditures for the year. This ratio has steadily dropped from 149 percent at the beginning of FY 2007 to 106 percent at the beginning of FY 2011.

TRUST FUND RATIO Beginning of Fiscal Year[6]					
	2007	2008	2009	2010	2011
HI	149%	139%	134%	124%	106%

Short-Term Financing

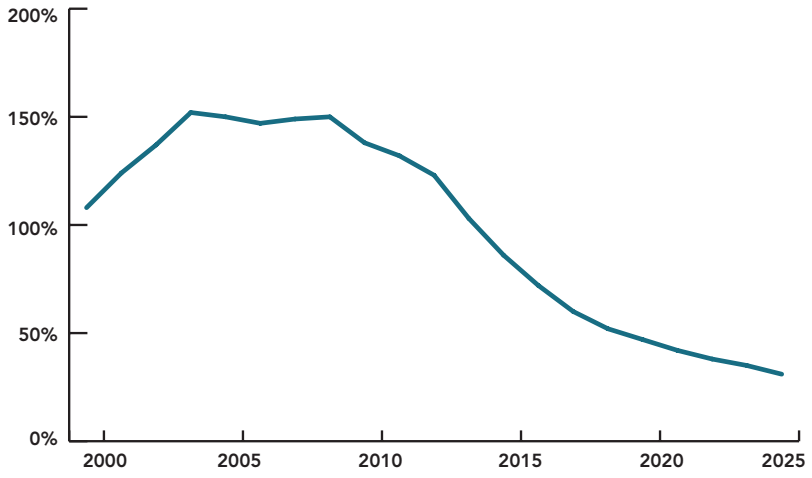
The HI Trust Fund is deemed adequately financed for the short term when actuarial estimates of Trust Fund assets for the beginning of each calendar year are at least as large as program obligations for the year. Estimates in the 2011 Trustees Report indicate that the HI Trust Fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2011 Trustees Report, the HI Trust Fund ratio is estimated to steadily decline to about 31 percent by the beginning of calendar year 2020. From the end of 2010 to the end of 2020, assets are expected to decline by 60 percent, from $272 billion to $108 billion.

Long-Term Financing

HI financing is not projected to be sustainable over the long term with the tax rates and expenditure levels projected in current law. Program cost will exceed total income in all years of the 75-year projection period. In 2024, the HI Trust Fund will be exhausted according to the projections by the CMS Office of the Actuary. Under current law, when the HI Trust Fund is exhausted, full benefits cannot be paid on a timely basis. Tax revenues are projected to be sufficient to support 90 percent of projected expenditures after the HI Trust Fund exhaustion in 2024, declining to 88 percent of projected expenditures in 2085.

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 3.4 in 2010 to about 2.0 by 2085. In addition, health care costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $3.3 trillion, which is 0.7 percent of taxable payroll and 0.3 percent of Gross Domestic Product (GDP) over the same period.

HI TRUST FUND RATIO



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

Significant uncertainty surrounds the estimates for the SOSI. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near-term and ultimate assumptions used in the projections. For more information, please refer to the *Required Supplementary Information: Social Insurance* disclosures required by the FASAB.

SMI TRUST FUND SOLVENCY

The SMI Trust Fund consists of two accounts—Part B and Part D. In order to evaluate the financial status of the SMI Trust Fund, each account needs to be assessed individually, since financing rates for each part are established separately, their program benefits are quite different in nature, and there is no provision for transferring assets.

While differences between the two accounts exist, the financing mechanism for each part is similar in that the financing is determined on a yearly basis. The Part B account is 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 income over expenditures for the 75-year projection period is $(21.3) 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 2010, SMI expenditures were 1.89 percent of GDP. By 2085, SMI expenditures are projected to grow to 4.13 percent of the GDP.

The following table presents key amounts from our basic financial statements for fiscal years 2009 through 2011.

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

	2011	2010	2009
Net Position (end of fiscal year)			
Assets	$424.2	$430.7	$435.5
Less Total Liabilities	$87.5	$80.5	$77.7
Net Position (assets net of liabilities)	$336.7	$350.2	$357.8
Change in Net Position (end of fiscal year)			
Net Costs	$754.1	$728.7	$691.5
Total Financing Sources	$730.4	$709.5	$681.6
Change in Net Position	$(23.7)	$(19.2)	$(9.9)
Statement of Social Insurance (calendar year basis)			
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation	$(3,252)	$(2,683)	$(13,770)
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	$(2,683)	$(13,770)	$(12,737)
Change in present value	$(569)	$11,087	$(1,033)

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

Statement of Changes in Social Insurance Amounts (SCSIA)

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

The present value as of January 1, 2011, would have decreased by $112 billion due to advancing the valuation date by one year and including the additional year 2085. Similarly, changes in the projection base and demographic assumptions further decreased the present value of future cash flows by $531 billion and $112 billion, respectively. However, (1) legislative changes, (2) changes in economic data, assumptions, and methods, and (3) changes in programmatic data, assumptions, and methods revisions in assumptions each increased the present value of future cash flows by about $185 billion (please refer to Note 17, *Statement of Changes in Social Insurance Amounts* for further explanation).

Required Supplementary Information (RSI)

As required by SFFAS Number 17 (as amended by SFFAS Number 37), CMS has included information about the Medicare trust funds—HI and SMI. The RSI presents required long-range cash-flow projections, the long-range projections of the ratio of contributors to beneficiaries (dependency ratio), and the sensitivity analysis illustrating the effect of the changes in the most significant assumptions on the actuarial projections and present values. The SFFAS 37 does not eliminate or otherwise affect the SFFAS 17 requirements for the supplementary information, except that actuarial projections of annual cash flow in nominal dollars are no longer required; as such, it will not be reported in the RSI. The RSI assesses the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the ***2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds***, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds.

Limitations of the Financial Statements

The principal financial statements have been prepared to report the financial position and results of operations of CMS, pursuant to the requirements of 31 U.S.C. 3515(b). While the financial statements have been prepared from the books and records of CMS in accordance with generally accepted accounting principles for Federal entities and the formats prescribed by OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources that are prepared from the same books and records.

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

The Required Supplementary Information section is unique to Federal financial reporting. This section is required under OMB Circular A-136, *Financial Reporting Requirements*, and is unaudited.

FINANCIAL SECTION

a message from the

CHIEF FINANCIAL OFFICER

DEBORAH A. TAYLOR, CPA

I am pleased to present the fiscal year (FY) 2011 CMS Financial Report, including the audited financial statements with related program and financial information. As the Agency's Chief Financial Officer, I understand the importance of providing the American people maximum transparency and setting high standards for accountability in the financial information displayed in our financial report. The scale and complexity of CMS' programs, the increasing level of corresponding financial management requirements, and the economic environment in which we operate have challenged the Agency to practice and successfully achieve sound fiscal policies and procedures to support CMS' mission, programs, systems, business partners, and the millions of beneficiaries we serve.

While we received an unqualified opinion on four out of the six principal financial statements, one of the challenges for our auditors continues to be the audit of the Statement of Social Insurance (SOSI). For the second consecutive year, the auditors did not express an opinion on SOSI, due primarily to the uncertainty of the long-range assumptions used in the model. We continue to believe that the FY 2011 SOSI projections contained in this statement appropriately incorporate the effects of the Affordable Care Act and provide suitable disclosures as to the nature and uncertainty of the projection. The SOSI is prepared based on current law, in accordance with standards required by the Federal Accounting Standards Advisory Board, and alternative results are also disclosed and discussed.

During FY 2011, an independent panel of expert actuaries and economists was established to review the assumptions and methods used by the Medicare Board of Trustees to make the projections reflected in the FY 2010 SOSI. While the work of the panel has not been completed, their interim report found that the long-range Medicare growth rate assumptions used in the FY 2010 report were not unreasonable. They also recommended continued use of projections based on an illustrative alternative to current law to help assess the possible understatement in the Medicare costs projected under current law. The 2010 and 2011 Statements of Social Insurance and accompanying footnotes are fully consistent with their interim findings and recommendations. The Medicare Trustees will continue their efforts, with the assistance of the panel, to develop possible improvements to the long-range assumptions underlying the SOSI projections, and we will continue to work closely with our auditors to develop those actions necessary to remediate the issue for the future.

We continue to improve our internal controls by institutionalizing accountability, and decreasing the risk of financial fraud and errors. We are proud that CMS continues to have no material weaknesses reported by the independent auditors. However, the auditors continue to cite significant deficiencies in information systems controls and financial reporting processes. We place a very high priority on correcting findings that are identified as a result of any audit or review. Some of these actions, especially those surrounding information systems, are a multi-year effort requiring dedicated resources. To that end, we are already implementing or are in the process of implementing corrective action plans to address

those findings. Over the last year, CMS' information security program has undergone, and continues to undergo, significant improvements that enhance security oversight, continuous monitoring, and vulnerability management enterprise-wide.

As of September 2011, 96 percent of total Medicare program payments are accounted for through the Healthcare Integrated General Ledger Accounting System (HIGLAS). An integrated accounting system coupled with sound financial management practices is a top priority for CMS. The availability of "real time" financial data provided by HIGLAS, along with CMS' implementation of new and/or revised policies and procedures over the past several years has resulted in significant improvements in the Medicare Administrative Contractors' financial management activities and the overall financial management of the Agency. These improvements will help ensure the delivery of high quality and timely data used for decision making, performance measurement, and data analysis.

The CMS now reports error rates for all of its high-risk programs and continues efforts to reduce improper payments. The Medicare fee-for-service (FFS), Medicare Advantage (Part C), and Medicaid error rates all decreased in FY 2011 and we are reporting a composite error rate for the Prescription Drug (Part D) program for the first time in FY 2011. The CMS has made incredible progress over the last few years in implementing the requirements of the Improper Payment Information Act of 2002, which was amended in FY 2010 by the Improper Payments Elimination and Recovery Act regarding payment error measurement and reporting.

While we consider the decreased error rates a significant accomplishment, we know our work is not yet done and will target our FY 2012 initiatives at reducing these error rates even further. The CMS has developed some innovative initiatives, including several Medicare FFS demonstrations that we anticipate starting in the coming months.

Another key initiative in protecting the Medicare Trust Funds' assets is the Medicare FFS Recovery Audit program. During FY 2011, the Recovery Audit Program corrected over $939 million in Medicare payments. This represents an increase in corrections of 918 percent over FY 2010.

While we celebrate our successes, we acknowledge that there are areas in which we can improve, and we strive to swiftly identify and address such areas. We have worked diligently to embrace any challenge and maintain our dedication toward achieving the financial and operating responsibilities for the programs we manage and the millions of beneficiaries we serve. Our successes in financial management have been, and will continue to be, a joint effort between our dedicated employees and the internal and external stakeholders of our programs. The improvements we made over the last year demonstrate that we take the responsibility for stewardship of the Medicare Trust Funds very seriously, and we will continue to find opportunities to ensure the solvency of the Medicare Trust Funds.

DEBORAH A. TAYLOR, CPA
CMS Chief Financial Officer

November 2011

CONSOLIDATED BALANCE SHEETS

as of September 30, 2011 and 2010

(IN MILLIONS)

	FY 2011 Consolidated Totals	FY 2010 Consolidated Totals
ASSETS		
Intragovernmental Assets:		
Fund Balance with Treasury ***(Note 2)***	$74,517	$64,841
Investments ***(Note 3)***	322,065	356,621
Accounts Receivable, Net ***(Note 4)***	516	493
Other Assets	91	5
Total Intragovernmental Assets	**397,189**	**421,960**
Accounts Receivable, Net ***(Note 4)***	10,527	7,046
General Property, Plant and Equipment, Net	389	398
Other Assets ***(Note 5)***	16,083	1,309
TOTAL ASSETS	**$424,188**	**$430,713**
LIABILITIES		
Intragovernmental Liabilities:		
Accounts Payable	$651	$959
Accrued Payroll and Benefits	4	8
Other Intragovernmental Liabilities	878	803
Total Intragovernmental Liabilities	**1,533**	**1,770**
Federal Employee and Veterans' Benefits	13	13
Entitlement Benefits Due and Payable ***(Note 6)***	80,882	72,712
Accrued Payroll and Benefits	54	71
Contingencies ***(Note 7)***	3,016	5,391
Other Liabilities	1,947	547
TOTAL LIABILITIES *(Note 8)*	**$87,445**	**$80,504**
NET POSITION		
Unexpended Appropriations-earmarked funds	$4,335	$1,776
Unexpended Appropriations-other funds	42,093	34,377
Total Unexpended Appropriations	**46,428**	**36,153**
Cumulative Results of Operations-earmarked funds	288,862	313,447
Cumulative Results of Operations-other funds	1,453	609
Total Cumulative Results of Operations	**290,315**	**314,056**
TOTAL NET POSITION	**$336,743**	**$350,209**
TOTAL LIABILITIES AND NET POSITION	**$424,188**	**$430,713**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF NET COST

for the years ended September 30, 2011 and 2010

(IN MILLIONS)

	FY 2011 Consolidated Totals	FY 2010 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS		
GPRA Programs		
Medicare (Earmarked)	$474,005	$447,162
Medicaid	268,116	272,995
CHIP	8,689	7,968
Net Cost: GPRA Programs	**750,810**	**728,125**
Other Activities		
CLIA	101	10
State Grants and Demonstrations	679	533
Other Health	2,418	
Other	137	36
Net Cost: Other Activities	3,335	579
NET COST OF OPERATIONS *(Notes 9, 13 and 18)*	**$754,145**	**$728,704**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2011

(IN MILLIONS)

	Consolidated Earmarked Funds	Consolidated Other Funds	FY 2011 Consolidated Total
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	$313,447	$609	$314,056
Budgetary Financing Sources:			
Appropriations Used	242,152	279,539	521,691
Nonexchange Revenue:			
FICA and SECA Taxes	192,063		192,063
Interest on Investments	15,651	5	15,656
Other Nonexchange Revenue	2,455		2,455
Transfers-in/out Without Reimbursement ***(Note 10)***	(2,942)	1,437	(1,505)
Other Financing Sources (Nonexchange):			
Imputed Financing	41	3	44
Total Financing Sources	**449,420**	**280,984**	**730,404**
Net Cost of Operations	**474,005**	**280,140**	**754,145**
Net Change	**(24,585)**	**844**	**(23,741)**
CUMULATIVE RESULTS OF OPERATIONS	**$288,862**	**$1,453**	**$290,315**
UNEXPENDED APPROPRIATIONS			
Beginning Balances	$1,776	$34,377	$36,153
Budgetary Financing Sources:			
Appropriations Received	245,949	310,168	556,117
Appropriations Transferred-in/out		3,779	3,779
Other Adjustments ***(Note 11)***	(1,238)	(26,692)	(27,930)
Appropriations Used	(242,152)	(279,539)	(521,691)
Total Budgetary Financing Sources	**2,559**	**7,716**	**10,275**
Total Unexpended Appropriations	**4,335**	**42,093**	**46,428**
NET POSITION	**$293,197**	**$43,546**	**$336,743**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2010

(IN MILLIONS)

	Consolidated Earmarked Funds	Consolidated Other Funds	FY 2010 Consolidated Total
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	$332,752	$507	$333,259
Budgetary Financing Sources:			
Appropriations Used	228,878	280,791	509,669
Nonexchange Revenue:			
FICA and SECA Taxes	183,615		183,615
Interest on Investments	17,251	4	17,255
Other Nonexchange Revenue	616		616
Transfers-in/out Without Reimbursement ***(Note 10)***	(2,542)	844	(1,698)
Other Financing Sources (Nonexchange):			
Imputed Financing	39	5	44
Total Financing Sources	**427,857**	**281,644**	**709,501**
Net Cost of Operations	**447,162**	**281,542**	**728,704**
Net Change	**(19,305)**	**102**	**(19,203)**
CUMULATIVE RESULTS OF OPERATIONS	**$313,447**	**$609**	**$314,056**
UNEXPENDED APPROPRIATIONS			
Beginning Balances	$3,590	$20,936	$24,526
Budgetary Financing Sources:			
Appropriations Received	230,497	298,055	528,552
Appropriations Transferred-in/out		(3,746)	(3,746)
Other Adjustments ***(Note 11)***	(3,433)	(77)	(3,510)
Appropriations Used	(228,878)	(280,791)	(509,669)
Total Budgetary Financing Sources	**(1,814)**	**13,441**	**11,627**
Total Unexpended Appropriations	**1,776**	**34,377**	**36,153**
NET POSITION	**$315,223**	**$34,986**	**$350,209**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENTS OF BUDGETARY RESOURCES

for the years ended September 30, 2011 and 2010

(IN MILLIONS)

	FY 2011 Combined Totals Budgetary	FY 2010 Combined Totals Budgetary
Budgetary Resources:		
Unobligated balance, brought forward, October 1:	$30,770	$21,079
Recoveries of prior year unpaid obligations	22,733	15,589
Budget authority:		
Appropriation	1,140,143	1,064,764
Spending authority from offsetting collections:		
Earned		
Collected	3,925	1,274
Change in unfilled customer orders:		
Without advance from Federal sources	43	19
Expenditure transfers from trust funds	7,783	3,932
Subtotal	**1,151,894**	**1,069,989**
Nonexpenditure transfers, net, anticipated & actual	3,488	(3,841)
Temporarily not available pursuant to Public Law	(59)	(11,238)
Permanently not available	(33,658)	(3,606)
TOTAL BUDGETARY RESOURCES	**$1,175,168**	**$1,087,972**
Status of Budgetary Resources:		
Obligations incurred *(Note 14)*:		
Direct	$1,133,080	$1,056,971
Reimbursable	309	231
Subtotal	**1,133,389**	**1,057,202**
Unobligated balance:		
Apportioned	37,674	26,237
Exempt from apportionment	136	220
Subtotal	**37,810**	**26,457**
Unobligated balance not available	3,969	4,313
TOTAL STATUS OF BUDGETARY RESOURCES	**$1,175,168**	**$1,087,972**
Change in Obligated Balance:		
Obligated balance, net:		
Unpaid obligations, brought forward, October 1	$89,406	$84,730
Uncollected customer payments from Federal sources, brought forward, October 1	(2,868)	(2,558)
Total unpaid obligated balance, net	**86,538**	**82,172**
Obligations incurred, net	1,133,389	1,057,202
Gross Outlays	(1,097,503)	(1,036,937)
Obligated balance transferred, net:		
Recoveries of prior year unpaid obligations, actual	(22,733)	(15,589)
Change in uncollected customer payments from Federal sources	(3,594)	(310)
Obligated balance, net, end of period:		
Unpaid Obligations	102,559	89,406
Uncollected customer payments from Federal sources	(6,462)	(2,868)
Total, unpaid obligated balance, net,end of period	**96,097**	**86,538**
Net Outlays:		
Net Outlays		
Gross outlays	1,097,503	1,036,937
Offsetting collections	(8,157)	(4,915)
Distributed offsetting receipts	(321,925)	(302,966)
NET OUTLAYS	**$767,421**	**$729,056**

The accompanying notes are an integral part of these statements.

STATEMENT OF SOCIAL INSURANCE

75-Year Projection as of January 1, 2011 and Prior Base Years

(IN BILLIONS)

		Estimates from Prior Years			
	2011 (Unaudited)	2010 (Unaudited)	2009	2008	2007
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)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$7,581	$7,216	$6,348	$6,320	$5,975
SMI Part B	13,595	12,688	16,323	14,932	12,112
SMI Part D	6,438	6,355	6,144	6,527	7,285
Have attained eligibility age (age 65 or over)					
HI	262	248	209	202	178
SMI Part B	2,122	1,972	1,924	1,785	1,648
SMI Part D	695	646	595	581	746
Those expected to become participants					
HI	7,260	6,944	5,451	5,361	4,870
SMI Part B	3,223	3,077	4,909	4,480	4,460
SMI Part D	2,817	2,714	2,632	2,856	2,735
All current and future participants					
HI	15,104	14,408	12,008	11,883	11,023
SMI Part B	18,940	17,737	23,156	21,197	18,221
SMI Part D	9,950	9,715	9,371	9,964	10,766
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 15 and 16)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	12,887	12,032	18,147	17,365	15,639
SMI Part B	13,489	12,587	16,342	14,949	12,130
SMI Part D	6,438	6,355	6,144	6,527	7,273
Have attained eligibility age (age 65 and over)					
HI	2,923	2,648	2,958	2,747	2,558
SMI Part B	2,343	2,166	2,142	1,986	1,834
SMI Part D	695	646	595	581	794
Those expected to become participants					
HI	2,546	2,411	4,673	4,506	5,118
SMI Part B	3,108	2,984	4,672	4,262	4,257
SMI Part D	2,817	2,714	2,632	2,856	2,699
All current and future participants:					
HI	18,356	17,090	25,778	24,619	23,315
SMI Part B	18,940	17,737	23,156	21,197	18,221
SMI Part D	9,950	9,715	9,371	9,964	10,766
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 15 and 16)					
HI	$(3,252)	$(2,683)	$(13,770)	$(12,737)	$(12,292)
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0
ADDITIONAL INFORMATION					
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 15 and 16)					
HI	$(3,252)	$(2,683)	$(13,770)	$(12,737)	$(12,292)
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0
Trust Fund assets at start of period					
HI	272	304	321	312	300
SMI Part B	71	76	59	53	38
SMI Part D	1	1	1	3	1
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over expenditures (Notes 15 and 16)					
HI	$(2,980)	$(2,378)	$(13,449)	$(12,425)	$(11,993)
SMI Part B	71	76	59	53	38
SMI Part D	1	1	1	3	1

STATEMENT OF SOCIAL INSURANCE *(Continued)*

75-Year Projection as of January 1, 2011 and Prior Base Years

(IN BILLIONS)

		Estimates from Prior Years			
	2011 (Unaudited)	2010 (Unaudited)	2009	2008	2007
MEDICARE SOCIAL INSURANCE SUMMARY					
Current Participants:					
Actuarial present value for the 75-year projection period from or on behalf of:					
Those who, in the starting year of the projection period, have attained eligiblitity age:					
Income (excluding interest)	$3,079	$2,866	$2,729	$2,568	$2,572
Expenditures	5,961	5,459	5,695	5,315	5,186
Income less expenditures	(2,882)	(2,593)	(2,967)	(2,746)	(2,614)
Those who, in the starting year of the projection period, have not yet attained eligiblitity age:					
Income (excluding interest)	27,615	26,259	28,815	27,778	25,372
Expenditures	32,814	30,974	40,634	38,841	35,042
Income less expenditures	(5,199)	(4,715)	(11,819)	(11,063)	(9,669)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(8,081)	(7,308)	(14,786)	(13,809)	(12,284)
Combined Medicare Trust Fund assets at start of period	344	381	381	368	338
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(7,737)	(6,927)	(14,405)	(13,441)	(11,945)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	13,300	12,735	12,991	12,698	12,065
Expenditures	8,471	8,109	11,976	11,625	12,074
Income less expenditures	4,829	4,626	1,016	1,073	(9)
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(3,252)	(2,683)	(13,770)	(12,737)	(12,292)
Combined Medicare Trust Fund assets at start of period	344	381	381	368	338
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$(2,908)	$(2,302)	$(13,390)	$(12,369)	$(11,954)

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

With the exception of the 2007 projections presented, 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. For the 2007 projections, the "closed group" are assumed to be individuals who are at least 18 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, 2010	$41,860	$44,543	$(2,683)	$381	$(2,302)
Reasons for change					
Change in the valuation period	1,952	2,063	(112)	(49)	(160)
Change in projection base	(1,069)	(538)	(531)	11	(519)
Changes in the demographic assumptions	(67)	44	(112)	0	(112)
Changes in economic and health care assumptions	1,299	1,115	185	0	185
Changes in law	19	19	0	1	1
Net changes	2,134	2,703	(569)	(37)	(606)
As of January 1, 2011	$43,993	$47,245	$(3,252)	$344	$(2,908)
HI: PART A *(Note 17)*					
As of January 1, 2010	$14,408	$17,090	$(2,683)	$304	$(2,378)
Reasons for change					
Change in the valuation period	611	723	(112)	(32)	(143)
Change in projection base	(427)	103	(531)	(1)	(531)
Changes in the demographic assumptions	(151)	(40)	(112)	0	(112)
Changes in economic and health care assumptions	664	479	185	0	185
Changes in law	0	0	0	0	0
Net changes	696	1,265	(569)	(32)	(602)
As of January 1, 2011	$15,104	$18,356	$(3,252)	$272	$(2,980)
SMI: PART B *(Note 17)*					
As of January 1, 2010	$17,737	$17,737	0	$76	$76
Reasons for change					
Change in the valuation period	807	807	0	(16)	(16)
Change in projection base	(552)	(552)	0	12	12
Changes in the demographic assumptions	123	123	0	0	0
Changes in economic and health care assumptions	806	806	0	0	0
Changes in law	19	19	0	1	1
Net changes	1,203	1,203	0	(4)	(4)
As of January 1, 2011	$18,940	$18,940	0	$71	$71
SMI: PART D *(Note 17)*					
As of January 1, 2010	$9,715	$9,715	0	$1	$1
Reasons for change					
Change in the valuation period	534	534	0	(1)	(1)
Change in projection base	(90)	(90)	0	0	0
Changes in the demographic assumptions	(39)	(39)	0	0	0
Changes in economic and health care assumptions	(170)	(170)	0	0	0
Changes in law	0	0	0	0	0
Net changes	234	234	0	0	0
As of January 1, 2011	$9,950	$9,950	0	$1	$1

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

NOTE 1:
SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity

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

The financial statements were prepared from CMS' accounting records in accordance with accounting principles generally accepted in the United States (GAAP) and the form and content specified by the Office of Management and Budget (OMB) in OMB Circular A-136, *Financial Reporting Requirements*. GAAP for Federal entities are the standards prescribed by the Federal Accounting Standards Advisory Board (FASAB).

The financial statements have been prepared to report the financial position, net cost, changes in net position, and budgetary resources for all programs administered by CMS. The 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.

Patient Protection and Affordable Care Act of 2010

The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) contains the most significant changes to health care coverage since the passing of the Social Security Act. The Affordable Care Act provided funding for the establishment by CMS of a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. During FY 2011, operational responsibility for several programs established by the Affordable Care Act was transferred from the HHS Office of the Secretary to CMS, as of April 1, 2011. These programs include: Qualified High Risk Pool for Pre-existing Conditions, Early Retiree Reinsurance Programs, American Health Benefit Exchanges (the "Exchanges"), and the Consumer Operated and Oriented Plan (CO-OP) Program, and are administered by CMS' Center for Consumer Information and Insurance Oversight (CCIIO). Obligations on or after April 1, 2011, were executed by CMS and will continue to be accounted for by CMS. The HHS Office of the Secretary will continue to account for obligations recorded prior to April 1, 2011 until expended or deobligated. A brief description of these programs and their impact on the CMS financial statements is presented below and are included in "Other Health" in the accompanying footnotes.

Qualified High Risk Pool for Pre-existing Conditions

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

Early Retiree Reinsurance Program

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

American Health Benefit Exchanges

Grants have been provided to the States to establish American Health Benefit Exchanges, better known as Health Benefit Insurance Exchanges. The initial grants were made by the HHS to the States "not later than one (1) year after the date of enactment." Thus, HHS made the initial grants by March 23, 2011. Subsequent grants were issued by CMS.

Consumer Operated and Oriented Plan (CO-OP) Program

The CO-OP Program was established to foster and encourage the creation of consumer-governed non-profit health plans in the individual and small group markets, with a goal of having at least one CO-OP in each state. These CO-OPs will operate a strong consumer focus and provide consumers with greater plan choice. Under this program, assistance is provided to organizations applying to become qualified, nonprofit health insurance issuers through loans to assist in meeting start-up costs, and state solvency requirements. In accordance with proposed regulations, as well as legislative requirements, loans shall be repaid within five years and 15 years, considering state reserve requirements and solvency regulations. Congress originally appropriated $6 billion to carry out this assistance program under the Affordable Care Act. The Department of Defense and Full-Year Continuing Appropriations Act of 2011 included a $2.2 billion rescission that reduced CO-OP budget authority to $3.8 billion. As of September 30, 2011, CMS has not awarded any loans and has no liability under this program.

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

Earmarked Funds

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

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

The Medicare **Earmarked** funds include:

Medicare Hospital Insurance Trust Fund – Part A

Section 1817 of the Social Security Act established the Medicare Hospital Insurance (HI) Trust Fund. Medicare contractors are paid by CMS to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI trust fund. A portion of CMS payments to Medicare Advantage plans are also charged to this fund. The financial statements include HI trust fund activities administered by the Department of the Treasury (Treasury). The HI trust fund has permanent indefinite authority. Employment tax revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA). Employees and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI trust fund. Self-employed individuals contribute the full 2.9 percent of their net income. The

Social Security Act requires the transfer of these contributions from the General Fund of Treasury to the HI trust fund based on the amount of wages certified by the Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 as the basis for conducting quarterly certification of regular wages. (See "Payments to the Health Care Trust Funds Appropriation" and "Permanent Appropriations" below for additional descriptions of revenues and financing sources for the HI trust fund.)

Medicare Supplementary Medical Insurance Trust Fund – Part B

Section 1841 of the Social Security Act established the Supplementary Medical Insurance (SMI) Trust Fund. Medicare contractors are paid by CMS to process Medicare claims for physicians, medical suppliers, laboratory services, hospital outpatient services and rehabilitation, end stage renal disease (ESRD), rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI trust fund. A portion of CMS payments to Medicare Advantage plans are also charged to this fund. The financial statements include SMI trust fund activities administered by Treasury. The SMI trust fund has permanent indefinite authority. SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. (See Note 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 provided for a one-time payment of $250 per beneficiary to applicable beneficiaries who enter the Part D coverage gap (as described in the Part D prescription drug program) during the 2010 calendar year. Additionally, beneficiary cost sharing in the Part D coverage gap is reduced for brand-name and generic drugs from 100 percent in 2010 (including the $250 rebate) to 25 percent by 2020. The Part D is considered part of the SMI trust fund and is reported in the SMI TF column of the financial statements.

Medicare and Medicaid Integrity Programs

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, *Public Law No. 104-191. § 202*) established the Medicare Integrity Program at section 1893 of the Social Security Act, and codified Medicare program integrity activities previously known as "payment safeguards." HIPAA section 201 also established the Health Care "Fraud and Abuse Control Account, which provides a dedicated appropriation for carrying out the Medicare Integrity Program." Through the Medicare Integrity Program, CMS contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews, cost report audits, and the education of providers and beneficiaries with respect to payment integrity and benefit quality assurance issues. The Medicare Integrity Program is funded by the HI trust fund.

Separately, the Medicaid Integrity Program was established by the Deficit Reduction Act of 2005 (DRA, Public Law No. 109-171. § 6034), and codified at section 1936 of the Social Security Act. The Medicaid Integrity Program represents the Federal government's first national strategy to detect and prevent Medicaid fraud and abuse. Under the Medicaid Integrity Program, CMS contracts with eligible entities to review provider claims and perform audits, with respect to Medicaid providers, similar to those activities currently performed by Medicare Integrity Program contractors with respect to Medicare providers.

Payments to the Health Care Trust Funds Appropriation

The Social Security Act provides for payments to the HI and SMI trust funds for SMI (appropriated funds to provide for Federal matching of SMI premium collections) and HI (for the Uninsured and Federal Uninsured Payments). The MMA prescribes that funds covering the Medicare Prescription Drug Benefit and associated administrative costs, retiree drug coverage, reimbursements to the States and Transitional Assistance benefits be transferred from Payments to the Health Care Trust Funds to the SMI trust fund. HIPPA 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 HIPPA prescribes that criminal fines and civil monetary penalties arising from health care cases be appropriated to the HCFAC account of the HI trust fund. There is permanent indefinite authority for the transfer of general funds containing criminal fines and civil monetary penalties to the HCFAC account of the HI trust fund.

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

Medicaid

Medicaid, the health care program for low-income Americans, is administered by CMS in partnership with the States. Grant awards limit the funds that can be drawn by the States to cover current expenses. The grant awards, prepared at the beginning of each quarter and amended as necessary, are an estimate of the Federal (CMS) share of the States' Medicaid costs. At the end of each quarter, states report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by CMS for the difference between approved expenses reported for the period and the grant awards previously issued.

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

Children's Health Insurance Program (CHIP)

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

to provide this insurance coverage. The MMSEA extended the funding through March 2009.

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) extends the program through September 2013. CHIPRA also establishes a Child Enrollment Contingency Fund to cover shortfalls in funding for the States. This fund is invested in interest-bearing Treasury securities.

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

State Grants and Demonstrations

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

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

The MMA appropriated funds annually, from FY 2005 through FY 2009, for the Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens. The Deficit Reduction Act Section 6201 provided Federal payments for several projects, including the Money Follows the Person demonstration, the Medicaid Integrity Program, and the establishment of alternative non-emergency providers.

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

Health Care Infrastructure Improvement Program

The Health Care Infrastructure Improvement Program loan program was enacted into law in December 2003 as part of the MMA. The loan program provides a loan to a hospital or entity that is engaged in research in the causes, prevention, and treatment of cancer; and is designated as a cancer center by the National Cancer Institute (NCI) or is designated by the State legislature as the official cancer institute of the State and such designation by the State legislature occurred prior to December 8, 2003, for payment of the capital costs of eligible projects. CMS expects that any loan made under this provision to be forgiven in five years as it is anticipated that borrowers will meet the requirements for forgiveness.

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.

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

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

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

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

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

Trust Fund (Earmarked) Investments are investments (plus the accrued interest on investments) held by Treasury. Sections 1817 for HI and 1841 for SMI of the Social Security Act require that trust fund investments not necessary to meet current expenditures be invested in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December) and was adjusted to include an accrual for interest earned from July 1 to September 30. The FASAB SFFAS 27 prescribes certain disclosures concerning earmarked investments, such as the fact that cash generated from earmarked funds is used by the U.S. Treasury for general Government purposes and that, upon redemption of investments to make expenditures, the Treasury will finance those expenditures in the same manner that it finances all other expenditures (see Note 3).

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

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 prior year balances have been reclassified to conform to FY 2011 financial statement presentations, the effect of which is immaterial.

Change in Presentation

Effective FY 2011, there were the following changes in presentation: (1) the Statement of Social Insurance presents a new summary section and (2) a Statement of Changes in Social Insurance Amounts. This change has been made in order to comply with the statement format change in SFFAS 37 and OMB's Circular A-136. In addition, changes have been made to the supplementary financial statements to reflect activities resulting from the Affordable Care Act.

Estimation of Obligations Related to Canceled Appropriations

As of September 30, 2011, CMS has canceled over $256 million in cumulative obligations related to FY 2006 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 2007 through 2011 related to canceled appropriations, CMS anticipates an additional $4 million will be paid from current year funds for canceled obligations.

NOTE 2:

FUND BALANCE WITH TREASURY

(DOLLARS IN MILLIONS)

	FY 2011 Consolidated Totals	FY 2010 Consolidated Totals
FUND BALANCES:		
Trust Funds:		
HI Trust Fund (Earmarked)	$443	$38
SMI Trust Fund (Earmarked)	5,687	1,958
Revolving Funds:		
CLIA	402	280
General Funds:		
Medicaid	28,230	44,878
CHIP	16,571	15,172
State Grants and Demonstrations	2,232	1,999
Other Health	20,370	
Other	3	
Program Management	572	509
Other Fund Types:		
CMS Deposit/Suspense Accounts	7	7
Total Fund Balances	**$74,517**	**$64,841**
STATUS OF FUND BALANCES WITH TREASURY:		
Unobligated Balance:		
Available	$37,810	$26,457
Unavailable	3,969	4,313
Obligated Balance not yet Disbursed	96,097	86,538
Non-Budgetary FBWT	(63,359)	(52,467)
Total Status of Fund Balances with Treasury	**$74,517**	**$64,841**

Fund Balances are funds with Treasury that are primarily available to pay current expenditures and liabilities. The Medicaid balance of $28,230 million ($44,878 million in FY 2010) includes $3,238 million ($8,043 million in FY 2010) of funds for ARRA. The Unobligated Balance Available includes $18,955 million ($6,994 million in FY 2010), which is restricted for future use and is not apportioned for current use for Affordable Care Act, CHIP, Program Management, State Grants and Demonstrations, and ARRA Health Information Technology.

NOTE 3:

INVESTMENTS

(DOLLARS IN MILLIONS)

FY 2011 MEDICARE INVESTMENTS *(Earmarked)*			
HI TF			
Certificates	June 2012	1 7/8%	$1,145
Bonds	June 2013 to June 2024	3 1/4 – 6 1/2%	244,794
Accrued Interest			2,879
SMI TF			
Bonds	June 2013 to June 2026	2 1/2 – 6 1/2%	$70,446
Accrued Interest			708

FY 2010 MEDICARE INVESTMENTS *(Earmarked)*	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2011	2 1/8%	$2,120
Bonds	June 2012 to June 2024	3 1/4 - 6 1/2%	277,355
Accrued Interest			3,319
Total HI TF Investments			**$282,794**
SMI TF			
Certificates	June 2011	2 1/4% - 2 1/2%	$5,939
Bonds	June 2012 to June 2025	2 7/8 - 6 7/8%	65,043
Accrued Interest			727
Total SMI TF Investments			**$71,709**
Total Medicare Investments			**$354,503**

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

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

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

FY 2011 MEDICARE INVESTMENTS *(Non-Earmarked)*				
Treasury Bill	02/09/12	$2,092		$2,092
Treasury Bill	02/09/12	1		1

FY 2010 MEDICARE INVESTMENTS *(Non-Earmarked)*				
Treasury Bill	12/16/10	$1,617	$1	$1,616
Treasury Bill	12/16/10	401		401
Treasury Bill	12/16/10	51		51
Treasury Bill	12/16/10	50		50

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

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

FY 2010 CMS INVESTMENT SUMMARY					
Certificates	$2,120	$5,939	$8,059		$8,059
Bonds	277,355	65,043	342,398		342,398
Treasury Bills				$2,118	2,118
Accrued Interest	3,319	727	4,046		4,046

Note 4:

ACCOUNTS RECEIVABLE, NET

(DOLLARS IN MILLIONS)

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

FY 2010	Medicare (earmarked)		Medicaid	Other	Consolidated Total
	HI TF	SMI TF			
INTRAGOVERNMENTAL					
Railroad Retirement Board Principal	$493				$493
WITH THE PUBLIC					
Provider & Beneficiary Overpayments					
Accounts Receivable Principal	$656	$485		$29	$1,170
Less: Allowance for Uncollectible Accounts	(135)	(178)		(13)	(326)
Accounts Receivable, Net	**521**	**307**		**16**	**844**
Medicare Secondary Payer (MSP)					
Accounts Receivable Principal	115	81		7	203
Less: Allowance for Uncollectible Accounts	(26)	(31)		(5)	(62)
Accounts Receivable, Net	**89**	**50**		**2**	**141**
Medicare Prescription Drug					
Accounts Receivable Principal		1,395			1,395
Less: Allowance for Uncollectible Accounts					
Accounts Receivable, Net		**1,395**			**1,395**
CMPs & Other Restitutions					
Accounts Receivable Principal	373	196			569
Less: Allowance for Uncollectible Accounts	(323)	(189)			(512)
Accounts Receivable, Net	**50**	**7**			**57**
Fraud & Abuse					
Accounts Receivable Principal	37	352	$414		803
Less: Allowance for Uncollectible Accounts	(37)	(333)	(36)		(406)
Accounts Receivable, Net		**19**	**378**		**397**
Medicare Premiums/Medicare Advantage					
Accounts Receivable Principal	288	1,009		4	1,301
Less: Allowance for Uncollectible Accounts	(61)	(113)		(3)	(177)
Accounts Receivable, Net	**227**	**896**		**1**	**1,124**
State Phased-Down Contributions					
Accounts Receivable Principal		811			811
Less: Allowance for Uncollectible Accounts					
Accounts Receivable, Net		**811**			**811**
Medicaid Overpayments					
Accounts Receivable Principal			664		664
Less: Allowance for Uncollectible Accounts			(143)		(143)
Accounts Receivable, Net			521		521
Audit Disallowances					
Accounts Receivable Principal			2,289		2,289
Less: Allowance for Uncollectible Accounts			(543)		(543)
Accounts Receivable, Net			**1,746**		**1,746**
Others Accounts Receivable					
Accounts Receivable Principal	3	2		15	20
Less: Allowance for Uncollectible Accounts				(10)	(10)
Accounts Receivable, Net	**3**	**2**		**5**	**10**
Total Accounts Receivable Principal	**$1,472**	**$4,331**	**$3,367**	**$55**	**$9,225**
Less: Allowance for Uncollectible Accounts Receivable	(582)	(844)	(722)	(31)	(2,179)
Total Accounts Receivable, Net	**$890**	**$3,487**	**$2,645**	**$24**	**$7,046**

Intragovernmental Accounts Receivable

Intragovernmental accounts receivable represent CMS claims for payment from other Federal agencies. CMS accounts receivable for transfers from the HI and SMI trust funds maintained by the Treasury Bureau of Public Debt (BPD) are eliminated against BPD's corresponding liabilities to CMS in the Consolidated Balance Sheets.

Accounts Receivable with the Public

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

Provider & Beneficiary Overpayments

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

Medicare Secondary Payer (MSP)

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

Medicare Prescription Drug

The Medicare Prescription Drug accounts receivable of $3,844 million ($1,395 million in FY 2010) consists of amounts due CMS after completion of the Part D payment reconciliation for calendar year (CY) 2010 in the amount of $2,195 million and the Coverage Gap Discount Program in the amount of $1,649 million. The estimate for the first nine months of CY 2011 is reported as an advance of $1,052 million ($1,098 million in 2010) in "Other Assets" on the Balance Sheet. The estimated advance is caused by the fact that CMS payments to the plans are made evenly throughout the year while payments made by the plans are more heavily weighted towards the fourth calendar quarter. This advance will be liquidated as claims are incurred and submitted to the plans during the first quarter of FY 2012. As a result, CMS management believes the Part D accrual estimate will become a liability by the end of CY 2011.

Civil Monetary Penalties (CMPs) & Other Restitutions

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

Medicare Premiums

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

State Phased-Down Contributions

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

Medicaid Overpayments

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

Audit Disallowances

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

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

Write Offs and Adjustments

The implementation of the revised policies and other initiatives undertaken in recent fiscal years resulted in significant adjustments and write offs made to CMS' accounts receivable balance. 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)

Medicare Advantage and Prescription Drug plans were issued advance payments on September 30, 2011, in the amount of $14,889 million ($5,220 million from the HI trust fund, $4,820 million from the SMI trust fund and $4,849 million from Medicare Prescription Drug program) for services that will be provided in October 2011. As noted in Note 4 the first nine months of CY 2011 Prescription Drug Plan payments are reported as an advance of $1,052 million (1,098 million in FY 2010). The remaining $142 million ($211 million in FY 2010) in Other Assets represent advances made to various contractors and vendors.

Note 6:

ENTITLEMENT BENEFITS DUE AND PAYABLE

(DOLLARS IN MILLIONS)

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

FY 2010	Medicare (Earmarked)						
	HI TF	SMI TF	Total	Medicaid	CHIP	Other	Consolidated Total
Medicare Benefits Payable (1)	$20,726	$18,976	$39,702				$39,702
Medicare Advantage/Prescription Drug Program (2)	1,050	2,329	3,379				3,379
Retiree Drug Subsidy (3)		1,926	1,926				1,926
Undocumented Aliens						$75	75
Medicaid/CHIP (4)				$27,215	$415		27,630
Total Entitlement Benefits Due and Payable	**$21,776**	**$23,231**	**$45,007**	**$27,215**	**$415**	**$75**	**$72,712**

(1) Medicare benefits payable consists of a $47,699 million estimate ($39,702 million in FY 2010) for Medicare services incurred but not paid as of September 30, 2011. 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 2011 that were paid in 2012 and (e) an estimate of retroactive settlements of cost reports. The September 30, 2011 and 2010 estimate also includes amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals; amounts which may be due/owed to providers for claims that must be reprocessed due to various provisions of the Affordable Care Act; and amounts which may be due/owed to hospitals for adjusted prospective payments (for 2011 only).

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

(2) Medicare Advantage and Prescription Drug Program benefits payable of $4,019 million ($3,379 million in FY 2010) consists of a $1,887 million estimate ($2,434 million in FY 2010) for amounts owed

to plans relating to risk and other payment related adjustments and $2,132 million ($866 million in FY 2010) owed to plans after the completion of the Prescription Drug Payment reconciliation. The FY 2010 liability also included $79 million for amounts owed to beneficiaries that qualified for the $250 rebate for reaching the Part D coverage gap as of September 30, 2010. As of September 30, 2011, a receivable has been recorded for the accrual related to the Coverage Gap Discount Program as prescription drug plans owe CMS $1,649 million.

(3) The Retiree Drug Subsidy (RDS) consists of a $2,574 million estimate ($1,926 million in FY 2010) of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2011. 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 $26,069 million ($27,215 million in FY 2010) 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, 2011. This estimate incorporates claim activity tracked under ARRA of $1,068 million ($4,007 million in FY 2010). An estimated CHIP benefits payable of $457 million has been recorded ($415 million in FY 2010) for the net Federal share of expenses that have been incurred by the States but not yet reported to CMS as of September 30, 2011.

Note 7:

CONTINGENCIES

CMS is a party in various administrative proceedings, legal actions, and tort claims which may ultimately result in settlements or decisions adverse to the Federal Government. CMS has accrued a contingent liability where a loss is determined to be probable and the amount can be estimated. Other contingencies exist where losses are reasonably possible, and an estimate can be determined or an estimate of the range of possible liability has been determined. CMS does not record an accrual for a contingent liability if it is not estimable and probable but does disclose those contingencies in the financial statements.

The Medicaid amount for $3,016 million ($5,391 million in FY 2010) consists of Medicaid audit and program disallowances of $1,056 million ($915 million in FY 2010) and $1,960 million ($4,476 million in FY 2010) 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. CMS will be required to pay these amounts if the appeals are decided in the favor of the States. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. There are also outstanding reviews of the State expenditures in which a final determination has not been made. Examples of these reviews are the Office of Inspector General Audits, Focused Financial Management Reviews, and Quarterly Medicaid Statement of Expenditures Report (Form CMS-64) reviews. The appropriate Center for Medicaid and CHIP Services (CMCS) Regional Office staff is responsible for reviewing the findings and recommendations. The monetary effect of these reviews is not known until a final decision is determined and rendered by the Director of CMCS. The outcome of these reviews is that CMS could be owed funds.

Appeals at the Provider Reimbursement Review Board

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. However, historical cases that have been appealed and settled by the PRRB are considered in the development of the actuarial Medicare IBNR liability. As of September 30, 2011, 6,683 cases (7,833 in FY 2010) remain on appeal. A total of 821 new cases (1,384 in FY 2010) were filed and 14 cases were reopened (4 in FY 2010). The PRRB rendered decisions on 122 cases (144 in FY 2010) in FY 2011 and 1,863 additional cases (1,395 in FY 2010) 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 2011 Intragovernmental	Medicare (Earmarked)								
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
Accrued Payroll and Benefits	$1	$2					$3		$3
Total Intragovernmental	**$1**	**$2**					**$3**		**$3**
Federal Employee and Veterans' Benefits	$4	$9					$13		$13
Accrued Payroll and Benefits	12	26	$1		$1	$2	42		42
Unfunded Liabilities					1,272		1,272		1,272
Contingencies			3,016				3,016		3,016
Total Liabilities Not Covered by Budgetary Resources	**17**	**37**	**3,017**		**1,273**	**2**	**4,346**		**4,346**
Total Liabilities Covered by Budgetary Resources	62,861	56,486	26,071	$457		116	145,991	$(62,892)	83,099
TOTAL LIABILITIES	**$62,878**	**$56,523**	**$29,088**	**$457**	**$1,273**	**$118**	**$150,337**	**$(62,892)**	**$87,445**

FY 2010 Intragovernmental	Medicare (Earmarked)								
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
Accrued Payroll and Benefits	$1	$2					$3		$3
Total Intragovernmental	**$1**	**$2**					**$3**		**$3**
Federal Employee and Veterans' Benefits	$4	$8	$1				$13		$13
Accrued Payroll and Benefits	15	24	2			$2	43		43
Contingencies			5,391				5,391		5,391
Total Liabilities Not Covered by Budgetary Resources	**20**	**34**	**5,394**			**2**	**5,450**		**5,450**
Total Liabilities Covered by Budgetary Resources	47,214	49,939	27,219	$415		125	124,912	$(49,858)	75,054
TOTAL LIABILITIES	**$47,234**	**$49,973**	**$32,613**	**$415**		**$127**	**$130,362**	**$(49,858)**	**$80,504**

All CMS 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, amounts billed by the Department of Labor for Federal Employee's Compensation Act (FECA) payments, and liabilities related to the Early Retiree Reinsurance Program. For CMS revolving funds, all liabilities are funded as they occur.

Note 9:

NET COST OF OPERATIONS

(DOLLARS IN MILLIONS)

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

FY 2010	Medicare (Earmarked)			Health				
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	Consolidated Total
PROGRAM/ACTIVITY COSTS								
Medicare								
Fee for Service	$184,412	$151,395	$335,807					$335,807
Medicare Advantage/ Managed Care	60,333	54,759	115,092					115,092
Prescription Drug (Part D)		52,695	52,695					52,695
Medicaid/CHIP/State Grants & Demos				$272,754	$7,943		$474	281,171
CLIA							193	193
Total Program/Activity Costs	**$244,745**	**$258,849**	**$503,594**	**$272,754**	**$7,943**		**$667**	**$784,958**
OPERATING COSTS								
Medicare Integrity Program	$1,201		$1,201					$1,201
Quality Improvement Organizations	280	$56	336					336
Bad Debt Expense and Writeoffs	(81)	(239)	(320)	$99			$17	(204)
Reimbursable Expenses	10	19	29	1			1	31
Administrative Expenses	1,151	1,890	3,041	141	$25		91	3,298
Depreciation and Amortization	13	42	55					55
Imputed Cost Subsidies	14	25	39	2			3	44
Total Operating Costs	**$2,588**	**$1,793**	**$4,381**	**$243**	**$25**		**$112**	**$4,761**
TOTAL COSTS	**$247,333**	**$260,642**	**$507,975**	**$272,997**	**$7,968**		**$779**	**$789,719**
Less: Exchange Revenues:								
Medicare Premiums	$3,504	$57,273	$60,777					$60,777
CLIA Revenues							$183	183
Other Exchange Revenues	11	25	36	$2			17	55
Total Exchange Revenues	**$3,515**	**$57,298**	**$60,813**	**$2**			**$200**	**$61,015**
TOTAL NET COST OF OPERATIONS	**$243,818**	**$203,344**	**$447,162**	**$272,995**	**$7,968**		**$579**	**$728,704**

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 $1,983 million ($1,928 million in FY 2010) 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 2011 Part D expense of $53,302 million ($52,695 million in FY 2010) is net of State reimbursements of $6,897 million ($4,205 million in FY 2010). The gross expense would have been $60,199 million in FY 2011 ($56,900 million in FY 2010).

Of the Medicaid benefit expense of $268,267 million ($272,754 million in FY 2010), $10,492 million were identified under ARRA ($40,774 million in FY 2010).

Note 10:

TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT

(DOLLARS IN MILLIONS)

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

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

FY 2010 Transfers-in Without Reimbursement	Medicare (Earmarked)								
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
Medicare Benefit Transfers	$249,551	$267,613					$517,164	$(517,164)	
Transfers to HCFAC	1,464						1,464	(1,464)	
Federal Matching Contributions		161,110					161,110	(161,110)	
Medicare Part D Benefits		52,341					52,341	(52,341)	
Medicare Part D Administrative		258					258	(258)	
Allocation to CMS Programs	1,132	2,063	$138	$16		$175	3,524	(3,524)	
Fraud and Abuse Appropriation	126						126	(126)	
Transfer-Uninsured Coverage	(142)						(142)	142	
Prog Mngmt Admin. Expense *(1)*	201						201	(201)	
Income Tax OASDI Benefits *(2)*	13,760						13,760	(13,760)	
Railroad Retirement Board	536						536		$536
Criminal Fines	1,225						1,225	(1,225)	
Medicaid Part B Premiums			515				515	(515)	
Medicare Advantage Stabilization	(54)	(54)					(108)	108	
Interest Adjustments	1	1					2		2
Miscellaneous	1	1					2		2
Total Transfers-in	**$267,801**	**$483,333**	**$653**	**$16**		**$175**	**$751,978**	**$(751,438)**	**$540**

FY 2010 Transfers-out Without Reimbursement	Medicare (Earmarked)								
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
SSA Administrative Expenses	$(1,024)	$(1,083)					$(2,107)		$(2,107)
Medicare Benefit Transfers	(249,551)	(267,613)					(517,164)	$517,164	
Transfers to HCFAC	(1,464)						(1,464)	1,464	
Federal Matching Contributions		(161,110)					(161,110)	161,110	
Medicare Part D Benefits		(52,341)					(52,341)	52,341	
Medicare Part D Administrative		(258)					(258)	258	
Transfers to Program Management	(1,375)	(2,149)					(3,524)	3,524	
Fraud and Abuse Appropriation	(126)						(126)	126	
Transfer-Uninsured Coverage	142						142	(142)	
Prog Mngmt Admin. Expense *(1)*	(201)						(201)	201	
Income Tax OASDI Benefits (2)	(13,760)						(13,760)	13,760	
Criminal Fines	(1,225)						(1,225)	1,225	
Medicaid Part B Premiums		(515)					(515)	515	
Medicare Advantage Stabilization	54	54					108	(108)	
Office of the Secretary	(41)	(39)					(80)		(80)
Payment Assessment Commission	(6)	(6)					(12)		(12)
AOA MIPPA Expense *(3)*	(16)	(14)					(30)		(30)
Railroad Retirement Board		(9)					(9)		(9)
Total Transfers-out	**$(268,593)**	**$(485,083)**					**$(753,676)**	**$751,438**	**$(2,238)**
Total Transfers-in/out without reimbursement	**$(792)**	**$(1,750)**	**$653**	**$16**		**$175**	**$(1,698)**		**$(1,698)**

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

(1) During FY 2011, the Payments to the Health Care Trust Funds appropriation paid the HI trust fund $214 million ($201 million in FY 2010) 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.

(3 In FY 2010, the HI and SMI trust funds recorded expenditure transfers of $16 million and $14 million, respectively, to the Administration on Aging to support outreach and assistance for low-income beneficiaries pursuant to the Affordable Care Act of 2010, *Public Law 111-148.§3306*. No expenditure transfers have occurred in FY 2011.

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 standard monthly SMI premium per beneficiary was $110.50 from October 1, 2010 through December 31, 2010, and $115.40 for January 1, 2011 through September 30, 2011. However, as a result of the zero cost-of-living adjustment (COLA) for Social Security beneficiaries effective January 1, 2011, most Part B enrollees are "held harmless" and do not have to pay the higher premium amount in 2011. New beneficiaries enrolling on January 1, 2011 and beyond, enrollees subject to an income-related additional premium and individuals who do not have their premium deducted from their Social Security benefit, including Medicare-Medicaid "dual-eligible beneficiaries," must pay a monthly premium based on the standard premium of $115.40 (premiums for dual-eligible beneficiaries are paid by the State Medicaid programs)." Premiums collected from beneficiaries totaled $57,027 million ($54,780 million in FY 2010) and were matched by a $168,849 million ($161,110 million in FY 2010) 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, 2011, approximately $56,329 million has been transferred-in ($52,599 million in FY 2010) to Part D from the general fund.

Note 11:

BUDGETARY FINANCING SOURCES: OTHER ADJUSTMENTS

(DOLLARS IN MILLIONS)

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

FY 2010 Unexpended Appropriations	Medicare (Earmarked)		Medicaid	CHIP	Other Health	Other	Consolidated Total
	HI TF	SMI TF					
Withdrawal of Expired or Canceled Year Authority	$(60)	$(3,373)		$(56)		$(21)	$(3,510)
Total Other Adjustments	**$(60)**	**$(3,373)**		**$(56)**		**$(21)**	**$(3,510)**

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

Note 12:

EARMARKED FUNDS

(DOLLARS IN MILLIONS)

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

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

	HI TF	SMI TF	Total Earmarked Funds
Balance Sheet as of September 30, 2010			
ASSETS			
Fund Balance with Treasury	$38	$1,958	$1,996
Investments	282,794	71,709	354,503
Other Assets	26,216	29,715	55,931
Total Assets	**$309,048**	**$103,382**	**$412,430**
Entitlement Benefits Due and Payable	$21,776	$23,231	$45,007
Other Liabilities	25,458	26,742	52,200
Total Liabilities	**$47,234**	**$49,973**	**$97,207**
Unexpended Appropriations	$702	$1,074	$1,776
Cumulative Results of Operations	261,112	52,335	313,447
Total Net Position	$261,814	$53,409	$315,223
Total Liabilities and Net Position	**$309,048**	**$103,382**	**$412,430**
Statement of Net Cost For the Year Ended September 30, 2010			
Benefit Expense	$244,745	$258,849	$503,594
Operating Costs	2,588	1,793	4,381
Total Costs	247,333	260,642	507,975
Less Earned Revenues	3,515	57,298	60,813
Net Cost of Operations	**$243,818**	**$203,344**	**$447,162**
Statement of Changes in Net Position For the Year Ended September 30, 2010			
Net Position, Beginning of Period	$292,374	$43,968	$336,342
Taxes and Other Nonexchange Revenue	198,423	3,059	201,482
Other Financing Sources	14,835	209,726	224,561
Less Net Cost of Operations	243,818	203,344	447,162
Change in Net Position	(30,560)	9,441	(21,119)
Net Position, End of Period	**$261,814**	**$53,409**	**$315,223**

Note 13:

INTRAGOVERNMENTAL COSTS AND EXCHANGE REVENUE

(DOLLARS IN MILLIONS)

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

FY 2010	Gross Cost			Less: Exchange Revenue			
	Intra-governmental	Public	Total	Intra-governmental	Public	Total	Consolidated Net Cost of Operations
PROGRAM/ACTIVITY COSTS							
GPRA Programs							
Medicare (Earmarked)							
HI TF	$668	$246,665	$247,333	$5	$3,510	$3,515	$243,818
SMI TF	195	260,447	260,642	11	57,287	57,298	203,344
Medicaid	13	272,984	272,997	1	1	2	272,995
CHIP	5	7,963	7,968				7,968
Subtotal	**881**	**788,059**	**788,940**	**17**	**60,798**	**60,815**	**728,125**
Other Activities							
CLIA	38	155	193		183	183	10
State Grants and Demonstrations	19	531	550		17	17	533
Other	4	32	36				36
Subtotal	**61**	**718**	**779**		**200**	**200**	**579**
PROGRAM/ ACTIVITY TOTALS	**$942**	**$788,777**	**$789,719**	**$17**	**$60,998**	**$61,015**	**$728,704**

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

FY 2010	Direct	Reimbursable	Combined Totals
Category A	$14,077	$230	$14,307
Category B	563,992	1	563,993
Exempt	478,902		478,902
Total	**$1,056,971**	**$231**	**$1,057,202**

Legal Arrangements Affecting Use of Unobligated Balances

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Statement of Budgetary Resources. The portion of trust fund receipts collected in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in that fiscal year is precluded by law from being available for obligation. This excess of receipts over obligations is reported as Temporarily Not Available Pursuant to Public Law in 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 $260,656 million as of September 30, 2011, ($300,470 million in FY 2010) are included in Investments on the Balance Sheets. The following table presents trust fund activities and balances for FY 2011 and FY 2010 (in millions):

	FY 2011 Combined Balance	FY 2010 Combined Balance
TRUST FUND BALANCE, BEGINNING	**$300,470**	**$320,064**
Receipts	468,579	445,878
Less Obligations	508,393	465,472
Shortage of Receipts Over Obligations	(39,814)	(19,594)
TRUST FUND BALANCE, ENDING	**$260,656**	**$300,470**

Explanations of Differences Between the Statement of Budgetary Resources and the Budget of the United States Government for FY 2010

	Budgetary Resources	Obligations Incurred	Offsetting Receipts	Net Outlays
Statement of Budgetary Resources	$1,087,972	$1,057,202	$302,966	$1,032,022
Unobligated Balances Not Available	(1,380)			
Other Adjustments	3,551	3,545		3,760
CCIIO Adjustments	16,329	943		6
President's Budget (actual)	**$1,106,472**	**$1,061,690**	**$302,966**	**$1,035,788**

The Other Adjustments Line for Budgetary Resources includes an increase in the amount of $3,767 million for the amounts reported in the President's Budget but reported on the Centers for Disease Control (CDC) SBR; amounts that are appropriately reported on the SBR but not included as new budgetary resources in the President's Budget (obligations incurred line for expired accounts) in the amount of $(216) million; and CCIIO adjustments in the amount of $16,329 million.

The Other Adjustments Line for Obligations Incurred includes an increase of $3,760 million for the amounts reported in the President's Budget but reported on the CDC SBR; the obligations incurred line for expired accounts in the amount of $(215) million that are appropriately reported on the SBR but not included as new obligations incurred in the President's Budget; and CCIIO adjustments in the amount of $943 million.

The Other Adjustments Line for Net Outlays includes an increase to net outlays in the amount of $3,762 million for the amounts reported in the President's Budget but reported on the CDC SBR; CCIIO adjustments in the amount of $6 million; and $(2) million due to rounding.

Undelivered Orders at the End of the Period

The amount of budgetary resources obligated for undelivered orders totaled $14,636 million at September 30, 2011 ($12,960 million in FY 2010).

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. Such a review is currently in progress. Please see note 16 below for further information on the 2010–2011 Medicare Technical Review 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 13, 2011, and do not reflect any actual or anticipated changes subsequent to that date. The present values are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments as well as administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of FICA and SECA payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and transfers from the general fund of the Treasury made on behalf of beneficiaries. Fees related to brand-name prescription drugs, required by the Affordable Care Act, are included as income for Part B of SMI, and transfers from State governments are included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

The Part A present values in the SOSI exclude the income and expenditures for the roughly 1 percent of beneficiaries who are 65 or over but are "uninsured" because they do not meet the normal insured status or related requirements to qualify for entitlement to Part A benefits. The primary purpose of the SOSI is to compare the projected future costs of Medicare with the program's scheduled revenues. Since costs for the uninsured are separately funded either through general revenue appropriations or through premium payments, the exclusion of such amounts does not materially affect the financial balance of Part A. In addition, such individuals are granted coverage outside of the social insurance framework underlying Medicare Part A. For these reasons, it is appropriate to exclude their income and expenditures from the statement of social insurance.

Actuarial present values of estimated future income (excluding interest) and estimated future expenditures are presented for three different groups of participants: (1) current participants who have not yet attained eligibility age; (2) current participants who have attained eligibility

age; and (3) new entrants, those who are expected to become participants in the future. With the exception of the 2007 expenditure projections presented, 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. For the 2007 expenditure projections, the "closed group" of individuals includes individuals who are at least 18 at the start of the projection period. Since the projection period consists of 75 years, the period covers virtually all of the current participants' working and retirement years.

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 (18 through 64 in the case of the 2007 projections). 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 16 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 13, 2011. 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 2011 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2011. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions. Detailed information, similar to that denoted within table 1, for the prior years is publicly available on the CMS website at: http://www.cms.hhs.gov/CFOReport/.

Table 1:

SIGNIFICANT ASSUMPTIONS AND SUMMARY MEASURES

Used for the Statement of Social Insurance 2011

					Annual percentage change in: Per beneficiary cost[8]						
	Fertility rate[1]	Net immigration[2]	Morality rate[3]	Real-wage rate[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI B	SMI D	Real-interest rate[9]
2011	2.07	895,000	766.5	2.9	4.1	1.2	2.7	2.3	3.7	3.1	1.5
2020	2.05	1,195,000	707.8	1.1	3.9	2.8	2.1	3.3	5.5	6.5	2.9
2030	2.02	1,115,000	648.7	1.2	4.0	2.8	2.2	4.6	4.9	5.7	2.9
2040	2.00	1,070,000	596.6	1.2	4.0	2.8	2.2	4.9	4.5	5.4	2.9
2050	2.00	1,050,000	550.8	1.2	4.0	2.8	2.2	3.9	4.1	5.1	2.9
2060	2.00	1,040,000	510.5	1.1	3.9	2.8	2.1	3.7	4.1	4.8	2.9
2070	2.00	1,030,000	474.9	1.1	3.9	2.8	2.1	3.6	3.9	4.6	2.9
2080	2.00	1,030,000	443.2	1.2	4.0	2.8	2.1	3.3	3.7	4.4	2.9

[1] Average number of children per woman.
[2] Includes legal immigration, net of emigration, as well as other, non-legal, immigration.
[3] The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.
[4] Difference between percentage increases in wages and the CPI.
[5] Average annual wage in covered employment.
[6] Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services.
[7] The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.
[8] These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of services provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.
[9] Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

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

Table 2:

SIGNIFICANT ULTIMATE ASSUMPTIONS

Used for the Statement of Social Insurance, FY 2011–2007

					Annual percentage change in: Per beneficiary cost[8]						
	Fertility rate[1]	Net immigration[2]	Morality rate[3]	Real-wage rate[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI B	SMI D	Real-interest rate[9]
FY 2011	2.0	1,030,000	443.2	1.2	4.0	2.8	2.1	3.3	3.7	4.4	2.9
FY 2010	2.0	1,025,000	446.1	1.2	4.0	2.8	2.1	3.3	3.8	4.4	2.9
FY 2009	2.0	1,025,000	458.2	1.1	3.9	2.8	2.1	4.4	4.3	4.3	2.9
FY 2008	2.0	1,025,000	476.8	1.1	3.9	2.8	2.1	4.4	4.3	4.4	2.9
FY 2007	2.0	900,000	496.8	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9

[1] Average number of children per woman. The ultimate fertility rate is assumed to be reached in the 25-year of the projection period.
[2] Includes legal immigration, net of emigration, as well as other, non-legal, immigration. For 2008–2011, the ultimate level of net legal immigration was increased from 600,000 to 750,000 persons per year. In addition, the method for projecting annual net other immigration was changed and it now varies throughout the projection period. So for 2008–2011, the assumption presented is the value assumed in the year 2080. For 2007, the ultimate assumption is displayed and is reached by the 20th year of each projection period.
[3] The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.
[4] Difference between percentage increases in wages and the CPI. Except for minor fluctuations, the ultimate assumption is reached within the first 10 years of the projection period.
[5] Average annual wage in covered employment. Except for minor fluctuations, the ultimate assumption is reached within the first 10 years of the projection period.
[6] Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services. The ultimate assumption is reached within the first 10 years of the projection period.
[7] The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.
[8] These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The annual rate of growth declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.
[9] Average rate of interest earned on new trust fund securities, above and beyond rate of inflation. The ultimate assumption is reached within the first 10 years of each projection period.

Part D Projections

In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the Part D program is still relatively new (having begun operations in January 2006), with relatively little actual program data currently available. The actual 2006 through 2011 bid submissions by the private plans offering this coverage, together with actual data on beneficiary enrollment and program spending through 2010, 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 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 longer-range future. For example, the Affordable Care Act initiative for aggressive research and development has the potential to reduce Medicare costs in the future; however, as specific reforms have not yet been designed, tested, or evaluated, their ability to reduce costs cannot be estimated at this time, and thus no specific savings have been reflected in the projections for the initiative.

Another important example involves lower payment rate updates to most categories of Medicare providers in 2011 and later. These updates will be adjusted downward by the increase in productivity experienced in the economy overall. Since the provision of health services tends to be labor-intensive and is often customized to match individuals' specific needs, most categories of health providers have not been able to improve their productivity to the same extent as the economy at large. Over time, the productivity adjustments mean that the prices paid for health services by Medicare will grow about 1.1 percent per year more slowly than the increase in prices that providers must pay to purchase the goods and services they use to provide health care services. Unless providers could reduce their cost per service correspondingly, through productivity improvements or other steps, they could eventually become unwilling or unable to treat Medicare beneficiaries.

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. Similarly, the implementation of payment and delivery system reforms, facilitated by the Affordable Care Act research and development program, could help constrain cost growth to a level consistent with the lower Medicare payments. These outcomes are far from certain, however. The feasibility of such sustained improvements is debatable. Without fundamental changes in current health care delivery systems and payment mechanisms, the Medicare price constraints would probably become unworkable, in which case Congress would likely override them, much as they have done to prevent the reductions in physician payment rates otherwise required by the sustainable growth rate formula in current law.

The reductions in provider payments reflected these updates, if implemented for all future years as required under current law[1], could have secondary impacts, for beneficiary access to care; utilization, intensity and 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.

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,

[1] *The Interim Report of the Technical Review Panel on the Medicare Trustees Report* is available at http://aspe.hhs.gov/health/medpanel/2010/interim1103.shtml.

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 were selected in October 2010 and began their deliberations in November. They were asked to focus their immediate attention on the long-range Medicare expenditure growth rate assumption. In its interim report, the Panel found that the long-range Medicare growth rate assumptions used in the 2010 report for the current-law projections were not unreasonable in light of the provisions of the Affordable Care Act. The Panel recommended the continued use of a supplemental analysis, similar to the illustrative alternative projection in the 2010 Trustees Report, 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.

The Panel members noted the extreme difficulty involved in developing long-range Medicare cost growth assumptions, due to the many uncertainties that surround not only the long-term evolution of the U.S. health care system but also the system's interaction with the provisions of the Affordable Care Act. The trustees will continue their efforts, with the assistance of the Panel, to develop possible improvements to the cost growth assumptions underlying the 2010 Medicare Trustees Report.

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 almost 30 percent reduction in Medicare payment rates for physician services in January 2012 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 out over the 16 years starting in 2020 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.

MEDICARE PRESENT VALUES

(IN BILLIONS)

	Current law (Unaudited)	Alternative Scenario[1,2](Unaudited)
Income		
Part A	$15,104	$15,104
Part B	18,940	28,744
Part D	9,950	9,950
Expenditures		
Part A	18,356	23,640
Part B	18,940	28,744
Part D	9,950	9,950
Income less expenditures		
Part A	(3,252)	(8,536)
Part B	0	0
Part D	0	0

[1]These amounts are not presented in the 2011 Trustees' Report.

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

As expected, the differences between the current-law projections and the illustrative alternative are substantial, although both represent a sizable improvement in the financial outlook for Medicare compared to the laws in effect prior to the Affordable Care Act. This difference in outlook serves as a compelling reminder of the importance of developing and implementing further means of reducing health care cost growth in the coming years. All Part A fee-for-service providers are affected by the productivity adjustments, so the current law projections reflect an estimated 1.1 percent reduction in annual Part A cost growth each year. If the productivity adjustments were gradually phased out, as illustrated under the alternative scenario, the present value of Part A expenditures is estimated to be roughly 29 percent higher than the current-law projection. As indicated above, the present value of Part A income is unchanged 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 annual increases in the Medicare Economic Index. The productivity adjustments are assumed to affect more than half of Part B expenditures at the time their phase-out is assumed to begin. Similarly, physician fee schedule services are assumed to be roughly 30 percent higher under the alternative scenario than 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 52 percent higher than the current-law projection.

The Part D projections are unaffected under the alternative projection because the services are not impacted by the productivity adjustments or the physician fee schedule reductions.

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 reconciliation identifies several components of the change that are significant and provides reasons for the changes.

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

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

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

All estimates in the table are presented as 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.

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

Change in the Valuation Period

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2010-84) to the current valuation period (2011-85) is measured by using the assumptions for the prior valuation period and applying them, in the absence of any

other changes, to the current valuation period. Changing the valuation period removes a small negative net cashflow for 2010 and replaces it with a much larger negative net cashflow for 2085. The present value of future net cashflow (including or excluding the combined Medicare Trust Fund assets at the start of the period) was therefore decreased (made more negative) when the 75-year valuation period changed from 2010-84 to 2011-85. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2010 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

Change in the Projection Base

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

Changes in Demographic Assumptions

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

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

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

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

Changes in Economic and Health Care Assumptions

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

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

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

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

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

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

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

Changes in Law

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

Note 18:

RECONCILIATION OF NET COST OF OPERATIONS TO BUDGET

(DOLLARS IN MILLIONS)	FY 2011 Consolidated Totals	FY 2010 Consolidated Totals
Resources Used to Finance Activities:		
Budgetary Resources Obligated:		
Obligations incurred	$1,133,389	$1,057,202
Less: Spending authority from offsetting collections and recoveries	34,484	20,814
Obligations net of offsetting collections and recoveries	1,098,905	1,036,388
Less: Distributed offsetting receipts	321,925	302,966
Net obligations	776,980	733,422
Other Resources:		
Imputed financing from costs absorbed by others	44	44
Net other resources used to finance activities	44	44
Total resources used to finance activities	**$777,024**	**$733,466**
Resources Used to Finance Items not Part of the Net Cost of Operations:		
Change in budgetary resources obligated for goods, services and benefits ordered but not yet provided	$16,486	$2,964
Budgetary offsetting collections and receipts that do not affect net cost of operations	(73)	(71)
Resources that finance the acquisition of assets	28	11
Other resources or adjustments to net obligated resources that do not affect net cost of operations	2,366	1,905
Total resources used to finance items not part of the net cost of operations	**$18,807**	**$4,809**
Total resources used to finance the net cost of operations	**$758,217**	**$728,657**
Components of the Net Cost of Operations that will not Require or Generate Resources in the Current Period:		
Components Requiring or Generating Resources in Future Periods:		
Increase in annual leave liability		$3
Decrease/(Increase) in receivables from the public	$(2,748)	(1,761)
Other	(1,103)	1,596
Total components of Net Cost of Operations that will require or generate resources in future periods	(3,851)	(162)
Components not Requiring or Generating Resources:		
Depreciation and amortization	37	55
Other	(258)	154
Total components of Net Cost of Operations that will not require or generate resources	(221)	209
***Total components of Net Cost of Operations that will not require* or generate resources in the current period**	**$(4,072)**	**$47**
Net Cost of Operations	**$754,145**	**$728,704**

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 (SF-133) and the Statement of Budgetary Resources. Therefore, these liabilities are recorded as contingent liabilities on the general ledger. Based on appropriation language, they are considered "funded" liabilities for purposes of the Balance Sheet, Statement of Net Cost, and Statement of Changes in Net Position.

REQUIRED SUPPLEMENTARY INFORMATION

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for over four 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 ***2011 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.

As was the case with last year's report, the projections shown here incorporate the effects of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010. This legislation, referred to collectively as the "Affordable Care Act," contained roughly 165 provisions affecting the Medicare program by reducing costs, increasing revenues, improving certain benefits, combating fraud and abuse, and initiating a major program of research and development for alternative provider payment mechanisms, health care delivery systems, and other changes intended to improve the quality of health care and reduce its costs to Medicare.

"Medicare, the largest health insurance program in the country..."

The Affordable Care Act improved the financial outlook for Medicare substantially, mainly as a result of permanent price update reductions for most fee-for-service providers, substantial reductions in payments to private health plans, and an increase in the Part A payroll tax rate for high-income earners. 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. These outcomes are far from certain, however. The feasibility of such sustained improvements is debatable. Without fundamental changes in current health care delivery systems and payment mechanisms, the Medicare price constraints would probably become unworkable, in which case Congress would likely override them, much as they have done to prevent the reductions in physician payment rates otherwise required by the sustainable growth rate formula in current law. 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, an almost 30-percent reduction in Medicare payment rates for physician services is assumed to be implemented in 2012 as required under current law, despite the virtual certainty that Congress will override the reduction.

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, references an alternative scenario 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 this theoretical alternative to current law. No endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred. Additional information on this theoretical alternative to current law is provided in Note 16 in these financial statements, 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

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. Prior to the 2006 Trustees Report, the long-range increase in average

expenditures per beneficiary was assumed to equal growth in per capita gross domestic product (GDP) plus 1 percentage point. Beginning with the 2006 report, the Board of Trustees adopted a refinement of these long-range growth assumptions. The refinement provides a smoother and more realistic transition from current Medicare cost growth rates, which have been significantly above the level of GDP growth, to the ultimate assumed level of GDP plus zero percent for the indefinite future. This same approach was used to establish "baseline" long-range growth rate assumptions for the 2010 Medicare Trustees Report, prior to the incorporation of the provisions in the Affordable Care Act.

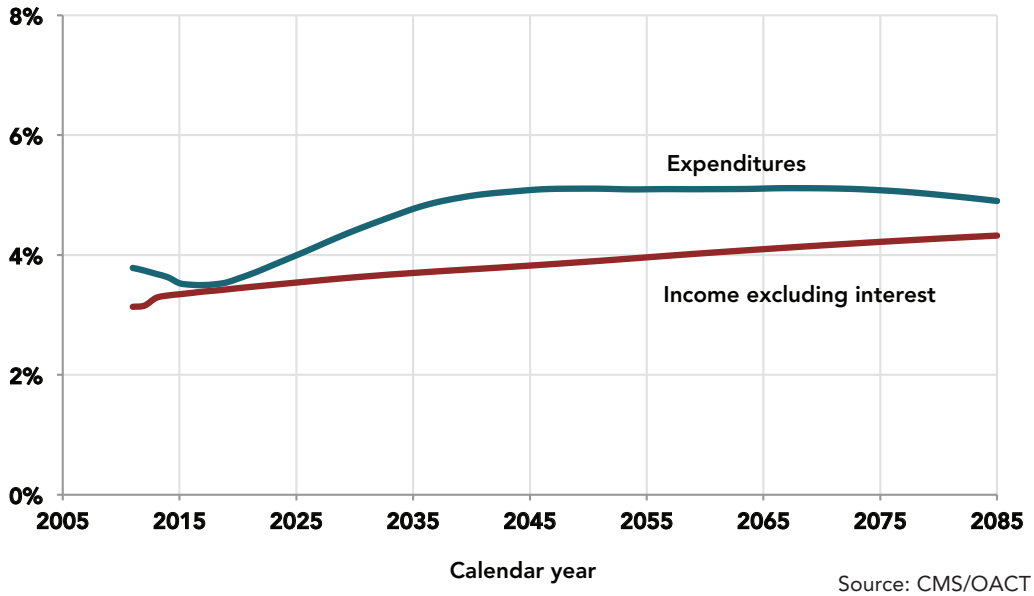
For the 2011 Medicare Trustees Report, the long-range Medicare cost growth assumptions are identical to the ones used by the Trustees in their 2010 report. Under the Office of the Actuary's economic model, in 2035 the pre-Affordable Care Act growth rate for all Medicare services is assumed to be about 1.3 percentage points above the rate of GDP growth for that year (before demographic impacts). This differential gradually declines to about 0.8 percentage point in 2055 and to less than 0.3 percentage point in 2085. Compared to a constant "GDP plus 1 percent" assumption, the pre-Affordable Care Act baseline growth assumption is initially higher, but subsequently lower.

In order to incorporate the effects of the permanent Medicare price update reductions required by the Affordable Care Act, adjustments were made to the per capita growth rates produced by the economic model for Parts A and B.[1] Since all Part A fee-for-service providers are affected, the assumed adjustment in each year is the full update reduction (1.1 percent).

Chart 1

HI EXPENDITURES AND INCOME EXCLUDING INTEREST AS A PERCENTAGE OF TAXABLE PAYROLL

2011–2085



Source: CMS/OACT

[1] The price update reductions do not affect Part D, and therefore the growth assumption for this account continues to be based on the pre-Affordable Care Act baseline growth of GDP plus 1 percent, as adjusted by the economic model.

For SMI Part B, only certain provider categories—for example, outpatient hospitals, ambulatory surgical centers, diagnostic laboratories, and most other non-physician services—are affected by the price update reductions. Accordingly, these services are subject to the same assumed long-range growth rate as Part A services. In contrast, Part B physician expenditures per beneficiary are increased at approximately the rate of per capita GDP growth, as required by the sustainable growth rate formula in current law. All other Part B outlays, which constitute an estimated 12.0 percent of total Part B expenditures in 2020, have an assumed average growth rate of per capita GDP plus 1 percent (adjusted by the economic model), as determined for the pre-Affordable Care Act "baseline" growth trend.

Based on these projections, the Medicare Trustees apply a formal test of "long-range close actuarial balance." The HI trust fund fails this test, as it has for many years.

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 as the economy recovers from the recent recession and as the savings provisions of the Affordable Care Act take effect. Subsequently, the cost rate will increase significantly due to retirements of those in the baby boom generation and continuing health services cost growth. The effect of these factors will be largely offset in 2045 and later under current law by the accumulating effect of the reduction in provider price updates, which will reduce annual HI cost growth by an estimated 1.1 percent per year. If the slower price updates were not feasible in the long range and were phased out during 2020-2035, then the HI cost rate would be 5.3 percent in 2035 and 9.4 percent in 2085. These levels are about 10 percent and 90 percent higher, respectively, than the current-law estimates under the intermediate assumptions, illustrating the very strong impact of the market basket reductions scheduled in current law.

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 2010, the expenditures were $247.9 billion, which was 1.7 percent of GDP. This percentage is projected to increase steadily through 2046 and then decrease throughout the remainder of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative projections,[2] HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 4.0 percent in 2085.

SMI

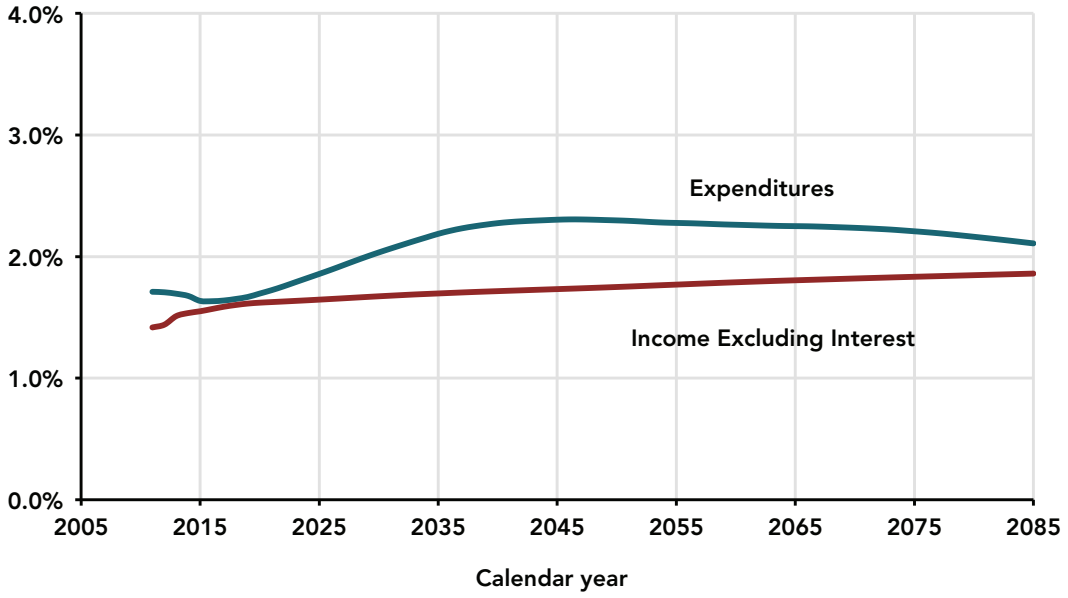
Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long-range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and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

[2] At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare trust fund projections under this theoretical alternative to current law, which assumes that (i) physician payment rates would be updated using the Medicare Economic Index, rather than through the sustainable growth rate (SGR) process; and (ii) the productivity adjustments would be gradually phased out starting in 2020. No endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred.

Chart 2

HI EXPENDITURES AND INCOME EXCLUDING INTEREST AS A PERCENTAGE OF GDP

2011–2085

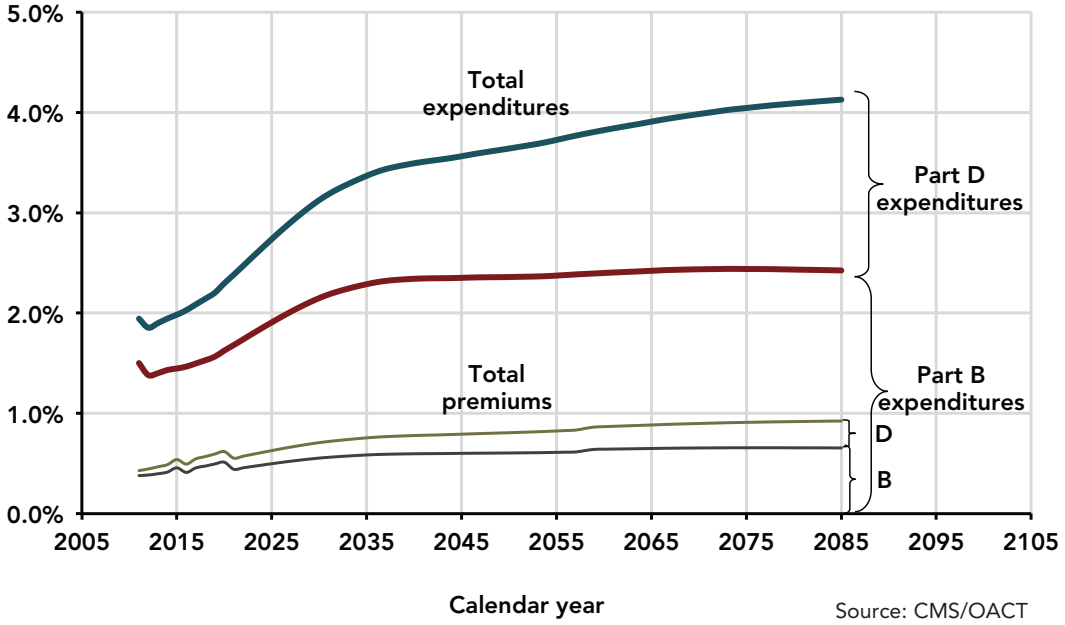


Source: CMS/OACT

Chart 3

SMI EXPENDITURES AND PREMIUMS AS A PERCENTAGE OF GDP

2011–2085



Source: CMS/OACT

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

Under the intermediate assumptions, annual SMI expenditures were $274.9 billion, or about 1.9 percent of GDP, in 2010. Then, in about 25 years, they would grow to roughly 3.4 percent of GDP and to approximately 4.1 percent by the end of the projection period. Total SMI expenditures in 2085 would be 6.6 percent of GDP under the illustrative alternative projection mentioned previously.

To match the faster growth rates for SMI expenditures, 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 2011 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 2010, every beneficiary had 3.4 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 2.0 workers per beneficiary by 2085.

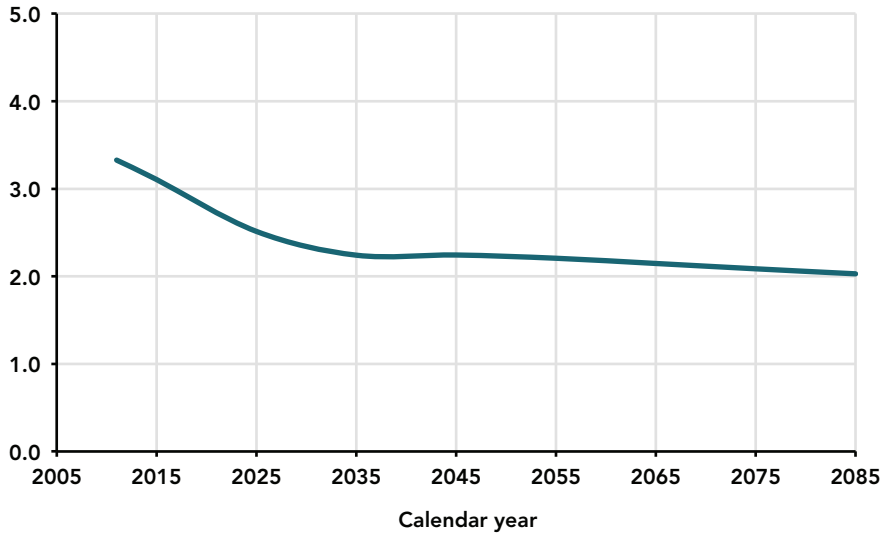
SENSITIVITY ANALYSIS

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

Chart 4

NUMBER OF COVERED WORKERS PER HI BENEFICIARY

2011–2085



Source: CMS/OACT

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.[3] The assumptions varied are the health care cost factors, real-wage differential, consumer price index (CPI), real-interest rate, fertility rate, and net immigration.[4]

For this analysis, the intermediate economic and demographic assumptions in the 2011 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, 2011, 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. 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 2040 when they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process used for computing present values, which is used to help interpret the net cashflow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price 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 one percent slower than the intermediate assumptions, the same as the intermediate assumptions, and one 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 one percentage point lower than the intermediate assumptions, the deficit decreases by $5,169 billion. On the other hand, if the ultimate growth rate assumption is one percentage point higher than the intermediate assumptions, the deficit increases substantially, by $8,193 billion.

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)*	$1,917	$(3,252)	$(11,445)

[3] 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.

[4] 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.

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 one 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.

Real-Wage Differential

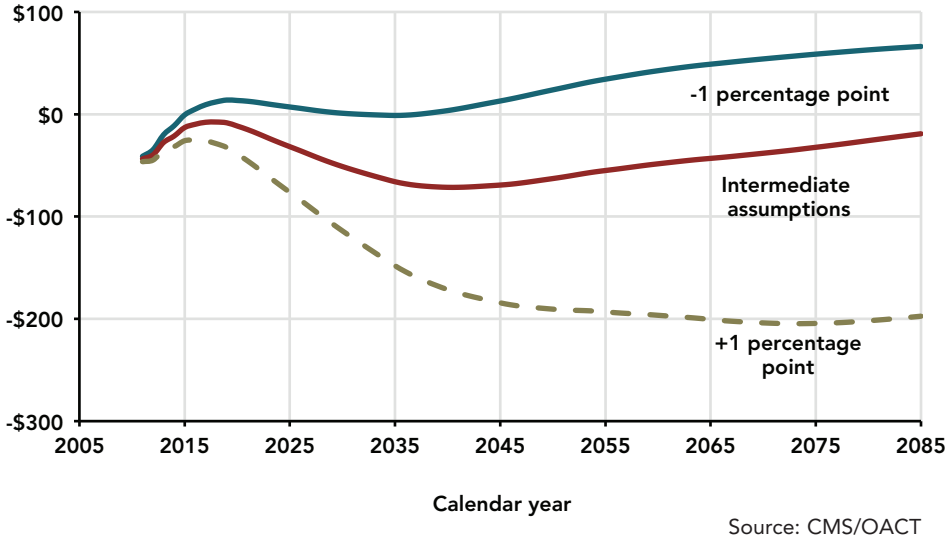
Table 2 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.6, 1.2, and 1.8 percentage[5] points. In each case, the ultimate CPI increase is assumed to be 2.8 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.4, 4.0, and 4.6 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 $910 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $470 billion.

Chart 5

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS HEALTH CARE COST FACTORS (IN BILLIONS)

2011–2085



Source: CMS/OACT

Table 2

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

Ultimate percentage increase in wages – CPI	3.4 – 2.8	4.0 – 2.8	4.6 – 2.8
Ultimate percentage increase in real-wage differential	0.6	1.2	1.8
Income minus expenditures *(in billions)*	$(3,819)	$(3,252)	$(2,156)

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

Chart 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. Prior to the Affordable Care Act, the deficit was increased under the higher real-wage assumptions on a present-value basis, since the dollar impact on expenditures was higher than the dollar impact on income. This is not the case this year because, compared to pre-Affordable Care Act projections, expenditures are substantially reduced as a result of the continued payment update reductions for all HI fee-for-service providers, and income is higher due to the additional HI tax rate for high-income earners. This reversal in the direction of the impact of higher real-wage growth illustrates a limitation of the use of present-value cashflows as a measure of financial status; 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 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 ultimate real-wage differential is assumed to be 1.2 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.0, 4.0, and 5.0 percent, respectively.

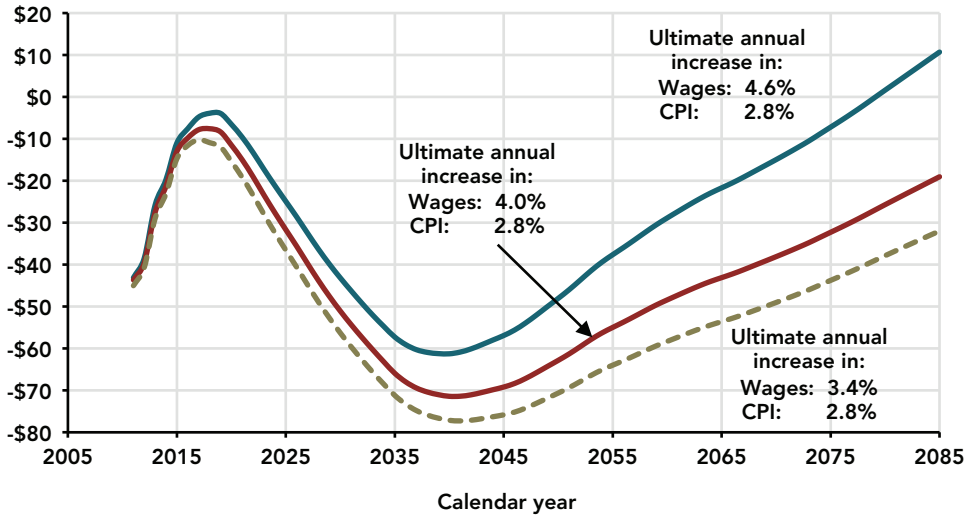
Table 3 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by $226 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit decreases by $246 billion.

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

Chart 6

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS REAL-WAGE ASSUMPTIONS (IN BILLIONS)

2011–2085



Source: CMS/OACT

As Chart 7 indicates, this assumption has a small impact when the cashflow is expressed as present values. The relative insensitivity of the projected present values of HI cashflow to different levels of general inflation occurs because inflation tends to affect both income and costs in a similar manner. In present value terms, a smaller deficit results under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios, but under high-inflation conditions the present value of HI income increases as more people become subject to the additional 0.9 percent HI tax rate required by the Affordable Care Act for workers with earnings above $200,000 or $250,000 (for single and joint income-tax filers, respectively). Since the thresholds are not indexed, additional workers become subject to the additional tax more quickly under conditions of faster inflation, and vice-versa.

Real-Interest Rate

Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.1, 2.9, and 3.6 percent. In each case, the ultimate annual increase in the CPI is assumed to be 2.8 percent, resulting in ultimate nominal annual yields of 4.9, 5.7, and 6.4 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 $110 billion.

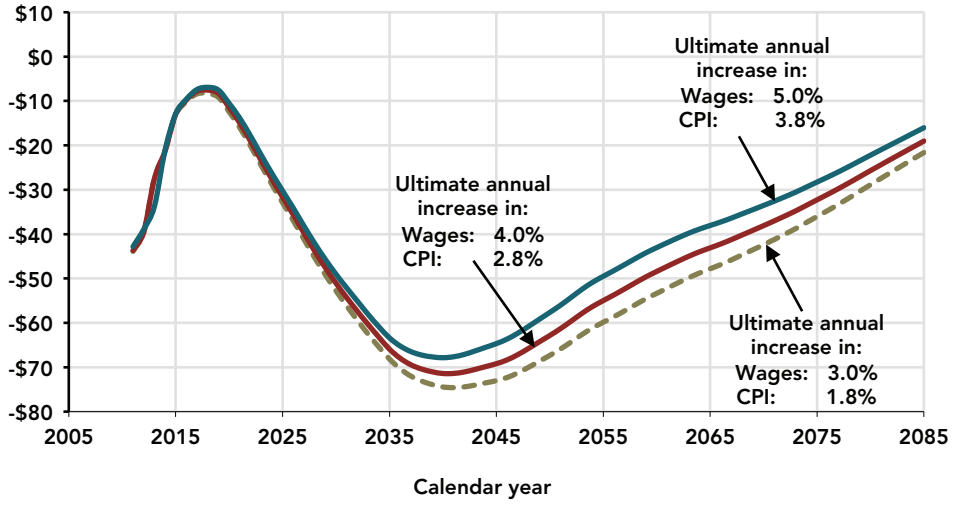
Chart 8 shows projections of the present value of the estimated net cashflow under the three alternative real-interest assumptions presented in Table 4.

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.

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

Ultimate percentage increase in wages – CPI	3.0 – 1.8	4.0 – 2.8	5.0 – 3.8
Income minus expenditures *(in billions)*	$(3,478)	$(3,252)	$(3,006)

Chart 7
PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS CPI-INCREASE ASSUMPTIONS (IN BILLIONS)
2011–2085



Source: CMS/OACT

In actuality, interest finances very little of the cost of the HI trust fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2024. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

Compared to past reports, however, the sensitivity of present values to different real-interest rate assumptions is substantially reduced as a result of the Affordable Care Act. Under this legislation, annual deficits would decrease due to the compounding effects of the price update reductions for HI fee-for-service providers. Discounting a relatively level series by high or low interest factors has much less effect than when the series is increasing rapidly, as with the pre-Affordable Care Act projections.

Fertility Rate

Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.7, 2.0, and 2.3 children per woman.

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

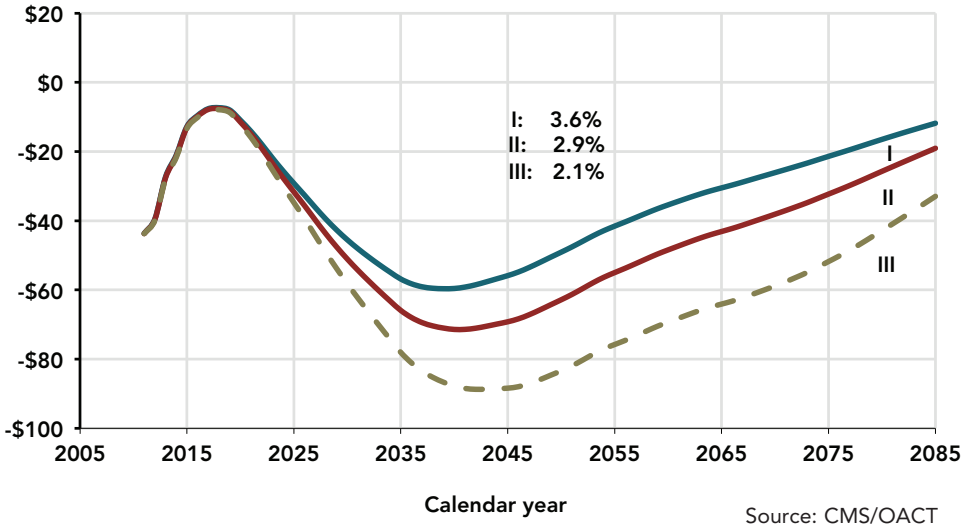
Chart 9 shows projections of the present value of the net cashflow under the three alternative fertility rate assumptions presented in Table 5.

As Chart 9 indicates, the fertility rate assumption has a fairly large impact on projected HI cashflows. This result is different than in past reports mainly due to the additional HI tax on high-income earners required by the Affordable Care Act. 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

Table 4
PRESENT VALUE OF ESTIMATED HI INCOME LESS EXPENDITURES UNDER VARIOUS REAL-INTEREST ASSUMPTIONS

Ultimate real-interest rate	2.1 percent	2.9 percent	3.6 percent
Income minus expenditures *(in billions)*	$(4,293)	$(3,252)	$(2,589)

Chart 8
PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS REAL-INTEREST RATE ASSUMPTIONS (IN BILLIONS)
2011–2085



Source: CMS/OACT

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 was used, the impact of a fertility rate change would be more pronounced.

Net Immigration

Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative average annual net immigration assumptions: 785,000 persons, 1,075,000 persons, and 1,385,000 persons per year.

As indicated in Table 6, if the average annual net immigration assumption is 785,000 persons, the deficit—expressed in present-value dollars—increases by $75 billion. Conversely, if the assumption is 1,385,000 persons, the deficit decreases by $83 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.

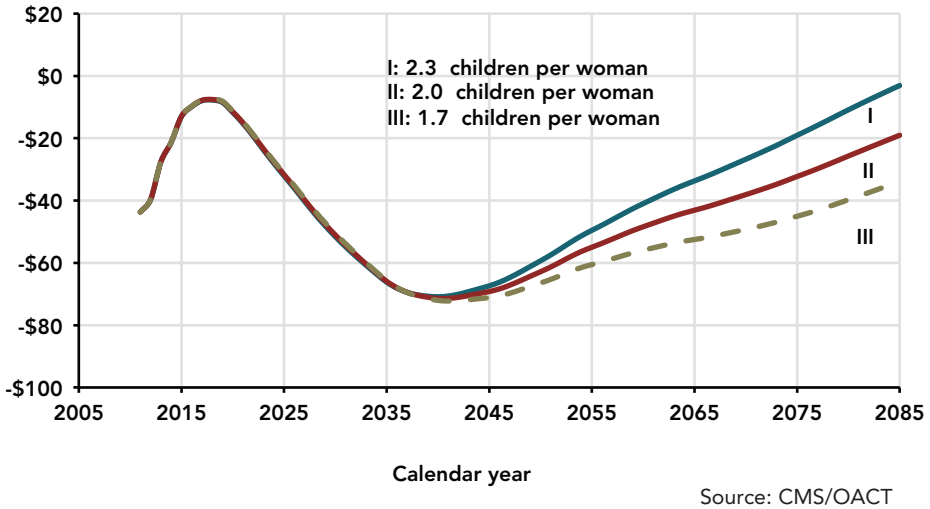
As illustrated in Chart 10, higher net immigration results in smaller HI cashflow deficits. Since immigration tends to occur most often among people at working ages, who work and pay taxes into the HI system, a change in the net immigration assumption affects revenues from payroll taxes

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)*	$(3,623)	$(3,252)	$(2,874)

[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 (IN BILLIONS)
2011–2085



Source: CMS/OACT

almost immediately. However, the impact on expenditures occurs later as those individuals age and become beneficiaries.

Prior to the Affordable Care Act, the deficit was increased under the higher-net immigration assumptions, since the cost of HI benefits for the additional participants was substantially greater than their HI taxes. This is not the case this year because, compared to pre-Affordable Care Act projections, expenditures are substantially reduced as a result of the continued payment update reductions for all HI fee-for service providers, and income is higher due to the additional HI tax for high-income earners. As shown in the Statement of Social Insurance, the value of the additional HI payroll taxes paid by new participants in the future, on average, will be greater than the cost of their benefits, assuming that the lower HI price updates can be continued indefinitely. As noted previously, there is a significant likelihood that the reduction in Medicare provider payment updates will not be feasible in the long range.

Trust Fund Finances and Sustainability

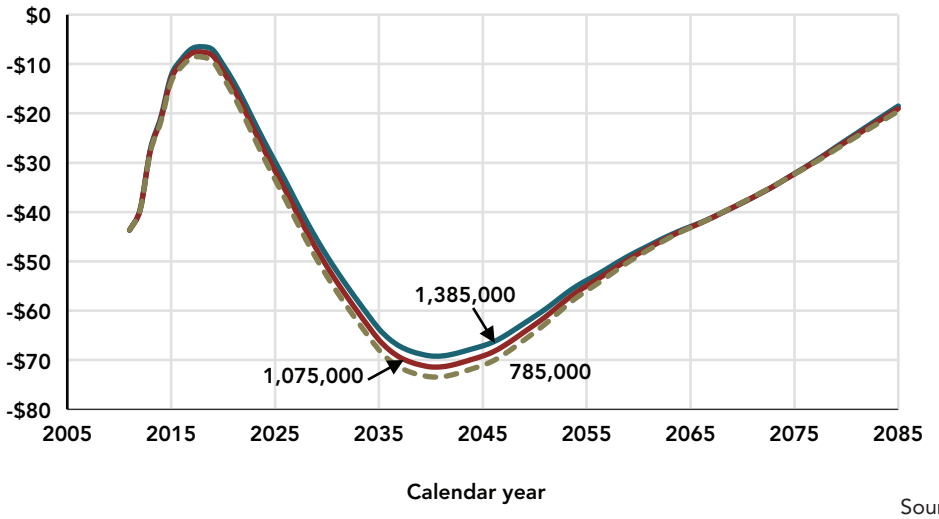
HI

The financial status of the HI trust fund was substantially improved by the lower expenditures and additional tax revenues instituted by the Affordable Care Act. However, the fund is now estimated to be exhausted in 2024, 5 years earlier than was shown in last year's report, and it is not adequately financed over the next 10 years. HI taxable earnings in 2010 were lower than previously

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

Average annual net immigration	785,000	1,075,000	1,385,000
Income minus expenditures *(in billions)*	$(3,327)	$(3,252)	$(3,169)

Chart 10
PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS NET IMMIGRATION ASSUMPTIONS (IN BILLIONS)
2011–2085



Source: CMS/OACT

estimated, and the rate of growth in these earnings is projected to accelerate and to exceed last year's growth assumptions in 2011-2019. HI expenditures in 2010 were close to the previous estimate, but the projected level grows more rapidly than shown in last year's report because of the projected faster growth in earnings. HI expenditures have exceeded income annually since 2008 and are projected to continue to do so through the short-range period until the fund becomes exhausted in 2024. The shortfalls can be met with increasing reliance on the redemption of trust fund assets, thereby adding to the draw on the Federal Budget. In the absence of corrective legislation, a depleted HI trust fund would initially produce payment delays but would very quickly lead to a curtailment of health care services to beneficiaries. In practice, Congress has never allowed a Medicare or Social Security trust fund to become fully depleted.

It is important to note that the improved outlook for the HI trust fund 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 impending retirement of the baby boom generation. If the reductions to HI provider price updates could be not 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 2011 is adequate to cover 2011 expected expenditures and to maintain the financial status of the account in 2011 at a satisfactory level. The Part B cost projections are understated as a result of the substantial reductions in physician payments that would be required under current law and are further understated if the reductions in

future price updates for most other Part B providers are not viable. Actual future Part B costs will depend on the steps that Congress might choose to take to address these situations.

No financial imbalance is anticipated for the Part D account, since the general revenue subsidy for this benefit is drawn on a daily, as-needed basis. The projected Part D costs shown in this section are somewhat lower than previously estimated, due to slightly better-than-expected experience of the Part D plans in 2010 and lower assumed growth rates for prescription drug expenditures in the U.S. overall.

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

Medicare Overall

The Medicare Modernization Act requires the Board of Trustees to determine whether the difference between Medicare outlays and "dedicated financing sources" is projected to exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2011–2017)[6]. This difference is expected to exceed 45 percent of total expenditures in fiscal year 2011, 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 2006–2010 annual reports to Congress. With this sixth 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.[7] This requirement helps to call attention to Medicare's impact on the Federal Budget.

The Medicare financial projections shown in this section represent a substantial, but very uncertain, improvement over those prior to 2010 as a result of the Affordable Care Act. In the long range, much of this improvement depends on the feasibility of the legislation's downward adjustments to future increases in Medicare prices for most categories of health care providers. These projections continue to demonstrate the need for timely and effective action to address the remaining financial challenges facing Medicare—including the projected exhaustion of the HI trust fund, this fund's long-range financial imbalance, and the issue of rapid growth in Medicare expenditures. Furthermore, if the lower prices payable for health services under Medicare are overridden, the financial challenges in the long range would be much more severe. In their 2011 annual report to Congress, the Medicare Boards of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to take "prompt action…to address these challenges." They also stated: "Consideration of… further reforms should occur in the near future."

[6] 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.

[7] In January 2009, the House of Representatives passed a resolution (H. Res.5, section 3(e)) stating that section 803 of the Medicare Modernization Act, governing action required by the House in response to a funding warning, would not apply to the 111th Congress.

COMBINING STATEMENT OF BUDGETARY RESOURCES

for the year ended September 30, 2011

(IN MILLIONS)

	Medicare		Payments to Trust Funds	Medicaid	CHIP	Medicare Part D	Other Health	All Others	Combined Totals Budgetary
	HI TF	SMI TF							
Budgetary Resources:									
Unobligated balance, brought forward, October 1:			$1,775	$17,000	$9,094	$536	$5	$2,360	$30,770
Recoveries of prior year unpaid obligations	$501	$347		20,027	1,245	265		348	22,733
Budget authority:									
Appropriation	272,411	236,336	245,949	285,153	13,512	67,863	16,000	2,919	1,140,143
Spending authority from offsetting collections: Earned									
Collected	1,811	11	19	129		1,612	19	324	3,925
Change in unfilled customer orders:									
Without advance from Federal sources								43	43
Expenditure transfers from trust funds				703				7,080	7,783
Subtotal	**274,222**	**236,347**	**245,968**	**285,985**	**13,512**	**69,475**	**16,019**	**10,366**	**1,151,894**
Nonexpenditure transfers, net, anticipated & actual	(142)	(150)		(3,937)			7,714	3	3,488
Temporarily not available pursuant to Public Law	(27)	(32)							(59)
Permanently not available	(2)	(1)	(1,239)	(26,680)	(3,500)		(2,200)	(36)	(33,658)
TOTAL BUDGETARY RESOURCES	**$274,552**	**$236,511**	**$246,504**	**$292,395**	**$20,351**	**$70,276**	**$21,538**	**$13,041**	**$1,175,168**
Status of Budgetary Resources:									
Obligations incurred:									
Direct	$274,551	$236,511	$242,170	$291,883	$8,815	$69,704	$1,759	$7,687	$1,133,080
Reimbursable	1						19	289	309
Subtotal	**274,552**	**236,511**	**242,170**	**291,883**	**8,815**	**69,704**	**1,778**	**7,976**	**1,133,389**
Unobligated balance:									
Apportioned			3,825		9,480		19,758	4,611	37,674
Exempt from apportionment						136			136
Subtotal			**3,825**		**9,480**	**136**	**19,758**	**4,611**	**37,810**
Unobligated balance not available			509	512	2,056	436	2	454	3,969
TOTAL STATUS OF BUDGETARY RESOURCES	**$274,552**	**$236,511**	**$246,504**	**$292,395**	**$20,351**	**$70,276**	**$21,538**	**$13,041**	**$1,175,168**
Change in Obligated Balance:									
Obligated balance, net:									
Unpaid obligations, brought forward, October 1	$23,423	$22,184		$27,887	$8,194	$3,626		$4,092	$89,406
Uncollected customer payments from Federal sources, brought forward, October 1	(1)							(2,867)	(2,868)
Total unpaid obligated balance, net	**23,422**	**22,184**		**27,887**	**8,194**	**3,626**		**1,225**	**86,538**
Obligations incurred, net	274,552	236,511	$242,170	291,883	8,815	69,704	1,778	7,976	1,133,389
Gross Outlays	(265,280)	(234,285)	(242,170)	(272,017)	(8,634)	(67,849)	(1,168)	(6,100)	(1,097,503)
Obligated balance transferred, net:									
Recoveries of prior year unpaid obligations, actual	(501)	(347)		(20,027)	(1,245)	(265)		(348)	(22,733)
Change in uncollected customer payments from Federal sources								(3,594)	(3,594)
Obligated balance, net, end of period:									
Unpaid Obligations	32,194	24,063		27,726	7,130	5,216	610	5,620	102,559
Uncollected customer payments from Federal sources	(1)							(6,461)	(6,462)
Total, unpaid obligated balance, net, end of period	**32,193**	**24,063**		**27,726**	**7,130**	**5,216**	**610**	**(841)**	**96,097**
Net Outlays:									
Net Outlays									
Gross outlays	265,280	234,285	242,170	272,017	8,634	67,849	1,168	6,100	1,097,503
Offsetting collections	(1,811)	(11)	(19)	(832)		(1,612)	(19)	(3,853)	(8,157)
Distributed offsetting receipts	(25,643)	(296,209)			(8)			(65)	(321,925)
NET OUTLAYS	**$237,826**	**$(61,935)**	**$242,151**	**$271,185**	**$8,626**	**$66,237**	**$1,149**	**$2,182**	**$767,421**

CONSOLIDATING BALANCE SHEET

as of September 30, 2011

(IN MILLIONS)

ASSETS										
Intragovernmental Assets:										
Fund Balance with Treasury	$443	$5,687	$6,130	$28,230	$16,571	$20,370	$3,216	$74,517		$74,517
Investments	248,818	71,154	319,972		2,093			322,065		322,065
Accounts Receivable, Net	33,936	28,612	62,548	103	14		743	63,408	$(62,892)	516
Other Assets	90		90		1			91		91
Accounts Receivable, Net	972	6,514	7,486	3,017	2	3	19	10,527		10,527
General Property, Plant & Equipment, Net	128	235	363	21	2		3	389		389
Other Assets	5,243	10,766	16,009	3		1	70	16,083		16,083
LIABILITIES										
Intragovernmental Liabilities:										
Accounts Payable	$33,762	$29,775	$63,537				$6	$63,543	$(62,892)	$651
Accrued Payroll and Benefits	1	3	4					4		4
Other Intragovernmental Liabilities	180	662	842	$1			35	878		878
Federal Employee and Veterans' Benefits	4	9	13					13		13
Entitlement Benefits Due and Payable	28,628	25,664	54,292	26,069	$457		64	80,882		80,882
Accrued Payroll and Benefits	15	33	48	2		$1	3	54		54
Contingencies				3,016				3,016		3,016
Other Liabilities	288	377	665			1,272	10	1,947		1,947
NET POSITION										
Unexpended Appropriations-earmarked funds	$836	$3,499	$4,335					$4,335		$4,335
Unexpended Appropriations-other funds				$2,171	$18,212	$18,765	$2,945	42,093		42,093
Cumulative Results of Operations-earmarked funds	225,916	62,946	288,862					288,862		288,862
Cumulative Results of Operations-other funds				115	14	336	988	1,453		1,453

CONSOLIDATING STATEMENT OF NET COST

for the year ended September 30, 2011

(IN MILLIONS)

	Medicare (Earmarked)			Health (Other Funds)				Consolidated Total
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	
NET PROGRAM/ACTIVITY COSTS								
GPRA Programs								
Medicare (Earmarked)	$256,316	$217,689	$474,005					$474,005
Medicaid				$268,116				268,116
CHIP					$8,689			$8,689
Net Cost: GPRA Programs	**256,316**	**217,689**	**474,005**	**268,116**	**8,689**			**750,810**
Other Activities								
CLIA							$101	$101
State Grants and Demonstrations							679	679
Other Health						$2,418		2,418
Other							137	137
Net Cost: Other Activities						**2,418**	**917**	**3,335**
NET COST OF OPERATIONS	**$256,316**	**$217,689**	**$474,005**	**$268,116**	**$8,689**	**$2,418**	**$917**	**$754,145**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2011

(IN MILLIONS)

	Medicare (Earmarked)			Health (Other Funds)				Consolidated Total
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	
CUMULATIVE RESULTS OF OPERATIONS								
Beginning Balances	$261,112	$52,335	$313,447	$122	$20		$467	$314,056
Budgetary Financing Sources:								
Appropriations Used	16,973	225,179	242,152	267,291	8,664	2,754	830	521,691
Nonexchange Revenue:								
FICA and SECA Taxes	192,063		192,063					192,063
Interest on Investments	12,439	3,212	15,651		5			15,656
Other Nonexchange Revenue	578	1,877	2,455					2,455
Transfers-in/out Without	(946)	(1,996)	(2,942)	817	14		606	(1,505)
Other Financing Sources (Nonexchange):								
Imputed Financing	13	28	41	1			2	44
Total Financing Sources	**221,120**	**228,300**	**449,420**	**268,109**	**8,683**	**2,754**	**1,438**	**730,404**
Net Cost of Operations	**256,316**	**217,689**	**474,005**	**268,116**	**8,689**	**2,418**	**917**	**754,145**
Net Change	**(35,196)**	**10,611**	**(24,585)**	**(7)**	**(6)**	**336**	**521**	**(23,741)**
CUMULATIVE RESULTS OF OPERATIONS	**$225,916**	**$62,946**	**$288,862**	**$115**	**$14**	**$336**	**$988**	**$290,315**
UNEXPENDED APPROPRIATIONS								
Beginning Balances	$702	$1,074	$1,776	$14,926	$16,872	$5	$2,574	$36,153
Budgetary Financing Sources:								
Appropriations Received	17,299	228,650	245,949	285,153	10,004	13,800	1,211	556,117
Appropriations Transferred-in/out				(3,937)		7,714	2	3,779
Other Adjustments ***(Note 10)***	(192)	(1,046)	(1,238)	(26,680)			(12)	(27,930)
Appropriations Used	(16,973)	(225,179)	(242,152)	(267,291)	(8,664)	(2,754)	(830)	(521,691)
Total Budgetary Financing Sources	**134**	**2,425**	**2,559**	**(12,755)**	**1,340**	**18,760**	**371**	**10,275**
Total Unexpended Appropriations	**836**	**3,499**	**4,335**	**2,171**	**18,212**	**18,765**	**2,945**	**46,428**
NET POSITION	**$226,752**	**$66,445**	**$293,197**	**$2,286**	**$18,226**	**$19,101**	**$3,933**	**$336,743**

AUDIT REPORTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

NOV 10 2011

TO: Donald M. Berwick, M.D.
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 2011 (A-17-11-02011)

This memorandum transmits the independent auditors' reports on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2011 financial statements, conclusions about the effectiveness of CMS's internal controls, and CMS's compliance with laws and regulations. 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 (E&Y), to audit the CMS consolidated balance sheets as of September 30, 2011 and 2010, and the related consolidated statements of net cost and changes in net position, the combined statement of budgetary resources for the years then ended, and the statement of social insurance as of January 1, 2011 and 2010, and the related statement of changes in social insurance amounts. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in the *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 07-04, "Audit Requirements for Federal Financial Statements."

Results of the Independent Audit

E&Y found that the FY 2011 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. E&Y was unable to determine that the statement of social insurance was fairly presented because of the uncertainties reported by the Chief Actuary in the *2011 Annual Report of the Board of Trustees of the Federal Hospital*

Page 2 – Donald M. Berwick, M.D.

Insurance and Federal Supplementary Medical Insurance Trust Funds. Furthermore, during testing of internal controls as of September 30, 2011, E&Y noted certain matters involving internal controls and their operation that we consider to be significant deficiencies under standards issued by the American Institute of Certified Public Accountants. Specifically, E&Y reported two significant deficiencies regarding CMS's information systems controls and CMS's financial reporting systems and processes.

Exclusive of the Improper Payments Elimination and Recovery Act of 2010 (IPERA) (P.L. No. 111-204), E&Y disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards* and OMB Bulletin 07-04.

Evaluation and Monitoring of Audit Performance

We reviewed the audit of the CMS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the audits;
- attending key meetings with auditors and CMS officials;
- monitoring the progress of the audit;
- examining audit documentation including those related to the review of internal controls over financial reporting;
- reviewing the auditors' reports; and
- reviewing the *CMS Financial Report* for FY 2011.

E&Y 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 CMS's internal controls, whether CMS's financial management systems substantially complied with the Federal Financial Management Improvement Act (P.L. No. 104-208), or CMS's compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which E&Y did not comply, in all material respects, with U.S. generally accepted government auditing standards.

We also noted that CMS management revised its methodology for the Medicare fee-for-service improper payment estimate to adjust for the effects of the receipt of late documentation and denied claims overturned on appeal. While we have suggested to management that including an adjustment for overturned Medicare claim payment denials could improve its estimates of reported errors, we have not yet had time to review the adjusted data and related methodology.

Page 3 – Donald M. Berwick, M.D.

Under IPERA, we are required to issue a report on compliance with the Improper Payments Information Act of 2002 and as part of that report will assess the accuracy and completeness of agency improper payment reporting.

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-17-11-02011.

Attachment

cc:
Ellen Murray
Assistant Secretary for Financial Resources
and Chief Financial Officer
Department of Health & Human Services

Sheila Conley
Deputy Assistant Secretary for Finance
and Deputy Chief Financial Officer
Department of Health & Human Services

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Report of Independent Auditors

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

We have audited the accompanying consolidated balance sheets of the Centers for Medicare and Medicaid Services (CMS) as of September 30, 2011 and 2010, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal years then ended, and the statements of social insurance as of January 1, 2009 and 2008. We were engaged to audit the statements of social insurance as of January 1, 2011 and 2010 and the related statement of changes in social insurance amounts. These financial statements are the responsibility of CMS' management. Our responsibility is to express an opinion on these financial statements based on our audits. The statement of social insurance as of January 1, 2007, was audited by other auditors whose report dated November 9, 2007, expressed an unqualified opinion on that statement.

Except as discussed in the following paragraphs with respect to the accompanying statements of social insurance as of January 1, 2011 and 2010 and the related statement of changes in social insurance amounts, we conducted our audits in accordance with auditing standards generally accepted in the United States, the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 07-04, *Audit Requirements for Federal Financial Statements*, as amended. Those standards and bulletin require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of CMS' internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of CMS' internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As discussed in Note 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. However, because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. Projections of Medicare costs are sensitive to assumptions about future decisions by policymakers and about the behavioral responses of consumers, employers, and health care providers as policies, incentives, and the health care sector change over time. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the SMI Part D projections have an added uncertainty in that they were prepared using very little program data upon which to base the estimates, and as discussed below, significant additional variability has been introduced by the passage of recent legislation as well as issues regarding the sustainability of the underlying assumptions under current law.

As further described in Note 16 to the financial statements, with respect to the estimates for the CMS social insurance program presented as of January 1, 2011 and 2010, management has reflected in the projections of the program the direct impact, but not the secondary impacts, if any, of productivity adjustments (reductions in anticipated rates of increase) and reductions in Medicare payment rates for physician services mandated in the Patient Protection and Affordable Care Act (ACA) and current law. Prior legislation mandating reductions in provider payments has been overridden in whole or in part by new legislation, including frequent adjustments to scheduled reductions in physician payments and to prior efforts to adjust payments for inpatient hospital services. Management has noted that actual future costs for Medicare are likely to exceed those shown by the current-law projections, and has developed illustrative alternative scenarios and projections intended to provide additional context to users of the actuarial estimates regarding the long-term sustainability of the social insurance program. As a result of these limitations, we were unable to obtain sufficient evidential support for the amounts presented in the statements of social insurance as of January 1, 2011 and 2010 and the related statement of changes in social insurance amounts.

Because of the matters discussed in the preceding paragraph, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the financial condition of the CMS social insurance program as of January 1, 2011 and 2010 and the related changes in the social insurance program.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of CMS as of September 30, 2011 and 2010, and its net cost, changes in net position, and budgetary resources for the years then ended, and the financial condition of its social insurance program as of January 1, 2009 and 2008 in conformity with accounting principles generally accepted in the United States.

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 10, 2011 on our consideration of CMS' internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations and other matters. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

Our audits were conducted for the purpose of forming opinions on the 2011 and 2010 basic financial statements taken as a whole. The information presented in the Management's Discussion and Analysis, required supplementary information, and other accompanying information is not a required part of the basic financial statements but is supplementary information required by OMB Circular No. A-136. The other accompanying information has not been subjected to the auditing procedures applied in our audits of the basic financial statements and, accordingly, we express no opinion on it. For the remaining information, we have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit the information and, accordingly, we express no opinion on it.

Ernst & Young LLP

November 10, 2011

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

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

We have audited the financial statements of the Centers for Medicare and Medicaid Services (CMS) as of and for the year ended September 30, 2011, and we were engaged to audit the statement of social insurance as of January 1, 2011 and the related statement of changes in social insurance amounts, and have issued our Report of Independent Auditors thereon dated November 10, 2011. That report states that because of the matters discussed therein, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2011 and the related statement of changes in social insurance amounts. Except for the matters discussed in the fourth paragraph of the Report of Independent Auditors, we conducted our audit in accordance with auditing standards generally accepted in the United States, the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 07-04, *Audit Requirements for Federal Financial Statements,* as amended.

As part of obtaining reasonable assurance about whether CMS' financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in OMB Bulletin No. 07-04, as amended. We limited our tests of compliance to these provisions, and we did not test compliance with all laws and regulations applicable to CMS.

The results of our tests of compliance with the laws and regulations described in the second paragraph of this report disclosed an instance of noncompliance with laws and regulations or other matters that is required to be reported under *Government Auditing Standards* and OMB Bulletin No. 07-04, as amended, as described below.

The Improper Payments Information Act (IPIA) and Improper Payment Eliminations and Recovery Act (IPERA) (hereinafter the Acts) require federal agencies to identify programs and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. Although CMS has reported error rates for each of its high-risk programs, or components of such programs, it is not in full compliance with the Acts.

It is our understanding that management agrees with the facts as presented and that relevant comments from CMS' management responsible for addressing the noncompliance are provided in their letter dated November 10, 2011. We did not audit management's comments and, accordingly, we express no opinion on it.

Providing an opinion on compliance with certain provisions of laws and regulations was not an objective of our audit and, accordingly, we do not express such an opinion.

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

Ernst & Young LLP

November 10, 2011

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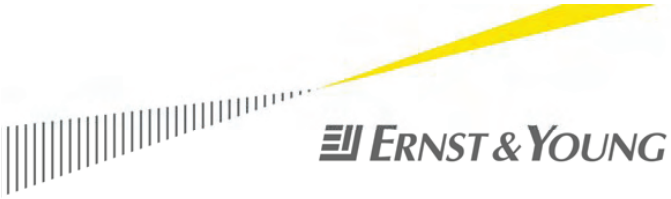
Report on Internal Control Over Financial Reporting Based on an Audit of the Financial Statements Performed in Accordance with *Government Auditing Standards*

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

We have audited the financial statements of the Centers for Medicare and Medicaid Services (CMS) as of and for the year ended September 30, 2011, and we were engaged to audit the statement of social insurance as of January 1, 2011, and the related statement of changes in social insurance amounts, and have issued our Report of Independent Auditors thereon dated November 10, 2011. That report states that because of the matters discussed therein, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2011 and the related statement of changes in social insurance amounts. Except for the matters discussed in the fourth paragraph of the Report of Independent Auditors, we conducted our audit in accordance with auditing standards generally accepted in the United States, the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 07-04, *Audit Requirements for Federal Financial Statements*, as amended.

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

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



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

A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider the deficiencies related to Information Systems Controls and Financial Reporting Processes to be significant deficiencies.

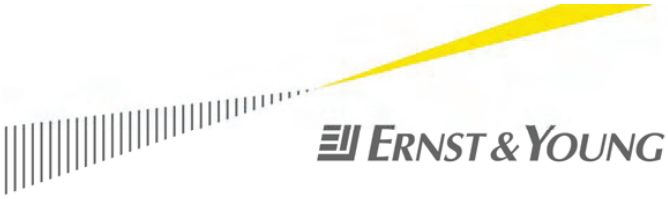
Significant Deficiencies

Information Systems Controls

During FY 2011, CMS further improved its internal controls over information technology and continues to take proactive steps to improve information security and software and systems configuration management at Central Office and its Medicare fee-for-service business partners, principally Fiscal Intermediaries (FIs), Carriers, Medicare Administrative Contractors (MACs), and Enterprise Data Centers (EDCs), collectively referred to as Medicare fee-for-service contractors.

Specifically, the change control process at Central Office was further formalized in FY 2011 through the use of change control boards for Central Office-managed applications, enterprise information technology (IT) vulnerability management was enhanced through the implementation of new technologies that permits active vulnerability monitoring on a continuous basis, and a structured approach for accreditation and acceptance of information systems was introduced.

However, because of the complexity, age, and size of the information systems used to process Medicare fee-for-service claims, the use of multiple processes to accomplish similar tasks such as configuration management and the number of connections between the Central Office and its contractors, CMS continues to experience a lack of consistent adherence to management control processes and procedures over the software used to process Medicare fee-for-service claims. In addition, further centralization of its change management program for the Medicare fee-for-service application programs occurred without adequate corresponding oversight procedures or integration strategies. Remediation of prior control deficiencies has been particularly slow and additional deficiencies were identified during the current year. These conditions may result in incomplete and inaccurate processing of transactions, causing an impact on the integrity and completeness of data used to prepare CMS' financial statements. The following sections provide more specifics regarding our information technology controls findings with a substantial



majority of the findings relating to the oversight or operation of the Medicare fee-for-service claims processing systems.

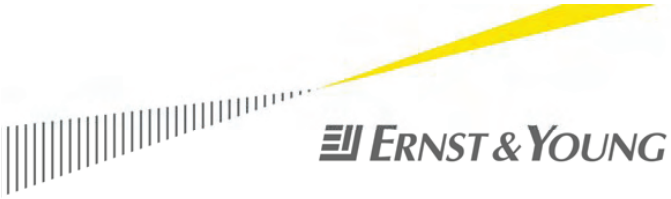
CMS' Systems Environment Overview

CMS manages national health care related programs, of which Medicare fee-for-service is the largest; other programs include Medicare Advantage (Part C), the Prescription Drug (Part D), Medicaid, and the Children's Health Insurance Program (CHIP). CMS' Central Office provides overall direction for these programs using a variety of information systems. Substantially all of CMS' Medicare fee-for-service claims and related data are processed under a decentralized business model by geographically dispersed contractors using complex and extensive information systems operations. These operations support a number of Medicare fee-for-service application systems that are intended to assure consistency in administering the Medicare fee-for-service activities, in addition to processing, accounting for, and reporting Medicare fee-for-service expenditures and related assets and liabilities. Internal controls over these operations are essential to manage the integrity, confidentiality, and reliability of Medicare fee-for-service data and application programs and to reduce the risk of errors, fraud or other illegal acts.

For Medicare fee-for-service claims, CMS has contracted with commercial insurance and technology organizations for claims administration/processing, claims payment and audit/reimbursement services. CMS has centralized its ongoing principal data processing needs into three separate EDCs.

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

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



CMS maintains a Business Partners Systems Security Manual (BPSSM) based on Federal guidelines for its application software systems used to direct the information security activities at the Medicare fee-for-service contractors. CMS communicates the requirements of their information assurance program through the requirements of the BPSSM; monitoring compliance with the BPSSM is accomplished through CMS' ongoing Certification and Accreditation (C&A) program. Each contractor is required to maintain a System Security Plan (SSP) developed in accordance with the BPSSM that outlines the contractor's plan for maintaining a secure environment for CMS' systems. Central Office and contractor personnel are required to receive annual security awareness training.

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

- Reports issued annually on the controls MACs placed in operation and tested to conclude on the operating effectiveness issued by independent auditors in accordance with the AICPA's Statement on Auditing Standards No. 70, *Service Organizations;*

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

- Annual reviews are performed to meet the requirements of the Office of Management and Budget (OMB) Circular No. A-123, *Management's Responsibility for Internal Control*, which provides updated internal control standards and specific requirements for conducting management's assessment of the effectiveness of internal control over financial reporting and financial systems;

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

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

These activities and our procedures continue to identify instances of non-compliance with CMS IT security and other requirements. While CMS continues to remediate identified deficiencies, these monitoring activities also revealed instances in which the remediation had not been timely or fully implemented.

The continued and growing complexity of the government health care business environment, coupled with the ongoing evolution of technology and related vulnerabilities, pose a significant challenge to CMS. The mainframe-centric Medicare fee-for-service claims systems that CMS uses to process data are aging and may be increasingly difficult to maintain when integrating future changes in the program.

Configuration Management

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 processes and policies to ensure the continued integrity, security and reliability of financial and claims data.

Medicare Fee-for-Service

CMS has contracted with several system software maintainers to provide application software development and testing support for the majority of the systems used to process Medicare fee-for-service claims. These maintainers provide services for the shared systems that include application development, system documentation, training and testing. The MACs that use the shared systems are responsible for the configuration of programmed edits (for example, a valid provider type was entered for the medical service rendered), the customization of automated adjudication software (AAS or "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 management directives issued by CMS impacts the overall integrity of the claims process.

Change requests for the shared systems are formulated and 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 system software maintainers 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.

During FY 2011, CMS completed its transition to a new single testing contractor. However, CMS did not ensure that sufficient controls were in effect at the completion of the transition. As a result of our procedures, numerous control deficiencies were identified at the single testing contractor as it relates to the business models being used to implement CMS' activities. Examples of configuration management deficiencies observed included:

- Testing of shared system change requests by the single testing contractor was neither complete nor successful but the changes were implemented.
- CMS approvals were not consistently obtained prior to the change being implemented.
- Changes to programs may be made after the final testing is performed just prior to implementation.

Configuration management is increasingly dependent on and significantly impacted by information security controls. However, we found that the single testing contractor did not have adequate information security controls. For example:

- The required system security plan was not current or complete and did not reflect an assessment of risks that the single testing contractor faces in its role supporting CMS.
- Reviews of access rights of user accounts for propriety were not performed or not documented.
- Evidence that vulnerability scans were performed was not retained, unapproved wireless technologies were identified, and laptop computers were not encrypted.

Some of these deficiencies are a result of a compressed schedule to implement numerous 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. Also, the MACs may implement certain local changes provided they are compliant with CMS' directives. We found, however, that local changes to Medicare fee-for-service data edits were not always documented or approved by CMS. However, as a result of these deficiencies, CMS may not be able to ensure the accuracy, completeness, or overall integrity of the shared systems.

Enterprise-Wide

In addition to the shared systems, CMS has implemented configuration and change control processes for other Central Office systems that affect Part C, Part D, Medicaid, and CHIP programs. However, we found deficiencies in these processes. Some examples include:

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

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

Information Security – Medicare Fee-for-Service

Information security controls are fundamental to the integrity of any information system, including configuration management. Such controls, including active monitoring of security events for proper assessment and timely remediation, properly designed and implemented controls, can help manage risks to critical data. These controls include physical and logical access restrictions to protect against unauthorized usage of CMS resources, including programs and data files.

CMS has developed policies that are designed to comply with and are consistent with Federal information security standards. However, the implementation of these policies is affected by the size and complexity of the Medicare fee-for-service environment and available resources. As a result, in addition to the previously cited deficiencies herein, an inconsistent and incomplete execution of CMS' directives and guidance was observed. These information security vulnerabilities relate primarily to Medicare fee-for-service activities and may lessen the ability of CMS to provide secure and reliable processing systems. Examples of these deficiencies include:

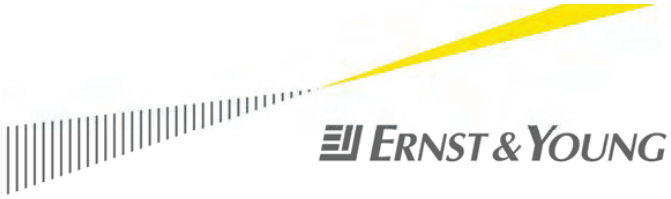
- System security plans were incomplete and not always current.

- Information security software for multiple contractors was not configured in accordance with CMS-required standards which are based on NIST guidance.

- Systems software used to implement shared system changes was not configured for adequate segregation of duties.

- Vulnerabilities in system configurations for contractor networks used to transport Medicare fee-for-service data were identified.

- Enterprise-wide vulnerability management software results are being collected but not consistently reviewed.



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

- Not all Medicare fee-for-service contractors performed periodic reviews of user access to sensitive data and the related application systems.

Transition to an Integrated Financial Management System

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

CMS continues their efforts to implement a web-based accounting system, HIGLAS, which will integrate the CMS contractors' standard claims processing system and eventually replace FACS (currently, HIGLAS has been placed "on top" of FACS). Although CMS is preparing financial statements using HIGLAS, the majority of the financial transactions and journal vouchers still are recorded within the current mainframe-based financial system. As a result, full functionality of HIGLAS has not been implemented nor has it been investigated to determine the effectiveness of the system and whether HIGLAS is capable of consolidating, or has the ability to consolidate, the financial data from the contractors and Central Office. In addition, there is no letter of credit or cash management module that currently exists within HIGLAS at Central Office that monitors the Medicare contractors' draws. The Medicare contractors' accounts receivable balances are recorded at Central Office through the manual journal voucher process.

There are a number of system interventions and manual adjustments or reconciliations to properly categorize the information within the financial statements, as required by OMB A-136. The creation of the periodic financial statements is largely system dependent. The information security controls over FACS are weak, primarily due to the lack of segregation of duties that continue to exist between the business and information security administration functions within the Office of Financial Management (OFM). OFM has assigned personnel the function of system and security administrators, and these personnel also are able to grant access to the FACS application to perform and process business transactions. Information security controls are fundamental to the integrity of any information system to protect against unauthorized usage of financial data. CMS is aware of the noted shortcomings within FACS but does not plan to make changes to this system as it will be decommissioned by fiscal year 2013.

Not all Medicare contractors have implemented HIGLAS, including the contractors responsible for the DME contracts, and continue to rely on a combination of claims processing systems, personal computer-based software applications and other ad hoc systems to tabulate, summarize and prepare information that is reported to CMS. The accuracy of the financial reports remains heavily dependent on inefficient, labor-intensive, manual processes that are also subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to CMS.

Recommendations

CMS should continually assess the governance and oversight across its organizational units charged with responsibility for the configuration management and information security of its Medicare fee-for-service systems and data. Such an approach will require continued and active communication and integration of efforts by the OFM, the Office of Information Services (OIS) and the Center for Medicare (CM).

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

- Proactive monitoring of Medicare fee-for-service contractor compliance with its directives for data access and controlling changes to the shared systems;

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

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

- Appropriate segregation of duties be established in 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.

- Compliance detection systems for the timely implementation and activation of new Medicare fee-for-service claims edits are monitored timely and appropriate system corrections are made for identified errors.

- All application changes to CMS software 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. In addition, relevant NIST guidance should be applied in the review and approval of changes. Documentation should be prepared for all phases of the change management process.

In addition, CMS should implement enhanced information security policies and techniques developed by OIS for all of CMS' information systems, including:

- Consistent, current and complete system security plans prepared by all system owners and the Medicare fee-for-service MACs, EDCs and system software maintainers.

- Continued implementation of new 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 errors.

- Continued and expanded oversight of the Medicare fee-for-service contractors' use of newer technologies, including wireless.

- Continue to implement an integrated financial management system for use by CMS and the Medicare contractors to promote consistency and reliability in accounting and financial reporting and assess the capability of and implement the full functionality of HIGLAS while working towards decommissioning FACS.

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 accumulate data for financial reporting. This structure results in a significant number of controls being performed at the contractors, regional offices, Centers and Offices outside of the Office of Financial Management (OFM). An organization comprised of a common set of accounting and reporting standards, an integrated financial system, a sufficient number of properly trained personnel and a strong oversight function are all necessary to ultimately prevent and/or detect and resolve errors and irregularities in a timely manner. Robust financial management systems also capture and produce key financial data and analyses, including critical performance measures and anomalies that chief decision-makers within the organization would monitor on a periodic basis to fulfill their fiduciary responsibility, deter fraud, waste and abuse of Federal government resources and facilitate efficient and effective delivery of designated programs.

Changes in CMS management structure resulting from the recent reorganization and passage of the Patient Protection and Affordable Care Act, as amended by the Healthcare Reconciliation Act of 2010, collectively referred to as the "Affordable Care Act" or ACA, requires close coordination within CMS, and with HHS, and provides opportunities to challenge and continuously improve the financial management processes.

As CMS continues its efforts to enhance internal controls, the following items noted in the current year audit merit continued focus in the financial reporting systems and processes.

Medicaid Oversight

The Medicaid program is designed to reimburse the various state programs for the Federal share of claim payments. CMS approves each state's budget (the authorized amount) on a quarterly or annual basis. The state draws against their authorized amounts, funds representing the Federal share of claims paid. The state has to support its draws by supplying CMS with a certified report of actual expenditures. The certification of the actual expenditures by the states, the review by CMS and determination of any adjustments required to the draws, is to occur within the succeeding two quarters (180 days). The grant awards are reconciled on an annual basis and any over or under draws by the states become an accounts receivable or payable on CMS financial statements.

In connection with the grant finalization process, the authorized amount (provided by the budget process), the draws made (provided by the Payment Management System (PMS), the Department of Health and Human Services' operation used to provide the bank-like services for the states) and the actual certified expenditures incurred (provided by the states' Chief Financial Officer) for the grant year are reviewed and analyzed by CMS. When the state's draws exceed the actual certified expenditures, the state owes that amount to CMS. Conversely, when the state draws are less than the actual certified expenditures, CMS owes that amount to the state. The program is intended to reimburse the state for those certified expenditures that have been made by the state. Therefore, states should have receivable or payable balances only related to differences in estimating the portion of current claims reimbursable by Medicaid or for disallowances or adjustments to the listing of certified expenditures.

As of September 30, 2011, a $1.3 billion accounts receivable and a $1.8 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. Our analyses of the grant award finalization identified the following weaknesses or vulnerabilities in the Medicaid program related to the financial reporting process:

- There is no effective monitoring of the state's draws compared to the related expenditures until the grant award is finalized.

- There is not a timely settlement of the receivables and payables with the state after the annual grant award has been finalized as certain receivables and payables that were recorded in the prior year have yet to be resolved (either collected or paid).

- The grant close out process within the Payment Management System (PMS) is not performed timely.

- The states have access to draw or transfer funds from open PMS accounts, even those for which CMS has finalized the grant awards.

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

- The accounting analysis performed to identify and record the payable or receivable balances are not reviewed or corroborated by Medicaid management.

Analyses Required for an Effective Financial Management System

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

- Effective April 1, 2011, the Center for Consumer Information and Insurance Oversight (CCIIO) transferred to CMS. The white paper analyzing the accounting for the transfer was not finalized by the September 30, 2011 year end closing. The transfer was not fully analyzed to verify that the balances recorded at CMS were complete and accurate. Because the reporting infrastructure was already established at DHHS Program Support Center (PSC), the transactions continued to be recorded for one program by PSC. PSC provides the period ending balances to CMS, and CMS records this financial information with only limited review, analysis and corroboration of the financial information. In addition, there was no accrual methodology documentation for two CCIIO programs.

- Statement of Federal Financial Accounting Standards No. 37, *Additional Requirements for Management's Discussion and Analysis and Basic Financial Statements*, required CMS to present a Statement of Changes in Social Insurance Amounts (SCSIA) and additional required disclosures. This Statement was issued in April 2010. Although a complex area, the SCSIA and additional required disclosures were not finalized by the September 30, 2011 year end closing while the changes were evaluated as part of the 2011 Trustees Report.

CMS does not ensure that the legal accrual is recorded in accordance with generally accepted accounting principles in the United States nor did CMS follow its own stated policy in assessing contingencies or potential accruals. In FY 2011, one instance where CMS did not follow its stated policy, which resulted in CMS not identifying a potential accrual in the prior year, and although that accrual would have been assessed as a remote likelihood of occurrence in that year, the potential contingency was not identified by CMS.

Consistent with the prior years, 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 2011 financial statements. CMS is not able to validate its methodology by using a claims-based approach and continues to rely on its estimation process (which is based on using a historical three-year average) to record the Medicaid EBDP without the ability to confirm the reasonableness of its methodology.

During the internal control tests, errors were noted 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, an $800 million difference identified during the audit between the Medicaid liabilities and entitlement benefits due and payable); and (ii) the review or monitoring function was not performed timely (for example, the monthly NCH validation process, which compares the NCH paid claims to the Medicare contractor reported draws).

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

Business Partner Risk Management

CMS administers an extensive internal control program to protect the Agency's resources from fraud, waste and mismanagement. CMS relies heavily on third-party contractors as it outsources substantially all the day-to-day operations for its information technology systems, the payment of Medicare fee-for-service and Medicaid claims and certain services related to the Part C and Part D programs.

CMS has developed internal controls that help prevent fraud and waste from occurring such as edits in the claims processing systems that attempt to identify and filter inappropriate claims. CMS also has developed internal controls that will help detect fraud and waste that may have occurred. Any strong control environment will have a combination of prevent and detect controls with a greater emphasis on prevent controls. While we noted during the current year audit that CMS had both prevent and detect controls in operation, we noted several examples of areas where improvements could be made in the overall control environment. This is especially true of CMS' relationships with its third-party contractors referred to herein as "contractors."

The contracts between CMS and its Medicare fee-for-service contractors include provisions that require the Medicare contractor to develop and follow objectives established by CMS. Through the established procedures, the Medicare contractors 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 reported amounts. Through its A-123, SAS 70 and regional office processes, CMS tests and monitors the Medicare contractors' compliance with its policies and procedures, established controls and the accuracy of financial reporting.

While this approach to financial integrity supports monitoring of the Medicare contractors' financial controls, the 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 Medicare contractors. As CMS continues its efforts to transition to HIGLAS and to implement the provisions of ACA, there will be greater significance placed on monitoring the Medicare and other contractors, accentuating not only the value but also the consequences, to the Agency. During our audit activities, we identified weaknesses in financial reporting oversight, and noted the following examples.

- Neither CMS nor the Medicare contractors were able to provide a system-generated subsidiary ledger for the amounts payable to providers or beneficiaries (or amounts owed to CMS) for certain ancillary accounts (for example, refunds payable) as of a balance sheet date. While account reconciliations are performed for the primary claims payable accounts, because there was no subsidiary ledger available for these ancillary accounts, neither CMS nor the Medicare contractors were able to fully reconcile or substantiate these account balances on a periodic basis. Certain balances presented were comprised of both receivable and payable amounts, which ultimately reduced the account balance without a clear understanding if that right of offset was appropriate. Although these

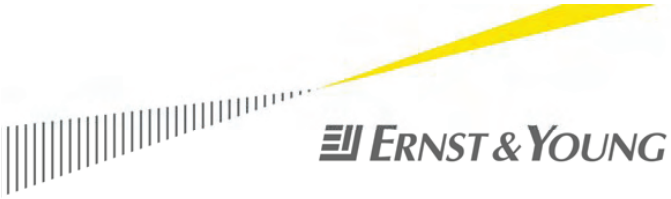
account balances generally are not significant, these balances are not being monitored or reviewed to ensure that the balances are properly and timely resolved.

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

- The Medicare contractors did not perform a periodic review of claims held (i.e., "invoices on hold" or payables held for specific reasons), and CMS did not monitor that the outstanding balances are properly and timely resolved. If aged claims are not tracked or monitored by the Medicare contractor periodically, the claims may not be paid or disposed of in a timely manner, and the payable balances reported by the Medicare contractor at the end of each reporting period may not be correct.

The processes designed to prevent errors should be supplemented by controls and analyses that highlight any material errors that may or could occur. In this regard, errors or abuses within the Medicare claim data, if material, should be detected in the annual Comprehensive Error Rate Testing (CERT) process and in the Payment Error Rate Measurement (PERM) process for Medicaid. Similar processes are used to monitor improper payments for Part C and Part D plans. To be fully effective in compensating for inherent risks in the programs, the monitoring activities must be well understood, susceptible to replication and highly credible. Timeliness of the availability of the error rate reports to the public is critical to the Agency's efforts to provide transparency and accountability. The FY 2010 CERT report has not been issued to date, due to the review process performed by other Federal agencies, and the FY 2010 PERM report was only recently issued. Similarly, the timeliness of finalizing the error rates for Part C and Part D continues to be a challenge.

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



Statements of Social Insurance

The Statement 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 SCSIA presents the changes in the open group measure from the end of the previous reporting period and reconciles the change between the current and prior period valuation. The presentation assumes the programs will continue in their current form under current law, albeit with certain economic assumptions that serve to constrain growth of the programs and imply refinements in response to the burden of the programs on economic activity. Departure from the current law construct also is made in assuming that the programs would continue to provide substantially consistent benefits after exhaustion of the Trust Funds, while under current law payment reductions would otherwise reduce or defer such payments. This approach allows for illustration of the excess of payments beneficiaries may expect over the related funding streams.

In FY 2010, the passage of the ACA significantly impacted the projections embodied in the Trustees Report and SOSI. The application of the current law formulation to development of the SOSI projection created significant challenges in applying this legislation. These challenges included modeling significant changes in provider payments arising from legislative limitations to constrain growth in the cost of the programs and considering potentially wide ranging impacts from investments in combating fraud and abuse, initiating a major program of research and development, and implementing accountable care organizations to assist in coordinating care.

The projections always have been complex and need considerable care in interpreting the resulting SOSI. The degree of uncertainty experienced in FY 2010 regarding the projections continued in FY 2011 and certain matters were called into question, and as a result, we were unable to assess, whether the presentation of the SOSI was fairly presented and fully useful for its intended purpose. Management has noted that the effects of some of ACA's provisions on Medicare are not known and the long-range feasibility of certain of the provisions is doubtful. The Trustees Report, related Actuarial Opinion and other materials incorporated by reference in the Trustees Report reflect uncertainty regarding the projections and reflect concerns that certain current law provisions are not sustainable or will, based on prior patterns, likely be modified. The extent to which the current law SOSI projections, as presented, are subject to ongoing uncertainty this year and may not reflect management's reasonable estimate of the ultimate cash flows of the social insurance program, is discussed in the footnotes to the FY 2011 Statements of Social Insurance.

The disclosure steps taken by management appear to have been reasoned judgments to aid users of the financial statements in interpreting the information pending further refinement of the projections and a more fundamental reexamination of the assumptions underlying the development of the SOSI and Trustees Report. The efforts needed in modeling the impacts of the ACA include work which management anticipates regarding potentially refining the assumptions and narrowing the range of projected outcomes for the cash flow models and seeking further

input in comprehensively considering the secondary impacts of price changes mandated by current law on access and utilization. Developing auditable estimates for SOSI that fairly present the financial condition of the Trust Funds may require revisiting provisions of Federal accounting standards and potentially reformulating the assumptions used in SOSI and the Trustees Report to help improve the usefulness of the estimates provided.

Certain efforts have been taken within CMS that will assist in narrowing areas of concern, including the appointment of public trustees and a panel of advisors to assist in reviewing the projections and related assumptions. Although the work of the panel of advisors was not completed for the FY 2011 SOSI presentation and Trustees Report development, these measures will assist CMS during the refinement of future projections and in considering the appropriate response to concerns about the sustainability of current law provisions over the projection period, which are significant enhancements. The investment made by the Office of the Actuary in formulating alternative illustrative scenarios will help inform the process. Similarly, the Federal Accounting Standards Advisory Board departed from a current law formulation when formulating guidance regarding developing analogous projections for sustainability reporting. The work devoted to this effort may also facilitate developing appropriate responses to the unique challenges faced by CMS in developing projections for SOSI under the current law construct referenced in applicable Federal reporting standards.

Recommendations

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

- Efforts to continuously monitor the state Medicaid draws and perform grant oversight activities should be improved. Routine and timely review of the draws would ensure that the states do not overdraw funds. Medicaid grant awards should be finalized timely and settled on a periodic basis. CMS should ensure that the grant close out process occurs timely and consistently within PMS to eliminate any erroneous draws to grant awards with remaining authority.

- Accounts receivable and payable Medicaid balances should be identified and recorded timely. A subsidiary ledger should be generated to validate the propriety of ending balances on a periodic basis and to understand the change in the respective balances. The information within the analyses and the corresponding subsidiary ledger should be reviewed and approved by the program management.

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

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

- Establish a 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 $26.1 billion accrual. One potential method to verify the reasonableness of the Medicaid EBDP balance would be to use the detail claims data from the PERM process or information being gathered by the Center for Program Integrity to calculate the average days outstanding or sample the largest states and determine if information is available for subsequent analysis.

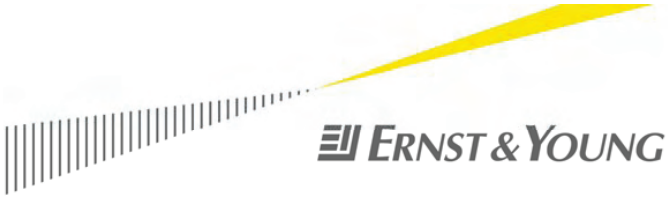
- Delegate to and ensure that the Centers or Offices provide robust analytical analyses to OFM on a periodic basis that would be analyzed and reconciled by OFM in connection with the preparation of the quarterly CMS financial reports and available for use throughout the organization.

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

- Revise and enhance the design of the financial review guidance provided to regional offices and Medicare contractors to incorporate more analyses and scrutiny in the review of the financial information.

- As CMS transitions to HIGLAS, challenge the policies and procedures to determine if the implementation has impacted the financial reporting and internal control processes (for example, generate and reconcile the subsidiary ledgers, MSNs and HIGLAS reporting). If current methods are impacted, provide updated guidance and communication to the contractor to incorporate the changes.

- Develop a system-generated subsidiary ledger or use analytical tools to create a detailed schedule of the outstanding amounts payable to providers or beneficiaries for certain Medicare contractor ancillary accounts (for example, refunds payable) as of the balance sheet date (month or quarter end). The subsidiary ledger should be reviewed, analyzed and adjusted to ensure that the provider balances are properly supported and recorded. The subsidiary ledger should be reconciled to the general ledger on a periodic basis.



- Continue to enhance the benefits of the CERT, PERM, Part C and Part D error rate development and analysis tools. Error rate results should be developed at a sufficient level of detail to analyze, scrutinize and identify anomalies to begin investigations of the root causes of the errors and prevention, mitigation and recovery plans. Continue efforts to further develop the eligibility process to ensure only appropriate parties participate.

- Assess and prioritize the findings from the OIG and other program reviews performed, implement the recommended changes and modify the internal control processes to hold plan sponsors more accountable for the findings identified. The financial management groups should monitor the programs and their activities to identify the appropriate financial statement impact and disclosure.

- Developing SOSI projections for use in general purpose financial statements, which represent management's reasonable estimate of the cash flows for the programs over a 75-year projection period, will continue to be a challenge. The fact pattern presented in FY 2010 and FY 2011 in developing the projections raises important issues regarding the role of SOSI reporting, and the merits of departing further from a current law formulation in instances in which management believes that legislative or regulatory changes will be needed to sustain the programs throughout the projection period. Pending resolution of these issues, the disclosures help to partially mitigate the potential adverse impact from presenting information management does not believe will actually occur. In pursuing the ultimate resolution of these matters, CMS should consider the following.

  – Efforts initiated late in FY 2010 and continued in FY 2011 to engage a panel of advisors to assist in addressing the challenges presented by the passage of ACA in developing and presenting projections for the Medicare programs which are reasonable estimates of the program cash flows.

  – Continue and broaden discussions with key stakeholders and standard setting bodies, including the Federal Accounting Standards Advisory Board, to co-develop appropriate recommendations for potential revisions to the approaches used in presenting projections for the programs in the Trustees Report and standards applicable to presentation of the SOSI to aid in ensuring that the SOSI projection is meaningful and presents fairly the financial condition of the Trust Funds. These consultations should address how patterns of revisions to law, and situations in which a continuation of current law is anticipated to potentially not be feasible should be addressed, if at all, in the projections.

We have reviewed our findings and recommendations with CMS management. CMS' response to our findings and recommendations is included in their letter dated November 10, 2011. Management will provide a corrective action plan to the Office of Inspector General in accordance with applicable Agency directives. We did not audit CMS' response and, accordingly, we express no opinion on it.

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

Ernst & Young LLP

November 10, 2011

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

November 10, 2011

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

Dear Sir:

Thank you for your audit report on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2011 financial statements. The CMS has reviewed the report prepared by Ernst & Young, LLP (E&Y) and we are pleased that the result of the audit is an unqualified opinion on our Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position and the Combined Statement of Budgetary Resources. However, once again E&Y did not express an opinion on SOSI. We continue to strongly believe that the FY 2011 SOSI projections appropriately incorporate the effects of the Affordable Care Act and that we provide sufficient disclosures regarding the nature and uncertainty of the projections. In addition, during FY 2011, CMS consulted with an independent panel of expert actuaries and economists to review the FY 2010 SOSI assumptions and methods. The panel's interim review found that the long-term assumptions and methods were not unreasonable. Furthermore, the panel recommended that we continue the use of the projections based on an illustrative alternative to current law to help assess the possible understatement in the Medicare costs projected under current law – which we continued to do in FY 2011. It is our position that the FY 2010 and FY 2011 SOSI and accompanying footnotes are fully consistent with the panel's interim findings and recommendations. While we have complied with Federal accounting standards and have put forth as much effort we possibly could to remediate this issue, CMS 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.

Your review also identified no material weaknesses – a fact we are proud of – and two significant deficiencies, Information Systems Controls and Financial Reporting Processes. As you noted in your report, CMS further improved its internal controls over information technology and continues to take proactive steps to improve information security and software and systems configuration management. Your recognition of the Agency's improvements throughout the report are greatly appreciated, and we generally concur with the findings and descriptions of the matters noted. CMS management is committed to resolving these issues and will develop corrective action plans to address the audit issues identified in your report. It is the Agency's intent to assess and address the root causes of these issues as quickly as possible.

In closing, we would like to confirm CMS' commitment to continual improvement in financial management, as well as the production of accurate and reliable financial information. The CMS would like to thank the OIG and the E&Y audit team for the professionalism exhibited throughout the audit process. We look forward to working with you in the next year to resolve these outstanding issues.

Sincerely,

Deborah A. Taylor, CPA
Chief Financial Officer

OTHER ACCOMPANYING INFORMATION

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

CMS assesses its internal controls through: (1) statements of assurance on internal controls from Center/Office Directors and Consortium Administrators, including annual tests of security controls, (2) OMB Circular A-123, Appendix A self-assessment, (3) OIG audits and Government Accountability Office (GAO) audits and High-Risk reports, (4) SAS 70 internal control audits, (5) evaluations and tests of Medicare contractor controls conducted pursuant to Section 912 of the Medicare Modernization Act, (6) the annual Chief Financial Officer (CFO) audit, and (7) certification and accreditation of systems. As of September 30, 2011, the internal controls and financial management systems of CMS provided reasonable assurance that the objectives of FMFIA were achieved; however, one instance of noncompliance was identified.

OMB Circular No. A-123 Statement of Assurance

CMS management is responsible for establishing and maintaining effective internal control and financial management systems that meet the objectives of the Federal Managers' Financial Integrity Act (FMFIA) and Office of Management and Budget (OMB) Circular No. A-123, *Management's Responsibility for Internal Control*, dated December 21, 2004. These objectives are to ensure: 1) effective and efficient operations, 2) compliance with applicable laws and regulations, and 3) reliable financial reporting.

As required by OMB Circular No. A-123, CMS evaluated its internal controls and financial management systems to determine whether these objectives are being met. Accordingly, CMS provided a qualified statement of 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).

After becoming substantially compliant with the Federal Financial Management Improvement Act (FFMIA) in FY 2010, we have continued our efforts to implement the Healthcare Integrated General Ledger Accounting System (HIGLAS), which will integrate the CMS claims administration contractors' shared claims processing system and replace the CMS current mainframe-based financial system with a web-based accounting system. CMS considers our financial systems to be integrated in accordance with OMB Circular A-127, Financial Management Systems. The HIGLAS has, as of September 2011, 96 percent of total Medicare program payments accounted for in HIGLAS. The HIGLAS will continue to enhance CMS' oversight of claims administration contractor financial operations, and the accounting and reporting of other CMS activities.

Assurance for Internal Control over Operations and Compliance

CMS conducted its assessment of internal control over the effectiveness and efficiency of operations and compliance with applicable laws and regulations in accordance with OMB Circular No. A-123. Based on the results of this evaluation, as of September 30, 2011, CMS provided reasonable assurance that internal controls over operations and compliance with applicable laws and regulations were effective, and no material weaknesses were found in the design or operation of these internal controls. While the GAO High-Risk Report continues to include the Medicare and Medicaid programs as high risk, we do not believe that they constitute a material weakness. GAO designated Medicare as a high-risk program with serious management challenges because of its size, complexity, and susceptibility to improper payments. GAO also designated Medicaid as a high-risk program in part due to concerns about the adequacy of fiscal oversight, which is necessary to prevent inappropriate program spending. GAO noted new laws, directives, and agency efforts as positive steps toward reducing improper payments in the Medicare and Medicaid programs and improving transparency.

Assurance for Internal Control over Financial Reporting

CMS conducted its assessment of the effectiveness of internal 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, 2011, were operating effectively and no material weaknesses were found in the design or operation of the internal controls over financial reporting.

Noncompliance

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

IMPROPER PAYMENTS

In July 2010, Congress amended the IPIA, with the IPERA to better standardize the way Federal agencies report improper payments in programs they oversee or administer. The IPERA includes requirements for identifying and reporting improper payments and defines improper payments as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments). Incorrect payments also include payments to ineligible recipients or payments for ineligible services, as well as duplicate payments and payments for services not received. During FY 2011, CMS has fully implemented the OMB's IPERA guidance and comprehensive processes that measure the payment error rates for the Medicare FFS, Medicaid, CHIP, Medicare Advantage (Part C), and Medicare Prescription Drug (Part D) programs.

Medicare

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

In 2011, CMS continued to review claims according to a significantly revised and improved methodology implemented in 2009. In addition, CMS included for the first time an estimate for activity related to the receipt of additional documentation and the outcome of appeals that routinely occur after the date of the CMS Financial Report. CMS developed an estimate for FY 2011 modeled after the FY 2010 actual results. Without this change in estimation methodology, the error rate would have been 9.9 percent. The CMS newly modified estimate for FY 2011 indicated that the paid claims gross error rate was 8.6 percent or $28,810 million in gross improper payments. This change in estimate provides a more accurate estimate of improper payments in the Medicare FFS program.

Medicare Advantage and Prescription Drugs

CMS has reported a Part C composite payment error rate since FY 2008. The Part C composite payment error rate combines two component error rates into a single composite measure for total Part C payments: (1) the Medicare Advantage and Prescription Drug System (MARx) payment error (MPE) rate for Part C; and (2) the Part C risk adjustment error (RAE) rate. A Part C composite payment error rate of 11.0 percent is reported in the FY 2011 HHS Agency Financial Report (AFR).

FY 2011 GROSS IMPROPER PAYMENTS AND ERROR RATES IN THE MEDICARE FFS PROGRAM

		GROSS	
Overpayments	Underpayments	Improper Payment Amount (Overpayments + underpayments)	Error Rate
$28,038 M	$772 M	$28,810 M	8.6%

For the first time, CMS has developed a payment error rate for the Medicare Prescription Drug Benefit, a Medicare benefit effective CY 2006. The Part D composite payment error rate combines five component error rates into a single composite measure for total Part D payments: (1) Medicare Advantage and Prescription Drug System (MARx) payment error (MPE) for Part D; (2) Payment Error related to Low Income Status (PELS); (3) Payment Error related to Incorrect Medicaid Status (PEMS); (4) Payment Error related to Prescription Drug Event Data Validation (PEPV); and (5) Payment Error related to Direct and Indirect Remuneration (PEDIR). A Part D composite payment error rate of 3.2 percent is reported in the FY 2011 HHS AFR.

Medicaid and CHIP

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

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

The national Medicaid error rate reported for FY 2011 is 8.1 percent, or $21,900 million in gross improper payments, which reflects a three-year weighted average national error rate including data from 2009, 2010, and 2011. The weighted national error component rates are as follows: Medicaid FFS: 2.7 percent; Medicaid managed care: 0.3 percent; and Medicaid eligibility: 6.1 percent.

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

REVIEW OF MEDICARE'S PROGRAM FOR OVERSIGHT OF ACCREDITATION ORGANIZATIONS

Section 1: Overview

In order to be eligible to receive Medicare reimbursement, certain types of health care facilities must demonstrate compliance with Medicare Conditions of Participation (CoPs) or Conditions for Coverage (CfCs). Section 1865 of the Social Security Act (the Act) allows health care facilities that are "provider entities"[1] to demonstrate this compliance through accreditation by an approved, private national Accreditation Organization (AO).[2] The Centers for Medicare & Medicaid Services (CMS) has the responsibility for oversight and approval of the AOs' programs, and for ensuring that providers or suppliers that are accredited by an approved AO meet the quality and patient safety standards required by the Medicare CoPs or CfCs.[3] A thorough review of each AO program is conducted by CMS, including equivalency of their accreditation requirements, survey processes and procedures, training, oversight, and enforcement. Also reviewed are the qualifications of the surveyors, staff, and the AO's fiscal fitness. Upon approval, any provider or supplier accredited by the AO's approved program would be deemed to meet the Medicare conditions.

CMS has a comprehensive approach to the review and approval of an AO's accreditation program and the ongoing oversight of AO activities. The primary goal of this review is to ensure that the AO's standards meet or exceed the Medicare CoPs or CfCs for each program type and that the organization has the capacity to adequately administer the program. Currently, CMS has approved accreditation programs for the following facility types: hospitals, critical access hospitals (CAHs), home health agencies (HHAs), hospices, ambulatory surgery centers (ASCs), psychiatric hospitals, and outpatient physical therapy and speech-language pathology services (OPTs).[4] During the past several years, CMS has implemented a comprehensive program to strengthen and enhance ongoing oversight of AOs, including:

- Rigorous review of the AO's programs to ascertain whether the AO can adequately ensure that facilities comply with Medicare requirements (deeming application reviews);
- Building and implementing electronic systems for AO reporting on their activities related to deemed facilities;
- Implementing measures which reflect each AO's compliance with administrative reporting requirements (performance measures); and
- Expanding the validation survey program; this measures the effectiveness of the AO survey process in identifying areas of serious non-compliance with Medicare conditions.

During the last year, CMS has worked with AOs to solidify and expand these significant improvements in systems for monitoring AO activities and AO compliance with CMS requirements.

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

- **Scope of AO activities (Section 2):** Describes the role of AOs in Medicare's health care facility certification process.
- **CMS approval of accreditation programs (Section 3):** Describes the process for CMS approval of AO accreditation programs, including the applicable regulatory citations; and, reviews the increased intensity of the review process for AO accreditation programs and the

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

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

[3] Conditions of Participation apply to providers and Conditions for Coverage apply to suppliers. The term "facility" is used to cover both types of institutional health care providers which require certification in order to participate in Medicare.

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

number and types of reviews completed in the past four years.

- **AO survey activities and assessment of compliance (Section 4):** Describes the FY 2010 survey activities of each AO, the most recent application review by CMS for each AO program, as well as scores on administrative performance measures. The results indicate that performance on these administrative measures has improved since performance reporting was initiated in FY 2009; while AOs score very well on some measures, further improvement is essential since scores should be at or near 100 percent for all measures.

- **AO survey validation performance (Section 5):** Describes the CMS program for 60-day validation of AO survey findings and gives performance results for FYs 2008, 2009, and 2010 for each AO. The results indicate some issues with the effectiveness of AO surveys in identifying areas of serious non-compliance with Medicare conditions over this time period.

- **Validation surveys for ASCs (Section 6):** Describes special, mid-cycle validation surveys that were undertaken in deemed ASCs to assess compliance with practices related to healthcare-associated infections.

- **Program improvements as reported by the AOs (Section 7):** Presents each AO's self-report of its recent management improvement activities.

- **CMS' management and oversight of AOs (Section 8):** Describes the changes CMS has made in its AO oversight activities.

Section 2: Scope of Accreditation Organization Medicare Deeming Programs

CMS reviews and approves separately each program type (hospital, CAH, HHA, hospice, ASC, psychiatric hospital, and OPTs) for which an AO seeks CMS recognition. Currently, there are seven recognized AOs with 18 approved accreditation programs, as described in Table 1. Some AOs focus on one or two accreditation programs while others have a range of programs.

As described in Table 2, these AOs are responsible for assuring compliance with Medicare CoPs and CfCs for 38 percent of all Medicare-certified facilities in the five categories of facility providers/suppliers for which there was an approved AO program in FY 2010. (The first CMS-approved accreditation programs for psychiatric hospitals and OPTs were approved in FY 2011 and, therefore,

Table 1:
APPROVED ACCREDITATION ORGANIZATION PROGRAMS (FY 2011)

	Hospital	Critical Access Hospital	Home Health Agency	Hospice	Ambulatory Surgery Center	Psych Hospital	OPT*	TOTAL
AAAHC					X			1
ACHC			X	X				2
AAAASF					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	3	3	3	4	1	1	18

* Outpatient physical therapy and speech-language pathology services

AAAHC: Accreditation Association for Ambulatory Health Care

ACHC: Accreditation Commission for Health Care

AAAASF: American Association for Accreditation of Ambulatory Surgery Facilities

AOA/HFAP: American Osteopathic Association/ Healthcare Facilities Accreditation Program

CHAP: Community Health Accreditation Program

DNVHC: Det Norske Veritas Health Care

JC: The Joint Commission

Table 2:
MEDICARE CERTIFIED FACILITY PROVIDERS/SUPPLIERS (FY 2010)

	Deemed* (percentage)	Non-Deemed** (percentage)	TOTAL
Hospital	4,144 (85)	742 (15)	4,886
CAH	402 (30)	919 (70)	1,321
HHA	3,563 (31)	7,985 (69)	11,548
Hospice	754 (21)	2,790 (79)	3,544
ASC	1,321 (24)	4,073 (76)	5,394
TOTAL	10,184 (38)	16,509 (62)	26,693

*As reported by AOs.
**Surveyed by a SA for compliance with Medicare conditions.

are not reflected in the deemed facility numbers presented in Table 2 or in subsequent tables in this report.) The AOs are responsible for monitoring compliance with health and safety standards for varying percentages of total Medicare-participating facilities for each facility type, ranging from a high of 85 percent for hospitals to a low of 21 percent for hospices.

The total number of Medicare-participating healthcare facilities in the five categories presented in Table 2 has increased from 24,752 in FY 2008 to 26,693 in FY 2010, an eight percent increase. The majority of this growth has been in HHAs, which increased by 17 percent. Hospices and ASCs increased by five percent and three percent respectively, while the numbers of hospitals and CAHs were largely unchanged. The number of facilities participating in Medicare via their deemed status grew from 29 percent of Medicare-participating facilities with an accreditation option in FY 2008 to 38 percent in FY 2010. This is attributable in part to CMS' priorities for State Survey Agencies' (SAs) workload. CMS determined that initial surveys for newly enrolling facilities with an approved accreditation option have a lower priority as compared to complaint investigations and recertification surveys of already participating facilities. Because a number of SAs have been unable to complete their entire workload each year (due primarily to constrained resources), facilities seeking initial Medicare participation have used CMS-approved AO accreditation programs to demonstrate their compliance with Medicare requirements to facilitate a faster enrollment process.

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

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

Section 3: CMS Approval of Accreditation Organization Deeming Programs

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

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

In order to be granted program approval by CMS, an AO must demonstrate its ability to meet or exceed the Medicare CoPs or CfCs as cited in the following portions of the Code of Federal Regulations (CFR):

- ASCs in accordance with 42 CFR Part 416;
- CAHs in accordance with 42 CFR Part 485 Subpart F;
- HHAs in accordance with 42 CFR Part 484;
- Hospices in accordance with 42 CFR Part 418;
- Hospitals in accordance with 42 CFR Part 482, Subparts A - D;
- OPTs in accordance with 42 CFR, Part 482, Subpart H; and
- Psychiatric hospitals in accordance with 42 CFR, Part 482, Subparts A - E.

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

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

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

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

Once approved, any subsequent changes in the AO's program standards or survey process must

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

The CMS process for review of accreditation program applications has intensified over the past four years both in terms of the complexity and number of reviews. The number of CMS-approved AO accreditation programs has also grown, from 13 in FY 2007 to 18 in FY 2011. During this time, CMS has approved one new accreditation organization (DNVHC) and three new accreditation programs (ACHC hospice program, DNVHC hospital program and DNVHC CAH program). In addition, during FY 2011, CMS approved accreditation programs for two facility types that previously did not have a deeming option (JC psychiatric hospital accreditation program and AAAASF OPT accreditation program).

During FY 2008 through FY 2011, CMS completed 24 reviews including 21 approvals published in the *Federal Register* and three applications withdrawn by the AO prior to publication. The reviews completed within the past four years cover all 18 currently approved accreditation programs as follows:

- **FY 2008:** three deeming application reviews (all renewal applications);
- **FY 2009:** ten deeming application reviews (six renewal applications, one initial application, one conditional approval, one final approval removing conditional approval status, and one application withdrawn prior to publication);
- **FY 2010:** eight deeming application reviews (one renewal application, one initial application, two conditional approvals, two final approvals removing conditional approval status, and two applications withdrawn prior to publication); and
- **FY 2011:** three deeming application reviews (all initial applications).

Section 4 of this report includes a *Federal Register* reference for the most recent deeming application approval for each AO program and summarizes the conditions for the FY 2011 approvals.

Section 4: Review of Accreditation Organization Survey Activities and Performance

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

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

Overview: Deemed Survey Activity

The AO is responsible for evaluating a facility through an on-site survey to determine whether the facility complies with the health care quality and patient safety standards required by the Medicare CoPs or CfCs. The AO may award accreditation from a CMS-approved accreditation program for up to three years. The evaluation performed by the AO includes, but is not limited to: a review of the care processes in the facility, the physical environment, administrative and patient medical records, and staff qualifications. Table 3 presents a summary of the number of deemed facilities by AO in FY 2010 as well as the number of initial and renewal surveys completed during the same year, as reported by the AOs. An initial survey indicates a facility which is being reviewed by this AO for the first time (either a facility which is seeking new Medicare certification or changing from oversight by a SA or another AO).

All AOs experienced growth in the number of deemed facilities between FYs 2008 and 2010 largely due to increases in the numbers of HHA, hospice and ASC facilities. As described in Section

2, this reflects the national growth in these Medicare-participating facilities and CMS priorities for SA workload, which resulted in facilities obtaining initial Medicare certification based upon accreditation by a CMS recognized AO and its approved accreditation program, and the AO recommendation for deemed status.

Overview: Performance Measures

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

Several strategies have been implemented to facilitate obtaining timely, accurate, and complete information from AOs, including:

- Implementation of the Accrediting Organization System for Storing User Recorded Experiences (ASSURE) in October 2009. This first ever electronic accreditation data base facilitates timely, accurate, and complete AO quarterly reporting on deemed status facility activities. The ASSURE application provides a means to collect, analyze, and manage data regarding the deemed facilities accredited by the AOs;
- Dedicated electronic mailboxes for submission by AOs to CMS copies of AO notification letters to facilities concerning their accreditation status;
- Monthly submission of AO survey schedules to CMS;
- Development and implementation of template AO notification letters to facilitate AO communication to CMS of all essential elements regarding a facility's accreditation status; and

Table 3:

NUMBER OF DEEMED FACILITIES, INITIAL, AND RENEWAL SURVEYS FOR EACH ACCREDITATION ORGANIZATION BY PROGRAM TYPE (FY 2010)

PROGRAMS	ACCREDITATION ORGANIZATION	TOTAL DEEMED FACILITIES	INITIAL SURVEYS	RENEWAL SURVEYS
Hospital	AOA/HFAP	186	6	27
	DNVHC	117	68	0*
	JC	3,841	58	1,287
Critical Access Hospital	AOA/HFAP	28	1	11
	JC	374	8	127
Home Health Agency	ACHC	533	210	33
	CHAP	1,502	383	195
	JC	1,528	409	215
Hospice	ACHC	19	20	0*
	CHAP	479	119	58
	JC	256	61	58
Ambulatory Surgery Center	AAAHC	914	147	226
	AAAASF	94	43	14
	AOA/HFAP	20	5	1
	JC	293	35	88

Source: As reported by AOs.

* The DNVHC hospital accreditation program and the ACHC hospice accreditation program received recent initial approvals; therefore, no renewal surveys were due in FY 2010.

- Analysis and feedback to AOs on the accuracy and completeness of their notification letters and deemed facility lists generated by ASSURE, including whether the listed facilities could be matched to facilities in CMS' national Medicare certification data base, and whether the facility lists were consistent with information in the notification letters.

Building on this foundation, formal AO performance measures were implemented in FY 2009 (October 2008) and modified in FY 2010 (October 2009). These basic measures relate to information and data submission requirements which have been a major area of focus in CMS' oversight activities. The performance measures are presented in Table 4.

Each measure is scored on a quarterly basis. For survey schedule measures, the quarterly score is calculated based on monthly scores. Measures are scored as Yes (100 percent)/No (0 percent) or as a percentage of correct submissions (e.g., the number of facility notification letters containing required information divided by the total number of letters received) for a specific month/quarter. Table 5 presents 2011 data, defined as the last two quarters of FY 2010 (April 2010 – September 2010), and the first two quarters of FY 2011 (October 2010 – March 2011), and 2010 data defined as the last two quarters of FY 2009 (April 2009 – September 2009), and the first two quarters of FY 2010 (October 2009 – March 2010). Modifications in several measures were made in October 2009 and for those measures, only the FY 2010 data are used. The 2010 scores in Table 5 were presented in the FY 2010 report. The average performance for all AOs on each measure is also included.

Performance on most measures has shown considerable improvement since performance measurement was initiated in FY 2009. Most AOs score at the 100 percent level for several ASSURE

Table 4:

PERFORMANCE MEASURES

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

- **Timeliness** of ASSURE export file submission
- **Accuracy and Completeness** of ASSURE export file
- **Deemed Facility Data** used to populate ASSURE is accurate and error free
- **Timely Triennial Surveys** are conducted

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

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

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

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

measures (timeliness, accuracy and timely triennial surveys), electronic submission of facility notification letters, and two survey schedule measures (timeliness and formatting). When comparing the FY 2010 annual report with this year's report, improvement was particularly evident for the ASSURE measure for timely triennial surveys (from 83 percent to 99 percent) and updating ASSURE for facility notification letters (from 32 percent to 64 percent). However, there continues to be room for improvement for this last measure as well as the accuracy of facility notification letters, which declined from the prior report (from 90 to 81 percent), and the accuracy of survey schedule submissions, which showed minimal improvement from the prior year (from 83 to 84 percent). Further, all AOs have lower scores on one component of the accuracy of survey schedule submission measure, i.e. matching the number of surveys they report having conducted to the survey data the report in ASSURE). CMS continues to work closely with AOs to improve performance in these areas as well as maintain high levels of performance in other areas. The goal is for all AOs to consistently score at or near 100 percent on all measures.

In the following discussion for each AO, the definitions used to describe AO performance are as follows: "performed well" means a 100 percent score; "substantial improvement" means improved by at least 15 percent compared to last year; and "opportunity for improvement" means any score below 90 percent.

Individual Accreditation Organization Summaries

1. Accreditation Association for Ambulatory Health Care (AAAHC)

Organization Background: AAAHC is a private, non-profit organization formed in 1979 to assist ambulatory health care organizations to improve the quality of care provided to patients. The organization supports accreditation programs for a wide range of ambulatory care organizations, including ambulatory health clinics, ASCs, endoscopy centers, diagnostic health centers and women's health centers.

Accreditation Activity (Table 3): AAAHC has a CMS-approved accreditation program for ASCs and was responsible for 914 deemed facilities in FY 2010. During FY 2010, AAAHC reported completing a total of 373 surveys. Of these, 147 (39 percent) were initial surveys and 226 (61 percent) were re-accreditation surveys of ASCs already participating in Medicare via deemed status. AAAHC used the following types of accreditation decisions:

Table 5:

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

Performance Measures	AAAHC		ACHC		AAAASF		AOA/HFAP		CHAP		DNVHC		JC		All AOs	
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
ASSURE Data Base																
Timeliness	100	100	100	100	100	100	100	100	100	100	100	100	100	75	100	96
Accuracy	100	100	100	100	100	100	100	85	100	100	100	100	100	100	100	98
Deemed Facility Data	94	97	91	89	85	100	100	100	89	97	96	99	93	95	93	97
Timely Triennial Surveys	85	100	99	100	74	100	63	98	95	100	NA	NA	80	98	83	99
Facility Notification Letters																
Electronic	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Updating	16	65	0	67	0	57	0	43	53	67	98	93	58	53	32	64
Accuracy	72	62	81	67	90	93	100	73	92	81	100	97	92	94	90	81
Survey Schedule																
Timeliness	75	100	100	100	84	100	92	92	100	100	100	100	100	92	93	98
Formatting	100	100	100	100	34	100	75	100	100	100	100	100	100	100	87	100
Accuracy	83	83	83	88	81	88	83	80	81	83	92	88	78	79	83	84

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

- ***Full Accreditation (three years):*** The organization is in substantial compliance with standards with no reservation about the accuracy of the survey findings or the facility's commitment to providing care consistent with standards.

- ***Denial:*** The organization is not in substantial compliance with standards. Facilities subjected to this type of decision are not recommended to CMS for deemed status.

AAAHC recommended full accreditation for 97 percent of the 373 ASCs it surveyed in FY 2010.

Accreditation Decisions	ASCs (percentage)
Total ASCs Surveyed:	373
Full Accreditation	362 (97)
Denial	11 (3)

Performance Measures (Table 5): AAAHC performs well on most measures related to ASSURE data base submission (timeliness, accuracy and timely triennial surveys), electronic submission of facility notification letters and some survey schedule measures (timeliness and formatting). In comparison to last year's annual report, AAAHC has achieved substantial improvement for timely triennial surveys, updating ASSURE for facility notification letters, and timeliness of survey schedule submissions. Opportunities for improvement exist for facility notification letters (updating ASSURE and accuracy) and accuracy of survey schedule submissions.

Approval of Accreditation Programs: AAAHC initially received CMS recognition as a national AO for ASCs on December 19, 1996. Most recently, AAAHC received approval of a four-year renewal term, effective December 20, 2008 through December 20, 2012. The final notice announcing this decision was published in the Federal Register on November 14, 2008, and can be accessed at http://edocket.access.gpo.gov/2008/pdf/E8-27122.pdf.

2. Accreditation Commission for Health Care (ACHC)

Organization Background: The ACHC was incorporated in 1986 and provides support and accreditation for HHAs, hospices, pharmacy services, durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) suppliers and other types of services.

Accreditation Activity (Table 3): ACHC has CMS-approved accreditation programs for HHAs and hospices. ACHC had responsibility for 533 deemed HHAs in FY 2010 and for 19 hospices in this initial year of survey activity. ACHC reported completing a total of 243 surveys for HHAs, with 210 (86 percent) initial and 33 (14 percent) re-accreditation surveys. For the hospice program, ACHC completed 20 surveys in FY 2010; all of these were initial surveys. The following are the types of accreditation decisions ACHC used:

- ***Full Accreditation (three years):*** The organization had very minimal or no deficiencies. Accreditation is granted upon receipt of an acceptable plan of correction (PoC) if deficiencies were cited during the survey.

- ***Denial:*** Many severe deficiencies that cause an organization to be outside of the deferred range. In this instance, the organization is out of compliance with ACHC standards and must reapply for accreditation. Facilities subjected to this type of decision are not recommended to CMS for deemed status.

ACHC awarded full accreditation for 75 percent of the 243 HHAs surveyed in FY 2010. Full accreditation was awarded to 90 percent of the 20 hospice facilities surveyed in the same year.

Accreditation Decisions	HHAs (percentage)	Hospices (percentage)
Total Surveyed:	243	20
Full Accreditation	183 (75)	18 (90)
Denial	60 (25)	2 (10)

Performance Measures (Table 5): ACHC performs well on measures related to the ASSURE data base (timeliness, accuracy and timely triennial surveys) and electronic submission of facility notification letters and some survey schedule submission measures (timeliness and formatting). In comparison to last year's annual report, ACHC has achieved substantial improvement in updating ASSURE

for facility notification letters but there is room for more improvement. Additional opportunities for improvement exist for the ASSURE measure for deemed facility data, the accuracy of facility notification measure and the accuracy of survey schedule submissions.

Approval of Accreditation Programs:

HOME HEALTH AGENCY

ACHC initially received recognition as a national AO for HHAs on February 24, 2006. Most recently, ACHC received a six-year renewal term, effective February 24, 2009 through February 24, 2015. The final notice announcing this decision was published in the *Federal Register* on January 23, 2009, and can be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-684.pdf.

On December 20, 2010, senior leadership from ACHC met with CMS staff to disclose serious and pervasive issues discovered during the course of a comprehensive internal audit of its entire CMS-approved HHA accreditation program. As a result of the ACHC-identified failures, CMS opened a deeming review of ACHC's HHA accreditation program in early February 2011. ACHC was provided 180 days to implement corrective actions and resolve identified issues. CMS conducted a follow up corporate onsite visit July 2011 to validate correction of identified issues and ensure comparability with CMS requirements. Although ACHC made considerable improvements in several areas, more time is necessary to provide CMS with reasonable assurance that ACHC's revised policies, procedures and program wide changes are fully implemented and sustainable over time.

In accordance with the regulations at § 488.8(f)(2)(i), *"if CMS determines, following the deeming authority review, that the accreditation organization has failed to adopt requirements comparable to CMS's or submit new requirements timely, the accreditation organization may be given conditional approval of its deeming authority during a probationary period of up to one year."*

Based on this regulatory authority, CMS provided ACHC one year to correct identified areas of noncompliance and adopt comparable requirements. To confirm compliance, CMS will conduct a corporate onsite visit after the probationary year. Within 60 days following the end of the probationary period, CMS will make a final determination as to whether or not ACHC's HHA accreditation program is comparable to the CMS requirements.

HOSPICE

ACHC submitted an application for initial certification as a hospice program and was awarded a four-year term effective November 27, 2009 through November 27, 2013. The notice appeared in the *Federal Register* on November 27, 2009, and may be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-28010.pdf.

3. American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

Organization Background: AAAASF was established in 1980 and supports quality in ambulatory surgery settings through accreditation.

Accreditation Activity (Table 3): AAAASF has CMS-approved accreditation programs for ASCs and OPTs. The OPT program was approved recently and not operational in FY 2010. AAAASF was responsible for 94 deemed ASCs in FY 2010. AAAASF performed a total of 57 surveys during FY 2010. Of these, 43 (75 percent) were initial surveys and 14 (25 percent) were re-accreditation surveys. The types of accreditation decisions AAAASF used are as follows:

- ***Full Accreditation:*** The organization is in 100 percent compliance with all standards.
- ***Denial:*** The organization does not meet full accreditation standards. Facilities subjected to this type of decision are not recommended to CMS for deemed status.

AAAASF awarded full accreditation to 75 percent of the 57 ASCs surveyed in FY 2010.

Accreditation Decisions	ASCs (percentage)
Total Surveyed:	57
Full Accreditation	43 (75)
Denial	14 (25)

Performance Measures (Table 5): AAAASF has performed well on all ASSURE measures (timeliness, accuracy, deemed facility data and timely triennial surveys). In addition, the AAAASF performs well on electronic submission of facility notification letters and several survey schedule measures (timeliness and formatting). AAAASF achieved substantial improvement for a number of measures in comparison to the 2010 annual report: several ASSURE measures (deemed facility data

and timely triennial surveys), updating ASSURE for facility notification measures and several survey schedule submission measures (timeliness and formatting). Despite better performance, further opportunities for improvement remain for updating ASSURE for facility notification letters and survey schedule accuracy.

Approval of Accreditation Programs:

AMBULATORY SURGERY CENTER

AAAASF initially received recognition as a national AO for ASCs on December 2, 1998. AAAASF submitted a renewal application in March 2009. CMS reviewed that application and awarded a three-year conditional approval with a 180-day probationary period. The final notice appeared in the Federal Register on November 27, 2009, and may be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-28048.pdf. AAAASF made the necessary revisions to its program and successfully implemented new requirements to ensure AAAASF's accreditation program for ASCs meets or exceeds the Medicare requirements. On August 20, 2010, CMS published its decision in the *Federal Register* to approve AAAASF's ASC program without condition. This final notice of approval is effective November 27, 2009 through November 27, 2012, and can be accessed at http://edocket.access.gpo.gov/2010/pdf/2010-19888.pdf.

OUTPATIENT PHYSICAL THERAPY AND SPEECH-LANGUAGE SERVICES

AAAASF's OPT accreditation program was granted 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 assessed at http://edocket.access.gpo.gov/2011/pdf/2011-9176.pdf. As this notice indicates, AAAASF was required to make a number of modifications to its program as a condition of approval.

4. American Osteopathic Association/ Healthcare Facilities Accreditation Program (AOA/HFAP)

Organization Background: AOA/HFAP was established in 1945 to review quality in osteopathic hospitals and has expanded its scope to support quality in all types of hospitals, CAHs, ambulatory care/surgical facilities, clinical laboratories, behavioral health, and primary stroke centers.

Accreditation Activities (Table 3): AOA/HFAP has CMS-approved accreditation programs for hospitals, CAHs and ASCs. In FY 2010, AOA/HFAP was responsible for the following deemed facilities: 186 hospitals, 28 CAHs, and 20 ASCs. During FY 2010, AOA/HFAP performed:

- 33 hospital surveys including 6 (18 percent) initial and 27 (82 percent) re-accreditation surveys;
- 12 surveys for CAHs including 1 (8 percent) initial and 11 (92 percent) re-accreditation surveys; and
- 6 surveys for ASCs including 5 (83 percent) initial and 1 (17 percent) re-accreditation survey.

The types of accreditation decisions used were as follows:

- ***Accreditation with resurvey within three years:*** The healthcare facility meets the AOA/HFAP accreditation requirements in all performance areas.
- ***Denial of Accreditation:*** The healthcare facility has been denied accreditation because it does not meet AOA/HFAP requirements. Facilities subjected to this type of decision are not recommended to CMS for deemed status.

AOA/HFAP awarded full accreditation for 100 percent of the 33 hospitals surveyed, 100 percent of the 12 CAHs reviewed and 100 percent of the 6 ASCs reviewed.

Accreditation Decisions	Hospitals (percentage)	CAHs (percentage)	CAHs (percentage)
Total Surveys	33	12	6
Full Accreditation	33 (100)	12 (100)	6 (100)
Denial	0	0	0

Performance Measures (Table 5): AOA/HFAP performs well on some ASSURE measures (timeliness and deemed facility data), electronic submission of facility notification letters, and formatting survey schedule submissions. In comparison to last year's annual report, AOA/HFAP achieved substantial improvement for timely triennial surveys, updating ASSURE for facility notification letters, and formatting survey schedules. Opportunities for improvement exist for accuracy of ASSURE, some measures related to facility notification letters (updating ASSURE and accuracy) and the accuracy of survey schedule submissions.

Approval of Accreditation Programs:

HOSPITAL

AOA/HFAP has had an approved hospital accreditation program since 1965. Although its hospital program is mentioned by name in the Act, it is also explicitly subject to the Secretary's review and approval. Most recently, AOA/HFAP received a four-year renewal term, effective September 25, 2009 through September 25, 2013. The final notice announcing this decision was published in the *Federal Register* on August 28, 2009, and can be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-20203.pdf.

To verify AOA/HFAP's continued compliance with the provisions of this final notice, CMS conducted a follow-up corporate onsite visit in August 2010, and found that problems previously identified remained uncorrected. Subsequently, CMS opened a deeming review of AOA/HFAP's CMS-approved hospital accreditation program in October 2010 for this and other reasons. AOA/HFAP was provided 180 days to implement corrective actions and resolve identified issues. CMS conducted another corporate onsite visit in May of 2011 to validate correction of identified issues and ensure comparability with CMS requirements. Although AOA/HFAP made improvements in several areas, more time is necessary to provide CMS with reasonable assurance that AOA/HFAP's revised policies, procedures and program-wide changes are fully implemented and sustainable over time.

In accordance with the regulations at § 488.8(f)(2)(i), *"if CMS determines, following the deeming authority review, that the accreditation organization has failed to adopt requirements comparable to CMS's or submit new requirements timely, the accreditation organization may be given conditional approval of its deeming authority during a probationary period of up to one year."*

Based on this regulatory authority, CMS provided AOA/HFAP one year to correct identified areas of noncompliance and adopt comparable requirements. To confirm compliance, CMS will conduct a corporate onsite visit after the probationary year. Within 60 days following the end of the probationary period, CMS will make a final determination as to whether or not AOA/HFAP's hospital accreditation program is comparable to the CMS requirements.

CRITICAL ACCESS HOSPITAL

AOA/HFAP first received CMS recognition of its CAH deeming program on December 27, 2001. More recently, AOA/HFAP received approval for a six-year renewal term, effective December 28, 2007 through December 28, 2013. The final notice announcing this approval was published in the *Federal Register* on November 23, 2007, and can be accessed at http://edocket.access.gpo.gov/2007/pdf/E7-22628.pdf.

AMBULATORY SURGERY CENTER

AOA/HFAP received initial recognition by CMS as a national AO for ASCs on January 30, 2003. More recently, AOA/HFAP received approval for renewal of its ASC deeming program effective October 23, 2009 through October 23, 2013. The final notice announcing this approval was published in the *Federal Register* on September 25, 2009, and can be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-22956.pdf.

To verify AOA/HFAP's continued compliance with the provisions of this final notice, CMS conducted a follow-up corporate onsite visit in August 2010 and found that problems previously identified remained uncorrected. Subsequently, CMS opened a deeming review of AOA/HFAP's CMS-approved ASC accreditation program for this and other reasons. AOA/HFAP was provided 180 days to implement corrective actions and resolve identified issues. CMS conducted a corporate onsite visit May 2011 to validate correction of identified issues and ensure comparability with CMS requirements. Although AOA/HFAP made improvements in several areas, more time is necessary to provide CMS with reasonable assurance that AOA/HFAP's revised policies, procedures and program wide changes are fully implemented and sustainable over time.

In accordance with the regulations at § 488.8(f)(2)(i), *"if CMS determines, following the deeming authority review, that the accreditation organization has failed to adopt requirements comparable to CMS's or submit new requirements timely, the accreditation organization may be given conditional approval of its deeming authority during a probationary period of up to one year."*

Based on this regulatory authority, CMS provided AOA/HFAP one year to correct identified areas of noncompliance and adopt comparable requirements. To confirm, CMS will conduct a corporate onsite visit after the probationary year. Within 60 days following the end of the probationary period, CMS will make a final determination as to whether or not AOA/HFAP's ASC accreditation program is comparable to the CMS requirements.

5. Community Health Accreditation Program (CHAP)

Organization Background: CHAP was created in 1965 to support community-based health care organizations, including DMEPOS suppliers.

Accreditation Activity (Table 3): CHAP has CMS-approved accreditation programs for HHAs and hospices. In FY 2010, CHAP was responsible for 1,502 deemed HHAs and 479 hospices. In FY 2010, CHAP conducted a total of 578 HHA surveys. Of these, 383 (66 percent) were initial surveys and 195 (34 percent) were re-accreditation surveys. In the same year, CHAP conducted a total of 177 hospice surveys. Of these, 119 (67 percent) were initial and 58 (33 percent) were re-accreditation surveys. The types of accreditation decisions are as follows:

- ***Accreditation:*** The organization meets standards; may include required facility actions.
- ***Denial:*** The organization does not meet standards. Facilities subjected to this type of decision are not recommended to CMS for deemed status.

CHAP awarded accreditation for 100 percent of the 578 HHAs and 100 percent of the 177 hospices surveyed.

Accreditation Decisions	HHAs (percentage)	Hospices (percentage)
Total Surveyed:	578	177
Full Accreditation	576 (100)	177 (100)
Denial	2 (0)	0

Performance Measures (Table 5): CHAP performs well on several ASSURE measures (timeliness, accuracy, and timely triennial surveys), electronic submission of facility notification letters, and several survey schedule submission measures (timeliness and formatting). Opportunities for improvement exist for updating ASSURE for facility notification letters, accuracy of facility notification letters and accuracy of survey schedule submissions.

Approval of Accreditation Programs:

HOME HEALTH AGENCY

CHAP initially received CMS recognition as a national AO for HHAs on August 27, 1992. Most recently, CHAP received a four-year renewal term, effective March 31, 2008 through March 31, 2012. 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/E8-5073.pdf. As part of this review, CMS conducted a follow-up corporate onsite one year following the publication of the final notice to assess CHAP's compliance with its own policies and procedures. CMS completed its review February 2010 and determined that CHAP had fully addressed and resolved these concerns. CHAP's HHA accreditation program meets or exceeds the Medicare requirements.

HOSPICE

CHAP received initial recognition from CMS as a national AO for hospices on April 20, 1999. More recently, CHAP submitted a renewal application for the hospice program in April 2009. CMS reviewed that application and awarded a three-year conditional approval with a 180-day probationary period. The final notice appeared in the *Federal Register* on October 23, 2009, and may be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-25072.pdf. During the 180-day probationary period, CHAP made the necessary revisions to its program and successfully implemented new requirements to ensure CHAP's accreditation program for hospices meets or exceeds the Medicare requirements. On July 16, 2010, CMS published the decision to approve CHAP's hospice program without condition. This final notice of approval is effective November 20, 2009 through November 20, 2012, and can be accessed at http://edocket.access.gpo.gov/2010/pdf/2010-17405.pdf.

6. Det Norske Veritas Health Care (DNVHC)

Organization Background: DNV is an independent foundation designed to manage risk and safeguard life, property, and the environment. DNV was originally established in Norway but is now an international organization. The major focus of DNV has been on the maritime, oil, gas and energy, food and beverage industries, with a recent expansion to health care through DNVHC.

Accreditation Activities (Table 3): DNVHC received initial recognition as a national AO for its hospital program on September 29, 2008. In FY 2011, the AO received CMS- approval for its CAH accreditation program; that program was not operational in FY 2010. DNVHC was responsible for 117 deemed hospitals in FY 2010. DNVHC conducted 68 initial surveys in FY 2010. No triennial reaccreditation surveys were due. The types of accreditation decisions are as follows:

- ***Full Accreditation:*** An organization is currently compliant or has provided corrective action plan(s) to address any nonconformity identified during the survey process, and has provided objective evidence as required to verify corrective action plans have been implemented and determined to be effective.

- ***Denial:*** An organization has failed to meet the DNVHC requirements. Facilities subjected to this type of decision are not recommended to CMS for deemed status.

DNVHC awarded full accreditation to 100 percent of the 68 hospitals surveyed.

Accreditation Decisions	Hospitals (Percentage)
Total Surveyed:	68
Full Accreditation	68 (100)
Denial	0

Performance Measures (Table 5): DNVHC performed well on several ASSURE measures (timeliness and accuracy), electronic submission of facility notification letters and several survey schedule submissions (timeliness and formatting). There is room for improvement in the accuracy of survey schedule submissions. Since no triennial surveys were due, this measure is not scored.

Approval of Accreditation Programs:

HOSPITAL

DNVHC received initial recognition by CMS as a national AO for hospitals on September 29, 2008. A four-year term of approval was awarded, effective September 26, 2008 through September 26, 2012. The final notice announcing this decision was published in the *Federal Register* September 29, 2008, and can be accessed at http://edocket.access.gpo.gov/2008/pdf/E8-22585.pdf.

CRITICAL ACCESS HOSPITAL

DNV received initial approval for its CAH program for a four-year term effective December 23, 2010 through December 23, 2014. The final notice appeared in the *Federal Register* on November 15, 2010, and can be accessed at http://edocket.access.gpo.gov/2010/pdf/2010-28666.pdf. As this notice indicates, DNVHC was required to make modifications to its program as a condition of approval.

7. The Joint Commission (JC)

Organization Background: The JC's goal is the improvement of patient safety and quality through accreditation and other means. While originally focused on hospitals, the JC now provides accreditation and other supportive services in a broad range of health care settings: ambulatory care, behavioral health care, CAHs, home care, laboratory services, long term care, office-based surgery, and DMEPOS suppliers.

Accreditation Activities (Table 3): The JC received initial approval for its psychiatric hospital accreditation program in FY 2011. In addition, the JC has CMS-approved accreditation programs for hospitals, CAHs, HHAs, hospices and ASCs. During FY 2010, the JC was responsible for 3,841 hospitals, 374 CAHs, 1,528 HHAs, 256 hospices, and 293 ASCs. During FY 2010, the JC performed:

- 1,345 hospital surveys with 58 (4 percent) initial and 1287 (96 percent) re-accreditation surveys;

- 135 CAH surveys with 8 (6 percent) initial and 127 (94 percent) re-accreditation surveys;

- 624 HHA surveys with 409 (66 percent) initial and 215 (34 percent) re-accreditation surveys;

- 119 surveys for hospice with 61 (51 percent) initial and 58 (49 percent) re-accreditation surveys; and

- 123 surveys for ASCs with 35 (28 percent) initial and 88 (72 percent) re-accreditation surveys.

The JC used the following types of accreditation decisions:

- ***Accreditation:*** The facility is in compliance with all standards at time of the onsite survey or has successfully addressed all requirements for improvement.

- ***Accreditation with requirements for improvement:*** The facility is granted accreditation after providing assurance that the recommendations for improvement identified in the JC survey process will be implemented.

- ***Conditional Accreditation:*** The facility was not in substantial compliance but is believed to be capable of achieving acceptable compliance with the JC standards. The JC will conduct a follow-up survey, during which the facility

must demonstrate substantial correction of the identified deficiencies before being considered for full accreditation. Facilities subjected to this type of decision are not recommended to CMS for deemed status.

- ***Preliminary Denial:*** The facility appears to have an immediate threat to health or safety or failure to resolve requirements of a Conditional Accreditation or significant noncompliance. This decision is subject to review and appeal. Facilities subjected to this type of decision are not recommended to CMS for deemed status.

- ***Denial:*** This final accreditation decision does not permit further appeals. Facilities subjected to this type of decision are not recommended to CMS for deemed status.

Table 6 lists the outcomes of the JC accreditation decisions by facility type for FY 2010:

- 1,345 hospital surveys with 100 percent resulting in either full accreditation or accreditation with requirements for improvements;

- 135 CAH surveys with 100 percent approved for accreditation with improvement requirements;

- 624 HHA surveys with 100 percent approved for full accreditation or accreditation with improvement requirements;

- 119 hospice surveys with 100 percent awarded full accreditation or accreditation with improvement requirements; and

- 123 ASC surveys with 100 percent awarded full accreditation or accreditation with improvements.

Performance Measures (Table 5): The JC performed well on measures for the accuracy of ASSURE submissions, electronic submission of facility notification letters and formatting survey schedules. The JC achieved substantial improvement as compared to last year's annual report in the timely triennial surveys measure. Opportunities exist for improving performance for the timeliness of ASSURE data base submissions, updating ASSURE based on facility notification letters and the accuracy of survey schedule submissions.

Approval of Accreditation Programs:

HOSPITAL

The JC initially received CMS approval as a national AO for hospitals effective July 15, 2010 through July 15, 2014. Prior to July 15, 2010, the JC's hospital program had statutory status and did not require CMS approval. The notice of approval appeared in the Federal Register on November 27, 2009, and may be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-27973.pdf. To insure compliance with provisions of that notice, CMS conducted a follow-up onsite visit and survey observation in September 2010. Results of this follow-up visit demonstrated that the JC has adopted and implemented requirements comparable to CMS requirements.

Table 6:

THE JOINT COMMISSION SURVEYS AND ACCREDITATION DECISIONS (FY 2010)

Accreditation Decisions	Hospitals (percentage)	CAHs (percentage)	HHAs (percentage)	Hospices (percentage)	ASCs (percentage)
Total Surveys	1,345	135	624	119	123
Full Accreditation	6 (0)	0	44 (7)	4 (3)	6 (5)
Accreditation with Improvement Requirements	1,339 (100)	135 (100)	580 (93)	115 (97)	117 (95)
Conditional Accreditation*	22 (2)	2 (1)	26 (4)	7 (6)	0
Preliminary Denial*	0	0	1 (0)	0	0
Denial	0	0	0	0	0

*The Conditional Accreditation and Preliminary Denial counts reflect stages in the JC accreditation status review process. Therefore, these numbers are not included in Total Surveys. (Source: The JC)

CRITICAL ACCESS HOSPITAL
The JC first received CMS recognition as a national AO for CAHs on November 21, 2002. More recently, CMS published the decision to approve the JC's CAH program in the *Federal Register* on June 26, 2009. The final notice of approval was effective on November 21, 2008 through November 21, 2011, and can be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-14778.pdf.

HOME HEALTH AGENCY
The JC initially received CMS recognition as a national AO for HHAs on September 28, 1993. More recently, the JC received a six-year renewal effective March 31, 2008 through March 31, 2014. The final notice announcing this decision was published in the *Federal Register* on March 28, 2008, and can be accessed at http://edocket.access.gpo.gov/2008/pdf/E8-5074.pdf.

HOSPICE
The JC initially received CMS recognition as a national AO for hospices on June 18, 1999. More recently, the JC received a six-year renewal effective June 18, 2009 through June 18, 2015. The final notice announcing this decision was published in the *Federal Register* on March 27, 2009, and can be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-6775.pdf.

AMBULATORY SURGERY CENTER
The JC initially received CMS recognition as a national AO for ASCs on December 19, 1996. More recently, the JC received a six-year renewal effective December 20, 2008 through December 20, 2014. The final notice announcing this decision was published in the *Federal Register* on November 14, 2008, and can be accessed at http://edocket.access.gpo.gov/2008/pdf/E8-27120.pdf.

PSYCHIATRIC HOSPITAL
The JC received initial approval of its psychiatric hospital accreditation program for a four-year period effective February 25, 2011 through February 25, 2015. The final notice appeared in the *Federal Register* on February 25, 2011, and may be accessed at http://edocket.access.gpo.gov/2011/pdf/2011-4294.pdf. As this notice indicates, JC was required to make numerous modifications to its program as a condition of approval.

Section 5: Accreditation Representative Sample Validation Program

Section 1865(d) of the Act permits validation surveys of all provider and supplier types that may be deemed for Medicare participation under Section 1865(a) of the Act. Section 1864 of the Act authorizes the SAs to conduct validation surveys on behalf of CMS in accredited facilities participating in Medicare, as a means of validating the AOs' accreditation processes. The Accreditation Validation Program is a significant component of CMS' oversight of AOs and consists of two types of validation surveys: (1) allegation surveys, i.e., focused surveys based on complaints which, if substantiated, would suggest serious noncompliance with Medicare CoPs or CfCs; and, (2) full surveys of a representative sample of deemed facilities. Representative sample validation surveys generally must be completed no more than 60 days after an AO survey of the same facility. This section discusses both the methodology and the results for the CMS validation of the AOs' deemed programs through the 60-day validation surveys. In some cases, representative sample mid-cycle validation surveys may also be conducted independent of a preceding AO survey. During FY 2010, SAs conducted mid-cycle validation surveys for a random sample of ASCs as part of a healthcare-associated infection initiative funded by the American Recovery and Reinvestment Act of 2009 (ARRA). Those results will be discussed separately in Section 6.

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

The CMS validation analysis presented in this section compares the condition-level deficiencies (i.e., serious deficiencies) cited by the SA with the deficiencies cited by the AO on its accreditation survey. The goal is to determine whether the AOs are comparable in their ability to identify serious problems. The premise of the analysis is that condition-level deficiencies cited by the SA during the 60-day validation survey would also have been present 60 days prior, during the AO's accreditation survey and should also have been cited by the AO.

Methodology: Sample Selection Process and Issues

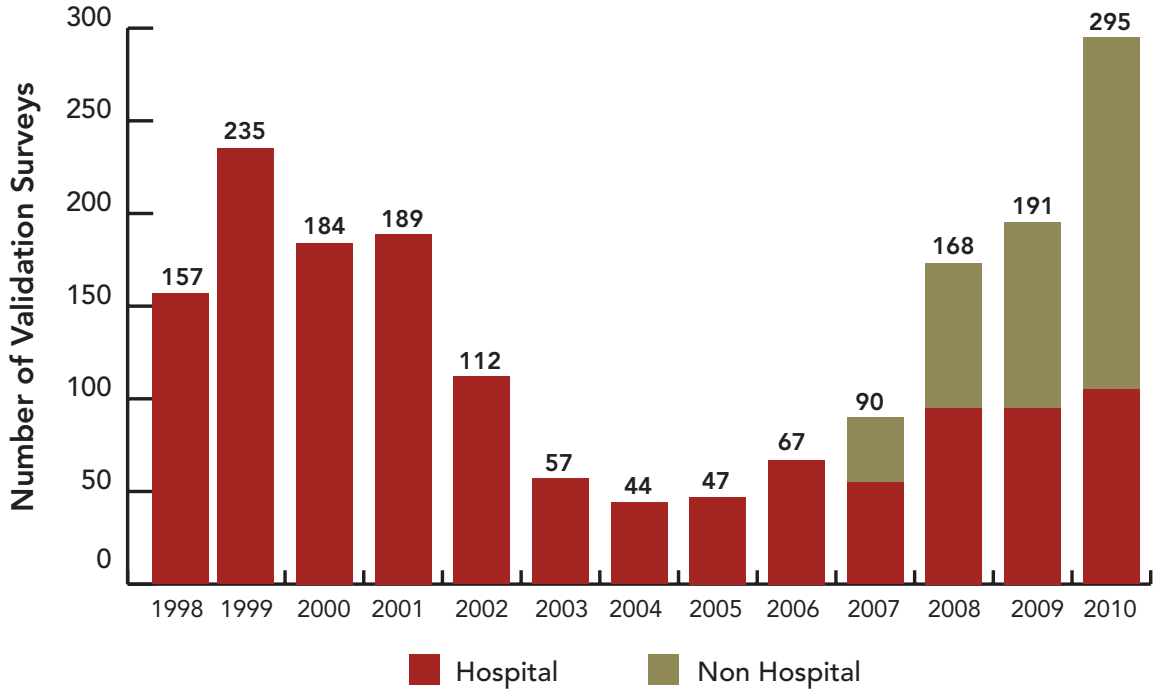
CMS has increased the number of validation surveys conducted the last several years. Until recently, Federal budget constraints have placed significant limits on the CMS representative sample validation program. Graph 1 presents the number of representative sample validation surveys performed by SAs over the past thirteen years. The largest number of 60-day validation surveys was conducted in 1999, when 235 60-day validation surveys were conducted for the JC hospital program. In FY 2007, CMS began conducting 60-day representative sample validation surveys for non-hospital facilities (i.e., CAHs, HHAs, and ASCs) in addition to the hospital validation surveys. Hospice 60-day validation surveys were added in FY 2010.

In recent years, more Federal resources have been made available for validation surveys. As a result, the total number of validation surveys conducted has increased; however, validation surveys are now spread across multiple facility types and AOs. (Prior to FY 2009, Section 1875 of the Act required CMS to report annually to Congress only on the JC's hospital program.) An additional constraint on expansion of the validation program in the past few years has been State budget restrictions that have limited hiring of additional surveyors as well as mandatory furloughs of existing surveyors. Nevertheless, the validation program has expanded significantly since FY 2007, with a 228 percent increase in the overall number of validation surveys conducted, from 90 in FY 2007 to 295 in FY 2010, including both 60-day validation and special, mid-cycle ASC validations. During the same time period, the number of non-hospital validation surveys conducted increased by 446 percent, from 35 surveys in FY 2007 to 191 surveys in FY 2010, including both 60-day validation surveys and special, mid-cycle ASC validations. The number of hospital validation surveys conducted increased by 89 percent, from 55 surveys in FY 2007 to 104 surveys in FY 2010. However, the hospital component of the 60-day validation program still remains less than half the 1999 level.

In FYs 2007, 2008 and 2009, CMS selected a representative sample of facilities within each of the following facility types: hospital, CAHs, HHAs, and ASCs for 60-day validation surveys. In FY 2010, CMS included hospices in the 60-day

Graph 1:

NUMBER OF REPRESENTATIVE SAMPLE VALIDATION SURVEYS FOR BOTH HOSPITAL AND NON-HOSPITAL FACILITIES (FY 1998-2010)*



*Includes 72 mid-cycle ASC validation surveys in FY 2010, as part of the ASC HAI initiative

validation surveys but treated all ASC validation surveys as mid-cycle surveys, as previously noted. CMS determines the number of validation surveys to perform for each AO based on the number of facilities the AO surveys each month, as well as the overall budgeted targets, by State and facility type, for validation surveys. CMS then attempts to build a representative national sample for individual accreditation programs. The validation sample is driven by a number of factors, including the total number of accreditation surveys conducted by the AO and reported on the monthly survey schedules furnished to CMS, the accuracy of those schedules, and individual State validation survey volume targets.

Figure 1 provides the calculation for the proportion of 60-day validation surveys completed for deemed facilities. The proportion of deemed facilities receiving a 60-day validation survey during FYs 2008 through 2010 are as follows:

- **Hospitals:** Three percent of deemed facilities received a validation survey in FY 2010. This represents an increase over FYs 2008 and 2009 levels when two percent of hospitals were included in each year's validation sample. A total of seven percent of deemed hospitals received a validation survey over the three-year period.

- **CAHs:** Six percent of CAHs received a validation survey in both FYs 2009 and 2010. Four percent received a survey in FY 2008 for a total of sixteen percent of the deemed facilities receiving a validation survey over the three-year period.

- **HHAs:** Two percent of deemed facilities received a survey in FY 2010, with the same percentage receiving a validation survey in FYs 2008 and 2009. A total of six percent received a survey over the three-year period.

- **Hospices:** Three percent of deemed facilities received a validation survey in FY 2010. This was the first year in which hospices had been included in the validation program.

- **ASCs:** Sixty-day validation surveys were not conducted in ASCs during FY 2010; instead all ASC validation surveys in FY 2010 were mid-cycle surveys of five percent of deemed ASCs. Two percent of deemed ASCs received a 60-day validation survey in FY 2009. Four percent of deemed ASCs received a 60-day validation survey during FY 2008, for a six percent total of 60-day validations over the three-year period.

Methodology: Validation Analysis

Each AO received feedback on the results of CMS' analysis of 60-day validation surveys for its deemed facilities conducted during FYs 2007 through 2010. The JC has received feedback on the results of the analysis of 60-day validation surveys conducted for its accredited hospitals since the beginning of the validation program in FY 1998. Tables 7 through 15 and Graph 2 use the following measures to review the survey results:

- **Disparity Rate:** A lower disparity rate indicates better AO performance. The methodology for the disparity rate is set by regulation at 42 CFR 488.1 and presented in Figure 2. The numerator is the number of surveys where the AO did not cite a comparable serious (conditional-level) deficiency cited by the SA. The denominator is the number of surveys in the 60-day validation sample. The result is the percentage of 60-day validation surveys where the AO did not cite a comparable serious deficiency cited by the SA. If the AO missed at least one serious deficiency in a third of the 60-day validation surveys, the disparity rate would be 33 percent.

Figure 1:

PROPORTION OF DEEMED FACILITIES RECEIVING VALIDATION SURVEYS

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

Figure 2:

DISPARITY RATE CALCULATION

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

* Number of 60-day validation surveys includes those with or without condition-level deficiency findings by the SA.

- **Sampling Fraction:** The sampling fraction, illustrated in Figure 3, is the proportion of AO surveys during the FY for which a representative sample 60-day validation survey was completed. For example, the sampling fraction for CHAP's accreditation program for HHAs is five percent, which is the number of FYs 2008 through 2010 validation surveys (75 validation surveys) divided by the number of HHA surveys CHAP conducted over the same time period (1,496 surveys). CMS has worked to increase this fraction for each AO and to include a minimum of five 60-day validation surveys per year for each AO program, no matter how small the program.

Figure 3:
SAMPLING FRACTION CALCULATION

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

In summary, the *disparity rate* focuses on the number of 60-day validation surveys where the AO did not cite comparable condition-level deficiencies cited by SAs in relation to the total number of validation surveys completed by the SA. The *sampling fraction* is the proportion of 60-day validation surveys completed by the SA in relation to the number of accreditation surveys completed by the AO.

When the number of 60-day validation surveys completed by the SA is less than five surveys, the disparity rates are not presented. The small 60-day validation sample sizes limited the analysis of some AO programs in the FY 2009 annual report to Congress. However, in this year's report, the results for FYs 2008 through 2010 60-day validation surveys for individual AOs have been combined to provide a more robust estimate of the disparity rates. (A similar approach was followed for the FY 2010 report where FYs 2008 and 2009 results were combined.) This action, coupled with the increase in 60-day validation samples in FYs 2009 and 2010, has improved the representativeness of the 60-day validation samples for individual AOs. This enables presentation of AO-specific disparity rates for all AO programs except one. CMS hopes to further expand 60-day validation samples in future years to ensure better estimates of these rates for all AO programs.

Validation Performance Results: Overall Scores

The tables in this section provide results of the validation survey program analysis. Table 7 presents the 2010 60-day validation disparity rates by Physical Environment and by Health, for facility types that require Life Safety Code (LSC) Survey. Table 8 presents the 2010 results of the 60-day validation disparity rates for facility types that do not require Life Safety Code Survey. These tables illustrate the challenges that the AOs are experiencing in identifying life safety code deficiencies. Table 9 presents the results of the 60-day validation surveys for FYs 2007 through 2010 by facility type. Graph 2 presents the highlights of the validation program results across the four FYs. Tables 10 through 14 present the combined results of the 60-day validation surveys for individual AO programs in FYs 2008 through 2010. The regulations at 42 CFR 488.8(d) require that CMS identify any AO with a disparity rate exceeding 20 percent. In cases where the disparity rate for the AO's accreditation program exceeded the 20 percent threshold, CMS notified the AO of the finding. Results of the 60-day validation surveys raise significant concerns about the effectiveness of certain aspects of the AOs' survey processes. In particular, the data identify difficulty on the part of most AOs in identifying physical environment deficiencies and other aspects of the Life Safety Code. Table 7 highlights this issue and subsequent Tables 15 and 16 provide additional information on this issue.

As shown in Table 9 and Graph 2, with the exception of HHAs, the disparity rate score for each facility type exceeds the 20 percent threshold established in the regulation for all four FYs. For example, a disparity rate of 38 percent in FY 2010 for hospitals means that the AOs did not cite comparable serious deficiencies as did the SA for almost four out of ten hospitals surveyed. Similarly, based on disparity rates for FY 2010, the AOs missed comparable serious deficiencies for 65 percent of CAHs and 25 percent of hospices surveyed. The disparity rates for hospitals are similar for FYs 2008 through 2010; the disparity rates for HHAs are similar for FY 2008 through FY 2010; and, for ASCs, disparity rates for FYs 2008 and 2009 are essentially the same. The disparity rates for CAHs increased between FYs 2008 and 2009, and remain at that higher level in FY 2010.

For FY 2010, SAs cited a lower percentage of condition-level deficiencies in the 60-day validation sample for HHAs (20 percent) as compared to other types of facilities (45 percent of validation sample hospitals, 70 percent of sample CAHs, and 41 percent of sample ASCs in FY 2009). The lower rate of condition–level deficiencies cited in HHAs is consistent across the four FYs presented in Table 9. For hospices, the percentage of condition-level deficiency citations is also comparatively low (25 percent) for FY 2010, the only year when validation surveys were conducted.

As shown in Tables 10 through 14, presenting the results for individual AO programs combined across three FYs increases the number of 60-day validation surveys for individual AO programs. The disparity rate for the one program with a validation sample size less than five is not presented. For two other AO programs, the rates could not be calculated since the SAs cited no condition-level deficiencies. Except for HHAs, the disparity rates for all AO programs are above the 20 percent threshold for the combined performance for FYs 2008 through 2010.

Table 7:

60-DAY VALIDATION SURVEY DISPARITY RATES FOR FACILITY TYPES WITH LSC REQUIREMENTS (FY 2010)

	HOSPITAL			CRITICAL ACCESS HOSPITAL		
60-Day Validation Surveys	104			23		
Deficiency Type	Health	Physical Environment	Overall Results*	Health	Physical Environment	Overall Results*
SA: Condition-level Deficiencies	19	39	47	3	16	16
Missed by AO	18	32	40	3	15	15
Disparity Rate	17%	31%	38%	13%	65%	65%

* The numbers under the Physical Environment and Health columns refer to the number of surveys where there was a disparity in the findings for the physical environment CoP, which includes the Life Safety Code, and the number of surveys where there was a disparity in the findings for the health CoPs. A survey might include both types of disparate findings; as a result, the numbers are not added together in the "Overall Results" column, which refers to an unduplicated total of surveys with disparate findings.

*For FY 2010, 60-day validation surveys were not conducted for ASCs; therefore, no data is provided.

Table 8:

60-DAY VALIDATION SURVEY DISPARITY RATES FOR FACILITY TYPES WITHOUT LSC REQUIREMENTS (FY 2010)

	Home Health Agency	Hospice
60-Day Validation Sample	76	20
SA: Condition-level Deficiencies	15	5
Missed by AO	11	5
Disparity Rate	14%	25%

Table 9:

60-DAY VALIDATION SURVEY DISPARITY RATES (FYs 2007 THROUGH 2010)

	FY 2007	FY 2008	FY 2009	FY 2010
HOSPITAL				
60-day Validation Surveys	55	92	89	104
SA: Condition-level Deficiencies	23	43	39	47
Missed by AO	22	30	32	40
Disparity Rate	40%	33%	36%	38%
CAH				
60-day Validation Surveys	12	17	22	23
SA: Condition-level Deficiencies	4	9	16	16
Missed by AO	3	7	15	15
Disparity Rate	25%	41%	68%	65%
HHA				
60-day Validation Surveys	6	21	51	76
SA: Condition-level Deficiencies	1	5	9	15
Missed by AO	0	3	8	11
Disparity Rate	0%	14%	16%	14%
HOSPICE				
60-day Validation Surveys	0	0	0	20
SA: Condition-level Deficiencies	NA	NA	NA	5
Missed by AO	NA	NA	NA	5
Disparity Rate	NA	NA	NA	25%
ASC				
60-day Validation Surveys	17	38	29	0
SA: Condition-level Deficiencies	5	17	12	NA
Missed by AO	4	16	12	NA
Disparity Rate	24%	42%	41%	NA

NA: Not applicable since 60 day surveys were not conducted.

Table 10:

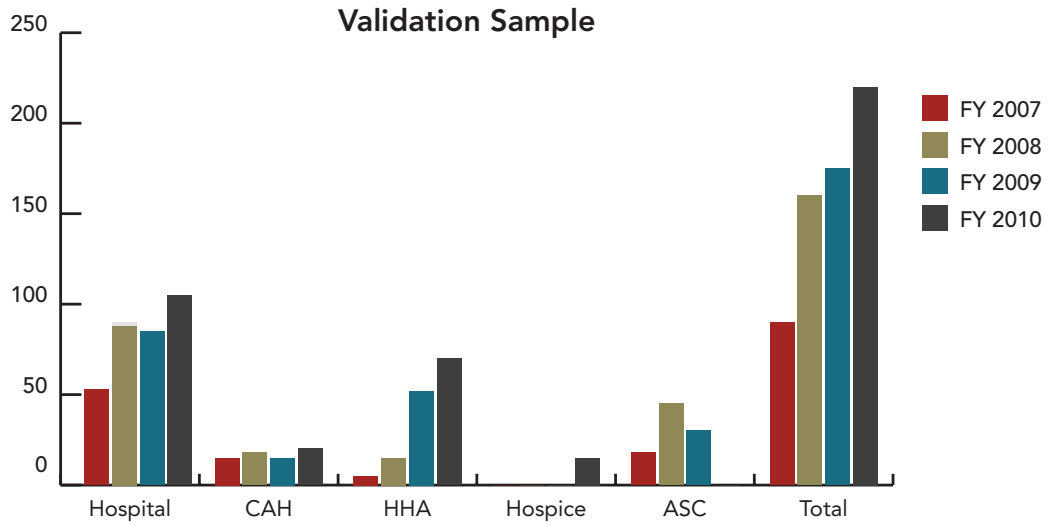
HOSPITAL 60-DAY VALIDATION SURVEY RESULTS BY AO (FYs 2008 THROUGH 2010)

Hospitals				
	JC	AOA/HFAP	DNVHC*	Total
60-Day Validation Sample	268	10	7	285
SA: Condition-level Deficiencies	118	8	3	129
Missed by AO	91	8	3	102
Disparity Rate	34%	80%	43%	36%
Sampling Fraction	.07	.06	.06	.06

*DNVHC hospital accreditation program was not CMS-approved prior to FY 2009.

Graph 2:

HIGHLIGHTS OF 60-DAY VALIDATION SURVEY RESULTS FOR EACH FACILITY TYPE (FYs 2007 THROUGH 2010)



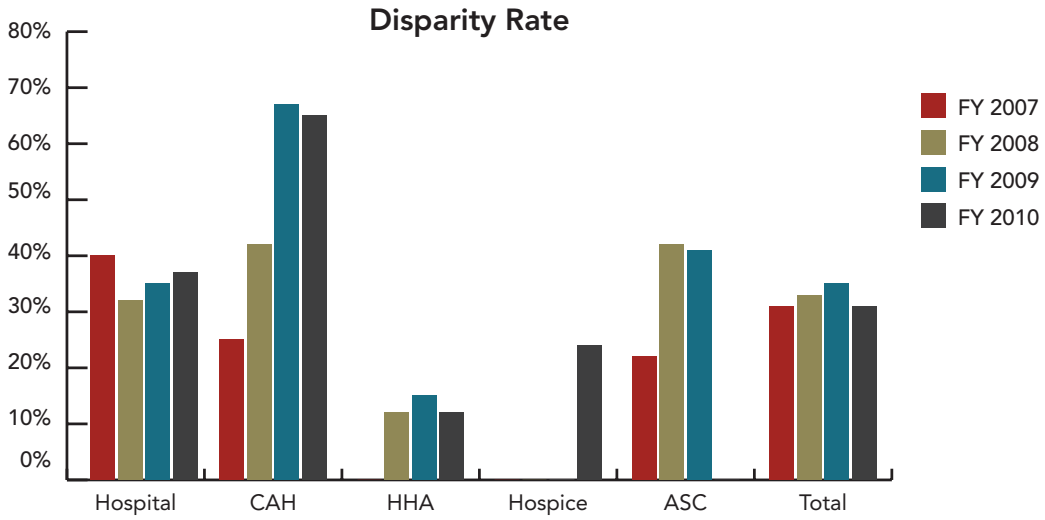


Table 11:

CRITICAL ACCESS HOSPITAL 60-DAY VALIDATION SURVEY RESULTS BY AO (FYs 2008 THROUGH 2010)

Critical Access Hospital			
	JC	AOA/HFAP	Total
60-Day Validation Sample	55	7	62
SA: Condition-level Deficiencies	36	5	41
Missed by AO	32	5	37
Disparity Rate	58%	71%	60%
Sampling Fraction	.14	.24	.15

Table 12:

HOME HEALTH AGENCY 60-DAY VALIDATION SURVEY RESULTS BY AO (FYs 2008 THROUGH 2010)

Home Health Agency				
	JC	ACHC	CHAP	Total
60-Day Validation Sample	58	15	75	148
SA: Condition-level Deficiencies	20	0	9	29
Missed by AO	14	NA	8	22
Disparity Rate	24%	NA	11%	15%
Sampling Fraction	.04	.02	.05	.04

NA: Not applicable since SAs cited no condition-level deficiencies

Table 13:

HOSPICE 60-DAY VALIDATION RESULTS FOR EACH AO (FY 2010)

Hospice			
	JC	CHAP	Total
60-Day Validation Sample	10	10	20
SA: Condition-level Deficiencies	0	5	5
Missed by AO	NA	5	5
Disparity Rate	NA	50%	25%
Sampling Fraction	.08	.06	.06

NA: Not applicable since SAs cited no condition-level deficiencies.

Table 14:

AMBULATORY SURGERY CENTER 60-DAY VALIDATION SURVEY RESULTS FOR EACH AO (FYs 2008 AND 2009)

Ambulatory Surgery Center				
	JC	AAAHC	AAAASF	Total
60-Day Validation Sample	13	52	2	67
SA: Condition-level Deficiencies	5	22	2	29
Missed by AO	5	21	2	28
Disparity Rate	38%	40%	NA	42%
Sampling Fraction	.07	.06	.03	.05

NA: Not applicable due to sample size less than five.

The number of surveys in which the AOs did not cite deficiencies comparable to condition-level deficiencies cited by the SAs suggests significant limitations in the AOs' ability to identify serious non-compliance with the Medicare conditions. This finding is consistent for FY 2008, 2009 and 2010. With the exception of the HHA surveys, all disparity rates for individual AO programs exceed the 20 percent threshold. Below is a more detailed discussion by type of facility and AO.

- **Hospital:** The FYs 2008, 2009, and 2010 results indicate that of the 285 60-day validation surveys conducted, SAs cited condition-level deficiencies in 129 hospitals. The AOs did not cite deficiencies comparable to the condition-level deficiencies cited by the SAs in 102 hospitals, for a disparity rate of 36 percent.

JC: For FYs 2008, 2009, and 2010 combined, the disparity rate is 34 percent based on 268 60-day validation surveys. The JC did not cite comparable findings in 91 of the 118 surveys cited for condition-level deficiencies by the SAs. The 60-day validation sample was seven percent of the surveys conducted by the JC during that period. The JC disparity rate has been above 20 percent for the past eleven years, as shown in Table 15. Due to prior statutory reporting requirements, 60-day validation surveys have been performed for the JC hospital program for a longer time period than for other AO programs.

AOA/HFAP: The 60-day validation sample for FYs 2008, 2009, and 2010 combined included ten hospitals and was a six percent sample of the surveys conducted by AOA/HFAP over the three-year period. The SAs cited eight hospitals with condition-level deficiencies. The AO cited no comparable deficiencies for a disparity rate of 80 percent.

DNVHC: The SAs cited three hospitals with condition-level deficiencies for the seven hospitals included in the 60-day validation sample for FYs 2009 and 2010. DNVHC did not cite comparable deficiencies for a disparity rate of 43 percent. The 60-day validation sample included six percent of the surveys done by DNVHC over the two-year period. The DNVHC hospital program was not CMS-approved in FY 2008 and, therefore, was not included in the 60-day validation analysis for that year.

- **CAH:** Of the 62 60-day validation surveys conducted in FYs 2008, 2009, and 2010, the SAs cited 41 facilities with condition-level deficiencies while the AOs did not cite comparable deficiencies in 37 facilities. The disparity rate is 60 percent.

  JC: The combined 60-day validation sample for FYs 2008, 2009, and 2010 included 55 surveys, a total that represented 14 percent of the surveys performed. The disparity rate is 58 percent based on the SAs citing condition-level deficiencies in 36 facilities and the AO citing comparable deficiencies in four facilities.

  AOA/HFAP: The 60-day validation sample for FYs 2008, 2009, and 2010 combined includes a total of seven hospitals. The disparity rate for the three-year period is 71 percent based on a 24 percent sample of the surveys performed. The SAs cited five facilities with condition-level deficiencies but the AO did not cite comparable findings.

- **HHA:** Of the 148 60-day validation surveys conducted in FYs 2008, 2009, and 2010, the SAs cited condition-level deficiencies in 29 HHAs. The AOs did not cite comparable deficiencies in 22 HHAs. Therefore, the disparity rate is 15 percent.

  JC: The 60-day validation sample for FYs 2008, 2009, and 2010 included 58 HHAs and resulted in a 24 percent disparity rate. The SAs cited 20 facilities with condition-level deficiencies and the AO did not cite comparable deficiencies in 14 surveys. These results are based on a four percent sample of the surveys conducted by the JC in the three FYs.

  ACHC: The 60-day validation sample included 15 HHA surveys over the three-year period. The SAs did not cite deficiencies on these validation surveys; therefore, the disparity and disagreement rates cannot be calculated.

  CHAP: In FYs 2008 through 2010, 75 60-day validation surveys were performed representing a five percent sample of the AO's surveys conducted for the three-year period. The SAs cited nine HHAs with condition-level deficiency citations; the AO did not cite comparable deficiencies in eight facilities resulting in an 11 percent disparity rate.

- **Hospice:** FY 2010 was the first year in which hospice 60-day validation surveys were conducted. The disparity rate is 25 percent based on a 60-day validation sample of 20 facilities. The SAs cited five facilities with condition-level deficiencies; the AOs did not cite comparable deficiencies for these facilities.

  JC: The 60-day validation sample included ten facilities, an eight percent sample of the surveys performed. The SAs cited no condition-level deficiencies; therefore, no further analysis was done.

  CHAP: The 60-day validation sample included ten surveys which was a six percent sample of the surveys performed. The SAs cited condition level deficiencies in five facilities. The AO did not cite comparable deficiencies in these facilities for a disparity rate of 50 percent.

Table 15:

THE JOINT COMMISSION HOSPITAL 60-DAY VALIDATION DISPARITY RATES (FYs 2000–2010)

Fiscal Year	Total Disparity Rate	Health and Safety CoPs only*	Physical Environment CoPs only*	Both Health/Safety and Physical Environment CoPs *
2000	27%	NA	NA	NA
2001	24%	NA	NA	NA
2002	22%	NA	NA	NA
2003	26%	NA	NA	NA
2004	27%	NA	NA	NA
2005	28%	4%	13%	11%
2006	25%	0%	18%	8%
2007	40%	7%	29%	4%
2008	32%	13%	13%	6%
2009	36%	10%	20%	4%
2010	36%	8%	21%	7%

* Data not available for FYs 2000 through 2004.

- **ASC:** Sixty-day validation surveys were not performed in FY 2010 as previously discussed. Of the 67 ASC 60-day validation surveys conducted for FYs 2008 and 2009, the SAs cited condition-level deficiencies in 29 facilities. The AOs did not cite comparable deficiencies in 28 facilities, for a disparity rate of 42 percent.

  JC: The 60-day validation sample for FYs 2008 and 2009 included 13 surveys. The SAs cited condition-level deficiencies in five facilities. The JC did not cite comparable deficiencies. The disparity rate is 38 percent based on a seven percent sample of the surveys completed over two years.

  AAAHC: The 60-day validation sample for FYs 2008 and 2009 included 52 surveys. SAs cited condition-level deficiencies in 22 facilities. The AO did not cite comparable deficiencies for 21 facilities, resulting in a disparity rate of 40 percent.

  AAAASF: The 60-day validation sample for FYs 2008 and 2009 included two surveys. The disparity and disagreement rates are not presented due to the small sample size.

Table 15 presents the history of the JC's hospital 60-day validation disparity rate for FYs 2000 through 2010. The total disparity rates for FY 2007 and subsequent years are higher than the disparity rates for the earlier years. Table 15 also divides the disparity rates into three components: (1) facilities cited for health and safety condition-level deficiencies only; (2) facilities cited for physical environment condition-level deficiencies only; and, (3) facilities cited for both health and safety, and physical environment condition-level deficiencies. The physical environment CoP accounts for the largest component of the overall disparity rate for most years where data is available.

Validation Performance Results: 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 CoPs. Table 16 presents the number of facilities that were cited by SAs for specific condition-level deficiencies and the number of comparable AO deficiencies cited.

- **Hospital:** As with the two previous years, the most prevalent condition-level deficiency cited by the SAs in FY 2010 was physical environment (deficiency cited for 39 of the 104 facilities in the sample). Comparable deficiencies were not cited by the AO for 32 of the 39 facilities. In FY 2009, the AO findings were closer to the SA findings on the physical environment CoP. Physical environment was cited in 30 of 88 validation surveys, with the AOs missing a lower percentage of deficiencies (14 facilities out of 30 deficiencies cited by SAs). In FY 2010, governing

body, infection control, quality assurance and performance improvement, and nursing services were the next most frequently cited CoPs by the SAs. Patterns for FYs 2008 and 2009 were similar.

- **CAH:** The SAs cited condition-level deficiencies for physical environment in 16 out of 23 facilities in FY 2010 with no comparable AO deficiency citations in 15 facilities. The pattern was similar for FY 2009, when physical environment was cited in 14 out of 22 facilities with the AOs had no comparable deficiency citations in 13 facilities. Physical environment was also the most frequently cited CoP in FY 2008. The clinical records CoP was cited for two facilities in FY 2010.

- **HHA:** The skilled nursing services condition was cited by the SAs for ten of the 76 facilities in the FY 2010 validation sample. Comparable AO deficiencies were not cited in six facilities. Other SA condition-level citations were: home health aide services; acceptance of patients, plan of care and medical supervision; organization services/administration; and, comprehensive patient assessment.

- **Hospice:** Analysis of the condition-level deficiencies for hospices is not presented in Table 14 due to the small sample size and the small number of deficiencies cited.

- **ASC:** The FY 2010 60-day validation sample did not include ASCs.

The physical environment condition continues to be the largest driver of the disparity rate. This issue was initially identified when the 60-day validation surveys included only the JC's hospital program; but the finding has been consistent for all AOs and facility types which have a physical environment condition. The AOs do not cite deficiencies comparable to SA condition-level deficiency citations related to the physical environment CoP, and more specifically, to the National Fire Protection Association Life Safety Code (LSC) requirements that CMS has adopted as part of its health and safety standards. CMS has been working with all AOs to provide guidance on the source of the problem and possible ways to improve performance.

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. The purpose of this analysis was to provide actionable information and education that would assist the AOs to strengthen their life safety code survey processes. The majority of the physical environment disparity consists of LSC deficiencies. CMS engineers identified the top ten disparate LSC deficiencies cited by the SA, but not cited by the AO. The top ten deficiencies are: extinguishment; means of egress; hazardous areas; detection, alarm, and communication systems; electric; corridor; heating, ventilating, and air conditioning; and minimum construction requirements. These ten deficiencies account for more than half of all LSC deficiencies. In addition, a gap in the average number of onsite life safety surveyor hours per survey provided by the AO versus the SA was identified. CMS also identified through this hospital validation survey analysis that the JC typically uses fewer onsite LSC surveyor hours per survey than do SAs. CMS engineers presented the results of this analysis to all AOs at the CMS-AO annual meeting in March 2011. All AOs are encouraged to utilize this information to strengthen their ability to evaluate compliance with the physical environment CoP and reduce disparity in this area.

Section 6: Ambulatory Surgery Center Representative Sample Validation Surveys

In its February 25, 2009 report on healthcare-associated infections in ASCs, the GAO recommended that the HHS develop and implement a written plan to use the infection control survey tool and methodology (then being tested in a CMS ASC pilot study) to conduct recurring periodic surveys of randomly selected ASCs.[5]

In order to implement the GAO recommendation within the context of the ASC-Healthcare Associated Infection (HAI) Initiative[6], CMS developed a randomly drawn sample of 72 deemed ASCs for validation surveys in thirty states selected through the annual budget and prioritization process. The sample size for each state in which a sample was drawn was based on the number of

[5] United States Government Accountability Office, Report to Congressional Requesters: Health-Care-Associated Infections – HHS Action Needed to Obtain Nationally Representative Data on Risks in Ambulatory Surgical Centers, February 2009 (GAO-09-213)

[6] This initiative provided SAs with funds for the execution and implementation of HAI reduction strategies by significantly expanding the awareness of proper infection control practices among ASCs through enhanced SA ability to identify deficient practices.

Table 16:

NUMBER AND TYPE OF CONDITION-LEVEL DEFICIENCIES CITED ON 60-DAY VALIDATION SURVEYS (FY 2010)

CONDITIONS OF PARTICIPATION	CITED BY STATE AGENCY	MISSED BY ACCREDITATION ORGANIZATION
Hospital Sample: 104		
Physical Environment	39	32
Governing Body	13	7
Infection Control	8	5
Quality Assurance	7	4
Nursing Services	6	1
Food/Dietetic	5	5
Surgical Services	5	4
Patient Rights	4	3
Pharmaceutical	3	0
Medical Staff	3	1
Discharge Planning	2	2
Anesthesia Services	1	1
Organ, Tissue, Eye Procurement	1	0
Outpatient Services	1	1
Emergency Services	1	1
TOTAL	99	67

CONDITIONS OF PARTICIPATION	CITED BY STATE AGENCY	MISSED BY ACCREDITATION ORGANIZATION
Critical Access Hospital Sample: 23		
Physical Environment	16	15
Clinical Records	2	2
Organizational Structure	1	1
Provision of Services	1	1
Periodic Evaluation	1	1
Surgical Services	1	1
TOTAL	22	21

Home Health Agency Sample: 76		
Skilled Nursing Services	10	6
HH Aide Services	7	4
Acceptance of Patients, Plan of Care	5	4
Organization Services	4	4
Comprehensive Patient Assessment	4	3
Professional Personnel	3	1
Therapy Services	2	2
Agency Evaluation	2	2
OASIS Reporting	1	1
Patient Rights	1	1
Clinical Records	1	0
TOTAL	40	28

Table 17:

MID-CYCLE VALIDATION SURVEYS: SAMPLE DESIGN FOR ASCS (FY 2010)

	Total Deemed ASCs	Total Validation Surveys
AAAHC	914	57
AAAASF	94	2
AOA	20	1
JC	293	12
TOTAL	1,321	72
Proportion of deemed facilities receiving validation surveys:	5.45%	

deemed ASCs in the state and the overall budget for ASC validation surveys. The 72 selected ASCs represented approximately five percent of deemed ASCs.

These ASC representative sample validation surveys were not traditional validation surveys conducted no more than 60 days after an AO survey of the same facility (as described in Section 5). Rather, these surveys were mid-cycle validations, conducted independent of a preceding AO survey. The intent was to create a representative national sample of deemed ASCs whose infection control practices, as identified on a tool used by ASC surveyors, the Centers for Disease Control and Prevention (CDC) could analyze and compare with practices in non-deemed ASCs. SAs were also instructed to survey one third of all non-deemed ASCs within their State, including within this group a five to eight percent subsample of ASCs randomly selected by CMS in each State. This CDC analysis of the ASC infection control survey tool results will be completed at a future date.

Mid-Cycle Validation Surveys: Sample Design and Analysis

This analysis reviews the condition-level deficiencies (i.e., serious deficiencies) as well as the deficiencies related to infection control that were identified in the sample of deemed ASCs by the SA. We will also compare the overall level of deemed ASC findings with those for all ASCs surveyed in FY 2010 by the SAs.

Sample Design: The sample design presented in Table 17 included 72 surveys for the four AOs with CMS-approved accreditation programs for ASCs. The validation sample is a five percent sample of the 1,321 deemed ASCs as described in Table 17.

Mid-Cycle Validation Results: Of the 72 selected and surveyed ASCs, SAs cited 65 condition-level deficiencies in 28 ASCs. The deficiencies cited in deemed status ASCs were concentrated in the areas of environment (primarily the LSC), infection control, and governing body, as shown in Table 18 and Graph 3. The remaining condition-level deficiencies were distributed among pharmaceutical services, patient rights, and surgical services.

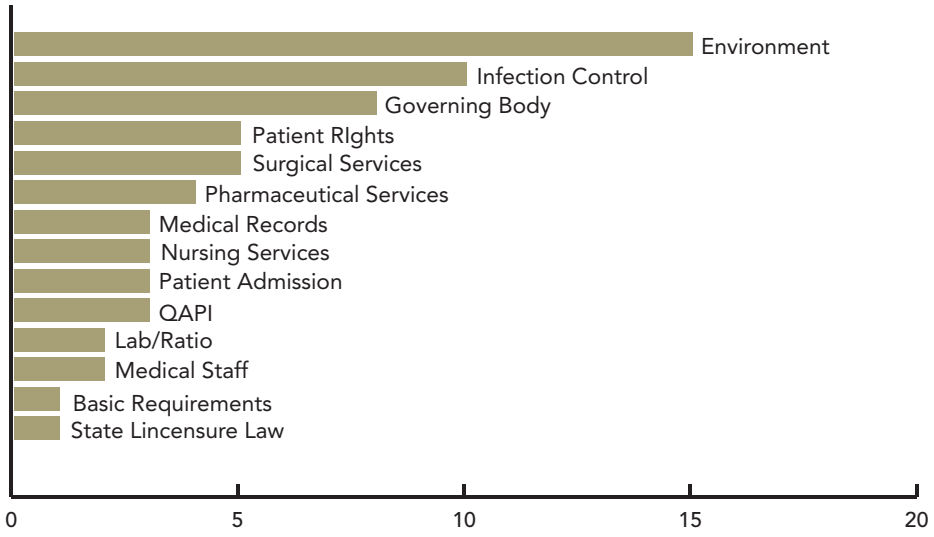
Table 18:

NUMBER AND TYPE OF CONDITION-LEVEL DEFICIENCIES CITED ON MID-CYCLE VALIDATION SURVEYS (FY 2010)

Ambulatory Surgery Center Sample: 72	
Condition for Coverage	**Cited by State Agency**
Environment	15
Life Safety Code	12
Health	3
Infection Control	10
Governing Body	8
Patient Rights	5
Surgical Services	5
Pharmaceutical Services	4
Medical Records	3
Nursing Service	3
Patient Admission, Assessment, and Discharge	3
Quality Assurance and Performance Improvement	3
Laboratory/Radiologic Services	2
Medical Staff	2
Basic Requirements	1
State Licensure Law	1
Total:	65

Graph 3:

NUMBER AND TYPE OF CONDITION-LEVEL DEFICIENCIES CITED ON MID-CYCLE VALIDATION SURVEYS (FY 2010)



Comparison between ASC Sample Validation Surveys and all FY 2010 ASC Surveys Conducted by SAs

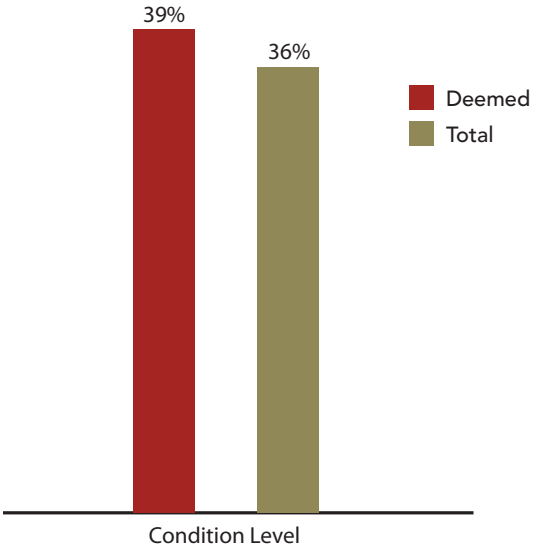
The following three graphs display a comparison of the 72 validation surveys conducted by SAs in deemed facilities and all 1,455 ASC surveys (deemed and non-deemed facilities) conducted by the SAs during FY 2010. CMS has been focusing on deficient infection control practices in ASCs and has conducted a preliminary analysis of both survey findings and infection control tools used by surveyors in FY 2010. This infection-control-focused analysis indicates that 40 percent of the deemed ASCs surveyed and 39 percent of the non-deemed ASCs surveyed had at least one lapse in injection practices. In addition, 20 percent of the deemed and 19 percent of the non-deemed surveys identified at least one lapse in environmental cleaning. Lastly, 34 percent of the deemed and 28 percent of the non-deemed surveys had at least one lapse in hand hygiene. The citation data shown in Graph 4 shows that 39 percent of the deemed facilities were found to have at least one condition-level citation, which is slightly more than the 36 percent of the total number of ASCs surveyed by SAs in FY 2010 that received at least one condition-level citation (with the exception of condition-level citations for infection control). It is not possible to ascertain with any certainty from the aggregated data why the infection control lapses identified on the worksheets show greater similarities between deemed and non-deemed ASCs than does the citation data for deemed ASCs compared to all ASCs.

Standard-level (less serious than condition-level) medication administration citations (where unsafe injection practices, among other lapses, would be cited) were also consistent between the deemed and total ASC surveys, resulting in 49 percent and 48 percent (respectively) of facilities receiving citations as shown in Graph 5. However, Graph 6 indicates that in the area of infection control condition-level citations, a notably smaller percent of deemed ASCs had citations: 14 percent in comparison to 21 percent of all ASCs surveyed.

Overall, this data suggests that there are no substantial differences between deemed and non-deemed ASCs, and therefore no significant difference in the ability of SAs and AOs to assure ongoing compliance with the CfCs. The CDC will be conducting a more detailed analysis of the worksheet data, which may or may not confirm and illuminate further these preliminary findings.

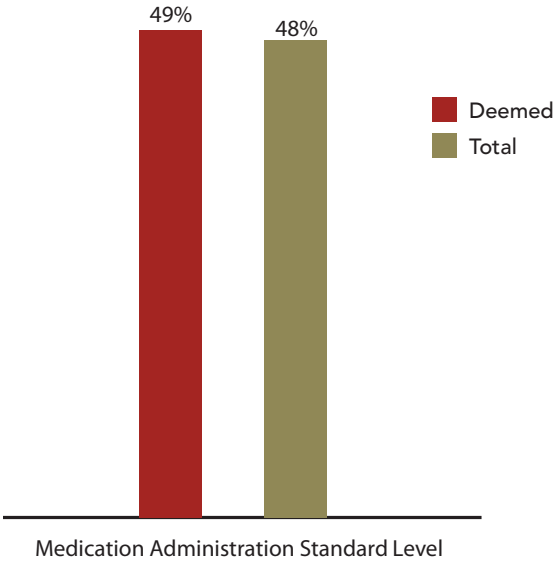
Graph 4:

CONDITION-LEVEL DEFICIENCIES DEEMED ASCs & ALL ASCs



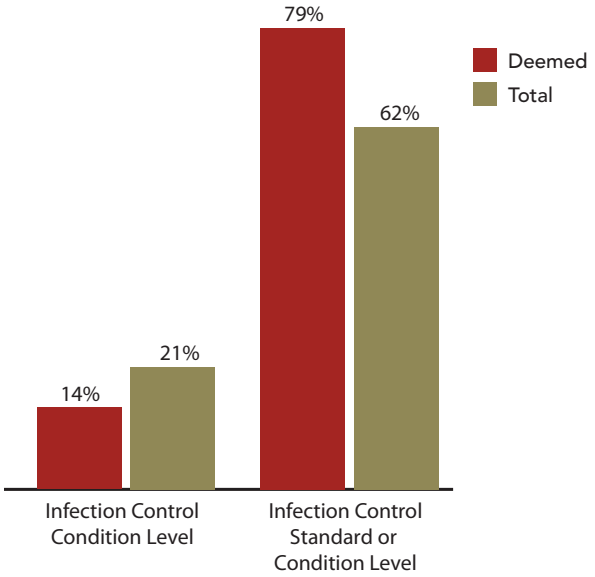
Graph 5:

MEDICATION ADMINISTRATION DEFICIENCIES DEEMED ASCs & ALL ASCs



Graph 6:

INFECTION CONTROL CITATION DATA: INFECTION CONTROL CONDITION- AND STANDARD- LEVEL DEFICIENCIES DEEMED ASCs & ALL ASCs



Section 7: Accreditation Organization Improvements Efforts

There is ongoing communication between CMS and the AOs regarding oversight activities, expectations, AO reporting, validation surveys and other requirements. As a continuation of that process, CMS requested that the AOs submit for inclusion in this annual report a summary of their activities to improve the operations of their approved accreditation programs. The following is the information as provided by all seven CMS-recognized AOs:

1. Accreditation Association for Ambulatory Health Care (AAAHC)

The AAAHC appreciates the opportunity to provide comments for the report to Congress about its ratings on the performance measures and has prepared the following comments:

- With respect to complete data for CMS certification numbers (CCNs), AAAHC has consistently scored 92 percent to 97 percent. AAAHC continues to communicate with the CMS ROs to confirm CCNs, as well as follow-up directly with the ASCs.

- With respect to the measure triennial surveys conducted timely, AAAHC has ensured thorough communication to CMS for the survey listings. AAAHC achieved a rating of 100 percent for the first quarter of FY 2011and will continue to provide feedback to CMS on the ASSURE database reports to maintain the highest rating.

- With respect to feedback about facility notification letters, AAAHC points out that significant policy changes regarding accreditation and Medicare deemed status terms have been implemented since the last report to Congress as a result of AAAHC's communication with CMS. Due to the time difference between implementation of revised policies and the processing of data by CMS, not all changes were evident in the data currently reported to Congress. AAAHC's compliance with CMS requirements is expected to be evident as future data are processed. In addition, AAAHC has continued to enhance its data system to support uploading information into the ASSURE program.

- With respect to feedback about the number of surveys reported as completed in ASSURE, AAAHC is continually refining the reconciliation processes to ensure data matches in all reports. CMS released specific procedures on how it measures these data and AAAHC has incorporated those procedures in its report preparation.

- The AAAHC is proud of its record of consistently attaining a 100 percent rating in 12 of 17 areas of performance measurement. The AAAHC continues to strive for a quarterly rating of 100 percent for all performance measures and will continue to work with CMS to ensure all data are accurate, timely, and meet CMS's reporting needs to the United States Congress.

2. Accreditation Commission for Health Care (ACHC)

ACHC inspires excellence in healthcare through a comprehensive accreditation approach. Enhancements have been made this year to ensure that the entire accreditation process is collaborative, educational and genuinely patient-focused:

- ***Ongoing Compliance and Certification ISO 9001:2008:*** ACHC's Quality Management System (QMS) promotes accuracy and consistency throughout all organizational operations. The QMS is audited through onsite visits annually by an outside registrar. The ISO quality policy statement commits ACHC to developing and improving health care accreditation programs and services, meeting customer and regulatory requirements, enhancing employee skills and efficiencies, continual improvement of quality management systems/processes, sustained fiscal growth, and improved market presence.

- ***Performance Excellence:*** The Malcolm Baldrige Criteria for Performance Excellence is being deployed company-wide. This business excellence model treats each organization as a series of interrelated systems which drive superior business outcomes. As a precursor to national submission, ACHC has submitted the Level 4 application for the North Carolina Awards for Excellence and is awaiting a site visit.

- ***Improved Surveyor Education:*** To ensure that all surveyors receive the optimum education, ACHC has instituted a new educational format. Enhanced tools were created with emphasis on understanding the Medicare CoPs.

- ***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 more comprehensive. All providers are currently using the standardized ACHC Plan of Correction form to ensure all components of the plan are comprehensively addressed.

3. American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

- ***AAAASF's Growth:*** AAAASF has been working over the last two years with CMS to achieve approval of our accreditation for Outpatient Physical Therapy/Rehabilitation Agencies (OPT/RA). We received approval April 23, 2011. The AAAASF Board of Director's vision is that AAAASF can be a stronger more fiscally sound organization with the development of these new programs. In an age when there is so much volatility in medicine, it is critical that AAAASF business not be solely dependent on a limited number of medical specialties.

- ***CMS Deemed Status:*** In 2010, CMS approval of AAAASF's ambulatory surgery center accreditation program was renewed. CMS made many changes to their conditions for coverage and this resulted in a total revision to the AO's Medicare Standards and entire operation.

- ***The Importance of Peer Review:*** An equally important area at AAAASF is the incorporation of the new OPT/RA Medicare Accreditation Program into the AO's nationally recognized Peer Review Patient Data System. Over the past decade, AAAASF has captured pertinent patient safety data from the AO's facilities for the benefit of all patients. Now, the soon to be completed project and development of adding this collated data by specialty will provide and share vital statistical information to the CDC, CMS, insurance companies and the GAO in the fight for infection control. AAAASF will continue to collect this data by specialty areas going into the future for all of the AO's approved Medicare-deemed programs, maintaining AAAASF in an unrivaled patient safety data clearinghouse position.

- ***Data Tracking Systems:*** AAAASF has improved the automation of several ASSURE reporting fields and has experienced a significant improvement in performance measures related to ASSURE reporting. The AAAASF staff has continued dialogue with Medicare personnel to improve compliance with performance measures related to notification letters, survey scheduling, and data matching between CMS and AAAASF internal databases. These performance scores have also improved over last year. As CMS continues to release patches and revisions to ASSURE, AAAASF responds as quickly as possible with compatible programming to accommodate the changing data needs. Collaboration has been positive and continues to produce tangible improvements to the reporting process. One such improvement has been the anticipation by AAAASF and CMS personnel of the newly deemed AAAASF OPT program which has been incorporated into ASSURE for reporting purposes. AAAASF continues to seek the best possible understanding of Medicare's reporting needs and to improve the management of facility and survey data to best fit those requirements. The ongoing development has progressed a great deal in the past year but will continue for several more before becoming a stationary target which will provide the greatest opportunity to consistently achieve perfect scoring.

- ***Personnel Additions:*** Additional staff is being added to manage the increased amount of Medicare and regular accreditation business growing at AAAASF. The AAAASF central office physical premises is also expanding, with the addition of more office square footage space providing new offices for additional staff, and protected file storage space for AAAASF's Medicare and regular accreditation archival purposes. In addition to onsite record storage, AAAASF also maintains off-site, temperature-controlled archival storage as mandated.

- ***Surveyor Education:***
  - *Web Academy:* AAAASF is in the final stages of development for the AAAASF Web Academy. This new training site will be linked to the AO's current Surveyor's website, and will allow AAAASF surveyors to login and participate in Webinars developed to assist them in maintaining their surveyor's certification and knowledge levels. New CMS regulatory information will be available immediately as released to AAAASF on the Web Academy site, keeping the AO's

surveyors up to date and well-informed at all times. The Web Academy will contain dynamic course content created by the AAAASF Education Committee, and it will also give AAAASF the ability to 'track' surveyor's compliance of successful completion of the required Webinars.

- *Medicare Surveyor's DVD:* A brand new DVD produced by AAAASF for assisting AAAASF Medicare surveyors is scheduled for release this summer in 2011. This DVD takes Medicare surveyors through the entire survey process, from beginning to end, and was created to support and assist all AAAASF Medicare surveyors in their work.

- ***Quality Assurance:*** AAAASF's Quality Assurance and Surveyor's Oversight Committee continues to monitor the progress of surveyors via reporting systems in place such as surveyor educational compliance, and performance surveys received from surveyed facilities. The Committee oversees and reviews all compliments, comments and complaints received by AAAASF staff concerning surveyors, and manages surveyor retraining accordingly.

- ***Future Focus:*** AAAASF's Board of Directors continues to actively support their approved and aggressive five-year strategic plan for continued growth in partnership with the Medicare sector to fund and support the adding of additional medical specialties for AAAASF/Medicare planned deeming now and into the future.

4. American Osteopathic Association/ Healthcare Facilities Accreditation Program (AOA/HFAP)

Under its internal Quality Assessment Performance Improvement initiative, HFAP established monthly internal audits of its entire accreditation process to help assure timeliness and thoroughness of all procedures. These audits monitor the processes and procedures of staff, surveyors, and the Bureau of Healthcare Facilities Accreditation (BHFA) (the accreditation oversight and decision making body appointed by the American Osteopathic Association's Board of Trustees, and the Executive Committee of the Board of Trustees) and the Executive Committee of the BHFA. Areas of implemented improvements include but are not limited:

1. Establishment of minimum competency standards for surveyor performance;
2. Revision of internal tracking tools to cover all elements of the survey process;
3. Implementation of tools to track surveyor compliance with appropriate documentation of deficiencies;
4. Ensured that resurveys are conducted in accordance with CMS requirements; and
5. Redevelopment of the system for processing complaints against HFAP accredited facilities to ensure timely response and follow-up.

Each month staff reviews a variety of processes and activities to assure that the program enhancements indicated in the final notice of renewal of HFAP deeming authority September 25, 2009 are maintained. During the past year HFAP has implemented a variety of new initiatives that they believe will enhance the value of HFAP to its facilities:

- ***Expanded Deeming Authority:*** The AOA/ HFAP is pleased to announce that it has been granted deeming authority from the Substance Abuse Mental Health Services (SAMHSA) to accredit mental health facilities with Opioid Treatment Services.

- ***HFAP Blog:*** An HFAP Blog was implemented to provide HFAP facilities with a communication path to read and respond to HFAP initiatives, program enhancement and other related business (http://www.hfap.org/blog).

- ***HFAP Accreditation Program Group (Online Forum):*** This discussion group is intended to assist HFAP facilities in networking with colleagues and peers across the country. The goal of this group is to offer HFAP facilities a venue whereby they can share ideas, lessons learned, best practices, interpretations of standards, and processes that have been successfully implemented in order to meet various HFAP standards. The sharing of information and participation is voluntary and no contract information will be shared with outside entities (http://health.groups.yahoo.com/group/hfap_accreditation).

- ***Dual Track Medical Record Review Process:*** This dual track system will incorporate the current Track 1 of reviewing both open and closed medical records. Track 2 will incorporate a review of a patient's progress through the facility from admission through discharge.

- ***Expansion of the Range of Accreditation Decisions Available to the BHFA and its Executive Committee:*** When completed this expansion will incorporate increased oversight for facilities based on the number and weight of the deficiencies cited during onsite surveys.

- ***LSC Waiver Process:*** As a result of the CMS decision that all waivers of the NFPA 101 LSC from Fire Edition 2000, be made exclusively by the CMS ROs, HFAP updated its processes to address and implement this change. In addition, the HFAP form related to requests for waivers of LSC was updated to incorporate explanations of the difference between compliance with code, code-specified alternatives and equivalency methodologies.

- ***ASC-QC Collaboration:*** HFAP participates in the Ambulatory Surgical Center Quality Collaboration (ASC QC). Ambulatory Surgical centers voluntarily report on six facility-level measures that have been developed by the ASC QC and endorsed by the National Quality Forum. To assist ASC facilities improve their internal quality monitoring and improvement processes, HFAP has also provided a link to the ASC-QC website to provide ASC facilities additional exposure to a variety of "toolkits" available at no charge on the ASC-QC website. The toolkits address the following topics: Hand Hygiene, Safe Injection Practices, Point of Care Devices, Environmental Infection Prevention, Single Use Device Reprocessing, Endoscopic Reprocessing and High Level Disinfection and Sterilization.

5. Community Health Accreditation Program (CHAP)

The following are the key improvement activities that CHAP undertook to manage and improve deemed home health and hospice programs during the most recent Federal FY:

- Updated accreditation policies to more clearly and specifically note timing and communication of deemed status surveys, and follow-up.

- Extensively upgraded CHAP website to provide improved provider education about accreditation policies and procedures.

- Provided a series of provider education webinars to address the top 10 deficient practices identified in 2009 for home health and hospice; including the related CMS tags where appropriate, and education on intent of standard, expected performance and rationale.

- Enhanced Site Visitor training and oversight to provide small regional meetings for face to face instruction, and a supervisory visit for each site visitor from the Director.

- Enhanced Site Visitor education and policies to include changes in distribution of clinical record review with and without home visits in response to changes in CMS home health survey procedures.

- Enhanced Site Visitor orientation and in-service programs to include case studies and hands-on application of knowledge and skills in the classroom setting.

- Expanded automated tools for plans of correction and management oversight of timeliness of notifying organizations of deficiencies.

- Updated provider notification letters to ensure consistent communication of CMS required elements.

- Worked closely with CMS staff to problem solve around CMS performance measures and use of ASSURE.

- Use of CMS validation surveys for Site Vistor education and internal performance improvement to help ensure consistent application of standards and CMS tags.

6. Det Norske Veritas Health Care (DNVHC)

DNVHC is pleased to provide information describing improvements regarding the AO's accreditation program for FY 2010. The following describes the actions and other measures taken to further develop the effectiveness of the DNVHC accreditation program:

- ***Quality Management System Training:*** is presented as an option to hospitals that are DNVHC clients. Client organizations can proceed with a training course designed to be provided to learn the concepts and methodology for implementation of the infrastructure of a quality management system designed to complement accreditation requirement. This training course further supports compliance and development of the

quality management system for the hospital:

- Provide the relationship between ISO 9001, NIAHO℠ and regulatory requirements;
- Develop the business application of ISO9001;
- Overview of management systems in healthcare; and
- Implementation and validation of the quality managements system.

- ***Continuing Surveyor Education:*** DNVHC continues to develop and refine training modules through Articulate® and other media to further educate surveyors regarding accreditation requirements and interpretive guidelines, ISO 9001 training, as well as report writing modules, submissions and templates, timelines, to further improve the documentation of findings as a part of the survey process.

- ***Increase of dedicated staff for accreditation activities:*** DNVHC has increased the staff dedicated to accreditation activities and hired additional surveyors. The AO has expanded the accreditation department to improve the consistency of survey reports and survey findings, focus on surveyor development, and improve the response and feedback to accredited organizations.

- ***BS OHSAS 18001:2007 Certification:*** DNV achieved certification to the OHSAS 18001:2007. OHSAS 18001:2007 is an occupational health and safety management standard. It defines a set of occupational health and safety (OH&S) management requirements for occupational health and safety management systems (OHSMS).

- ***Management Standard on Biorisk:*** Developed first and only management standard on Biorisk – CWA 15793, sponsored by 24 countries (co-shared with U.S. Department of Agriculture).

DNVHC continues to improve its internal processes based on communication and feedback from the CMS Survey & Certification Group. The CMS Central and Regional Offices provide copies of the reports for Validation Surveys completed of DNV accredited hospitals. This in turn is provided as a means to educate and inform surveyor cadre to improve the consistency of the survey process. This process has been very beneficial to improve the AO's methods for reporting and receiving information to further improve the accreditation process and continue meeting the expectations of CMS.

7. The Joint Commission (JC)

In accordance with its mission *"…to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value,"* the JC continues to evaluate and improve its accreditation processes to help insure that they are contemporary, comprehensive, objective, and measurable. To that end, during the past year, improvement activities have included:

- Changing the JC's policy to conduct all triennial surveys within 36 months, rather than 39 months, after the organization's previous triennial survey.
- Establishing a policy whereby all hospital surveys have a life safety code specialist for a minimum of two days in order to be sure the environment of care area is comprehensively evaluated.
- Increasing surveyor education and technology resources to heighten awareness of potential healthcare compliance issues and promote critical evaluation of serious patient safety issues.
- Leveraging organizational data to monitor performance and guide actions taken by the JC so that surveys are completed based on the facility's conduct, allowing issues to be addressed not only during a triennial survey, but on an as-necessary basis.
- Initiating the use of the "second-generation" tracer methodology that allows surveyors to track patients' courses of care throughout their facility stay to provide for a more thorough evaluation of additional treatment areas such as the cleaning of endoscopy equipment, diagnostic radiology, and contracted services.
- Permitting surveyors to adjust the "template" survey agenda on-site when survey duration and activity time allotment evaluation indicates that additional time or manpower is necessary for the comprehensive assessment of a facility.
- Utilizing additional performance data for consideration in the accreditation process, whereby organizational performance may either positively or adversely affect a facility's accreditation.

- Providing urgent safety information to the field on sentinel events, such as prevention of maternal death, prevention violence in health care settings, and preventing suicide in emergency departments and medical/surgical units.

- Issuing guidance for hospitals for advancing effective communication, patient-centered care, and cultural competence within their facilities.

- Implementing a new National Patient Safety Goal for the second half of 2011 aimed at improving medication reconciliation practices within health care organizations.

- Proposing nine new performance measures for the Advanced Certification in Heart Failure program, targeted at evaluating care in heart failure patients with an emphasis on care transitions from inpatient to outpatient settings.

- Launching online solution tools and resources for the JC accredited health care organizations to enhance the efforts made in addressing issues such as hand hygiene, surgical site infections, and hand-off communications.

8. Centers for Medicare & Medicaid Services Oversight Improvement

The volume of facilities that participate in the Medicare and Medicaid programs through accreditation by a CMS-approved accreditation program and are awarded deemed status by CMS continued to grow in FY 2010. Currently, 38 percent of all Medicare-participating facilities that have an approved accreditation option, more than 10,000 facilities, demonstrate compliance with the Medicare requirements and receive Medicare reimbursement via their deemed status. There are currently seven CMS-recognized AOs and 18 approved programs. CMS continues to strengthen its oversight as the number of CMS-recognized AOs, CMS-approved accreditation programs, and deemed facilities increases. Over the past few years, CMS has focused on developing and implementing an effective oversight infrastructure, including rebuilding systems and processes, data exchange between AOs and CMS regarding deemed facilities, data management and analysis, CMS–AO communication and relationship building, AO education, and performance management. CMS continues its focus on these core functions and is increasing its efforts to assist the AOs to utilize the data which they have entered into the ASSURE data system for continuous performance improvement and self monitoring.

- **Deeming Application Reviews.** Deeming application and standards reviews are conducted by a team of trained analysts to ensure consistent application of a standardized rigorous review methodology. All findings are subject to detailed supervisory review to enhance reliability and consistency. As a result, AO applications and standards are reviewed more comprehensively and consistently, and more areas for improvement are being identified and communicated to the AOs for correction before applications may be approved. In FY 2010, the team completed eight deeming application reviews (including one renewal of an existing program, one initial application, two conditional approvals, two final approvals removing conditional approval and two applications withdrawn prior to publication). Other deeming program review activity included three 180-day deeming authority reviews, 19 standards reviews, and five survey process and surveyor guidance revisions. For AOs that receive a four-year term of renewal, CMS conducts follow up corporate onsite visits and survey observations within one year to validate continued compliance with the provisions set forth in the final notice. In addition, for AOs that receive a conditional probationary approval, a written plan of correction, monthly AO progress reports, and follow up corporate onsite survey or survey observation are required.

- **Accreditation Organization Reporting on Deemed Facilities.** CMS continues to focus on obtaining complete, accurate and timely deemed facility data from AOs. This has been a major challenge for both CMS and the AOs. In October 2009, CMS went live with, the first-ever, electronic database to inventory and track AO actions that affect the deemed status of a facility. This database, ASSURE, enables the AOs to provide demographic and survey activity information for deemed facilities to CMS on a quarterly basis. It provides both CMS and the AOs with the means to collect, analyze, and manage data regarding deemed facilities, and has improved CMS oversight of the AOs and their CMS-approved accreditation programs. This electronic database replaced the manual, more labor-intensive processes for AO data submissions, and CMS tracking and monitoring of deemed facility activity.

- **Ongoing Communications with Accreditation Organizations.** CMS continues its series of periodic meetings with recognized national

AOs, including quarterly teleconferences and an annual face-to-face meeting. These meetings serve to foster communication between the AOs and CMS, and serve as a forum to: discuss any issues as they arise; better assure ongoing deemed facility compliance with Medicare conditions; and, provide information and education for AO staff. CMS and individual AOs communicate on a weekly, if not daily, basis, either by email or telephone, to address a wide variety of issues related to: deemed facilities, operations, surveys, and data. In addition, CMS implemented dedicated electronic mailboxes for use by AOs when submitting deemed facility notification letters and other required reports to CMS. Finally, CMS standardized the communication of written feedback to AOs during the deeming application review process.

- **Ongoing Education and Support of Accreditation Organizations.** AO staff is afforded many opportunities for education. CMS provides detailed 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 State Operations Manual 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. This year, CMS updated its AO resource manual. This resource manual contains a wide variety of information on CMS requirements and expectations of AO performance. In addition, the CMS-AO meeting this year included breakout sessions on topics of interest to the AOs and interactive sessions utilizing actual ASSURE data for each AO.

- **Methodological Changes to Improve Oversight.** CMS continues to refine and improve the current methods for measuring AO performance in assuring compliance with the Medicare requirements. In FY 2008, CMS implemented the first-ever performance measures for the AOs (see Table 4). Implementation of the electronic data base, ASSURE, permitted further refinement and expansion of the performance measures in FY 2010. During the CMS-AO meeting this year, AO staff reviewed their organization's data and calculated selected performance measures. By working with the data, AOs are better able to understand their data, data issues, as well as how to improve their documentation.

- **Validation Program Sample Size.** CMS' budget for FY 2010 permitted CMS to increase the representative sample validation program more than what was possible in FYs 2005–2009. For FY 2010, additional resources were provided to allow further expansion of the program across deemed providers and suppliers. Consequently, CMS steadily increased the number of validation surveys conducted from 90 in FY 2007 to 295 in FY 2010. This represents an increase of nearly to 228 percent, including both 60-day validation and special, mid-cycle ASC validations. Not only has the total number of validations surveys conducted increased, but the number of 60-day validation surveys conducted for each AO and facility type has also increased. As sample sizes increase, so does the reliability and validity of the analysis. The increase in the funding has also enabled CMS to include hospices in the FY 2010 validation surveys. Currently, all deemed facility types are included in the validation program.

- **Emergency Preparedness.** CMS continues to collaborate and communicate with AOs on strategies for improved health care facility emergency preparedness in response to all hazards regardless of the magnitude. Close collaboration with the JC in the aftermath of Hurricane Katrina in 2005, as well as collaboration with the AOs regarding Midwest flooding in 2010 and Missouri tornadoes in 2011, highlights the importance of close coordination between CMS and the AOs.

- **Quality Assessment and Performance Improvement.** In FYs 2007 through 2009, CMS added requirements to its conditions for hospices, transplant hospitals, dialysis facilities, and ASCs that these facilities have an effectively-working, internal quality assessment and performance improvement (QAPI) system. As part of the Department of Health and Human Services Partnership for Patients initiative launched in April 2011, CMS is focusing on reducing hospital readmissions and healthcare acquired conditions. One aspect of CMS' efforts in this area targets strengthening the survey process, revising surveyor guidance, and developing and testing surveyor tools related to the evaluation of a hospital's compliance with the CoPs for QAPI, Infection Control and Discharge Planning. AOs with approved hospital accreditation programs have been invited to participate and partner with CMS in this initiative.

- **Physical Environment.** In FY 2010, CMS Life Safety Engineers completed an analysis of AO and SA physical environment findings for validation surveys conducted in FYs 2006 through 2009. The purpose of this analysis was to provide information and education that would assist the AOs to strengthen their survey process in this area. The majority of the physical environment disparity consists of LSC deficiencies. The CMS Engineers identified the top ten disparate deficiencies for LSC cited by the SA, but not cited by the AO. These ten deficiencies account for more than half of all LSC deficiencies. In addition, a gap in the average number of onsite life safety surveyor hours per survey provided by the AO versus the SA was identified. We identified through this hospital validation survey analysis that the JC typically uses fewer onsite LSC surveyor hours per survey than do SAs. The CMS Engineers presented the results of this analysis to all AOs at the CMS-AO annual meeting in March 2011. All AOs are encouraged to utilize this information to strengthen their ability to evaluate compliance with the physical environment CoP and reduce disparity in this area.

CLINICAL LABORATORY IMPROVEMENT VALIDATION PROGRAM

Introduction

This report on the Clinical Laboratory Improvement Validation Program covers the evaluations of fiscal year (FY) 2010 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 can re-evaluate whether the accreditation organization continues to meet the criteria for an approved accreditation organization (also called "deeming authority"). Section 493.575 further provides that CMS has the discretion to conduct a review of an accreditation organization program if validation review findings, irrespective of the rate of disparity, indicate such widespread or systematic problems in the organization's accreditation process that the requirements are no longer equivalent to CLIA requirements.

Validation Reviews

The validation review methodology focuses on the actual implementation of an organization's accreditation program described in its request for approval. The accreditation organization's standards, as a whole, were approved by CMS as being equivalent to or more stringent than, the CLIA condition-level requirements[7], as a whole. This equivalency is the basis for granting deeming authority.

In evaluating an organization's performance, it is important to examine whether the organization's inspection findings are similar to the CLIA validation survey findings. It is also important to examine whether the organization's inspection process sufficiently identifies, brings about correction, and monitors for sustained correction, laboratory practices and outcomes that do not meet their accreditation standards, so that equivalency of the accreditation program is maintained.

The organization's inspection findings are compared, case-by-case for each laboratory in the sample, to the CLIA validation survey findings at the condition level. If it is reasonable to conclude that one or more of those condition-level deficiencies were present in the laboratory's operations at the time of the organization's inspection, yet the inspection results did not note them, the case is a disparity. When all of the cases in each sample have been reviewed, the "rate of disparity" for each organization is calculated by dividing the number of disparate cases by the total number of validation surveys, in the manner prescribed by section 493.2 of the CLIA regulations.

Number of Validation Surveys Performed

As directed by the CLIA statute, the number of validation surveys should be sufficient to "allow a reasonable estimate of the performance" of each accreditation organization. A representative sample of the approximately 17,000 accredited laboratories received a validation survey in 2010. Laboratories seek and relinquish accreditation on an ongoing basis, so the number of laboratories accredited by an organization during any given year fluctuates. Moreover, many laboratories are accredited by more than one organization. Each laboratory holding a Certificate of Accreditation, however, is subject to only one validation survey for the accreditation organization it designates for CLIA compliance, irrespective of the number of accreditations it attains.

Nationwide, fewer than 500 of the accredited laboratories used AABB, AOA, or ASHI accreditation for CLIA purposes. Given these proportions, very few validation surveys were performed in laboratories accredited by those organizations. The overwhelming majority of accredited laboratories in the CLIA program used their accreditation by COLA, the College or the JC, thus the sample sizes for these organizations were larger. The sample sizes are roughly proportionate to each organization's representation in the universe of accredited laboratories; however, true proportionality is not always possible due to the complexities of scheduling.

The number of validation surveys performed for each organization is specified below in the summary findings for the organization.

[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.

Results of the Validation Reviews of Each Accreditation Organization

AABB

***Rate of disparity:* zero percent**

In FY 2010, approximately 220 laboratories used their AABB accreditation for CLIA program purposes. Validation surveys were conducted in eight AABB-accredited laboratories. No condition-level deficiencies were cited in any of the validation surveys. When each validation survey results in compliance with the applicable CLIA condition-level requirements, as is the case with AABB-accredited laboratories this year, disparity is precluded. The AABB is to be commended for this outcome.

American Osteopathic Association

***Rate of disparity:* 10 percent**

For CLIA purposes, approximately 80 laboratories used their AOA accreditation. Eleven validation surveys were conducted. One survey was removed from the validation review pool for administrative reasons. Of the remaining 10 validation surveys, eight had no condition-level deficiency citations; thus, two AOA-accredited laboratories were cited with condition-level deficiencies. One of the AOA inspection reports did not have comparable findings for the condition-level deficiency cited, thus it is a disparity. As a consequence, this sole disparity accounts for the 10 percent disparity rate because the review pool is small. The outcome this year is a significant improvement compared to the 17 percent disparity rate last year.

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 six ASHI-accredited laboratories. No condition-level deficiencies were cited in any of the validation surveys. When each validation survey results in compliance with the CLIA condition-level requirements, as is the case with the ASHI-accredited laboratories this year, disparity is precluded.

The ASHI is to be commended for its history of zero percent disparity in 14 out of 15 validation reviews.

COLA

***Rate of disparity:* 12 percent**

A total of 159 validation surveys were conducted in COLA-accredited laboratories. Three surveys were removed from the review pool for administrative reasons. Of the remaining 156 surveys, 21 laboratories were cited with condition-level deficiencies. In three of those laboratories, COLA noted deficiencies comparable to all of the CLIA condition-level deficiencies cited. In 18 of the laboratories, however, COLA noted comparable deficiencies to only some or none of the CLIA condition-level deficiencies cited; thus, there were 18 disparate cases. The disparity rate this year is an improvement compared to the 18 percent disparity rate last year.

College of American Pathologists

***Rate of disparity:* six percent**

A total of 111 validation surveys were conducted in CAP-accredited laboratories. Nine laboratories were cited with CLIA condition-level deficiencies. In two of those laboratories, the College noted comparable deficiencies to all of the CLIA condition-level deficiencies cited. In the other seven laboratories, the College noted comparable deficiencies to only some or none of the CLIA condition-level deficiencies cited; thus, there were seven disparate cases. The disparity rate this year is a significant improvement compared to the results of the previous two years: 12 percent and 14 percent respectively.

The Joint Commission

***Rate of disparity:* 14 percent**

During this validation period, a total of 80 validation surveys were conducted in JC-accredited laboratories. One survey was removed from the validation review pool for administrative reasons. Of the remaining 79 validation surveys, 13 laboratories were cited with CLIA condition-level deficiencies. In two of those laboratories, the JC noted deficiencies comparable to all of the CLIA condition-level deficiencies cited. In the other 11 laboratories, the JC noted comparable deficiencies to only some or none of the CLIA condition-level deficiencies cited; thus, there were 11 disparate cases. The outcome for the JC this year is slightly lower than the 15 percent disparity rate last year.

Conclusion

CMS has performed this 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. CMS has indicated to the organizations in the last several years, another important measure is an organization's capability to ensure sustained equivalency. That is, when an accredited laboratory's practices and outcomes waiver from full conformance to the accreditation standards, does the accreditation organization's inspection protocol sufficiently identify, bring about correction and monitor for sustained correction, 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, which includes the six accreditation organizations, and addresses these issues on an ongoing basis. The Partners in Laboratory Oversight group meets regularly to discuss and resolve issues of mutual interest and to share best practices. This group endeavors to improve their overall consistency in application of laboratory standards, coordination, collaboration and communication in both routine and emergent situations, which ultimately improves the level of laboratory oversight.

GLOSSARY

A

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

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

Actuarial Soundness: A measure of the adequacy of Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) financing as determined by the difference between trust fund assets and liabilities for specified periods.

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

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

B

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

Beneficiary: A person entitled under the law to receive Medicare or Medicaid benefits (also referred to as an enrollee).

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

C

Carrier: A private business, typically an insurance company, that contracts with CMS to receive, review, and pay physician and supplier claims. Carriers have been largely replaced by Medicare Administrative Contractors.

Cash Basis Accounting: A basis of accounting that tracks outlays or new expenditures during the current period regardless of the fiscal year the service was provided or the expenditure was incurred.

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.

Chief Financial Officers Act of 1990 (CFO): The CFO Act of 1990 established a leadership structure, provided for long range planning, required audited financial statements, and strengthened accountability reporting. The aim of the CFO Act is to improve financial management systems and information, and requires the development and maintenance of agency financial management systems that comply with: applicable accounting principles, standards, and requirements; internal control standards; and requirements of OMB, the Department of the Treasury, and others.

Corrective Action Plan: The detailed actions that are taken to resolve an audit finding or internal control deficiency.

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.

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

D

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

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

Discretionary Spending: Outlays of funds subject to the Federal appropriations process.

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

Durable Medical Equipment (DME): Purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

Durable Medical Equipment Medicare Administrative Contractors (DME MACS): In an effort to provide greater efficiency in the Medicare program as it applies to Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), CMS awarded contracts to four health care contractors which cover a specific geographic region of the country and only processes Medicare claims for DMEPOS items.

E

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

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

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

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 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.

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.

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.

Fiscal Intermediary Shared System (FISS): The shared claims adjudication system for Part A Medicare claims.

H

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Major provisions include portability provisions for group and individual health insurance, established the Medicare Integrity Program, and provides for standardization of health data and privacy of health records.

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

I

Improper Payments Elimination and Recovery Act (IPERA): In FY 2010, Congress amended the Improper Payment Information Act (IPIA), which is now known as the Improper Payment Eliminations and Recovery Act (IPERA) (Public Law 111-204), to aim in standardizing the way Federal agencies report improper payments in programs they oversee or administer. The IPERA includes requirements for identifying and reporting improper payments and defines improper payments as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments). Incorrect payments also include payments to ineligible recipients or payments for ineligible services, as well as duplicate payments and payments for services not received.

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

Internal Controls: Are management's tools, such as the organization's policies and procedures that help program and financial managers achieve results and safeguard the integrity of their programs. Such controls include, program, operational, and administrative areas, as well as accounting and financial management.

M

Mandatory Spending: Outlays for entitlement programs such as Medicaid and Medicare benefits.

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

Medical Review/Utilization Review (MR/UR): Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

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

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

Multi-Carrier System (MCS): The shared claims adjudication system for Part B Medicare claims.

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

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA): Legislation passed that established a new program in Medicare to provide a prescription drug benefit, Medicare Part D, which became available on January 1, 2006. Additionally, MMA sets forth numerous changes to existing programs, including a revised managed care program, certain payment reforms, rural health care improvements, and other changes involving administrative improvements, regulatory reduction, administrative appeals, and contracting reform.

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

Medicare 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.

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.

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. It also puts the budget on a more stable path, since it is expected to reduce the deficit over the next ten years.

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

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

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

Q

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

R

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

Revenue: The recognition of income earned and the use of appropriated capital from the rendering of services in the current period.

Risk-Based Health Maintenance Organization (HMO)/Competitive Medical Plan (CMP): A type of managed care organization. After any applicable deductible or co-payment, all of an enrollee/member's medical care costs are paid for in return for a monthly premium. However, due to the "lock-in" provision, all of the enrollee/member's services (except for out-of-area emergency services) must be arranged for by the risk HMO. Should the Medicare enrollee/member choose to obtain service not arranged for by the plan, he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for services from providers that are not part of the HMO's health care system/network.

S

Statement on Auditing Standards No. 70: A report issued by an independent public accountant in accordance with standards promulgated by American Institute of Certified Public Accountants (AICPA) on the internal controls of a servicing organization. AICPA SAS 70 defines the professional standard used by a service organization's auditor to assess the internal controls at a service organization.

Self Employment Contribution Act (SECA) Payroll Tax: Medicare's share of SECA is used to fund the HI trust fund. Self-employed individuals contribute 2.9 percent of taxable annual net income, with no limitation.

Significant Deficiency: A deficiency or 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.

State Certification: Inspections of Medicare provider facilities to ensure compliance with Federal health, safety, and program standards.

Supplementary Medical Insurance (SMI) (Part B): The part of Medicare that pays physician and supplier claims.

T

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

V

ViPS Medicare System (VMS): The standard claims adjudication system for Medicare Durable Medical Equipment (DME) claims.

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