CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

TRANSFORMING HEALTH CARE
FOR ALL AMERICANS

Financial Report

FISCAL YEAR 2014

14

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AT A GLANCE

The Centers for Medicare & Medicaid Services (CMS) is an Operating Division within the Department of Health and Human Services (HHS). The CMS Annual Financial Report for FY 2014 presents the agency's detailed financial information relative to our mission and the stewardship of those resources entrusted to us. This report is organized into the following three sections:

1 MANAGEMENT'S DISCUSSION & ANALYSIS:

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

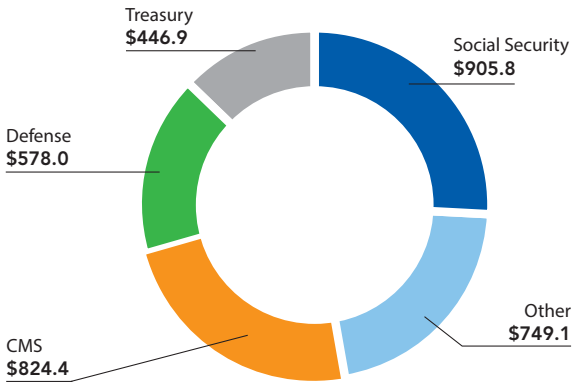
2 FINANCIAL SECTION:

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

3 OTHER INFORMATION:

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

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



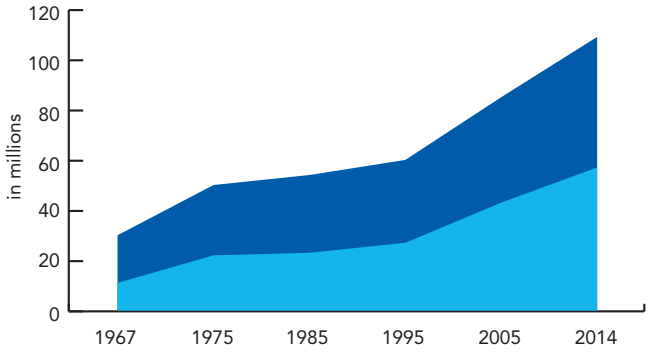
$ in billions

Source: U.S. Treasury

2014 FEDERAL OUTLAYS

CMS has outlays of approximately $824.4. billion (net of offsetting receipts and Payments of the Health Care Trust Funds) in fiscal year (FY) 2014, approximately 24 percent of total Federal outlays.

CMS has almost 6,000 Federal employees, but does most of its work through third parties. CMS and its contractors process over one billion Medicare claims annually, monitor quality of care, provide the states with matching funds for Medicaid benefits, and develop policies and procedures designed to give the best possible service to beneficiaries. CMS also assures the safety and quality of medical facilities, provides health insurance protection to workers changing jobs, and maintains the largest collection of health care data in the United States.



2014 PROGRAM ENROLLMENT

CMS is one of the largest purchasers of health care in the world. Medicare, Medicaid, and Children's Health Insurance Program (CHIP) provide health care for one in four Americans. Medicare enrollment has increased from 19 million beneficiaries in 1966 to approximately 54 million beneficiaries. Medicaid enrollment has increased from 10 million beneficiaries in 1967 to about 64 million beneficiaries.

A MESSAGE FROM THE ADMINISTRATOR

MARILYN TAVENNER

In Fiscal Year 2014, the Centers for Medicare & Medicaid Services (CMS) moved closer to fulfilling its vision of a high quality health care system that ensures better care, access to coverage and improved health. Efforts to focus on transparency, accountability and availability of health care, which we provide to so many Americans, are shown on our 2014 CMS Financial Report. This report reflects our commitment to safeguarding the taxpayer resources.

The new Health Insurance Marketplace helps individuals better understand their insurance options, and assists them in shopping for, selecting, and enrolling in high-quality, competitively-priced, private health insurance plans. By providing one-stop shopping, the Health Insurance Marketplace makes purchasing health insurance easy and understandable, giving individuals access to increased options for and control over their health insurance purchases. During the first open enrollment period, over 7.3 million individuals enrolled in Qualified Health Plans through the Health Insurance Marketplace. The strong enrollment in the Marketplace contributed to an estimated 10.3 million fewer adults who are uninsured today than in 2013, or a reduction in the number of uninsured adults of 26 percent. The Small Business Health Options Program (SHOP) Marketplace also started up in 2014, and helped small employers provide health coverage to their employees. The SHOP also helps small businesses afford coverage by providing access to the Small Business Health Care Tax Credit, which is available to businesses with fewer than 25 employees.

CMS has also worked vigorously with states across the country to help them take advantage of the Medicaid coverage expansion made possible by the Affordable Care Act. CMS has accomplished this while giving states flexibility and protecting the rights and benefits of Medicaid individuals and families. Currently, 27 states and the District of Columbia have taken up expansion. The federal government will pay for the entire coverage costs of the expansion through 2016, and that number gradually reduces but never falls below 90 percent. As a result of CMS' efforts to spur enrollment in all states, since October of 2013, approximately 8 million additional individuals have gained Medicaid coverage. We are eager to continue to work with states still considering the expansion in order to bring affordable coverage to millions more Americans.

As Medicare continues to grow, CMS is continuing to make meaningful improvements to the beneficiary experience. The Medicare Prescription Drug (Part D) program once again offers all beneficiaries access to a wide range of prescription drug plans, which remain affordable, thanks to stable premiums and changes from the Affordable Care Act. Since the passage of the Affordable Care Act, more than 8.3 million people with Medicare have saved over $12 billion on prescription drugs, an average of $1,443 per beneficiary. Enrollment in Medicare Advantage is expected to reach another all-time high in 2015, while premiums remain affordable. The quality of Medicare Advantage plans also continue to improve while more plans offer supplemental benefits that beneficiaries value, such as dental and vision benefits.

Additionally, currently 361 organizations are participating in Medicare Accountable Care Organizations (ACO) initiatives that reward health care providers for providing patients with high quality care and lowering the rate of growth in Medicare expenditures. In 2012, CMS launched the initial performance periods of the Medicare Shared Savings Program (MSSP) and the Pioneer ACO Model. The ACOs participating in these initiatives now offer care to over 5.5 million beneficiaries. ACOs participating in CMS initiatives are highly diverse, and include integrated health systems and networks of individual physician practices offering care in rural and urban areas in 47 states including the District of Columbia and Puerto Rico.

Also in 2014, CMS restructured the keystone initiative of Medicare's national health care quality improvement portfolio, the Quality Improvement Organization (QIO) program. The QIO program is one of the largest federal programs dedicated to improving the health quality of Medicare beneficiaries at the local level. As such, the QIO program serves as CMS' key implementer of its quality improvement goals for Medicare at the grassroots, "bedside" level.

The recent restructuring has resulted in a few changes, such as separating beneficiary case review from quality improvement work, extending the contract period of performance from three to five years, removing requirements to restrict QIO activity to a single entity in each state/territory, and opening contractor consideration to a broad range of entities to perform the work. Also, by working with QIOs, communities across the country have collectively saved over 95,000 people from being admitted and 27,000 people from being readmitted to the hospital. This implies nearly $1 billion in cost savings.

CMS continues to improve the link between payment and better patient outcomes and lower cost through our value-based payment (VBP) and quality measure reporting programs. We believe that aligning payment with performance that reflects high quality provides

patient and provider incentives for better outcomes and more efficient care. It also provides new incentives that encourage care coordination, high quality, and efficient care delivery. VBP ensures providers are incentivized to provide high quality and efficient care.

CMS supports and monitors its progress with the Partnership for Patients (PfP) program by using rapid cycle evaluation to identify, spread, and increase the utilization of evidence-based best practices. The PfP is a quality improvement network designed to reduce preventable Hospital Acquired Conditions (HACs) by 40 percent and readmissions by 20 percent. The PfP works to generate results on these aims by stimulating and aligning the work of Federal programs, private partners, and through an Innovation Center investment in a national infrastructure to provide quality improvement support to hospitals throughout the Nation. The PfP actively supports more than 3,700 hospitals distributed throughout all 50 states, through one of 27 Hospital Engagement Networks (HENs). These networks have the potential to effect rapid changes in the health care system with the intent to prevent hospital-based harm and readmissions for CMS' beneficiaries in addition to commercial and other hospital patient populations. The PfP established a national monitoring system for hospital harm, which has been in place since 2010. This monitoring system is showing significant declines in the prevalence of hospital harm. These declines are associated estimated cost savings of several billion dollars over the past three years. While results for 2013 are still preliminary, they are also trending in a favorable direction. These cost savings result from the aligned impacts of many programs and forces, including the PfP and the QIO Programs.

To support and accelerate delivery system reform and the transition to a data-driven, information-based health economy, CMS is releasing data, with appropriate privacy and security protections, to numerous stakeholders. For example, CMS makes data available on a regular basis to ACOs and State Medicaid Agencies to support care coordination for assigned beneficiaries and Medicare-Medicaid enrollees, respectively. In addition, CMS disseminates certain Medicare data to Qualified Entities who are evaluating provider performance and making the results publicly available so consumers can compare quality and cost information for providers in their region. CMS is also a leader in providing beneficiaries with convenient access to their own claims data through MyMedicare.gov's Blue Button. Medicare's Blue Button allows beneficiaries to electronically download three years of their Medicare Part A, B and D claims and, if they choose, share this information with their family members or doctors. CMS has also publicly released a number of data sets that give consumers, researchers, policymakers and other stakeholders a new window into CMS programs. In particular, CMS has published three data sets that summarize utilization and payments, including charges submitted by the provider, for procedures and services provided to Medicare beneficiaries by inpatient and outpatient hospitals, physicians, and other suppliers. These three data sets offer unprecedented access to information about health care spending and care delivery patterns in the Medicare program.

We have made significant progress using the Fraud Prevention System (FPS) to identify fraudulent providers and take administrative action to protect the Medicare Trust Funds. In the second implementation year, CMS took administrative action against 938 providers and suppliers due to the FPS. The identified savings associated with these prevention and detection actions due to FPS was $210.7 million, almost double the amount identified during the first year of the program. This resulted in more than a $5 to $1 return on investment, an increase from last year's $3 to $1 return. There are also other benefits of the FPS activity, such as the sentinel effect it creates, and the highly collaborative environment it has fostered between CMS and law enforcement, as well as between and among CMS and its program integrity contractors.

Building on strong anti-fraud efforts already underway in the home health provider and ambulance supplier arenas, CMS announced the first use of its temporary moratoria authority granted by the Affordable Care Act. The moratoria stops the enrollment of new home health and ambulance enrollments in Medicare, Medicaid and within fraud "hot spot" areas of the country which have a demonstrated oversupply of certain types of providers. CMS is required to re-evaluate the need for such moratoria every six months, and in January 2014, CMS extended the original enrollment moratoria in the original locations, and expanded it to include HHAs in the Broward area of Florida, several counties in the Detroit, Michigan, area and several counties in the Dallas and Houston areas of Texas. CMS concurrently expanded the moratoria to ground ambulance suppliers into the Philadelphia area. The moratoria actions were extended for an additional six months with the most recent notice, effective July 2014. The goal of the temporary moratoria is to fight fraud and safeguard taxpayer dollars, while ensuring patient access to care. Under the moratoria, existing providers and suppliers will continue to deliver and bill for services. However, new provider and supplier applications will not be approved in these areas. This action allows CMS and its law enforcement partners to remove fraudulent providers from the program while blocking provider entry or re-entry into these already over-supplied markets.

Meeting CMS' mission, vision and goals is an awesome task and an increasingly complex but rewarding challenge. CMS has met every challenge head on and will continue to do so. We know that the American people depend on our programs and I am pleased with the progress we have made.

MARYLYN TAVENNER
CMS Administrator

November 2014

FINANCING OF CMS PROGRAMS & OPERATIONS

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

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

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

APPROVED LEADERSHIP
as of September 30, 2014

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Administrator

Andrew Slavitt
Principal Deputy Administrator

Tim Love
Chief Operating Officer

Aryana Khalid
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Olen Clybourn, Deputy Director

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Jean Moody-Williams, Deputy Director
Debbie Hattery, Deputy Director
Shari Ling, M.D., Deputy Chief Medical Officer

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Tim Love, Chief Operating Officer
David Nelson, Deputy Chief Operating Officer & CMS Chief Information Officer

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OAGM: Daniel Kane, Director
OFM: Deborah Taylor, Director & Chief Financial Officer
OIS: Janet Vogel, Director
OOM: James Weber, Director
CFMFFSO: Nanette Foster Reilly, Consortium Administrator
CMCHO: Jackie Garner, Consortium Administrator
CMHPO: James Kerr, Consortium Administrator
CQISCO: James Randolph Farris, M.D., Consortium Administrator
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Cynthia Tudor, Deputy Director

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Karen Jackson, Deputy Director for Operations

* Acting

1 MANAGEMENT'S DISCUSSION AND ANALYSIS

Overview // Programs // Performance Goals
Financial Accomplishments

OVERVIEW

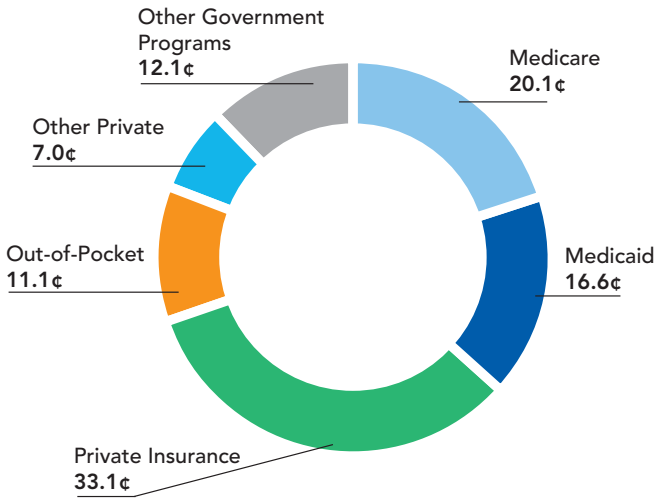
CMS, a component of HHS, administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Clinical Laboratory Improvement Amendments of 1988 (CLIA). With the passage of the Affordable Care Act, CMS' role in the larger health care arena has been further expanded beyond our traditional role of administering the Medicare, Medicaid and CHIP Programs. The Affordable Care Act puts in place comprehensive health insurance reforms'. Because of this law, all Americans will have access to affordable health insurance options. The Marketplace allows individuals and small businesses to compare health plans on a level playing field. Middle and low-income families will get tax credits that cover a significant portion of the cost of coverage. The Medicaid program was expanded to cover more low-income Americans. These reforms mean that millions of people who were previously uninsured will gain coverage. The Affordable Care Act takes significant steps towards expanding coverage and improving access to health care while also improving the quality and affordability of health care for all Americans.

As the largest purchaser of health care in the world, CMS maintains the Nation's largest collection of health care data. Based on the latest projections, Medicare and Medicaid (including state funding), represent 37 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, 45 cents of every dollar received by U.S. hospitals, and 33 cents of every dollar spent on physician services. CMS outlays totaled approximately $824.4 billion (net of offsetting collections and receipts) in fiscal year (FY) 2014. Our expenses totaled approximately $911.1 billion, of which $4.9 billion (or less than one percent) were administrative expenses.

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

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

THE NATION'S HEALTH CARE DOLLAR 2014



Source: U.S. Treasury

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

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

PROGRAMS

Medicare

Medicare was established in 1965 as title XVIII of the Social Security Act. It was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people aged 65 and over. In 1972, the program was expanded to cover the disabled, people with end-stage renal disease (ESRD) requiring dialysis or kidney transplant, and people age 65 or older that elect Medicare coverage. The Medicare program was further expanded in 2003 to include a prescription drug benefit. In 2010, the President signed legislation to develop comprehensive reforms that strengthen the Medicare program - the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act, collectively referred to as the Affordable Care Act. The significance of the Affordable Care Act continues to impact CMS' roles and responsibilities.

Medicare processes over one billion fee-for-service (FFS) claims a year, and accounts for approximately 14 percent of the Federal Budget. Medicare is a combination of four programs: Hospital Insurance, Supplementary Medical Insurance, Medicare Advantage, and Medicare Prescription Drug Benefit. Since 1966, Medicare enrollment has increased from 19 million to approximately 54 million beneficiaries.

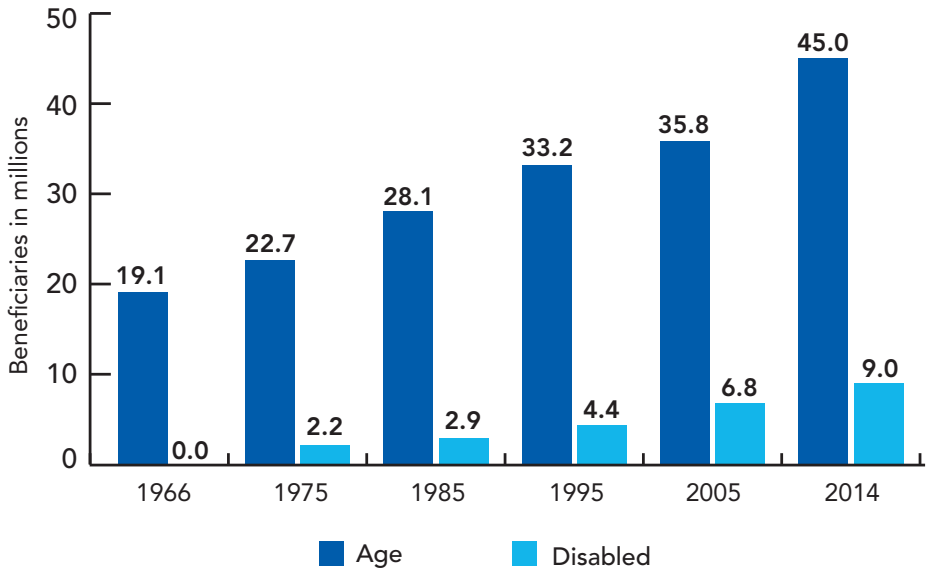
Hospital Insurance

Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. The HI program pays for hospital, skilled nursing facility, home health, and hospice care and is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the HI Trust Fund, and invested in Treasury securities. Based on estimates from the Midsession Review of the FY 2015 President's budget, inpatient hospital spending accounted for 52 percent of HI benefit outlays in FY 2014. Managed care spending comprised 28 percent of total HI outlays. During FY 2014, HI benefit outlays increased by 0.7 percent, and the HI benefit outlays per enrollee were projected to decrease by 2.5 percent to $4,950.

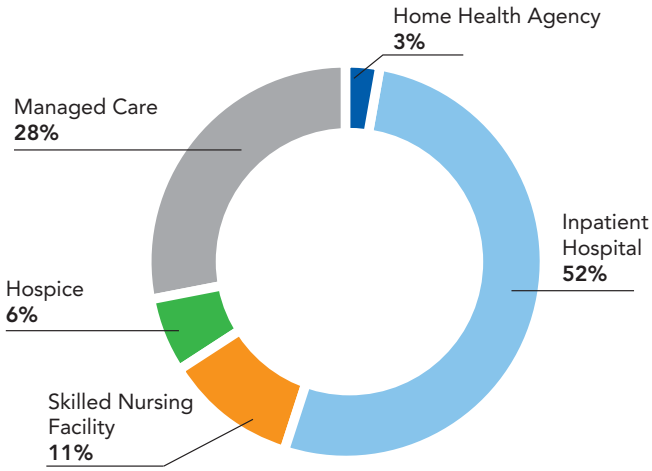
Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI or Medicare Part B, is voluntary and available to nearly all people aged 65 and over, the disabled, and people with ESRD who are entitled to Part A benefits. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment (DME), designated

MEDICARE ENROLLMENT

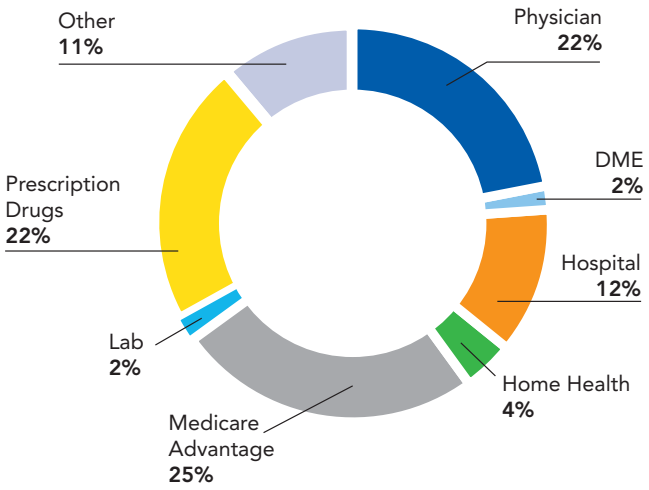


HI MEDICARE BENEFIT PAYMENTS



Source: CMS/OACT

SMI MEDICARE BENEFIT PAYMENTS



Source: CMS/OACT

therapy, some outpatient prescription drugs, and other services not covered by HI. The SMI coverage is optional, and beneficiaries are subject to monthly premium payments. About 92 percent of HI enrollees elect to enroll in SMI to receive Part B benefits. The SMI program is financed primarily by transfers from the general fund of the U.S. Treasury and by monthly premiums paid by beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the SMI Trust Fund and invested in U.S. Treasury securities.

Also based on estimates from the Midsession Review of the FY 2015 President's budget, SMI benefit outlays increased by 5.7 percent during FY 2014. Managed care payments, the largest component of SMI, accounted for 25 percent of SMI benefit outlays. During FY 2014, the SMI benefit outlays per enrollee were projected to increase 2.6 percent to $6,710.

Medicare Advantage

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) created the Medicare Advantage (MA) program, which is designed to provide more health care coverage choices for Medicare beneficiaries. Those who are eligible because of age (65 or older) or disability may choose to join a MA plan servicing their area if they are entitled to Part A and enrolled in Part B. Those who are eligible for Medicare because of ESRD may join a MA plan only under special circumstances. Medicare beneficiaries have long had the option to choose to enroll in prepaid health care plans that contract with CMS instead of receiving services under traditional FFS arrangements offered under original Medicare. The types of MA plans are as follows: (1) coordinated care plans, which include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Provider-Sponsored Organizations (PSOs), and other network plans; (2) Medical Savings Accounts (MSA) plans; and (3) Private Fee-For-Service (PFFS) plans. MA coordinated care plans have their own providers or a network of contracting health care providers who agree to provide health care services for members. Non-network PFFS plans, for example, do not have an established network of contracted providers and plan members can receive services from any provider who is eligible to receive payment from Medicare and agrees to the terms and conditions of the PFFS plan sponsor. MA demonstration projects, as well as cost plans and Health Care Prepayment Plans (HCPPs), also exist.

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

Managed care expenses were approximately $155.9 billion of the total $584.7 billion in Medicare benefit payment expenses in FY 2014.

Medicare Prescription Drug Benefit

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

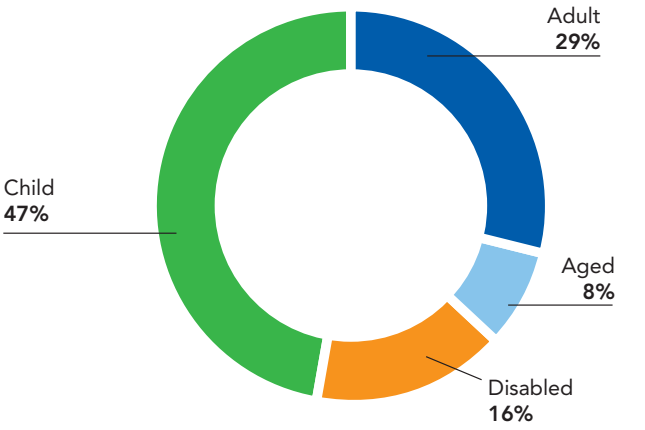
The program was effective January 1, 2006, and established an optional prescription drug benefit (Medicare Part D) for individuals who are entitled to or enrolled in Medicare benefits under Part A or Part B. Beneficiaries who qualify for both Medicare and Medicaid (full-benefit dual-eligibles) are automatically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

Participating Part D plans must offer a statutorily defined standard benefit or an alternative that is at least actuarially equivalent to standard coverage benefit. The 2014 standard benefits generally have a $310 deductible and coinsurance of 25 percent after the deductible up to the initial coverage limit of $2,850 in total drug spending. This was historically followed by a coverage gap for which beneficiaries paid 100 percent to an out-of-pocket spending limit of $4,550. 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. Starting in year 2011, the Affordable Care Act added additional coverage for prescription drugs to gradually eliminate the coverage gap by year 2020 for qualifying beneficiaries. For year 2014, it includes 28 percent plan coverage for generic drugs and a 52.5 percent discount on the ingredient cost of brand name drugs. PDPs and MA-PDs submit annual bids to CMS reflecting expected benefit payments plus administrative costs after a deduction for expected reinsurance subsidies. Payment for basic Part D benefits is made using five funding streams. Throughout the benefit year, CMS pays plans monthly prospective payments through a direct subsidy, a prospective payment for the low-income cost-sharing subsidy (LICS), a payment for the low-income premium subsidy (LIPS), and a prospective payment for the reinsurance subsidy.

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

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

FY 2014 MEDICAID ENROLLEES



Source: CMS/OACT

Medicaid

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, most recently with the Affordable Care Act. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including low-income families, pregnant women, people of all ages with disabilities, and people who require long-term care services, who all should receive coordinated, quality care. The average enrollment for Medicaid was estimated at about 64 million in FY 2014, about 20 percent of the U.S. population. About 10 million people are dually eligible, that is, covered by both Medicare and Medicaid.

CMS provides matching payments to the states and territories for Medicaid program expenditures and related administrative costs. State medical assistance payments are matched according to a formula relating each state's per capita income to the national average. In FY 2014, the basic Federal matching rate for Medicaid program costs among the states according to the formula ranged from 50 to 73.1 percent. The weighted average matching rate for FY 2014 is estimated to be 59.8 percent. Federal matching rates for various state and local administrative costs are set by statute. The Federal Government currently pays about 62 percent of these costs. Medicaid payments to states are funded by Federal general revenues provided to CMS through an annual appropriation.

States set eligibility, coverage, and payment standards within broad statutory and regulatory guidelines that include providing coverage to persons receiving Supplemental Security Income (disabled, blind, and elderly population), low-income families, the medically needy, pregnant women, young children, low-income Medicare beneficiaries, and certain other groups; and covering 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 2014, Medicaid spending for persons with AIDS as well as others infected with the Human Immunodeficiency Virus (HIV) is estimated to be about $11.2 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[1]

Under Medicaid, state payments for both medical assistance payments (MAP) and administrative (ADM) costs are matched with Federal funds. In FY 2014, state and Federal ADM gross outlays are estimated at $24.8 billion, about 5 percent of the gross Medicaid outlays. State and Federal MAP total outlays were $491.0 billion or 95 percent of total Medicaid outlays, an increase of 13.2 percent over FY 2013. Thus, estimated state and Federal MAP and ADM outlays for FY 2014 totaled $515.8 billion. The Federal share of Medicaid outlays totaled $310.2 billion in FY 2014.

[1] Payments in this paragraph are estimated, based on the Mid-Session Review of the President's FY 2015 budget.

Enrollees

Children comprise about half of Medicaid enrollees, and account for only an estimated 47 percent of Medicaid outlays. In contrast, the elderly and disabled comprise 24 percent of Medicaid enrollees, but accounted for an estimated 61 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 and territories now offer a form of managed care. CMS and the states have worked in partnership to offer managed care to Medicaid beneficiaries. Moreover, as a result of the Balanced Budget Act of 1997 (BBA), the states may amend their state plan to require certain Medicaid beneficiaries in their state to enroll in a managed care program, such as a managed care organization or primary care case manager. Medicaid law provides for two kinds of waivers of existing Federal statutes and two other options through the state plan process to implement managed care delivery systems.

1. **Medicaid waivers:** section 1115 of the Social Security Act provides discretion to waive certain provisions of Medicaid law for experimental, pilot, or demonstration projects. Many of the pioneering efforts to develop Medicaid managed care were authorized as section 1115 demonstrations and states continue to use this authority to develop innovative programs.
2. **Freedom of choice waivers:** section 1915(b) of the Social Security Act allows certain provisions of Medicaid law to be waived to allow the states to develop innovative managed health care delivery systems.
3. **Other state plan options to implement managed care:** section 1932(a) of the Social Security Act allows the states to mandate managed care enrollment for certain groups of Medicaid beneficiaries. Certain populations—including dual eligibles, children receiving SSI, children with special health care needs, and American Indians—are exempted from the state plan option. For these groups, the states require waivers to mandate enrollment into managed care.
4. **States may also elect to include the Program of All-Inclusive Care for the Elderly (PACE) as a state plan option.** The PACE is a prepaid, capitated plan that provides comprehensive health care services to frail, older adults in the community, who enroll on a voluntary basis, who are eligible for care in nursing homes according to state standards.

Congress has passed several pieces of legislation that have impacted Medicaid. The Affordable Care Act expanded eligibility for Medicaid to adults with incomes below 133 percent of the Federal Poverty Level beginning January 1, 2014, 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) and the Health Information Exchange (HIE) in the health care system. The law provides incentives to encourage the use of electronic health records (EHR) for exchanging information across the health care system. This investment in HIT/HIE is key to CMS' efforts to better measure, monitor and assure the quality of care provided in Medicaid. Finally, CHIPRA established a new foundation for building a comprehensive, high quality system of care for children by addressing key components essential to accessing coverage and implementing quality improvement strategies related to health care.

Medicaid Quality Improvement Initiatives

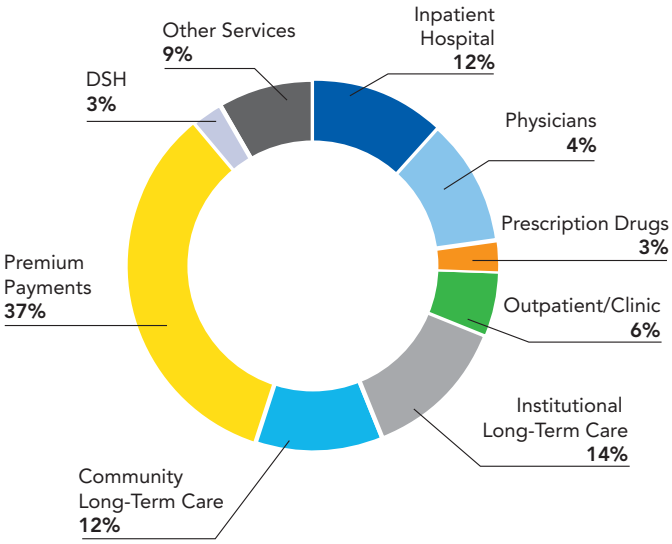
Recent provisions under the Affordable Care Act, ARRA and CHIPRA also expand the Federal-state partnership in disease prevention and quality improvement in health care. These initiatives include:

- Establishing an initial and annual core set of child and adult quality performance measures for voluntary reporting by state Medicaid and CHIP programs;

MEDICAL ASSISTANCE PAYMENTS BY AGGREGATE SERVICE CATEGORIES

IN BILLIONS

Total Payments: $467 billion



Source: President's FY 2015 Budget, Mid-session Review

- $100 million across ten grants (that include 18 states) to test innovative approaches to using performance measures, HIT/HIE, EHR, and provider delivery models to improve the quality of care for children;
- Establishing a model EHR format specifically for children;
- Establishing Medicaid incentive payments for Medicaid eligible providers to demonstrate meaningful use of certified EHRs—which includes exchange of health information and reporting of clinical quality measures selected by the Secretary of HHS;
- Improved data collection for measuring, evaluating, and addressing health disparities in Medicaid and CHIP by race, ethnicity, primary language, and disability status;

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

- A Maternal and Infant Health Initiative that leverages existing partnerships and activities to increase the rate of postpartum visits and increase the use of effective methods of contraception in both Medicaid and CHIP in at least twenty states over a 3 year period;
- A Children's Oral Health Improvement Initiative that has goals to improve the use of preventive dental services over five years and to increase the use of sealants among children;
- Improving access, data collection/reporting, and assessment of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services; and
- Demonstration grants across 26 states to measure and improve the quality of healthcare for adults in Medicaid.

Federal Medical Assistance Percentages (FMAP) Increases for Territories

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

Medicaid Home and Community-Based 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, has provided technical assistance to states. The TA to states covered quality in all HCBS programs, including sections 1915(c), 1915(i), 1915(c) (b), and was 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 NQE Technical Assistance concluded on September 30, 2013.

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

Children's Health Insurance Program (CHIP)

CHIP was created through the BBA of 1997 to address the fact that, at the time, nearly 11 million American children—one in seven— were uninsured and therefore at increased risk for preventable health problems. Many of these children were in working families that earned too little to afford private insurance on their own, but too much to be eligible for Medicaid. Congress agreed to set aside nearly $40 billion over ten years, beginning in FY 1998, to create CHIP—the largest health care investment in children since the creation of Medicaid in 1965. The original CHIP budget authority expired September 30, 2007, but was extended by Congress through March 31, 2009 in the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007. On February 4, 2009, CHIPRA further extended appropriating funds through FY 2013 for the purposes of providing allotments to the states for their CHIP programs. CHIPRA also changed the availability of the states' annual CHIP allotments from three to two years beginning with the FY 2009 CHIP allotments. The Affordable Care Act appropriated additional funding for allotment to states through September 30, 2015.

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

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

States also set their own eligibility criteria regarding age, income, and residency within broad Federal guidelines. The Federal role is to ensure that state programs meet statutory requirements that are designed to ensure meaningful coverage under the program. CMS works closely with the states, Congress, and other Federal agencies to meet the challenges of implementing this program. CMS provides extensive guidance and technical assistance so the states can further develop their CHIP state plans and use Federal funds to provide health care coverage to as many children as possible. All 50 states, the District of Columbia, and the territories had approved CHIP state plans. As of September 2014, state programs for CHIP included 14 Medicaid expansions (includes District of Columbia and all of the territories), 1 separate CHIP and 29 combination CHIP programs (includes 12 states with separate CHIP programs but for the transition of children).

Consumer Information and Insurance Oversight

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

CMS works in conjunction with states to ensure compliance with a Patient's Bill of Rights and other market reforms that protect consumers through policies like prohibiting insurers from denying coverage for pre-existing conditions, prohibiting annual and lifetime dollar limits on coverage, and ensuring that issuers are complying with new rating requirements. CMS also oversees the implementation of rules related to rate review and medical loss ratio.

Health Insurance Rate Review/ Medical Loss Ratio

The rate review and medical loss ratio programs are two mechanisms to help ensure that consumers receive a good value for their premium dollar and to make the marketplace more transparent. Between FY 2010 and FY 2014, CMS has awarded $242 million in Health Insurance Rate Review Grants to states, territories and the District of Columbia, to help strengthen and improve their rate review processes. CMS works in conjunction with states to ensure that all proposed rate increases at or above 10 percent are based on reasonable cost assumptions and solid evidence. Additionally, beginning January 1, 2014, CMS is also responsible for monitoring all rate increases.

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

Enforcement

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

Consumer Information and Support

CMS has given consumers an unprecedented amount of clear information about their coverage options. One avenue is via www.Healthcare.gov, which houses the Plan Finder, the first central database of health coverage options, combining information about public programs with information on more than 10,000 private insurance plans. CMS updates this data regularly to allow consumers to review options specific to their personal situation and local community. Another way CMS has increased transparency for consumers is by requiring all plans and issuers currently providing health benefits to provide to consumers a Summary of Benefits and Coverage (SBC), including coverage examples which details on costs for distinct treatment scenarios, and a uniform glossary of common health insurance terms. The SBC and uniform glossary help consumers make an "apples to apples" comparison of health insurance products by providing consumers with equivalent information on available coverage options. CMS further protects consumers through the establishment of a set of uniform standards for external review of claims denials. Now, consumers in employer sponsored group health plans and in individual health insurance policies can ask an independent third party to review decisions made by their plans and insurance companies to deny preauthorization or payment for a service.

CMS has direct jurisdictional authority over self-funded non-Federal Governmental plans and provides some health insurance assistance services to consumers enrolled in such plans. Additionally, to support states' efforts to establish or strengthen programs that provide direct services to consumers with questions about health insurance, CMS provides limited direct assistance and referral services to consumers with Affordable Care Act related questions who reside in states without Consumer Assistance Programs (CAP). In late FY 2012, CMS made additional funds available across the country, and continues to provide technical support to CAPs, including training on assisting consumers with resolving problems with obtaining premium tax credits in the Marketplaces. CMS provides consumers with casework assistance to resolve complex Marketplace issues allowing CMS to monitor and track qualified health plan (QHP) issuer compliance, Marketplace operations and in-person enrollment assisted behavior. In late FY 2013, CMS awarded Navigator cooperative agreements to states with a Federally Facilitated Marketplace (FFM) or State Partnership Marketplace (SPM) to conduct public education activities to raise

awareness of QHPs; distribute fair, impartial, and linguistically appropriate information concerning enrollment in QHPs and the availability of premium tax credits; facilitate enrollment in QHPs; and provide referrals for any enrollee with a grievance, complaint or question regarding existing.

Affordable Insurance Marketplaces

CMS is working closely with states to implement the Marketplaces. Since January 1, 2014, Marketplaces have helped individuals and small businesses to better understand their insurance options, and assist them in shopping for, selecting, and enrolling in high-quality, competitively-priced private health insurance plans. By providing one-stop shopping, the Marketplaces will make purchasing health insurance easy and understandable; giving individuals and small businesses access to increased options for and control over their health insurance purchases. During the first open enrollment period, from October 1, 2013 to March 31, 2014, over 8 million individuals selected QHPs through the Marketplaces.

To help make health insurance more affordable to consumers, CMS makes payments of the advance premium tax credit (APTC) and cost-sharing reductions (CSR) to health insurance issuers on behalf of consumers who are eligible for financial assistance. APTC and CSR payments (which are not included in CMS' financial statements; for more information, see note 1) are a critical component of the Marketplace, and $30 billion has been allocated for these payments. In addition to these payments on behalf of consumers, CMS collects the Marketplace user fee from issuers participating in the Federally-facilitated Marketplace (FFM).

As of September 2014, approximately $5 billion has been awarded to states to support the establishment of their Marketplace. CMS monitors the progress on establishing the Marketplaces through Establishment Reviews. These reviews assess progress through planning, design, development, implementation, and operations. Grants may be awarded through December 31, 2014, for all Marketplace models. Grant funds are available for permissible and approved establishment activities, which include expenses for outreach, testing, and necessary improvements during the establishment phase. Funding can also be used to support states that wish to transition from a State-Partnership Marketplace (SPM) or FFM to a State-based Marketplace (SBM).

Access to Affordable Health Benefits Coverage

To help increase consumer access to affordable benefits coverage options today, CMS oversees the Pre-Existing Condition Insurance Plan (PCIP) program, the Early Retiree Reinsurance Program (ERRP), and the Consumer Operated and Oriented Plan (CO-OP) program. The PCIP program made health insurance available to Americans who were uninsured and had a pre-existing condition. The temporary program covered a broad range of health benefits and was designed as a bridge to 2014 for people with pre-existing conditions who cannot obtain health insurance coverage in today's private insurance market. The PCIP program extended benefits coverage to April 30, 2014, to help ensure enrollees did not experience a break in coverage as they transitioned to other coverage through the Marketplace. CMS directly administers the PCIP program on behalf of 40 states and the District of Columbia, while 10 states have chosen to run their own programs. The PCIP program began accepting applications for enrollment July 2010. A total of 134,708 people were enrolled in PCIP during its existence.

ERRP, a temporary program that ended January 1, 2014, provided reimbursement to sponsors of qualified employment-based health plans for a portion of the cost of health benefits for early retirees and their spouses, surviving spouses and dependents. ERRP reimbursed 80 percent of the actual cost of health benefit expenses (paid by the plan or paid by or on behalf of an individual) between a cost threshold and cost limit. ERRP supported the availability of affordable health benefits coverage to early retirees and their families through the disbursement of nearly $4.9 billion in payments to approximately 2,900 plan sponsors. Participating plan sponsors included commercial, non-profit, union and religious organizations as well as state and local governments.

The CO-OP program fosters and encourages the creation of new non-profit, consumer-governed health insurance companies to provide more competition and choice in the Affordable Insurance Marketplace that is responsive to consumer needs. The CO-OP program provided low-interest loans to eligible nonprofit groups to help set up and maintain these new health insurance issuers. CO-OPs that improve the coordination of care, can operate statewide, and have private support are more likely to be funded. After a rigorous selection process, 24 CO-OPs were established, 23 of which were subsequently licensed and are now operating in 23 states in every region of the country, coast-

to-coast and border-to-border. With four CO-OPs expanding into other states, the CO-OP program will have a 27 state reach for 2015. All bring plans for better coordination of care to the market to improve health outcomes. As of September 30, 2014, CMS awarded $2.4 billion in CO-OP loans with $1.4 billion disbursed.

Other Program Initiatives and Activities

In addition to making health care payments to providers and the states on behalf of our beneficiaries, CMS makes other important contributions to the delivery of health care in the U.S. CMS continues to make progress toward strengthening and modernizing the Nation's health care to provide access to high quality and improved health at lower costs. CMS' strategy outlines the critical work that the Agency conducts in achieving – (1) better care and lower costs; (2) prevention and improved population health; (3) expanded health care coverage; and (4) enterprise excellence.

Business Transformation

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

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

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

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

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

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

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

- Strategic and Tactical Planning and Analysis;
- Conceptual Planning and Proof of Concept;
- Acquisition Assistance;
- Organizational Planning and Relationship Management;
- Continuous Process Improvement;
- Strategic Technology Evaluation; and
- Feasibility Analysis and Design.

Medicare and Medicaid Innovation

CMS continually tests innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid and CHIP expenditures 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 for the design, implementation, and evaluation of these payment and service delivery model tests. CMS' efforts, coupled with transformational payment changes instituted by the Affordable Care Act, will help drive continual improvement of health and health care for Medicare, Medicaid and CHIP beneficiaries and achieve better value for our health care dollars.

CMS is transforming itself from a claims payer in a fragmented care system into a partner working with health care providers to provide better quality health care at lower cost. CMS envisions a people-

centered health care system where individuals receive the right care, in the right setting, at the right time, every time. In order to promote innovation in health care payment and delivery, CMS actively consults with a wide array of stakeholders from the health care community, including sister agencies, health care providers and organizations, clinical researchers, insurers, academic medical systems, advocacy groups, the health care industry, and State Medicaid Directors. CMS also posts Requests for Information (RFIs) to learn more about health care community interests and needs, and holds listening sessions for targeted groups, call-in "Open Door Forums" for both providers and beneficiaries, and webinars and conference calls about new health care model tests and initiatives.

CMS has actively sought to partner with professional societies, health care education and research institutions, the media, and other organizations to disseminate best practices and encourage further innovation, and has developed a significant online presence in support of these efforts, including a website devoted to Medicare and Medicaid Innovation (**http://innovation.cms.gov**). CMS tests and evaluates new models of health care payment and delivery in three primary ways: through initiatives designed to advance and diffuse best practices, through the development and oversight of Congressionally-mandated demonstrations, and through the development and testing of new payment and service delivery models based on ideas from the caregiver community, on current research, and on specific model of improvements in care and payments suggested in the Affordable Care Act.

Medicare and Medicaid Coordination

Under the Affordable Care Act, CMS brings together Medicare and Medicaid in order to more effectively integrate benefits, and improve the coordination between the Federal Government and states to ensure access to quality services for Medicare-Medicaid enrollees. Medicare-Medicaid enrollees have significant health needs and account for a disproportionate share of Medicare and Medicaid program expenditures. Improved care coordination for this population could dramatically improve health outcomes for the Medicare-Medicaid enrollee population, but the current lack of alignment between the two programs often creates barriers to better care coordination, improved quality and lower costs.

To date, CMS has implemented a number of initiatives to assure it meets the statutory goals and responsibilities in section 2602 of the Affordable Care Act. CMS' ongoing initiatives supported three main areas: Program Alignment; Data and Analytics; and Demonstrations and Models.

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

Data and Analytics. A major barrier for states in providing integrated care for Medicare-Medicaid enrollees has been lack of access to Medicare data. CMS established a process for states to access Medicare data to support care coordination for Medicare-Medicaid enrollees, while also protecting beneficiary privacy and confidentiality. Thirty three states continue to work with CMS to receive and use these data, and with the availability of an improved version of the integrated data set tool, are better equipped to coordinate benefits and services in a seamless, cost-effective manner. In 2014, CMS added assessment data to the list of data sets accessible to states.

In addition, CMS made available a Medicare-Medicaid integrated data set within the Chronic Condition Warehouse that is now available to researchers, states and policymakers. This data set provides tools to identify new opportunities for care coordination, including information on eligibility, enrollment, beneficiary conditions, service use and expenditures for both the Medicare and Medicaid programs. The data set will assist researchers, as well as Federal and state policymakers, to better identify regions, populations or necessary interventions to improve the quality, cost, and utilization of care for Medicare-Medicaid enrollees.

As part of our efforts to better coordinate the Medicare and Medicaid programs, CMS has begun releasing a series of analytical reports to help provide policymakers, researchers, and other interested parties with a greater understanding and awareness of the population to foster program improvement. CMS released two years worth of state profiles, including a national summary and overview of data methodology underlying the analysis, along with individual profiles for each

of the 50 states and the District of Columbia. CMS is continuing to analyze and report on Medicare-Medicaid enrollee demographic characteristics, utilization and the spending patterns of the Medicare-Medicaid enrollees and the state Medicaid programs that serve them while the national summary provides a composite sketch of Medicare-Medicaid enrollees including demographics, selected chronic conditions, service utilizations, expenditures and availability of integrated delivery programs.

CMS is focused on improving quality for Medicare-Medicaid enrollees. To this end, it has worked with the National Quality Forum (NQF) on developing a recommended core set of quality measures, as well as priority gaps in measurement and measure stratification for high leverage areas that are responsive to the unique needs of Medicare-Medicaid enrollees. CMS is incorporating the recommended starter set of measures in each of the Medicare-Medicaid Financial Alignment Demonstrations. CMS is continuing to work with NQF, the National Committee for Quality Assurance, as well as other partners on the development of programs and measures that support quality improvement for the entire Medicare-Medicaid enrollee population.

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

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

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

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

In early 2012, CMS launched the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents where it is partnering with seven organizations to test strategies to reduce avoidable hospitalizations for Medicare and Medicaid enrollees who are long-stay residents of nursing facilities. Selected organizations are partnering with nursing facilities to test evidence-based interventions to accomplish these goals and will implement and operate proposed interventions over a four year period. The demonstration began serving Medicare and Medicaid enrollees in February of 2013.

Medicare Shared Savings Program

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

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

As part of the final rule, 42 CFR 425, CMS estimated that between 50 and 270 ACOs would participate in the Shared Savings Program and generate $470 million in net Federal savings between 2012 and 2015.

With the exception of ACOs with 2012 start dates, ACOs enter the program January 1st of each year with an agreement period that spans three performance years (equating to calendar years). We offered start dates on April 1, 2012 (agreement period of 3 years and 9 months), and July 1, 2012 (agreement period of 3 years and 6 months). The first performance year for April 1 and July 1 starters was defined as 21 and 18 months, respectively. The methodology for determining the first year financial performance of 2012 starters included interim payment determination (§425.608). To be eligible to receive a shared savings payment based on interim reconciliation, ACOs with 2012 start dates must have elected interim payment on their program application and established the required repayment mechanism, generated sufficient shared savings and have met the program's quality performance standard. For a typical performance year, retrospective reconciliation will occur after the end of the calendar year (performance year), allowing for 3 months claims run out and determination of the ACO's quality performance.

CMS publicly announced Performance Year 1 Interim financial reconciliation results for all ACOs with 2012 start dates in January 2014, and made payments to eligible ACOs between December 2013 and February 2014. CMS announced Performance Year 1 Final financial reconciliation results for ACOs with 2012 and 2013 start dates in September 2014. The Shared Saving Program accepts applications on an annual basis with the next group scheduled to start January 1, 2015.

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

CMS Quality Strategy

The CMS Quality Strategy is built on the foundation of the CMS Strategy, and the HHS NQS. Like the NQS, the CMS Quality Strategy was developed through a participatory, transparent, and collaborative process that included the input of a wide array of stakeholders. The goals of the CMS Quality Strategy are based on the six priorities outlined in the NQS. For more than a year, a group of leaders from across CMS met and developed the strategy. This group also sought out advice and input from other HHS agencies, the community, and CMS beneficiaries to support their efforts.

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.

In 2014, CMS restructured the QIO program to improve patient care, health outcomes, and save

taxpayer resources. The new structure separated medical case review from quality improvement work creating two separate structures: (1) medical case review to be performed by Beneficiary Family Centered Care Quality Improvement Organizations (BFCC-QIOs) and (2) quality improvement and technical assistance to be performed by Quality Innovation Network Quality Improvement Organizations (QIN-QIOs). QIN-QIOs will drive quality by providing technical assistance, convening learning and action networks for sharing best practices, and collecting and analyzing data for improvement, while BFCC-QIOs will review beneficiary and hospital appeals of discharge decisions, and beneficiary complaints. All 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 14 QIN-QIOs, and two BFCC QIOs that maintain a local presence in each of the 50 states, the District of Columbia, Puerto Rico and the Virgin Islands.

The QIO program has supported health care providers nationwide in delivering safer, more effective care to Medicare beneficiaries. Through these efforts hospitals, nursing homes and physicians have worked with their local QIO in preventing health care-associated infections; reducing health care-acquired conditions such as adverse drug events, pressure ulcers, and physical restraints; improving rates of preventive services; reducing health care disparities; decreasing avoidable re-hospitalizations; and establishing a foundation for related future QIO Program Initiatives.

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

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 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 311,143 medical facilities of different types, including hospitals, laboratories, nursing homes, home health agencies, hospices, rural health clinics, ambulatory surgical centers, organ transplant centers, and end stage renal disease facilities that are active during the year.

Clinical Laboratory Improvement Amendments (CLIA) Program

The 1988 CLIA legislation expanded survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing human specimens for health purposes, regardless of location. CMS regulates all laboratory testing (whether provided to beneficiaries of CMS programs or to others), including those performed in physicians' offices, for a total of 246,270 facilities. The CLIA standards are based on the complexity of testing; thus, the more complex the test is to perform, the more stringent the requirements. There are three categories of tests: waived, moderate and high complexity. Waived laboratories are not subject to the quality standards or routine oversight. Laboratories which perform moderate and high complexity testing are subject to routine onsite surveys. These laboratories have a choice of the agency they wish to survey their laboratory. They can select CMS via the state agencies or a CMS-approved accrediting organization. CMS partners with the states to certify and inspect approximately 19,970 laboratories on a biennial basis. CMS-approved accrediting organizations conduct onsite surveys of an additional 16,375 laboratories biennially. Data from these inspections reflect significant improvements in the quality of testing over time. The CLIA program is 100 percent user-fee financed and is jointly administered by three HHS components: (1) CMS manages the financial aspects, contracts and trains state surveyors to inspect labs, and oversees program administration including enrollment, fee assessment, regulation and policy development, approval of accrediting organizations, exempt

states and proficiency testing providers, certificate generation, enforcement and data system design; (2) the Centers for Disease Control and Prevention (CDC) provides research and technical support, and coordinates the Secretary's Clinical Laboratory Improvement Advisory Committee (CLIAC); and (3) the Food and Drug Administration (FDA) performs test categorization.

Coverage Policy

Medicare's coverage policy affects every insurer and health care purchaser in today's health care market since many third-party payers tend to follow CMS' lead. To that end, CMS has established an open and transparent National Coverage Determination (NCD) process that provides multiple opportunities for public participation. Specifically, CMS holds numerous meetings each year that are open to the public with 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.

On behalf of HHS, 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 administrative transactions to increase efficiency and reduce administrative costs across all sectors of the health care industry. Title II of HIPAA requires 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. HIPAA requires that adopted standards be used for the electronic transmission of specific administrative transactions, including claims, remittance advices, eligibility requests and responses, and coordination of benefits. Title II of HIPAA also requires that an individual's electronic personal health information be maintained securely while being stored or transmitted.

In January 2009, HHS published a final rule to adopt the International Classification of Diseases, 10th Edition (ICD-10) code set for diagnosis and inpatient hospital procedure coding with a compliance date of October 1, 2013. On September 5, 2012, HHS published a final rule that changed the ICD-10 compliance date to October 1, 2014, in order to give covered health care providers and other covered entities more time to prepare and fully test their systems to ensure a smooth and coordinated transition by all covered entities. On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) was enacted, which said that HHS may not adopt ICD-10 prior to October 1, 2015. Accordingly, HHS released a final rule. On July 31, 2014, requiring the use of ICD-10 beginning October 1, 2015. The rule also requires HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015.

The Administrative Simplification provisions of the Affordable Care Act included several new, expanded, or revised provisions. To implement the Administrative Simplification provisions, HHS published an interim final rule on July 8, 2011, that adopted operating rules regarding eligibility for health plans and health care claim status transactions, with a compliance date of January 1, 2013. On January 10, 2012, HHS adopted standards for health care electronic funds transfers (EFT) and remittance advice transactions through an interim final rule, and on August 10, 2012, HHS adopted

operating rules for the same transactions. Both the standards and the operating rules for EFT and remittance advice transactions had a compliance date of January 1, 2014. Over the next three years, more regulations will be released adopting operating rules or new standards. CMS will be responsible for all of the new provisions and will collaborate across the public and private sector on implementation.

On September 5, 2012, HHS adopted a standard health plan identifier (HPID). According to the rule, all large "controlling health plans" must obtain an HPID by November 7, 2014. On January 2, 2014, HHS issued a proposed rule that controlling health plans submit documentation that demonstrates compliance with the adopted standards and operating rules for three specific electronic transactions or face penalty fees. According to the Affordable Care Act, this "certification of compliance" process will be ongoing as new standards and operating rules are adopted.

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.

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. HHS released an FY 2014 – 2018 Strategic Plan, as required by the GPRA Modernization Act of 2010 (GPRAMA). Consistent with GPRA principles, the CMS FY 2014 performance plan is structured to reflect the HHS mission: To enhance the health and well-being of Americans by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health and social services. Our measures link to the HHS Strategic Goal 1: Strengthen Health Care and Goal 4: Increase Efficiency, Transparency, Accountability and Effectiveness of HHS programs.

Our FY 2014 performance measures track progress in our major program areas. We track program integrity in Medicare, Medicaid and the CHIP through measuring error rates. In addition, we measure quality improvement initiatives geared toward elderly, disabled and child populations as they are served by the Medicare, Medicaid, CHIP and the QIO programs. We continue to develop metrics to track progress of health reform efforts as we work to make affordable health insurance available to all Americans. Detailed information and available results about the FY 2014 measures are included in the FY 2015 HHS Annual Performance Plan and Performance Report (formerly known as the Online Performance Appendix) and progress on our measures will be reported through the FY 2016 President's Budget request process.

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

FINANCIAL HIGHLIGHTS

CMS maintains strong financial management operations and continues to improve upon its financial management and reporting processes to provide timely, reliable, and accurate financial information that CMS management and other decision makers use to make timely and accurate program and administrative decisions. CMS' Risk Management and Financial Oversight Committee, which is comprised of members of CMS' senior leadership, is responsible for overseeing financial management issues and budget concerns impacting the day-to-day operations of the Agency, its financial statements and the Chief Financial Officer (CFO) audit.

CMS prepares "white papers" to ensure that any significant changes/updates to CMS' accounting and financial reporting policies are properly

evaluated and approved by CMS financial managers. This process ensures that changes are implemented in an effective and efficient manner; that changes/updates to accounting policy conform to generally accepted accounting principles and Federal Financial Accounting Standards; and are transparent to the public.

During FY 2014, CMS achieved several initiatives that ensured accurate and reliable financial management and reporting, and contributed to the solvency of the Medicare Trust Funds.

Budget Execution

For FY 2014, CMS' budget execution function continues to be a major strength. CMS' Chief Operating Officer works closely with the CFO to ensure that an Administrator approved operating plan is developed timely and supports CMS' priorities. Strong fund control procedures ensure resources are only used for those activities in the operating plan that has been approved by the Administrator. CMS closely monitors available resources throughout the year to ensure the Anti-Deficiency Act is not violated, while at the same time meeting reasonable but aggressive lapse targets.

Administrative Payments

During FY 2014, we continued to make all of our payments, in accordance with the Prompt Payment Act. We also continue to have more than 99 percent of our vendor payments made via Automated Clearing House (ACH) and nearly 100 percent of our travel payments made via ACH.

Debt Management

CMS is committed to maximizing the collection of Medicare overpayments. CMS identifies debt in numerous ways, including payment reviews performed by MACs, Zone Program Integrity Contractors (ZPICs), RACs, and the Office of Inspector General (OIG). Once a debt is identified, CMS' contractors follow established collection processes to collect the debt. These processes include issuing demand letters, making telephone calls, recouping subsequent Medicare payments to the debtor, and when appropriate, establishing repayment plans to allow payment over an extended period of time. When payment is not made, CMS refers uncollected debt to the Department of the Treasury for further collection activities. From October 1, 2013 to September 30, 2014, the total amount of delinquent debt referred by CMS to the Program Support Center to process and transfer to Treasury is approximately $969 million.

Healthcare Integrated General Ledger Accounting System

CMS' Healthcare Integrated General Ledger Accounting System (HIGLAS) is a single, integrated dual-entry accounting system that standardizes and centralizes Federal financial accounting functions for all of CMS' programs. The FY 2014 program dollars processed through HIGLAS is projected to be approximately $887.7 billion. HIGLAS continues to enhance CMS' oversight of all financial operations, in order to achieve accurate, reliable, and timely financial accounting and reporting for all of CMS' programs and activities.

Oversight of Medicare Contractor Financial Operations & Reporting

The day-to-day operations of the Medicare FFS program, administered by the MACs, include paying claims, auditing provider cost reports, and establishing and collecting overpayments. The MACs are required to maintain a vast array of financial data. The availability of real time financial data provided by HIGLAS has resulted in significant improvements in the MACs' financial management activities and in the oversight of the Agency. CMS continues to revise policies and implement other key initiatives to review contractor operations and train staff. The Agency continues to enhance its analytical tools to provide the steps to identify and mitigate potential errors, unusual fluctuations, system weaknesses, or inappropriate patterns of financial data accumulation.

The MACs are subject to various financial management and information technology (IT) security audits and reviews performed by the OIG, Government Accountability Office (GAO), independent Certified Public Accountant (CPA) firms, and CMS staff to provide reasonable assurance that they have developed and implemented effective internal controls. The results of these audits and reviews indicate whether the MACs' internal controls have significant design or operational deficiencies. Audit resolution is a top priority at CMS and correcting these deficiencies is essential to improving financial management. Therefore, MACs are required to develop corrective action plans (CAPs), which define activities to remedy findings and the timeframes for which they will be implemented. CMS also requires all MACs

to submit an annual self-certification known as a Certification Package for Internal Controls (CPIC). In the CPIC, MACs are required to report any material weaknesses and significant deficiencies identified during the FY, along with CAPs to remedy the weaknesses. The CPIC provides CMS with assurance that contractors are in compliance with Federal Manager's Financial Integrity Act, Office of Management and Budget (OMB) Circular A-123 and the CFO Act of 1990.

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

CMS continued to build upon its success in implementing OMB's revisions to Circular A-123, *Management's Responsibility for Internal Control*. The Agency procured an independent CPA firm in FY 2014 to assist in performing management's self-assessment in support of the assurance statement regarding internal control over financial reporting, as of June 30. The MACs also continued to contract with independent CPA firms to conduct Statement on Standards for Attestation Engagements No. 16 (SSAE 16) internal control audits. The results of our comprehensive self-assessment are provided in the ***Summary of Federal Managers' Financial Integrity Act Report and OMB Circular A-123 Statement of Assurance*** section.

Federal Payment Levy Program

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

CMS began participating in the FPLP in October 2008, for Medicare FFS payments made through HIGLAS. Specifically, Medicare Improvements for Patients and Providers Act legislation requires that Medicare FFS payments to providers will be offset by a maximum of 15 percent to satisfy payment of delinquent Federal tax debt and 100 percent to satisfy payment of Administrative Offsets for Federal non-tax debt. Non-tax debts include unpaid loans, overpayments or duplicate payments to Federal salary or benefit payment receipts, misused grant funds and fines, penalties, or fees assessed by Federal agencies. As of September 30, 2014, CMS has realized a cumulative total of $261 million in tax levy offsets and $139 million in non-tax offsets through HIGLAS on behalf of FPLP.

Recovery Audit Program

Medicare FFS

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

Due to the process of closing out current contracts and an unexpected delay in awarding new contracts, recoveries in FY 2014 have decreased compared to FY 2013. In FY 2014, the Medicare FFS Recovery Audit program demanded approximately $1.9 billion and recovered approximately $2.3 billion. Recoveries can include amounts identified and demanded in prior fiscal years. The majority of collections continued to be from reviews of inpatient hospital and DME claims. 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 may also decrease as a result of the delay in awarding new Recovery Auditor contracts.

CMS continues to monitor the Recovery Audit program and make continuous improvements to activities, such as, the appeals process, feedback to providers, and system improvements. CMS remains focused on taking the findings identified by the Recovery Auditors and putting actions into place to prevent future improper payments. In FY 2014, CMS released four Provider Compliance Newsletters that provided detailed information on 19 findings identified by the Recovery Auditors. CMS also implemented local and/or national system edits to automatically prevent improper payments.

The Medicare FFS Recovery Audit Program's 3-year Prepayment Review Demonstration, which was launched in 2012 and permits Recovery Auditors to review claims before they are paid, was paused in early 2014, in preparation for the closeout of current Recovery Auditor contracts. To allow providers ample time to submit their documentation and have it reviewed prior to June 1, 2014, the last Additional Documentation Request letters went out on February 28, 2014. Prepayment reviews were being conducted in the seven Health Care Fraud

Prevention and Enforcement Action Team (HEAT) states (Florida, California, Michigan, Texas, New York, Louisiana, Illinois) and four states with the highest number of inpatient stays (Pennsylvania, Ohio, North Carolina, Missouri). Claim selection criteria was initially based on the Medicare Severity Diagnosis Related Groups (MS-DRG) selected by CMS with the highest payment error rate, identified through the Comprehensive Error Rate Testing (CERT). However, those claims were removed from selection on September 30, 2013 in response to the new Inpatient Prospective Payment System (IPPS) Rule that was going into effect on October 1, 2013.

Manual medical record review for Occupational Therapy services above $3,700 and for combined Physical Therapy and Speech Language Pathology services above $3,700, which began in April 2013, continued until the "pause" of the demonstration.

In FY 2014, the Medicare FFS Recovery Audit Program denied approximately $62.7 million in claims through the Prepayment Review Demonstration.

The procurement process continues for the next Recovery Auditor contracts, with Region 3 (one of four Part A/B regions) and Region 5 (the national DMEPOS/Home Health &Hospice Region) expected to be awarded in CY 2014. A transition plan has been implemented to ensure recovery operations continue while minimizing the impact on providers. The remaining three Part A/B Regions are currently under pre-award protest and a judge has ordered that CMS not award those contracts until a decision is made at the Federal Circuit Court.

Medicare Parts C and D Recovery Audit Contractors

CMS contracted with a Part D Recovery Auditor in January 2011. During the first year of operation, the Part D Recovery Auditor completed its systems approval requirements and began analysis of contract year 2007 prescription drug event (PDE) data to identify instances where excluded providers either received payment or prescribed drugs that were paid for by Medicare Part D. The appeals process for the 2007 Excluded Provider Audit Review was completed in the beginning of FY 2013 and CMS recovered approximately $2 Million. The Part D recovery audit contractor has now completed its Excluded Provider Review of data for 2008-2011 and recovered $2.6 million in FY 2014. Additionally, the Part D recovery audit contractor initiated its review of prescribers that are unauthorized to prescribe Part D Drugs for CYs 2009-2012, potential duplicate payments for CY 2010 and DEA schedule refill errors for CYs 2010-2011. The reviews are ongoing and will continue through FY 2015. As part of the procurement process to secure a recovery audit contractor for Medicare Part C, CMS posted a Request for Quote (RFQ) in June 2014; however no responses were received as a result of that solicitation. CMS continues its implementation efforts and anticipates awarding a Part C Recovery Auditor contract in FY 2015.

Medicare Secondary Payer

The MSP Recovery Auditor recovers Medicare Part A and Part B payments mistakenly made when a beneficiary has coverage through an employer-sponsored Group Health Plan (GHP). The mistaken payments are recovered from the entity that had primary payment responsibility for those services (typically the employer, insurer, claims processing administrator, or other plan sponsor). The MSP Recovery Auditor began full operations at the close of FY 2013. The MSP Recovery Auditor recovered $59.3 million in FY 2014. The MSP Recovery Auditor is also developing enhancements to the GHP paper-based recovery process. These planned enhancements are designed to improve customer service, increase efficiency, and ultimately increase recoveries for the program.

Medicaid

Section 6411(a) of the Affordable Care Act required states to establish Medicaid Recovery Audit contractor programs by submitting state plan amendments, attesting that their programs meet the statutory requirements. HHS published a final rule titled, "Medicaid Program: Recovery Audit Contractors" in the Federal Register on September 16, 2011, that implemented section 6411(a) of the Affordable Care Act. The final rule, effective January 1, 2012, required states to implement recovery audit contractor programs in an effort to identify and recover improper payments in their Medicaid programs. The final rule aligns the state Medicaid Recovery Audit contractor requirements to existing Medicare Recovery Audit contractor FFS program requirements, where feasible, and provides each state the flexibility to tailor its Recovery Audit contractor program where appropriate. Forty-seven states and the District of Columbia have implemented Medicaid Recovery Auditor contractor programs. The remaining three states have CMS-approved exceptions due to small beneficiary populations or high managed care penetration.

Medical Review Program

Medicare Administrative Contractors

Consistent with sections 1833(e), 1842(a)(2)(B), and 1862(a)(1) of the Social Security Act, CMS is required to protect the Medicare Trust Fund against inappropriate payments that pose the greatest risk to the Trust Fund and take corrective actions. To meet this requirement, CMS contracts with Part A and Part B MACs, DME MACs, and others to perform analysis of FFS claims data to identify atypical billing patterns and perform claims review. Medical review is the collection of information and clinical review of medical records to ensure that payment is made only for services that meet all Medicare coverage, coding, and medical necessity requirements. Medical review activities are directed toward areas where data analysis, Comprehensive Error Rate Testing results, Office of Inspector General/Government Accountability Office findings, and Recovery Audit findings indicate questionable billing patterns. CMS continues to enhance medical review efforts and has encouraged MACs to incorporate increased provider feedback processes, such as one-on-one education and more detailed review results notification, in an effort to increase proper billing.

Prior Authorization of Power Mobility Devices Demonstration

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

Since implementation, CMS has observed a decrease in the expenditures for power mobility devices in the demonstration states and non-demonstration states. Based on claims submitted as of July 2014, monthly expenditures for the power mobility device Healthcare Common Procedure Coding System codes included in the demonstration decreased from $12 million in September 2012 to $2 million in March 2014, in the demonstration states and from $20 million to $5 million in the non-demonstration states. The prior authorization reviews are being performed timely, industry feedback has been positive, and we have received no complaints from the beneficiaries we serve. In May 2014, CMS announced it would expand the demonstration to 12 additional states. We will continue to closely monitor and evaluate the effectiveness of the demonstration and plan to analyze demonstration data to assist in the investigation and prosecution of fraud.

Medicare Secondary Payer (MSP)

CMS' efforts in the MSP area saved the Medicare Trust Funds approximately $8.2 billion in the first 11 months FY 2014. 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 recoveries of Medicare conditional payments. CMS recently completed the transition of the MSP functions to a new MSP contracting strategy. This strategy consolidates coordination of benefits and recovery operations to improve customer service and streamline the recovery process. Part of this new process includes the implementation of a MSP Recovery Audit Program, to recover primary payments made by Medicare that should have been made by group health plans (GHP).

Section 111 of the Medicare and Medicaid SCHIP Extension Act of 2007, amended existing MSP provisions, adding a new mandatory MSP reporting requirement for all GHP insurance and Workers' Compensation, Liability Insurance (including Self-Insurance) and No-Fault insurance. Implementation of the reporting requirements is being phased in. GHPs 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 will be implemented by January 1, 2015.

Data submitted under section 111 is now the primary source of new MSP information for CMS. 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 "pay-and-chase" efforts. This is confirmed in that cost-avoided savings continue to grow at a faster rate than recoveries. Finally, in those situations

where past mistaken payments are identified as the result of the section 111 data, the more comprehensive section 111 data assists in more efficient recovery operations. The implementation of section 111 is the single largest contributor to growth of Medicare savings.

Program Integrity

Program Integrity (PI) encompasses the operations and oversight necessary to ensure that accurate payments are made to legitimate providers for appropriate and reasonable services for eligible beneficiaries of the Medicare, Medicaid, and CHIP programs. PI activities target the range of causes of improper payments, including errors, fraud, waste, and abuse.

Strategic Direction

CMS' Program Integrity direction has six key strategies for becoming more effective while reducing the burden on legitimate providers and suppliers. The first is moving beyond "pay and chase" operations to innovative prevention and detection activities. The second shift is to develop a risk-based approach for program integrity requirements, rather than operating as if "one size fits all." The third strategy is to rethink legacy processes with innovation as a requirement. The fourth strategy - to become more transparent and accountable - complements the fifth strategy of meaningfully engaging our public and private partners. Finally, CMS is dedicated to continuing to coordinate and integrate Medicare and Medicaid program integrity activities.

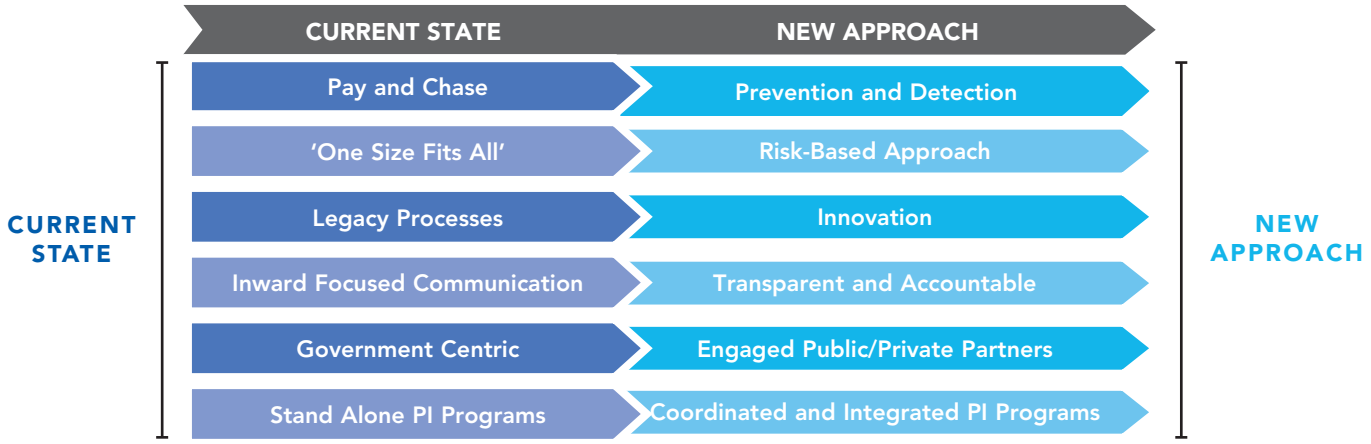
The four major approaches CMS uses to organize its key anti-fraud activities:

1. **Fraud Prevention:** Providing enrollment and screening, engaging Medicare beneficiaries, educating state Medicaid program integrity staff, antifraud marketing, and improving payment accuracy through National Fraud Prevention Program;
2. **Fraud Detection:** Greatly enhancing data analytics, partnering with providers, law enforcement, Part C and D compliance activities, Medicaid data analytics and audit activities;
3. **Transparency and Accountability:** Increasing coordination with law enforcement, collaborating with the private sector and states; including the Healthcare Fraud Prevention Partnership (HFPP) and the OPEN PAYMENTS (Affordable Care Act section 6002: Physician Payments Sunshine Act) transparency program.
4. **Recovery:** Collaborating with law enforcement (HEAT) and implementation of the Medicaid and Medicare Part C/D RACs.

The Affordable Care Act

CMS has implemented many of the important PI provisions included in the Affordable Care Act. These are helping not only to move the PI strategy beyond "pay and chase," but also to better align Medicare and Medicaid program integrity requirements. CMS continues its work in revalidating the enrollments of all existing 1.5 million Medicare suppliers and providers, under the new Affordable Care Act screening requirements. These efforts will ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries, and only legitimate providers and suppliers can bill the Medicare program. CMS has revalidated about 60 percent of the 1.5 million providers and suppliers and is on target to have all revalidation notices mailed by March 25, 2015, as required by the Affordable Care Act.

CMS also continues to use its authority to suspend payments pending the investigation of a credible



allegation of fraud, assess provider enrollment application fees, and impose temporary provider enrollment moratoria when the Secretary of HHS determines there is a risk of fraud. The Affordable Care Act also requires the termination of providers from Medicaid if they have been terminated for cause from Medicare or any other Medicaid program; and enables CMS to terminate from Medicare if the provider has been terminated from any Medicaid program.

CMS also published a final rule in April 2012 that implements the provisions of section 6405 of the Affordable Care Act, "Physicians Who Order Items Or Services Required To Be Medicare Enrolled Physicians Or Eligible Professionals." This rule codified CMS requirements and processes associated with validating that physicians who order or certify the need for durable medical equipment, prosthetics, orthotics, and suppliers (DMEPOS), home health care, and services of independent diagnostic testing facilities and clinical laboratories are enrolled in Medicare or have validly opted out of the Medicare program. Effective January 6, 2014, CMS began denying DMEPOS, home health care, and Part B clinical laboratory and imaging claims if the provider listed on the claim did not meet the ordering and referring requirements. In addition, CMS published a final rule on May 23, 2014, including a requirement that individuals who prescribe Part D drugs must be enrolled in or validly opted out of Medicare. In this way we can assure that only those eligible professionals who meet Medicare requirements can prescribe Part D drugs for Medicare beneficiaries. Pursuant to other provisions in the same final rule, CMS now has authority to revoke (or deny) the Medicare enrollment of any physician or eligible professional that exhibits a pattern of abusive prescribing.

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

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

Further information regarding this program can be located at **http://go.cms.gov/openpayments**.

Medicare Program Integrity

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

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

Enhancing program integrity is a top priority for the Agency, and we have made important strides in reducing fraud, waste, and improper payments across the government. This past year, CMS used its powerful new anti-fraud tools, as well as designed and implemented large-scale, innovative improvements to our Medicare program integrity strategy to shift beyond a "pay and chase"

approach to preventing fraud. CMS reported on the completion of the second implementation year of the Fraud Prevention System, the predictive analytic technology that identified potential fraud before payment, which resulted in an estimated $210 million in identified savings. CMS is also strengthening our provider enrollment rules, and reported that as a result of the targeted screening requirements in the Affordable Care Act and other enrollment activities, the number of provider revocations had doubled compared to the two years prior to the passage of the health law. Temporary provider enrollment moratoria are in place under the Affordable Care Act in several geographic areas at high risk of fraud, waste and abuse.

The Agency also continued to demonstrate its commitment to being effective financial stewards in FY 2014. We have developed a Unified Program Integrity Contractor strategy, with an overarching goal to integrate the program integrity functions for audits and investigations across Medicare and Medicaid by implementing a contracting strategy that rationalizes our relationships with providers, leverages existing resources, and enhances our cooperative efforts with partners.

Healthcare Fraud Prevention Partnership (HFPP)

One of the Secretary's key health care fraud prevention initiatives is to establish an ongoing partnership with the private sector to fight fraud across the health care sector. HFPP was developed for that purpose. HFPP is a public-private partnership among the Federal Government, states and private health insurance companies and associations to prevent and detect fraud across the healthcare industry. Data collected and shared across payers can assist payers in evaluating trends, recognizing patterns consistent with potential fraud, and potentially uncover schemes or bad actors they could not otherwise identify using only their own information. Such collaboration is the purpose of the HFPP.

Several key milestones occurred in FY 2014:

- Expanding the number of participating entities in data collection and analysis;
- Establishing a Trusted Third Party (TTP) to conduct data studies of various degrees of complexity.

Six additional partners have joined the HFPP in 2014 and the TTP is targeting further expansion of the partnership to include additional willing public and private payers.

Medicare Drug Integrity Contractor (MEDIC)

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

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

In FY 2014, the NBI MEDIC received approximately 662 actionable complaints per month; processed 39 requests for information from law enforcement per month; and referred an average of 40 cases per month. NBI MEDIC referrals have resulted in restitution of $38.8 million; forfeitures of $16 million; and $2.3 million in civil settlements. The NBI MEDIC was responsible for assisting the OIG and the Department of Justice (DOJ), through data analysis and investigative case development, in achieving 67 convictions, 33 arrests, and 47 indictments. One particular pharmacy fraud case involved six pharmacies in the Western District of Michigan which resulted in guilty pleas from twelve pharmacy employees. The indictment included charges of conspiracy to commit health care fraud, conspiracy to cause drugs held for sale to be misbranded, structuring, and conspiracy to make and use false documents in connection with health care benefits, money laundering and causing drugs held for sale after shipment in interstate commerce to be misbranded. All twelve are awaiting sentencing. The owner/Chief Executive Officer is awaiting trial.

In FY 2014, the O&E MEDIC facilitated the CMS Parts C & D Fraud Waste and Abuse (FWA) training which offer Medicare Advantage organizations and Prescription Drug plans an opportunity to collaborate and discuss techniques on how to prevent and detect fraud, waste, and abuse in the Medicare Advantage and Part D programs. The FWA training is designed to educate Medicare Advantage organization and Prescription Drug plan staff through enhanced collaboration, information sharing, data analytics and communication. FWA training stakeholders include Plan Sponsors, Pharmacy Benefit Managers (PBMs), representatives from law enforcement agencies-- including HHS/OIG, U.S. DOJ, and other state and local law enforcement entities. The FWA trainings provide

a forum for stakeholders to learn about the most recent fraud schemes and fraud prevention best practices to assist in developing effective fraud prevention programs.

The O&E MEDIC was responsible for many other outreach activities in FY 2014. In March 2014, CPI released its most comprehensive fraud fighting tools to date, the Medicare Advantage and Part D Fraud Handbook: Practical Techniques and Approaches on Detecting and Preventing Fraud, and an Online Training Module for Medicare Advantage organizations (MAOs) and Part D sponsors. The Handbook is a modular online reference providing MAOs and Part D sponsors with industry best practices regarding processes, methods, and resources to support fraud prevention, detection, corrective action, preliminary investigation, and referral activities. The training is an online presentation covering each chapter of the Fraud Handbook in an on-demand webcast format.

Medicare Program Integrity Field Offices

The designated Program Integrity Field Offices (FOs) in Los Angeles, Miami, and New York provide a boots-on-the-ground presence in high risk fraud areas of the country. The FOs conduct data analysis to identify local vulnerabilities and coordinate special projects with contractors and agencies on issues that have a national or regional impact. The Miami FO has implemented a comprehensive, multipronged approach to address all aspects of health care fraud in South Florida and has served as a testing ground for efforts that have been expanded to a national level.

Health Care Fraud Prevention and Enforcement Action Team (HEAT)

CMS is a major participant in the HEAT, the joint initiative between HHS and DOJ to target tools and resources to fight fraud. Since 2009, HEAT has resulted in cabinet-level coordination and collaboration on efforts to prevent and detect health care fraud. These efforts include:

- **Coordination of nationwide takedowns:**CMS has used its new payment suspension authority from the Affordable Care Act in coordination with two law enforcement multi-state takedowns.
- **Supporting the Medicare Fraud Strike Forces:** The Strike Forces are a key component of the HEAT strategy designed to reduce Medicare fraud. The Strike Forces combine data analysis capabilities of CMS and the investigative resources of the Federal Bureau of Investigation (FBI) and HHS/OIG with the prosecutorial resources of the DOJ Criminal Division, Fraud Section and the United States Attorney Offices. There are currently nine Strike Force cities.
- **Health Care Fraud Prevention Summits:** CMS partnered with the DOJ to host Health Care Fraud Prevention Summits in seven cities since 2010 – Brooklyn, NY; Boston, MA; Chicago, IL; Detroit, MI; Los Angeles, CA; Miami, FL and Philadelphia, PA. These summits bring together a wide array of federal, state and local partners, beneficiaries, and providers to discuss innovative ways to eliminate fraud across the U.S. health care system. The summits are part of the larger joint effort of the DOJ and HHS through the HEAT.

Medicaid Program Integrity

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

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

CMS is evaluating how best to leverage tools used in Medicare for opportunities to transfer the knowledge and lessons learned to the Medicaid program. The Small Business Jobs Act of 2010 requires CMS, at the end of a three-year period of implementing predictive modeling and other analytics technologies in Medicare, to submit a report on 1) the cost-effectiveness and feasibility of expanding predictive analytics technologies to Medicaid and CHIP, 2) an analysis of the effect on states and territories, and 3) recommendations

regarding any technical assistance that may be necessary. The expansion of predictive analytics technologies to Medicaid and CHIP is to be made based on the results of this report and its recommendations. Several initiatives are currently underway in furtherance of this analysis.

National Medicaid Audit Program (NMAP)

In FY 2014, the NMAP continued to work collaboratively with states in the development of audits. The collaborative approach allows CMS to work alongside states in identifying areas that warrant further investigation and to develop audit targets. Through this process, CMS has been able to more effectively support a state's program integrity efforts. In addition, the corresponding data for the collaborative audits is typically provided or supplemented by the states, making the data more complete and thus increasing the accuracy of audit findings. The number of collaborative audits has progressively increased since the first collaborative audits were assigned in January 2010, resulting in a cumulative total of 691 collaborative audits assigned in 40 states as of July 2014. These 40 states represent 87 percent of all Medicaid expenditures. Areas of collaboration have included hospice, Medicaid credit balances, emergency services to non-citizens, and several audits of mental health services provided by a Tribe. As of July 2014, there have been 158 Final Audit Reports related to collaborative audits issued to states valued at roughly $28 million. Overall, a total of $49.6 million in estimated overpayments has been identified by the efforts of CMS and the Audit Medicaid Integrity Contractors (MICs) as of July 2014. CMS renewed all five of the Audit MIC task orders in FY 2014.

Improper Payments

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

The supplemental measures will be calculated based on the results of state Payment Accuracy Improvement Groups (PAIG). A PAIG is a group of states with a shared, identified Medicaid program integrity vulnerability and a common approach or intervention to address the problem. CMS launched the first PAIG project in the area of pharmacy education to target physicians with aberrant prescribing practices to reduce the number of prescriptions that exceed recommended dosages. The education program developed materials designed to reduce overprescribing for five therapeutic drug classes identified as having the highest potential improper payment rates. The educational initiative was completed in the three participating states, with targeted prescribers receiving educational materials and/or personal contacts. CMS has initiated a second PAIG project aimed at reducing improper payments in the high risk area of home and community based services (HCBS), using the results produced by the FY 2012 PERM program to target the root causes of errors. Based on this information, during late FY 2013 and FY 2014, CMS prepared a variety of educational materials on service types identified in HCBS as having high potential PERM improper payment rates. With the support of states, CMS plans to launch an education program aimed at a targeted audience of physicians, direct care staff, home health agencies, and beneficiaries in FY 2015.

Education for States

To address Medicaid's structure as a Federal-state partnership, CMS has developed initiatives specifically designed to assist states in strengthening their own efforts to combat fraud, waste, and abuse. The Medicaid Integrity Institute (MII) is one of CMS' most significant achievements in Medicaid program integrity. The MII provides for the continuing education of state program integrity employees, including specific coursework focused on Medicaid managed care and predictive analytics. At the MII, CMS has a unique opportunity to offer substantive training, technical assistance, and support to states in a structured learning environment. From its inception in 2008 through June 2014, CMS has provided training to state employees from 50 states, the District of Columbia, and Puerto Rico through almost 5,000 enrollments in 110 courses and 8 workgroups at no cost to the states. These state employees are able to learn and share information with program integrity staff from other states on topics such as emerging trends in Medicaid fraud, data collection, and fraud detection skills, along with other helpful topics. As of July, 2014, the MII conducted 15 courses and 2 workgroups, with 4 courses scheduled for the remainder of the fiscal year.

In FY 2013, MII began offering a credentialing program for state Medicaid program integrity employees to certify professional qualifications. As of July 2014, 151 state employees in 42 states have received the credential of Certified Program Integrity Professional (CPIP). The MII also supports state access to the DOJ's Regional Information Sharing System—a secure web-based portal where states can exchange documents, tips, and best practices about Medicaid program integrity issues.

The Education MIC is responsible for promoting the integrity of Medicaid programs by developing education and training for Medicaid service providers, Managed Care Organizations, Medicaid recipients and state agencies regarding Medicaid payment integrity and quality of care. Products such as webinars, train-the-trainer activities, fact sheets, resource handouts, and referral guidelines are developed in collaboration with key stakeholders, including some states. At the end of FY 2013, CMS launched a new online resource for Medicaid program integrity education which provides public access to educational toolkits covering topics on managed care compliance, dental professional compliance, provider medical identity theft, drug diversion prevention, beneficiary card sharing, and fraud awareness and reporting. New toolkits released in FY 2014 cover program integrity education in personal care services, non-emergency transportation services, and a broad overview of healthcare fraud and program integrity.

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

Support and Assistance to the States

CMS provides substantial oversight of state program integrity activities and effective support and assistance to states to combat Medicaid fraud, waste, and abuse. To gauge states' efforts in this regard, CMS conducts both comprehensive reviews of state's program integrity activities as well as reviews focusing on issues of special interest. From FY 2007 through FY 2013, CMS completed two comprehensive reviews of each state, the District of Columbia, and Puerto Rico. In response to the Medicaid expansion in FY 2014, CMS is conducting focused reviews in nine states that are expected to enroll large numbers of Medicaid beneficiaries for the expansion of their Medicaid programs. These FY 2014 reviews will focus on enhanced provider screening and enrollment activities required by the Affordable Care Act and program integrity issues in Medicaid managed care to report on vulnerabilities and best practices. CMS is also conducting a focused review of the District of Columbia in FY 2014 which will examine how personal care services are managed.

CMS also works to enhance opportunities for states to share ideas and network with peers and other program integrity stakeholders. For example, the Agency provides staff support to the Medicaid Fraud and Abuse Technical Advisory Group, which provides a monthly forum for the exchange of information on Medicaid integrity issues between CMS and representative state program integrity directors. In addition, CMS sponsors quarterly calls for the Program Integrity Directors of each region as well as monthly calls for the Program Integrity Directors from small state Medicaid programs. CMS' New York Regional Office also hosts semi-annual regional meetings of program integrity stakeholders from Medicaid, Medicare, and law enforcement to discuss current fraud issues and recent cases. In addition, each year CMS routinely fulfills requests for technical assistance from state employees, attorneys, providers and others in a variety of program integrity-related areas.

In FY 2014, CMS participated in two field projects with the State of Florida. The first Florida project took place in January 2014, and involved visits to 30 providers of various types in Monroe County. The site visits cited violations which resulted in provider sanctions including fines, referrals to other agencies, and placement on manual prepayment review. The second Florida review took place in April and May 2014, and involved site visits to 50 of the top-billing group homes for the developmentally disabled in a tri-county area north of Miami. This field project identified compliance deficiencies, imposed provider sanctions, and made disciplinary referrals to other agencies.

Medicare Advantage and Prescription Drug Financial Oversight

Sections 1857(d)(1) and 1860D-12(b)(c) of the Social Security Act requires the HHS Secretary to provide for the annual audit of financial records of at least one-third of the Medicare Advantage

Organizations (MAOs) and Prescription Drug Plans (PDPs). The one-third financial audit program is designed to examine the health plans' financial records, data relating to costs, Medicare utilization, and the computation of the bids. During FY 2014, CMS completed 246 audits of MAOs and PDPs for contract year 2011 and awarded contracts for 251 audits for contract year 2012. In addition, through our ROs, CMS conducts audits of the MAOs and PDPs—outside of the one- third audit requirement—to further improve oversight of both Part C and Part D sponsors.

In FY 2014, CMS' contractors audited Medicare cost reports for years 2006 through 2012, reducing the backlog of unaudited cost reports. Disallowances resulting from FY 2014 settlement activity saved about $47.6 million producing a rate of return of $23.44 to $1.

Information Technology (IT)

During FY 2014, CMS continued to make great strides to strengthen IT internal controls, particularly its oversight of the implementation of those controls. The management approach featured a strategy to leverage information security processes and technologies to improve the overall security posture of the CMS Enterprise. In recent years, CMS' information security program has undergone, and continues to undergo, significant change that extends security oversight, continuous monitoring, and vulnerability management to the CMS Enterprise. CMS has expanded several programs to enhance continuous monitoring to help drive real-time enterprise-level situational awareness, increase the efficiency of the CMS system authorization process, and drive ongoing communications with business stakeholders. For example, SharePoint has been implemented to modernize the project management office and improve scheduling and reporting performance. To enhance the performance of SharePoint, the Information Infrastructure Architecture was redesigned and built into a Two-Tier environment. The upgrading of the infrastructure has helped to improve performance in the development, validation and production environments.

Additionally, CMS continues to implement and enhance the following information security initiatives:

- An Enterprise Security Operations Center (ESOC) that provides an enterprise view of the overall security posture at CMS, and is a key component in driving oversight, in monitoring compliance, and in identifying misuse or fraudulent use of CMS Enterprise resources. Overall development activities continue with the Secure Enclave tool implementations at the CMS data centers. CMS has deployed and continues to enhance a Cyber Forensics and Malware Analysis capability that has broadened the ESOC's spectrum of technical capabilities to include monitoring the integrity of the CMS enterprise and further assisting OIG and CMS in effective investigations. In addition, CMS has established a security penetration testing team to objectively test the security posture of CMS systems through the identification of vulnerabilities that can be used to exploit CMS systems.
- 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 threats. A monthly EVM Report Card process is in place with the data centers to assist in the analysis and management of security performance. Last year, the EVM program continued to expand its outreach so that every CMS data center can be incorporated into the EVM Report Card.
- A comprehensive security awareness and training program that provides role-based classroom and computer-based training for all CMS staff including managers, Contracting Officer's Representatives, Information System Security Officers, and other CMS personnel that require security training.
- CMS has continued centralizing all CMS Security and Risk Management Framework practices, procedures, standards, and guidelines into a comprehensive three-volume CMS Risk Management Handbook (RMH). This document details the integration of information security into the eXpedited Life Cycle (XLC). As part of the RMH development, the CMS is continuing to establish and update security policies, standards and procedures including: Cloud Computing, Authentication, Incident Handling, and other security program management tasks. In addition, CMS performed a major update to the principle CMS security and privacy policy, the CMS Policy for Information Security and Privacy. This policy update provides the framework for security and privacy policy and provides for programmatic integration throughout the Agency. CMS also continues to be a major contributor to Chief Information Officer (CIO) Directives and IT governance documents for the CMS CIO.

- In accordance with Memo 14-04, Fiscal Year 2013 Reporting Instructions for the Federal Information Security Management Act (FISMA) and Agency Privacy Management, CMS continues to work to meet and improve the Agency's reporting requirements under FISMA. On a monthly, quarterly and annual basis, CMS performs a data-call in relation to the cybersecurity Cross Agency Priority goals. This data-call allows the organization to measure the Agency's implementation of Trusted Internet Connection, strong authentication through the use of Homeland Security Presidential Directive (HSPD)-12, and the continuous monitoring of Agency security controls of its information systems.

CMS is dedicated to protecting information and information systems with a comprehensive Information Security program, which integrates safeguards through the implementation of preventative, detective, and corrective controls throughout the organization. In 2014, CMS focused its efforts on improvements to the information security awareness and training programs and on the development of the RMH. Both those efforts enhanced its preventative controls by setting comprehensive standards throughout CMS' diverse and decentralized processing environment. As part of its efforts to improve detective controls, CMS also enhanced its continuous monitoring program with the expansion of the EVM program and implementation of cyber forensics and malware analysis capability. CMS' FISMA Access Control Tracking System (CFACTS) requires that information security deficiencies be recorded, tracked and corrected by system security personnel as part of its corrective control process. Overall, CMS has set high standards and has implemented policies and procedures to ensure that technical and operational threats to its system environment are mitigated.

Financial Statements Introduction & Highlights

Introduction

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

Consolidated Balance Sheets

The Consolidated Balance Sheets present as of September 30, 2014 and 2013, 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 $380.0 billion. The bulk of these assets are in Investments totaling $275.4 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 $92.3 billion, most of which is for Medicaid, Other Health, and CHIP. Liabilities of $104.7 billion consist primarily of the Entitlement Benefits Due and Payable of $91.0 billion. CMS' net position totals $275.3 billion and reflects primarily the cumulative results of operations for the Medicare Trust Funds and the unexpended balances for Medicaid and CHIP.

Consolidated Statements of Net Cost

The Consolidated Statements of Net Cost present the net cost of operations for the years ended September 30, 2014 and 2013. The Statement of Net Cost shows only a single dollar amount: the actual net cost of CMS' operations for the period by program. The three major programs that CMS administers are: Medicare, Medicaid, and CHIP. The majority of CMS' expenses are allocated to these programs. Both Medicare and Medicaid program integrity funding are included under the HI Trust Fund. The costs related to the Program Management Appropriation are cost-allocated to all three major components. The net cost of operations under "Other Activities" include: CLIA, State Grants and Demonstrations, Other Health, and Other. A Consolidating Statement of Net Cost is provided to show the funds from dedicated collection vs. other fund components of net cost as additional information.

Total Benefit Payments were $902.6 billion for FY 2014. Administrative Expenses were $4.9 billion, less than one percent of total net Program/Activity Costs of $911.0 billion.

The net cost of the Medicare program including benefit payments, QIOs, Medicare Integrity Program spending, and administrative costs, was $518.1

billion. The HI total costs of $270.4 billion were offset by $3.6 billion in revenues. The SMI total costs of $320.2 billion were offset by premiums and other revenues of $68.9 billion. Medicaid total costs of $305.4 billion represent expenses incurred by the states and territories that were reimbursed by CMS during the FY, plus accrued payables. The CHIP total costs were $9.6 billion.

Consolidated Statements of Changes in Net Position

The Consolidated Statements of Changes in Net Position present the change in net position for the years ended September 30, 2014 and 2013. The Statement of Changes in Net Position (SCNP) reports the change in net position during the FY that occurred in the two components of net position: Cumulative Results of Operations and Unexpended Appropriations. Funds from dedicated collections are shown in a separate column from other funds. A Consolidating Statement of Changes in Net Position is provided to present the change in net position by major programs as additional information.

The line, Appropriations Used, represents the Medicaid appropriations used of $304.5 billion; $260.4 billion in transfers from Payments to Health Care Trust Funds to HI and SMI; CHIP appropriations of $9.6 billion and State Grants and Demonstrations and general fund-financed Program Management appropriations of $3.3 billion. 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 $227.6 billion. The Federal matching contribution is income to the SMI program from a general fund appropriation (Payments to Health Care Trust Funds) of $180.2 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, 2014 and 2013. 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 $1,275.4 billion ($431 million in non-budgetary). Obligations of $1,245.5 billion ($431.0 million in non-budgetary) leave unobligated balances of $29.9 billion - none in non-budgetary. Total outlays, net of collections, were $1,183.1 billion. When offset by $358.7 billion relating to collection of premiums and general fund transfers from the Payments to Health Care Trust Funds, as well as refunds of MAC overpayments, the net outlays were $824.4 billion.

Statement of Social Insurance (SOSI)

The SOSI presents the 75-year actuarial present value of the income and expenditures of the HI and SMI Trust Funds. Future expenditures are expected to arise for current and future program participants. This projection is considered to be important information regarding the potential future cost of the program. These projected potential future obligations are not included in the Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position, or Combined Statement of Budgetary Resources.

Actuarial present values are computed under the intermediate set of assumptions specified in the Annual Report of the Medicare Board of Trustees. As noted in the Trustees Report, the basis for the Part B projections has changed since last year (for more information, see footnotes 14 and 15).

The SOSI presents the following estimates:

- The present value of future income (income excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income to be received from or on behalf of current participants who have not yet attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income less future cost for the closed group, which represents all current participants who attain age 15 or older in the first year of the projection period, plus the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period;
- The present value of income to be received from or on behalf of future participants and the cost of providing benefits to those same individuals;
- The present value of future income less future cost for the open group, which represents all

current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program, plus the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period; and

- The present value of future cash flows for all current and future participants over the next 75 years (open group measure) increased from $(4.8) trillion, determined as of January 1, 2013, to $(3.8) trillion, determined as of January 1, 2014.

Including the combined HI and SMI Trust Fund assets increases the present value, as of January 1, 2014, of future cash flow for all current and future participants to $(3.5) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI Trust Fund assets, is $(8.8) 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 124 percent at the beginning of FY 2010 to 77 percent at the beginning of FY 2014.

TRUST FUND RATIO
(Beginning of Fiscal Year[5])[2]

	2010	2011	2012	2013	2014
HI	124%	107%	95%	86%	77%

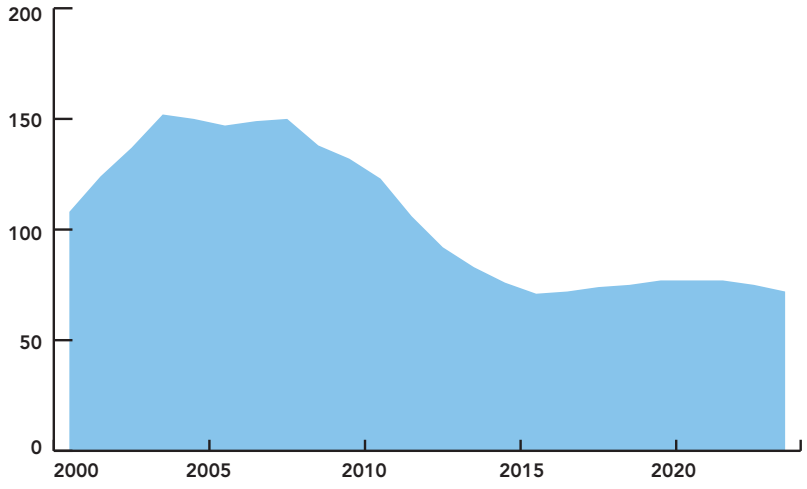
Short-Term Financing

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 2014 Trustees Report indicate that the HI Trust Fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2014 Trustees Report, the HI Trust Fund ratio is estimated to continue to decline through 2015 and remain at approximately that level through 2023. From the end of 2013 to the end of 2023, assets are expected to increase, from $205 billion to $320 billion.

Long-Term Financing

The short-range outlook for the HI Trust Fund is somewhat better than projected last year, and the estimated depletion is 4 years later. After 2023, the trust fund ratio starts to decline quickly until the fund is depleted in 2030. HI financing is not projected to be sustainable over the long term with the tax rates and expenditure levels projected.

HI TRUST FUND RATIO



Source: CMS/OACT

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

Program cost is expected to exceed total income in 2014, and thereafter, income is projected to exceed costs for several years before falling below it in 2022 and later. 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 85 percent of projected expenditures after the HI Trust Fund exhaustion in 2030, declining to 75 percent of projected expenditures in 2045, and to stabilize at about this level thereafter.

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 3.2 in 2013 to about 2.1 by 2088. In addition, health care costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $3.6 trillion, which translates to 0.8. percent of taxable payroll over the same period.

Significant uncertainty surrounds the estimates for the SOSI. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near-term and ultimate assumptions used in the projections. For more information, please refer to the Required Supplementary Information: Social Insurance disclosures required by the Federal Accounting Standards Advisory Board (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, and their program benefits are quite different in nature.

While differences between the two accounts exist, the financing mechanism for each part is similar in that the financing is determined on a yearly basis. The Part B account is generally financed by premiums and general revenue matching appropriations determined annually to cover projected program expenditures and to provide a contingency for unexpected program variation. The Part D account is financed by premiums, general revenues, and transfers from state governments. Unlike the Part B account, Part D has generally included an indefinite authority provision allowing for amounts to be transferred to the Part D account on an as-needed basis. This provision allows previously apportioned amounts to change without additional Congressional action if those amounts are later determined to be insufficient. Consequently, once an appropriation with this provision has been made, no deficit will occur in the Part D account, and no contingency fund will be necessary to cover deficits.

Since both the Part B and Part D programs are financed on a yearly basis, from a program perspective, there is no unfunded liability in the short or long-range. Therefore, in this financial statement the present value of estimated future excess of income over expenditures for current and future participants over the next 75 years is $0. However, from a government wide perspective, general fund transfers as well as interest payments to the Medicare Trust Funds and asset redemption, represent a draw on other Federal resources for which there is no earmarked source of revenue from the public. Hence, from a government wide perspective, the corresponding estimate of future expenditures less income for the 75-year projection period is $(24.7) 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 2013, SMI expenditures were 1.92 percent of GDP. By 2088, SMI expenditures are projected to grow to 4.54 percent of the GDP.

The following table presents key amounts from our basic financial statements for fiscal year 2012 through 2014.

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, 2014, would have decreased by $239 billion due to advancing the valuation date by one year and including the additional year 2088, and by $139 billion due to the change in demographic assumptions. However, changes in the projection base, economic and health care assumptions, and legislation changes increased the present value of future cash flows by $447 billion, $772 billion, and $108 billion, respectively.

TABLE OF KEY MEASURES[3] (Dollars in Billions)	2014	2013	2012
Net Position (end of fiscal year)			
Assets	$380.0	$370.2	$424.8
Less Total Liabilities	$104.7	$88.3	$80.5
Net Position (assets net of liabilities)	$275.3	$281.9	$344.3
Change in Net Position (end of fiscal year)			
Net Costs	$837.8	$779.8	$737.8
Total Financing Sources	$820.4	$756.1	$710.8
Change in Net Position	$(17.4)	$(23.7)	$(27.0)
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	($3,823)	$(4,772)	$(5,581)
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	($4,772)	$(5,581)	$(3,252)
Change in present value	$949	$809	$(2,329)

Required Supplementary Information (RSI)

As required by Statement of Federal Financial Accounting Standards (SSFAS) Number 17, Accounting for Social Insurance (as amended by SFFAS Number 37, Social Insurance: Additional Requirements for Management Discussion and Analysis and Basic Financial Statements), CMS has included information about the Medicare trust funds – HI and SMI. The RSI presents required long-range cash-flow projections, the long-range projections of the ratio of contributors to beneficiaries (dependency ratio), and the sensitivity analysis illustrating the effect of the changes in the most significant assumptions on the actuarial projections and present values. The SFFAS 37 does not eliminate or otherwise affect the SFFAS 17 requirements for the supplementary information, except that actuarial projections of annual cash flow in nominal dollars are no longer required; as such, it will not be reported in the RSI. The RSI assesses the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the 2014 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.

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

2 FINANCIAL SECTION

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

A MESSAGE FROM THE CHIEF FINANCIAL OFFICER

DEBORAH A. TAYLOR, CPA

The Centers for Medicare & Medicaid Services (CMS) is committed to fiscal accountability and sound financial planning and management over its programs. Our dedication is driven by our desire for financial excellence. We received an unqualified opinion on four of the six principal financial statements with no material weaknesses identified in our internal controls; yet, the auditors did cite significant deficiencies in information systems, and financial reporting and oversight. The Agency takes these deficiencies seriously and continues to pursue and implement corrective actions to resolve the issues identified and strengthen our controls. Many of the corrective actions for information systems issues are complex and will require multi-year efforts.

The uncertainty of the long–range assumptions used in our Statement of Social Insurance (SOSI) continues to be a challenge for our auditors to express an opinion. As in previous years, the auditors did not express an opinion. CMS remains confident that the fiscal year (FY) 2014 SOSI projections fairly represent the effects of the Affordable Care Act and properly disclose the purpose of the projection.

FY 2014 was a very critical year for CMS, given several new legislative mandates and initiatives the Agency was responsible for managing. Although the fiscal year brought many challenges, CMS effectively managed its programs and fiscal responsibilities. We continue to seek innovative ways to deliver sound financial management while managing our complex programs. The following significant activities were noted for FY 2014.

- The Health Insurance Marketplace officially opened for enrollment in October 2013, with coverage beginning January 2014. While we recognize the difficulties faced with the start of Marketplace activities in the beginning of the fiscal year, CMS was able to make timely payments to Qualified Health Plan issuers on behalf of enrollees for the Advanced Premium Tax Credit (APTC) and Cost-Sharing Reduction (CSR) programs, thereby assisting the uninsured in receiving access to much needed healthcare services.

- During FY 2014, CMS successfully implemented the Government-wide Treasury Account Symbol Adjusted Trial Balance System (GTAS) reporting, as mandated by the Office of Management and Budget (OMB). GTAS replaced the functionality of several Treasury financial reporting systems as the primary means of reporting agency trial balance data. We worked tirelessly to ensure the completion of the implementation of this system in order to provide a single data collection system that will pave the way for more consistent and complete financial data and will allow for better analytical reporting. CMS was able to meet OMB's objectives of improving data quality, streamlining agency reporting, and implementing data standardization.

- CMS developed and began implementing a plan to maintain the Healthcare Integrated General Ledger Accounting System (HIGLAS) on the most current version of Oracle's Federal Financial software. OMB and the Department of Health and Human Services have reviewed and approved our plan, and we are well underway to upgrading our system and ensuring that the accounting system is maintained and operational for years to come. This is the first major upgrade for HIGLAS since it went live nine years ago. In addition, we are also upgrading the hardware to increase performance to keep up with the ever increasing demands and high volume of transactions to support CMS' lines of business.

- Savings for the Medicare Secondary Payer (MSP) program continued to increase in FY 2014. The Medicare Trust Fund's savings were $6.5 billion for this fiscal year. We continued our efforts to improve and streamline the MSP program by successfully implementing a new MSP contract strategy that provides stakeholders with one central point of contact for coordination of benefits and recovery matters. In addition, CMS enhanced program integrity through additional

review measures by completing pre-payment Meaningful Use audits for the Electronic Health Record Incentive Program. Over 5,200 pre-payment Meaningful Use audits have been successfully completed, resulting in savings of approximately $14 million in FY 2014.

- CMS continually seeks innovative methods for reducing the risk of improper payments, and this fiscal year prevented and recovered billions of dollars in improper Medicare payments. One such method is prior authorization. Based on the success of the Power Mobility Device (PMD) Prior Authorization demonstration, which reduced monthly spending nationwide from $32 million to $7 million from September 2012 to March 2014. During FY 2014, CMS announced the following broader prior authorization initiatives: (1) the expansion of the PMD demonstration to twelve additional states; (2) prior authorization demonstrations of repetitive, scheduled non emergent ambulance transport and non-emergent hyperbaric oxygen services; and (3) a proposed regulation for prior authorization for certain durable medical equipment, prosthetics, orthotics, and supplies. Prior authorization supports the Agency's ongoing efforts to safeguard beneficiaries' access to medically necessary items and services, while reducing improper Medicare billings and payments.
- We continue to improve our oversight activities in a way that balances our fiscal responsibilities over the programs we manage, as well as reducing provider burden. We are currently in the procurement process to award five Medicare Fee-For-Service Recovery Auditor program contracts. Four will be responsible for improper payment identification of hospital, physician and facility claims. The fifth will identify improper payments among durable medical equipment, hospice and home health claims.

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 2014

CONSOLIDATED BALANCE SHEETS

as of September 30, 2014 and September 30, 2013

(IN MILLIONS)

	FY 2014 Consolidated Totals	FY 2013 Consolidated Totals
ASSETS		
Intragovernmental Assets:		
Fund Balance with Treasury *(Note 2)*	$92,285	$76,609
Investments *(Note 3)*	275,386	278,270
Accounts Receivable, Net *(Note 4)*	613	3,371
Other Assets	26	114
Total Intragovernmental Assets	368,310	358,364
Accounts Receivable, Net *(Note 4)*	9,860	10,637
General Property, Plant and Equipment, Net	403	369
Other Assets *(Note 5)*	1,460	831
TOTAL ASSETS	**$380,033**	**$370,201**
LIABILITIES		
Intragovernmental Liabilities:		
Accounts Payable	$608	$655
Accrued Payroll and Benefits	6	1
Other Intragovernmental Liabilities	1,833	1,472
Total Intragovernmental Liabilities	**2,447**	**2,128**
Accounts Payable	134	147
Federal Employee and Veterans' Benefits	14	15
Entitlement Benefits Due and Payable *(Note 6)*	91,037	77,277
Accrued Payroll and Benefits	71	72
Contingencies *(Note 7)*	9,760	7,366
Other Liabilities	1,239	1,282
TOTAL LIABILITIES (Note 8)	**$104,702**	**$88,287**
NET POSITION		
Unexpended Appropriations–Dedicated Collections	$16,315	$4,569
Unexpended Appropriations–Other Funds	36,683	37,655
Total Unexpended Appropriations	**52,998**	**42,224**
Cumulative Results of Operations–Dedicated Collections	220,795	238,145
Cumulative Results of Operations–Other Funds	1,538	1,545
Total Cumulative Results of Operations	**222,333**	**239,690**
TOTAL NET POSITION	**$275,331**	**$281,914**
TOTAL LIABILITIES AND NET POSITION	**$380,033**	**$370,201**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF NET COST

for the Years Ended September 30, 2014 and September 30, 2013

(IN MILLIONS)

	FY 2014 Consolidated Totals	FY 2013 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS		
GPRA Programs		
Medicare (Dedicated Collections)	$518,066	$498,576
Medicaid	305,359	266,624
CHIP	9,574	9,548
Net Cost: GPRA Programs	**832,999**	**774,748**
Other Activities		
State Grants and Demonstrations	555	712
Other Health	3,811	4,023
Other	399	308
Net Cost: Other Activities	4,765	5,043
NET COST OF OPERATIONS *(Notes 9, 12, and 17)*	**$837,764**	**$779,791**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the Year Ended September 30, 2014

(IN MILLIONS)

	Consolidated Dedicated Collections	Consolidated Other Funds	FY 2014 Consolidated Total
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	$238,145	$1,545	$239,690
Budgetary Financing Sources:			
Appropriations Used	260,360	318,559	578,919
Nonexchange Revenue:			
FICA and SECA Taxes	227,579		227,579
Interest on Investments	11,299	3	11,302
Other Nonexchange Revenue	3,823		3,823
Transfers-in/out Without Reimbursement	(2,381)	1,123	(1,258)
Other Financing Sources (Nonexchange):			
Transfers-in/out Without Reimbursement		(7)	(7)
Imputed Financing	36	13	49
Total Financing Sources	**500,716**	**319,691**	**820,407**
Net Cost of Operations	**518,066**	**319,698**	**837,764**
Net Change	**(17,350)**	**(7)**	**(17,357)**
CUMULATIVE RESULTS OF OPERATIONS	**$220,795**	**$1,538**	**$222,333**
UNEXPENDED APPROPRIATIONS			
Beginning Balances	$4,569	$37,655	$42,224
Budgetary Financing Sources:			
Appropriations Received	273,772	345,593	619,365
Appropriations Transferred-in/out		(3,452)	(3,452)
Other Adjustments *(Note 10)*	(1,666)	(24,554)	(26,220)
Appropriations Used	(260,360)	(318,559)	(578,919)
Total Budgetary Financing Sources	**11,746**	**(972)**	**10,774**
Total Unexpended Appropriations	**16,315**	**36,683**	**52,998**
NET POSITION	**$237,110**	**$38,221**	**$275,331**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the Year Ended September 30, 2013

(IN MILLIONS)

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

The accompanying notes are an integral part of these statements.

COMBINED STATEMENTS OF BUDGETARY RESOURCES

for the Years Ended September 30, 2014 and September 30, 2013

(IN MILLIONS)

	FY 2014 Combined Totals Budgetary	FY 2014 Non-Budgetary Credit Reform Financing Account	FY 2013 Combined Totals Budgetary	FY 2013 Non-Budgetary Credit Reform Financing Account
Budgetary Resources:				
Unobligated balance, brought forward, October 1:	$34,387		$72,274	$3,123
Recoveries of prior year unpaid obligations	23,985		22,295	
Other changes in unobligated balance	(290)		(671)	
Unobligated balance from prior year budget authority, net	58,082		93,898	3,123
Appropriations	1,204,005		1,083,649	
Borrowing authority		$237		(2,064)
Spending authority from offsetting collections	13,314	194	16,122	(754)
TOTAL BUDGETARY RESOURCES	**$1,275,401**	**$431**	**$1,193,669**	**$305**
Status of Budgetary Resources:				
Obligations incurred	$1,245,505	$431	$1,159,282	$305
Unobligated balance, end of year:				
Apportioned	25,142		26,084	
Exempt from apportionment			1,864	
Unapportioned	4,754		6,439	
Total unobligated balance, end of year	29,896		34,387	
TOTAL BUDGETARY RESOURCES	**$1,275,401**	**$431**	**$1,193,669**	**$305**
Change in Obligated Balance:				
Unpaid obligations:				
Unpaid obligations, brought forward, October 1	$110,623	$1,249	$98,570	$1,602
Adjustment to unpaid obligations	($126)			
Obligations incurred	1,245,505	431	1,159,282	305
Outlays (gross)	(1,196,249)	(680)	(1,124,934)	(658)
Recoveries of prior year unpaid obligations	(23,985)		(22,295)	
Unpaid obligations end of year	**135,768**	**1,000**	**110,623**	**1,249**
Uncollected Payments:				
Uncollected payments, Federal sources, brought forward, October 1	(7,754)	(536)	(7,250)	(1,587)
Adjustment to uncollected payments, Federal sources	156	(10)		
Change in uncollected payments, Federal sources	(191)	117	(504)	1,051
Uncollected payments, Federal sources, end of year	(7,789)	(429)	(7,754)	(536)
Memorandum entries:				
Obligated start of year, net	102,869	713	91,320	15
Obligated balance, end of year, net	$127,979	$571	$102,869	$713
Budgetary Authority and Outlays, Net:				
Budget authority, gross	$1,217,319	$431	$1,099,771	$(2,818)
Actual offsetting collections	(13,123)	(310)	(15,618)	(296)
Change in uncollected customer payments from Federal sources	(191)	117	(504)	1,051
Budget authority, net	1,204,005	238	1,083,649	(2,063)
Outlays, gross	1,196,249	680	1,124,934	658
Actual offsetting collections	(13,123)	(310)	(15,618)	(296)
Outlays, net	1,183,126	370	1,109,316	362
Distributed offsetting receipts	(358,745)		(335,935)	
AGENCY OUTLAYS, NET	**$824,381**	**$370**	**$773,381**	**$362**

The accompanying notes are an integral part of these statements.

STATEMENT OF SOCIAL INSURANCE

75-Year Projection as of January 1, 2014 and Prior Base Years

(IN BILLIONS)

		Estimates from Prior Years			
	2014 (unaudited)	2013 (unaudited)	2012 (unaudited)	2011 (unaudited)	2010 (unaudited)
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 14 and 15)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$8,398	$8,147	$7,929	$7,581	$7,216
SMI Part B	17,127	15,227	14,431	13,595	12,688
SMI Part D	5,928	5,871	5,866	6,438	6,355
Have attained eligibility age (age 65 or over)					
HI	332	301	302	262	248
SMI Part B	2,873	2,620	2,395	2,122	1,972
SMI Part D	775	722	694	695	646
Those expected to become participants					
HI	7,812	7,744	7,367	7,260	6,944
SMI Part B	4,311	3,530	3,333	3,223	3,077
SMI Part D	2,609	2,617	2,568	2,817	2,714
All current and future participants					
HI	16,542	16,192	15,598	15,104	14,408
SMI Part B	24,311	21,377	20,159	18,940	17,737
SMI Part D	9,312	9,211	9,128	9,950	9,715
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 14 and 15)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	14,117	14,629	14,919	12,887	12,032
SMI Part B	17,003	15,075	14,303	13,489	12,587
SMI Part D	5,928	5,871	5,866	6,438	6,355
Have attained eligibility age (age 65 and over)					
HI	3,484	3,422	3,369	2,923	2,648
SMI Part B	3,171	2,887	2,646	2,343	2,166
SMI Part D	775	722	694	695	646
Those expected to become participants					
HI	2,764	2,913	2,891	2,546	2,411
SMI Part B	4,137	3,415	3,211	3,108	2,984
SMI Part D	2,609	2,617	2,568	2,817	2,714
All current and future participants:					
HI	20,365	20,963	21,179	18,356	17,090
SMI Part B	24,311	21,377	20,159	18,940	17,737
SMI Part D	9,312	9,211	9,128	9,950	9,715
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 14 and 15)					
HI	(3,823)	(4,772)	(5,581)	(3,252)	(2,683)
SMI Part B	0	0	0	0	
SMI Part D	0	0	0	0	
ADDITIONAL INFORMATION					
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 14 and 15)					
HI	$(3,823)	$(4,772)	$(5,581)	$(3,252)	$(2,683)
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0
Trust Fund assets at start of period					
HI	205	220	244	272	304
SMI Part B	74	66	80	71	76
SMI Part D	1	1	1	1	
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over expenditures (Notes 14 and 15)					
HI	(3,618)	(4,551)	(5,337)	(2,980)	(2,378)
SMI Part B	74	66	80	71	76
SMI Part D	1	1	1	1	

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

STATEMENT OF SOCIAL INSURANCE *(Continued)*

75-Year Projection as of January 1, 2014 and Prior Base Years

(IN BILLIONS)

		Estimates from Prior Years			
	2014 (unaudited)	**2013 (unaudited)**	**2012 (unaudited)**	**2011 (unaudited)**	**2010 (unaudited)**
MEDICARE SOCIAL INSURANCE SUMMARY					
Current Participants: *Actuarial present value for the 75-year projection period from or on behalf of:*					
Those who, in the starting year of the projection period, have attained eligibility age:					
Income (excluding interest)	$3,980	$3,643	$3,391	$3,079	$2,866
Expenditures	7,430	7,031	6,709	5,961	5,459
Income less expenditures	(3,450)	(3,388)	(3,319)	(2,882)	(2,593)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	31,453	29,244	28,227	27,615	26,259
Expenditures	37,048	35,574	35,088	32,814	30,974
Income less expenditures	(5,595)	(6,330)	(6,861)	(5,199)	(4,715)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(9,045)	(9,718)	(10,180)	(8,081)	(7,308)
Combined Medicare Trust Fund assets at start of period	280	288	325	344	381
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(8,764)	(9,430)	(9,855)	(7,737)	(6,927)
Future Participants: *Actuarial present value for the 75-year projection period:*					
Income (excluding interest)	14,732	13,891	13,268	13,300	12,735
Expenditures	9,510	8,945	8,669	8,471	8,109
Income less expenditures	5,222	4,946	4,599	4,829	4,626
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(3,823)	(4,772)	(5,581)	(3,252)	(2,683)
Combined Medicare Trust Fund assets at start of period	280	288	325	344	381
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$(3,542)	$(4,484)	$(5,256)	$(2,908)	$(2,302)

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

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

January 1, 2013 to January 1, 2014

(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 16)*					
As of January 1, 2013	$46,779	$51,550	($4,772)	$288	($4,484)
Reasons for change					
Change in the valuation period	1,962	2,201	(239)	(19)	(258)
Change in projection base	(98)	(545)	447	12	458
Changes in the demographic assumptions	180	318	(139)	0	(139)
Changes in economic and health care assumptions	1,293	521	772	0	772
Changes in law	50	(57)	108	0	108
Net changes	3,387	2,438	949	(7)	942
As of January 1, 2014	$50,166	$53,988	$(3,823)	$280	$(3,542)
HI: PART A *(Note 16)*					
As of January 1, 2013	$16,192	$20,963	$(4,772)	$220	$(4,551)
Reasons for change					
Change in the valuation period	619	858	(239)	(22)	(261)
Change in projection base	123	(323)	447	7	454
Changes in the demographic assumptions	(45)	93	(139)	0	(139)
Changes in economic and health care assumptions	(346)	(1,118)	772	0	772
Changes in law	0	(108)	108	0	108
Net changes	350	(598)	949	(15)	934
As of January 1, 2014	$16,542	$20,365	$(3,823)	$205	$(3,618)
SMI: PART B *(Note 16)*					
As of January 1, 2013	$21,377	$21,377	$0	$66	$66
Reasons for change					
Change in the valuation period	894	894	0	3	3
Change in projection base	(391)	(391)	0	4	4
Changes in the demographic assumptions	(203)	(203)	0	0	0
Changes in economic and health care assumptions	2,638	2,638	0	0	0
Changes in law	(2)	(2)	0	0	0
Net changes	2,935	2,935	0	8	8
As of January 1, 2014	$24,311	$24,311	$0	$74	$74
SMI: PART D *(Note 16)*					
As of January 1, 2013	$9,211	$9,211	$0	$1	$1
Reasons for change					
Change in the valuation period	450	450	0	(0)	(0)
Change in projection base	170	170	0	0	0
Changes in the demographic assumptions	428	428	0	0	0
Changes in economic and health care assumptions	(999)	(999)	0	0	0
Changes in law	53	53	0	0	0
Net changes	102	102	0	(0)	(0)
As of January 1, 2014	$9,312	$9,312	$0	$1	$1

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

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

January 1, 2012 to January 1, 2013

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

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

NOTE 1:

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity

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

Basis of Accounting and Presentation

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

The financial statements have been prepared to report the financial position, net cost, changes in net position, and budgetary resources for all programs administered by CMS. CMS' fiscal year ends September 30. These financial statements reflect both accrual and budgetary accounting transactions. Under the accrual method of accounting, revenues are recognized when earned and expenses are recognized when incurred, without regard to the receipt or payment of cash. Budgetary accounting is designed to recognize the obligation of funds according to legal requirements which, in many cases, is made prior to the occurrence of an accrual-based transaction. Budgetary accounting is essential for compliance with legal constraints and controls over the use of Federal funds.

Use of Estimates

The preparation of financial statements, in conformity with GAAP, requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the dates of the financial statements and the reported amounts of revenues and expenses during the reporting periods. Further, the estimates are based on current conditions that may change in the future. Actual results could differ materially from the estimated amounts. The financial statements include information to assist in understanding the effect of changes in assumptions to the related information.

Parent/Child Reporting

CMS is a party to allocation transfers with other Federal agencies as both a transferring (parent) entity and/or a receiving (child) entity. Allocation transfers are legal delegations by one agency of its authority to obligate budget authority and outlay funds to another agency. Most financial activity related to these allocation transfers (e.g., budget authority, obligations, outlays) is reported in the financial statements of the parent entity, from which the underlying legislative authority, appropriations and budget apportionments are derived. CMS has a child relationship with the Internal Revenue Service for the payment of APTC and CSR payments; these payments are not included in CMS' financial statements.

Funds from Dedicated Collections

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

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

CMS' major funds from dedicated collections include:

Medicare Hospital Insurance Trust Fund – Part A

Section 1817 of the Social Security Act established the Medicare Hospital Insurance (HI) Trust Fund. Medicare contractors are paid by CMS to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI trust fund. A portion of CMS payments to Medicare Advantage plans are also charged to this fund. The financial statements include HI trust fund activities administered by the Department of the Treasury (Treasury). The HI trust fund has permanent indefinite authority.

Employment tax revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA). Employees and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI trust fund. Self-employed individuals contribute the full 2.9 percent of their net income. The Social Security Act requires the transfer of these contributions from the General Fund of Treasury to the HI trust fund based on the amount of wages certified by the Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 as the basis for conducting quarterly certification of regular wages.

Medicare Supplementary Medical Insurance Trust Fund – Part B

Section 1841 of the Social Security Act established the Supplementary Medical Insurance (SMI) Trust Fund. Medicare contractors are paid by CMS to process Medicare claims for physicians, medical suppliers, laboratory services, hospital outpatient services and rehabilitation, 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.

Medicare Supplementary Medical Insurance Trust Fund – Part D

The Medicare Modernization Act of 2003 (MMA), established the Medicare Prescription Drug Benefit – Part D. The program makes a prescription drug benefit available to everyone who is in Medicare, though beneficiaries must join a drug plan to obtain coverage. The drug plans are offered by insurance companies and other private companies approved by Medicare and are of two types: Medicare Prescription Drug Plans (which add the coverage to basic Medicare) and Medicare Advantage Prescription Drug Plans and other Medicare Health Plans in which drug coverage is offered as part of a benefit package that includes Part A and Part B services. In addition, Medicare helps employers or unions continue to provide retiree drug coverage that meets Medicare's standards through the Retiree Drug Subsidy (RDS). In addition, the Low Income Subsidy (LIS) helps those with limited income and resources.

The Affordable Care Act provides that beneficiary cost sharing in the Part D coverage gap is reduced for brand-name and generic drugs from 100 percent in 2010 (including the $250 rebate) to 25 percent by 2020. The Part D is considered part of the SMI trust fund and is reported in the SMI TF column of the financial statements.

Medicare and Medicaid Integrity Programs

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the Medicare Integrity Program at section 1893 of the Social Security Act, and codified Medicare program integrity activities previously known as "payment safeguards." HIPAA section 201 also established the Health Care "Fraud and Abuse Control Account, which provides a dedicated appropriation for carrying out the Medicare Integrity Program." Through the Medicare Integrity Program, CMS contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews, cost report audits, and the education of providers and beneficiaries with respect to payment integrity and benefit quality assurance issues. The Medicare Integrity Program is funded by the HI trust fund.

Separately, the Medicaid Integrity Program was established by the Deficit Reduction Act of 2005 (DRA), and codified at section 1936 of the Social Security Act. The Medicaid Integrity Program represents the Federal government's first national strategy to detect and prevent Medicaid fraud and abuse. Under the Medicaid Integrity Program, CMS contracts with eligible entities to review provider claims and perform audits, with respect to Medicaid providers, similar to those activities currently performed by Medicare Integrity Program contractors with respect to Medicare providers.

Payments to the Health Care Trust Funds Appropriation

The Social Security Act provides for payments to the HI and SMI trust funds for SMI (appropriated funds to provide for Federal matching of SMI premium collections) and HI (for the Uninsured and Federal Uninsured Payments). The MMA prescribes that funds covering the Medicare Prescription Drug Benefit and associated administrative costs, retiree drug coverage, reimbursements to the States and Transitional Assistance benefits be transferred from Payments to the Health Care Trust Funds to the SMI trust fund. HIPAA prescribes that criminal fines and civil monetary penalties arising from health care cases be transferred to the Health Care Fraud and Abuse Control (HCFAC) account of the HI trust fund through permanent appropriations of the Payments to the Health Care Trust Funds as well as payments to support FBI activities related to health care fraud and abuse activities. In addition, funds are provided by this appropriation to cover CMS' administrative costs that are not related to the Medicare program. To prevent duplicative reporting, the Fund Balance, Unexpended Appropriation, Financing Sources and Expenditure Transfers of this appropriation are reported only in the Medicare HI TF and SMI TF columns of the financial statements.

There is permanent indefinite authority for the transfer of general funds to the HI trust fund in amounts equal to SECA tax credits and receipts from taxation of Old Age Survivors and Disability Insurance (OASDI) beneficiaries. The Social Security Amendments of 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989. The Social Security Amendments of 1994, provided for additional tax payments from Social Security OASDI benefits and Tier 1 Railroad Retirement beneficiaries.

The HIPAA prescribes that criminal fines and civil monetary penalties arising from health care cases be appropriated to the HCFAC account of the HI trust fund. There is permanent indefinite authority for the transfer of general funds containing criminal fines and civil monetary penalties to the HCFAC account of the HI trust fund.

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

Medicaid

Medicaid, the health care program for low-income Americans, is administered by CMS in partnership with the States. Grant awards limit the funds that can be drawn by the States to cover current expenses. The grant awards, prepared at the beginning of each quarter and amended as necessary, are an estimate of the Federal (CMS) share of the States' Medicaid costs. At the end of each quarter, states report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by CMS for the difference between approved expenses reported for the period and the grant awards previously issued. Medicaid also provides funding for the Health Information Technology for Economic and Clinical Health (HITECH) incentive payments made to the States. Beginning January 1, 2014, the Affordable Care Act expanded eligibility for Medicaid to certain low-income adults with the Federal government paying 100% of those claims for Medicaid expansion for the

first three years and 90% of those claims every year thereafter. This year's methodology for estimating the Medicaid Entitlement Benefits Due and Payable was changed to account for those claims incurred as the result of Medicaid expanded coverage.

Children's Health Insurance Program (CHIP)

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

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) extended the program through September 2013; the Affordable Care Act extends the program through September 2015. CHIPRA also establishes a Child Enrollment Contingency Fund to cover shortfalls in funding for the States. This fund is invested in interest-bearing Treasury securities.

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

State Grants and Demonstrations

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

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

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

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

Program Management User Fees: Medicare Advantage, Clinical Laboratory Improvement Program, Marketplace, and Other User Fees

This account operates as a revolving fund without fiscal year restriction. The BBA established the Medicare + Choice program, now known as the Medicare Advantage program under the MMA, that requires Medicare Advantage plans to make payments for their share of the estimated costs related to enrollment, dissemination of information, and certain counseling and assistance programs. These user fees are devoted to educational efforts for beneficiaries and outreach partners. The Clinical Laboratory Improvement Amendments of 1988 (CLIA) marked the first comprehensive effort by the Federal government to regulate medical laboratory testing. 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. Beginning January 1, 2014, the Affordable Care Act requires the collection of a user fee from each issuer offering coverage through a Federally-facilitated Marketplace to offset operating costs. Other user fees are charged for certification of some nursing facilities and for sale of the data on nursing facilities surveys, for coordination of benefits for the Part D program, and for new providers of medical or other items or services. Proceeds from the sale of data from the public use files and publications under the Freedom of Information Act (FOIA) are also credited to this fund.

Program Management Appropriation

The Program Management Appropriation provides CMS with the major source of administrative funds to manage the Medicare and Medicaid programs. The funds for this activity are provided from the HI and SMI trust funds, the general fund, and reimbursable activities. The Payments to the Health Care Trust Funds Appropriation reimburses the Medicare HI trust fund to cover the Health programs' share of CMS administrative costs. User fees collected from Medicare Advantage plans seeking Federal qualification and funds received from other Federal agencies to reimburse CMS for services performed for them are credited to the Program Management Appropriation.

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

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

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

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

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

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

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

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

Unexpended Appropriations include the portion of CMS' appropriations represented by undelivered orders and unobligated balances.

Benefit Payments are payments made by Medicare contractors, CMS, and State Medicaid agencies to health care providers for their services. CMS recognizes the cost associated with payments in the period incurred and based on entitlement. In accordance with Public Law and existing Federal accounting standards, no

expense or liability is recorded for any future payment to be made on behalf of current workers contributing to the Medicare HI trust fund. By law, if the monthly disbursement date falls on a weekend or a federal recognized holiday, CMS is required to accelerate the disbursement date to the preceding business day.

State Phased-Down Contributions are reimbursements to the SMI trust fund for the Federal assumption of Medicaid prescription drug costs for dually eligible beneficiaries pursuant to the MMA. This subsection prescribes a formula for computing the states' contributions and allows states to make monthly payments. Amounts billed and collected under the State Phased-Down provision are recognized as a reduction to expense.

Premiums Collected are used to finance SMI benefits and administrative expenses. Monthly premiums paid by Medicare beneficiaries are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year.

Budgetary Financing Sources (Other than Exchange Revenues) arise primarily from exercise of the Government's power to demand payments from the public (e.g., taxes, duties, fines, and penalties). These include appropriations used, transfers of assets from other Government entities, donations, and imputed financing. The major sources of Budgetary financing sources are as follows:

- **Appropriations Used and Federal Matching Contributions** are described in the Medicare Premiums section above. For financial statement purposes, appropriations used are recognized as a financing source as expenses are incurred. A transfer of general funds to the HI trust fund in an amount equal to SECA tax credits is made through the Payments to the Health Care Trust Funds Appropriation. The Social Security Amendments of 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989.
- **Nonexchange Revenues** arise primarily from the exercise of the Government's power to demand payment from the public (e.g., taxes, duties, fines and penalties) but also include donations. Employment tax revenue is the primary source of financing for Medicare's HI program. Interest earned on HI and SMI trust fund investments, as well as on the Child Enrollment Contingency Fund investments, is also reported as nonexchange revenue.

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

Obligations Incurred consists of expended authority and the change in undelivered orders. OMB has exempted CMS from the Circular No. A-11 requirement to report Medicare's refunds of prior year obligations separately from refunds of current year obligations on the SF-133. OMB has mandated that CMS report all Medicare cash collections as an offsetting receipt.

Estimation of Obligations Related to Canceled Appropriations

As of September 30, 2014, CMS has canceled over $114 million in cumulative obligations related to FY 2009 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 2010 through 2014 related to canceled appropriations, CMS anticipates an additional $3.5 million will be paid from current year funds for canceled obligations.

The Affordable Care Act

The Affordable Care Act contains the most significant changes to health care coverage since the passing of the Social Security Act. The Affordable Care Act provided funding for the establishment by CMS of a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. It also allowed for the establishment of a Center for Consumer Information and Insurance Oversight (CCIIO). The programs under CCIIO include: Affordable Insurance Marketplaces (the "Marketplaces") and the Consumer Operated and Oriented Plan (CO-OP) program. A brief description of these programs and their impact on the CMS financial statements is presented below.

Affordable Insurance Marketplaces

Grants have been provided to the States to establish Affordable Insurance Marketplaces. The initial grants were made by the HHS to the States "not later than one (1) year after the date of enactment." Thus, HHS made the initial grants by March 23, 2011. Subsequent grants were issued by CMS. All Marketplaces were launched on October 1, 2013.

Consumer Operated and Oriented Plan (CO-OP) Program

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

NOTE 2:

FUND BALANCE WITH TREASURY

(DOLLARS IN MILLIONS)

	FY 2014	FY 2013
FUND BALANCES:		
Trust Funds:		
HI Trust Fund Balance	$744	$1,959
SMI Trust Fund Balance	18,445	7,489
Special Funds:		
CHIP Child Enrollment Contingency	9	12
Revolving Funds:		
COOP Financing	105	121
Appropriated Funds:		
Medicaid	36,781	32,150
CHIP	20,586	17,127
State Grants and Demonstrations	3,156	2,246
Other Health	11,119	14,012
Program Management Direct/Reimbursables	1,320	1,477
Other	-	
Other Fund Types:		
CMS Suspense Account	20	16
Total Fund Balances	**$92,285**	**$76,609**
STATUS OF FUND BALANCES WITH TREASURY:		
Unobligated Balance:		
Available	$25,142	$27,948
Unavailable	4,754	6,439
Obligated Balance not yet Disbursed	128,550	103,582
Non-Budgetary FBWT	(66,161)	(61,360)
Total Status of Fund Balances with Treasury	**$92,285**	**$76,609**

Fund Balances are funds with Treasury that are primarily available to pay current expenditures and liabilities. The Medicaid balance of $36,781 million ($32,150 million in FY 2013) includes $2,662 million ($3,772 million in FY 2013) of funds for ARRA. The Unobligated Balance Available includes $12,374 million ($12,972 million in FY 2013), which is restricted for future use and is not apportioned for current use for Affordable Care Act, CHIP, Program Management, and State Grants and Demonstrations.

NOTE 3:

INVESTMENTS

(DOLLARS IN MILLIONS)

FY 2014 MEDICARE INVESTMENTS *(Dedicated Collections)*	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2015	2 1/8%	$9,543
Bonds	June 2016 to June 2024	3 1/4 – 5 5/8%	192,665
Accrued Interest			2,153
Total HI TF Investments			**$204,361**
SMI TF			
Certificates	June 2015	2 1/8 – 2 3/8%	$6,172
Bonds	June 2016 to June 2029	2 1/4 – 5 5/8%	62,219
Accrued Interest			534
Total SMI TF Investments			**$68,925**
Total Medicare Investments			**$273,286**

FY 2013 MEDICARE INVESTMENTS *(Dedicated Collections)*	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2014	2 3/8%	$8,841
Bonds	June 2015 to June 2024	3 1/4 – 6 1/2%	197,169
Accrued Interest			2,221
Total HI TF Investments			**$208,231**
SMI TF			
Certificates	June 2014	2 3/8%	$9,147
Bonds	June 2014 to June 2026	1 3/4 – 6 1/2%	58,238
Accrued Interest			557
Total SMI TF Investments			**$67,942**
Total Medicare Investments			**$276,173**

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

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

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

NOTE 3:

INVESTMENTS *(Continued)*

(DOLLARS IN MILLIONS)

FY 2014 CHIP CHILD ENROLLMENT CONTINGENCY FUND INVESTMENTS *(Non-Dedicated Collections)*	Maturity Date	Cost	Unamortized Discount	Investments, Net
Treasury Bill	01/08/2015	$2,101	$1	$2,100
Total Non-Dedicated Collections Investments		**$2,101**	**$1**	**$2,100**

FY 2013 CHIP CHILD ENROLLMENT CONTINGENCY FUND INVESTMENTS *(Non-Dedicated Collections)*	Maturity Date	Cost	Unamortized Discount	Investments, Net
Treasury Bill	01/09/14	$2,098	$1	$2,097
Total Non-Dedicated Collections Investments		**$2,098**	**$1**	**$2,097**

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

CMS INVESTMENT SUMMARY

(DOLLARS IN MILLIONS)

	Medicare (Dedicated Collections)			Non-Dedicated Collections	Consolidated Total
FY 2014	HI TF	SMI TF	Total	CHIP	
Certificates	$9,543	$6,172	$15,715		$15,715
Bonds	192,665	62,219	254,884		254,884
Treasury Bills				$2,100	2,100
Accrued Interest	2,153	534	2,687		2,687
Total Investments	**$204,361**	**$68,925**	**$273,286**	**$2,100**	**$275,386**

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

Note 4:

ACCOUNTS RECEIVABLE, NET

(DOLLARS IN MILLIONS)

FY 2014	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable Gross	Allowance	Net CMS Receivables
Intragovernmental						
Entity	$613	$ -	$ -	$613	$ -	$613
Total Intragovernmental	**$613**	**$ -**	**$ -**	**$613**	**$ -**	**$613**
With the Public						
Entity						
Medicare FFS	$5,723			$5,723	$ (1,649)	$4,074
Medicare Advantage/Prescription Drug Program	2,158			2,158		2,158
Medicaid	5,199			5,199	(1,607)	3,592
CHIP	7			7	(2)	5
Other	24			24	(13)	11
Non-Entity		39		39	(19)	20
Total With the Public	**$13,111**	**$ 39**	**$ -**	**$13,150**	**$(3,290)**	**$9,860**

FY 2013	Accounts Receivable Principal	Interest Receivable	Penalties, Fines, & Admin Fees Receivable	Accounts Receivable Gross	Allowance	Net CMS Receivables
Intragovernmental						
Entity	$3,371	$ -	$ -	$3,371	$ -	$ 3,371
Total Intragovernmental	**$3,371**	**$ -**	**$ -**	**$3,371**	**$ -**	**$ 3,371**
With the Public						
Entity						
Medicare FFS	$6,286			$6,286	$(1,606)	$ 4,680
Medicare Advantage/Prescription Drug Program	2,536			2,536		2,536
Medicaid	4,217			4,217	(842)	3,375
CHIP	13			13	(2)	11
Other	22			22	(15)	7
Non-Entity		49		49	(21)	28
Total With the Public	**$13,074**	**$49**	**$ -**	**$13,123**	**($2,486)**	**$10,637**

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

No allowance for uncollectible amounts is established for intragovernmental accounts receivable because they are considered fully collectible.

Accounts receivable with the public are primarily composed of provider and beneficiary overpayments, Medicare Prescription drug overpayments, Medicare premiums, State phased-down contributions, Medicaid/CHIP overpayments, audit disallowances, civil monetary penalties and restitutions, and the recognition of Medicare secondary payer (MSP) accounts receivable. Accounts receivable with the public is presented net of an allowance for uncollectible amounts. The allowance is based on past collection experience and an analysis of outstanding balances. For Medicare accounts receivable, the allowance for uncollectible accounts receivable derived this year has been calculated from data based on the agency's collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the past five years. The Medicaid accounts receivable has been recorded at a net realizable value based on a historic analysis of actual recoveries and the rate of disallowances found in favor of the States.

Note 5:

OTHER ASSETS

(DOLLARS IN MILLIONS)

As of September 30, 2014, CMS has $1,460 million ($831 million in FY 2013) in Other Assets. This includes the direct loans for the CO-OP programs, CDC vaccine program inventory and grant advances.

Note 6:

ENTITLEMENT BENEFITS DUE AND PAYABLE

(DOLLARS IN MILLIONS)

	2014	2013
Medicare FFS	$41,311	$38,729
Medicare Advantage/Prescription Drug Program	16,280	9,885
Medicaid	32,275	27,588
CHIP	923	693
Other	248	382
TOTALS	$91,037	$77,277

Entitlement Benefits Due and Payable represents a liability for Medicare FFS, Medicare Advantage and the Prescription Drug Program, Medicaid, and CHIP owed to the public for medical services/claims incurred but not reported (IBNR) as of the end of the reporting period.

The Medicare FFS liability is primarily an actuarial liability which represents (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (d) periodic interim payments for services rendered in the current fiscal year but paid in the subsequent fiscal year and (e) an estimate of retroactive settlements of cost reports. The September 30, 2014 and 2013 estimate also includes amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals and teaching hospitals as well as amounts which may be due/owed to hospitals for adjusted prospective payments.

The Medicare Advantage and Prescription Drug program liability represents amounts owed to plans after the completion of the Prescription Drug payment reconciliation and estimates relating to risk and other payment related adjustments including the estimate for the first nine months of calendar year 2014. In addition, it includes an estimate of payments to plan sponsors of retiree prescription drug coverage incurred but not yet paid as of September 30, 2014.

The Medicaid and CHIP estimates represent the net Federal share of expenses that have been incurred by the States but not yet reported to CMS.

Note 7:

CONTINGENCIES

The contingencies balance as of September 30, 2014, is $9,760 million ($7,366 million in FY 2013). Additionally, CMS may owe amounts to providers for previous years' disputed cost report adjustments for disproportionate share hospitals. CMS is a party in various administrative proceedings, legal actions, and tort claims which may ultimately result in settlements or decisions adverse to the Federal Government. CMS accrues contingent liabilities where a loss is determined to be probable and the amount can be estimated. Other contingencies exist where losses are reasonably possible, and an estimate can be determined or an estimate of the range of possible liability has been determined. CMS does not record an accrual for a contingent liability if it is not estimable and probable but does disclose those contingencies in the financial statements, if the future settlement could be material to the financial statements.

The Medicaid amount for $8,460 million ($6,066 million in FY 2013) consists of Medicaid audit and program disallowances of $2,918 million ($2,978 million in FY 2013) and $5,542 million ($3,088 million in FY 2013) for reimbursement of state plan amendments. Contingent liabilities have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the states. The funds could have been returned or CMS can decrease the state's authority. CMS will be required to pay these amounts if the appeals are decided in the favor of the states. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a state. There are also outstanding reviews of the state expenditures in which a final determination has not been made. Examples of these reviews are the Office of Inspector General Audits, Focused Financial Management Reviews, and Quarterly Medicaid Statement of Expenditures Report (Form CMS-64) reviews. The appropriate Center for Medicaid and CHIP Services (CMCS) Regional Office staff is responsible for reviewing the findings and recommendations. The monetary effect of these reviews is not known until a final decision is determined and rendered by the Director of CMCS. The outcome of these reviews may result in funds being owed to CMS.

Appeals at the Provider Reimbursement Review Board

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. However, historical cases that have been appealed and settled by the PRRB are considered in the development of the actuarial Medicare IBNR liability. As of September 30, 2014, 9,311 cases (7,124 in FY 2013) remain on appeal. A total of 4,400 new cases (3,907 in FY 2013) were filed and 12 cases were reopened (9 in FY 2013). The PRRB rendered decisions on 73 cases (210 in FY 2013) and additional 2,152 cases (1,623 in FY 2013) 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 2014 Intragovernmental	Medicare (Dedicated Collections)								
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
Accrued Payroll and Benefits	$1	$2					$3		$3
Other Health					$6		6		6
Total Intragovernmental	**$1**	**$2**			**$6**		**$9**		**$9**
Federal Employee and Veterans' Benefits	$3	$8	$1		$2		$14		$14
Accrued Payroll and Benefits	15	25	2		9	$2	53		53
Other Health					21		21		21
Contingencies		1,300	8,460				9,760		9,760
Total Liabilities Not Covered by Budgetary Resources	**19**	**1,335**	**8,463**		**38**	**2**	**9,857**		**9,857**
Total Liabilities Covered by Budgetary Resources	57,152	69,281	32,289	926	1,206	76	160,930	$(66,085)	94,845
TOTAL LIABILITIES	**$57,171**	**70,616**	**$40,752**	**$926**	**$1,244**	**$78**	**$170,787**	**$(66,085)**	**$104,702**

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

All CMS liabilities other than contingent liabilities are considered current. Liabilities not covered by budgetary resources are incurred when funding has not yet been made available through Congressional appropriations or current earnings. CMS recognizes such liabilities for employee annual leave earned but not taken and amounts billed by the Department of Labor for Federal Employee's Compensation Act (FECA) payments. For CMS revolving funds, all liabilities are funded as they occur.

Starting January 1, 2014, the Affordable Care Act provides for a permanent Risk Adjustment program, a transitional Reinsurance program and a temporary Risk Corridors program that will be administered by CMS. With these programs, amounts may be owed to or due from private health insurers who participate in the Exchanges (Marketplaces) that began on January 1, 2014. The Risk Adjustment and Reinsurance programs will be administered in a budget neutral manner in any calendar year. Risk Adjustment and Reinsurance payments for a year are constrained to amounts collected under the program for a year, and in any event cannot exceed amounts already collected. The Risk Corridor program will be administered in a budget neutral manner over a three-year period, with any deficits or surpluses from earlier years being held over into later years. However, for any individual year except the last, cumulative payments cannot exceed cumulative collections. For each of the three programs, collections will not be due and payments will not be made until the year following the calendar year for which the program operates. Regarding the Reinsurance program, the Affordable Care Act provides that CMS could potentially collect contributions totaling up to $12 billion (up to $10 billion to be paid to private health insurers and $2 billion to be transferred to the General Fund of the Department of the Treasury). However, with respect to all three programs, any potential liabilities and accounts receivable amounts can only be determined with any degree of certainty when data is submitted, collections made and calculations are performed in FY 2015. These amounts are not reasonably estimable as of September 30, 2014.

Note 9:

NET COST OF OPERATIONS

(DOLLARS IN MILLIONS)

	Medicare (Dedicated Collections)			Health				
FY 2014	**HI TF**	**SMI TF**	**Total**	**Medicaid**	**CHIP**	**Other Health**	**Other**	**Consolidated Total**
PROGRAM/ACTIVITY COSTS								
Medicare								
Fee for Service	$193,625	$173,503	$367,128					$367,128
Medicare Advantage/ Managed Care	73,642	82,266	155,908					155,908
Prescription Drug (Part D)		61,707	61,707					61,707
Medicaid/CHIP/State Grants & Demos				$304,426	$9,555		$486	314,467
Other Health						$3,420		3,420
Total Program/Activity Costs	**267,267**	**317,476**	**584,743**	**304,426**	**9,555**	**3,420**	**486**	**902,630**
OPERATING COSTS								
Medicare Integrity Program	$1,462		$1,462					$1,462
Quality Improvement Organizations	438	$148	586					586
Bad Debt Expense and Writeoffs	(17)	61	44	$766	$1	$(1)	$2	812
Reimbursable Expenses	125	272	397	20	2	63	6	488
Administrative Expenses	1,112	2,174	3,286	156	17	464	1,008	4,931
Depreciation and Amortization	25	54	79	4		12	2	97
Imputed Cost Subsidies	12	24	36	2		9	2	49
Total Operating Costs	**$3,157**	**$2,733**	**$5,890**	**$948**	**$20**	**$547**	**$1,020**	**$8,425**
TOTAL COSTS	**$270,424**	**$320,209**	**$590,633**	**$305,374**	**$9,575**	**$3,967**	**$1,506**	**$911,055**
Less: Exchange Revenues:								
Medicare Premiums	$3,538	$68,742	$72,280					$72,280
Other Exchange Revenues	90	197	287	$15	$1	$156	$552	1,011
Total Exchange Revenues	**$3,628**	**$68,939**	**$72,567**	**$15**	**$1**	**$156**	**$552**	**$73,291**
TOTAL NET COST OF OPERATIONS	**$266,796**	**$251,270**	**$518,066**	**$305,359**	**$9,574**	**$3,811**	**$954**	**$837,764**

Note 9:

NET COST OF OPERATIONS *(Continued)*

(DOLLARS IN MILLIONS)

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

For purposes of financial statement presentation, non-CMS administrative costs are considered expenses to the Medicare trust funds when outlayed by Treasury even though some funds may have been used to pay for assets such as property and equipment. CMS administrative costs have been allocated to the Medicare, Medicaid, CHIP, and State Grants and Demonstrations programs based on the CMS cost allocation system. Administrative costs allocated to the Medicare program include $2,480 million ($2,380 million in FY 2013) 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 2014 Part D expense of $61,707 million ($57,170 million in FY 2013) is net of State reimbursements of $8,633 million ($8,758 million in FY 2013). The gross expense would have been $70,340 million in FY 2014 ($65,928 million in FY 2013).

Of the Medicaid benefit expense of $304,426 million ($266,137 million in FY 2013), $2,303 million were identified under ARRA ($2,857 million in FY 2013).

Note 10:

BUDGETARY FINANCING SOURCES: OTHER ADJUSTMENTS

(DOLLARS IN MILLIONS)

FY 2014 Unexpended Appropriations	Medicare (Dedicated Collections)		Medicaid	CHIP	Other Health	Other	Consolidated Total
	HI TF	SMI TF					
Withdrawal of Expired or Canceled Year Authority	$(163)	$(1,503)		$(58)		$(22)	$(1,746)
Return of Indefinite Authority			$(17,908)		$(59)		(17,967)
Rescissions				(6,317)			(6,317)
Sequestration					(61)	(129)	(190)
Total Other Adjustments	**$(163)**	**$(1,503)**	**$(17,908)**	**$(6,375)**	**$(120)**	**$(151)**	**$(26,220)**

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

Other adjustments include decreases to Unexpended Appropriations that result from sequestration. In FY 2014, the decreases result from transactions other than the receipt of appropriations, transfers in or out of appropriated authority, or the expenditure of appropriations. Such transactions include the return to the Treasury general fund of expired or canceled year authority, rescissions, return of indefinite authority, or other adjustments.

Note 11:

FUNDS FROM DEDICATED COLLECTIONS

(DOLLARS IN MILLIONS)

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

	HI TF	SMI TF	Total Dedicated Collections Funds
Balance Sheet as of September 30, 2014			
ASSETS			
Fund Balance with Treasury	$744	$18,445	$19,189
Investments	204,361	68,925	273,286
Other Assets	31,929	40,493	72,422
Total Assets	**$237,034**	**$127,863**	**$364,897**
Entitlement Benefits Due and Payable	$25,719	$31,872	$57,591
Other Liabilities	31,452	38,744	70,196
Total Liabilities	**$57,171**	**$70,616**	**$127,787**
Unexpended Appropriations	$691	$15,624	$16,315
Cumulative Results of Operations	179,172	41,623	220,795
Total Net Position	**$179,863**	**$57,247**	**237,110**
Total Liabilities and Net Position	**$237,034**	**$127,863**	**364,897**
Statement of Net Cost *For the Year Ended September 30, 2014*			
Benefit Expense	$267,267	$317,476	$584,743
Operating Costs	3,157	2,733	5,890
Total Costs	270,424	320,209	590,633
Less Earned Revenues	3,628	68,939	72,567
Net Cost of Operations	**$266,796**	**$251,270**	**518,066**
Statement of Changes in Net Position *For the Year Ended September 30, 2014*			
Net Position, Beginning of Period	$190,002	$52,712	$242,714
Taxes and Other Nonexchange Revenue	237,249	5,452	242,701
Other Financing Sources	19,408	250,353	269,761
Less Net Cost of Operations	266,796	251,270	518,066
Change in Net Position	(10,139)	4,535	(5,604)
Net Position, End of Period	**$179,863**	**$57,247**	**$237,110**

Note 11:

FUNDS FROM DEDICATED COLLECTIONS *(Continued)*

(DOLLARS IN MILLIONS)

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

Note 12:

INTRAGOVERNMENTAL COSTS AND EXCHANGE REVENUE

(DOLLARS IN MILLIONS)

FY 2014	Gross Cost			Less: Exchange Revenue			
	Intra-governmental	Public	Total	Intra-governmental	Public	Total	Consolidated Net Cost of Operations
PROGRAM/ACTIVITY COSTS							
GPRA Programs							
Medicare (Dedicated Collections)							
HI TF	$835	$269,589	$270,424	$5	$3,623	$3,628	$266,796
SMI TF	217	319,992	320,209	11	68,928	68,939	251,270
Medicaid	13	305,361	305,374	1	14	15	305,359
CHIP	31	9,544	9,575		1	1	9,574
Subtotal	1,096	904,486	905,582	17	72,566	72,583	832,999
Other Activities							
State Grants and Demonstrations	16	544	560	1	4	5	555
Other Health	186	3,781	3,967	12	144	156	3,811
Other	46	900	946		547	547	399
Subtotal	248	5,225	5,473	13	695	708	4,765
PROGRAM/ ACTIVITY TOTALS	**$1,344**	**$909,711**	**$911,055**	**$30**	**$73,261**	**$73,291**	**$837,764**

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

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

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

Note 13:

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 2014	Direct	Reimbursable	Combined Totals
Category A	$13,957	$387	$14,344
Category B	590,681	873	591,554
Exempt	640,038		640,038
Total	**$1,244,676**	**$1,260**	**$1,245,936**

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

LEGAL ARRANGEMENTS AFFECTING USE OF UNOBLIGATED BALANCES

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Combined Statement of Budgetary Resources (SBR). The portion of trust fund receipts collected in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in that fiscal year is precluded by law from being available for obligation. This excess of receipts over obligations is Temporarily Not Available Pursuant to Public Law and is included in the calculation for appropriations on the Statement of Budgetary Resources and, therefore, is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the trust funds and currently become available for obligation as needed. The entire trust fund balances in the amount of $225,453 million as of September 30, 2014, ($245,041 million in FY 2013) are included in Investments on the Balance Sheets. The following table presents trust fund activities and balances for FY 2014 and FY 2013 (in millions):

	FY 2014 Combined Balance	FY 2013 Combined Balance
TRUST FUND BALANCE, BEGINNING	**$245,041**	**$245,356**
Receipts	522,641	528,467
Less Obligations	542,229	528,782
Excess (Shortage) of Receipts Over Obligations	(19,588)	(315)
TRUST FUND BALANCE, ENDING	**$225,453**	**$245,041**

EXPLANATIONS OF DIFFERENCES BETWEEN THE COMBINED STATEMENT OF BUDGETARY RESOURCES AND THE BUDGET OF THE UNITED STATES GOVERNMENT FOR FY 2013

(DOLLARS IN MILLIONS)

CMS reconciled the amounts of the FY 2013 column of the SBR to the actual amounts for FY 2013 from the Appendix in the FY 2014 President's Budget for budgetary resources, obligations incurred, offsetting receipts and net outlays (gross outlays less offsetting collections).

FY 2013	Budgetary Resources	Obligations Incurred	Distributed Offsetting Receipts	Net Outlays
Combined Statement of Budgetary Resources	1,193,974	1,159,587	335,935	1,109,678
Expired Accounts	(6,750)			
Other	3,461	3,340		3,858
President's Budget (2013 Actual)	**1,190,685**	**1,162,927**	**335,935**	**1,113,536**

For the budgetary resources reconciliation, the amount used from the President's Budget was the total budgetary resources available for obligation. Therefore, a reconciling item that is contained in the Combined Statement of Budgetary Resources and not in the President's Budget is the budgetary resources that were not available. The Expired accounts line in the above schedule includes expired authority, recoveries and other amounts included in the Combined Statement of Budgetary Resources that are not included in the President's Budget.

The Other differences in the resources and obligations incurred include amounts reported in the President's Budget for CDC and CIIO but not in CMS' Combined Statement of Budgetary Resources, overstated PYA, recoveries and unfilled order adjustment, and FACTS II adjustments that were not in the SBR.

Lastly, the Other differences in the net outlays include outlays reported in the President's Budget for CDC and CIIO but not in CMS' Combined Statement of Budgetary Resources, and outlays reported for Executive Office of the President in CMS' Combined Statement of Budgetary Resources but not in the President's Budget.

Undelivered Orders at the End of the Period
The amount of budgetary resources obligated for undelivered orders totaled $40,510 million for Budgetary and $998 million for Non-Budgetary at September 30, 2014 ($19,230 million for Budgetary and $1,243 million for Non-Budgetary at FY 2013). In 2014, the Payments to the Health Care Trust Funds was definite, and an undelivered order was recorded for $16,314 million, estimated to be paid to the SMI trust fund for both Part D benefits and SMI premium federal matching.

Non-Budgetary Credit Reform Financing Account
The negative balance for borrowing authority, net of $2,064 million under the FY 2013 Non-Budgetary Credit Program Financing Account column on the SBR reflects a prior period adjustment occurring in FY 2013 to return 2012 indefinite borrowing authority of $2,228 million that should have been made at September 30, 2012. In addition, the negative balance of $754 million for spending authority from offsetting collections under that column represents a reduction to unfilled orders for an $894 million overstatement at September 30, 2012. These adjustments were determined to be immaterial to the overall financial statements and the error was corrected in the 2013 financial statements.

Note 14:

STATEMENT OF SOCIAL INSURANCE (UNAUDITED)

The Statement of Social Insurance (SOSI) presents, for the 75-year projection period, the present values of the income and expenditures of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds for both the open group and closed group of participants. The open group consists of all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program. The closed group comprises only current participants—those who attain age 15 or older in the first year of the projection period.

Actuarial present values are computed under the intermediate set of assumptions specified *Annual Report of the Medicare Board of Trustees*. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and health care-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent review occurred with the 2010–2011 Technical Review Panel.

As noted in the Trustees Report, the basis for the Part B projections has changed since last year. The scheduled reductions under the sustainable growth rate (SGR) formula for updating the physician fee schedule have been overridden by lawmakers each year beginning with 2003. Current law requires CMS to implement a reduction in Medicare payment rates for physician services of an estimated 20.8 percent in April 2015. However, it is a virtual certainty that lawmakers will override this reduction as they have for every year starting with 2003. For this reason, the income, expenditures, and assets for Part B reflect the Trustees' *projected baseline* scenario, which includes an override of the provisions of the SGR and an assumed annual increase in the physician fee schedule equal to the average SGR override over the 10 year period ending with March 31, 2015.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. The Trustees' projections are based on the current Medicare laws, regulations, and policies in effect on July 28, 2014 but also reflect the nearly certain override of the physician fee reductions scheduled under current law. The present values are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments as well as administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of *FICA* and *SECA* payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and transfers from the general fund of the Treasury made on behalf of beneficiaries. Fees related to brand-name prescription drugs, required by the Affordable Care Act, are included as income for Part B of SMI, and transfers from State governments are included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

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

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

age; and (3) new entrants, those who are expected to become participants in the future. Current participants are the closed group of individuals who are at least age 15 at the start of the projection period and are participating in the program as either taxpayers, beneficiaries, or both.

The SOSI sets forth, for each of these three groups, the projected actuarial present values of all future expenditures and of all future non-interest income for the next 75 years. The SOSI also presents the net present values of future net cash flows, which are calculated by subtracting the actuarial present value of estimated future expenditures from the actuarial present value of estimated future income. The HI trust fund is expected to have an actuarial deficit indicating that, under these assumptions as to economic, demographic, and health care cost trends for the future, HI income is expected to fall short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar 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 consists of those who, in the starting year of the projection period, have attained retirement eligibility age or have attained ages 15 through 64. In order to calculate the actuarial net present value of the excess of estimated future income over estimated future expenditures for the closed group, the actuarial present value of estimated future expenditures for or on behalf of current participants is subtracted from the actuarial present value of estimated future income (excluding interest) for current participants.

Since its enactment in 1965, the Medicare program has experienced substantial variability in expenditure growth rates. These different rates of growth have reflected new developments in medical care, demographic factors affecting the relative number and average age of beneficiaries and covered workers, and numerous economic factors. The future cost of Medicare will also be affected by further changes in these inherently uncertain factors and by the application of future payment updates. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and could differ materially from the projections shown in the SOSI. Moreover, these differences could affect the long-term sustainability of this social insurance program.

To develop projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the Trustees' projected baseline scenario. 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 following table includes the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. The assumptions underlying the 2014 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2014. 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 2014

					Annual percentage change in:						
								Per beneficiary cost[8]			
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI		Real-interest rate[9]
									B	D	
2014	1.91	1,345,000	779.8	2.18	3.78	1.61	3.1	–2.9	3.4	0.2	0.3
2020	2.06	1,350,000	730.2	1.42	4.12	2.70	2.6	4.0	5.6	6.3	2.7
2030	2.03	1,160,000	667.6	1.24	3.94	2.70	2.1	4.5	5.1	5.3	2.9
2040	2.00	1,105,000	614.6	1.15	3.85	2.70	2.2	5.2	4.9	5.2	2.9
2050	2.00	1,085,000	568.1	1.11	3.81	2.70	2.1	4.1	4.5	5.0	2.9
2060	2.00	1,070,000	527.1	1.10	3.80	2.70	2.1	3.8	4.3	4.7	2.9
2070	2.00	1,065,000	490.8	1.09	3.79	2.70	2.1	4.0	4.2	4.6	2.9
2080	2.00	1,060,000	458.4	1.13	3.83	2.70	2.1	3.8	4.1	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 service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.
[9] Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

The projections presented in the 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 4 years, based on the intermediate assumptions of the respective Medicare Trustees Reports, are summarized in table 2 below.

Table 2:

SIGNIFICANT ULTIMATE ASSUMPTIONS USED FOR THE STATEMENT OF SOCIAL INSURANCE, FY 2014–2010

					Annual percentage change in:						
									Per beneficiary cost[8]		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI		Real-interest rate[9]
									B	D	
FY 2014	2.0	1,060,000	458.4	1.13	3.83	2.7	2.1	3.8	4.1	4.4	2.9
FY 2013	2.0	1,055,000	419.8	1.13	3.93	2.8	2.1	3.8	3.8	4.5	2.9
FY 2012	2.0	1,030,000	446.0	1.12	3.92	2.8	2.0	3.7	3.8	4.5	2.9
FY 2011	2.0	1,030,000	443.2	1.2	4.0	2.8	2.1	3.3	3.7	4.4	2.9
FY 2010	2.0	1,025,000	446.1	1.2	4.0	2.8	2.1	3.3	3.8	4.4	2.9

[1] Average number of children per woman. The ultimate fertility rate is assumed to be reached in the 25th year of the projection period.
[2] Includes legal immigration, net of emigration, as well as other, non-legal, immigration. The ultimate level of net legal immigration is 790,000 persons per year and the assumption for annual net other immigration varies throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.
[3] The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.
[4] Difference between percentage increases in wages and the CPI. The value presented is the average of annual real-wage differentials for the last 65 years of the 75-year projection period, is consistent with the annual differentials shown in table 1, and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.
[5] Average annual wage in covered employment. The value presented is the average annual percentage change from the 10th year of the 75-year projection period to the 75th year, and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.
[6] Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services. The ultimate assumption is reached within the first 10 years of the projection period.
[7] The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.
[8] These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The annual rate of growth declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.
[9] Average rate of interest earned on new trust fund securities, above and beyond rate of inflation. The ultimate assumption is reached soon after the 10th year of each projection period.

Note 15:

ALTERNATIVE SOSI PROJECTIONS (UNAUDITED)

As mentioned previously, the SOSI projections reflect a projected baseline scenario, which includes an override of the SGR formula for updating physician payment rates. This scenario also assumes that the various cost-reduction measures—the most important of which are the reductions in the annual payment rate updates for most categories of Medicare providers by the growth in economy-wide multifactor productivity—will occur as the Affordable Care Act requires. The Board of Trustees believes that this outcome is achievable if health care providers are able to realize productivity improvements at a faster rate than experienced historically. The ability of health care providers to sustain these price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time.

Absent an unprecedented change in health care delivery systems and payment mechanisms, the prices paid by Medicare for health services will fall increasingly short of the costs of providing these services. By the end of the long-range projection period, Medicare prices for many services would be less than half of their level without consideration of the productivity price reductions. Before such an outcome would occur, lawmakers would likely intervene to prevent the withdrawal of providers from the Medicare market and the severe problems with beneficiary access to care that would result. Overriding the productivity adjustments, as lawmakers have done repeatedly in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in this report.

To help illustrate and quantify the potential magnitude of the cost understatement, the Trustees asked the Office of the Actuary at CMS to prepare an illustrative Medicare trust fund projection under a hypothetical alternative that assumes that, starting in 2020, the economy-wide productivity adjustments gradually phase down to 0.4 percent.[1] This alternative was developed for illustrative purposes only; the calculations have not been audited; no endorsement of the policies underlying the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation affecting the productivity adjustments 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 estimated future income and estimated future expenditures under the projected baseline with those under current law—including the almost 21-percent scheduled reduction in physician payment rates under the SGR formula—and the illustrative alternative scenario.

[1] The Trustees have used this approach since 2007 to address concerns with the SGR provision. Starting with the 2010 annual report, following enactment of the Affordable Care Act, the illustrative alternative projections have included changes to the productivity adjustments.

MEDICARE PRESENT VALUES

(IN BILLIONS)

	Projected baseline (Unaudited)	Current law (Unaudited)	Alternative Scenario[1, 2] (Unaudited)
Income			
Part A	$16,542	$16,542	$16,550
Part B	24,311	21,847	27,286
Part D	9,312	9,327	9,440
Expenditures			
Part A	20,365	20,396	24,848
Part B	24,311	21,847	27,286
Part D	9,312	9,327	9,440
Income less expenditures			
Part A	(3,823)	(3,854)	(8,297)
Part B	0	0	0
Part D	0	0	0

[1] These amounts are not presented in the 2014 Trustees Report.

[2] At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare trust fund projections that differs both from the projected baseline emphasized throughout the 2014 Trustees Report and from current law. No endorsement of the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred.

As expected, the projected baseline and current-law projections differ most markedly for Part B, since the physician fee reductions do not affect Part A and Part D directly.[2] The present values of estimated future income and expenditures under current law are roughly 10 percent lower than under the projected baseline projections.

The difference between the projected baseline and illustrative alternative projections is substantial for Parts A and B. All Part A fee-for-service providers and roughly half of Part B fee-for-service providers are affected by the productivity adjustments, so the projected baseline and current-law projections reflect an estimated 1.1-percent reduction in annual cost growth each year. If the productivity adjustments were gradually phased out, as illustrated under the alternative scenario, the estimated present value of Part A and Part B expenditures would be higher than the projected baseline projections by roughly 22 percent and 12 percent, respectively. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario; and the present value of Part B income is also 12 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

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

The extent to which actual future Part A and Part B costs exceed the projected amounts due to changes to the productivity adjustments depends on what specific changes might be legislated and whether Congress would pass further provisions to help offset such costs. As noted, these examples reflect only hypothetical changes to provider payment rates.

[2] The differences between the projected baseline and current law for Parts A and D are the result of (1) changes in the operations of the Independent Payment Advisory Board (IPAB) due to modifications in the Part B projections; and (2) slight changes to the discount rates.

Note 16:

STATEMENT OF CHANGES IN SOCIAL INSURANCE AMOUNTS (UNAUDITED)

The Statement of Changes in Social Insurance Amounts (SCSIA) reconciles the change (between the current valuation and the prior valuation) in the (1) present value of estimated future income (excluding interest) for current and future participants; (2) present value of estimated future expenditures for current and future participants; (3) present value of estimated future noninterest income less estimated future expenditures for current and future participants (the open-group measure) over the next 75 years; (4) assets of the combined Medicare Trust Funds; and (5) present value of estimated future noninterest income less estimated future expenditures for current and future participants over the next 75 years plus the assets of the combined Medicare Trust Funds. The SCSIA shows the reconciliation from the period beginning on January 1, 2013 to the period beginning on January 1, 2014, and the reconciliation from the period beginning on January 1, 2012 to the period beginning on January 1, 2013. The reconciliation identifies several components of the change that are significant and provides reasons for the changes.

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

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

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

All estimates in the Statement of Changes in Social Insurance Amounts represent values that are incremental to the prior change. As an example, the present values shown for demographic assumptions, represent the additional effect that these assumptions have, once the effects from the change in the valuation period and projection base have been considered.

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 14 summarizes these assumptions for the current year.

Period beginning on January 1, 2013 and ending January 1, 2014

Present values as of January 1, 2013 are calculated using interest rates from the intermediate assumptions of the 2013 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2014. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are determined using the interest rates under the intermediate assumptions of the 2013 Trustees Report. Since interest rates are economic assumptions, the estimates of the present values of changes in economic and health care assumptions are presented using the interest rates under the intermediate assumptions of the 2014 Trustees Report.

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

Present values as of January 1, 2012 are calculated using interest rates from the intermediate assumptions of the 2012 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2013. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are determined using the interest rates under the intermediate assumptions of the 2012 Trustees

Report. Since interest rates are economic assumptions, the estimates of the present values of changes in economic and health care assumptions are presented using the interest rates under the intermediate assumptions of the 2013 Trustees Report.

Change in the Valuation Period

Period beginning on January 1, 2013 and ending January 1, 2014

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2013-87) to the current valuation period (2014-88) 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 2013 and replaces it with a much larger negative net cashflow for 2088. The present value of estimated 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 2013-87 to 2014-88. 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 2013 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

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

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2012-86) to the current valuation period (2013-87) is measured by using the assumptions for the prior valuation period and applying them, in the absence of any other changes, to the current valuation period. Changing the valuation period removes a small negative net cashflow for 2012 and replaces it with a much larger negative net cashflow for 2087. The present value of estimated future net cashflow (including or excluding the combined Medicare Trust Fund assets at the start of the period) was therefore decreased (made more negative) when the 75-year valuation period changed from 2012-86 to 2013-87. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2012 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

Change in Projection Base

Period beginning on January 1, 2013 and ending January 1, 2014

Actual income and expenditures in 2013 were different than what was anticipated when the 2013 Trustees Report projections were prepared. Part A income was slightly higher and expenditures were lower than anticipated, based on actual experience. Part B total income and expenditures were also lower than estimated based on actual experience. For Part D, actual income and expenditures were both slightly higher on an incurred basis than prior estimates. The net impact of the Part A, B, and D projection base changes is an increase in the estimated future net cashflow. Actual experience of the Medicare Trust Funds between January 1, 2013 and January 1, 2014 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

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

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

Changes in the Demographic Assumptions

Period beginning on January 1, 2013 and ending January 1, 2014

The demographic assumptions used in the Medicare projections are the same as those

used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2014) are the same as those for the prior valuation. However, the starting demographic values, and the way these values transition to the ultimate assumptions, were changed.

- Preliminary birth rate data for 2012 indicated lower birth rates than were expected in the prior valuation. During the period of transition to their ultimate values, the birth rates in the current valuation are generally lower than they were in the prior valuation.

There was one change in demographic methodology:

The modeling of the other immigrant population was divided into three distinct groups for the current valuation: (1) those with temporary legal status; (2) those never authorized to be in the country; and (3) those who had temporary legal status previously but are no longer authorized to be in the country.

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

A further assumption change was made that resulted in higher Part D enrollment for the current valuation period. The participation rate represents the percentage of beneficiaries assumed to enroll in a Part D plan out of all eligible and, in prior years, was assumed to stay relatively constant at the same rate as the recent historical period. However, since actual participation has consistently been higher than expected, it was decided to increase the participation rate by 1 percent per year for the first 3 years of the projection period, before leveling out. This results in an assumed 62.4 percent participation rate, prior to adjustments for beneficiaries who have retiree drug subsidy coverage and those who are assumed to drop out because they are required to pay an income-related premium, for 2017 and later, which is higher than the 57.2 percent that was assumed for all years in the prior valuation period. This assumption change resulted in an increase in the present value of estimated future income and estimated future expenditures for Part D, and had no impact on the Part A and Part B present values.

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

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

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

- The assumed ultimate annual immigration of "other immigrants", that is, those entering the country without legal permanent resident (LPR) status, is 1.4 million in the current valuation, compared with 1.5 million assumed for the prior valuation.
- The assumed ultimate annual number of persons attaining LPR status is 1.05 million for the current valuation, compared with 1.0 million assumed for the prior valuation. The distribution of the ultimate number between those entering the country with LPR status and those adjusting status after having already entered the country was also revised.

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

Final mortality data for 2008 and 2009 show substantially larger reductions in death rates for the current valuation than were expected in the prior valuation. The new data show a lower starting level of death rates and a faster rate of decline in death rates over the next 25 years.

Final fertility (birth) data for 2009 and 2010, and preliminary data for 2011, indicate lower birth rates for these years than were assumed in the prior valuation.

New historical data for marital status, for the number of new marriages, for "other immigration", and for the size of the population (based on the 2010 Census) were used in the current valuation.

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

Changes in Economic and Health Care Assumptions

Period beginning on January 1, 2013 and ending January 1, 2014

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

For the current valuation (beginning on January 1, 2014), there was one change to the ultimate economic assumptions:

The ultimate annual rate of change in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) is assumed to be 2.7 percent per year in the current valuation period, compared to 2.8 percent per year in the previous valuation period. Lowering the ultimate average annual increase in the CPI-W makes it more comparable to recent historical annual increases.

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

The ratio of average taxable earnings to the average wage index is lower by 1.9 percent in 2012 and 1.5 percent in 2013, compared to the previous valuation period.

There were two main changes in the economic methodology:

- Projected labor force participation rates for the older population are slightly lower for the current valuation in order to better reflect the difference in participation rates between never-married and married populations and the projected improvement in life expectancy.
- Different earnings levels are assigned to the three distinct groups of the other immigrant population supplied by demography. (This change decreased the present value of future cashflows by about the same amount as the related change in the demography methodology increased the present value of future cashflows.)

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

- The projections emphasized in the 2014 Medicare Trustees Report were changed to reflect the projected baseline scenario. This scenario assumes that the physician payment updates required under the current-law sustainable growth rate formula will be permanently overridden by lawmakers. The use of these projections increases the present value of estimated future expenditures, compared to the current law projections, for Part B by roughly 11 percent, and for total Medicare by about 5 percent.
- Utilization rate assumptions for inpatient hospital services were decreased.
- Case mix increase assumptions for skilled nursing facilities and home health agencies were decreased.
- Market basket differential for skilled nursing facilities was lowered.
- Higher assumed enrollment in Medicare Advantage plans where benefits are more costly.
- Higher increases in productivity rates, resulting in lower payment updates.
- The methodology used to transition from the short-range projections to the long-range projections was refined, resulting in smaller increases during this transition period.
- Lower projected prescription drug trend rates.
- Higher assumed rebates from drug manufacturers.

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

estimated future expenditures (and also income) for Part D.

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

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

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

The real interest rate is projected to be lower over the first ten years of the current valuation.

The starting economic values and near-term economic growth rate assumptions were updated.

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

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

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

Changes in Law

Period beginning on January 1, 2013 and ending January 1, 2014

Although Medicare legislation was enacted since the prior valuation date, many of the provisions have a negligible impact on the present value of the 75-year estimated future income, expenditures, and net cashflow. The Continuing Appropriations Resolution of 2014 included several provisions that had an impact on the Medicare program, including a 0.5 percent physician payment update for January through March of 2014, extension of the Medicare sequester to FY 2022 and 2023, and payment reform for long-term care hospitals. Further, sections 1 and 3 of Public Law 113-82 included a further extension of the Medicare sequester to FY 2024. Lastly, the Protecting Access to Medicare Act of 2014 extended the 0.5 percent physician update through December 2014, enacted a 0 percent update for January through March of 2015, improved payment policy for clinical diagnostic lab tests, made revisions to the end-stage renal disease (ESRD) prospective payment system and physician fee schedule, and realigned the Medicare sequester in FY 2024. Overall these provisions resulted in an increase in the estimated future net cashflow for total Medicare. For Part A, these changes resulted in an increase to the present value of estimated future expenditures, with an overall increase in the estimated future net cashflow. For Part B, these changes lowered the present value of estimated future expenditures (and also income) only very slightly. For Part D, the above-mentioned changes increased the present value of estimated future expenditures (and also income) also very slightly.

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

Although Medicare legislation was enacted since the prior valuation date, many of the provisions have a negligible impact on the present value of the 75-year income, expenditures, and net cashflow. The American Taxpayer Relief Act of 2012 included several provisions that had an impact on the Medicare program. These include the extension of the 0 percent physician payment update through 2013, which slightly increases the present value of Part B expenditures; payments for inpatient hospital services in 2014-2017

are reduced in order to recoup $11 billion in overpayments associated with documentation and coding adjustments during 2008-2010 that were not previously recovered, which lowers the present value of Part A expenditures; reductions to the ESRD bundled payment rate to reflect changes in the utilization of certain drugs and biological and a delay in the inclusion of oral-only ESRD drugs in the rate, which reduces the present value of Part B estimated future expenditures and increases the present value of Part D estimated future expenditures; and the coding intensity adjustment used in determining payments to Medicare Advantage plans was revised, which lowers the present value of Part A and Part B estimated future expenditures.

Note 17:

RECONCILIATION OF NET COST OF OPERATIONS TO BUDGET

	FY 2014 Totals	FY 2013 Totals
Resources Used to Finance Activities:		
Budgetary Resources Obligated:		
Obligations incurred	$1,245,936	$1,159,587
Less: Spending authority from offsetting collections and recoveries	37,492	37,663
Obligations net of offsetting collections and recoveries	1,208,444	1,121,924
Less: Distributed offsetting receipts	358,745	335,935
Net obligations	849,699	785,989
Other Resources:		
Imputed financing from costs absorbed by others	49	48
Net other resources used to finance activities	49	48
TOTAL RESOURCES USED TO FINANCE ACTIVITIES	**$849,748**	**$786,037**
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	$19,870	$1,019
Resources that fund expenses recognized in prior periods	(7)	(15)
Budgetary offsetting collections and receipts that do not affect net cost of operations	(5,835)	(411)
Resources that finance the acquisition of assets	839	696
Other resources or adjustments to net obligated resources that do not affect net cost of operations	3,447	7,310
Total resources used to finance items not part of the net cost of operations	**18,314**	**8,599**
TOTAL RESOURCES USED TO FINANCE THE NET COST OF OPERATIONS	**$831,434**	**$777,438**
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:		
Decrease/(Increase) in annual leave liability	$1	$(41)
Decrease/(Increase) in receivables from the public	(101)	(274)
Other	2,339	2,137
Total components of Net Cost of Operations that will require or generate resources in future periods	**2,239**	**1,822**
Components not Requiring or Generating Resources:		
Depreciation and amortization	98	42
Other	3,993	489
Total components of Net Cost of Operations that will not require or generate resources	4,091	531
Total components of Net Cost of Operations that will not require or generate resources in the current period	**$6,330**	**$2,353**
NET COST OF OPERATIONS	**$837,764**	**$779,791**

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

REQUIRED SUPPLEMENTARY INFORMATION

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for almost five decades. A brief description of the provisions of Medicare's Hospital Insurance (HI, or Part A) Trust Fund and Supplementary Medical Insurance (SMI, or Parts B and D) Trust Fund is included in this financial report.

The Required Supplementary Information (RSI) contained in this section is 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 *2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds,* which represents the official government evaluation of the financial and actuarial status of the Medicare Trust Funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

The projections in this report reflect an exception to current law with regard to the sustainable growth rate (SGR) formula for physician fee schedule payment under Part B. Current law requires CMS to implement a reduction in Medicare payment rates for physician services of almost 21 percent in April 2015. However, it is a virtual certainty that lawmakers will override this reduction as they have every year beginning with 2003. For this reason, the income, expenditures, and assets for Part B shown throughout the report reflect a *projected baseline*, which includes an override of the provisions of the SGR and an assumed annual increase in the physician fee schedule equal to the average SGR override over the 10-year period ending with March 31, 2015. The projections do not represent either a policy recommendation or a prediction of legislative outcomes.

Incorporated in these projections is the sequestration of non-salary Medicare expenditures as required by the following laws: the Budget Control Act of 2011 (Public Law 112-25, enacted on August 2, 2011), as amended by the American Taxpayer Relief Act of 2012; the Continuing Appropriations Resolution, 2014 (Public Law 113-67, enacted on December 26, 2013); Sections 1 and 3 of Public Law 113-82, enacted on February 15, 2014; and the Protecting Access to Medicare Act of 2014 (Public Law 113-93, enacted on April 1, 2014). The sequestration reduces benefit payments by 2 percent from April 1, 2013 through March 31, 2023, by 2.9 percent from April 1, 2023 through September 30, 2023, by 1.1 percent from October 1, 2023 through March 31, 2024, and by 4 percent from April 1, 2024 through September 30, 2024. Due to sequestration, non-salary administrative expenses are reduced by an estimated 5 percent from March 1, 2013 through September 30, 2024.

These projections also incorporate the effects of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010. This legislation, referred to collectively as the Affordable Care Act, contained roughly 165 provisions affecting the Medicare program by reducing costs, increasing revenues, improving benefits, combating fraud and abuse, and initiating a major program of research and development to identify alternative provider payment mechanisms, health care delivery systems, and other changes intended to improve the quality of health care and reduce costs.

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from provisions of the Affordable Care Act. These improved results for HI and SMI Part B depend in part on the long-range feasibility of the various cost-saving measures in the Affordable Care Act—in particular, the lower increases in Medicare payment rates to most categories of health care providers. Without fundamental changes in current health care delivery systems, these adjustments would probably not be viable indefinitely. 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. For such efforts to be successful in the long range, however, providers would have to generate and sustain unprecedented levels of productivity gains—a very challenging and uncertain prospect.

In view of the factors described above, it is important to note that Medicare's actual future costs are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. The current-law cost projections reflect the scheduled SGR reductions to physicians' payment rates and the Affordable Care Act-mandated reductions in other Medicare payment rates. Because the physician payment reduction required by current law has been overridden for 12 consecutive years, the Medicare Board of Trustees decided for the 2014 Medicare Trustees Report to emphasize projections under a projected baseline, as mentioned previously. In addition, the Trustees reference in their report an illustrative alternative scenario, which incorporates the override of SGR physician payment rates included in the projected baseline and a partial phase-out of the Affordable Care Act reductions in Medicare payment rates, as well as an assumed legislative override of the cost-saving actions of the Independent Payment Advisory Board. The difference between the illustrative alternative and the projected baseline projections demonstrates that the long-range costs could be substantially higher than those shown throughout much of the 2014 report if the Affordable Care Act's cost reduction measures prove ineffectual or are scaled back.

Additional information on the projected baseline, current-law, and illustrative alternative projections is provided in note 15 in these financial statements, in appendix V.C of this year's annual Medicare Trustees Report, and in an auxiliary memorandum prepared by the CMS Office of the Actuary at the request of the Board of Trustees.

Printed copies of the Trustees Report and auxiliary memorandum may be obtained from the CMS Office of the Actuary (410-786-6386) or can be downloaded from **http://www.cms.hhs.gov/ReportsTrustFunds/**.

ACTUARIAL PROJECTIONS

Long-Range Medicare Cost Growth Assumptions

The assumed long-range rate of growth in annual Medicare expenditures per beneficiary is based on statutory price updates (except for physician fee schedule services) and assumptions for volume and intensity growth derived from a "factors contributing to growth" model, which, developed by the Office of the Actuary at CMS, decomposes the major drivers of historical and projected health spending growth into distinct factors. Additionally, the Trustees assume that the Medicare payment rate updates that reflect an economy-wide productivity adjustment will reduce volume and intensity growth slightly below the assumption from the factors model for affected Medicare services. The Trustees' methodology is consistent with the recommendations by the 2010-2011 Technical Review Panel on the Medicare Trustees Report,[1] which incorporated a more refined analysis of the factors behind those assumptions. The Trustees plan to continue to direct research into the factors approach and will consider additional refinements and improvements in forthcoming reports.

In December 2011, the Technical Panel unanimously recommended a new approach that builds off of the longstanding GDP plus 1 percent assumption while incorporating several key refinements.[2] Specifically, the Panel recommended two separate means of establishing long-range growth rates:

- The first approach is a refinement to the traditional GDP plus 1 percent growth assumption that better accounts for the level of payment rate updates for Medicare (prior to the effects of the Affordable Care Act) compared to private health insurance and other payers of health care in the U.S. This refinement results in an increase in the long-range pre-Affordable Care Act
- Baseline cost growth assumption for Medicare to GDP plus 1.4 percent. (The corresponding assumed average growth rate for all national health expenditures continues to be GDP plus 1 percent.)
- The second approach recommended by the Technical Panel is the factors model developed by the Office of the Actuary at CMS as a

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

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

possible replacement for the existing process. This model builds upon the key considerations used in establishing the earlier GDP plus 1 percent assumption, together with subsequent refinements in the analysis of growth factors, additional years of data on national health expenditures available since the 2000 Medicare Technical Review Panel's deliberations, and use of projected trends in the model's key factors. The model is based on economic research that decomposes health spending growth into its major drivers—income growth, relative medical price inflation, insurance coverage, and a residual factor that primarily reflects the impact of technological development.[3]

The Trustees (i) used the statutory price updates and the volume and intensity assumptions from the factors model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period and (ii) checked the ultimate Medicare cost growth assumptions derived from this approach for reasonableness by comparing them to results produced by an average "GDP plus" approach.

For some time, the Trustees have assumed that it is reasonable to expect over the long range that the drivers of health spending will be similar for the overall health sector and for the Medicare program. This view was affirmed by the 2010-2011 Medicare Technical Review Panel, which recommended use of the same long-range assumptions for the increase in the volume and intensity of health care services for the total health sector and for Medicare. Therefore, the overall health sector long-range cost growth assumptions for volume and intensity are used as the starting point for developing the Medicare-specific assumptions under current law.

Prior to the Affordable Care Act, Medicare payment rates for most non-physician provider categories were updated annually by the increase in providers' input prices for the market basket of employee wages and benefits, facility costs, medical supplies, energy and utility costs, professional liability insurance, and other inputs needed to produce the health care goods and services. To the extent that health care providers can improve their productivity each year, their net costs of production (other things being equal) will increase more slowly than their input prices—but the Medicare payment rate updates prior to the Affordable Care Act were not adjusted for potential productivity gains. Accordingly, Medicare costs per beneficiary would have increased somewhat faster than for the health sector overall.[4] The Affordable Care Act requires that many of these Medicare payment updates be reduced by the 10-year moving average increase in private, nonfarm business multifactor productivity, which the Trustees assume will be 1.1 percent per year over the long range. The different statutory provisions for updating payment rates require the development of separate long-range Medicare cost growth assumptions for three categories of health care providers:

(i). ***All HI, and some SMI Part B, services that are updated annually by provider input price increases less the increase in economy-wide productivity***.

HI services are inpatient hospital, skilled nursing facility, home health, and hospice. The primary Part B services affected are outpatient hospital, home health, and dialysis. Under the Trustees' intermediate economic assumptions, the year-by-year increases for these provider services start at 4.4 percent in 2038, or GDP plus 0.4 percent, declining gradually to 3.5 percent in 2088, or GDP minus 0.5 percent. On average, the ultimate cost growth rate for these provider services is 4.2 percent, or GDP plus 0.2 percent.

(ii). ***Certain SMI Part B services that are updated annually by the CPI increase less the increase in productivity.***

Such services include durable medical equipment, care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the per beneficiary year-by-year rates to be 3.6 percent in 2038, or GDP minus 0.4 percent, declining to 2.7 percent in 2088, or GDP minus 1.3 percent. On average, the total assumed rate of growth for these services is 3.4 percent, which equates to GDP minus 0.6 percent.

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

[4] Historically, lawmakers frequently reduced the payment updates below the increase in providers' input prices in an effort to slow Medicare cost growth or to offset unwarranted changes in claims coding practices. Prior to the Affordable Care Act, the law did not specify any such adjustments after 2009.

(iii). ***All other Medicare services, for which payments are established based on market processes, such as prescription drugs provided through Part D and the remaining Part B services, including physician payments.***[5]

These Part B outlays constitute an estimated 50 percent of total Part B expenditures in 2023 and consist mostly of payments for physician services, laboratory tests, physician-administered drugs, and small facility services. Medicare payments to Part D plans are based on a competitive-bidding process and are not affected by the productivity adjustments. Similarly, payments for the other Part B services are based on market factors.[6] The long-range per beneficiary cost growth rate for Part D and these Part B services is assumed to equal the increase in per capita national health expenditures as determined from the factors model. The corresponding year-by-year growth rates for these services are 5.2 percent in 2038, or GDP plus 1.2 percent, declining to 4.3 percent by 2088, or GDP plus 0.3 percent. On average, the rate of growth for these services is 5.0 percent, or GDP plus 1 percent.

In addition, these long-range cost growth rates must be modified to reflect demographic impacts. For example, beneficiaries at ages 80 and above use Part A skilled nursing and home health services much more frequently than do younger beneficiaries. As the beneficiary population ages, Part A costs will grow at a faster rate due to increased use of these services. In contrast, the incidence of prescription drug use is more evenly distributed by age, and an increase in the average age of Part D enrollees has significantly less of an effect on Part D costs.

After combining the rates of growth from the three long-range assumptions, the weighted average growth rate for Part B is 4.6 percent per year for the last 50 years of the projection period, or GDP plus 0.6 percent, on average. When Parts A, B, and D are combined, the weighted average growth rate is 4.5 percent over this same time period or GDP plus 0.5 percent, while the growth rate in 2088 is 3.8 percent or GDP minus 0.2 percent.

HI Cashflow as a Percentage of Taxable Payroll

Each year, estimates of the financial and actuarial status of the HI Trust Fund are prepared for the next 75 years. It is difficult to meaningfully compare dollar values for different periods without some type of relative scale; therefore, income and expenditure amounts are shown relative to the earnings in covered employment that are taxable under HI (referred to as taxable payroll).

Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected long-range HI cost rates shown in the 2014 report are lower than those from the 2013 report. The primary reasons for the difference are lower-than-expected recent spending and revised utilization assumptions.

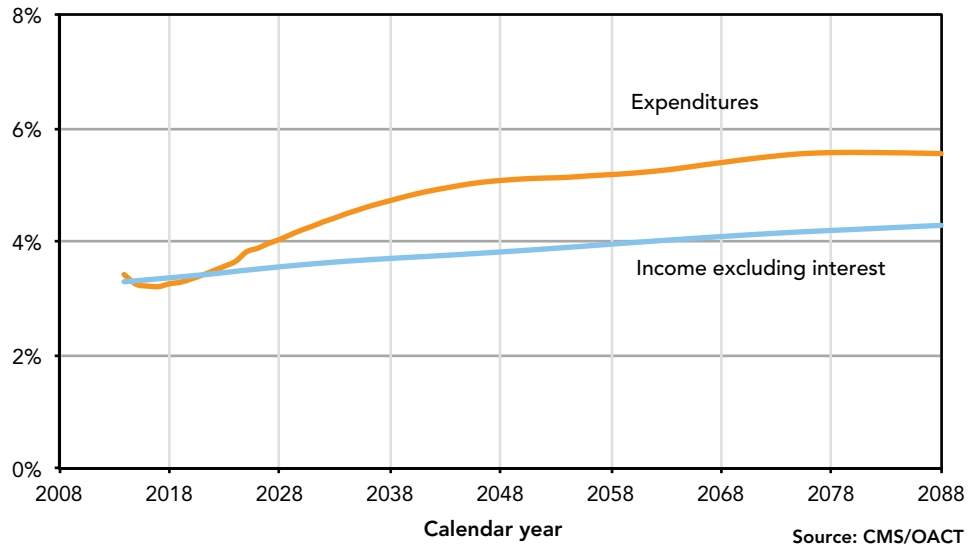
Since the standard HI payroll tax rates are not scheduled to change in the future under present law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. Under the Affordable Care Act, however, high-income workers pay an additional 0.9 percent of 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.

[5] In the long range under the projected baseline, physician services are assumed to increase at the rate equal to the per capita increase in health spending in the U.S. overall.

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

Chart 1

HI EXPENDITURES AND INCOME EXCLUDING INTEREST AS A PERCENTAGE OF TAXABLE PAYROLL (2014–2088)



Source: CMS/OACT

As indicated in chart 1, the cost rate will initially decline due to the expected continuation of the economic recovery, the savings provisions of the Affordable Care Act, and the sequestration of Medicare expenditures for 2013-2024. Subsequently, the cost rate will increase significantly due to retirements of those in the baby boom generation and partly due to health services cost growth. The effect of these factors will be somewhat offset by the accumulating effect of the reduction in provider price updates, which will reduce annual HI cost growth by an estimated 1.1 percent per year. Under the illustrative alternative scenario, if the slower price updates were not feasible in the long range and were phased down during 2020-2034, then the HI cost rate would be 4.9 percent in 2035 and 8.8 percent in 2085. These levels are about 8 percent and 57 percent higher, respectively, than the projected baseline estimates under the intermediate assumptions.

HI and SMI Cashflow as a Percentage of GDP

Expressing Medicare incurred expenditures as a percentage of GDP gives a relative measure of the size of the Medicare program compared to the general economy. The GDP represents the total value of goods and services produced in the United States. This measure provides an idea of the relative financial resources that will be necessary to pay for Medicare services.

HI

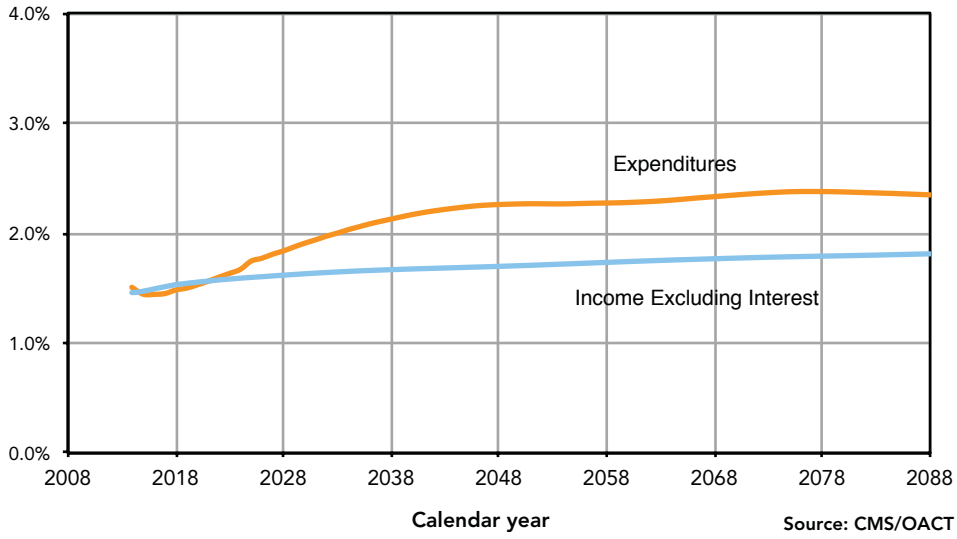
Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2013, the expenditures were $266.2 billion, which was 1.6 percent of GDP. This percentage is projected to increase steadily through 2046 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 3.8 percent in 2088.

SMI

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

Chart 2

HI EXPENDITURES AND INCOME EXCLUDING INTEREST AS A PERCENTAGE OF GDP (2014–2088)



Source: CMS/OACT

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

In 2013, SMI expenditures were $316.7 billion, or about 1.9 percent of GDP. Under the projected baseline, they would grow to roughly 3.4 percent of GDP in about 25 years and to more than 4.5 percent by the end of the projection period. (Total SMI expenditures in 2088 would be 4.0 percent of GDP if physician payment rates were set as assumed under the current-law projections. Such costs would represent more than 4.6 percent of GDP under the illustrative alternative, which includes larger payment updates for most non-physician categories of Part B providers.)

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 2014 by about 4.6 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate. The special State payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the State payments are also expected to increase faster than GDP.

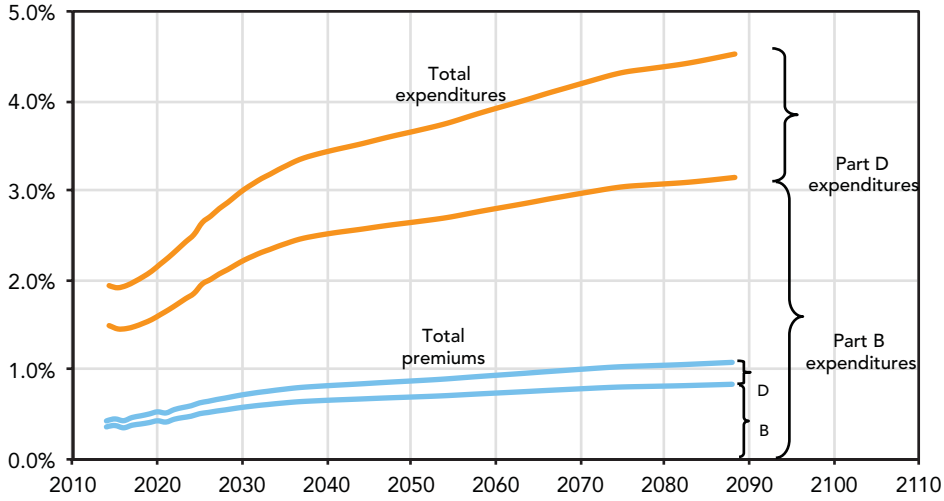
Worker-to-Beneficiary Ratio

HI

Another way to evaluate the long-range outlook of the HI Trust Fund is to examine the projected number of workers per HI beneficiary. Chart 4 illustrates this ratio over the next 75 years. For the most part, current workers pay for current benefits. The relatively smaller number of persons born after the baby boom will therefore finance the retirement of the baby boom generation. In 2013, every beneficiary had 3.2 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.3 workers per beneficiary. The projected ratio continues to decline until there are just 2.1 workers per beneficiary by 2088.

Chart 3

SMI EXPENDITURES AND PREMIUMS AS A PERCENTAGE OF GDP (2014–2088)



Source: CMS/OACT

SENSITIVITY ANALYSIS

To prepare projections regarding the future financial status of the HI and SMI Trust Funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that both trust funds will continue under present law. In addition, the estimates depend on many economic and demographic assumptions. Because of revisions to these assumptions, due to either changed conditions or updated information, estimates sometimes change substantially compared to those made in prior years. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty.

To illustrate the sensitivity of the long-range projections and determine the impact on the HI actuarial present values, six of the key assumptions were varied individually.[7] The assumptions varied are the health care cost factors, real-wage differential, CPI, real-interest rate, fertility rate, and net immigration.[8]

For this analysis, the intermediate economic and demographic assumptions in the *2014 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, 2014 and are based on estimates of income and expenditures during the 75-year projection period.

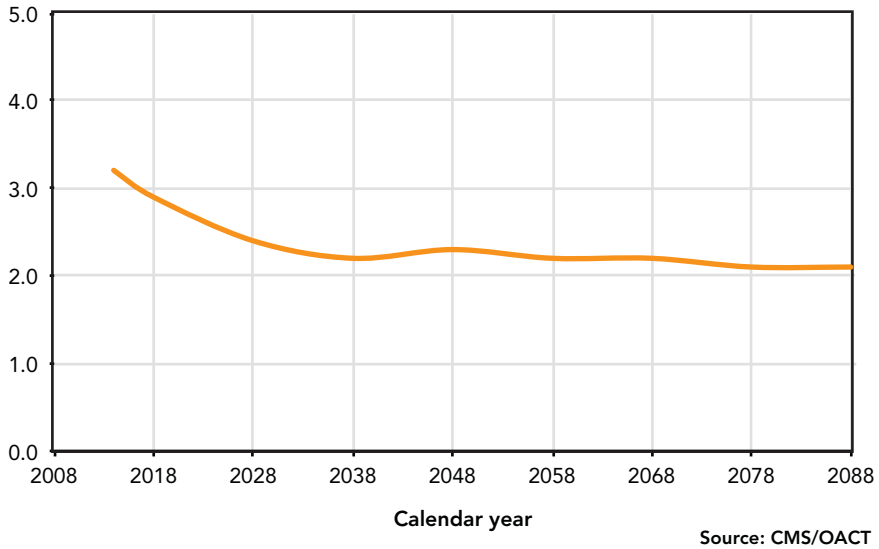
Charts 5 through 10 show the present value of the estimated net cashflow for each assumption varied. Generally, under all three scenarios, the present values initially increase, as the effects of the Affordable Care Act result in trust fund surpluses, and then decrease until about 2047 when they start 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

[7] Sensitivity analysis is not done for Parts B or D of the SMI Trust Fund due to the financing mechanism for each account. Any change in assumptions would have a negligible impact on the net cashflow, since the change would affect income and expenditures equally.

[8] The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures. As a result, it is not possible at present to prepare meaningful estimates of the HI mortality sensitivity.

Chart 4

NUMBER OF COVERED WORKERS PER HI BENEFICIARY (2014–2088)



Source: CMS/OACT

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 1 percent slower than the intermediate assumptions, the same as the intermediate assumptions, and 1 percent faster than the intermediate assumptions. In each case, the taxable payroll will be the same as that which was assumed for the intermediate assumptions.

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $5,819 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by $9,267 billion.

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

This assumption has a dramatic impact on projected HI cashflow. The present value of the net cashflow under the ultimate growth rate assumption of 1 percentage point lower than the intermediate assumption actually becomes a surplus and remains positive throughout the entire period, due to the improved financial outlook for the HI Trust Fund as a result of the Affordable Care Act. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As chart 5 indicates, the financial status of the HI Trust Fund is extremely sensitive to the relative growth rates for health care service costs.

Table 1

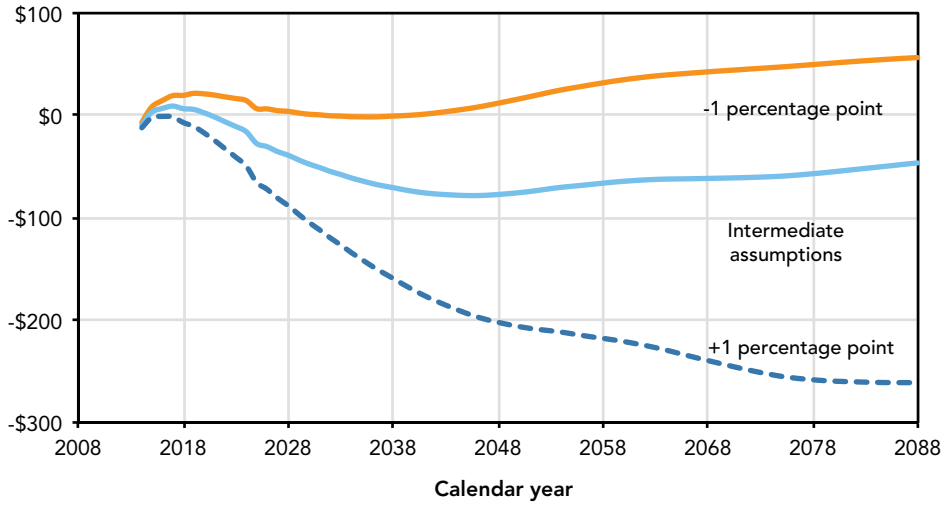
PRESENT VALUE OF ESTIMATED HI INCOME LESS EXPENDITURES UNDER VARIOUS HEALTH CARE COST GROWTH RATE ASSUMPTIONS

Annual cost/payroll relative growth rate	–1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures *(in billions)*	$1,996	–$3,823	–$13,090

Chart 5

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS HEALTH CARE COST FACTORS (2014–2088)

(IN BILLIONS)



Source: CMS/OACT

Real-Wage Differential

Table 2 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.5, 1.1, and 1.8 percentage points.[9] In each case, the assumed ultimate annual increase in the CPI is 2.7 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 3.2, 3.8, and 4.5 percent, respectively.

As indicated in table 2, for a halfpoint increase in the ultimate realwage differential assumption, the deficit—expressed in present-value dollars—decreases by approximately $1,230 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $795 billion.

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

As illustrated in chart 6, faster real-wage growth results in smaller HI cashflow deficits, when expressed in present-value dollars. A higher real-wage differential immediately increases both HI expenditures for health care and wages for all workers. There is a full effect on wages and payroll taxes, but the effect on benefits is only partial, since not all health care costs are wage-related. In practice, faster real-wage growth always improves the financial status of the HI Trust Fund, regardless of whether there is a small or large imbalance between income and expenditures. Also, as noted previously, the closer financial balance for the HI Trust Fund under the Affordable Care Act depends critically on the long-range feasibility of the lower Medicare price updates for hospitals and other HI

Table 2

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

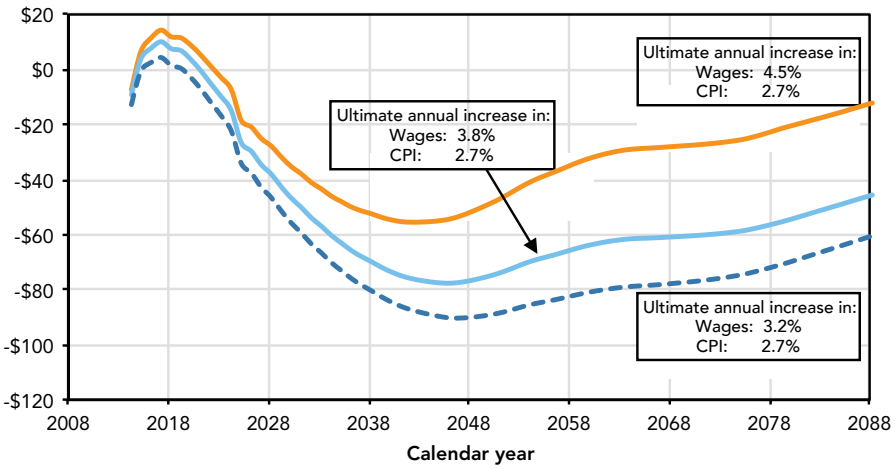
Ultimate percentage increase in wages – CPI	**3.2 – 2.7**	**3.8 – 2.7**	**4.5 – 2.7**
Ultimate percentage increase in real-wage differential	**0.5**	**1.1**	**1.8**
Income minus expenditures *(in billions)*	**–$4,777**	**–$3,823**	**–$2,101**

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

Chart 6

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS REAL-WAGE ASSUMPTIONS (2014–2088)

(IN BILLIONS)



Source: CMS/OACT

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: 3.4, 2.7, and 2.0 percent. In each case, the assumed ultimate real-wage differential is 1.1 percent, which yields ultimate percentage increases in average annual wages in covered employment of 4.5, 3.8, and 3.1 percent, respectively.

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.4 percent, the deficit decreases by $767 billion. On the other hand, if the ultimate CPI-increase assumption is 2.0 percent, the deficit increases by $957 billion.

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

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

Table 3

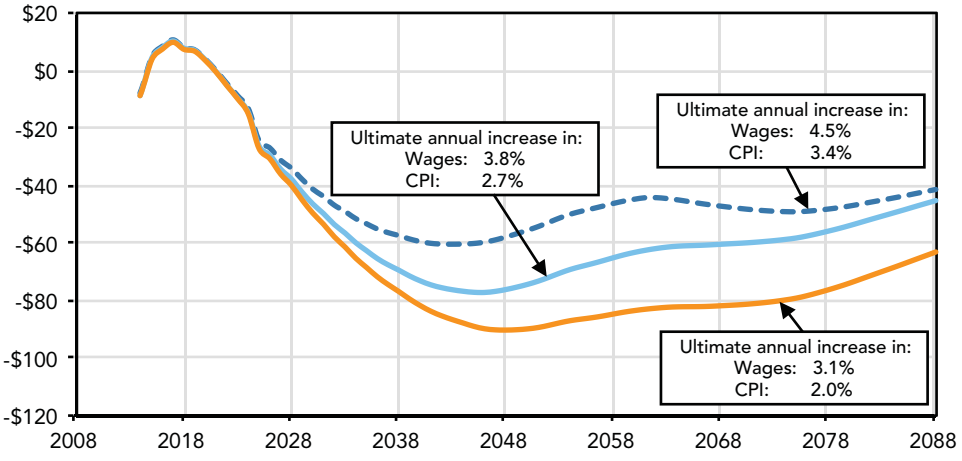
PRESENT VALUE OF ESTIMATED HI INCOME LESS EXPENDITURES UNDER VARIOUS CPI—INCREASE ASSUMPTIONS

Ultimate percentage increase in wages – CPI	4.5 – 3.4	3.8 – 2.7	3.1 – 2.0
Income minus expenditures *(in billions)*	–$3,055	–$3,823	–$4,780

Chart 7

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS CPI-INCREASE ASSUMPTIONS (2014–2088)

(IN BILLIONS)



Source: CMS/OACT

Real-Interest Rate

Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate annual real-interest assumptions: 2.4, 2.9, and 3.4 percent. In each case, the assumed ultimate annual increase in the CPI is 2.7 percent, which results in ultimate annual yields of 5.1, 5.6, and 6.1 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 $140 billion.

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

As shown in chart 8, the projected HI cashflow when expressed in present values is fairly sensitive to the interest assumption. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI Trust Fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2030. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

Table 4

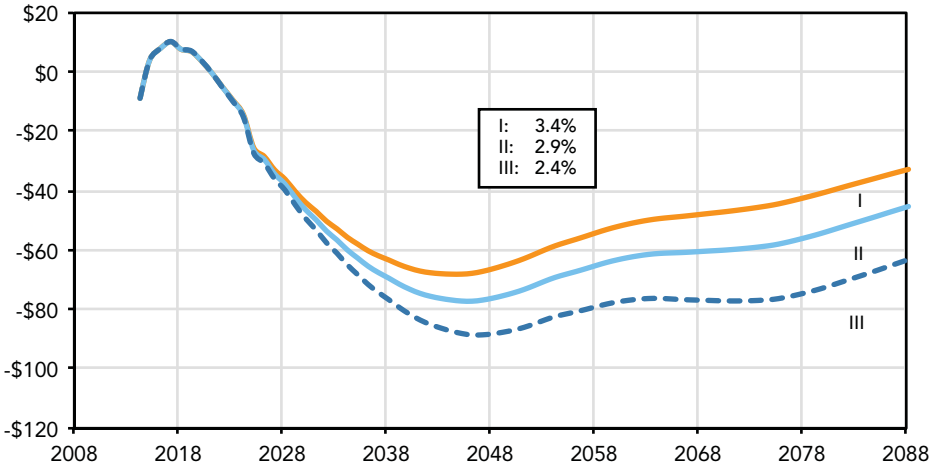
PRESENT VALUE OF ESTIMATED HI INCOME LESS EXPENDITURES UNDER VARIOUS REAL-INTEREST ASSUMPTIONS

Ultimate real-interest rate	2.4 percent	2.9 percent	3.4 percent
Income minus expenditures *(in billions)*	–$4,626	–$3,823	–$3,204

Chart 8

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS REAL-INTEREST RATE ASSUMPTIONS (2014–2088)

(IN BILLIONS)



Source: CMS/OACT

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)*	**–$4,211**	**–$3,823**	**–$3,426**

[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.

Fertility Rate

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

As table 5 demonstrates, for an increase of 0.3 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $390 billion.

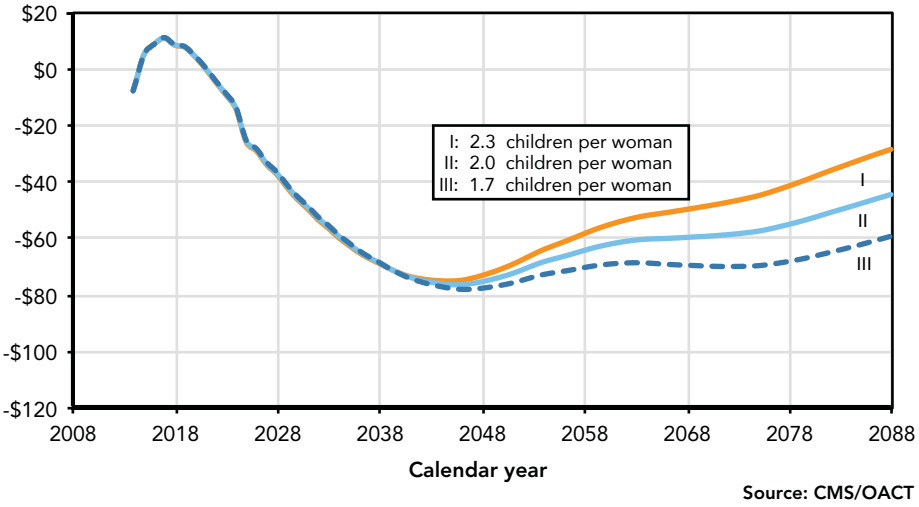
Chart 9 shows projections of the present value of the net cashflow under the three alternative fertility rate assumptions presented in table 5.

As chart 9 indicates, the fertility rate assumption has a substantial impact on projected HI cashflows. Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, but their impact on future HI taxes will be relatively greater, since many will become subject to the additional HI tax, thereby lowering the deficit proportionately more on a present-value-dollar basis. Under the lower fertility rate assumptions, on the other hand, there will be fewer workers in the workforce with a smaller number subject to the additional tax, in turn raising the HI deficit. It is important to point out that if a longer projection period were used, the impact of a fertility rate change would be more pronounced.

Chart 9

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS ULTIMATE FERTILITY RATE ASSUMPTIONS (20143–2088)

(IN BILLIONS)



Source: CMS/OACT

Net Immigration

Table 6 shows the net present value of cashflow during the 75year projection period under three alternative average annual net immigration assumptions: 830,000 persons, 1,125,000 persons, and 1,430,000 persons per year.

As indicated in table 6, if the average annual net immigration assumption is 830,000 persons, the deficit—expressed in present-value dollars—increases by $216 billion. Conversely, if the assumption is 1,430,000 persons, the deficit decreases by about $168.5 billion.

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

Higher net immigration results in smaller HI cashflow deficits, as illustrated in chart 10. Since immigration tends to occur most often among people at working ages, who work and pay taxes into the HI system, a change in the net immigration assumption affects revenues from payroll taxes almost immediately. However, the impact on expenditures occurs later as those individuals age and become beneficiaries.

Table 6

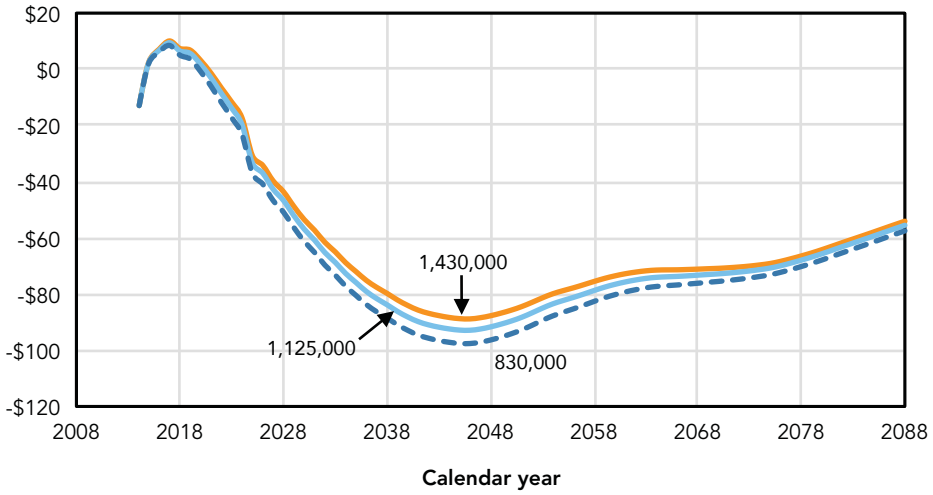
PRESENT VALUE OF ESTIMATED HI INCOME LESS EXPENDITURES UNDER VARIOUS NET IMMIGRATION ASSUMPTIONS

Average annual net immigration	830,000	1,125,000	1,430,000
Income minus expenditures *(in billions)*	–$4,039	–$3,823	–$3,654

Chart 10

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS NET IMMIGRATION ASSUMPTIONS (2014–20887)

(IN BILLIONS)



Source: CMS/OACT

TRUST FUND FINANCES AND SUSTAINABILITY

HI

Under the Medicare Trustees' intermediate assumptions, the estimated depletion date for the HI Trust Fund is 2030, 4 years later than in the 2013 report. As in past years, the Trustees have determined that the fund is not adequately financed over the next 10 years. HI taxable earnings in 2013 were slightly higher than last year's estimate; after 2013, however, projections of earnings throughout the period are lower mostly due to lower assumptions for the GDP deflator and real GDP. HI expenditures in 2013 were significantly lower than the previous estimate, and through 2016 the projected level grows more slowly than shown in last year's report largely due to reductions in utilization assumptions, reflecting recent trends. HI expenditures have exceeded income annually since 2008 and are projected to continue doing so through 2014. The Trustees project slight surpluses in 2015-2022, with a return to deficits thereafter until the fund becomes depleted in 2030. 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. To date, Congress has never allowed a Medicare or Social Security trust fund to become fully depleted.

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

The HI Trust Fund remains out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require significant increases in revenues and/or reductions in benefits. These changes are needed partially as a result of the retirement of the baby boom generation. If the reductions to HI provider price updates could not be continued in the long run, then the actuarial deficit would be much greater.

SMI

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 2014 is adequate to cover 2014 expected expenditures and to maintain the financial status of the account in 2014 at a satisfactory level. No financial imbalance is anticipated for the Part D account, since the general revenue subsidy for this benefit is drawn on a daily, as-needed basis. The projected Part D costs shown in this section are lower than previously estimated. The difference is primarily attributable to a lower projected drug cost trend, and higher drug rebates, consistent with recent experience.

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

Medicare Overall

The Medicare Modernization Act requires the Board of Trustees to determine whether the difference between Medicare outlays and dedicated financing sources[8] is projected to exceed 45 percent of total Medicare outlays under current law within the next 7 fiscal years (2014-2020). If this level is attained within the 7-year timeframe, Federal law requires a determination of projected excess general revenue Medicare funding. For the 2014 Medicare Trustees Report, this difference is not expected to exceed 45 percent of total expenditures in fiscal years 2014-2020 (the first 7 years of the projection), and therefore, the Trustees are not issuing this determination.

The projections shown in this section continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the projected depletion of the HI Trust Fund, this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures. Furthermore, if the growth in Medicare costs is comparable to growth under the illustrative alternative, then these further policy reforms will have to address much larger financial challenges than those assumed under the projected baseline scenario. In their 2014 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the Nation's policy makers to "work closely together with a sense of urgency to address these challenges." They also stated: "Consideration of such reforms should not be delayed."

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

COMBINING STATEMENT OF BUDGETARY RESOURCES

for the year ended September 30, 2014

(IN MILLIONS)

	Medicare		Payments to Trust Funds	Medicaid	CHIP	Medicare Part D	Other Health	All Others	Combined Totals Budgetary	Non-Budgetary Credit Reform Financing Account
	HI TF	SMI TF								
BUDGETARY RESOURCES:										
Unobligated balance, brought forward, October 1:			$4,568	$2,282	$13,107	$439	$8,855	$5,136	$34,387	
Recoveries of prior year unpaid obligations	$777	$2	100	21,569	202	911	172	252	23,985	
Other changes in unobligated balance			(163)	12	(58)		(41)	(40)	(290)	
Unobligated balance from prior year budget authority, net	**777**	**2**	**4,505**	**23,863**	**13,251**	**1,350**	**8,986**	**5,348**	**58,082**	
Appropriation	278,190	264,039	272,268	302,282	12,833	70,409	803	3,181	1,204,005	
Borrowing authority										$237
Spending authority from offsetting collections	5	18	19	693	5		115	12,459	13,314	194
TOTAL BUDGETARY RESOURCES	**$278,972**	**$264,059**	**$276,792**	**$326,838**	**$26,089**	**$71,759**	**$9,904**	**$20,988**	**$1,275,401**	**$431**
STATUS OF BUDGETARY RESOURCES:										
Obligations incurred	$278,972	$264,059	$276,792	$325,463	$10,112	$71,581	$2,621	$15,905	$1,245,505	$431
Unobligated balance, end of year:										
Apportioned				1,309	14,386		7,105	2,342	25,142	
Unapportioned				66	1,591	178	178	2,741	4,754	
Total unobligated balance, end of year				**1,375**	**15,977**	**178**	**7,283**	**5,083**	**29,896**	
TOTAL BUDGETARY RESOURCES	**$278,972**	**$264,059**	**$276,792**	**$326,838**	**$26,089**	**$71,759**	**$9,904**	**$20,988**	**$1,275,401**	**$431**
CHANGE IN OBLIGATED BALANCE:										
Unpaid obligations:										
Unpaid obligations, brought forward, October 1	$25,103	$24,691	$5,278	$29,877	$6,129	$7,398	$5,188	$6,959	$110,623	$1,249
Adjustment to unpaid obligations	(161)	1	(1)	1		(1)	(1)	36	(126)	
Obligations incurred	278,972	264,059	$276,792	325,463	10,112	71,581	2,621	15,905	1,245,505	431
Outlays (gross)	(273,796)	(265,932)	(265,655)	(298,365)	(9,323)	(65,098)	(3,756)	(14,324)	(1,196,249)	(680)
Recoveries of prior year unpaid obligations	(777)	(2)	(100)	(21,569)	(202)	(911)	(172)	(252)	(23,985)	
Unpaid obligations end of year	**29,341**	**22,817**	**16,314**	**35,407**	**6,716**	**12,969**	**3,880**	**8,324**	**135,768**	**1,000**
Uncollected Payments:										
Uncollected payments, Federal sources, brought forward, October 1								(7,754)	(7,754)	(536)
Adjustment to uncollected payments, Federal sources								156	156	(10)
Change in uncollected payments, Federal sources							(29)	(162)	(191)	117
Uncollected payments, Federal sources, end of year							**(29)**	**(7,760)**	**(7,789)**	**(429)**
Memorandum entries:										
Obligated balance, start of year, net	$25,103	$24,691	$5,278	$29,877	$6,129	$7,398	$5,188	$(795)	$102,869	$713
Obligated balance, end of year, net	$29,341	$22,817	$16,314	$35,407	$6,716	$12,969	$3,851	$564	$127,979	$571
BUDGET AUTHORITY AND OUTLAYS, NET:										
Budget authority, gross	$278,195	$264,057	$272,287	$302,975	$12,838	$70,409	$918	$15,640	$1,217,319	$431
Actual offsetting collections	(5)	(18)	(19)	(693)	(5)		(86)	(12,297)	(13,123)	(310)
Change in uncollected customer payments from Federal sources							(29)	(162)	(191)	117
Budget authority, net	278,190	264,039	272,268	302,282	12,833	70,409	803	3,181	1,204,005	238
Outlays (gross)	273,796	265,932	265,655	298,365	9,323	65,098	3,756	14,324	1,196,249	680
Actual offsetting collections	(5)	(18)	(19)	(693)	(5)	0	(86)	(12,297)	(13,123)	(310)
Outlays, net	273,791	265,914	265,636	297,672	9,318	65,098	3,670	2,027	1,183,126	370
Distributed offsetting receipts	(31,770)	(326,854)			(3)			(118)	(358,745)	
AGENCY OUTLAYS, NET	**$242,021**	**$(60,940)**	**$265,636**	**$297,672**	**$9,315**	**$65,098**	**$3,670**	**$1,909**	**$824,381**	**$370**

SUPPLEMENTARY INFORMATION

CONSOLIDATING BALANCE SHEET

as of September 30, 2014

(IN MILLIONS)

	Medicare (Dedicated Collections)			Health (Other Funds)						
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	Combined Totals	Intra-CMS Eliminations	Consolidated Totals
ASSETS										
Intragovernmental Assets:										
Fund Balance with Treasury	$744	$18,445	$19,189	$36,781	$20,595	$11,224	$4,496	$92,285		$92,285
Investments	204,361	68,925	273,286		2,100			275,386		275,386
Accounts Receivable, Net	30,699	35,111	65,810	111	13	256	508	66,698	$(66,085)	613
Other Assets	25		25			1		26		26
Total Intragovernmental Assets	**235,829**	**122,481**	**358,310**	**36,892**	**22,708**	**11,481**	**5,004**	**434,395**	**(66,085)**	**368,310**
Accounts Receivable, Net	1,076	5,156	6,232	3,592	5	3	28	9,860		9,860
General Property, Plant & Equipment, Net	114	193	307	15	1	75	5	403		403
Other Assets	15	33	48	44		1,287	81	1,460		1,460
TOTAL ASSETS	**$237,034**	**$127,863**	**$364,897**	**$40,543**	**$22,714**	**$12,846**	**$5,118**	**$446,118**	**$(66,085)**	**$380,033**
LIABILITIES										
Intragovernmental Liabilities:										
Accounts Payable	$30,997	$35,624	$66,621			$63	$9	$66,693	$(66,085)	$608
Accrued Payroll and Benefits	2	3	5			1		6		6
Other Intragovernmental Liabilities	144	769	913			900	20	1,833		1,833
Total Intragovernmental Liabilities	**31,143**	**36,396**	**67,539**			**964**	**29**	**68,532**	**(66,085)**	**2,447**
Accounts Payable	28	76	104	14	$1	5	10	134		134
Federal Employee and Veterans' Benefits	3	8	11	1		2		14		14
Entitlement Benefits Due and Payable	25,719	31,872	57,591	32,275	923	239	9	91,037		91,037
Accrued Payroll and Benefits	20	34	54	2		12	3	71		71
Contingencies		1,300	1,300	8,460				9,760		9,760
Other Liabilities	258	930	1,188		2	22	27	1,239		1,239
TOTAL LIABILITIES	**$57,171**	**$70,616**	**$127,787**	**$40,752**	**$926**	**$1,244**	**$78**	**$170,787**	**$(66,085)**	**$104,702**
NET POSITION										
Unexpended Appropriations-Dedicated Collections	$691	$15,624	$16,315					$16,315		$16,315
Unexpended Appropriations-Other Funds				$(331)	$21,769	$11,253	$3,992	36,683		36,683
Cumulative Results of Operations-Dedicated Collections	179,172	41,623	220,795					220,795		220,795
Cumulative Results of Operations-Other Funds				122	19	349	1,048	1,538		1,538
TOTAL NET POSITION	**$179,863**	**$57,247**	**$237,110**	**$(209)**	**$21,788**	**$11,602**	**$5,040**	**$275,331**		**$275,331**
TOTAL LIABILITIES AND NET POSITION	**$237,034**	**$127,863**	**$364,897**	**$40,543**	**$22,714**	**$12,846**	**$5,118**	**$446,118**	**$(66,085)**	**$380,033**

CONSOLIDATING STATEMENT OF NET COST

for the year ended September 30, 2014

(IN MILLIONS)

	Medicare (Dedicated Collections)			Health (Other Funds)				Consolidated Total
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	
NET PROGRAM/ACTIVITY COSTS								
GPRA Programs:								
Medicare (Dedicated Collections)	$266,796	$251,270	$518,066					$518,066
Medicaid				$305,359				305,359
CHIP					$9,574			9,574
Net Cost: GPRA Programs	**266,796**	**251,270**	**518,066**	**305,359**	**9,574**			**832,999**
Other Activities:								
State Grants and Demonstrations							$555	555
Other Health						$3,811		3,811
Other							399	399
Net Cost: Other Activities						**3,811**	**954**	**4,765**
NET COST OF OPERATIONS	**$266,796**	**$251,270**	**$518,066**	**$305,359**	**$9,574**	**$3,811**	**$954**	**$837,764**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2014

(IN MILLIONS)

	Medicare (Dedicated Collections)			Health (Other Funds)				Consolidated Total
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	
CUMULATIVE RESULTS OF OPERATIONS								
Beginning Balances	$189,024	$49,121	$238,145	$121	$18	$367	$1,039	$239,690
Budgetary Financing Sources:								
Appropriations Used	20,362	239,998	260,360	304,505	9,554	3,322	1,178	578,919
Nonexchange Revenue:								
FICA and SECA Taxes	227,579		227,579					227,579
Interest on Investments	8,861	2,438	11,299		3			11,302
Other Nonexchange Revenue	809	3,014	3,823					3,823
Transfers-in/out Without Reimbursement	(679)	(1,702)	(2,381)	853	18	469	(217)	(1,258)
Other Financing Sources (Nonexchange):								
Transfers-in/out Without Reimbursement						(7)		(7)
Imputed Financing	12	24	36	2		9	2	49
Total Financing Sources	**256,944**	**243,772**	**500,716**	**305,360**	**9,575**	**3,793**	**963**	**820,407**
Net Cost of Operations	**266,796**	**251,270**	**518,066**	**305,359**	**9,574**	**3,811**	**954**	**837,764**
Net Change	**(9,852)**	**(7,498)**	**(17,350)**	**1**	**1**	**(18)**	**9**	**(17,357)**
CUMULATIVE RESULTS OF OPERATIONS	**$179,172**	**$41,623**	**$220,795**	**$122**	**$19**	**$349**	**$1,048**	**$222,333**
UNEXPENDED APPROPRIATIONS								
Beginning Balances	$978	$3,591	$4,569	$1,881	$18,551	$13,813	$3,410	$42,224
Budgetary Financing Sources:								
Appropriations Received	20,238	253,534	273,772	323,751	19,147	903	1,792	619,365
Appropriations Transferred-in/out				(3,550)		(21)	119	(3,452)
Other Adjustments	(163)	(1,503)	(1,666)	(17,908)	(6,375)	(120)	(151)	(26,220)
Appropriations Used	(20,362)	(239,998)	(260,360)	(304,505)	(9,554)	(3,322)	(1,178)	(578,919)
Total Budgetary Financing Sources	**(287)**	**12,033**	**11,746**	**(2,212)**	**3,218**	**(2,560)**	**582**	**10,774**
Total Unexpended Appropriations	**691**	**15,624**	**16,315**	**(331)**	**21,769**	**11,253**	**3,992**	**52,998**
NET POSITION	**$179,863**	**$57,247**	**$237,110**	**$(209)**	**$21,788**	**$11,602**	**$5,040**	**$275,331**

AUDIT REPORTS

The following reports were prepared by Ernst & Young.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

NOV 1 0 2014

TO: Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson
Inspector General

SUBJECT: Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2014 (A-17-14-02014)

This memorandum transmits the independent auditors' reports on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2014 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and other matters. The Chief Financial Officers Act of 1990 (P.L. No. 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the CMS financial statements in support of the U.S. Department of Health and Human Services audit.

We contracted with the independent certified public accounting firm of Ernst & Young, LLP, to audit the CMS (1) consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of net cost and changes in net position, (2) the combined statement of budgetary resources for the years then ended, and (3) the statement of social insurance as of January 1, 2014 and related statement of changes in social insurance amounts. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in the *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 14-02, *Audit Requirements for Federal Financial Statements*.

Results of the Independent Audit

Ernst & Young found that the FY 2014 CMS consolidated balance sheets and the related consolidated statements of net cost and changes in net position and the combined statement of budgetary resources were fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. As presented in notes to the financial statements, with respect to the estimates for the statement of social insurance as of January 1, 2014 and 2013, CMS management has assumed in the projections of the program that the various cost-reduction measures will occur as the Patient Protection and Affordable Care Act (P.L. No. 111-148) (ACA) requires. The Medicare Board of Trustees, in its annual report to

Congress, stated, "While the ACA has been successful in reducing many Medicare expenditures to date, there is a strong possibility that certain of these changes will not be viable in the long range." It further showed the potential impact of this uncertainty in illustrative alternative scenarios and projections intended to provide additional context of the actuarial estimates regarding the long-term sustainability of the social insurance program. The width of the range of the social insurance liability estimates in the various scenarios was significant. As a result, Ernst & Young was unable to obtain sufficient audit evidence for the particular amounts presented in the statements of social insurance as of January 1, 2014,2013,2012,2011, and 2010, and the related statements of changes in social insurance amounts for the periods ended January 1, 2014 and 2013. Ernst & Young was not able to and did not express an opinion on the financial condition of the CMS social insurance program and related changes in the social insurance program for the specified periods.

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

- *Financial Reporting Processes-Ernst* & Young noted that CMS should continue to focus efforts on identifying the underlying cause of deficiencies. During the FY 2014 audit, errors were noted that were not detected by the organization's monitoring and review function, which showed the control was not functioning as designed or intended. Weaknesses in oversight of the Medicaid program and third-party contractors were identified. Also, CMS lacks needed functionality in its Healthcare Integrated General Ledger and Accounting System, which prompts the need for system interventions to properly categorize information in the financial statements. These deficiencies collectively represent a significant deficiency in internal control.

- *Information Systems Controls-Ernst* & Young noted that CMS continues to experience difficulties in implementing its policy of least-privilege access, monitoring for inconsistencies in access rights, and mitigating the potential impact on adequate segregation of duties. CMS continues to experience deficiencies in the implementation and monitoring of compliance with its computer security policies. Ernst & Young noted that additional focus is required to minimize the risk of current and unresolved prior-year deficiencies. These conditions may result in incomplete and inaccurate processing of transactions, impacting the integrity and completeness of data used to prepare C\1S's financial statements. The deficiencies found continue to constitute a significant deficiency in internal control.

Ernst & Young identified that CMS was not in full compliance with the Improper Payments Information Act of2002 (P.L. No. 107-300) (IPIA), as amended. Notably, the Medicare Fee-for-Service program error rate exceeded the mandated I0-percent threshold, and the Medicaid program did not meet its targeted reduction rate of 5.6 percent. We will be communicating further details on agency compliance with improper-payment reporting, as required by the IPIA, later in fiscal year 2015. Also, CMS was not in compliance with section 6411 of the ACA as

CMS had not yet implemented recovery audit activities for the Medicare Advantage program. Ernst & Young disclosed no other instances of noncompliance that are required to be reported under *Government Auditing Standards* and OMB Bulletin 14-02.

Evaluation and Monitoring of Audit Performance

We reviewed the audit of the CMS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the audit;
- attending key meetings with auditors and CMS officials;
- monitoring the progress of the audit;
- examining audit documentation related to the review of internal controls over financial reporting;
- reviewing the auditors' reports; and
- reviewing CMS's "Management Discussion and Analysis," "Financial Statements and Footnotes," and "Supplementary Information."

Ernst & Young is responsible for the attached auditors' reports and the conclusions expressed in the reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on CMS's financial statements, the effectiveness of internal controls, whether financial management systems substantially complied with the Federal Financial Management Improvement Act of 1996 (P.L. No. 104-208), or compliance with other laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which Ernst & Young did not comply, in all material respects, with U.S. generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Gloria L. Jarmon, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at Gloria.Jarmon@oig.hhs.gov. Please refer to report number A-17-14-02014.

Attachment

Page 4–Marilyn Tavenner

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

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

Deborah Taylor
Director Office of Financial Management
and Chief Financial Officer

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Report of Independent Auditors

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

Report on the Financial Statements

We have audited the accompanying consolidated balance sheets of the Centers for Medicare and Medicaid Services (CMS) as of September 30, 2014 and 2013, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal years then ended, and the related notes to the financial statements. We were engaged to audit the statements of social insurance as of January 1, 2014, 2013, 2012, 2011 and 2010, the related statements of changes in social insurance amounts for the periods ended January 1, 2014 and 2013, and the related notes to these financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audits. Except as discussed in the Basis for Disclaimer of Opinion paragraphs with respect to the accompanying statements of social insurance as of January 1, 2014, 2013, 2012, 2011 and 2010, the related statements of changes in social insurance amounts for the periods ended January 1, 2014 and 2013, and the related notes to these financial statements, we conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget Bulletin No. 14-02, *Audit Requirements for Federal Financial Statements*. Those standards and bulletin require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's

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

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion on the consolidated balance sheets as of September 30, 2014 and 2013, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal years then ended, and the related notes to these financial statements.

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

As discussed in Note 14 to the financial statements, the statement of social insurance presents the actuarial present value of the CMS' Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds' estimated future income to be received from or on behalf of the participants and estimated future expenditures to be paid to or on behalf of participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. In preparing the statement of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statement. Because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. Projections of Medicare costs are sensitive to assumptions about future decisions by policymakers and about the behavioral responses of consumers, employers, and health care providers as policies, incentives, and the health care sector change over time. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, and as discussed below, significant additional variability and issues regarding the sustainability of the underlying assumptions under current law were introduced by the passage of the Patient Protection and Affordable Care Act (ACA).

As further described in Note 15 to the financial statements, with respect to the estimates for the CMS social insurance program presented as of January 1, 2014, 2013, 2012, 2011 and 2010, management has assumed in the projections of the program that the various cost-reduction measures will occur as the ACA requires. Management 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. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 15, the

ability of health care providers to sustain these price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services. If the health sector cannot transition to more efficient models of care delivery and achieve productivity increases commensurate with economy-wide productivity, actual future costs for Medicare could exceed those shown in the projections. As a result of these limitations, we were unable to obtain sufficient audit evidence for the amounts presented in the statements of social insurance as of January 1, 2014, 2013, 2012, 2011 and 2010, and the related statements of changes in social insurance amounts for the periods ended January 1, 2014 and 2013.

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

Because of the significance of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the financial condition of the CMS social insurance program as of January 1, 2014, 2013, 2012, 2011 and 2010, and the related changes in the social insurance program for the periods ended January 1, 2014 and 2013.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of CMS as of September 30, 2014 and 2013, and its net cost, changes in net position, and budgetary resources for the years then ended in conformity with U.S. generally accepted accounting principles.

Required Supplementary Information

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

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Supplementary and Other Information

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

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

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

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 10, 2014 on our consideration of CMS' internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations and other matters. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* in considering CMS' internal control over financial reporting and compliance.

Ernst & Young LLP

November 10, 2014

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

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

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 14-02, *Audit Requirements for Federal Financial Statements*, the financial statements of the Centers for Medicare and Medicaid Services (CMS), which comprise the consolidated balance sheet as of September 30, 2014 and the related consolidated statements of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal year then ended, and the related notes to the financial statements, and we were engaged to audit the statement of social insurance as of January 1, 2014, and the related statement of changes in social insurance amounts for the period ended January 1, 2014, and have issued our report thereon dated November 10, 2014. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2014 and the related statement of changes in social insurance amounts for the period ended January 1, 2014.

Compliance and Other Matters

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

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

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The Improper Payments Information Act of 2002 as amended by the Improper Payments Elimination and Recovery Act of 2010 and the Improper Payments Elimination and Recovery Improvement Act of 2013 (hereinafter the Acts) require federal agencies to identify programs and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. Although CMS has reported error rates for each of its high-risk programs, or components of such programs, it is not in full compliance with the Acts. For example, the Medicare fee-for-service error rate is greater than the statutorily required maximum of 10 percent. In addition, CMS is not in full compliance with Section 6411 of the Patient Protection and Affordable Care Act, as CMS has not yet implemented recovery activities of the identified improper payments for the Medicare Advantage (Part C) program. To date, CMS posted a Request for Quote in June 2014; however, no responses were received but CMS anticipates executing a contract in fiscal year 2015.

CMS' Response to Findings

CMS' response to the findings identified in our audit are described in their letter dated November 10, 2014. CMS' response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Purpose of this Report

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

Ernst & Young LLP

November 10, 2014

1411-1348645

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Building a better working world

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

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

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 14-02, *Audit Requirements for Federal Financial Statements*, the financial statements of the Centers for Medicare and Medicaid Services (CMS), which comprise the consolidated balance sheet as of September 30, 2014 and the related consolidated statements of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal year then ended, and the related notes to the financial statements, and we were engaged to audit the statement of social insurance as of January 1, 2014, and the related statement of changes in social insurance amounts for the period ended January 1, 2014, and have issued our report thereon dated November 10, 2014. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2014 and the related statement of changes in social insurance amounts for the period ended January 1, 2014.

Internal Control Over Financial Reporting

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

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

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

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

Significant Deficiencies

Financial Reporting Processes

Financial management in the Federal government requires accountability of financial and program managers for financial results of actions taken, control over the Federal government's financial resources and protection of Federal assets. To enable these requirements to be met, financial management systems and internal controls must be in place to process and record financial events effectively and efficiently and to provide complete, timely, reliable and consistent information for decision-makers and the public. CMS has a fiduciary responsibility over the financial relationships between the qualified health plans and the Federal government to authorize and reconcile the subsidy payments. The effort to build processes to handle these new activities to date has been formidable. Significant work remains to automate and solidify the controls over these expenditures in a manner that is reliable and sustainable over the long term.

CMS relies on a decentralized organization and complex financial management systems to operate and accumulate data for financial reporting. The business owners and users of the systems are located at contracted organizations, providers, regional offices, Centers and Offices outside of the Office of Financial Management (OFM). Providing oversight requires a common set of accounting and reporting standards, proper execution of those standards/policies, an integrated financial system, properly trained personnel, and meaningful collaboration within CMS and with the Department of Health and Human Services (HHS). We identified deficiencies in designing the proper controls, the precision in executing controls and monitoring adherence to established policies and procedures and, at times, a lack of coordination and collaboration within the organization to resolve either the symptoms of or the broader organizational findings. To ultimately prevent and/or detect and resolve errors and irregularities in a timely manner, deter fraud, waste and abuse of Federal government resources, and facilitate efficient and effective delivery of designated programs, CMS should continue to focus its efforts on identifying the

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

As CMS continues its efforts to enhance internal controls, the following items noted in the current year audit merit continued focus on the areas highlighted as part of the financial reporting systems and processes significant deficiency. Additional focus is required to minimize the risk of current and unresolved prior year deficiencies.

Analyses Required for an Effective Financial Management System

Critical or new financial matters identified within CMS require a robust analysis and review process, including close coordination and meaningful collaboration with Centers and Offices, timely summarization of considerations and conclusions, and documentation of the significant accounting and budget matters through a series of white papers. The dispersed nature of the financial management environment and the current process that borrows professionals from other tasks to complete the white papers leaves CMS vulnerable to delays in the financial management implications of issues being recognized and addressed and creates a challenge to gather and analyze the information from across the organization to timely complete the required white papers. Several significant provisions of the Affordable Care Act (ACA) were effective on January 1, 2014 (for example, the Marketplaces, premium subsidies, risk corridors, re-insurance provisions, and risk adjustment). The analysis of the accounting impact to CMS was not completed until October 2014. This compressed the timeframe for senior financial management and financial statement auditors to evaluate the estimates and the related conclusions that impact the annual financial report released in November 2014. The white papers supporting the conclusions on unique, non-routine and critical accounting matters should be prepared timely to assure that all aspects of the important financial matters are thoroughly considered prior to publishing financial information.

During the internal control tests, errors were noted, consistent with the prior year, that were not detected by the organization's monitoring and review function, and accordingly, the control was not functioning as designed or intended. The errors identified by our audit procedures at the Central Office and regional offices may be summarized, including an example for each category, as follows: (i) policies and procedures are not properly designed and implemented; (ii) review or monitoring functions are established but failed to adhere to policies and procedures (for example, the managed care plan payment adjustment policy was not followed); and (iii) activity or accounts for which no formal, documented review or monitoring function was established.

As previously noted, because of its size and complexity, CMS by design relies upon a vast decentralized set of controls, performed by a very large number of people. Oversight of the effectiveness of that control structure at the Central Office could be enhanced by increasing the use of data analytics. Developing robust analytical procedures or measures against benchmarks to monitor and mitigate risks associated with the decentralized nature of CMS operations should be enhanced and documented as part of the entity level control structure. To the extent more

robust analysis occurs within Centers and Offices, identifying, evaluating and reviewing such analysis would also assist in ensuring that a perspective that incorporates a financial reporting point of view is captured and considered. It may be beneficial for CMS to identify a cross-functional working group to perform such analyses.

Oversight of Third-Party Contractors

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

The contracts between CMS and its Medicare fee-for-service contractors include provisions that require the Medicare Administrative Contractors (MACs) to develop and follow objectives established by CMS. Through the established procedures, the MACs are required to a) periodically certify to the completeness and accuracy of the financial information transmitted; b) document specific objectives and maintain supporting documentation for review and audit; and c) provide monthly shared system reports and related support for recorded amounts. Through its OMB Circular No. A-123, *Management's Responsibility for Internal Control* (A-123), AT Section 801, *Reporting on Controls at a Service Organization* (AT Section 801), and regional office processes, CMS monitors the MACs' compliance with its policies and procedures, established controls and the accuracy of financial reporting.

While this approach to financial integrity supports monitoring of the MACs' financial controls, the oversight/monitoring process has not been fully effective in identifying and resolving financial recording and reporting issues or ensuring that the issues are timely remediated by the MACs. During our audit activities, we identified deficiencies where actions are required in the following circumstances: (1) the claims completeness validation process between the claims submitted by the providers and the claims received by the MACs; (2) the Medicare Summary Notices, which are returned to the MACs but are not investigated as to why they are returned; (3) the claims outstanding greater than one year – periodic review, track or monitor those aged claims other than those identified as bankruptcy, fraud or abuse; and (4) the provider records – reconcile, review or monitor provider records and provider eligibility status on a periodic basis to verify that all changes were timely, accurately and completely processed.

The nature and volume of its expenditures present a substantial challenge to CMS in the quantification, evaluation and remediation of improper payments. Health insurance claims represent the vast majority of the CMS payments. These payments are highly complex and involve the evaluation of the program eligibility of both the recipient of the services and of the health provider, oversight of the medical necessity of each covered treatment and concurrence with the cost to be paid, some of which is based on very complex financial formulas and/or coding decisions. The fee-for-service portion of the Medicare program alone accounts for more

than one billion transactions per year. CMS has developed sophisticated sampling processes for estimating error rates in the various CMS insurance programs. These include the annual Comprehensive Error Rate Testing (CERT) process for Medicare Parts A and B and the Payment Error Rate Measurement (PERM) process for Medicaid and Children's Health Insurance Program (CHIP). Similar processes are used to monitor improper payments for Medicare Part C and Part D plans.

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

Continued Implementation of the Integrated Financial Management System

CMS continues their efforts to implement a web-based accounting system, Healthcare Integrated General Ledger Accounting System (HIGLAS), which will integrate the reporting of financial data related to the CMS contractors' standard claims processing systems. HIGLAS is the system of record and CMS is preparing financial statements using HIGLAS; however, the full functionality of HIGLAS has not yet been implemented. The MACs' accounts receivable balances are recorded at Central Office through the manual journal voucher process. While the creation of the periodic financial statements is largely system dependent; however, there is a need for manual interventions to properly categorize the information within the financial statements, as required by OMB A-136.

All MACs have implemented HIGLAS, except for the Durable Medical Equipment MACs. For these contractors, the accuracy of the financial reports remains heavily dependent on inefficient,

labor-intensive, manual processes that are also subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to CMS.

Medicaid Oversight

The Medicaid program is the primary source of medical assistance for low-income Americans. Medicaid operates as a partnership between the states and the Federal government. The Federal government establishes the minimum requirements and provides oversight for the program and the states design, implement, administer and oversee their own Medicaid programs within the Federal parameters. In general, states pay for the health benefits provided, and the Federal government in turn matches qualified state expenditures based on the Federal medical assistance percentage. On average, the Federal government estimates to match state costs at a rate of approximately 60 percent. However, beginning January 1, 2014, ACA expanded eligibility for Medicaid to certain low-income adults and increased the Federal medical assistance percentage to 100 percent for those qualifying claims for the first three years, and 90 percent thereafter, for states that elected to participate in the program (Medicaid Expansion). The Center for Medicaid and CHIP Services (CMCS) is responsible for providing the Federal government oversight of the program and executing the internal controls at the Federal level, which includes: approval of the state plans and amendments, which serve as the contract describing how that state administers the program; approval of each state's budget (the authorized amount) on a quarterly or annual basis; reconciling the Federal share of the expenditures to amounts reported by the state; requiring the states to have program audits and performing analytical procedures over program expenditures. The Federal government controls were designed assuming that the states would have their own set of procedures and controls over program costs and that the states would have an incentive to enforce compliance with their procedures and controls to protect the integrity of their own program costs as well as the expenditures shared by the Federal government.

In FY 2013, CMCS established a protocol to address negative balances and implemented review procedures to compare the quarterly expenditures, budgeted grant awards and quarterly draws. Due to this protocol, grant finalizations are performed more consistently and timely than in prior years. To increase the likelihood of continued progress, CMCS should move forward on formalizing their supplementary monthly controls whereby all negative balances are analyzed and documented consistently.

The changes brought about by ACA have presented additional challenges that also warrant additional consideration:

- Due to the implementation of Medicaid Expansion in January 2014, six states have not yet certified their quarterly expenditure reports for the quarter ended March 31, 2014, and six states have not certified for the quarter ended June 30, 2014. This will result in a backlog of uncertified claims as well as delays in grant finalizations for FY 2014 as the regional offices and CMCS reviews are not completed.

- CMS did not evaluate and record the financial accounting impact on the Entitlement Benefits Due and Payable (EBDP) liability of the Medicaid Expansion until September 30, 2014, even though it was in effect for the second and third quarters of FY 2014.

CMCS has been working on a multiyear project to define data and analytics to improve their program and financial management. That project is not operational at a level where it currently provides controls supporting program integrity. CMCS should continue to enhance its financial management systems and its related data analyses capability to develop robust analytical procedures and measures against benchmarks to monitor and identify risks associated with the Medicaid program, including outliers and unusual or unexpected results that may identify abnormalities in state-related Medicaid expenditures. In addition, CMS does not perform a claims-level detailed look-back analysis for the Medicaid 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 2014 financial statements. CMS is not able to validate its methodology by using a claims-based approach due to the lack of individual claims-level detail and continues to rely on its estimation process to record the Medicaid EBDP without the ability to confirm the reasonableness of its methodology.

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:

- Establish a policy individual or group to analyze the accounting and reporting of unique, newly implemented, non-routine or significant transactions, enhance the financial reporting process and address or identify transactions that required cross-functional input. Enhancement of this process may assist to develop, document and validate the new critical accounting matters that are identified or implemented during the year and improve the timeliness and completeness of the white papers. In addition, prepare the required presentations and disclosures to ensure adequate time for analysis and feedback from key stakeholders.

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

- Revise and enhance the design of the financial review guidance provided to the various Centers, regional offices and MACs to incorporate more analyses and scrutiny in the review of the financial information. Ensure that the appropriate policies are established and implemented by the various Centers, regional offices and MACs or if the specific policy is not implemented determine that the required documentation and approval exists

to demonstrate how the risk is appropriately mitigated or responded to through other procedures.

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

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

- Continue the significant work required to automate and solidify the controls over the ACA expenditures related to the health insurance subsidies in a manner that is reliable and sustainable over the long term.

- Supplement the Medicaid negative balance protocol to include monthly detect controls whereby all negative balances are analyzed and documented consistently.

- Until the states become accustomed to the Medicaid Expansion policies and procedures, CMCS should strengthen oversight and support that will serve to prevent an inordinate backlog of uncertified claims.

- Establish a process to perform a claims-level detailed look-back analysis on the Medicaid EBDP to determine the reasonableness of the methodology utilized to record the approximately $32.3 billion accrual.

Information Systems Controls

The nature, size and complexity of its operations require CMS to manage its programs under a decentralized business model by using numerous geographically dispersed contractors using complex and extensive information systems operations. Each Center or Office with oversight of contractor systems provides guidance on the overall direction for its enterprise information systems operations.

Internal controls over these operations are essential to manage the integrity, confidentiality, and reliability of these programs and application systems and to reduce the risk of errors, fraud or other illegal acts. To manage the operational and financial risk presented by these information systems, CMS has developed information security and configuration management policies and procedures based on control techniques mandated by Federal standards-setting organizations and

adopted government-wide. These policies and procedures are used for Central Office systems and also are incorporated by reference in CMS' agreements with its contractors. Formal monitoring procedures have been developed and implemented by CMS Central Office.

CMS' Central Office supports a number of Medicare fee-for-service computerized systems that are used by numerous external organizations such as MACs, Shared Systems Maintainers (SSMs) and Virtual Data Centers (VDCs), collectively referred to as Medicare fee-for-service contractors, to administer Medicare fee-for-service claims and related beneficiary, provider, payment, and financial management data processes.

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

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

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

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

CMS maintains the Business Partners Systems Security Manual (BPSSM) which is based on Federal guidelines to direct the information security and assurance activities at the Medicare fee-for-service contractors. Monitoring compliance with the BPSSM is accomplished through CMS' ongoing security authorization program. Each contractor is required to maintain a system

security plan developed in accordance with the CMS requirements that outlines the contractor's plan for maintaining a secure environment for CMS' systems.

In addition to periodic assessments of contractors' financial and information systems controls conducted through reports in accordance with audit and attestation standards issued by the American Institute of Certified Public Accountants (for example, AT Section 801, formerly SSAE 16), and OMB A-123, CMS principally monitors its Medicare fee-for-service contractors' compliance with its information systems control standards through the following processes:

- Annual evaluations of the implementation of information security requirements outlined in Section 912 of the Medicare Modernization Act of 2003 are performed at the MACs; and

- Monitoring procedures performed by CMS including ongoing contractor management assessments and regular reviews of computer security configurations submitted by the MACs and the VDCs.

In addition, annual independent assessments of CMS' compliance with guidance provided by the National Institute of Standards and Technology (NIST) is in part accomplished through the performance of an annual review conducted by the HHS OIG under the *Federal Information Security Management Act of 2002 (FISMA).*

As CMS continues its efforts to enhance its internal controls, the following items noted in the current year audit merit continued focus on the Information Systems controls and processes. Additional focus is required to minimize the risk of current and unresolved prior year deficiencies.

Governance Over Implementation of Information Systems Control Standards and Processes

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

- The use and reliance upon contractors to accomplish most business functions, including operation of the computer systems. In many cases, the degree of computer security is dependent upon a contractor's interpretation of and adherence to CMS security policies.

- The responsibilities of the information systems controls oversight includes multiple business units within CMS Central Office, such as the Office of Information Services (OIS) and the Center for Medicare (CM), resulting in potentially varying interpretations of CMS' security standards and guidance, the degree of monitoring and enforcement, and the translation of Federal security mandates into actual CMS practices.

- The large number of users required to have access to CMS systems to process claims and to support beneficiaries in a timely and effective manner.

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

CMS continues to experience deficiencies in the implementation and monitoring of compliance with its defined computer security polices at both the Medicare fee-for-service contractors and the Central Office. Periodically, change management policies are waived to accommodate a compressed schedule to implement numerous required change requests across the broad range of claims systems. This is indicative of the complexity faced by CMS in its daily business activities and the need for assigning priorities to tasks. CMS allows in certain circumstances the Medicare fee-for-service contractors to self-approve these waivers. Those waivers are reported as part of the quarterly oversight process. Monitoring controls would be strengthened if CMS required those waivers for all Medicare fee-for-service contractors to be formally documented in writing, accessible to and reviewed by CMS. The documentation should assess the risk and include mitigating factors to reduce the risk to acceptable levels. Further, CMS' quarterly oversight process should be documented in writing and include acknowledgement of approval from the responsible CMS official.

The Medicare fee-for-service contractors are subject to regular audits as part of the overall oversight by CMS. CMS annually engages, or requires the Medicare fee-for-service contractors to engage, external independent public accounting firms to test various information systems controls at the Medicare fee-for-service contractors. We noted that information security and configuration management-related findings identified by these audits remain unresolved from prior years.

To mitigate the risk of insufficient integration of the information systems, CMS has developed a process requiring Interface Control Documents (ICDs) for its major applications, but these are not standardized in content, are not used by all relevant programming groups, and have not been inventoried.

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

Controls over System Access and Monitoring of System Access

Information management security and configuration controls are fundamental to the integrity of all information systems. Such controls, including properly authorized, designed and implemented controls, and active monitoring of security events for proper assessment and timely remediation,

can help manage risks such as unauthorized access and changes to critical data. These controls include physical and logical access restrictions to protect against unauthorized usage of CMS information resources, including programs and data files. In addition, without maintaining an appropriate level of segregation of duties through robust information management security and configuration controls, the integrity of CMS' information resources could be compromised.

Our findings related to system access include:

- For one MAC, access violations for a shared system were not reviewed. At the Central Office and two MACS, procedures for adding or removing users were not consistently followed and at the Central Office, data center physical access reviews were not consistently performed.

- Certain authentication mechanisms were insufficiently implemented or documented for system access and had not been completed for a key application that is used for controlling system access.

- Oversight of periodic access reviews for key applications was not performed as required or not adequately performed.

- Several vulnerabilities related to system configurations, program changes, and input validation were noted with the Central Office and Medicare fee-for-service networks.

- System security plans were incomplete and not always current.

- Authorization for connecting Medicare contractor systems to the CMS network was not always current.

- Secure access configuration settings were not consistently implemented or reviewed. In addition, computer communications network maps were not complete.

- Evidence supporting testing of claims processing software changes was not always retained.

- CMS does not have a documented standard process for assessing or confirming computer configuration waiver requests submitted by all of its Medicare fee-for-service contractors.

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

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

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

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

- At two MACs, user accounts for shared systems had excessive sensitive access levels that did not have sufficient business justification or documentation.
- At two VDCs, we found that system software used to implement shared system changes was not configured for adequate segregation of duties.
- Some Central Office applications did not have adequate segregation of duties as it relates to implementing new program code. In addition, for one application, the documentation for authorization, testing and approval of changes was not retained.
- Documentation for security interfaces between key applications was not maintained consistently.
- Business users for one key application were able to increase their access capabilities, such as maintaining application program code and the system configuration files.

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

Recommendations

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

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

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

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

- Follow relevant CMS guidance during the review and approval of all changes. Documentation should be prepared and retained for all phases of the change management process.

Specific to the implementation of access controls and related control activities pertaining to configuration management and information security, we recommend that CMS ensure:

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

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

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

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

- Appropriate segregation of duties is established for all systems that support CMS' programs, including Medicare fee-for-service claims and related financial processing at the MACs and VDCs to prevent excessive or inappropriate access. In addition, access to all systems should be periodically assessed to ensure that access remains appropriate and no incompatible duties exist.

CMS' Response to Findings

CMS' response to the findings identified in our audit are described in their letter dated November 10, 2014. CMS' response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Building a better working world

Purpose of this Report

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

Ernst & Young LLP

November 10, 2014

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

November 10, 2014

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

Dear Sir:

This letter is in response to your audit report on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2014 financial statements. CMS has reviewed the report and we are pleased to receive an unqualified opinion on our Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position and the Combined Statement of Budgetary Resources. As in previous years, you continue to disclaim an opinion on the Statement of Social Insurance (SOSI), primarily due to the uncertainty of the long–range assumptions used in the SOSI model. CMS continues to believe that the SOSI projections appropriately show the effects of the Affordable Care Act and that we have provided sufficient disclosures regarding the nature and uncertainty of these projections.

The results of the audit also identified no material weaknesses in our internal controls; however, you continue to cite significant deficiencies in our financial reporting processes and information systems controls. Some of the issues surrounding information systems and the complexity of our programs will require multi-year efforts to implement corrective actions to mitigate these issues and strengthen our controls. We remain committed to determining the root causes of the deficiencies in order to build effective corrective action plans.

The annual financial audit serves as an on-going catalyst to improving our processes and always helps us improve our internal controls. I would like to thank your office for its diligence in completing the audit and look forward to working with our auditors on the appropriate corrective action for the future.

Sincerely,

Deborah A. Taylor, CPA
Chief Financial Officer

3 OTHER INFORMATION

Summary of Federal Manager's Financial Integrity Act

OMB Circular A-123 Statement of Assurance // Improper Payments

Review of Medicare's Program for Oversight of Accrediting Organizations

Clinical Laboratory Improvement Validation Program

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

CMS assesses its internal controls through: (1) management self-assessments, including annual tests of security controls; (2) Office of Management and Budget (OMB) Circular A-123, Appendix A self-assessments; (3) assessments of internal control over the acquisition function; (4) Office of Inspector General (OIG) audits, and Government Accountability Office (GAO) audits and High-Risk reports; (5) Statement on Standards for Attestation Engagements (SSAE) 16 internal control audits; (6) evaluations and tests of Medicare contractor controls conducted pursuant to section 912 of the Medicare Modernization Act; (7) the annual Chief Financial Officer (CFO) audit; (8) certification and accreditation of systems; and (9) HHS' Program Integrity Initiative. As of September 30, 2014, the internal controls and financial management systems of CMS provided reasonable assurance that the objectives of the Federal Managers' Financial Integrity Act (FMFIA) were achieved; however, two instances of noncompliance were identified.

OMB Circular No. A-123 Statement of Assurance

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

As required by OMB Circular No. A-123, CMS evaluated its internal controls and financial management systems to determine whether these objectives are being met. Accordingly, CMS provided a qualified statement of reasonable assurance that its internal controls and financial management systems met the objectives of FMFIA due to its noncompliance with the Improper Payments Elimination and Recovery Improvement Act (IPERIA), and section 6411 of the Affordable Care Act.

Assurance for Internal Control over Financial Reporting

CMS conducted its assessment of the effectiveness of internal controls over financial reporting, which includes the safeguarding of assets and compliance with applicable laws and regulations, in accordance with the requirements of Appendix A of OMB Circular No. A-123. Based on the results of this assessment, CMS provided reasonable assurance that internal controls over financial reporting as of June 30, 2014, were operating effectively and no material weaknesses were found in the design or operation of the internal control over financial reporting.

Assurance for Internal Control over Operations and Compliance

CMS conducted its assessment of internal control over the effectiveness and efficiency of operations and compliance with applicable laws and regulations in accordance with OMB Circular No. A-123. Based on the results of this evaluation, as of September 30, 2014, CMS provided reasonable assurance that internal controls over operations were effective, and no material weaknesses were found in the design or operation of these internal controls. As of September 30, 2014, we also complied with applicable laws and regulations, except for the two instances of noncompliance noted above.

Assurance for the Federal Financial Management Improvement Act of 1996

The Federal Financial Management Improvement Act of 1996 (FFMIA) requires agencies to implement and maintain financial management systems that are substantially in compliance with Federal financial management systems requirements, Federal accounting standards, and the United States Standard General Ledger at the transaction level. CMS conducted its assessment of financial management systems for compliance with FFMIA. Based on the results of this evaluation, CMS provided reasonable assurance that all CMS financial management and related systems substantially comply with FFMIA as of September 30, 2014.

After becoming substantially compliant with FFMIA in fiscal year (FY) 2010, we have continued our efforts to implement the Healthcare Integrated General Ledger Accounting System (HIGLAS), which integrates the CMS claims administration contractors' shared claims processing systems and replaces CMS' mainframe-based financial system with a web-based accounting system. CMS considers our financial systems to be integrated in accordance with OMB Circular A-123, Appendix D. Through the implementation of HIGLAS at the Medicare Administrative Contractors (MACs), and the implementation of administrative program accounting functions at CMS central office, 100 percent of CMS core program dollars are accounted for in HIGLAS. HIGLAS will continue to enhance CMS' oversight of claims administration contractor financial operations, and the accounting and reporting of other CMS activities.

Noncompliance—Actions and Accomplishments

CMS did not fully comply with Improper Payments Elimination and Recovery Act (IPERA), Improper Payment Information Act (IPIA), IPERIA, and section 6411 of the Affordable Care Act.

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

In FY 2014, the Medicare Part C improper payment rate was 9.0 percent, meeting the IPERIA compliance threshold of reporting an error rate below 10 percent. Furthermore, the Part C improper payment rate met its previously established target of 10.4 percent.

In FY 2014, the Medicare Part D improper payment rate was 3.3 percent, meeting the IPERIA compliance threshold of reporting an improper payment rate below 10 percent. Furthermore, Part D improper payment rate met and exceeded its previously established target of 3.6 percent.

The FY 2014 Medicaid improper payment rate was 6.7 percent. Although the improper payment rate was lower than 10 percent, CMS did not meet its previously established target of 5.6 percent.

CMS has taken, and continues to take a number of actions outlined in the FY 2013 AFR, (please see 2013 HHS AFR), released December 16, 2013) to reduce error rates in all of its programs, including the Medicare FFS and Part D programs. CMS continues its efforts to comply with IPERA and OMB's implementing guidance.

Regarding compliance with section 6411 of the Affordable Care Act, CMS began implementation efforts in December 2010, by publishing a solicitation of comments regarding the development of the Medicare Part C Recovery Audit Contractor (RAC) program. More recently, a Request for Quote (RFQ) was posted in June 2014; however, no responses were received as a result of that solicitation. CMS continues its implementation efforts and anticipates awarding a contract in FY 2015.

IMPROPER PAYMENTS

In July 2010, Congress amended the IPIA, with the IPERA[1] to better standardize the way Federal agencies report improper payments in programs they oversee or administer. In January 2013, Congress amended IPERA with the Improper Payments Elimination and Recovery Improvement Act (IPERIA), which emphasizes the importance of not only measuring improper payments, but also recovering and reducing improper payments.

The IPERA includes requirements for identifying and reporting improper payments and defines improper payments as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments). Incorrect payments also include payments to ineligible recipients or payments for ineligible services, as well as duplicate payments and payments for services not received.

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

Since FY 2011, CMS complied with the OMB's IPERA reporting guidance and implemented comprehensive processes that measure the payment error rates for the Medicare FFS, Medicaid, CHIP, Medicare Advantage (Part C), and Medicare Prescription Drug (Part D) programs.

Medicare Fee-for-Service (FFS)

The identification and reporting of improper payments has been in place for Medicare FFS since FY 1996 as a part of CMS' financial reporting. The OIG estimated the Medicare FFS rate from 1996 through 2002. With the passage of the IPIA, CMS took responsibility for the error rate program beginning with FY 2003. To comply with the IPIA, IPERA and IPERIA, CMS established the Comprehensive Error Rate Testing (CERT) program to estimate improper payment error rates in the Medicare FFS program.

Medicare FFS measurement methodology is the same as the 2013 methodology. The Medicare FFS payment accuracy rate was 87.3 percent during the FY 2014 report period. That is, Medicare FFS claim payments were made correctly 87.3 percent of the time, which is an estimated $314.4 billion in proper payments.

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

Medicare Advantage and Prescription Drugs

CMS has reported a Part C payment error rate since FY 2008. The Part C error rate measures risk adjustment error, improper payments made to Medicare Advantage (MA) plans based on diagnoses submitted by MA plans for payment. The Part C payment error rate was 9.0 percent for the FY 2014 reporting period.

Since FY 2011, CMS has reported a composite payment error rate for the Medicare Prescription Drug Benefit, a Medicare benefit effective calendar year 2006. The Part D composite payment error rate combines four component error rates into a single composite measure for total Part D payments: (1) Payment Error Related to Low Income Status (PELS); (2) Payment Error Related to Incorrect Medicaid Status (PEMS); (3) Payment Error Related to Prescription Drug Event (PDE) Data Validation (PEPV); and (4) Payment Error Related to Direct and Indirect Remuneration (PEDIR). The Part D composite payment error rate was 3.3 percent for the FY 2014 reporting period.

Medicaid and CHIP

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

CMS measures the national improper payment rate for Medicaid and CHIP annually, through the Payment Error Rate Measurement (PERM) program. Through the PERM, CMS measures three areas of Medicaid and CHIP: FFS claims, managed care payments, and eligibility cases. Using CMS' guidelines, the states lead the effort in measuring

FY 2014 GROSS IMPROPER PAYMENTS AND ERROR RATES IN THE MEDICARE FFS PROGRAM

GROSS

Overpayments	Underpayments	Improper Payment Amount (Overpayments + Underpayments)	Error Rate
$44.2 B	$1.5 B	$45.8 B	12.7 %[2]

Totals do not necessarily equal the sum of the rounded components.

[2] As of the cutoff date for the FY 2014 Medicare FFS improper payment rate, approximately 670 claims were pending final Administrative Law Judge (ALJ) appeal adjudication. Historically, claims have been fully overturned by the ALJ at an average rate of 28.6 percent. If sufficient time was allowed for the pending appeals to complete final adjudication and this historical overturn rate above continued, the overall FY 2014 improper payment rate would be lowered by 0.2 percentage points to 12.5 percent, or $44.9 billion in projected improper payments.

errors in the eligibility cases. The PERM program uses a 17 State three-year rotation for measuring Medicaid improper payments to produce and report national program error rates.

The FY 2014 Medicaid and CHIP improper payment rate report period covers payments made through September 30, 2013, which occurred prior to the implementation of many of the Affordable Care Act required changes in Medicaid and CHIP eligibility; therefore, the FY 2014 improper payment rates do not reflect eligibility determinations made under new Affordable Care Act requirements.

The national Medicaid improper payment rate reported for FY 2014 is 6.7 percent, or $17.5 billion in gross improper payments based on measurements conducted in FY 2012, 2013, and 2014. The national component improper payment rates are as follows: Medicaid FFS: 5.1 percent; Medicaid managed care: 0.2 percent; and Medicaid eligibility: 3.1 percent.

The Medicaid improper payment rate increased from 5.8 percent in FY 2013 to 6.7 percent in FY 2014. The increase was due to state difficulties getting systems into compliance with new requirements. In particular, all referring or ordering providers must now be enrolled in Medicaid, States are required to screen providers under a risk-based screening process prior to enrollment, and attending providers must include their National Provider Identifier (NPI) on all electronically filed institutional claims. While these requirements will strengthen the integrity of the program, they require systems changes that many States had not fully implemented during the period of measurement. CMS works closely with states to develop state-specific corrective action plans which address improper payments and systems updates to bring states into compliance.

The FY 2014 national CHIP improper payment rate is the first baseline CHIP measurement based on measurements of all 50 States and the District of Columbia conducted in FY 2012, 2013, and 2014. The FY 2014 national CHIP improper payment rate is 6.5 percent or $0.6 billion in gross improper payments. The national FY 2014 CHIP error component rates are as follows: CHIP FFS: 6.2 percent; CHIP managed care: 0.2 percent; and CHIP eligibility: 4.2 percent.

The FY 2014 CHIP improper payment rate is lower than the 2013 rate of 7.1 percent, however, this does not necessarily represent a reduction in improper payments; rather, CMS has incorporated the final cycle of states into the estimate. CMS works closely with states to develop state-specific corrective action plans which address improper payments identified.

REVIEW OF MEDICARE'S PROGRAM FOR OVERSIGHT OF ACCREDITING ORGANIZATIONS

Introduction

In order to be eligible to receive Medicare reimbursement, certain types of health care facilities must demonstrate compliance with Medicare conditions of participation (CoPs), conditions for coverage (CfCs), or conditions for certification. Section 1865 of the Social Security Act (the Act) allows health care facilities that are "provider entities"[3] to demonstrate this compliance through accreditation by a Centers for Medicare & Medicaid Services (CMS)-approved accreditation program of a private, national Accrediting Organization (AO).[4] AOs may voluntarily submit for CMS review and approval provider- and supplier-specific accreditation programs intended to demonstrate compliance with the applicable Medicare standards. AOs charge fees to facilities that seek their accreditation. Generally, AOs offer facilities at least two accreditation options: accreditation alone, or accreditation under a CMS-approved program for the purpose of participating in Medicare. CMS reviews and provides oversight only to those

[3] 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 entity" does not include suppliers of durable medical equipment or the technical component of advanced diagnostic imaging, which are required to be accredited under sections 1834(a)(20)(F) and 1834(e)(2)of the Act. Oversight of these mandatory accreditation programs is administered separately by CMS, are not subject to the section 1875 reporting requirement, and are not addressed in this report.

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

accreditation programs submitted by an AO requesting to have the program recognized as a Medicare accreditation program. Accordingly, this report addresses AO activity only as it relates to CMS-approved Medicare accreditation programs.

CMS has the responsibility for oversight and approval of AO programs used for Medicare certification purposes, and for ensuring that providers or suppliers that are accredited under an approved AO program meet the quality and patient safety standards required by the Medicare conditions.[5] A thorough review of each Medicare accreditation program voluntarily submitted by an AO is conducted by CMS, including a review of the equivalency to the Medicare standards of its accreditation requirements, survey processes and procedures, training, oversight of provider entities, and enforcement. Also reviewed are the qualifications of the surveyors, staff, and the AO's financial status. Upon approval, an AO may recommend deemed status for its accredited provider or supplier, i.e., that its accredited provider of supplier be "deemed" to have met the applicable Medicare conditions. After receipt of this recommendation, CMS makes the final determination whether to grant deemed status.

Section 1875 of the Act requires CMS to submit this annual report to Congress on its oversight of all AO Medicare accreditation programs. CMS has implemented a comprehensive approach to the review and approval of an AO's Medicare accreditation program and its ongoing oversight of AO activities. The primary goal of this review is to ensure that the AO's standards meet or exceed the Medicare conditions for each program type and that the organization has the capacity to adequately administer the program and provide ongoing oversight of facilities it accredits.

Currently, CMS has approved accreditation programs for the following facility types: hospitals, psychiatric hospitals, critical access hospitals (CAHs), home health agencies (HHAs), hospices, ambulatory surgical centers (ASCs), outpatient physical therapy and speech-language pathology services (OPTs), and rural health clinics (RHCs).[6] CMS maintains a comprehensive AO Medicare accreditation oversight program and continually strives to strengthen and enhance its ongoing oversight. The program includes:

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

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

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

Validation survey program: CMS is required under section 1875 to "validate" approved AO Medicare accreditation programs, and authorized under section 1864 to use State survey agency (SA) representative sample validation surveys as part of its overall validation of an AO's program. Each year CMS measures the effectiveness of the AOs' survey processes in identifying areas of serious non-compliance with Medicare conditions across a wide range of AO programs and types of facilities. CMS may include in its representative sample validation survey program both traditional "look-back" surveys which compare results of AO and State surveys conducted in close time proximity as well as mid-cycle validation surveys which focus on specific facility types to address specific issues of concern. No mid-cycle validation surveys were conducted in the FY 2013 validation program reported here.

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

In FY 2013, CMS continues to work with AOs to expand on these significant enhancements in systems for monitoring AO activities and AO compliance with CMS requirements. Specifically, CMS worked to improve the program by:

- Maintaining the previously expanded number of representative sample validation surveys, as well as maximizing the number of 60-day look-back validation surveys conducted for each AO and facility type, when possible. These efforts

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

[6] 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.

increase the reliability and validity of the disparity analysis.
- Continuing to update the electronic database used to collect, analyze, and manage data regarding the facilities accredited by the AOs, including implementing the move of the database to a web-based platform, to improve its accuracy and increase the frequency of data reporting.
- Significantly revising the AO performance measures to require continued improvement in the submission of timely, accurate and complete information.

Overview

This report reviews AO activities in FY 2013, compares this activity to past years, and describes the current CMS oversight of approved Medicare accreditation programs as follows:

Section 1: CMS-Approval of Medicare Accreditation Programs
Discusses the process used for CMS approval and renewal of AO Medicare accreditation programs; the types of CMS reviews and decisions; the number of these reviews that were performed and decisions made since FY 2009; the current AOs with approved Medicare accreditation programs; and the most recent CMS approval or review status for each AO Medicare accreditation program.

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

Section 3: Summary of Medicare AO Accreditation Program Activity
Discusses the overall Medicare accreditation survey activities of each AO in FY 2013, including the number of initial and renewal accreditation surveys performed and the types of accreditation decisions made for each AO's approved Medicare accreditation programs.

Section 4: State Survey Validation of AO Surveys
Describes the Accreditation Validation Program and presents the number of representative sample validation surveys that have been performed for hospital and non-hospital facilities since FY 2007. The section also describes the components of the analysis of the 60-day validation surveys used in assessing each AO program's ability to ensure compliance with Medicare conditions. The validation performance results for FYs 2008-2013 are presented by facility type for each AO. The FY 2013 AO and State Survey Agency (SA) condition-level citations for each facility type are presented and compared. For hospital accreditation programs, separate comparisons of validation performance results are made for short-term acute care and long term care hospitals.

Section 5: AO Performance Measures
Describes AO reporting requirements, and CMS' methods for analyzing quarterly AO-submitted data on Medicare accreditation program activities and deemed facilities. Presents and discusses the FY 2013 AO performance measures and the results for each AO; and compares FY2013 results with FYs 2011 and 2012 performance measure results.

Section 6: AO Self-Reported Program Improvements
Presents each AO's self-report of recent program improvement activities.

Section 7: CMS Improvements
Describes the various areas in which CMS has executed and improved its program management and oversight activities.

SECTION 1: CMS-Approval of Medicare Accreditation Programs

Application and Renewal Process

Approval of a National AO's Medicare Accreditation Program

The process for CMS-approval of a national AO's Medicare accreditation program is applicant-driven. In order to gain approval of an accreditation program for Medicare deemed status purposes, an AO must demonstrate the ability to effectively evaluate a facility using accreditation standards which meet or exceed the applicable Medicare conditions, as well as survey processes comparable to those we require for SA, as specified in the State Operations Manual (SOM). Section 1865 of the Act requires that CMS shall base approval of an AO's Medicare accreditation program application on the AO's:

- Requirements for accreditation meeting or exceeding the Medicare requirements;
- Survey procedures;
- Ability to provide adequate resources for conducting surveys;
- Capacity to furnish information for use by CMS in enforcement activities;

- Monitoring procedures for providers or suppliers found out of compliance with conditions or requirements; and
- Ability to provide the necessary data for validation to CMS.

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

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

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

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

Other Reviews of AO Medicare Accreditation Programs

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

- **Standards and Survey Process Reviews:** Once approved, any subsequent changes in the AO's Medicare accreditation program standards or survey process must also be reviewed prior to implementation by the AO, in order for CMS to determine whether the proposed revised program meets or exceeds Medicare requirements, and thus warrants our continued approval. Such reviews are conducted in accordance with 42 CFR 488.4(b)(3)(iii) and 488.8(d)(1)(ii) when an AO notifies CMS of any proposed changes in accreditation requirements, and when AO requirements are revised in response to changes in CMS requirements, in accordance with 42 CFR 488.4(b)(3)(iv) and 488.8(d)(1)(i). The AO must notify CMS in writing of any proposed changes in its approved Medicare accreditation program at least 30 days in advance of the effective date of the changes. Additionally, when CMS adopts changes to the applicable Medicare requirements, the AO must submit documentation that it has revised its Medicare program to comply with the new requirement(s) within 30 days of CMS' notification to the AO of the change(s). During this review process, an AO may be required to make changes in its accreditation program in order to maintain CMS-approval.
- **Issue Review and Resolution:** AOs must demonstrate that their standards and review processes meet or exceed all applicable conditions of the Act. CMS works with AOs when issues are identified.
- **Performance Review:** CMS reviews AO performance on an ongoing basis in accordance with section 1875(b) of the Act. This includes, but is not limited to, review of the AO's survey activity, analysis of representative sample validation surveys, and review of the AO's continued fulfillment of the requirements at 42 CFR 488.4.

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

TABLE 1:

CMS REVIEW OF AO MEDICARE ACCREDITATION PROGRAMS (FYs 2009–2013)

TYPE OF REVIEW AND CMS DECISION	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
INITIAL APPLICATIONS					
Decision: Full approval	1	1	3	1	1
Decision: Denied	0	0	0	0	0
Incomplete application	0	0	0	2	0
Application withdrawn	1	2	1	1	1
RENEWAL APPLICATIONS					
Decision: Full approval	6	1	0	3	6
Decision: Denied	0	0	0	0	0
Decision: Conditional approval	1	2	0	0	0
Decision: Final approval removing conditional status	1	2	0	0	0
TOTAL REVIEWS OF INITIAL AND RENEWAL APPLICATIONS	**10**	**8**	**4**	**7**	**8**
OTHER REVIEWS					
Standards review	4	15	18	20	3
Survey process review	4	12	10	5	0
Issue review and resolution	*	*	44	22	41
Performance review	1	2	3	3	0
TOTAL OTHER REVIEWS	**9**	**29**	**75**	**50**	**44**

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

From FY 2009 through FY 2013 CMS completed 37 reviews of renewal and initial applications (which include approvals published in the *Federal Register* as well as initial applications withdrawn by the AO prior to publication). In this same timeframe, CMS completed 207 other reviews.

Approved AO Medicare Accreditation Programs

CMS reviews, and approves separately, each type of provider or supplier Medicare accreditation program for which an AO seeks CMS approval. AOs currently have CMS-approval for eight provider/supplier program types: hospital, psychiatric hospital, critical access hospital (CAH), home health agency (HHA), hospice, ambulatory surgical center (ASC), outpatient physical therapy and speech-language pathology (OPT), and rural health clinic (RHC). As of September 30, 2013, there were eight national AOs with 20 approved Medicare accreditation programs. (See Tables 2 and 3)

TABLE 2:

AOs WITH APPROVED MEDICARE ACCREDITATION PROGRAMS (FY 2013)

AO Acronym	Description
AAAHC	Accreditation Association for Ambulatory Health Care
AAAASF	American Association for Accreditation of Ambulatory Surgery Facilities
ACHC	Accreditation Commission for Health Care
AOA/HFAP	American Osteopathic Association/Healthcare Facilities Accreditation Program
CHAP	Community Health Accreditation Program
CIHQ	Center for Improvement in Healthcare Quality
DNV GL	DNV GL – Healthcare[7]
TJC	The Joint Commission

TABLE 3:

APPROVED MEDICARE ACCREDITATION PROGRAMS BY AO (FY 2013)

AO	Hospital	Psych Hospital	Critical Access Hospital	Home Health Agency	Hospice	Ambulatory Surgery Center	OPT	Rural Health Clinic	TOTAL
AAAHC						X			1
AAAASF						X	X	X	3
ACHC				X	X				2
AOA/HFAP	X		X			X			3
CHAP				X	X				2
CIHQ	X								1
DNV GL	X		X						2
TJC	X	X	X	X	X	X			6
TOTAL	4	1	3	3	3	4	1	1	20

The number of CMS-approved Medicare accreditation programs has grown steadily over the past several years. Currently, there are 20 approved programs. In FY 2013, CMS recognized a new AO, CIHQ, and approved its hospital Medicare accreditation program.

[7] Formerly known as Det Norske Veritas Healthcare, Inc. (DNVHC)

Approval of Medicare Accreditation Programs

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

Accreditation Association for Ambulatory Health Care (AAAHC)

Ambulatory Surgery Center

AAAHC's ASC Medicare accreditation program was initially approved on December 19, 1996. Most recently, AAAHC's ASC program received approval for a six-year renewal term effective December 20, 2012 through December 20, 2018. The final notice announcing this decision was published in the *Federal Register* on November 27, 2012, and can be accessed at http://edocket.access.gpo.gov/2012/pdf/2012-28728.pdf.

American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

Ambulatory Surgery Center

AAAASF's ASC Medicare accreditation program was initially approved on December 2, 1998. Most recently, AAAASF received a six-year term of approval effective November 27, 2012 through November 27, 2018. The final notice announcing this decision was published in the *Federal Register* on November 26, 2012, and can be accessed at http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28640.pdf.

Outpatient Physical Therapy and Speech-Language Services

AAAASF's OPT Medicare accreditation program was granted initial approval with a four-year term effective April 22, 2011 through April 22, 2015. The final notice appeared in the *Federal Register* on April 22, 2011, and can be accessed at http://edocket.access.gpo.gov/2011/pdf/2011-9176.pdf.

Rural Health Clinic

AAAASF's RHC Medicare accreditation program was granted approval with a four-year term effective May 23, 2012 to May 23, 2016. The final notice appeared in the *Federal Register* on May 23, 2012, and can be accessed at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6331.pdf.

Accreditation Commission for Health Care (ACHC)

Home Health Agency

ACHC's HHA Medicare accreditation program was initially approved February 24, 2006. Most recently, ACHC received a six-year renewal term, effective February 24, 2009 through February 24, 2015. The final notice announcing this decision was published in the *Federal Register* on January 23, 2009, and can be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-684.pdf.

Hospice

ACHC's hospice Medicare accreditation program was initially approved for a four-year term effective November 27, 2009 through November 27, 2013. Most recently, ACHC submitted a renewal application for continued approval of its hospice accreditation program on February 3, 2013. The proposed notice announcing this reapplication was published in the *Federal Register* on May 3, 2013, and can be accessed at http://edocket.access.gpo.gov/2013/pdf/2013-10421.pdf. The application is currently under review to ensure accreditation requirements continue to meet or exceed the Medicare requirements.

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

Hospital

AOA/HFAP has had an approved hospital Medicare accreditation program since 1965. Most recently, AOA/HFAP received a six-year renewal term effective September 25, 2013 through September 25, 2019. The final notice announcing this decision was published in the *Federal Register* on August 28, 2013, and can be accessed at http://edocket.access.gpo.gov/2013/pdf/2013-21008.pdf.

Critical Access Hospital

AOA/HFAP's CAH Medicare accreditation program was initially approved December 27, 2001. Most recently, AOA/HFAP received a six-year renewal term effective December 27, 2013 through December 27, 2019. The final notice announcing this decision was published in the *Federal Register* on November 29, 2013, and can be accessed at http://www.gpo.gov/fdsys/pkg/FR-2013-11-29/pdf/2013-28521.pdf.

Ambulatory Surgery Center

AOA/HFAP's ASC Medicare accreditation program was initially approved January 30, 2003. More recently, AOA/HFAP received approval for a four-year renewal term effective October 23, 2013 through October 23, 2017. The final notice announcing this approval was published in the *Federal Register* on September 28, 2012, and can be accessed at http://www.gpo.gov/fdsys/pkg/FR-2012-09-28/pdf/2012-23996.pdf.

Center for Improvement in Healthcare Quality (CIHQ)

Hospital

CIHQ's hospital Medicare accreditation program was initially approved for a four-year term effective July 26, 2013 through July 26, 2017. The final notice announcing this approval was published in the *Federal Register* on July 26, 2013, and can be accessed at http://www.gpo.gov/fdsys/pkg/FR-2013-07-26/pdf/2013-18014.pdf.

Community Health Accreditation Program (CHAP)

Home Health Agency

CHAP's HHA Medicare accreditation program was initially approved August 27, 1992. Most recently, CHAP received approval of a six-year renewal term effective March 31, 2012 through March 31, 2018. The final notice announcing this decision was published in the *Federal Register* on March 23, 2012 and can be accessed at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6598.pdf.

Hospice

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

DNV GL Healthcare (DNV GL)

Hospital

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

Critical Access Hospital

DNV GL's CAH Medicare accreditation program was initially approved December 23, 2010 and is effective through December 23, 2014. The final notice announcing this decision was published on November 15, 2010 in the *Federal Register* and can be accessed at http://edocket.access.gpo.gov/2010/pdf/2010-28666.pdf. Most recently DNV GL submitted a renewal application for continued approval of this program; that application is currently under review.

The Joint Commission (TJC)

Hospital

TJC's hospital Medicare accreditation program was initially approved July 15, 2010 effective through July 15, 2014. Prior to July 15, 2010, TJC's hospital accreditation program had statutory status and did not require CMS review and approval. More recently, CMS approved a six-year renewal term, effective July 15, 2014 through July 15, 2020. The final notice announcing this decision was published June 27, 2014 in the *Federal Register* and can be accessed at http://www.gpo.gov/fdsys/pkg/FR-2014-06-27/pdf/2014-15103.pdf.

Psychiatric Hospital

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

Critical Access Hospital

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

Home Health Agency

TJC's HHA Medicare accreditation program was initially approved September 28, 1993. More recently, CMS approved a six-year renewal term effective March 31, 2014 through March 31, 2020. The final notice announcing this decision was published in the *Federal Register* March 12, 2014 and can be accessed at http://www.gpo.gov/fdsys/pkg/FR-2014-03-12/pdf/2014-05328.pdf.

Hospice

TJC's hospice Medicare accreditation program was initially approved June 18, 1999. More recently, CMS approved a six-year renewal term effective June 18, 2009 through June 18, 2015. The final notice announcing this decision was published in the *Federal Register* on March 27, 2009, and can be accessed at http://edocket.access.gpo.gov/2009/pdf/E9-6775.pdf.

Ambulatory Surgery Center

TJC's ASC Medicare accreditation program was initially approved December 19, 1996. More recently, CMS approved a six-year renewal term effective December 20, 2008 through December 20, 2014. More recently TJC submitted a renewal application for continued approval of its ASC accreditation program and notice of our receipt of a complete application was published in the *Federal Register* on June 27, 2014 and may be accessed at http://www.gpo.gov/fdsys/pkg/FR-2014-06-27/pdf/2014-15101.pdf. This application is currently under review.

SECTION 2: Scope of Medicare AO Accreditation Programs

Medicare-Certified Facilities by Program Type

In FY 2013, AOs were responsible for assuring compliance with Medicare conditions for 36 percent of all Medicare-certified facilities in the eight program types for which there was an approved AO program. (See Table 4)

TABLE 4:

DEEMED & NON-DEEMED MEDICARE-CERTIFIED FACILITIES (FY 2013)

Program Types with a Medicare Accreditation Program Option

Program Type	Deemed* (percentage)	Non-Deemed** (percentage)	TOTAL
Hospital	3,793 (83)	804 (17)	4,597
Psychiatric Hospital	435 (80)	110 (20)	545
CAH	443 (33)	893 (67)	1,336
HHA	5,014 (39)	7,959 (61)	12,973
Hospice	1,424 (36)	2,552 (64)	3,976
ASC	1,516 (28)	3,947 (72)	5,463
OPT	89 (4)	2,204 (96)	2,293
RHC	62 (1)	4,122 (99)	4,184
TOTAL	**12,776 (36)**	**22,591 (64)**	**35,367**

* As reported by AOs.

** Surveyed by a SA for compliance with Medicare conditions

In FY 2013, the AOs with CMS-approved Medicare accreditation programs were responsible for monitoring compliance with health and safety standards for varying percentages of the total number of Medicare-participating facilities for each program type, ranging from a high of 83 percent for hospitals to a low of one percent for RHC facilities. The Hospital category continues to have the largest percentage of facilities participating in Medicare via deemed status.

Growth in Medicare Deemed Facilities

The total number of Medicare-participating certified health care facilities across all program types has increased from 24,752 in FY 2008 to 35,367 in FY 2013. This represents a 43 percent increase. Since FY 2008 the majority of the newly-participating facilities enrolled and certified in the Medicare program have entered the program via accreditation from a CMS-approved Medicare accreditation program and deemed status.

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

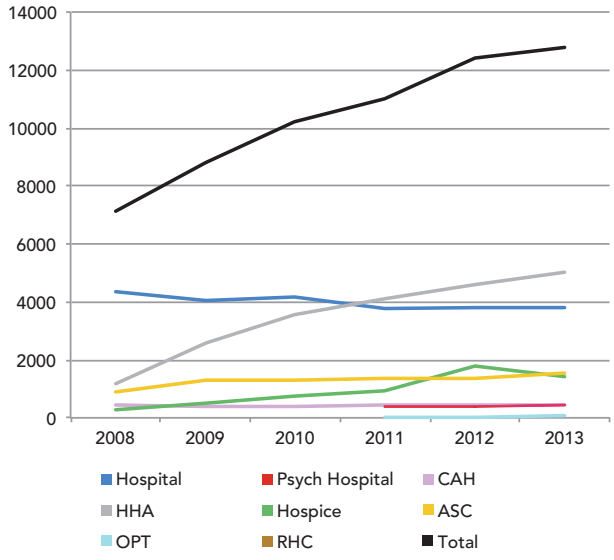
AO Accreditation Program Types

Five AO Medicare accreditation program types, including hospital, CAH, HHA, hospice and ASC, have been operational prior to FY 2008. The OPT and psychiatric hospital accreditation program types became operational in FY 2011. Historically, CMS permitted psychiatric hospitals to be partially deemed, with respect to their compliance with the general hospital conditions, and non-deemed, with respect to the special psychiatric hospital conditions. Since our approval of a psychiatric hospital accreditation program, however, we no longer permit new cases of partial deeming of psychiatric hospitals. The RHC program was newly-operational in FY 2012.

Graphs 1 and 2 below show the number of facilities certified each year by CMS by virtue of a CMS-recognized Medicare accreditation program, and the percentage of all Medicare-certified facilities

GRAPH 1

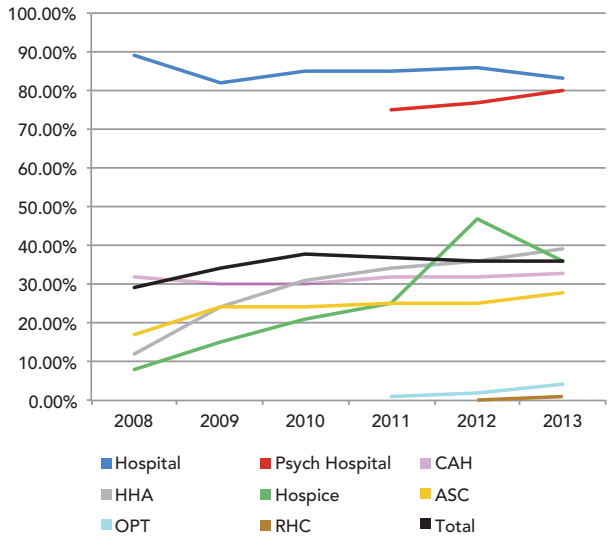
Number of Deemed Facilities by Program Type (FYs 2008–2013)



Note: The RHC program was initially approved in FY 2012. The number of deemed RHC programs increased from three in FY 2012 to 62 in FY 2013. The numbers are small and not reflected on the graph.

GRAPH 2:

Deemed Facilities as Percentage of Medicare Certified Facilities by Program Type (FYs 2008–2013)



that these deemed facilities represent. These graphs represent the eight program types for which there is currently more than one year of data.

Total: : For the five Medicare accreditation program types which began operations prior to FY 2008 together with the OPT and psychiatric hospital programs which have been operational since FY 2011, and the RHC program which has been operational since FY 2012, the number of Medicare-certified facilities in all of these program types combined increased from 24,752 in FY 2008 to 35,367 in FY 2013. This represents an increase of 43 percent. However, the percentage growth in deemed facilities during that same period has been much larger.

- The number of facilities participating in Medicare via deemed status increased from 7,128 in FY 2008 to 12,776 in FY 2013, a 79 percent increase.
- While SAs continue to survey the majority of facilities requiring certification, the proportion of all certified facilities in these categories represented by deemed status facilities grew from 29 percent to 36 percent.

Hospital: The number of Medicare-certified hospitals was largely unchanged between FYs 2008 and 2013. The hospital and psychiatric hospital programs are the only categories in which the majority of facilities participate in Medicare by virtue of accreditation under an approved Medicare accreditation program.

- The number of deemed hospitals decreased from 4,381 in FY 2008 to 3,793 in FY 2013, a reduction of 15 percent. Please note: the approval of a separate Medicare psychiatric hospital accreditation program in FY 2011 resulted in the movement of 435 deemed psychiatric hospitals from the hospital category into a separate psychiatric hospital category in FY 2013. In order to assess the trend in the number of deemed hospitals, we also removed these 435 deemed psychiatric hospitals from the FY 2008 total of deemed hospitals.
- The proportion of all Medicare-certified hospitals that were deemed decreased from 89 percent to 83 percent during this period.

Psychiatric Hospital: The number of Medicare-certified psychiatric hospitals increased from 516 in FY 2011 to 545 in FY 2013, a six percent increase.

- The number of deemed psychiatric hospitals increased from 388 in FY 2011 to 435 in FY 2013, a 12 percent increase.
- The proportion of all Medicare-certified psychiatric hospitals which were deemed increased from 75 percent to 80 percent during the same time period.

CAH: The number of Medicare-certified CAHs increased from 1,310 in FY 2008 to 1,336 in FY 2013, a two percent increase.

- The number of deemed CAHs increased from 415 in FY 2008 to 443 in FY 2013, a seven percent increase.
- The proportion of all Medicare-certified CAHs which were deemed increased slightly from 32 percent to 33 percent.

HHA: The number of Medicare-certified HHAs increased from 9,893 in FY 2008 to 12,973 in FY 2013, a 31 percent increase.

- The number of deemed HHAs increased from 1,161 in FY 2008 to 5,014 in FY 2013, a 332 percent increase.
- The proportion of all Medicare-certified HHAs which were deemed increased significantly from 12 percent to 39 percent.

Hospice: The number of Medicare-certified hospices increased from 3,388 in FY 2008 to 3,976 in FY 2013, a 17 percent increase.

- The number of deemed hospices increased from 278 in FY 2008 to 1,424 in FY 2013, a 412 percent increase.
- The proportion of all Medicare-certified hospices which were deemed significantly increased from eight percent to 36 percent during the same time period.

ASC: The number of Medicare-certified ASCs increased from 5,217 in FY 2008 to 5,463 in FY 2013, a five percent increase.

- The number of deemed ASCs increased from 893 in FY 2008 to 1,516 in FY 2013, a 70 percent increase.
- The proportion of all Medicare-certified ASCs which were deemed increased from 17 percent to 28 percent during the same time period.

OPT: The number of Medicare-certified OPTs decreased from 2,471 in FY 2011 to 2,293 in FY 2013, a seven percent decrease.

- The number of deemed OPTs increased from 13 in FY 2011 to 89 in FY 2013, a 585 percent increase.
- The proportion of all Medicare-certified OPTs which were deemed increased from one percent to four percent during the same time period.

RHC: The number of Medicare-certified RHCs increased from 4,108 in FY 2012 to 4,184 in FY 2013, a two percent increase.

- The number of deemed RHCs increased from three in FY 2012 to 62 in FY 2013, a 1,967 percent increase.
- The proportion of all Medicare-certified RHCs which were deemed slightly increased from less than one percent to one percent during the same time period.

SECTION 3: Summary of AO Medicare Accreditation Program Activity

Medicare Accreditation Program Survey Activity

An AO with a CMS-recognized Medicare accreditation program is responsible for evaluating a facility through an on-site survey to determine whether the facility complies with the AO's accreditation standards, which CMS has determined meet or exceed the health care quality and patient safety standards required by the Medicare conditions. The evaluation performed by the AO includes, but is not limited to, observation and review of the following: care processes in the facility, the physical environment, administrative and patient medical records, and staff qualifications. The AO performs an initial survey for a facility that is being reviewed by the AO for the first time. Initial surveys for AO oversight purposes include surveys of facilities that are seeking to enroll in the Medicare as new applicants as well as those of Medicare-participating facilities previously overseen by a SA or another AO. The AO may award accreditation under a Medicare accreditation program for up to three years. A renewal survey must be completed prior to the expiration date of the facility's Medicare accreditation, to ensure that the facility remains in compliance with participation requirements.

In FY 2013, the AOs reported having performed 1,770 initial surveys and 3,324 renewal surveys. The total number of deemed status facilities in FY 2013 was 12,776. (See Table 5)

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

Below are summaries of all types of Medicare accreditation surveys performed, and all types of accreditation decisions made by each AO for each of their Medicare accreditation programs in FY 2013. The various accreditation decisions are also presented as a percentage of the total surveys performed by each AO for each of their Medicare accreditation programs.

AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY SURGERY FACILITIES (AAAASF)

Program Type	Total Deemed	Initial Surveys	Renewal Surveys
ASC	158	34	47
OPT	89	56	2
RHC	62	86	0*
TOTAL	309	176	49

* The first accreditation program for RHC received initial approval in FY 2012. Therefore, no renewal surveys were due to be performed in FY 2013.

AAAASF awarded full accreditation to 91 percent of the total ASCs surveyed, 88 percent of the total OPTs surveyed and 97 percent of the total RHCs surveyed.

Accreditation Decisions	ASCs (percent)	OPT (percent)	RHC (percent)
Full Accreditation	74 (91)	51 (88)	83 (97)
Denial	7 (9)	7 (12)	3 (3)
Pending	0	0	0
TOTAL SURVEYS	81 (100)	58 (100)	86 (100)

ACCREDITATION ASSOCIATION FOR AMBULATORY HEALTH CARE (AAAHC)

Program Type	Total Deemed	Initial Surveys	Renewal Surveys
ASC	846	120	197

AAAHC awarded full accreditation to 94 percent of the total ASCs surveyed.

Accreditation Decisions	ASCs (percent)
Full Accreditation	301 (94)
Denial	8 (3)
Pending	8 (3)
TOTAL SURVEYS	317 (100)

TABLE 5

TOTAL NUMBER OF DEEMED FACILITIES INITIAL SURVEYS AND RENEWAL SURVEYS BY AO ACCREDITATION PROGRAM (FY 2013)

PROGRAM TYPE/ ACCREDITATION ORGANIZATIONS	TOTAL DEEMED FACILITIES	INITIAL SURVEYS	RENEWAL SURVEYS
Hospital			
AOA/HFAP	168	6	52
DNV GL	253	41	62
TJC	3,372	48	1,165
Psychiatric Hospital			
TJC	435	21	153
Critical Access Hospital			
AOA/HFAP	31	0	9
DNV GL	55	19	0*
TJC	357	6	116
Home Health Agency			
ACHC	624	140	94
CHAP	2,343	520	469
TJC	2,047	275	536
Hospice			
ACHC	99	31	13
CHAP	713	146	159
TJC	612	144	117
Ambulatory Surgery Center			
AAAASF	158	34	47
AAAHC	846	120	197
AOA/HFAP	29	3	7
TJC	483	74	126
Outpatient Physical Therapy			
AAAASF	89	56	2
Rural Health Clinic			
AAAASF	62	86	0**
TOTAL	**12,776**	**1,770**	**3,324**

Source: As reported by AOs.

* The DNV GL CAH accreditation program received initial approval in FY 2011. Therefore, no renewal surveys were due to be conducted in FY 2013.

**The AAAASF RHC accreditation program received initial approval in FY 2012. Therefore, no renewal surveys were due to be conducted in FY 2013.

ACCREDITATION COMMISSION FOR HEALTH CARE (ACHC)

Program Type	Total Deemed	Initial Surveys	Renewal Surveys
HHA	624	140	94
Hospice	99	31	13
TOTAL	723	171	107

ACHC awarded full accreditation to 80 percent of the total HHAs surveyed and 84 percent of the total hospice facilities surveyed.

Accreditation Decisions	HHA (percent)	Hospice (percent)
Full Accreditation	186 (80)	37 (84)
Denial	12 (5)	1 (2)
Pending	36 (15)	6 (14)
TOTAL SURVEYS	234 (100)	44 (100)

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

Program Type	Total Deemed	Initial Surveys	Renewal Surveys
ASC	29	3	7
CAH	31	0	9
Hospital	168	6	52
TOTAL	228	9	68

AOA/HFAP awarded full accreditation to 90 percent of the total ASCs surveyed, 100 percent of the total CAHs surveyed and 100 percent of the total hospitals surveyed.

Accreditation Decisions	ASC (percent)	CAH (percent)	Hospital (percent)
Full Accreditation	9 (90)	9 (100)	58 (100)
Denial	1 (10)	0 (0)	0
Pending	0	0	0
TOTAL SURVEYS	10 (100)	9 (100)	58 (100)

COMMUNITY HEALTH ACCREDITATION PROGRAM (CHAP)

Program Type	Total Deemed	Initial Surveys	Renewal Surveys
HHA	2,343	520	469
Hospice	713	146	159
TOTAL	3,056	666	628

CHAP awarded full accreditation to 90 percent of the total HHAs surveyed and 93 percent of the total hospice facilities surveyed.

Accreditation Decisions	HHA (percent)	Hospice (percent)
Full Accreditation	894 (90)	283 (93)
Denial	57 (6)	9 (3)
Pending	38 (4)	13 (4)
TOTAL SURVEYS	989	305

DNV GL HEALTHCARE (DNV GL)

Program Type	Total Deemed	Initial Surveys	Renewal Surveys
CAH	55	19	0*
Hospital	253	41	62
TOTAL	308	60	62

* The DNV GL CAH accreditation program received initial approval in FY 2011. Therefore, no renewal surveys were due to be performed in FY 2013.

DNV GL awarded full accreditation to 100 percent of the total CAHs surveyed and 98 percent of the total hospitals surveyed.

Accreditation Decisions	CAH (percent)	Hospital (percent)
Full Accreditation	19 (100)	101 (98)
Denial	0	0
Pending	0	2 (2)
TOTAL SURVEYS	19 (100)	103 (100)

THE JOINT COMMISSION (TJC)

Program Type	Total Deemed	Initial Surveys	Renewal Surveys
ASC	483	74	126
CAH	357	6	116
HHA	2,047	275	536
Hospice	612	144	117
Hospital	3,372	48	1,165
Psychiatric Hospital	435	21	153
TOTAL	7,306	568	2,213

TJC awarded full accreditation to:

- 97 percent of the total ASCs surveyed;
- 97 percent of the total CAHs surveyed;
- 96 percent of the total HHAs surveyed;
- 98 percent of the total hospice facilities surveyed;
- 98 percent of the total hospitals surveyed; and
- 99 percent of the total psychiatric hospitals surveyed.

Accreditation Decisions	ASC (percent)	CAH (percent)	HHA (percent)	Hospice (percent)	Hospital (percent)	Psychiatric Hospital (percent)
Full Accreditation	193 (97)	118 (97)	778 (96)	256 (98)	1,191 (98)	172 (99)
Denial	1 (<1)	1 (1)	11 (1)	0	3 (<1)	0
Pending	6 (3)	3 (2)	22 (3)	5 (2)	19 (2)	2 (1)
TOTAL SURVEYS	200 (100)	122 (100)	811 (100)	261 (100)	1,213 (100)	174 (100)

SECTION 4: State Survey Validation of AO Surveys

Accreditation Validation Program

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

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

- **Substantial allegation surveys (also called "complaint surveys")**: these are focused surveys based on complaints alleging circumstances which, if found to be present, would adversely affect the health and safety of patients and raise doubts as to the facility's compliance with one or more Medicare conditions; and
- **Representative sample validation surveys:** these full surveys are routinely performed for a representative sample of deemed facilities as part of the annual CMS AO representative sample validation survey program. These surveys, generally, must be completed by the SA no more than 60 days after an AO full accreditation survey of the same facility. In some cases, representative sample "mid-cycle" validation surveys may be conducted independent of a preceding AO survey.

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

Prior to 2009, section 1875 of the Act required CMS to report to Congress annually only on the Joint Commission's hospital program. Nevertheless, in FY 2007, CMS began conducting 60-day representative sample validation surveys for selected non-hospital facility types (CAHs, HHAs, and ASCs), in addition to those already being performed for deemed status hospitals. Amendments to section 1875 effective July 15, 2008 require CMS to report to Congress annually on the performance of all accreditation programs approved under section 1865. In FY 2010, hospice 60-day validation surveys were added to the validation survey program, and in FY 2011, psychiatric hospital 60-day validation surveys. In FY 2013, CMS conducted a total of 298 representative sample 60-day validation surveys for eight facility types across eight AOs. This total was comprised of 106 hospital and 192 non-hospital validation surveys. (See Graph 3)

Since 2007, CMS has worked to strengthen oversight of accrediting organizations. From FYs 2007 – 2012, the number of validation surveys conducted expanded significantly as more attention and Federal resources have been made available to this priority area; however, FY 2013 showed a slight decrease in the number of representative sample validation surveys completed, due to decreased funding available for validation surveys. The recent history of validation survey sample size is as follows:

- **2007:** 55 hospitals and 35 non-hospital surveys totaling 90 surveys.
- **2008:** 92 hospitals and 76 non-hospital surveys totaling 168 surveys.
- **2009:** 89 hospital and 102 non-hospital surveys totaling 191 surveys.
- **2010:** 104 hospital and 191 non-hospital surveys, including 72 ASC mid-cycle surveys, totaling 295 surveys.
- **2011:** 106 hospital surveys, including 33 LTCH mid-cycle surveys, and 183 non-hospital surveys totaling 289 surveys.
- **2012:** 102 hospital and 230 non-hospital surveys totaling 332 surveys.
- **2013:** 106 hospitals and 192 non-hospital surveys totaling 298 surveys.

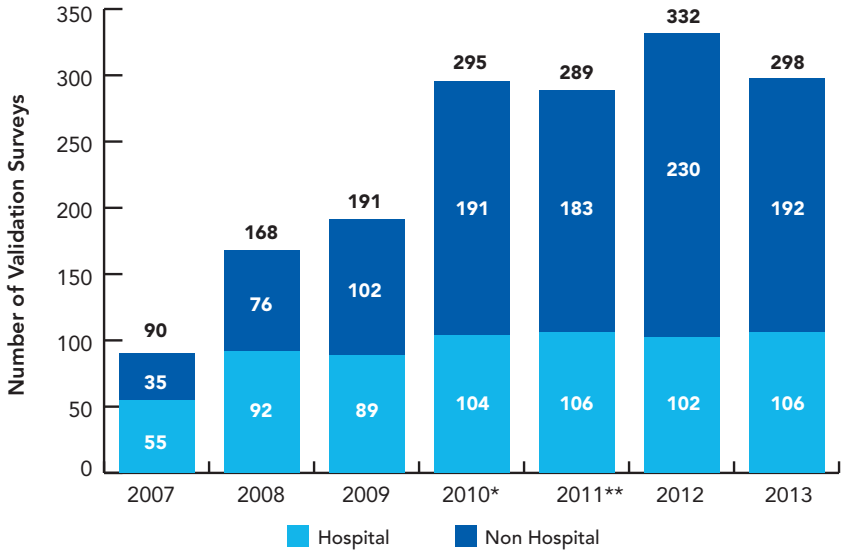
These numbers represent a 231 percent increase in the overall number of validation surveys conducted, from 90 in FY 2007 to 298 in FY 2013. During the same time period, the number of non-hospital validation surveys conducted increased by 449 percent, from 35 surveys in FY 2007 to 192 surveys in FY 2013. The number of hospital validation surveys conducted increased by 93 percent, from 55 surveys in FY 2007 to 106 surveys in FY 2013.

60-Day Validation Surveys

The purpose of 60-day validation surveys is to assess the AO's ability to identify noncompliance with Medicare conditions. These validation surveys are on-site full surveys completed by SA surveyors no later than 60 days after the end date of an AO's

GRAPH 3:

NUMBER OF REPRESENTATIVE SAMPLE VALIDATION SURVEYS FOR BOTH HOSPITAL AND NON-HOSPITAL FACILITIES (FYs 2007–2013)



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

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

Medicare accreditation program full survey. The SA performs these surveys without any knowledge of the findings of the AO's accreditation survey.

The composition of the 60-day validation sample is driven by a number of factors, including the total number of Medicare accreditation surveys scheduled by the AO and reported on monthly survey schedules furnished to CMS, the accuracy of those schedules, and individual State validation survey volume targets. CMS determines the number of validation surveys to perform for each AO based on the number of facilities the AO surveys each month, as well as the overall budgeted targets, by State and facility type, for validation surveys. CMS then attempts to build a representative national sample for individual accreditation programs.

Proportion of Deemed Facilities Receiving Validation Surveys

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

FIGURE 1:

PROPORTION OF DEEMED FACILITIES RECEIVING VALIDATION SURVEYS

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

The proportion of facilities that received a 60-day validation survey in FY 2013 is as follows:

- **Hospitals:** Three percent of deemed hospitals received a validation survey in FY 2013 [96 validation surveys conducted out of 3,793 deemed facilities].
- **Psychiatric Hospitals:** Two percent of deemed psychiatric hospitals received a validation survey in FY 2013 [10 validation surveys conducted out of 435 deemed facilities].
- **CAHs:** Eight percent of deemed CAHs received a validation survey in FY 2013 [35 validation surveys conducted out of 443 deemed facilities].
- **HHAs:** Two percent of deemed HHAs received a survey in FY 2013 [80 validation surveys conducted out of 5,014 deemed facilities].
- **Hospices:** One percent of deemed hospices received a validation survey in FY 2013 [18 validation surveys conducted out of 1,424 deemed facilities]. Hospice has been included in the validation program since FY 2010.
- **ASCs:** Four percent of deemed ASCs received a validation survey in FY 2013 [61validation surveys conducted out of 1,516 deemed facilities].

Note: No validation surveys were targeted for OPTs or RHCs in FY 2013 due to the small numbers of deemed facilities in these recently approved Medicare accreditation programs (approved in FYs 2011 and 2012 respectively).

Validation Analysis

Condition-Level Deficiencies and Disparity Rate

Once the 60-day validation surveys are completed, CMS performs a validation analysis and compares the "condition-level deficiencies" (i.e., serious deficiencies) cited by the SA with all deficiencies cited by the AO on its Medicare accreditation survey. The goal of this validation analysis is to determine whether the AOs are able to accurately identify serious noncompliance in a facility. The premise of the analysis is that condition-level deficiencies cited by the SA during the 60-day validation survey represent systemic noncompliance and therefore would also likely have been present 60 days prior, during the AO's Medicare accreditation survey, and should also have been cited by the AO.

When the SA finds a condition-level deficiency in a deemed status facility, CMS removes the facility's deemed status and places it under the jurisdiction of the SA until the facility comes into substantial compliance. If the facility is unable to demonstrate substantial compliance in a timely manner, the facility's participation in Medicare is terminated. If compliance is demonstrated, CMS restores the facility's deemed status and returns the facility to the AO's jurisdiction.

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

FIGURE 2:

DISPARITY RATE CALCULATION

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

* The number of 60-day validation surveys includes the total number of 60-day validation surveys conducted, including those where the SA did not cite any condition-level deficiencies.

The methodology for the disparity rate is set by regulation at 42 CFR 488.1. The numerator is the number of surveys where the AO did not cite a deficiency that was substantively comparable to the condition-level deficiency cited by the SA.

The denominator is the total number of surveys in the 60-day representative validation sample. The result is the percentage of 60-day validation surveys where the AO did not cite a deficiency comparable to a serious deficiency cited by the SA. For example, if there were 77 60-day validation surveys conducted, and the AO missed condition-level deficiencies in 12 surveys that were cited by the SA, the disparity rate would be 16 percent (12 divided by 77).

A lower disparity rate indicates better AO performance. The regulations at 42 CFR 488.8(d) require that CMS identify any AO with a disparity rate exceeding 20 percent.

Sampling Fraction

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

FIGURE 3:

SAMPLING FRACTION CALCULATION

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

For example, if the number of 60-day validation surveys conducted by the SA is 33 and the overall number of accreditation surveys conducted by the AO over the same time period is 638, then the sampling fraction would be 33 divided by 638—which is five percent (.052). CMS has worked to increase this sampling fraction for each AO and to include a minimum of five 60-day validation surveys per year for each AO program, no matter how small the program.

In summary, the *disparity rate* focuses on the number of 60-day validation surveys where the AO did not cite deficiencies comparable in substance to condition-level noncompliance cited by SAs in relation to the total number of validation surveys completed by the SA. The *sampling fraction* is the proportion of 60-day validation surveys completed by the SA in relation to the number of Medicare accreditation surveys completed by the AO.

Validation Performance Results: Each Facility Type

The table below presents the results of the 60-day validation surveys for all AOs from FY 2008 through FY 2013 by facility type. (See Table 6)

In FY 2013, with the exception of Hospice and HHA, the disparity rate score for each facility type exceeded the 20 percent threshold established in the regulation. In cases where the disparity rate for the AO's Medicare accreditation program exceeded the 20 percent threshold, CMS notified the AO of the finding.

Note: The Hospice and HHA disparity rates are significantly different than the other facility types due to the lower percentage of surveys with condition-level deficiencies cited by SAs in the 60-day validation samples for both hospice and HHA for FYs 2010-2013. This lower deficiency rate is primarily due to these facility types not having deficiencies related to physical environment requirements. There is no physical environment condition for HHAs since these services are provided in the patient's home. Although hospices do have a physical environment condition, a number of hospice services are provided in the patient's home as well. This finding is discussed in more detail later in this section.

In FY 2013, the disparity rate for ASCs was 39 percent, which exceeds the 20 percent threshold. This disparity rate has increased by seven percent from FY 2012.

TABLE 6:

60-DAY VALIDATION SURVEY RESULTS FOR EACH FACILITY TYPE (FYs 2008 THROUGH 2013)

FY	2008	2009	2010	2011	2012	2013
HOSPITAL						
60-day Validation Sample	92	89	104	73	102	96
SA: Condition-level Deficiencies	43	39	47	36	50	52
Missed by AO	30	32	40	32	45	44
Disparity Rate	33%	36%	38%	44%	44%	46%
Sampling Fraction	.06	.06	.07	.05	.08	.07
PSYCHIATRIC HOSPITAL						
60-day Validation Sample*	-	-	-	-	8	10
SA: Condition-level Deficiencies	-	-	-	-	6	6
Missed by AO	-	-	-	-	6	6
Disparity Rate	-	-	-	-	75%	60%
Sampling Fraction	-	-	-	-	.05	.06
CAH						
60-day Validation Sample	17	22	23	20	33	35
SA: Condition-level Deficiencies	9	16	16	11	15	17
Missed by AO	7	15	15	9	12	14
Disparity Rate	41%	68%	65%	45%	36%	40%
Sampling Fraction	.15	.14	.16	.14	.13	.23
HHA						
60-day Validation Sample	21	51	76	77	102	80
SA: Condition-level Deficiencies	5	9	15	15	30	15
Missed by AO	3	8	11	12	19	11
Disparity Rate	14%	16%	14%	16%	19%	14%
Sampling Fraction	.03	.03	.05	.05	.05	.04
HOSPICE						
60-day Validation Sample**	0	0	20	20	21	18
SA: Condition-level Deficiencies	NA	NA	5	3	2	1
Missed by AO	NA	NA	5	1	2	1
Disparity Rate	NA	NA	25%	5%	10%	6%
Sampling Fraction	NA	NA	.06	.07	.04	.03
ASC						
60-day Validation Sample***	38	29	0	66	66	61
SA: Condition-level Deficiencies	17	12	NA	34	25	30
Missed by AO	16	12	NA	30	21	24
Disparity Rate	42%	41%	NA	45%	32%	39%
Sampling Fraction	.06	.05	NA	.11	.11	.10

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

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

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

Validation Performance Results: Individual AOs

Each AO receives feedback on the results of CMS' analysis of 60-day validation surveys for its deemed status facilities. The series of tables below presents the results of the 60-day validation surveys by facility type for each of the AO Medicare accreditation programs from FYs 2008–2013. (See Tables 7–12)

When the number of 60-day validation surveys completed by the SA is less than five surveys, the disparity rate is not presented. The small 60-day validation sample sizes limited the analysis of some AO programs. Since 2008, CMS has tried to significantly increase the number of 60-day validation samples. With minimal exception, the sample size for every AO program was either maintained or increased from FYs 2011 to 2012. However, in FY 2013, due to decreased funding, the number of validation surveys for hospitals, HHAs, Hospices and ASCs decreased. There was a slight increase in the number of validation surveys for psychiatric hospitals and CAHs (see table 7). CMS hopes to maintain a larger sample size in the future based on the availability of Federal funds. The presentation of validation results for several time periods provides a more complete examination of the consistency of individual AO performance. Therefore, the results for the FYs 2008–2011 60-day validation surveys for individual AOs have been combined in the tables below to provide a more robust and reliable estimate of the disparity rates.

As was true for the national disparity rates for each facility type, the disparity rates between FYs 2008 and 2013 for each of the individual AO programs that received 60-day validation surveys consistently exceeded 20 percent, with the same exceptions of AO hospice and HHA programs. As stated earlier, this is primarily due to a large portion of hospice and all HHA services being provided in the patient's home.

Hospital

The AOs with hospital programs in FY 2013 were AOA/HFAP, DNV GL, and TJC. (See Table 7)

- **AOA:** In FY 2013, the disparity rate was 67 percent based on the completion of nine validation surveys. The number of validation surveys conducted represents a 16 percent sample of the surveys conducted by AOA. The FY 2013 disparity rate is significantly higher compared to the disparity rate of 29 percent for FY 2012, which was based on a two percent sample of the surveys conducted during that period.
- **DNV GL:** In FY 2013, the disparity rate was 64 percent based on the completion of 11 validation surveys. The number of validation surveys conducted represents an 11 percent sample of the surveys conducted by DNV GL. The FY 2013 disparity rate is higher than the disparity rate of 44 percent for FY 2012, which was based on a nine percent sample of the surveys conducted during that period.
- **TJC:** In FY 2013, the disparity rate was 41 percent based on the completion of 76 validation surveys. The number of validation surveys conducted represents a six percent sample of surveys conducted by TJC. The FY 2013 disparity rate is relatively consistent with the disparity rate of 45 percent for FY 2012, which was based on a seven percent sample of TJC surveys conducted during that period.

TABLE 7:

HOSPITAL 60-DAY VALIDATION SURVEY RESULTS BY AO (FYs 2008–2013)

Validation Survey Analysis	AOA/HFAP			DNV GL*			TJC			TOTAL		
	2008–2011	2012	2013	2009–2011*	2012	2013	2008–2011	2012	2013	2008–2011	2012	2013
60-Day Validation Sample	13*	7	9	11+	9	11	334	86	76	358*	102	96
SA: Condition-level Deficiencies	11+	2	6	3	4	9	151	44	37	165+	50	52
Missed by AO	11+	2	6	3	4	7	120	39	31	134+	45	44
Disparity Rate	85%+	29%	67%	27%+	44%	64%	36%	45%	41%	37%	44%	46%
Sampling Fraction	.05+	.02	.16	.06+	.09	.11	.06+	.07	.06	.06+	.04	.07

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

+ Data corrected from FY 2013 report.

Psychiatric Hospital

The only AO with a CMS-approved psychiatric hospital Medicare accreditation program in FY 2013 was the TJC. The psychiatric hospital program was initially approved by CMS in FY 2011. (See Table 8)

TABLE 8:

PSYCHIATRIC HOSPITAL 60-DAY VALIDATION SURVEY RESULTS BY AO (FYS 2012–2013)

	TJC	
FYs	2012	2013
60-Day Validation Sample	8	10
SA: Condition-level Deficiencies	6	6
Missed by AO	6	6
Disparity Rate	75%	60%
Sampling Fraction	.05	.06

TJC: In FY 2013, the disparity rate was 60 percent based on 10 validation surveys completed. The number of validation surveys completed represents a six percent sample of the surveys conducted by the TJC. The FY 2013 disparity rate is lower than the disparity rate of 75 percent for FY 2012 which was based on a five percent sample of the survey conducted during that period.

Critical Access Hospital

The AOs with CAH accreditation programs in FY 2013 were TJC, AOA/HFAP and DNV GL. (See Table 9)

- **AOA:** In FY 2013, the disparity rate was 50 percent based on the completion of six validation surveys. The number of validation surveys completed represents a 67 percent sample of the surveys conducted by the AOA. In FY 2012 no disparity rate was calculated due to the small validation survey sample size.
- **DNV GL:** In FY 2013, the disparity rate was 67 percent based on the completion of six validation surveys. The number of validation surveys completed represents a 32 percent sample of the surveys conducted by the DNV GL. In FYs 2011 and 2012 no disparity rate was calculated due to the small validation survey sample size.
- **TJC:** In FY 2013, the disparity rate was 30 percent based on the completion of 23 validation surveys. The number of validation surveys completed represents a 19 percent sample of the surveys conducted by TJC. The FY 2013 disparity rate is an improvement compared to the disparity rate of 36 percent for FY 2012, which was also based on a 19 percent sample of surveys conducted during that period.

Home Health Agency

The AOs with HHA accreditation programs in FY 2013 were TJC, ACHC and CHAP. (See Table 10)

- **ACHC:** In FY 2013 the disparity rate was nine percent based on the completion of 11 validation surveys. The number of validation surveys completed represents a five percent sample of surveys conducted by ACHC. The FY 2013 disparity rate is lower than the disparity rate of 12 percent for FY 2012, which was based on a nine percent sample of surveys conducted during that period.
- **CHAP:** In FY 2013, the disparity rate was 19 percent based on the completion of 48 validation surveys. The number of validation surveys completed represents a five percent sample of the surveys conducted by CHAP. The FY 2013 disparity rate is lower than the disparity rate of 22 percent for FY 2012, which was also based on a five percent sample of the surveys conducted during that time.

TABLE 9:

CRITICAL ACCESS HOSPITAL 60-DAY VALIDATION SURVEY RESULTS BY AO (FYs 2008–2013)

Validation Survey Analysis	AOA/HFAP			DNV GL			TJC			TOTAL		
	2008–2011	2012	2013	2008–2011*	2012	2013	2008–2011*	2012	2013	2008–2011	2012	2013
60-Day Validation Sample	8	2	6	1	3	6	73	28	23	82	33	35
SA: Condition-level Deficiencies	6	0	4	0	2	4	46	13	9	52	15	17
Missed by AO	6	NA	3	NA	NA	4	40	10	7	46	12	14
Disparity Rate	75%	NA	50%	NA	NA	67%	55%	36%	30%	56%	36%	40%
Sampling Fraction	.21	.14	.67	.04	.03	.32	.15	.19	.19	.15	.19	.23

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

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

- **TJC:** In FY 2013 the disparity rate was five percent based on the completion of 21 validation surveys. The number of validation surveys completed represents a three percent sample of the surveys conducted by TJC. The FY 2013 disparity rate represents improvement compared to the disparity rate of 19 percent for FY 2012, which was based on a four percent sample of the surveys conducted during that period.

Hospice

The AOs with hospice accreditation programs in FY 2013 were the TJC, CHAP and ACHC. Hospice validation surveys were initiated in FY 2010. (See Table 11)

- **ACHC:** : In FYs 2012-2013, no disparity rate was calculated due to the small validation survey sample size.
- **CHAP:** In FY 2013 the disparity rate was nine percent based on the completion of 11 validation surveys. The number of validation surveys completed represents a four percent sample of the surveys performed by CHAP. The FY 2013 disparity rate is an improvement compared to the disparity rate of 20 percent for FY 2012 which was based on a three percent sample of the surveys conducted during that period.
- **TJC:** In FYs 2012-2013 the disparity rate was not applicable as there were no condition-level deficiencies cited by the SA. There were six validation surveys completed in FY 2013 which represents a two percent sample of the surveys performed by TJC. In combined FYs 2010-2011, the disparity rate was five percent. This disparity rate was based on the completion of 21 validation surveys which represents eight percent sample of the surveys conducted by TJC during that period.

TABLE 10:
HOME HEALTH AGENCY 60-DAY VALIDATION SURVEY RESULTS BY AO (FYs 2008–2013)

	DNV GL	ACHC		CHAP			TJC			TOTAL		
FY	2008–2011	2012	2013	2008–2011	2012	2013	2008–2011	2012	2013	2008–2011	2012	2013
60-Day Validation Sample	31	25	11	108	50	48	86	27	21	225	102	80
SA: Condition-level Deficiencies	4	6	3	15	17	11	25	7	1	44	30	15
Missed by AO	3	3	1	12	11	9	19	5	1	34	19	11
Disparity Rate	10%	12%	9%	11%	22%	19%	22%	19%	5%	15%	19%	14%
Sampling Fraction	.03	.09	.05	.05	.05	.05	.04	.04	.03	.04	.05	.04

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

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

TABLE 11:
HOSPICE 60-DAY VALIDATION SURVEY RESULTS BY AO (FYs 2010–2013)

	ACHC		CHAP			TJC			TOTAL		
FY	2012*	2013	2010–2011	2012	2013	2010–2011	2012	2013	2010–2011	2012	2013
60-Day Validation Sample	1	1	19	10	11	21	10	6	40	21	18
SA: Condition-level Deficiencies	0	0	6	2	1	2	0	0	8	2	1
Missed by AO	NA	NA	5	2	1	1	0	NA	6	2	1
Disparity Rate	NA	NA	26%	20%	9%	5%	0	NA	15%	10%	6%
Sampling Fraction	.03	.02	.06	.03	.04	.08	.05	.02	.07	.04	.03

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

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

Ambulatory Surgery Center

The AOs with ASC accreditation programs in FY 2013 were TJC, AAAHC, AOA, and AAAASF. (See Table 12)

- **TJC:** In FY 2013, the disparity rate was 27 percent based on the completion of 15 validation surveys. The number of validation surveys completed represents an 8 percent sample of the surveys performed by TJC. The FY 2013 disparity rate was an improvement compared to the disparity rate of 41 percent for FY 2012, which was based on an 11 percent sample of surveys conducted during that period.
- **AAAHC:** In FY 2013, the disparity rate was 45 percent based on the completion of 38 validation surveys. The number of validation surveys completed represents a twelve percent sample of the surveys performed by AAAHC. The FY 2013 disparity rate significantly increased compared to the disparity rate of 25 percent for FY 2012, which was also based on a 12 percent sample of surveys conducted during that period.
- **AAAASF:** In FY 2013, the disparity rate was 33 percent based on the completion of six validation surveys. The number of completed validation surveys represents a seven percent sample of the surveys performed by AAAASF. The FY 2013 disparity rate was an improvement compared to the disparity rate of 60 percent for FY 2012, which was based on a seven percent sample of the surveys conducted during that period.
- **AOA/HFAP:** In FY 2013 no disparity rate was calculated, due to the small validation survey sample size. The number of completed validation surveys represents a 20 percent sample of the surveys performed by AOA/HFAP.

Validation Performance Results: Physical Environment vs. Other Health Conditions Cited

Examining the specific condition-level deficiencies cited by the SAs across all 60-day validation surveys provides an indication of the types of quality problems that exist in these facility types as well as the relationship between SA and AO citations for specific conditions. CMS uses two approaches for this analysis: (1) a review of the types of condition-level citations identified by SAs and the comparable AO deficiency findings; and (2) a comparison of the number of surveys with where the SA found physical environment condition-level deficiencies and the number of surveys with other types of SA-identified condition-level deficiencies. Both approaches highlight the same conclusion: SAs identify more serious physical environment deficiencies than any other type of serious deficiency on validation surveys; and AOs miss a significant number of these physical environment deficiencies. These findings are consistent with validation analysis results for the past several years.

TABLE 12:

AMBULATORY SURGERY CENTER 60-DAY VALIDATION SURVEY RESULTS BY AO (FYs 2008–2013)

	AAAHC			AAAASF			AOA	TJC			Total	
FYs	2008–2011*	2012	2013	2008–2011*	2012	2013	2013	2008–2011*	2012	2013	2008–2011	2012	2013
60-Day Validation Sample	101	44	38	7	5	6	2	25	17	15	133	66	61
SA: Condition-level Deficiencies	46	14	21	5	3	3	1	12	8	5	63	25	30
Missed by AO	42	11	17	5	3	2	NA	11	7	4	58	21	24
Disparity Rate	42%	25%	45%	71%	60%	33%	NA	44%	41%	27%	44%	32%	39%
Sampling Fraction	.08	.12	.12	.07	.07	.07	.20	.07	.11	.08	.08	.11	.10

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

Note: No AOA ASC selections in FYs 2008-2012.

Comparison of SA Condition-Level and AO Citation Findings

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

TABLE 13:

NUMBER AND TYPE OF CONDITION-LEVEL DEFICIENCIES CITED BY SAs/MISSED BY AOs HOSPITAL (FY 2013)

Medicare Conditions	Cited by State Agency	Missed by Accrediting Organization
Sample Size: 96		
Governing Body	12	8
Patient Rights	7	1
QAPI	8	7
Medical Staff	4	0
Nursing Services	2	2
Medical Record Services	4	0
Pharmaceutical Services	8	2
Food and Dietetic Services	4	4
Physical Environment	33	31
Infection Control	15	7
Surgical Services	4	2
Outpatient Services	2	1

In FY 2013, the hospital sample consisted of 96 validation surveys. In this sample, 52 facilities were cited at the condition-level by the SAs. Physical Environment was the most prevalent condition-level deficiency cited by the SAs, with 33 SA condition-level citations. The AOs missed citing comparable deficiencies for Physical Environment in 31 of these 33 surveys. The findings regarding Physical Environment were similar in FYs 2010–2012.

In FY 2013, the next most frequently SA-cited conditions were: Infection Control cited 15 times by the SAs and missed seven times by the AOs, and Governing Body, cited 12 times by the SAs and missed eight times by the AOs.

TABLE 14:

NUMBER AND TYPE OF CONDITION-LEVEL DEFICIENCIES CITED BY SAs/MISSED BY AOs PSYCHIATRIC HOSPITAL (FY 2013)

Medicare Conditions	Cited by State Agency	Missed by Accrediting Organization
Sample Size: 10		
Compliance with Other State/Federal Law	1	1
Governing Body	1	1
Patient Rights	4	1
QAPI	3	1
Nursing Services	2	0
Laboratory Services	1	1
Food and Dietetic Services	2	2
Physical Environment	4	2
Infection Control	1	0
Organ, Tissue, and Eye Procurement	1	1
Anesthesia Services	1	0
Respiratory Care Services	1	1
Special Medical Requirements for Psychiatric Hospitals	1	0

In FY 2013, the psychiatric hospital sample consisted of 10 validation surveys. In this sample, six facilities were cited at the condition-level by the SAs. Physical Environment and Patient Rights were the most prevalent condition-level deficiencies cited by the SAs, with four SA condition-level citations each. The AO missed two comparable deficiencies for Physical Environment and one comparable deficiency for Patient Rights.

In FY 2013, the next most frequently SA-cited condition for Psychiatric Hospitals was QAPI, with three SA condition-level citations and one comparable deficiency missed by the AO.

TABLE 15:

NUMBER AND TYPE OF CONDITION-LEVEL DEFICIENCIES CITED BY SAs/MISSED BY AOs CRITICAL ACCESS HOSPITAL (FY 2013)

Medicare Conditions	Cited by State Agency	Missed by Accrediting Organization
Sample Size: 35		
Emergency Services	1	1
Physical Plant and Environment	14	11
Organizational Structure	1	0
Provision of Services	3	1
Clinical Records	1	0
Surgical Services	2	1
Periodic Evaluation and Quality Assurance Review	2	1

In FY 2013, the CAH sample consisted of 35 validation surveys. In this sample, 17 facilities were cited at the condition-level by the SAs. Physical Environment was the most prevalent condition-level deficiency cited by the SAs with 14 SA condition-level citations. The AOs missed 11 comparable deficiencies for Physical Environment. Physical Environment was also the most frequently cited condition in FYs 2010–2012.

In FY 2013, the next most frequently SA-cited condition for CAHs was for Provision of Services with three SA condition-level citations and one comparable deficiency missed by the AO.

TABLE 16:

NUMBER AND TYPE OF CONDITION-LEVEL DEFICIENCIES CITED BY SAs/MISSED BY AOs HOME HEALTH AGENCY (FY 2013)

Medicare Conditions	Cited by State Agency	Missed by Accrediting Organization
Sample Size: 80		
Patient Rights	1	0
Compliance with Federal, State and Local Laws	1	1
Organization, Services, and Administration	7	5
Group of Professional Personnel	2	0
Acceptance of Patients, Plan of Care & Medical Supervision	7	3
Reporting Oasis Information	1	1
Skilled Nursing Services	7	4
Therapy Services	3	1
Home Health Aide Services	3	1
Clinical Records	1	1
Evaluation of the Agency's Program	1	0
Comprehensive Assessment of Patients	1	0

In FY 2013, the HHA sample consisted of 80 validation surveys. In this sample 15 facilities were cited for condition-level deficiencies by the SAs. The most frequently cited conditions were: Organization, Services, and Administration, with seven SA condition-level citations and five comparable deficiencies missed by the AOs, Acceptance of Patients, Plan of Care & Medical Supervision, with seven condition-level SA citations with three comparable deficiencies missed by the AOs, and Skilled Nursing Services with seven SA condition-level citations and four comparable deficiencies missed by the AOs. Organization, Services, and Administration and Acceptance of Patients, Plan of Care & Medical Supervision were also the most frequently cited conditions in FY 2012.

In FY 2013, the next most frequently cited conditions were Therapy Services and Home Health Aide Services, both with three SA condition-level citations and one comparable deficiency missed by the AOs.

TABLE 17:

NUMBER AND TYPE OF CONDITION-LEVEL DEFICIENCIES CITED BY SAs/MISSED BY AOs HOSPICE (FY 2013)

Medicare Conditions	Cited by State Agency	Missed by Accrediting Organization
Sample Size: 18		
Patient Rights	1	1
Initial and Comprehensive Assessment of Patient	1	1
IDG, Care Planning, Coordination of Services	1	1
Quality Assessment & Performance Improvement	1	1
Organizational Environment	1	1

In FY 2013, the Hospice sample consisted of 18 validation surveys. In this sample, one facility was cited for condition-level deficiencies by the SA. Patient Rights, Initial and Comprehensive Assessment of Patient, IDG, Care Planning, Coordination of Services, Quality Assessment & Performance Improvement, and Organizational Environment were each cited at the condition-level once by the SA and all were missed by the AOs. In FY 2012, two facilities were cited for condition-level deficiencies by the SAs. Quality Assessment and Home Aide & Homemaker Services were each cited at the condition-level once by the SAs and both were missed by the AOs.

TABLE 18:

NUMBER AND TYPE OF CONDITION-LEVEL DEFICIENCIES CITED BY SAs/MISSED BY AOs AMBULATORY SURGICAL CENTER (FY 2013)

Medicare Conditions	Cited by State Agency	Missed by Accrediting Organization
Sample Size: 61		
Compliance with State Licensure Law	2	0
Governing Body and Management	13	6
Surgical Services	8	4
Quality Assessment & Performance Improvement	6	3
Physical Environment	14	14
Medical Staff	3	0
Nursing Services	4	3
Medical Records	3	1
Pharmaceutical Services	8	3
Laboratory and Radiologic Services	1	0
Patient Rights	2	2
Infection Control	13	6
Patient Admission, Assessment and Discharge	5	3

In FY 2013, the ASC sample consisted of 61 validation surveys. In this sample 30 facilities were cited for condition-level deficiencies by the SAs. The most frequently cited condition was Physical Environment, with 14 SA condition-level citations. The AOs missed 14 comparable deficiencies for Physical Environment. Physical Environment was also the most prevalent SA condition-level deficiency for ACSs in FYs 2009, 2011 and 2012. The FY 2010 60-day validation sample did not include ASCs.

The next most frequently cited conditions were Governing Body and Management, cited 13 times by SAs and missed 6 times by AOs, and Infection Control, cited 13 times by SAs, and missed six times by AOs. Surgical Services was cited eight times by SAs and missed three times by AOs and Pharmaceutical Services was also cited eight times by SAs, but missed three times by AOs. These findings were similar to the FY 2012 findings.

Comparison of Deficiencies for Physical Environment and Other Health Conditions

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

TABLE 19:

NUMBER OF 60-DAY VALIDATION SURVEYS FOR FACILITY TYPES WITH LSC REQUIREMENTS (FY 2013)

Validation Survey Analysis	Hospital*	Psych Hospital	Critical Access Hospital	Ambulatory Surgery Center
60-Day Validation Sample Surveys	96	10	35	61

*Acute Care and Long Term Care Hospitals

TABLE 20:

60-DAY VALIDATION SURVEY RESULTS FOR FACILITY TYPES WITH LSC REQUIREMENTS (FY 2013)

Validation Survey Analysis	Hospital All Other CoPs	Hospital PE	Psych Hospital All Other CoPs	Psych Hospital PE	CAH All Other CoPs	CAH PE	ASC All Other CoPs	ASC PE
SA: Condition-level Deficiencies	39	33	7	4	7	14	26	14
Missed by AO	18	31	3	2	3	11	14	14
Disparity Rate	19%	32%	30%	20%	9%	31%	23%	23%

Comparison Between All Other CoPs Cited and Physical Environment

In FY 2013, Physical Environment continued to have a significant impact on each facility type's overall disparity rate. The FY 2013 results show that the Physical Environment condition is still the single largest driver of the disparity rate for hospitals and CAHs. For hospitals and CAHs, the range of disparity rates based on the Physical Environment condition are between 13 and 22 percentage points higher than the disparity rates calculated based on other health and safety conditions. In FY 2013, the Physical Environment disparity rate for Psychiatric Hospitals was 10 percentage points lower than the disparity rate for other health and safety conditions. The Physical Environment disparity rate for ASCs was the same as the disparity rate for other health and safety conditions. Physical Environment is an extremely significant driver of the disparity rate for CAHs, yielding a 22 percentage point difference between the Physical Environment and All Other Conditions disparity rates. There is a 13 percent point difference for hospitals.

The majority of the physical environment disparity consists of LSC deficiencies. CMS engineers generated a report which identifies the top LSC deficiencies cited by the SAs in FY 2013. These top LSC deficiencies are consistent with SA deficiencies cited in FY 2011 and 2012. This report is shared with the AOs on an annual basis. This report is intended to provide the AOs with an understanding of the emphasis of CMS LSC surveys, which should allow the AOs to ensure their programs are focusing on the same LSC provisions. Should AOs choose to focus on the top LSC deficiencies cited by the SAs, we would expect this to result in a reduced LSC disparity.

The AOs have had particular difficulty identifying deficiencies that SAs have cited related to the LSC 2000 edition requirements that CMS has adopted. Fire safety requirements are statutorily mandated for hospitals. CMS has been working with all AOs to provide guidance on the source of this problem and possible ways to improve performance. CMS has continued to discuss with the AOs their concerns as well as their performance in the area of evaluating health care facility safety from fire. In response to concerns of AOs and others, CMS has issued a number of categorical waivers to the LSC 2000 edition that aligns our requirements more closely with the LSC 2012 edition. CMS has also proposed to update Federal regulations to adopt the LSC 2012 edition. Nevertheless, we note that AOs are required to employ standards that are consistent with the Medicare standards, and may not unilaterally impose a different LSC edition

than CMS has adopted. Further, we do not believe that the difference in LSC editions accounts for the extent and persistence of AOs' problems in identifying LSC deficiencies.

Deficiencies and Disparities for Long Term Care Hospitals (LTCHS) and Other Hospital Subtypes

In 2010, CMS became concerned about the quality of care provided in LTCHs based on available SA survey findings. In the 2011 report to Congress, CMS reported on the analysis of mid-cycle validation surveys for 33 LTCHs. The Government Accountability Office (GAO) recommended in a September 2011 report that CMS strengthen oversight of LTCHs by, among other things, increasing the number of LTCH representative sample validation surveys and calculating a separate disparity rate for them.[8] (See Tables 21 and 22) We attempted to increase the LTCH sample size for 60-day representative sample surveys, but are limited in our ability to do so by the scheduling of LTCH Medicare accreditation surveys by the AOs, as well as the concentration of LTCHs in certain states. The fixed surveyor capacity of SAs makes it impractical for SAs in those states to conduct a larger number of LTCH validation surveys.

TABLE 21:

NUMBER OF 60-DAY VALIDATION SURVEYS AND OVERALL DISPARITY RATE LONG TERM CARE HOSPITALS AND ALL OTHER HOSPITAL SUBTYPES (FY 2013)

Validation Survey Analysis	LTCHs	All Other Hospitals
60-Day Validation Surveys	17	79
Overall Disparity Rate	24%	51%

TABLE 22:

COMPARISON OF 60-DAY HEALTH AND PHYSICAL ENVIRONMENT VALIDATION SURVEY RESULTS FOR LTCHS AND ALL OTHER HOSPITAL SUBTYPES (FY 2013)

Validation Survey Analysis	LTCHs All Other Conditions	LTCHs PE	All Other Hospitals All Other Conditions	All Other Hospitals PE
SA: Condition-level Deficiencies	5	2	34	31
Missed by AO	2	2	16	29
Disparity Rate	12%	12%	20%	37%

There is a 25 percent difference between the overall disparity rates in LTCHs and all other hospital subtypes. However, when comparing the drivers of the disparity rates, Physical Environment is the biggest driver of the disparity rate in all other hospital subtypes. Excluding Physical Environment, the most frequent disparate condition-level deficiencies for all other hospital subtypes and LTCHs are Governing Body, Infection Control and QAPI.

SECTION 5: AO Performance Measures

AO Reporting Requirements

A major focus of CMS' ongoing work with each AO is monitoring and improving the AO's ability to provide CMS with complete, timely, and accurate information regarding deemed status facilities, as required at 42 CFR 488.4. It is important that AOs and CMS be able to accurately determine a facility's Medicare accreditation status on an ongoing basis. This information is vital for CMS to identify which facilities have deemed status and are, therefore, subject to AO versus SA oversight. Additionally, when an AO makes an adverse Medicare accreditation program decision based on a facility's failure to satisfy the AO's health and safety standards, it is imperative that CMS be notified promptly in order to take appropriate follow-up enforcement action. It is also essential for CMS to have information concerning upcoming AO survey schedules to effectively implement the validation program. To this end, AOs must submit the following to CMS:

- Monthly survey schedules which document the surveys that were completed for the previous month, and those scheduled for the current and following months;
- A report of all data pertaining to all Medicare accreditation and enforcement activity for each month;

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

- Facility notification letters for all Medicare accreditation program actions and any follow-up communication associated with those facility notification letters; and
- Responses to any formal correspondence from CMS.

CMS employs several methods to facilitate obtaining this information. In addition to the provision and ongoing improvements of ASSURE, CMS provides AOs with:

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

AO Performance Measures and Scoring

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

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

TABLE 23:

FYS 2012–2013 AO PERFORMANCE MEASURES

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

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

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

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

SURVEY SCHEDULE: AOs are required to submit a monthly schedule which documents surveys completed in the past month as well as scheduled surveys for the current and next two months. Performance in this area is based on:
• The accuracy of monthly survey schedules (specifically, no instances of arrival of the SA to conduct a validation survey and being informed that the accreditation survey had not been conducted as indicated on the survey schedule) • The timeliness of reporting changes in the survey schedule and incorporating these changes in the next survey schedule submission (and in the proper format) • The accuracy of the data in ASSURE regarding number of surveys reported as completed for the quarter and the number of surveys actually completed each quarter
FORMAL CORRESPONDENCE: AOs required to submit a response to formal CMS correspondence addressing issues of concern. Performance in this area is based on:
• The timely responses to formal correspondence (on or before the specified due date)

FYs 2012–2013 AO Performance Measures

In FY 2012 and FY 2013, AOs were scored on their performance on 13 measures in four key performance focus areas: ASSURE Database; Facility Notification Letters; Survey Schedule; and Formal Correspondence. (See Table 23)

Significant Changes for FY 2012 AO Performance Measures

Retired FY 2011 Performance Measures

In FY 2012, CMS retired 11 of the FY 2011 performance measures in three key performance focus areas. After conducting a thorough review and evaluation of past performance, CMS determined that the AOs had consistently scored at 100 percent on these measures for the previous two years. There were no additional retired performance measures in FY 2013.

ASSURE DATA BASE

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

FACILITY NOTIFICATION LETTERS
Electronic submission of facility notification letters:

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

SURVEY SCHEDULES

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

Expanded FY 2011 Performance Measure in FY 2012

CMS expanded one FY 2011 performance measure in one key performance focus area in FY 2012. This performance measure remains unchanged for FY 2013.

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

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

New FY 2012 Performance Measures

CMS added four new performance measures in two key performance focus areas in FY 2012. These performance measures remain the same for FY 2013.

FACILITY NOTIFICATION LETTERS
Electronic submission of facility notification letters:

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

FORMAL CORRESPONDENCE
(which is also a new key performance focus area)

- Timely responses to formal correspondence

Performance Measure Results

The FY 2012 and FY 2013 performance data for each AO is presented below in two tables. The first table presents results for performance measures that were monitored in FYs 2011, 2012 and 2013. A comparison is presented by AO for these three fiscal years. The second table presents results for performance measures specific to FYs 2012 and 2013 due to the addition of new measures in FY 2012 or the modification of measures from FY 2011. Therefore, the data in the second table cannot be directly compared to the FY 2011 performance measures results and are presented independently. Both tables present the performance measures according to the key focus areas. All results include quarterly averages utilizing standard rounding rules. The data represent the percent frequency with which the task required by the measure was performed in an accurate, timely, complete manner. (See Tables 24 and 25) A discussion of the performance measure scoring and results follows the tables.

TABLE 24:

PERFORMANCE MEASURE RESULTS (PERCENTAGE) BY AO COMPARABLE MEASURES FOR FYs 2011–2013

	AAAHC			AAAASF			ACHC			AOA / HFAP			CHAP			DNV GL			TJC			All AOs		
FYs	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013	2011	2012	2013
ASSURE Database																								
Timely triennial surveys	100	100	100	100	100	100	99	99	100	91	97	100	100	100	100	100	99	99	100	99	98	98	99	100
Facility Notification Letters																								
ASSURE updates are consistent with letters*	93	96	N/A	47	40	N/A	70	100	N/A	57	60	N/A	87	79	N/A	100	90	N/A	78	66	N/A	76	76	N/A

N/A: Measure temporarily discontinued.

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

Scoring:

- "Performed well" means a 100 percent score.
- "Substantial improvement" means improved by at least nine percent in FY 2013 compared to the previous year.
- "Opportunity for improvement" means any score below 90 percent in FY 2013.
- "Lower score" means a decrease of at least nine percent in FY 2013 compared to the previous year.

Highlights:

1. Assure Database

- All AOs scored 100 percent for the measure, "Number of pending surveys (not > 180 days)," in both FYs 2012 and FY 2013.
- All AOs scored at the 95 percent level or higher on every measure in both FYs 2012 and 2013.

2. Facility Notification Letters

- In FY 2012, all AOs scored 100 percent for the measure, "No duplicate notices submitted." In FY 2013, all but one AO scored at the 97 percent level or higher for the same measure.
- All but one AO scored 100 percent in the measure, "Only required notifications submitted," in FY 2012. All AOs scored 100 percent in this measure in FY 2013.
- The measure, "ASSURE updates are consistent with letters," had mixed results in FY 2012, with several AOs showing opportunity for improvement while several others scored 90 percent or above. In FY 2013, this measure was temporarily discontinued.
- In FY 2012, all AOs showed significant opportunity for improvement on the measure, "ASSURE data corrected according to CMS-identified deficiencies," from the previous quarter. In FY 2013, this measure was temporarily discontinued.

3. Survey Schedule

- In FY 2012, all but one AO achieved a 100 percent score on two of the three measures. In FY 2013, all but two AOs achieved a 100 percent score on two of the three measures.
- The measure, "Number of surveys performed matches the number reported in ASSURE," shows the opportunity for improvement for most AOs in both FYs 2012 and 2013.

4. Formal CMS Correspondence

- In FY 2012, the average score for this new performance measure for all AOs was 98 percent. In FY 2013, all but one AO achieved a 100 percent score.

CMS continues to work closely with AOs to improve performance in areas that need improvement as well as to maintain high levels of performance in other areas. The goal is for all AOs to consistently score at or near 100 percent on all measures to ensure that AOs are effectively managing their Medicare accreditation programs and communicating vital program information to CMS.

AO Specific Discussion

AAAHC: For the performance measures that can be compared to FY 2011 scores, AAAHC once again performed well with regard to the measure, "timely triennial surveys" in FY 2013. In summary, AAAHC performed well on six of 13 measures and had a slightly improved level of performance with regard to the measure, "letters submitted with attachments." However, AAAHC has an opportunity

TABLE 25:

PERFORMANCE MEASURE RESULTS (PERCENTAGE) BY AO FYS 2012–2013

(Not Comparable to FY 2011 Measures)

	AAAHC		AAAASF		ACHC		AOA / HFAP		CHAP		DNV GL		JC		All AOs	
FYs	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013	2012	2013
ASSURE Database																
Number of CCNs present (not missing >180 days)	97	95	100	100	98	100	100	100	99	98	100	100	96	95	99	98
Number of pending surveys (not > 180 days)	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
Facility Notification Letters																
Letters submitted with attachments	97	99	100	97	100	100	100	84	98	100	100	100	100	97	99	97
Only required notifications submitted	100	100	100	100	100	100	100	100	100	100	100	100	96	100	99	100
No duplicate notices submitted	100	99	100	97	100	99	100	100	100	100	100	98	100	69	100	95
Contain all required information	94	N/A	97	N/A	100	N/A	100	N/A	98	N/A	100	N/A	98	N/A	98	N/A
ASSURE data corrected according to CMS-identified deficiencies from previous quarter*	N/A	N/A	48	N/A	63	N/A	10	N/A	0	N/A	0	N/A	28	N/A	25	N/A
Survey Schedule																
AO conducted survey as reported on survey schedule	100	100	92	100	100	100	100	100	100	92	100	100	100	100	99	99
Timely submission of schedule changes and proper in-corporation into the next monthly schedule.	100	100	100	100	100	92	92	100	100	100	100	100	100	100	99	99
Number of surveys performed matches number reported in ASSURE	97	85	74	97	93	91	35	76	100	95	97	89	92	97	84	90
Formal Correspondence																
Responses to CMS on or before specified due date	100	100	100	50	100	100	96	100	100	100	89	100	100	100	98	93

FY 2012 N/A: No discrepancies to correct.

FY 2013 N/A: Measure temporarily discontinued.

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

for improvement with regard to the measure, "number of surveys performed matches number reported in ASSURE."

AAAASF: For the performance measures that can be compared to FY 2011 scores, AAAASF once again performed well with regard to measure, "timely triennial surveys," in FY 2013. In summary, AAAASF performed well on six of 13 measures in FY 2013 and showed substantial improvement with regard to the measure, "number of surveys performed matches number reported in ASSURE." However, AAAASF has an opportunity for improvement with regard to the measure, "responses to CMS on or before specified due date," a measure on which they performed well in FY 2012.

ACHC: For the performance measures that can be compared to FY 2011 scores, ACHC continues to improve and performed well with regard to the measure, "timely triennial surveys," in FY 2013. In summary, ACHC performed well on seven of 13 measures in FY 2013. However, ACHC has an opportunity for some improvement with regard to the measure "timely submission of schedule changes and proper incorporation into the next monthly schedule," a measure on which they performed well in FY 2012.

AOA/HFAP: For the performance measures that can be compared to FY 2011 scores, AOA/HFAP continues to improve and performed well with regard to the measure, "timely triennial surveys," in FY 2013. In summary, AOA/HFAP performed well on eight of 13 measures and showed substantial improvement and continued opportunity for improvement with regard to the measure, "number of surveys performed matches number reported in

ASSURE." However, AOA/HFAP has an opportunity for improvement with regard to the measure, "letters submitted with attachments," a measure on which they performed well in FY 2012.

CHAP: For the performance measures that can be compared to FY 2011 scores, CHAP once again performed well with regard to the measure, "timely triennial surveys." In summary, CHAP performed well on seven of 13 measures. However, CHAP has an opportunity for improvement with regard to the measures, "AO conducted survey as reported on survey schedule" and "number of surveys performed matches number reported in ASSURE," measures on which they performed well in FY 2013.

DNV GL: For the performance measures that can be compared to FY 2011 scores, DNV GL maintained their level of performance with regard to timely triennial surveys in FY 2013. In summary, DNV GL performed well on seven of 13 measures and showed substantial improvement and performed well with regard to the measure, "responses to CMS on or before specified due date." However, DNV GL has an opportunity for improvement with regard to the measure, "number of surveys performed matches number reported in ASSURE."

TJC: For the performance measures that can be compared to FY 2011 scores, TJC continues to have a slightly decreased level of performance with regard to the measure, "timely triennial surveys," in FY 2013. In summary, TJC performed well on five of 13 measures and had slightly improved levels of performance with regard to the measures, "number of survey performed matches number reported in ASSURE," and "submission of required notification letters." However, TJC has an opportunity for improvement with regard to the measure, "submission of duplicate notices," a measure on which they performed well in FY 2012.

SECTION 6: AO Self-Reported Program Improvements

Accreditation Association for Ambulatory Health Care (AAAHC)

AAAHC welcomes the opportunity to provide information regarding ongoing improvements that have been made for the AAAHC/Medicare Deemed program. From October 2012 to September 2013, AAAHC continued to review and modify the AAAHC/Medicare Deemed Status program to improve the customer experience.

Process Improvements

Effective in 2012, AAAHC implemented a three-year term of accreditation. Previously, accreditable facilities could be granted accreditation terms of six months, one year, or three years. This policy change streamlined our process and we implemented an interim survey process, which allows for oversight within the three-year term. When deficiencies are cited through the AAAHC/Medicare Deemed Status survey, an ASC is required to submit an acceptable plan of correction. Depending on the severity of the deficiencies, an ASC may also be required to undergo an interim survey, as a means of following-up on deficiencies cited to ensure compliance. This determination is made after receipt of an organization's plan of correction. AAAHC continues to refine this accreditation model, reviewing recurring factors that lead to interim surveys and developing educational opportunities to address those common obstacles within the three-year term.

Throughout our last fiscal year, AAAHC worked tirelessly to implement a new survey process to review Life Safety Code requirements and physical plant requirements during the on-site survey. Specialized Life Safety Surveyors were recruited, targeting those with expertise and experience in reviewing physical plant and Life Safety requirements. This process improvement resulted in more consistency in identifying deficiencies related to these environmental requirements.

System Improvements

Every year AAAHC reviews its electronic reporting systems to ensure that complete information is consistently reported to CMS. AAAHC updated its data systems to address changes in the environment and to assist the implementation of the web-based ASSURE reporting system. This year, AAAHC updated its website to include an area for organizations to report significant organizational changes. This allows better tracking of changes that are reported and, as a result, AAAHC cut the time for internal review of these changes by half. AAAHC continues to improve access to customers by allowing every organization to complete its plan of correction through a web-based system. This streamlines the electronic capture of documentation and provides better access to data mining.

In addition to reviewing electronic reporting and database systems, AAAHC reviews its staffing

needs on a regular basis. Throughout its history, the AAAHC has ensured staff availability to answer questions and concerns directly, instead of relying on automated systems. AAAHC increased staff capacity in 2013 to address customer service needs. AAAHC continues to strive for improvements in customer service.

Performance Measures

AAAHC is proud of its record of consistent high scores for the performance measures set by the CMS. Outside of the CMS performance measures, AAAHC surveys organizations after the on-site survey to determine customer satisfaction. AAAHC has consistently received high satisfaction ratings from accredited organizations. AAAHC uses the data collected on both the CMS performance measures and its internal customer surveys to search for ways to improve the accreditation and survey process.

Education

AAAHC maintains resources to help ASCs understand and meet CMS requirements. AAAHC communicates with ASCs through newsletters, e-mail blasts, and web-site links. AAAHC continues to provide quarterly face-to-face education programs with focused sessions on issues related to the CMS Conditions for Coverage. During this past year, AAAHC improved its on-site educational seminars in many ways, including:

- Using the collected data to provide targeted education on commonly found deficiencies;
- Including time for organizations to network with one another; and
- Adding a "chat room" where participants can ask AAAHC staff questions related to the accreditation process and requirements.

AAAHC also introduced webinars in 2013 aimed at providing education for challenging topics. These included Infection Prevention, Life Safety Code, and Common Accreditation Errors.

Since 2009, AAAHC has partnered with Association for Professionals in Infection Control and Epidemiology (APIC). This partnership has enabled AAAHC to provide surveyors and organizations with a deeper understanding of infection prevention and safety. Quarterly education sessions have been developed to address infection prevention concerns for different types of health care organizations from primary care to surgical settings. AAAHC Surveyors are provided access to the resources for ASCs, as well as surveyor-specific resources and educational tools that provide in-depth information on CMS requirements. Weekly e-mail communications and online training provide updates on CMS requirements, as needed.

New Resources

AAAHC has expanded use of its data warehouse by releasing its first annual Accreditation Association Electronic National Evaluation and Information Dataset (AENEID) report on the Top AAAHC Standard Deficiencies. During the on-site educational seminars, data from the AENEID and ASSURE systems are used to correlate the top-cited AAAHC and CMS Conditions for Coverage. This allows any organization to learn about common obstacles and challenges within AAAHC Standards.

Disparity Rate Analysis

AAAHC conducts ongoing, in-depth analysis of validation and Accreditation/Deemed Status Survey findings. The analysis compares data received from validation surveys conducted by regional authorities with AAAHC survey documents. Through this analysis, AAAHC continues to identify opportunities to reduce disparities and improve survey processes and education. AAAHC is proud to note the reduction of its disparity rate by almost half. Surveyors are given additional training and information related to these issues of disparity. ASCs and patients realize the benefit of this improvement through the survey process.

AAAHC Recognition

This past year saw a renewal of recognition for AAAHC as an accreditation organization for California Outpatient Surgery Settings. The AAAHC was also recently approved as an accreditation organization for Qualified Health Plans under the Center for Consumer Information and Insurance Oversight. AAAHC has been accrediting health plans since 1983 and has been recognized by CMS for Medicare Advantage plans since 2002. AAAHC continues to receive recognition as an accreditation organization for the US Air Force, US Coast Guard, and Federally Qualified Health Centers.

The American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

AAAASF Growth

AAAASF is very proud of the continued growth of all three of its CMS Deemed programs, particularly the OPT and RHC programs. As of February 13, 2014, AAAASF has recommended 113 OPT facilities and 123 RHC facilities for deemed status. The AAAASF Board of Directors has continued to demonstrate its sensitivity to the changing needs of

the Deemed programs. In FY 2013, AAAASF once again added staff to improve efficiency. By creating a scheduling department, AAAASF has streamlined the assignment of surveyors and removed one of the most labor intensive components of the survey process from its accreditation staff. This has permitted specialists to focus on technical assistance and review of survey documentation. The AAAASF Board of Directors approved the hire of a Compliance Specialist at the end of FY 2013. The Compliance Specialist, who will be required to have clinical training and experience, will be tasked with providing clinical review of surveyor and facility documentation assessing facilities' compliance and corrective action. Finally, the AAAASF has created auditor seats on its Board of Directors for representatives from the OPT and RHC community to ensure that the programs have the direct attention of Board-Level Leadership.

The Importance of Peer Review

AAAASF has collected patient safety data on over eight million procedures conducted in accredited facilities. This data, collated by specialty, provides statistical information to public agencies, academia, and private institutions to inform vital patient safety and outcomes discussions and drive the revision of standards. In 2013, AAAASF redesigned its Peer Review entry website to improve administration. This new generation of peer review is about to conclude its second semi-annual collection period. AAAASF has tasked its newly appointed Board Auditors to lead task forces of subject matter experts in the creation of a meaningful peer review program for RHC and OPT.

Data Tracking Systems

AAAASF revised its process for uploading facility and survey data into the Web-Based ASSURE system. The new upload is more reliable and automated; resulting in more on-time error free uploads. Additionally, AAAASF is in the process of producing a revised crosswalk to achieve a more accurate relationship between AAAASF standards and the CMS Conditions. The AAAASF staff continues to have improved dialogue with Medicare contact personnel in regional offices and state agencies.

AAAASF continues to perform well in performance measures due in large part to internal upgrades. AAAASF began working with a new IT provider in the latter half of the year, resulting in dramatic improvements in various areas of data capture and tracking. AAAASF anticipates some growing pains during the revision of notification letters and the automated generation of notices. However, these should ultimately benefit AAAASF, CMS, and facilities, as the resulting notices will more accurately reflect CMS' expected outputs.

The Manager of Data Analysis, added to staff in early FY 2013, is dedicated to fostering the improvement of the accreditation process and administration of accreditation programs though the aggregation and analysis of collected data. This staff member has facilitated more timely submission of AAAASF's various reporting functions as well as rapid identification and correction of data errors. The Manager of Data Analysis has created internal reporting mechanisms to improve the efficiency and capacity of the accreditation team.

Surveyor Education

AAAASF regularly reviews training content for surveyors to provide enhancements to the critical surveyor skill sets necessary to perform thorough and comprehensive survey processes. Surveyor Training includes a combination of interactive and lecture training segments as well as mentoring with an experienced survey team during survey participation. The surveyors provide evaluation on performance. Continuing education is provided with live surveyor training presentations and web-based modules delivered through the AAAASF Surveyor Web Institute for Facilitated Training platform (SWIFT). This ensures the timely distribution of information to surveyors.

Quality Assurance

In FY 2013, the Quality Assurance (QA) Committee began meeting on a quarterly basis to examine various aspects of overall surveyor performance in AAAASF, in addition to performing its annual review of surveyor performance in the Medicare Deemed Programs for FY 2012. In 2013 the committee began testing various thresholds for acceptable performance and analyzed aggregate survey information. The committee instituted a case review process for surveyors that fall below an acceptable threshold or receive a complaint. Final disposition of a surveyor review requires QA Committee action.

AAAASF has pursued its own staff quality assurance as well through quarterly meetings. AAAASF conducts team meetings shortly after submitting its responses to each CMS quarterly performance measure report. In the meetings AAAASF examines the resolution of prior scores, the scoring trends, CMS revisions or directives and discusses staff questions presenting unique accreditation challenges.

Electronic Resources

Following the FY 2012 website redesign, AAAASF continued its commitment to improved online resources by creating the AAAASF e-weekly newsletter. The e-Weekly is distributed to all accredited facilities as well as those who sign up at the AAAASF website. It provides recipients with information relevant to health care and working in an accredited environment. There are dedicated sections that provide content specific to each provider type, including RHC and OPT.

Future Focus

The AAAASF Board of Directors continues to pursue its aggressive five-year Strategic Plan for growth in partnership with the Medicare sector. AAAASF has dedicated many staff and resources to educate the provider groups and engage state and regional contacts. AAAASF hopes to achieve a team approach to the certification of deemed providers by developing positive relationships with appropriate personnel involved in the process. AAAASF will continue to engage the appropriate specialty societies, industry groups, and state offices to better understand facilities' needs.

Accreditation Commission for Health Care (ACHC)

ACHC strives to achieve continuous improvement in the quality and value of accreditation services offered. During the past year, ACHC has implemented the following initiatives to enhance the accreditation process and result in increased patient safety and quality of care.

Hospice Deeming Authority

The CMS approved ACHC for continued recognition as a national accrediting organization for hospices that wish to participate in the Medicare or Medicaid programs. The status reflects ACHC's commitment to providing the highest-quality accreditation services with standards that meet or exceed Medicare Conditions of Participation. The status will remain in effect through November 27, 2019.

Ongoing Compliance and Certification ISO 9001:2008

ACHC's Quality Management System (QMS) promotes accuracy and consistency throughout all organizational operations. The QMS is audited through on-site visits annually by an outside registrar. The ISO quality policy statement commits ACHC to developing and improving healthcare accreditation programs and services, meeting customer and regulatory requirements, enhancing employee skills and efficiencies, continual improvement of quality management systems/ processes, sustaining fiscal growth and improving market presence.

Health Insurance Portability and Accountability Act

ACHC conducted an initiative to achieve full compliance with HIPAA HITECH regulations. While ACHC has always followed procedures to ensure the protection of all personal health information, compliance with HIPAA HITECH regulations demonstrates the highest level of security for protected health information. The dedication to protecting any private information is reflected in ACHC's requirement for all downstream business associates to also sign business associate agreements. The added level of security not only protects personal health information, but also any information pertaining to the companies with which ACHC conducts business.

Educational Resources

As a nationally-recognized accrediting organization, ACHC places great value on continuing education in regard to achieving and maintaining accreditation. As such, workshops are regularly offered throughout the year to provide healthcare organizations the opportunity to familiarize themselves with ACHC compliance requirements, learn about industry best practices, and enhance the overall quality of patient care. ACHC also offers program-specific resources, including ACHC *Accreditation Guide to Success* workbooks, compliance checklists, and regular multimedia updates.

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

The AOA/HFAP is delighted to report the following improvements for FY 2013 in its continuing efforts to promote the delivery of quality and safe patient care in its accredited facilities, as well as meet the requirement of CMS.

Deeming Authority Review

The AOA/HFAP is proud of the ongoing program-wide changes and improvements that were initiated during FY 2013 for its three deeming programs. The AOA/HFAP has demonstrated that its program requirements continued to meet or exceed the requirements of CMS, and that the changes were sustainable. Three deeming programs were reviewed by CMS during FY 2013, as a result of

which, CMS granted continued approval to the AOA/HFAP's following programs: Ambulatory Surgical Centers (four years), Acute Care Hospitals (six years, the maximum allowable by law) and Critical Access Hospitals (six years, the maximum allowable by law).

Staffing and Resources

The AOA/HFAP is delighted to report the addition of life safety surveyors to the acute care and critical access hospital surveys in order to provide a comprehensive assessment of the Physical Environment Condition of Participation, and assessment of the Life Safety Code. The life safety surveyors are experts in compliance with the Life Safety Code requirements based on their daily professional careers. The AOA/HFAP has expanded the overall number of surveyor days to the agenda, with nominal costs passed on to the customers, in order to allow the surveyors sufficient time to evaluate compliance.

Education and Improvement Activities

The AOA/HFAP has provided surveyors and central office staff with significant training and development on various accreditation requirements and standards-related topics, particularly in the principles of documentation. Deficiency Assessment Reports undergo a two-level clinical and/or technical review for accuracy and clarity before issuance to the accredited facility. From these reports, facilities were able to submit detailed and comprehensive Plans of Correction.

For purposes of quality control, the AOA/HFAP continued to assess surveyor performance and initiated improvement activities through the monthly newsletters, quarterly telephone conference calls, and on-site mentoring activities. The aforementioned activities were all contributing factors that led to the improved performance of AOA/HFAP as an accreditation organization, which continues to add value to AOA/HFAP's accredited customers.

Accreditation Standards Manuals

The AOA/HFAP ensures that its accredited customers remained in compliance with the CMS Conditions of Participation. The AOA/HFAP reviewed each accreditation program manual to ensure a 1:1 crosswalk of the AOA/HFAP standards to the CMS health and safety standards for each deemed program. In addition, the AOA/HFAP had added additional standards that are relevant to the patient safety initiatives.

Accreditation Agenda Revisions

During FY 2013, the AOA/HFAP formed an advisory committee to provide a direct channel for communications with surveyors regarding their concerns and suggestions for improvement. The participants included leaders of the surveyor cadre, as well as key central office staff, for the purpose of improving the program and the experiences of accredited customers. The outcomes of the discussions included improvements to the survey process and agenda activities, and incorporated more opportunities to observe facility staff provide direct patient care, treatment or services during a survey. HFAP prides itself on providing a more thorough approach to the survey by reviewing every standard in the accreditation manual. Accordingly, more time was, and continues to be, invested in evaluating system and processes implemented by the facility, as well as educating facilities and providing them with best practices for compliance.

Waivers and Equivalency Process

In order to fully comply with all CMS requirements, HFAP reviewed and revised its policies and procedures related to handling requests for waivers and Life Safety Code equivalencies that are submitted to HFAP by accredited facilities.

Certification Program Development

To complement the accreditation programs and ensure that the AOA/HFAP stroke certification guidelines meet nationally recognized guidelines, the AOA/HFAP updated the Primary Stroke Certification Manual. The updated manuals incorporated several changes to the standards and performance measures. The changes were facilitated by the American Hospital Association/American Stroke Association recommendations released in 2013, along with the introduction of CMS stroke measures.

In addition, an expert panel of nationally recognized neuroscience physicians and clinical nurse specialists, from HFAP and non-HFAP accredited hospitals, convened, reviewed and provided guidance on the requirements for the Comprehensive Stroke and Stroke Ready certification programs, which were subsequently launched. The certification program model allows for the inclusion of non-HFAP accredited hospitals to achieve Comprehensive Stroke, Primary Stroke or Stroke Ready certification through the AOA/HFAP.

Other Initiatives

The AOA/HFAP has been engaged in significant activities at the state level for recognition of

accreditation programs to increase public awareness of the AOA/HFAP's accreditation services, and expansion activities that added value to its customers.

Community Health Accreditation Program (CHAP)

Investments in Technology

In 2013 CHAP launched a new suite of accreditation management software system, CHAP LinQ (Linking Innovation and Quality). The system is designed to enhance communication and transparency internally and with organizations seeking accreditation. It provides a comprehensive view of accreditation, from the initial application through the final determination and plan of correction. All organizations accredited by CHAP have access to the system. CHAP LinQ includes more robust data collection, documentation and reporting capabilities to monitor compliance and increase the consistency and quality of the CHAP accreditation process. The new technology platform is also better aligned with CMS assessment and reporting requirements, including the automation of reporting to ASSURE.

Performance Measurement and Improvement

A comprehensive review of CHAP accreditation processes was conducted to objectively evaluate how accreditation practices could be improved, resulting in more consistent, efficient and effective performance. Specific performance improvement activities included:

- An internal audit of accreditation practices led to process improvements in ASSURE reporting, standardization of accreditation letters to ensure consistency between data reported in ASSURE and facility notification letters, and an improved workflow in response to surveys with condition-level findings.
- A systematic review of the disparity rate for condition-level findings and other state validation surveys led to the development of a decision algorithm for assessment of deficiencies and a peer review program to increase the reliability of accreditation outcomes.
- Agency Plans of Correction (POCs), written in response to deficient survey findings, were assessed for consistency with CHAP policy and regulatory requirements resulting in the development of a POC evaluation and quality improvement instrument. As performance data are collected and aggregated, educational programs will be developed to support sustained performance improvement.

Surveyor Training and Education

An important aspect of CHAP's new accreditation management system is surveyor tools that standardize assessment and streamline internal and external reporting. CHAP surveyors participated in a series of training sessions and web-based courses throughout 2013 on the use of the new technologies to assess and analyze organizational performance. Training focused on improving surveyor skills associated with data collection, assessment of evidence, and documentation of findings. Additional guidance was provided related to conducting substantial allegation/complaint surveys and assessment of Condition Level and Immediate Jeopardy findings.

Center for Improvement in Healthcare Quality (CIHQ)

Identified Opportunity for Improvement

CIHQ identified an opportunity to transition the application process for facilities wishing to be accredited from a paper-based system to an electronic online system. The paper-based application process was cumbersome and required the client to print and, fill out, then either fax, scan, or email it to the corporate office.

Goal

Create and implement a user-friendly online accreditation application process used by clients that have selected CIHQ as their accrediting organization.

Actions Taken to Implement the Process

1. Software was developed by the information systems team that would allow an organization to create an account and then to complete the application for accreditation
2. The software was launched in a test environment.
3. The system was tested by CIHQ staff to assure functionality and ease of use.
4. The system was launched in the live environment.
5. Clients using the online process were interviewed regarding the ease of use and the functionality of the system.

Identified Opportunity for Improvement

CIHQ identified an opportunity to provide organizations that are accredited or have completed an application to become an accredited organization with the ability to have the CIHQ standards, the CMS Conditions of Participation (CoP) and the CMS Interpretive Guidance in the same location.

Goal
Create a tool to assist clients with compliance by placing the CIHQ and CMS Regulations side by side.

Actions Taken to Implement the Process
1. Software was developed by the information systems team that would allow an organization to access CIHQ and CMS regulations in one location.
2. The software was loaded with the CIHQ Requirements, CMS CoP and the CMS Interpretive Guidance.
3. The regulations and interpretive guidance were separated by tabs.
4. The system was tested by CIHQ staff to assure functionality and ease of use.
5. The system was launched in the live environment.
6. Clients were notified and in-serviced on the new online standard section of the website.

Identified Opportunity for Improvement
CIHQ identified an opportunity to provide organizations that are accredited or have completed an application to become an accredited organization with CIHQ interpretive guidance in an effort to be transparent and provide clients with information regarding standard interpretation and/or survey expectations.

Goal
Develop written interpretive guidance regarding CIHQ requirements to provide additional or clarifying information in order to assist organizations with compliance to the regulations. Additionally, a goal was set to attach the interpretive guidance to the specific requirement so that it is readily available and accessible when clients are viewing the CIHQ standards online.

Actions Taken to Implement the Process
1. Based in part on questions received from clients CIHQ Interpretive Guidance was written and placed in the online standard software program.
2. A decision was made to maintain the interpretive guidance by date in perpetuity and to update it as appropriate.
3. The interpretive guidance was placed in a separate tab for easy identification by clients.
4. The system was tested by CIHQ staff to assure functionality and ease of use.
5. The system was launched in the live environment.

Identified Opportunity for Improvement
CIHQ identified an opportunity to provide organizations that are accredited or have completed an application to become an accredited organization with resources from its affiliate division, Accreditation Resource Services (ARS), in the form of template policies, forms, and tools in order to provide a framework for compliance to CIHQ requirements.

Goal
Develop and make available template policies, forms or tools from ARS that accredited organizations may use to demonstrate documented compliance. Additionally, a goal was set to attach the resources to the specific requirement so that it is readily available and accessible when clients are viewing the CIHQ standards online and also to create a resource library so that clients can see all resources available.

Actions Taken to Implement the Process
1. Template policies, forms and tools were developed by ARS based on CIHQ requirements.
2. The resources were placed in the online standard software program using a link through the firewall to the ARS division of CIHQ.
3. A resource library of ARS documents was created that could be accessed by clients from the CIHQ homepage.
4. A separate tab entitled, "Resources to Assist You" was created in the online standards software program.
5. The system was tested by CIHQ staff to assure functionality and ease of use.
6. The system was launched in the live environment.

DNV GL Health Care (DNV GL)
DNV GL Healthcare (DNV GL) is pleased to provide information describing improvements regarding its accreditation program for Fiscal Year 2013.

Training Programs
DNV GL has expanded its training programs to focus on both developing and facilitating the implementation of an effective quality management system. This training program ties directly to its accreditation program to encompass the requirements of ISO 9001 which must be demonstrated by the hospital at the time of their re-accreditation under DNV GL. The course work is offered to all hospitals as a part of a curriculum that addresses auditing processes to enhance consistency and improve effectiveness of the quality management system.

Managing Infection Risk

DNV GL developed the first and only management standard on Biorisk – CWA 15793, sponsored by 24 countries (co-shared with U.S. Department of Agriculture). Based on this standard, DNV has launched a Managing Infection Risk Management Certification Program for designation of excellence to effectively reduce the risk of healthcare acquired infections. This provides a framework to enhance the management of infection risks and work at changing organizational culture and practice by meeting requirements outlined in 18 respective elements that include both infection preventionists and engage the hospital staff by focusing on proactive risk assessment strategies to identify hazards to mitigate risks beyond the aspects of traditional surveillance methods.

Ventricular Assist Devices-Application to CMS for Approval

DNV submitted its formal application to CMS on 11/8/13 to be recognized as a VAD Credentialing Organization. This application was submitted pursuant to the CMS Decision Memo for Ventricular Assist Devices for Bridge-to-Transplant and Destination Therapy (CAG-00432R) (Decision Memo) and the Process for CMS Approval of Credentialing Organizations specified in the Decision Memo. CMS responded to DNV on January 23, 2014 with some questions and a request for additional information. DNV is working on its response to CMS to clarify the outstanding issues. This may be one of the first applications of this nature to CMS under the new protocol and the CMS review is not bound by any specific time frame.

Research and Innovation

- **Development of a person-centered care guide:** Focusing on how person-centered care can provide a solution to the many challenges healthcare is facing. This guide will also focus on how to overcome the obstacles. This is a co-production with a Danish professional group funded by DNV. This is planned to launch this year.
- **Safety culture assessment:** Taking best practice from other safety-critical industries in assessing safety culture with the aim of identifying areas for improvement. We will apply a mixed method that DNV applies in other industries. We are piloting this in the United Kingdom, with the aim of this being a service we can provide to the customers in the US, as a differentiator for accreditation.
- **Models for risk management:** Looking to other safety-critical industries to see how they manage safety. DNV GL is focusing on safety cases (assurance cases) as a model to manage risk in healthcare. DNV GL is applying known methods such as the bow-tie to identify and communicate risk. This project is in the early stages, with the first output later this year describing this as a concept in healthcare.

DNV GL 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 (Form 2567) for Validation Surveys completed of DNV accredited hospitals. This information is used to identify common findings and assist surveyors to improve the consistency of the survey process. This has helped in identifying focus areas for survey and helping to identify issues to facilitate a better understanding of the CMS Conditions of Participation.

The Joint Commission (TJC)

The Joint Commission is pleased to provide information on the various initiatives implemented during the past year to enhance the effectiveness of the Joint Commission's accreditation process and improve patient safety and quality. These initiatives are:

1. Continued recognition of the Top Performer on Key Quality Measures™ Program for hospitals and critical access hospitals that attain and sustain excellence in accountability measure performance: Almost all of the Joint Commission's accountability measures have been recognized for inclusion in CMS' Value-Based Purchasing program. In the Joint Commission's 2013 Annual Report on Quality and Safety, 1,099, representing 33 percent of Joint Commission-accredited hospitals, were identified as attaining and sustaining excellence in accountability measure performance 2012. This represents an increase of 77 percent from 2011 in terms of the total number of hospitals achieving this distinction, including a total of 424 hospitals that achieved the distinction for a second straight year and 182 hospitals that achieved the distinction for the third consecutive year.

2. Continued emphasis on finding solutions to health care's most critical safety and quality problems: Since its establishment in 2009, The Joint Commission Center for Transforming Healthcare has launched seven projects in collaboration with hospitals and health systems that include hand hygiene compliance, wrong site surgery prevention, hand-off communication, surgical site infection reduction, avoidable heart failure hospitalization prevention, safety culture improvement, the

prevention of falls with injury, reducing sepsis mortality, and reducing insulin related medication errors. Additional resources are provided to Joint Commission accredited organizations via the *Targeted Solutions Tool*™, which allows facilities to share their successful practices, experiences, and helps them, evaluate their own unique concerns and solutions.

3. Collaborating with the Institute for Healthcare Improvement (IHI) to improve hand hygiene: The Joint Commission Center for Transforming Healthcare's *Targeted Solutions Tool*™ (TST) for Hand Hygiene was featured in IHI's Expedition program: "Impacting Hand Hygiene at the Frontline". Beginning in July 2013, the Expedition program was created as a series of six web-based sessions designed to help more hospitals achieve higher rates of hand washing compliance. The Expedition program offered the latest ideas, methods, and systems for increasing hand washing and reducing infections, including better techniques for surveillance, monitoring, measurement, engineering, and education with a focus on changing behavior and culture.

4. Continuation of a three-year initiative to define methods for achieving improvement in the effectiveness of the transitions of patients between health care organizations, which provide for the continuation of safe, quality care for patients in all settings: All three components of The Joint Commission enterprise (The Joint Commission, Joint Commission Resources, and the Center for Transforming Healthcare) continued to develop interventions and resources that are designed collectively to improve transitions of care. The interventions apply to the Joint Commission's accreditation programs for hospitals, critical access hospitals (CAHs), behavioral health care, home care, long term care, and ambulatory care settings. In 2013, the Joint Commission organized a series of learning visits and focus groups to better understand the progress organizations are making and the challenges that they continue to face in these areas. The common element identified was the need for collaboration. In addition, there were seven "foundations" identified for organizations to establish to assure safe transitions from one healthcare setting to another:

- Leadership support;
- Multidisciplinary collaboration;
- Early identification of patients/clients at risk;
- Transitional planning;
- Medication management;
- Patient and family action/engagement; and
- Transfer of information.

Introduction of Sentinel Event Alert #50: Medical Device Alarm Safety

The Joint Commission developed this complimentary publication to help healthcare organizations and health care professionals identify specific types of sentinel events, describe their common underlying causes, and suggest steps to prevent occurrences in the future. Many healthcare settings contain numerous alarm-equipped medical devices that clinicians depend on to deliver appropriate care and guide treatment decisions. However, these devices present a multitude of challenges and opportunities for healthcare organizations when their alarms create similar sounds, when their default settings are not changed, and when there is a failure to respond to their alarm signals. The Joint Commission Sentinel Event database includes reports of 98 alarm-related events between January 2009 and June 2012. Of the 98 reported events, 80 resulted in death, 13 in permanent loss of function, and five in unexpected additional care or extended stay. In June 2013, the Joint Commission approved a new National Patient Safety Goal (NPSG.06.01.01) on clinical alarm safety for hospitals and critical access hospitals. Beginning January 1, 2014, hospitals are required to establish alarms as an organization priority and identify the most important alarms to manage based on their own internal situations.

Introduction of Sentinel Event Alert #51: Preventing the Unintended Retention of Foreign Objects (URFO) following surgical procedures

This alert urges hospitals and ambulatory surgical centers to revisit how to avoid leaving items such as sponges, towels and instruments in a patient's body after surgery. Specifically, this publication encourages hospitals and ambulatory surgical centers to:

- Create highly reliable standardized counting system to prevent URFOs;
- Develop and implement effective evidence-based organization-wide standardization policy and procedures for the prevention of URFOs;
- Institute team briefings and debriefings as a standard part of the surgical procedure to allow the opportunity for any team members to express concerns regarding the safety of the patient, including the potential for an URFO;
- Ensure the surgeon verbally verifies the results of the counting procedure;

- Document the results of counts of surgical items, instruments, or items intentionally left inside a patient and actions should count discrepancies occur; and
- Research the potential of using assistive technologies to supplement manual counting procedures and methodical wound exploration.

Working with the federal Office of the National Coordinator for Health Information Technology (ONC) to address a key recommendation in the Institute of Medicine (IOM) report 'Health IT and Patient Safety: Building Safer Systems for Better Care'

The Joint Commission was awarded a sole source contract from the ONC to help identify and prevent unsafe health IT conditions associated with serious patient safety events through the evaluation of aggregate data and the review of root cause analyses to increase public knowledge of and prevention strategies for sentinel events.

Diagnostic imaging service requirements

The areas addressed in the new and revised Elements of Performance are focused on quality and safety issues within the diagnostic imaging arenas within hospitals, CAHs and ambulatory healthcare organizations and include the following:

Minimum qualifications for radiologic technologists, including registration and certification, and participation in annual training;

- Annual performance evaluations of imaging equipment by a medical physicist;
- Quality control and maintenance activities for preserving the quality of diagnostic images;
- Compiling and analyzing data on patient radiation doses; and
- Verifying correct patient, patient position, imaging site, imaging protocol (computed tomography only), and scanner parameters (computed tomography only) prior to imaging studies.

These requirements align with the Joint Commission's goal to assist organizations with evaluating areas of risk associated with increased or overexposure to radiation, and reviewing their processes to ensure they are providing radiologic services in a safe and effective manner.

SECTION 7: CMS Improvements

The number of CMS-approved accreditation options for health care facilities has grown significantly since 2007. By mid FY 2012 there were eight CMS-recognized AOs and 20 approved programs covering eight facility types. The volume of facilities that participate in the Medicare programs through accreditation by a CMS-approved accreditation program continued to grow in FY 2013. Currently, 36 percent of all Medicare-participating facilities that have an approved accreditation program option, nearly 13,000 facilities, demonstrate compliance with the Medicare requirements and participate in the Medicare program via accreditation and deemed status.

During this same time frame, CMS has significantly strengthened its program oversight. CMS has worked to enhance systems and processes to ensure the completeness and accuracy of the data exchange between AOs and CMS regarding deemed facilities, and the management and analysis of that data. In FY 2013, CMS focused on a number of key areas in order to continue to refine and maintain an effective oversight infrastructure:

- CMS/AO Communication and Relationship Building
- AO Education
- AO Performance Management
- Deemed Facility Data

CMS/AO Communication and Relationship Building

Communications

CMS continues its periodic meetings with recognized national AOs, including quarterly teleconferences and an annual face-to-face meeting. These meetings serve to foster communication between the AOs and CMS, and serve as a forum to: discuss operational and programmatic issues, 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, requirements, interpretation of regulations, and data.

Consultation

CMS increased opportunities for AOs as well as for other stakeholders to provide input into the development of sub-regulatory guidance concerning Medicare standards and survey processes. CMS

has committed to ongoing consultation in an effort to provide comprehensive, current guidance for surveyors and health care providers.

AO Education

CMS affords AO staff many opportunities for education. CMS provides detailed, written and verbal feedback to the AOs as part of the deeming application and data review processes. This feedback includes specific reference to Medicare regulatory requirements as well as CMS official interpretation of these requirements. 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. In March of 2013, CMS provided the AOs with a three day training session on the new web-based ASSURE database. During this training, the AOs were introduced to the new functionality, processes and requirements of web-ASSURE.

AO Performance Management

Deeming Application, Standards, and Survey Process Reviews

Deeming application, standards, and survey process reviews are conducted by a team of trained analysts to ensure consistent application of a standardized rigorous review methodology. All findings are subject to detailed supervisory review to enhance reliability and consistency. As a result, AO applications, standards, and survey process are reviewed comprehensively and consistently, and areas for improvement are being identified and communicated to the AOs for revision, as necessary, before applications may be approved.

In FY 2013, the team completed eight deeming application reviews (one application was withdrawn prior to publication) and three standards reviews. CMS also identified and addressed 41 issues outside an application review that arose in case-specific instances which suggested problems with the manner in which an AO implemented its CMS-approved accreditation program. Through this case-based process, CMS facilitated resolution of issues, and improved AO performance and oversight of deemed facilities. (See Section 1 for discussion of CMS' review of AO accreditation programs.)

AO Performance Measures

CMS continues to refine and improve the current methods for measuring AO performance in assuring compliance with the Medicare requirements. Measures are calculated and shared with individual AOs on a quarterly basis. Measures are reviewed, evaluated and updated on an annual basis. (See Section 5 for discussion of FY 2013 AO Performance Measures).

Deemed Facility Data

CMS continues to focus on obtaining complete, accurate and timely data from AOs on facilities accredited under their CMS-approved accreditation programs. This has been a major challenge for both CMS and the AOs. ASSURE, a CMS electronic database to inventory and track AO actions that affect the deemed status of a facility, enables the AOs to provide demographic and survey activity information for deemed facilities to CMS on a monthly basis. It provides both CMS and the AOs with the means to collect, analyze, and manage data regarding deemed facilities, and supports CMS oversight of the AOs and their CMS-approved accreditation programs.

In May of 2013, CMS replaced its desktop version of the ASSURE database with a web-based application. Web-ASSURE now centralizes data capture and reporting; supports the integration of AO data into the existing CMS Quality Improvement Evaluation System (QIES) infrastructure for network access; ensures that data conforms to the national data structures framework; and allows for Certification and Survey Provider Enhanced Reports (CASPER) authentication and reporting. The web-based version of ASSURE decreases the time and effort required to maintain and update the data in ASSURE for both the AOs and CMS. Internet accessibility greatly increases access to facility and survey data and allows for changes to be made in real time.

Benefits of the web-based ASSURE system include:

- Increased functionality;
- Ability for AO continued use of their own proprietary systems;
- One central database versus multiple decentralized databases;
- Increased accessibility;
- Enhanced system integrity and data security;
- More adaptable by providing the capability for more timely reporting of vital program information—AOs now submit data on a monthly versus quarterly basis;
- Improved processing times;
- Stronger and more simplified procedures for reconciling AO data with data contained in the national database;

- Electronic matching of deemed facility records with records in the national database on a nightly basis, increasing record accuracy;
- Direct database entries are updated in real time;
- Pre-validation function allows the AO to review and address errors before the actual import of data is made to the system. The test mode processes the import file and returns an error/success message immediately, without loading the data into ASSURE. This removes the possibility of a data file submission which may contain errors related to imposed business rules;
- Immediately match facilities with CCNs to facilities already in the national database; and
- Software updates and system backups are managed centrally by CMS.

CLINICAL LABORATORY IMPROVEMENT VALIDATION PROGRAM

Introduction

This report on the Clinical Laboratory Improvement Validation Program covers the evaluations of fiscal year (FY) 2013 performance by the six accreditation organizations approved under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The six organizations are as follows:

- AABB
- American Osteopathic Association (AOA)
- American Society for Histocompatibility and Immunogenetics (ASHI)
- COLA
- College of American Pathologists (the College)
- The Joint Commission (JC)

CMS appreciates the cooperation of all of the organizations in providing their inspection schedules and results. While an annual performance evaluation of each approved accreditation organization is required by law, we see this as an opportunity to present information about, and dialogue with, each organization as part of our mutual interest in improving the quality of testing performed by clinical laboratories across the Nation.

Legislative Authority and Mandate

Section 353 of the Public Health Service Act, as amended by CLIA, requires any laboratory that performs testing on human specimens to meet the requirements established by HHS and have in effect an applicable certificate. Section 353 further provides that a laboratory meeting the standards of an approved accreditation organization may obtain a CLIA Certificate of Accreditation. Under the CLIA Certificate of Accreditation, the laboratory is not routinely subject to direct Federal oversight by CMS. Instead, the laboratory receives an inspection by the accreditation organization in the course of maintaining its accreditation, and by virtue of this accreditation, is "deemed" to meet the CLIA requirements. The CLIA requirements pertain to quality assurance and quality control programs, records, equipment, personnel, proficiency testing, and others to assure accurate and reliable laboratory examinations and procedures.

In section 353(e) (2) (D), the Secretary is required to evaluate each approved accreditation organization by inspecting a sample of the laboratories they accredit and "such other means as the Secretary determines appropriate." In addition, section 353(e) (3) requires the Secretary to submit to Congress an annual report on the results of the evaluation. This report is submitted to satisfy that requirement.

Regulations implementing section 353 are contained in 42CFR part 493 Laboratory Requirements. Subpart E of part 493 contains the requirements for validation inspections, which are conducted by CMS or its agent to ascertain whether the laboratory is in compliance with the applicable CLIA requirements. Validation inspections are conducted no more than 90 days after the accreditation organization's inspection, on a representative sample basis or in response to a complaint. The results of these validation inspections or "surveys" provide:

- on a laboratory-specific basis, insight into the effectiveness of the accreditation organization's standards and accreditation process; and
- in the aggregate, an indication of the organization's capability to assure laboratory performance equal to or more stringent than that required by CLIA.

The CLIA regulations, in section 493.575 of subpart E, provide that if the validation inspection results over a one-year period indicate a rate of disparity of 20 percent or more between the findings in the accreditation organization's results and the findings of the CLIA validation surveys, CMS will re-evaluate whether the accreditation organization

continues to meet the criteria for an approved accreditation organization (also called "deeming authority"). Section 493.575 further provides that CMS has the discretion to conduct a review of an accreditation organization program if validation review findings, irrespective of the rate of disparity, indicate such widespread or systematic problems in the organization's accreditation process that the requirements are no longer equivalent to CLIA requirements.

Validation Reviews

The validation review methodology focuses on the actual implementation of an organization's accreditation program described in its request for approval. The accreditation organization's standards, as a whole, were approved by CMS as being equivalent to or more stringent than, the CLIA condition-level requirements[9], as a whole. This equivalency is the basis for granting deeming authority.

In evaluating an organization's performance, it is important to examine whether the organization's inspection findings are similar to the CLIA validation survey findings. It is also important to examine whether the organization's inspection process sufficiently identifies, brings about correction, and monitors for sustained correction, laboratory practices and outcomes that do not meet their accreditation standards, so that equivalency of the accreditation program is maintained.

The organization's inspection findings are compared, case-by-case for each laboratory in the sample, to the CLIA validation survey findings at the condition level. If it is reasonable to conclude that one or more of those condition-level deficiencies were present in the laboratory's operations at the time of the organization's inspection, yet the inspection results did not note them, the case is a disparity. When all of the cases in each sample have been reviewed, the "rate of disparity" for each organization is calculated by dividing the number of disparate cases by the total number of validation surveys, in the manner prescribed by section 493.2 of the CLIA regulations.

Number of Validation Surveys Performed

As directed by the CLIA statute, the number of validation surveys should be sufficient to "allow a reasonable estimate of the performance" of each accreditation organization. A representative sample of more than 16,000 accredited laboratories received a validation survey in 2013. 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 are performed in laboratories accredited by those organizations. Due to limited resources during the FY2013 CLIA survey cycle, there were no AABB or AOA validation surveys performed. However, each of these organizations participate fully in the performance measures efforts within The Partners for Laboratory Oversight group. The overwhelming majority of accredited laboratories in the CLIA program used their accreditation by COLA, the College or the JC, thus the sample sizes for these organizations were larger. The sample sizes are roughly proportionate to each organization's representation in the universe of accredited laboratories; however, true proportionality is not always possible due to the complexities of scheduling.

The number of validation surveys performed for each organization is specified below in the summary findings for the organization.

Results of the Validation Reviews of Each Accreditation Organization

AABB

Rate of disparity: see below.

In FY 2013, approximately 220 laboratories used their AABB accreditation for CLIA program purposes. Constraints on resources coupled with a limited number of laboratories identified as meeting the selection criteria, i.e., laboratory had not received a validation survey during the previous survey cycle and the CLIA survey could

[9] *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.*

be performed within 90 days of AABB's inspection date, has resulted in zero validation surveys performed during the FY2013 survey cycle. CMS is closely monitoring the selection for the FY2014 survey cycle and can confirm that a representative sample set of surveys have been performed. Additionally, as a member of The Partners in Laboratory Oversight, AABB submits annual performance measures that are closely monitored by CMS.

American Osteopathic Association

Rate of disparity: see below

For CLIA purposes, approximately 130 laboratories used their AOA accreditation. Constraints on resources coupled with a limited number of laboratories identified as meeting the selection criteria, i.e., laboratory had not received a validation survey during the previous survey cycle and the CLIA survey could be performed within 90 days of AO''s inspection date, has resulted in zero validation surveys performed during the FY2013 survey cycle. CMS is closely monitoring the selection for the FY2014 survey cycle and can confirm that a representative sample set of surveys have been performed. Additionally, as a member of The Partners in Laboratory Oversight, AOA submits annual performance measures that are closely monitored by CMS.

American Society for Histocompatibility and Immunogenetics

Rate of disparity: zero percent

Approximately 120 laboratories used their ASHI accreditation for CLIA purposes. A validation survey was conducted in one ASHI-accredited laboratory. No condition-level deficiencies were cited. When a validation survey results in compliance with the CLIA condition-level requirements, as is the case with the ASHI-accredited laboratory this year, disparity is precluded. We commend the ASHI for its history of zero percent disparity in 17 out of the past 18 validation reviews.

COLA

Rate of disparity: 12 percent

A total of 179 validation surveys were conducted in COLA-accredited laboratories. Two surveys were removed from the review pool for administrative reasons. Of the remaining 177, twenty-eight laboratories were cited with condition-level deficiencies. In six of those laboratories, COLA findings were comparable to all of the CLIA condition-level deficiencies cited. In the remaining 22 laboratories, however, COLA noted comparable findings to only some or none of the CLIA condition-level deficiencies cited; thus, there were 22 disparate cases yielding a disparity rate of 12 percent.

College of American Pathologists

Rate of disparity: 17 percent

A total of 103 validation surveys were conducted in CAP-accredited laboratories. Two surveys were removed from the review pool for administrative reasons. Of the remaining 101 cases, 19 laboratories were cited with CLIA condition-level deficiencies. In two of those laboratories, the College noted comparable findings to all of the CLIA condition-level deficiencies cited. In the remaining 17 laboratories, however, the College noted comparable findings to only some or none of the CLIA condition-level deficiencies cited; thus, there were 17 disparate cases for a disparity rate of 17 percent.

The Joint Commission

Rate of disparity: 21 percent

During this validation period, a total of 44 validation surveys were conducted in JC-accredited laboratories. One survey was removed from the validation review pool for administrative reasons. Of the remaining 43 validation surveys, 10 laboratories were cited with CLIA condition-level deficiencies. In one of those laboratories, the JC findings were comparable to all of the CLIA condition-level deficiencies cited. In the other 9 laboratories, however, the JC noted comparable findings to only some or none of the CLIA condition-level deficiencies cited; thus, there were 9 disparate cases yielding a disparity rate of 21 percent. Because this disparity rate exceeds the allowable regulatory limit, CMS will be closely following up with JC on their response and root cause analysis used to determine the source of the disparities and their action plan to implement programs to ensure more effective laboratory oversight to enable CMS to determine whether the accreditation organization continues to meet the criteria for an approved accreditation organization.

Conclusion

CMS has performed this statutorily-mandated validation review in order to evaluate and report to Congress on the performance of the six laboratory accreditation organizations approved under CLIA. This endeavor is two-fold: to verify each organization's capability to assure laboratory

performance equal to, or more stringent than, that required by CLIA ("equivalency"); and to gain insight into the effectiveness of the accreditation organization's standards and accreditation process on a laboratory-specific basis.

CMS recognizes that similarity of accreditation organization findings to CLIA validation survey findings is an important measure of the organization's capability to ensure equivalency and effectiveness of oversight. Another important measure is an organization's capability to sustain equivalency and effectiveness of oversight. When an accredited laboratory's practices and outcomes fail to conform fully to the accreditation standards, it is important that the accreditation organization's inspection protocol sufficiently identifies the deficiencies, brings about correction and monitors for sustained compliance, so that the laboratory is again in full conformance with the accreditation standards and equivalency is sustained.

In the interest of furthering the mutual goal of promoting quality testing in clinical laboratories and furthering the goal of sustained equivalency, CMS has formed the Partners in Laboratory Oversight group. The group includes the six accreditation organizations. It meets regularly to discuss and resolve issues of mutual interest and to share best practices. The group endeavors to improve their overall consistency in application of laboratory standards, coordination, collaboration and communication in both routine and emergent situations. Through these efforts we hope to further improve the level of laboratory oversight and ultimately, patient care

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.

Advance Premium Tax Credit: A tax credit in an amount based on the costs of health plans in the applicable marketplace and the amount of household income as compared to the poverty line.

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

B

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

Beneficiary: A person entitled under the law to receive Medicare or Medicaid benefits (also referred to as an enrollee).

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

C

Carrier: A private business, typically an insurance company, that contracts with CMS to receive, review, and pay physician and supplier claims. Carriers have been largely replaced by Medicare Administrative Contractors.

Cash Basis Accounting: A basis of accounting that tracks outlays or new expenditures during the current period regardless of the fiscal year the service was provided or the expenditure was incurred.

Chief Financial Officers Act of 1990 (CFO): The CFO Act of 1990 established a leadership structure, provided for long range planning, required audited financial statements, and strengthened accountability reporting. The aim of the CFO Act is to improve financial management systems and information, and require the development and maintenance of agency financial management systems that comply with: applicable accounting principles, standards, and requirements; internal control standards; and requirements of the Office of Management and Budget (OMB), the Department of the Treasury, and others.

Children's Health Insurance Program (CHIP) (also known as title XXI): CHIP (previously known as the State Children's Health Insurance Program, or SCHIP) was originally created in 1997 as title XXI of the Social Security Act. CHIP is a state and Federal partnership that targets uninsured children and pregnant women in families with incomes too high to qualify for Medicaid but often too low to afford private coverage.

Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009: The CHIPRA extended and expanded CHIP which was enacted as part of the Balanced Budget Act of 1997 (BBA).

Clinical Laboratory Improvement Amendments of 1988 (CLIA): Requires any laboratory that performs testing on specimens derived from humans to meet the requirements established by the Department of Health and Human Services and have in effect an applicable certificate.

Common Working File (CWF): A pre-payment claims validation and Medicare Part A/Part B benefit coordination system, which uses localized databases, maintained by a host contractor.

Consumer Operated and Oriented Plan Program (CO-OP): The Affordable Care Act calls for the establishment of the CO-OP Program, which will foster the creation of qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets.

Corrective Action Plan (CAP): The detailed actions that are taken to resolve an audit finding or internal control deficiency.

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

Cost Sharing Reduction: Payments to health care insurers on behalf of eligible insured based on the amount of household income for the insured as compared to the poverty line.

D

The Debt Collection Improvement Act of 1996 (DCIA of 1996): The DCIA requires Federal agencies to refer delinquent non-tax debts to the Department of Treasury's Financial Management Service (FMS) for purposes of collection by offset of non-tax payments. Non-tax payments include vendor, Federal retirement, Federal salary, and Social Security benefits.

Deficit Reduction Act of 2005: The Deficit Reduction Act restrains Federal spending for entitlement programs (i.e., Medicare and Medicaid) while ensuring that Americans who rely on these programs continue to get needed care. Provisions of the act include a requirement for wealthier seniors to pay higher premiums for their Medicare coverage; restrain Medicaid spending by reducing Federal overpayment for prescription drugs so that taxpayers do not have to pay inflated markups; and includes increased benefits to students and to those with the greatest need.

Demonstrations: Projects that allow CMS to test various or specific attributes such as payment methodologies, preventive care, and social care, and determine if such projects/pilots should be continued or expanded to meet the health care needs of the Nation. Demonstrations are used to evaluate the effects and impact of various health care initiatives and the cost implications to the public.

Discretionary Spending: Outlays of funds subject to the Federal appropriations process.

Disproportionate Share Hospital (DSH): A hospital with a disproportionately large share of low-income patients. Under Medicaid, states augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

Durable Medical Equipment (DME): Purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

Durable Medical Equipment Medicare Administrative Contractors (DME MACs): In an effort to provide greater efficiency in the Medicare program as it applies to Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), CMS awarded contracts to four health care contractors which cover a specific geographic region of the country and only process Medicare claims for DMEPOS items.

E

Early Retiree Reinsurance Program (ERRP): The ERRP provides reimbursement to employer and union sponsors of participating employment-based plans for a portion of the cost of health benefits for early retirees and their spouses, surviving spouses and dependents.

Electronic Health Record (EHR): An EHR is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users.

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

Expense: An outlay or an accrued liability for services incurred in the current period.

F

Federal Financial Management Improvement Act of 1996 (FFMIA): The FFMIA requires agencies to have financial management systems that substantially comply with the Federal management systems requirements, standards promulgated by the Federal Accounting Standards Advisory Board (FASAB), and the U.S. Standard General Ledger (USSGL) at the transaction level.

Federal General Revenues: Federal tax revenues (principally individual and business income taxes) not identified for a particular use.

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

Federal Insurance Contribution Act (FICA) Payroll Tax: Medicare's share of FICA is used to fund the HI trust fund. Employers and employees each contribute 1.45 percent of taxable wages, with no compensation limits, to the HI trust fund.

Federal Managers' Financial Integrity Act (FMFIA): A program that identifies management inefficiencies and areas vulnerable to fraud and abuse so that such weaknesses can be corrected with improved internal controls.

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

Fiscal Intermediary (FI): A private business—typically an insurance company—that contracts with CMS to process hospital and other institutional provider benefit claims. FIs have been largely replaced by Medicare Administrative Contractors.

Fiscal Intermediary Shared System (FISS): The shared claims adjudication system for Part A Medicare claims.

G

Government and Performance and Results Act Modernization Act (GPRA Modernization Act): Amends the Government Performance and Results Act of 1993 to require each executive agency to make its strategic plan available on its public website and to the Office of Management and Budget (OMB) on the first Monday in February of any year following that in which the term of the President commences and to notify the President and Congress.

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

H

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

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

Health Information Exchange (HIE): The electronic sharing of health-related information among organizations.

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

Health Information Technology for Economic and Clinical Health Act (HITECH): The American Recovery and Reinvestment Act of 2009 (ARRA) includes the "HITECH Act," which established programs under Medicare and Medicaid to provide incentive payments to eligible professionals (EPs), hospitals, and critical access hospitals for the "meaningful use" of certified EHR technology.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Major provisions include portability provisions for group and individual health insurance, established the Medicare Integrity Program, and provides for standardization of health data and privacy of health records.

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

I

Improper Payments Elimination and Recovery Act (IPERA): In FY 2010, Congress amended the Improper Payment Information Act (IPIA), which is now known as the Improper Payment Eliminations and Recovery Act (IPERA) (Public Law 111-204), to aim in standardizing the way Federal agencies report improper payments in programs they oversee or administer. The IPERA includes requirements for identifying and reporting improper payments and defines improper payments as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments). Incorrect payments also include payments to ineligible recipients or payments for ineligible services, as well as duplicate payments and payments for services not received.

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

Internal Controls: Management's tools, such as the organization's policies and procedures, that help program and financial managers achieve results and safeguard the integrity of their programs. Such controls include program, operational, and administrative areas, as well as accounting and financial management.

M

Mandatory Spending: Outlays for entitlement programs such as Medicaid and Medicare benefits.

Marketplace: See definition for Health Care Exchanges.

Material Weakness: A deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.

Medicaid: A joint Federal and state program that helps with medical costs for persons with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if one qualifies for both Medicare and Medicaid.

Medical Review/Utilization Review (MR/UR): Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

Medicare: Medicare is the Federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicare Administrative Contractor (MAC): A private entity that CMS contracts with under section 1874A of the Social Security Act, as added by the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003. The Part A and Part B MACs handle Medicare Part A and Medicare Part B claims processing and related services under the MMA, and DME MACs handle Medicare claims for Durable Medical Equipment.

Medicare Advantage (MA) Program (Part C): This program reforms and expands the availability of private health options that were previously offered to Medicare beneficiaries by allowing for the establishment of new regional preferred provider organizations plans as well as a new process for determining beneficiary premiums and benefits. Title II of MMA modified and renamed the existing Medicare+Choice program established under title XVIII of the Social Security Act to the MA program.

Medicare Integrity Program (MIP): The program established by HIPAA to promote the integrity of the Medicare program, as specified in Section 1893 of the Social Security Act.

Medicare, Medicaid, and State Children's Health Insurance Program Extension Act 2007: Legislation that extended the original CHIP budget authority.

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA): Legislation passed that established a new program in Medicare to provide a prescription drug benefit, Medicare Part D, which became available on January 1, 2006. Additionally, MMA sets forth numerous changes to existing programs, including a revised managed care program, certain payment reforms, rural health care improvements, and other changes involving administrative improvements, regulatory reduction, administrative appeals, and contracting reform.

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

Medicare Secondary Payer (MSP): A statutory requirement that private insurers who provide general health insurance coverage to Medicare beneficiaries must pay beneficiary claims as primary payers.

Medicare Trust Funds: Treasury accounts established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for the HI and SMI programs.

Multi-Carrier System (MCS): The shared claims adjudication system for Part B Medicare claims.

N

National Institute of Standards and Technology (NIST): A non-regulatory Federal agency within the U.S. Department of Commerce. The NIST mission is to promote U.S. innovation and industrial competitiveness by advancing measurement science, standards, and technology in ways that enhance economic security and improve our quality of life.

O

Obligation: Budgeted funds committed to be spent.

Office of Management and Budget (OMB) Circular A-123: Circular that provides guidance to Federal managers on improving the accountability and effectiveness of Federal programs and operations by establishing, assessing, correcting, and reporting on management's controls. The Circular is issued under the authority of the Federal Managers' Financial Integrity Act of 1982.

Outlay: Budgeted funds actually spent. When used in the discussion of the Medicaid program, outlays refer to amounts advanced to the states for Medicaid benefits.

P

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

Part B: The part of Medicare that pays physician and supplier claims also referred to as Medicare Supplementary Medical Insurance or "SMI."

Part C: Medicare Advantage Program.

Part D: Medicare Prescription Drug Benefit.

Patient Protection and Affordable Care Act (Affordable Care Act) (P.l. 111-148): In FY 2010, Congress passed, and the President signed into law, the Affordable Care Act which puts in place comprehensive health insurance reforms that will hold insurance companies more accountable, lower the deficit, provide more health care choices, and enhance the quality of health care for all Americans. Once fully implemented, the Affordable Care Act will provide Americans with access to affordable health coverage by setting up a new competitive private health insurance market, holding insurance companies accountable by keeping premiums down and preventing many types of insurance industry abuses and denials of care, and ending discrimination against Americans with pre-existing conditions.

Payment Safeguards: Activities to prevent and recover inappropriate Medicare benefit payments, including MSP, MR/UR, provider audits, and fraud and abuse detection.

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

Program Management: The CMS operational account which supplies CMS with the resources to administer Medicare, the Federal portion of Medicaid, and other CMS responsibilities. The components of Program Management are: Medicare contractors, survey and certification, research, and administrative costs.

Provider: A health care professional or organization that provides medical services.

Q

Qualified Health Plans: Health insurance plans which meet minimum standards for health benefit coverage.

Quality Improvement Organizations (QIOs): Formerly known as Peer Review Organizations (PROs), QIOs monitor the quality of care provided to Medicare beneficiaries to ensure that health care services are medically necessary, appropriate, provided in a proper setting, and are of acceptable quality.

R

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

Retiree Drug Subsidy Program: The retiree drug subsidy (RDS) is one of several options available under Medicare that enables employers and unions to continue assisting their Medicare eligible retirees in obtaining more generous drug coverage.

Revenue: The recognition of income earned and the use of appropriated capital from the rendering of services in the current period.

Risk-Based Health Maintenance Organization (HMO)/Competitive Medical Plan (CMP): A type of managed care organization. After any applicable deductible or co-payment, all of an enrollee/member's medical care costs are paid for in return for a monthly premium. However, due to the "lock-in" provision, all of the enrollee/member's services (except for out-of-area emergency services) must be arranged for by the risk HMO. Should the Medicare enrollee/member choose to obtain service not arranged for by the plan, he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for services from providers that are not part of the HMO's health care system/network.

S

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

Significant Deficiency: Is a deficiency, or a combination of deficiencies, in internal control that is less serve 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.

Statement on Standards for Attestation Engagements (SSAE) Number 16 (SSAE 16): A report issued by an independent public accountant in accordance with standards promulgated by the American Institute of Certified Public Accountants (AICPA) on the internal controls of a servicing organization. The AICPA SSAE 16 defines the professional standard used by a service organization's auditor to assess the internal controls at a service organization.

Supplementary Medical Insurance (SMI) (Part B): The part of Medicare that pays physician and supplier claims also referred to as Part B.

T

Tax Relief and Health Care Act: Legislation that required HHS to implement the Medicare FFS Recovery Audit Program in all 50 states no later than January 1, 2010.

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

V

ViPS Medicare System (VMS): The standard claims adjudication system for Medicare Durable Medical Equipment (DME) claims.

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

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