Financial Report

FISCAL YEAR
2020

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 Agency Financial Report for fiscal year (FY) 2020 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:

MANAGEMENT'S DISCUSSION & ANALYSIS

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

FINANCIAL SECTION

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

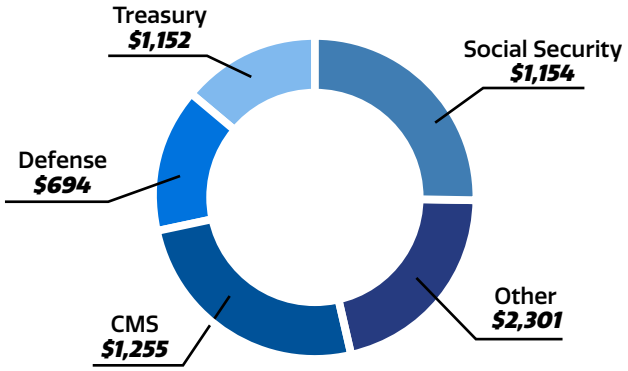
OTHER INFORMATION

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

2020 FEDERAL OUTLAYS

CMS has outlays of approximately $1,255 billion (net of offsetting receipts and payments of the Health Care Trust Funds) in fiscal year (FY) 2020, approximately 19 percent of total Federal outlays.

CMS employs approximately 6,300 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 (U.S.).

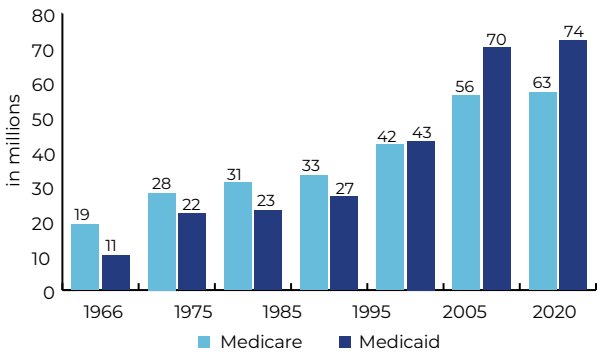


$ in billions

Source: U.S. Department of the Treasury

2020 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 63 million beneficiaries. Medicaid enrollment has increased from 11 million beneficiaries in 1966 to about 74 million beneficiaries.



A MESSAGE FROM THE ADMINISTRATOR

SEEMA VERMA

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2020 CMS Agency Financial Report (AFR).

We are the nation's largest insurer, covering over 140 million Americans through Medicare, Medicaid, CHIP, and the health insurance exchanges. Our responsibility to set essential quality and safety standards also gives us regulatory authority over virtually the entire health care system. It is difficult to overstate the importance of that role.

The importance of that role and the weight it carries has been unprecedented this year during the 2019 Novel Coronavirus Disease (COVID-19) public health emergency (PHE). The pandemic has tested CMS in ways that would have been unimaginable at the start of the year, but the agency has repeatedly met and exceeded expectations. From the beginning, we have led efforts to protect some of our nation's most vulnerable citizens and support the health care system in its hour of extreme need.

CMS coordinated with our colleagues in the Department of Health and Human Services (HHS) as well as the Federal Emergency Management Agency (FEMA) to support efforts related to the COVID-19 response. This included a wide variety of actions. For example, CMS assisted FEMA as it shipped out millions of critical supplies to nursing homes and coordinated with the HHS Office of the Assistant Secretary for Health (OASH) to distribute point-of-care testing machines and test kits to thousands of nursing homes. CMS worked with states to ensure a survey of virtually every nursing home in America and worked with the Centers for Disease Control and Prevention (CDC) to stand up a truly unprecedented and brand new nationwide nursing home reporting system for over 15,000 nursing homes. CMS helped HHS to provide America's nursing homes $20 billion in funding and led a joint CMS-CDC-OASH effort to send Federal Task Force Strike Teams to nursing homes particularly afflicted by the pandemic. Finally, CMS directed its network of Quality Improvement Organizations to provide intensive, onsite assistance, and developed and implemented a nationwide training program for nursing home staff to help them comply with critical infection control practices and federal infection control rules and guidance. Countless residents are alive today thanks to this unprecedented response.

More generally, we took a long, hard look at what our regulations demand of the health care system during this trying time. Many that might make sense during periods of relative calm were getting in the way of patient care during this public emergency. We approved over 500 Medicaid state waivers and amendments in support of the pandemic response.

Wherever possible, we have waived requirements on hospitals, health care workers, and others laboring on the frontlines of this fight. We helped hospitals and health systems expand their capacity to care for a surge of patients, boosted our health care workforce by removing restrictions on hiring, and eliminated burdensome paperwork requirements.

One change in particular that was instituted in response to the pandemic deserves special attention because its effects promise to reverberate well beyond the end of the pandemic and change the face of health care delivery for good: telehealth. Under our new rules and waivers, more than 135 new services can now be provided via telehealth, in urban areas as well as rural, from the comfort of a beneficiary's home. We have dramatically expanded the use of Medicare telehealth, building on previous progress we made in this area. That means at-risk, elderly Medicare beneficiaries can easily and conveniently receive necessary care without leaving home and risking unnecessary exposure to the virus.

In addition, CMS made changes early on during the public health emergency to make getting tests easier and more accessible for Medicare and Medicaid beneficiaries. CMS issued waivers and obtained rule changes to Medicare coverage that no longer require an order from the treating physician or other practitioner for beneficiaries to get COVID-19 tests and certain laboratory tests required as part of a COVID-19 diagnosis.

Thanks to these swift and decisive actions, staying home to slow the spread of the virus did not have to come at the cost of critical medical care for seniors. This work was so successful that the telehealth revolution is here to stay: we have already begun the process of making some of the expanded list of services permanent, extending others beyond the end of the PHE, and determining what else should be made a permanent feature of the program.

As we carry out this historic work, CMS has hardly slackened its pace on non-COVID work. At every turn, we have sought to deliver more options, better care, and lower costs. Average benchmark plan premiums on HealthCare.gov are down eight percent over the last three years after years of double digit rate increases; likewise, average premiums in Medicare Advantage are at historic lows, down 34 percent since 2017, while average basic part D premiums are down 12 percent since that same time; and, work on innovative payment models to transform health care has continued swiftly.

Patients over Paperwork is the central plank of CMS's ongoing initiative to "Cut the Red Tape" and reduce burden. Patients belong at the center of the health care system. We have searched high and low for duplicative, unnecessary or excessively costly requirements. This effort was driven by the conviction that reams of prescriptive government regulations that dictate processes for the health system have failed. Regulations should identify expected outcomes, results and standards – not micro-manage everything the health industry does. Our burden reduction efforts have saved $6.6 billion and 42 million burden hours through 2021.

These changes have allowed us to be proactive rather than reactive on policy – to take a truly leading role. For example, our reforms on price transparency and interoperability represent arguably two of the most consequential changes made to America's health care system in decades.

CMS has finalized historic price transparency requirements that will empower patients and increase competition among all hospitals, as well as most group health plans and health insurance issuers in the individual and group markets, by requiring them to make certain pricing information publicly available. These rules are a historic step toward putting health care price information in the hands of consumers, advancing the Administration's goal to ensure consumers are empowered with the information they need to make more informed health care decisions. These policies

will bring greater transparency across the health care industry and empower consumers to shop and compare costs between specific providers before receiving care.

In March 2020, meanwhile, CMS released the Interoperability and Patient Access final rule as part of our MyHealthEData Initiative. It gives patients access to their health information with the click of a button and allows them to carry it with them throughout their health care journey. In a future where data flows freely and securely between payers, providers, and patients, we can coordinate care, promote innovation, and reduce costs.

This barely scratches the surface of what our agency has achieved this year. None of it would have been possible without the tireless work of the CMS staff. Their efforts have been wide-ranging and literally life-saving.

On behalf of all those we serve, I thank you for your continued support of CMS and its programs.

Seema Verma

SEEMA VERMA
CMS Administrator
November 2020

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
		Medicaid Integrity Program
		Program Management
Issuers/Health Plan/Providers	Offsetting Collections	CMS User Fees
Beneficiaries		Recovery Audit Contracts
Federal Agencies		Reimbursables
States		
General Public		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED LEADERSHIP
as of October 1, 2020

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Kimberly Brandt
Principal Deputy Administrator for Policy and Operations

Demetrios Kouzoukas
Principal Deputy Administrator for Medicare & Director, Center for Medicare

Brad Smith
Deputy Administrator and Director

Jennifer Main
Chief Operating Officer

Karen Jackson
Deputy Chief Operating Officer

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Vacant, Deputy *Director*

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Vacant, *Center Chief Technology Officer*

* Acting

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MANAGEMENT'S DISCUSSION & ANALYSIS

Our Organization // Overview // Performance Management // CMS Strategic Goals, Initiatives & Objectives // Overview of Financial Data // Overview of Social Insurance Data

OUR ORGANIZATION

CMS, an operating division of the Department of Health and Human Services (HHS), employs approximately 6,300 federal employees in Maryland, Washington, DC, and many other states throughout the country. CMS provides direct services to state agencies, health care providers, individuals with Medicare, sponsors of group health plans, Medicare health and prescription drug plans, and the general public.

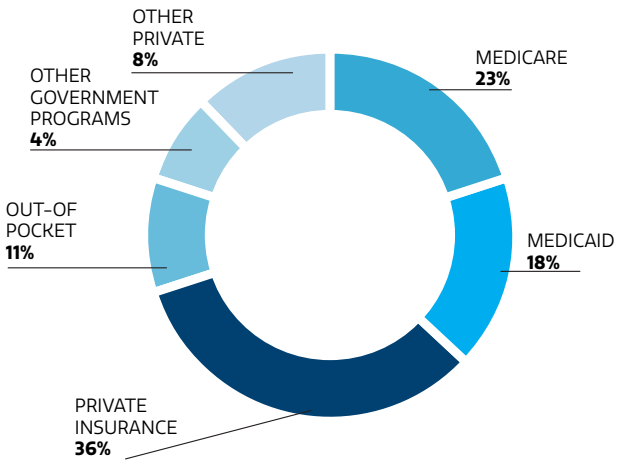
CMS's employees write policies and regulations that establish program eligibility and benefit coverage; set payment rates; safeguard the fiscal integrity of the programs it administers from fraud, waste, and abuse; and develop quality measurement systems to monitor quality, performance, and compliance. In addition, CMS's staff provides technical assistance to Congress, the Executive branch, universities, and other private sector researchers.

CMS also contracts and/or partners with third parties to operate many of its important activities. Each state administers the Medicaid program and the Children's Health Insurance Program (CHIP). States inspect hospitals, nursing homes, and other facilities to ensure that health and safety standards are met. The Medicare Administrative Contractors (MACs) process claims, provide technical assistance to providers, and answer inquiries from individuals with Medicare. Additionally, Quality Improvement Organizations (QIOs) conduct a wide variety of quality improvement programs to ensure quality of care is provided to individuals with Medicare.

OVERVIEW

CMS administers Medicare, Medicaid, CHIP, and the Clinical Laboratory Improvement Amendments of 1988 (CLIA) program. The passage of the *Patient Protection and Affordable Care Act* (PPACA) led to the expansion of CMS's role in the health care arena beyond our traditional role of administering the Medicare, Medicaid, and CHIP Programs. Over the last 50 years, CMS evolved into the largest purchaser of health care and now maintains the nation's largest collection of health care data. Based on the latest 2020 projections, Medicare and Medicaid (including state funding) represent 41 cents of every dollar spent on health care in the United States (U.S.)—or looked at from three different perspectives: 52 cents of every dollar spent on nursing homes, 41 cents of every dollar received by U.S. hospitals, and 35 cents of every dollar spent on physician services.

THE NATION'S HEALTH CARE DOLLAR FY2020



Source: U.S. Department of the Treasury

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 expanded to cover people with disabilities and people with End-Stage Renal Disease (ESRD). The Medicare program was further expanded in 2003 with the *Medicare Prescription Drug, Improvement, and Modernization Act* (MMA), which included a prescription drug benefit for all Americans with Medicare beginning January 1, 2006.

Medicare processes over one billion fee-for-service (FFS) claims a year and accounts for approximately 12 percent of the federal budget. Medicare is a combination of four programs: Hospital Insurance (Part A), Supplementary Medical Insurance (Part B), Medicare Advantage (MA, also known as Part C), and Medicare Prescription Drug Benefit (Part D). Since 1966, Medicare enrollment has increased from 19 million to almost 63 million individuals.

Hospital Insurance

Hospital Insurance, also known as HI or Medicare Part A, is provided to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most people entitled to Social Security or Railroad Retirement benefits. Most people do not pay

a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. The HI program pays for hospital, skilled nursing facility (SNF), 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 individuals with Medicare.

Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI or Medicare Part B, is voluntary and available to nearly all people aged 65 and over, people with disabilities, and people with ESRD who are entitled to Part A benefits. Medicare Part B helps cover doctors' services and outpatient care. The SMI program pays for physician care, outpatient hospital services, some home health care, laboratory tests, durable medical equipment, designated therapy, some outpatient prescription drugs, and other services not covered by HI, such as some of the services of physical and occupational therapists. Part B helps pay for these covered services and supplies when they are medically necessary. The SMI coverage is optional, and individuals who elect SMI are subject to monthly premium payments.

Medicare Advantage

The *Balanced Budget Act of 1997* established the Medicare+Choice program, now known as the Medicare Advantage Program or Medicare Part C, to provide more health care coverage choices for individuals with Medicare. 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 beginning January 1, 2021. Individuals with Medicare have the option to choose to enroll in health care plans that contract with CMS instead of receiving services under traditional FFS arrangements offered under original Medicare. Many MA plans offer additional services such as prescription drugs, vision, and dental benefits, and also may cover some or all of an enrollee's out-of-pocket costs. MA plans assume full financial risk for care provided to their Medicare enrollees. Individuals with Medicare can also enroll in cost plans where they can receive services through the cost plan's network or Original Medicare.

Medicare Prescription Drug Benefit

The Medicare Prescription Drug Benefit, also known as Medicare Part D, is an optional prescription drug benefit created by the MMA for individuals with Medicare. Eligible individuals have the opportunity to enroll in either a stand-alone prescription drug plan to supplement their traditional Medicare coverage, or in a MA prescription drug plan, which integrates basic medical coverage with added prescription drug coverage. Individuals who qualify for both Medicare and Medicaid (full-benefit dual-eligible) are automatically enrolled in the Part D program; assistance with premiums and cost sharing is available to full benefit dual-eligible, and other qualified low-income, individuals.

Medicaid

Enacted in 1965 as Title XIX of the *Social Security Act*, Medicaid is administered by CMS in partnership with the states. Although the federal government establishes certain parameters for all states to follow, each state administers its Medicaid program differently, resulting in variations in Medicaid coverage across the country. States have flexibility in determining Medicaid benefit packages within federal guidelines; however, states are required to cover certain mandatory benefits. States have additional options for coverage and may choose to cover other groups, such as individuals receiving home and community based services (HCBS) and children in state-funded foster care. The Medicaid program is jointly funded by states and the federal government; CMS provides matching payments to the states and territories for Medicaid program expenditures and related administrative costs. Medicaid provides access to comprehensive health coverage that may not be affordable otherwise for millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. For FY 2020, CMS projects about 74 million Medicaid enrollees and about 10 million dual eligibles enrollees (both Medicare and Medicaid).

CHIP

CHIP was created through the *Balanced Budget Act of 1997* and provides health coverage to low-income uninsured children and pregnant women whose income is too high to qualify for Medicaid. Title XXI of the *Social Security Act* outlines the program's structure and establishes a partnership between federal and state governments. States administer CHIP according to federal requirements while working closely with CMS, Congress, and other federal agencies. CMS ensures state programs meet statutory requirements designed to ensure meaningful coverage. CMS provides extensive guidance and technical assistance

so states can further develop their CHIP state plans and use federal funds to provide health care coverage to as many children as possible. CHIP funds cover the cost of health care services, reasonable costs for administration, and outreach services to enroll children. States are given broad flexibility in designing their programs, such as choosing to provide benchmark coverage, benchmark-equivalent coverage, or Secretary-approved coverage. In addition, states can create or expand their own separate CHIP programs, expand Medicaid, or combine both approaches. Important cost-sharing protections in CHIP safeguard families from incurring unaffordable out-of-pocket expenses. In fiscal year (FY) 2020, CMS projects that approximately 10 million children will be enrolled in CHIP for at least one month during the year.

CLIA

CLIA legislation expanded the 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 on patients, including those performed in physicians' offices, for a total of 262,105 facilities.

The CLIA program is 100 percent user-fee financed and is jointly administered by three HHS operating divisions: CMS, Centers for Disease Control and Prevention (CDC), and the Food and Drug Administration (FDA). CMS manages the overall CLIA program, including its regulatory and financial aspects. This includes enrollment, regulation, and policy development; approval of accrediting organizations and exempt states; proficiency testing and certification of providers; and enforcement. CDC provides research, technical support, and coordination of the Clinical Laboratory Improvement Advisory Committee, while FDA performs test categorization.

Health Insurance Exchanges

CMS is charged with implementing many of the provisions of the PPACA that relate to private health insurance. CMS oversees compliance with federal market reforms on health insurance issuers while working to increase industry transparency, and to provide access to private health insurance through the oversight of the Health Insurance Exchanges (Exchanges) where health insurance issuers compete on the basis of price and quality.

CMS works with states to ensure issuers comply with market reforms through policies like the federal prohibition on denying coverage for pre-existing conditions, the prohibition on annual and lifetime dollar limits on essential health benefits, and rating requirements. CMS also implements a process for states or CMS to review rates of non-grandfathered health insurance products in the individual and small group markets to determine compliance with federal health insurance rating rules. CMS is also responsible for enforcing compliance with a federal minimum medical loss ratio (MLR) requiring that health insurance issuers spend a predetermined portion of premium revenues on clinical services and quality improvement, or provide a rebate to policyholders if the MLR standard is not met.

Permanent Risk Adjustment Transfers

The risk adjustment program transfers funds from plans with lower risk enrollees to plans with higher risk enrollees (such as those with chronic conditions) in a state market to incentivize health insurance issuers that attract high risk enrollees and reduce the incentives for issuers to avoid those enrollees. The risk adjustment program also lessens the potential influence of risk selection on the premiums that plans charge. The risk adjustment program is designed to support plans offering a wide range of benefits available to consumers.

State Relief and Empowerment Waivers

Under section 1332 of the PPACA, states can apply for a State Relief and Empowerment Waiver (also referred to as a "state innovation waiver" or "section 1332 waiver" or "1332 waiver") from HHS and the Department of the Treasury (collectively, the Departments). If approved, the waiver allows states to implement innovative programs to provide access to quality health care. Through section 1332 waivers, the Departments aim to assist states with developing health insurance markets that offer more choice, competition, and affordability to Americans. State innovation waivers became available beginning January 1, 2017, and can be approved for up to a 5-year period. Waivers must not increase the federal deficit.

Enhanced Direct Enrollment

Enhanced Direct Enrollment allows consumers to apply for and enroll in health coverage through the Federally-facilitated Exchanges and State-based Exchanges that use the federal platform without needing to visit HealthCare.gov. This capability improves the consumer experience while shopping for, applying for, and enrolling in Exchange coverage through third party websites. It allows consumers to interact directly with

private enrollment partners and complete all steps in the eligibility and enrollment process for qualified health plans on an approved single website. Enhanced Direct Enrollment is the result of years of work between CMS, issuers, and other third party partners seeking to provide consumers a more tailored enrollment experience and ability to manage their information and coverage year-round.

PERFORMANCE MANAGEMENT

Performance measurement results provide valuable information on the success of CMS's programs and activities. CMS uses performance information for improvement opportunities and to shape its programs. The use of performance measures also provides a clear communication method of CMS's programmatic objectives to the public and 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.

The *Government Performance and Results Act of 1993* (GPRA) mandates that cabinet-level agencies have strategic plans, annual performance goals, and annual performance reports that encourage accountable stewardship of public programs.

HHS released its current **Strategic Plan (2018-2022)** in March 2018, as required by the *GPRA Modernization Act of 2010*. Key CMS performance measures from the Strategic Plan are featured in the **HHS Annual Performance Plan and Report**. Consistent with GPRA principles, the CMS GPRA performance goals reinforce the mission, goals, and objectives of the Administration's Strategic Plan. We look forward to the challenges represented by our performance goals and are optimistic of our ability to meet them.

Our FY 2020 performance measures track progress in our major program areas, this includes measuring error rates. In addition, we measure quality improvement initiatives geared toward older adults, children, and people with disabilities, who are served by the Medicare, Medicaid, CHIP, and the QIO programs. Detailed CMS performance measure information and available results are included in the **CMS Budget**. Progress on our measures will be reported through the FY 2022 President's Budget process.

CMS STRATEGIC GOALS, INITIATIVES & OBJECTIVES

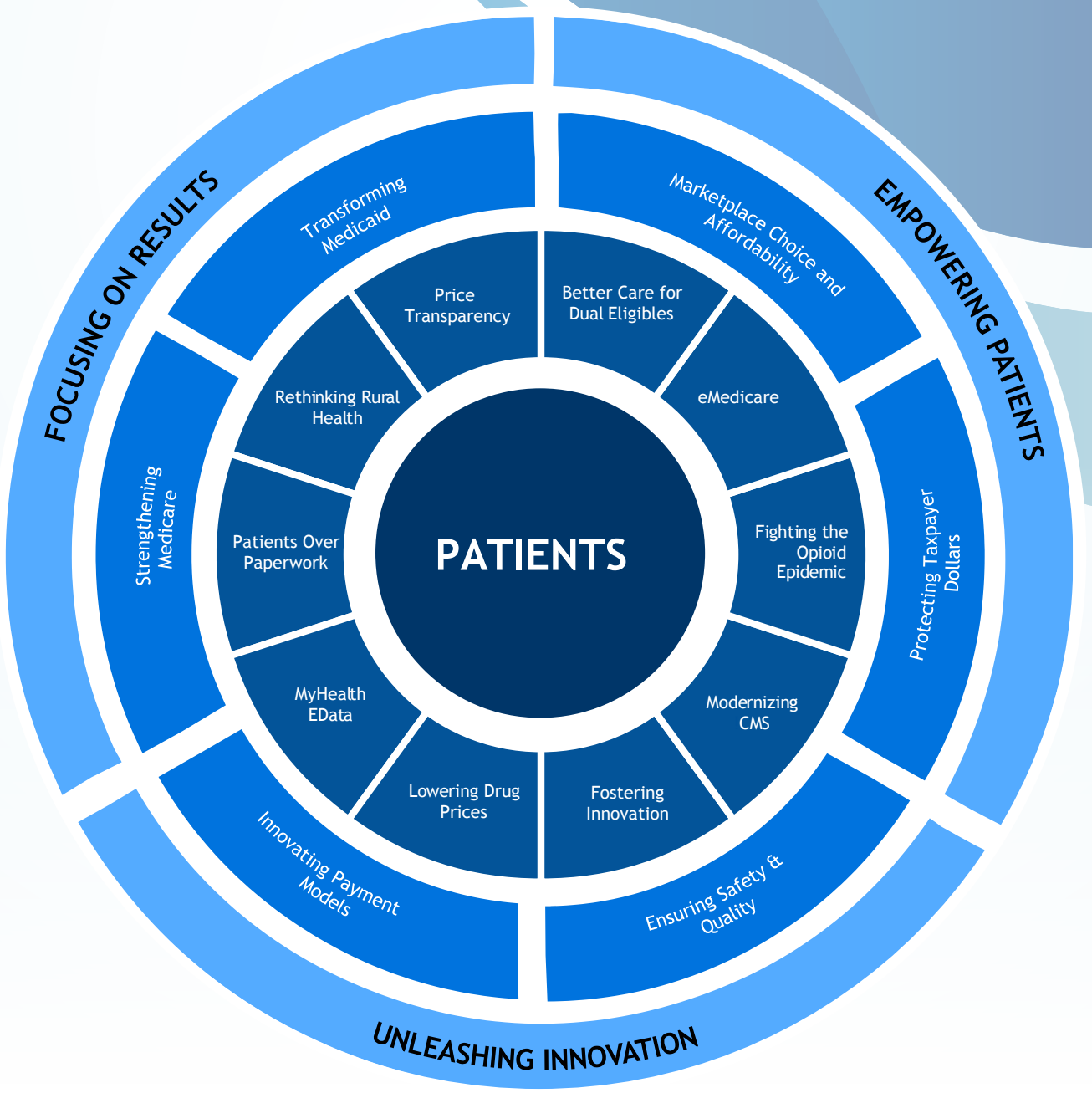
During 2020, CMS continued to build on successes of previous years focusing its authority and programs on one objective: transforming the health care system to deliver better value and results for patients through competition and innovation. CMS is holding the entire health care system—health plans, states, contractors, providers, clinicians—accountable by encouraging choice and competition to develop new tools and solutions that will allow the system to deliver value to patients.

CMS set an overall agency objective to "Improve the Nation's Health and Quality of Life" for FY 2020. To achieve this, we focused on three overarching strategic goals of empowering patients, focusing on results, and unleashing innovation. ***Empowering Patients*** - fully engaging patients with our health care system by giving them price, quality information, and seamless access to their health care record so they can make the best decisions for themselves and their families. ***Focusing on Results*** - holding the entire health care system, including health plans, states, contractors, providers and clinicians, accountable by demanding high quality outcomes for beneficiaries to benefit the American taxpayer. ***Unleashing Innovation*** - ensuring America continues to have a world-class health care system by unleashing innovation in technology, medical records, and the states by removing the barriers to innovation and competition through which providers and health plans compete to deliver better care for beneficiaries at lower cost.

The graphic on page 6 depicts how CMS will achieve these goals. It begins with patients in the center, representing our core. The two inner circles represent our 16 strategic initiatives that will drive us to achieve our three main strategic goals.

Along with focusing on the agency's strategic initiatives, CMS was at the forefront in responding to and containing the spread of the 2019 Novel Coronavirus Disease (COVID-19). CMS took aggressive actions and regulatory flexibilities to help health care providers and states during this unprecedented public health emergency.

The following pages provide a brief overview of CMS's 16 FY 2020 strategic initiatives and actions we have taken to demonstrate our commitment to deliver on our promise to ensure all patients get the best health care, even in the midst of a pandemic.


FOCUSING ON RESULTS
EMPOWERING PATIENTS
UNLEASHING INNOVATION
Transforming Medicaid
Marketplace Choice and Affordability
Strengthening Medicare
Protecting Taxpayer Dollars
Innovating Payment Models
Ensuring Safety & Quality
Price Transparency
Better Care for Dual Eligibles
Rethinking Rural Health
eMedicare
Patients Over Paperwork
Fighting the Opioid Epidemic
MyHealth EData
Modernizing CMS
Lowering Drug Prices
Fostering Innovation
PATIENTS

STRENGTHENING MEDICARE

Modernize Medicare to empower beneficiary choices and unleash private sector innovation to improve care.

Implement the President's Executive Order on Protecting & Improving Medicare

The Health Care Payment Learning and Action Network (LAN) is an active partnership between public and private health care leaders dedicated to providing thought leadership, strategic direction, and ongoing support to accelerate our health care system's adoption of alternative payment models. The LAN mobilizes payers, providers, purchasers, patients, product manufacturers, policymakers, and others in a shared mission to lower care costs and improve patient experiences and outcomes, encouraging public/private adoption of value-based approaches to health care payment and delivery. The LAN strengthens Medicare by aligning and expanding value-based payment options for health care in the public and private sectors; promoting shared definitions and standards for alternative payment models; providing guidance to stakeholders seeking to transition to value-based payment; and creating a forum for sharing best practices.

CMS also added a deductible-based adjustment to the MLR calculation for MA medical savings account (MSA) contracts receiving a credibility adjustment. The addition of a deductible-based adjustment for MSA contracts aligns with the directive in the Executive Order on Protecting and Improving Medicare for Our Nation's Seniors for HHS to propose regulatory changes that reduce barriers to obtaining MSAs.

CMS also made it easier for Americans to be tested for COVID-19 while ensuring they are not burdened by the costs for testing services. To expand coverage and payment for testing, CMS quickly implemented recently enacted legislation that removed barriers to testing, increased funding to Medicare providers for testing of uninsured individuals, ensured all beneficiaries can receive COVID-19 tests without cost sharing, and allowed Medicare (and Medicaid) to pay for certain COVID-19 tests without a physician order. To ensure availability and timeliness of testing, CMS:

- Extended Medicare payment to laboratories to collect COVID-19 lab specimens from certain people at home or in other community settings in certain circumstances;
- Allowed healthcare facilities like pharmacies to set up drive-through COVID-19 testing stations; expedited reviews of applications for lab certification, ensuring that labs are able to begin testing as quickly as possible to meet consumer needs; and
- Developed new billing codes and offered guidance on additional billing codes developed by the American Medical Association for COVID-19 lab tests that allow for better tracking of the public health response to this virus.

Strengthen Medicare–Administrative Contractor performance and engagement

To strengthen the Medicare program, CMS collaborated with the MACs and focused on two significant initiatives relative to MAC performance and engagement. In January 2020, CMS held three public listening sessions to gather provider, practitioner and supplier feedback regarding actions CMS can take to improve the overall beneficiary quality of care and customer service they experience with the MACs. As a result of this feedback, CMS was able to make immediate updates to the MAC provider contact centers to streamline the caller identification process for the MAC customer service representatives to improve provider satisfaction with the MACs and Medicare overall. Additionally, CMS explored opportunities for MACs to focus on provider care for particular high-needs beneficiary groups with the aim of addressing demonstrable (i.e., data driven) care deficits in the MAC's specific jurisdiction to improve beneficiary quality of care.

Decrease barriers to services being provided at the site of care preferred by FFS beneficiaries and their clinicians

CMS made payment system updates to increase patient choice and providers for further site neutrality. CMS removed multiple procedures from the inpatient only list, allowing Medicare to pay for these procedures in the hospital outpatient setting, in addition to the hospital inpatient setting.

To further allow patients to safely receive services in a setting of their choice, CMS added multiple procedures to the ambulatory surgical center (ASC) covered procedures list, making these procedures eligible for payment by

Medicare. Currently, CMS and beneficiaries often pay more for the same type of clinic visit in the hospital outpatient setting than the physician office setting. CMS is completing the 2-year phase in of the Clinic Visit Policy, which will result in lower copayments for beneficiaries and savings for the Medicare program and taxpayers.

Improving care coordination for the chronically ill, including through the use of care management services

To better deliver high quality patient care, CMS created a Medicare-specific code to pay practitioners for additional time spent beyond the initial 20 minutes allowed in the current coding for chronic care management services to patients with multiple chronic conditions. This change will pay providers more for spending additional time delivering high quality care.

CMS increased payments to practitioners for transitional care management services furnished to beneficiaries after discharge from an inpatient stay or certain outpatient stays. This will enhance patient care coordination for chronically ill Medicare beneficiaries.

CMS introduced a new principal care management code for separate payment for care management furnished to patients with a single, high-risk chronic condition, to ensure these patients receive the important care management services they require.

Transforming MEDICAID

Transform and strengthen Medicaid by fostering increased state flexibility and innovation, promoting greater accountability for improved outcomes for beneficiaries, and ensuring stronger program integrity for taxpayers.

Advance innovation in state Medicaid programs by implementing changes that decrease burden while increasing accountability for outcomes

During the COVID-19 pandemic, CMS took swift action to provide state Medicaid and CHIP programs with much needed flexibility to address the pandemic locally to better meet their population's needs. Specifically, CMS:

- Rapidly approved Medicaid emergency waivers (section 1135 waivers) for all 50 states as well as the District of Columbia, Puerto Rico, U.S. Virgin Islands, and the Commonwealth of the Northern Mariana Islands;
- Permitted state Medicaid programs to pay providers from other states for care delivered during the public health emergency, increasing the number of practitioners available to serve beneficiaries;
- Allowed states to enroll eligible beneficiaries more quickly in programs that care for the elderly and people with disabilities, and to make changes to state rules to enhance access and delivery of services for the vulnerable populations in home and community-based settings;
- Approved emergency information technology funding for certain states to enhance the systems that support Medicaid healthcare providers, patients, and state staff to ensure they have the resources they need to address the crisis;
- Fostered acceleration of broader telehealth coverage policies and payment by issuing new guidance on telehealth opportunities, outlining ways that states can remove barriers to telehealth, and rapidly approving state requests for emergency waivers and funding; and
- Updated regulations to allow more flexibility for Medicaid home health services and Medicaid lab services.

Through the *Coronavirus Aid, Relief, and Economic Security Act* (CARES Act), CMS permanently expanded the list of practitioners (including nurse practitioners, clinical nurse specialists, and physician assistants) who may bill Medicaid. These practitioners can now order home health services; establish and periodically review a plan of care for home health patients; and certify and re-certify that patients are eligible for home health services. Previously, home health beneficiaries could only receive home health services with the certification of a physician. These changes allow any licensed practitioner working within his/her scope of practice to perform home health services.

The *Families First Coronavirus Response Act* added a new mandatory benefit in the Medicaid statute at section 1905(a)(3)(B) of the act. This provision was amended by the CARES Act. Section 1905(a)(3)(B) of the act provides that, for any portion of the COVID-19 public health emergency period that begins on or after March 18, 2020, Medicaid coverage must include certain tests for the detection of COVID-19, as well as administration of these tests. CMS amended the Medicaid laboratory benefit to provide flexibility with respect to Medicaid coverage of certain COVID-19 related laboratory tests in a greater variety of circumstances and settings. The flexibility is not limited to COVID-19, but would also be available for any future public health emergencies resulting from outbreaks of communicable diseases during which measures are necessary to avoid transmission. The flexibilities would also apply to any period of active surveillance subsequent to the declared public health emergency.

The Medicaid Innovation Accelerator Program provides states with technical assistance in such areas as data analytics, service delivery and financial modeling, quality measurement, and rapid cycle evaluation to accelerate the development and testing of state led payment and service delivery innovations which has helped raise states' awareness of ongoing Medicaid reforms through technical support.

Accelerate quality improvement and drive accountability through data

In an effort to increase public transparency and accountability in the Medicaid program's administration and outcomes, CMS released an updated and expanded version of the Medicaid CHIP Scorecard. The scorecard includes measures, many that are voluntarily reported by states, as well as federally reported measures in three areas: (1) state health system performance; (2) state administrative accountability; and (3) federal administrative accountability. The scorecard promotes a significant step to improve transparency and accountability for program outcomes through public reporting.

Make Medicaid the most value driven payer in the United States

The State Innovation Models Initiative tests the ability of state governments to accelerate health transformation using the full range of regulatory and policy levers available to improve health, improve care and lower costs for the state's citizens, including Medicaid beneficiaries. Through State Innovation Models Round 2, states are driving delivery transformation among Medicaid providers and expanding value-based purchasing contracts for Medicaid and public employee sectors. Additional state efforts seek to improve care coordination and address social determinants of health for Medicaid beneficiaries.

Ensure that Medicaid coverage results in better quality of life for beneficiaries

The Maryland All-Payer model seeks to modernize Maryland's unique all-payer rate-setting system for hospital services that will improve patients' health and reduce costs. Maryland committed to achieving quality targets pertaining to readmissions, hospital acquired conditions, and population health, ultimately, to improve the care for Maryland residents, including Medicaid beneficiaries. As per the Maryland All-Payer model final evaluation, participants saw a downward trend in inpatient admissions and emergency department visits for Maryland Medicaid beneficiaries.

The Vermont All-Payer Accountable Care Organization (ACO) model offers ACOs in Vermont the opportunity to participate in a Medicare ACO initiative tailored to the state. Under the Vermont All-Payer ACO model, the state commits to achieving statewide health outcomes, financial, and ACO scale targets across all significant health care payers. Medicaid is a critical health care payer in the Vermont All-Payer ACO model. In 2016, CMS approved a 5-year extension of Vermont's section 1115(a) Medicaid demonstration, which enables Medicaid to be a full partner in the Vermont All-Payer ACO model.

MARKETPLACE CHOICE and AFFORDABILITY

Create affordable coverage options for every American seeking insurance on the individual health insurance market.

Provide states flexibility to implement programs that lower premiums and increase consumer choice through approval of State Relief and Empowerment Waivers

CMS continued its efforts to encourage and approve state applications for section 1332 State Relief and Empowerment Waivers and also continued working with states on section 1332 waiver proposals. In addition to 13 state waivers already in operation, CMS has approved two new section 1332 waivers for plan year 2021. CMS also released a data brief on State Relief and Empowerment 1332 waivers to provide an overview of the state-based reinsurance programs implemented using section 1332 waivers, including relevant information about premiums, issuer participation, and enrollment.

Increase participation in the Individual Market through Individual Coverage Health Reimbursement Arrangements (HRAs)

CMS remains engaged with a variety of stakeholders to expand interest and participation in HRAs. In FY 2020, CMS worked to increase our operational capacity to facilitate employer participation in HRAs through the Exchanges. Under the 2019 HRA rule, employers are now able to provide their workers with tax-preferred funds to pay for the cost of health insurance coverage that workers purchase in the individual market.

Increase consumer choice in enrolling in health plans by continuing to expand the use of Enhanced Direct Enrollment

CMS is increasing its participation in an 'enhanced' direct enrollment pathway for consumers to enroll in health insurance coverage through the Federally-facilitated Exchange. Through this fully integrated platform, consumers and agents and brokers assisting consumers are able to go directly to the approved enrollment partner's website for the entire application and enrollment experience without being redirected to HealthCare.gov. In addition, consumers can download Exchange notices, get status updates, or follow up on actions they need to take directly through the partner's website. In the most recent open enrollment period, the combination of direct and enhanced direct enrollment represented 30 percent of active plan selections, the highest ever rate through these channels.

Increase issuer participation and competition on the Exchanges to expand consumer choices and promote lower premiums

CMS actively engaged with insurance carriers and states to promote greater issuer participation in the individual market for plan year 2021. This approach specifically focused on further growth into rural areas, as well as increasing the amount of large group brand name plans available on the Exchange.

Maintain level playing fields in individual and small group markets by updating risk adjustment data validation

In order to further stabilize the marketplace and encourage participation, CMS promulgated rules to amend our risk adjustment data validation methodology in light of feedback received from the first non-pilot year of the program. In addition, we continue to increase internal operational efficiency to reduce operating costs, with the goal of reducing premiums by holding down user fees for the Federally-facilitated Exchange.

LOWERING

DRUG PRICES

Lower prescription drug prices for all Americans through stronger competition, better negotiation, incentives for lower prices, and increased transparency.

Empower Medicare Advantage (MA) and Part D plans to negotiate lower costs for seniors, including lower prices for prescription drugs

CMS proposed provisions for a calendar year (CY) 2021 and 2022 Parts C and D rule with innovative policy approaches to lower drug prices and reduce out-of-pocket costs in the Part D program. Specifically, to allow for Part D sponsors to provide their enrollees with improved access to specialty-tier Part D drugs, CMS has proposed to allow Part D sponsors to have a second, "preferred" specialty tier in order to improve competition for preferred specialty tier formulary placement resulting in better negotiations for Part D sponsors, which could result in lower cost sharing for Part D enrollees.

The Part D Senior Savings Model tests the impact of offering beneficiaries an increased choice of enhanced alternative Part D plan options that offer lower out-of-pocket costs for insulin. Beginning January 1, 2021, CMS will be testing a change to the Manufacturer Coverage Gap Discount Program (the "discount program") to allow Part D sponsors, through eligible enhanced alternative plans, to offer a Part D benefit design. This change includes having predictable $35 copays for a 30-days' equivalent supply of a broad range of insulins in the deductible, initial coverage, and coverage gap phases. This will be accomplished by applying Part D sponsor supplemental benefits after the manufacturer provided discount on the negotiated price.

Facilitate value-based payment arrangements and provide state flexibility to expand outcome-based payments

On June 19, 2020, CMS published the proposed rule *Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) and Supporting Value-Based Purchasing (VBP) for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third Party Liability Requirements (CMS 2482-P).* This notice of proposed rulemaking advances CMS' efforts to support state flexibility to enter into innovative VBP arrangements with drug manufacturers, and to provide manufacturers with regulatory flexibility that will encourage VBP arrangements with payers, including Medicaid. CMS believes providing states with flexibility to enter into VBP arrangements with drug manufacturers is an important strategy to manage drug costs and promote beneficiary access to needed medications. By removing the regulatory hurdles in this proposed regulation, CMS will encourage states to enter into VBP arrangements for drug therapies, especially in cases when the therapy will safeguard against unnecessary utilization of other, more expensive medical services.

Promote value-based drug payment models

In January 2020, CMS began the Part D Payment Modernization Model which aims to lower drug prices via Part D program design and incentive alignment on overall Part D prescription drug spending and beneficiary out-of-pocket costs. This voluntary, 5-year model tests the impact of a modernized Part D payment structure that creates new incentives for plans, patients, and providers to choose drugs with lower list prices in order to address rising federal reinsurance subsidy costs in Part D.

Update CMS's drug-pricing dashboards to provide the latest information on prices and spending

To improve price transparency under Part D by January 1, 2021, CMS is requiring Part D sponsors to adopt one or more real time benefit tools with the capability to inform prescribers when lower-cost alternative therapies are available under the beneficiary's prescription drug benefit, which can improve medication adherence, lower prescription drug costs, and minimize beneficiary out-of-pocket costs. To further improve price transparency under Part D, CMS is also proposing that each Part D plan implement a beneficiary real time benefit tool that will allow enrollees to view plan-provided, patient-specific, real-time formulary and benefit information by January 1, 2022.

PRICE TRANSPARENCY

Empower patients with information on the cost and quality of health care services.

Promulgate policies that will bring price transparency to health care service markets

CMS continues to work on ways to increase transparency in pricing for consumers of health care services. As directed by the Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First, in FY 2020, CMS finalized and proposed historic price transparency requirements to help empower patients and increase competition among hospitals, group health plans, and health insurance issuers in the individual and group markets by requiring them to make pricing information publicly available.

The Department of the Treasury, Department of Labor, and CMS released a Notice of Proposed Rulemaking that included proposals that would require most group health plans, including self-insured plans, and health insurance issuers in the individual and group markets to disclose pricing and cost-sharing information. This would make previously unavailable price information accessible to patients and other stakeholders in a standardized way, allowing for easy comparisons.

RETHINKING Rural Health

By applying a rural lens to CMS policies, we are expanding value-based care, ensuring access, and improving outcomes, to provide patients in rural communities with access to quality, more affordable health care.

Increase participation of rural providers and health care systems in alternative payment models

The Pennsylvania Rural Health Model seeks to increase rural Pennsylvanians' access to high-quality care and improve their health, while also reducing the growth of hospital expenditures across payers, including Medicare and Medicaid, and improving the financial state of acute care hospitals and critical access hospitals in rural Pennsylvania to ensure continued access to care. The two key components of this model are hospital global budgets and deliberate hospital care delivery transformation. Under this model, participating rural hospitals are paid based on all-payer global budgets—a fixed amount that is set in advance for inpatient and outpatient hospital-based services, and paid throughout the year by Medicare FFS and other participating payers. In addition, participating rural hospitals will thoughtfully redesign the delivery of care in accordance with their CMS and state approved rural hospital transformation plans to improve quality of care and meet the health needs of their local communities. By doing so, the model tests whether the predictable nature of the global budgets will enable participating rural hospitals to invest in quality and preventive care, and to tailor the services they deliver to better meet the needs of their local communities.

Promote and encourage the adoption of telehealth, especially in rural areas

CMS published guidance that addressed facilitation of access to services delivered via telehealth in rural areas along with guidance in response to the *Substance Use Disorder (SUD) Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act).* With this Informational Bulletin, CMS hopes to enhance

our work with states to improve care for Medicaid beneficiaries through the use of telehealth delivery methods. In addition, CMS released a State Medicaid & CHIP Telehealth Toolkit that provides information on how states can expand the utilization of telehealth, both during the COVID-19 pandemic and beyond. Such telehealth expansions can be particularly important for ensuring access to services in rural areas.

Americans now have access to broader telehealth services, ensuring access to care while reducing the risk of COVID-19 exposure for both patients and healthcare providers. In Medicare, CMS temporarily expanded telehealth coverage to people living in all areas of the country so that beneficiaries living in both rural and urban settings can get care from their home rather than unnecessarily traveling to their doctor's office. CMS accomplished this by expanding the types of services patients can receive via telehealth by expanding Medicare payment for telehealth and allowing telecommunications technologies to be used in lieu of in-person services across many settings of care. CMS also expanded the types of health care providers that can provide telehealth services.

Reduce administrative burdens that impact rural areas and remove policy barriers that disadvantage rural areas

Through its Rethinking Rural Health Strategic Initiative, CMS sought to apply a rural lens to its policies, expand value-based care, ensure access, and improve outcomes to provide patients in rural communities with access to quality, more affordable health care. CMS released an Informational Bulletin *Living at Home in Rural America: Improving Accessibility for Older Adults and People with a Disability*. This bulletin was developed in partnership with other federal agencies (Department of Housing and Urban Development, the Department of Agriculture), and three HHS operating divisions (the Administration on Community Living, CDC, and Health Resources and Services Administration) to support the CMS Rural Health Strategic Initiative. The bulletin was developed to provide states with better understanding of the range of federal programs and resources available for improved home accessibility and will help states and local rural communities to more effectively coordinate resources and provide opportunities for people with a disability and older adults to live in and age-in-place in rural America.

PROTECTING TAXPAYER DOLLARS

Enhance and modernize program integrity to combat waste, fraud, and abuse.

Implement new program integrity approaches in value-based payment programs to mitigate and prevent potential fraud and abuse

MA plans receive additional payments from CMS for beneficiaries with clinical conditions. Plans submit requests for risk adjusted payments based on beneficiary diagnoses. CMS conducts contract-level Risk Adjustment Data Validation audits to verify the accuracy of payments made to MA organizations for the purpose of identifying and recovering improper payments. In 2019 through early 2020, CMS started contract-level Risk Adjustment Data Validation audits for contract years 2014 and 2015, with the expectation of recovering between $200-300 million per year in MA overpayments by fall 2021.

The Repetitive Scheduled Non-Emergent Ambulance Transport Model tested whether prior authorization helps reduce improper payments and reduce Medicare costs while maintaining or improving quality of care. The model did not create additional documentation requirements; it required the same information that has always been necessary to support Medicare payment, but earlier in the process. This helped to confirm that all relevant coverage, coding, and clinical documentation requirements are met before the service is rendered to the beneficiary and before the claim is submitted for payment.

For low acuity patients, the Emergency Triage, Treat, and Transport Model seeks to provide savings to Medicare and possibly Medicaid by substituting transports to alternative destinations and treatment in place for emergency department visits. Potential savings may result from care provided at lower cost substitute facilities (urgi-centers) and modalities.

The Medicare Diabetes Prevention Program Expanded Model uses an evidence-based structured health behavior change intervention to prevent the onset of

type 2 diabetes. The goals of the Medicare Diabetes Prevention Program Expanded Model are to prevent or delay progression from prediabetes to type 2 diabetes in beneficiaries with an indication of prediabetes, and to reduce Medicare costs for services related to type 2 diabetes.

Leverage new and emerging technology to modernize our program integrity tools

To ensure proper documentation supports billing for specific home services, CMS is supporting states in their implementation of Electronic Visit Verification (EVV) systems as required by the *21st Century Cures Act*. No later than January 1, 2020, all states were required to incorporate functional EVV systems for personal care services. States must incorporate EVV systems for home health care services no later than January 1, 2023, absent a 1-year good faith effort exemption. States receive education, training, and technical assistance to ensure they are successfully initiating this fiscal integrity control and directly linking it to billing and/or payment through pre- or post-payment audits. This process better ensures accountability for CMS's information technology investments in state systems.

Safeguard the Medicare and Medicaid programs by adding protections to ensure that legitimate providers are enrolled while taking aggressive actions to keep out those who seek to defraud the programs

CMS coordinated with insurance companies offering plans on the Federally-facilitated Exchange to retroactively cancel, back to their start date, more than 100 inappropriate enrollments fitting a pattern of fraud involving sober home schemes. These schemes begin with enrolling "patients" into health insurance plans with generous out-of-network benefits and low out-of-pocket costs even though the enrollees do not live in the service area and are not eligible for these plans. Schemes involve collusion among substance abuse treatment facilities, laboratories and sober homes (i.e., group homes for substance abusers that provide no medical services and have no billing codes) that recruit and refer patients back and forth to each other, send issuers tens of thousands of dollars in claims over a few months, then share the payments. CMS implemented a new process for sending consumer allegations of unauthorized enrollments to the insurance companies. As part of this process, the insurance companies check if CMS's three criteria for enrollment fraud are all met and, if so, cancel the policies back to the start date. From October 2019 through June 2020, insurance companies reviewed 5,930 policies and cancelled 4,009 (approximately 68 percent) for fraud. The new process reduced resolution time from 82 days in May 2019 to 8 days in May 2020. For all cancelled policies, the insurance companies return to CMS any advance premium tax credits received on behalf of the enrollees, and the consumers are relieved of any tax liabilities for the advance premium tax credits.

Beginning in FY 2018, CMS launched its Major Case Coordination (MCC) initiative that includes representation from the HHS Office of Inspector General (OIG), Department of Justice (DOJ), and CMS. This initiative provides an opportunity for Medicare and Medicaid policy experts, law enforcement officials, and fraud investigators to collaborate before, during, and after the development of fraud leads and investigations. This level of collaboration has contributed to several successfully coordinated law enforcement actions and helped CMS to better identify national fraud trends and program vulnerabilities along with being able to apply applicable administrative actions when appropriate. As a result of the MCC, there has been a marked increase in the number and quality of law enforcement referrals. Since implementation of the MCC, there have been over 1,400 MCC reviews and 800 law enforcement referrals.

CMS has also established the Medicaid MCC process. The Medicaid MCC brings together representatives from the OIG, Medicaid Fraud Control Units, state program integrity units, and CMS in a forum where the Unified Program Integrity Contractors can discuss their proposed Medicaid-only and joint Medicare-Medicaid law enforcement referrals. To date, CMS has convened Medicaid MCCS in 4 states, which resulted in 12 law enforcement actions.

The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary public-private partnership that helps detect and prevent healthcare fraud through data and information sharing. Partners include 5 federal, 44 state and local agencies, 29 law enforcement, 79 private health insurance plans, and 13 employer organizations/health care anti-fraud associations. The HFPP helps partners identify and reduce fraud, waste, and abuse across the healthcare sector through collaboration, data and information sharing, and cross-payer research studies. As of September 30, 2020, the HFFP grew from 152 to 170 partners, of which 41 are state Medicaid agencies and 14 are Medicaid Fraud Control Units.

Mitigate emerging Medicaid eligibility program risks by identifying and addressing key risk drivers and leveraging newly available T-MSIS data

CMS is conducting reviews of states' Medicaid and CHIP beneficiary eligibility determinations to evaluate whether states are making accurate determinations. By the end of FY 2020, CMS will identify several additional states that are considered "high risk" for audits of beneficiary eligibility determinations, taking into account such factors as findings of non-compliance by state and federal auditing entities, recent expansion activities, and Payment Error Rate Measurement and Medicaid Eligibility Quality Control data and findings.

CMS is also implementing pilots under the Medicaid Eligibility Quality Control program, which requires states to conduct their own reviews of their eligibility determinations in error-prone areas and areas that are not reviewed under our improper payment rate measurement process for Medicaid and CHIP. This work complements CMS's improper payment rate measurement work by allowing CMS to have continuous oversight of states' eligibility determination processes and quickly and effectively work with states to address any issues.

CMS is currently reviewing financial data that was submitted by managed care plans to states and used to calculate and report a MLR consistent with Title 42 of the Code of Federal Regulations sections 438.8 and 438.74, applicable CMS guidance, and plans' contractual obligations with states. For states that elect to mandate a minimum MLR for their Medicaid managed care plans, that minimum MLR must be equal to 85 percent or higher. CMS's review of Medicaid managed care plans' MLRs helps to ensure that plans are complying with applicable federal requirements and can assist states and CMS with ensuring that plans are not overpaid.

Utilize demonstration authority to target services and supplies at a high risk for Medicare fraud while reducing provider burden

CMS established the Vulnerability Collaboration Council, bringing together key players to collaborate and discuss the underlying vulnerabilities that can lead to fraud, waste and abuse, as well as mitigation strategies that can be implemented to address them. Mitigation strategies can include such actions as implementing sophisticated data analytics and models, executing innovative medical review programs, coordinating with law enforcement on fraud investigations, and educating providers and beneficiaries on how to avoid these issues in the future. In FY 2020 CMS focused on the potential vulnerabilities arising from the waivers and flexibilities that CMS issued as a result of the COVID-19 public health emergency. CMS also implemented several demonstrations and models using prior authorization on particular items and services where there are high improper payment rates. CMS designed various demonstrations and actions to focus on a highly vulnerable area and put protections in place to ensure the right payment is made at the right time and for the right service/item, while also minimizing unnecessary provider burden. The specific focus areas are: Durable Medical Equipment, Prosthetics, Orthotics, and Supplies, home health services, and repetitive scheduled non-emergent ambulance transport services.

eMedicare

Provide a seamless online health care customer experience to meet the growing expectations and needs of tech savvy Medicare beneficiaries.

Maintain high customer satisfaction at 1-800-MEDICARE as we do online transformation

Approximately 2.2 million beneficiaries are required to pay their Part B Premiums directly to Medicare each month because they are not yet receiving Social Security benefits. The number of calls to 1-800-MEDICARE regarding premium payment increased in the past several years as more beneficiaries defer their Social Security benefits and continue working. Beneficiaries were unable to pay online using a credit card; as such CMS developed and implemented a way for beneficiaries to pay their bill online through their secure online **Medicare.gov** account 24 hours a day, 7 days a week. Adoption of the online premium payment feature far exceeded our expectations, with close to one million electronic payments totaling over $450 million processed since launch (February 2019). Additionally, the number of premium billing-related inquiries plateaued and customer satisfaction on those premium-related inquires climbed to over 96 percent.

Increase engagement of personalized services, as an example, with the pre-populated drug lists in the Medicare Plan Finder

CMS's Office of Communications led an effort to modernize the Medicare Plan Finder in time for last year's open enrollment period. The new MPF addressed numerous issues with the old system, including an improved front-end (mobile optimized), improved data processing, improved performance and scalability, a consolidated plan preview, and expanded web chat capabilities. It also allows for much faster improvement in response to user feedback. As a result of our efforts, Plan Finder experienced the following successes: exceptional system performance with 100 percent system uptime throughout all of Medicare open enrollment; improved customer satisfaction (10 percent increase); and an increased number of Medicare beneficiaries creating online accounts (almost 1.4 million new accounts). Sessions per user dropped by 36 percent, suggesting more users were able to conduct their business in a single visit with the new tool. Total online enrollments increased by 42 percent over last open enrollment.

With a focus on better patient quality of care and health outcomes, CMS is holding providers accountable for providing safe and effective care, while minimizing administrative burden that takes away time from patients.

Modernize the conditions of participation and the CMS oversight strategy to ensure better enforcement of quality and safety standards

CMS is focused on ensuring individuals with Medicare are empowered to make decisions about their health care based on quality and cost information. To achieve this, we are moving our quality programs to more robustly measure value and to give consumers access to understandable and actionable information.

With our Modernize Conditions of Participation and Enforcement Strategy, CMS ensures safety by partnering with state agencies and accrediting organizations who are responsible for ensuring that all facilities meet the minimum health and safety standards. CMS takes a hard look at how we oversee these entities, and we are strengthening our oversight to ensure they are held accountable for consistency and effectiveness in serving this vital public trust role while ensuring more transparency for beneficiaries. In addition, we are incorporating public comments about potential conflicts of interests for accrediting organizations that serve a role in identifying quality issues for Medicare purposes and who also offer fee-based consultation services, into rulemaking.

In July 2019, CMS issued the HCBS Incident Management Survey as part of our effort to ensure the provision of quality services to Medicaid beneficiaries and in response to health and welfare concerns identified in 1915(c) HCBS waiver programs. The goal of this survey was to identify methods and promising practices for identifying, reporting, tracking, and resolving incidents of abuse, neglect, and exploitation. Forty-five states responded to the survey, representing about 94 percent of 1915(c) HCBS waiver programs. Results of the survey will help inform technical assistance activities and ensure that states have necessary guidance for meeting 1915(c) waiver reporting requirements.

CMS is also working to identify, prevent and appropriately deal with systemic problems in state implementation of and compliance with health and safety oversight systems for home and community based settings including group homes and assisted living programs. Activities initiated include health and welfare issue research and analysis, special onsite reviews, data compilation, and education and training. To date, CMS completed nine special onsite review visits to allow additional work to continue during COVID-19 restrictions.

Leverage the expertise of external stakeholders to develop quality and safety standards for which they will ultimately be held accountable

CMS refocused the scope of the work of our QIOs to target their technical assistance to small, rural and

vulnerable (without access to care) populations and low-performing providers in areas where access to other care options is limited. Through our efforts to strengthen oversight of the accrediting organizations, CMS is intensifying our commitment to quality and patient safety. CMS's efforts include seeking additional transparency about accrediting organization findings and processes, ensuring identification of quality issues, and reviewing all areas of the application and oversight process to maximize our efficiency and effectiveness.

The Kidney Care Choices Model builds upon the existing Comprehensive ESRD Care Model structure in which dialysis facilities, nephrologists, and other health care providers form ESRD focused ACOs to manage care for beneficiaries with ESRD – by adding strong financial incentives for health care providers to manage the care for Medicare beneficiaries with chronic kidney disease, stages 4 and 5, and ESRD, to delay the onset of dialysis and to incentivize kidney transplantation. The patient is a key component of the model design. The tendency now is for patients with kidney disease to follow the most expensive path with little prevention of disease progression and an unplanned start to in-center hemodialysis treatment. By increasing education and understanding of the kidney disease process, aligned beneficiaries may be better prepared to actively participate in shared decision making for their care.

Catalyze the transformation to valued-based care through the use of data analysis and transparency of quality and cost data to promote consumer choice and competition

CMS is incorporating the voices of both beneficiaries and providers as we unleash innovative tools, provide better public information, and modernize quality payment and improvement programs to meet the needs of beneficiaries for generations to come by expanding the Availability, Transparency, and Use of Data initiative. This is in addition to supporting the transformation to value-based care through the use of data analysis and transparency.

Support the transformation to value-based care through Meaningful Measures, Merit-Based Incentive Payment System to Value Program and alignment of other incentive and quality improvement network programs across the continuum of care

In transforming Merit-based Incentive Payment System to Value and the Meaningful Measures 2.0 initiatives, CMS is focused on ensuring beneficiaries are empowered to make decisions about their health care based on quality and cost information. To achieve that, we are modernizing our quality programs to more robustly measure value, giving consumers access to information that is understandable and actionable.

Reduce the administrative burden of participating in quality programs so that clinicians can spend more time with patients

Through our Nursing Home Strategic Plan initiative, CMS is strengthening oversight, enhancing enforcement, increasing transparency, and improving quality, all while reducing burden to providers. We continued to ensure this progress as we worked to prevent the of transmission of the COVID-19 virus in the current wave and plan to prevent or prepare for a possible "second wave" of infections in autumn 2020 and into 2021.

CMS's Leverage Our Influence as a Payor initiative is mobilizing our external stakeholders to improve quality and safety and reduce the administrative burden of participating in quality programs so that clinicians can spend more time with patients.

PATIENTS OVER PAPERWORK

Reduce unnecessary regulatory burden to allow providers to concentrate on their primary mission: improving patient health outcomes and reduce cost.

Increase the estimated dollar and hour savings to health care providers by reducing administrative burden

In reducing unnecessary regulatory burden, CMS is allowing providers to concentrate on their primary mission to improve patient health outcomes and reduce cost. We continue to engage our external stakeholders in onsite engagements, listening sessions, and interviews on CMS burden-reduction actions. CMS is increasing compliance-related tasks that providers can perform digitally. Our goal is to improve efficiency, transparency, and standardization of the prior authorization process across CMS programs.

Our commitment to reducing unnecessary burden, increasing efficiencies, and improving the beneficiary experience by putting patients over paperwork is demonstrated in testing models such as the Direct Contracting (DC) Model Options. DC is a set of voluntary payment model options aimed at reducing expenditures and preserving or enhancing quality of care for beneficiaries in Medicare FFS. The payment model options available under DC create opportunities for a broad range of organizations to participate with CMS in testing the next evolution of risk-sharing arrangements to produce value and high quality health care. The payment model options are anticipated to appeal to a broad range of physician practices and other organizations because they are expected to reduce burden, support a focus on beneficiaries with complex, chronic conditions, and encourage participation from organizations that have not typically participated in Medicare FFS or CMS models.

Unleash data, in a private, secure and usable format, to give patients control of their health care information and allow that data to follow them throughout their health care journey.

Ensure that patients and providers who interact with CMS have access to Medicare FFS claims data via a secure standards-based Application Programming Interface

CMS is enabling and empowering patients to securely share their health information with any provider, application, or researcher they choose. Through Blue Button 2.0, beneficiaries can securely connect their data to applications and other tools developed by innovative companies. Information is shared in an electronic, standards-based format that is commonly accepted and used across the healthcare system. Blue Button 2.0 applications can help beneficiaries organize and share their claims data, find health plans, make care appointments, and check symptoms. CMS is also taking important steps to modernize how it shares data with ACOs and Medicare Part D plan sponsors. These partners can now access claims data for their aligned beneficiaries or enrollees through a standards-based application programming interface that enables seamless access to claims data.

Advance interoperability standards and policies to drive a fully connected andinteroperable health system that empowers patients, caregivers, and their health care providers to use electronic health information to improve care and reduce cost

The MyHealthEData initiative is aimed at unleashing data to empower patients by giving them access and use of their healthcare information when and where they need it most, and allowing it to follow them throughout their healthcare journey. Ensuring the seamless sharing of data will ultimately increase efficiency and patient safety while also reducing burden and costs. Delivering on these goals in March 2020, CMS released the *Interoperability and Patient Access* final rule (CMS-9115-F) which is focused on driving interoperability and patient access to health information by liberating patient data. The final rule establishes policies that breakdown barriers in the nation's health system to enable better patient access to their health information, improve interoperability, and unleash innovation while reducing burden on payers and providers. Among other benefits, this rule allows patients across CMS-regulated insurers to get secure access to their claims and available clinical data through applications of their choice; and this rule supports patients' transitions in care through admission, discharge, and transfer event notifications.

Promote data privacy and security across all efforts to unleash data

CMS is unleashing data, in a private, secure, and usable format to give patients control of their health care information and allowing that data to follow them throughout their health care journey. We are providing academic researchers, health tech companies, and non-profit organizations with streamlined, user-friendly access to CMS program data in public use and restricted access formats that is compliant with all privacy rules. CMS will provide advanced interoperable standards and policies to drive a fully connectable health care system that empowers patients, caregivers, and their health care providers to use electronic health information to improve care and reduce cost.

Fostering INNOVATION

Ensure beneficiaries have access to the latest medical technologies and remove barriers to advancing innovation across our health care system.

Increase beneficiary access to innovative medical technologies

CMS will proactively react to the evolving health care marketplace, including emerging medical technologies (e.g., drugs, biologics, medical devices), to create policies that focus on results, ensuring access to cutting-edge therapies for our beneficiaries while improving the quality of care and reducing costs. We will ensure beneficiaries have access to the latest medical innovations and remove barriers to support unleashing innovation across our healthcare system.

Provide support, transparency, and predictability to innovators

As a part of improving efficiency and Medicaid claims accuracy, CMS is modernizing its state expenditure reporting system through improved technology, workflows, and automation. These changes will support innovation in fiscal oversight of the Medicaid program by reducing manual data entry, enabling expenditure uploads from other systems, and enhancing reporting capabilities. CMS continues to engage state Medicaid agencies and other stakeholders through the design and development of CMS's Medicaid and CHIP Financial System.

Unleash real-world evidence to support CMS decision-making

CMS used real-world evidence to support its decision making in response to COVID-19. Some of the actions taken are listed below.

Americans now have access to broader telehealth services, ensuring access to care while reducing the risk of COVID-19 exposure for both patients and healthcare providers. In Medicare, CMS expanded the scope of separately billable services that allow Medicare physicians to speak with patients virtually, by phone or video, rather than in person in order to prevent risk of infection. CMS also added payment for services of physicians and practitioners who treat patients over the phone to meet the needs of Medicare beneficiaries who may not have access to interactive audio/video technology.

CMS also reduced regulatory and reporting requirements during the COVID-19 public health emergency, allowing providers to focus on patient care. CMS temporarily eliminated certain paperwork requirements; paused the requirement for hospitals to have written policies and processes on visitation of patients who are in COVID-19 isolation; allowed more diabetic patients to monitor their glucose and adjust insulin doses at home; and paused prior authorization for certain items and services, including durable medical equipment, during the COVID-19 public health emergency so providers can act quickly to provide time-sensitive care to beneficiaries. CMS also provided additional flexibility to issuers offering coverage on the federal Exchange platform to allow them to extend premium payment deadlines and delay coverage terminations to help individuals maintain Exchange coverage who may be experiencing difficulty paying their premium due to a loss of income.

CMS ensured that local hospitals and health systems have the capacity to handle and safely treat COVID-19 patients through temporary expansion sites (also known as the CMS Hospital Without Walls initiative). CMS enhanced hospital capacity to manage COVID-19 surges by allowing hospitals to transfer patients to alternative care sites; allowed Community Mental Health Centers to offer partial hospitalization and other mental health services to clients in the safety of their homes; and allowed non-SNF buildings that are state-approved to be temporarily certified as and available for use by a SNF in the event there are needs for isolation processes for COVID-19 positive residents.

CMS expanded its accelerated and advance payment program for Medicare participating health care providers and suppliers to ensure they had the resources needed (i.e., address cash flow issues due to disruption in claims submissions) to combat the COVID-19. There were significant disruptions to the healthcare industry, with providers being asked to delay non-essential surgeries and procedures, other healthcare staff unable to work due to childcare demands, and disruption to billing among the challenges related to the pandemic. This program expansion, which includes changes from the CARES Act, worked to lessen the financial hardships of providers facing extraordinary challenges related to the COVID-19 pandemic, and ensures the nation's providers can focus on patient care.

CMS made data-driven decisions to protect nursing home residents and employees from COVID-19. CMS took the following actions to effecutate these decisions and protections:

- Issued a call to action for nursing homes and state and local governments to work together to determine their needs for COVID-19 testing as well as designate certain treatment sites exclusively for COVID-19-positive or COVID-19-negative patients to avoid further transmissions;
- Announced a new, independent commission to conduct a comprehensive assessment of nursing homes' responses to the pandemic and inform CMS decisions on threats to resident safety and public health;
- Issued guidance on limiting visitors and nonessential healthcare personnel at nursing homes to prevent the transmission of COVID-19;
- Provided clear guidance on infection control and how to prepare the nation's healthcare facilities for the COVID-19 threat;
- Increased surveillance and transparency by requiring all Medicare and Medicaid nursing homes to report cases of COVID-19 to all residents, their families, and the CDC;
- Conducted investigations of patient health and safety in nursing homes nationwide since March, prioritizing infection control and situations in which residents are in immediate jeopardy for serious injury or death; and
- Increased enforcement (e.g., civil money penalties) for facilities with persistent infection control violations, and imposed enforcement actions on lower level infection control deficiencies to ensure they are addressed with increased gravity.

FIGHTING THE OPIOID CRISIS

Decrease the rate of opioid use disorder and reduce deaths by focusing on preventing opioid overuse, increasing access to treatment, and targeting improvements through data analysis.

Increase access to evidence-based treatment through Medicare coverage of Opioid Treatment Programs

During FY 2020, CMS proposed changes to the Part D Prescription Drug Program to assist with fighting the opioid epidemic. These proposed changes would require Part D sponsors to adopt drug management programs and require inclusion of Part D beneficiaries with a history of opioid-related overdoses in a sponsor's drug management program beginning January 2022, as required by the *SUPPORT for Patients and Communities Act* to reduce the abuse or misuse of opioid medications. In accordance with the *SUPPORT for Patients and Communities Act*, CMS also proposes to include beneficiaries at-risk for prescription drug abuse as qualifying participants in medication therapy management programs under the Medicare prescription drug benefit; require plans to provide enrollees with educational resources regarding opioid use and pain management, as well as descriptions of covered alternative (non-opioid) pain-management treatments; and require Part D sponsors to support electronic prescription programs to allow prescribers/providers to securely transmit prior authorization requests for covered drugs under Medicare.

Implementation of Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act Provisions

In November 2019, CMS issued guidance about the implementation of section 5052 of the *SUPPORT for Patients and Communities Act*. Section 5052 of the *SUPPORT for Patients and Communities Act* amended the institution for mental diseases exclusion and established a new section 1915(l) of the *Social Security Act* to include a state plan option to provide services to Medicaid beneficiaries between the ages of 21 through 64 who have at least one SUD diagnosis and reside in an eligible institution for mental diseases from October 1, 2019, through September 30, 2023. During October 2019, CMS released the SUD Data Book as required by the *SUPPORT for Patients and Communities Act*. The SUD data book reports the numbers of Medicaid beneficiaries with a substance use and the services they received in 2017, as reported to CMS.

On April 2, 2020, CMS issued guidance that identified opportunities for the utilization of telehealth delivery methods to increase access to Medicaid services and to comply with the requirement to publish guidance to

states regarding federal reimbursement for furnishing services and treatment for SUDs under Medicaid using services delivered via telehealth, including in School-Based Health Centers. This informational bulletin provides State Medicaid Agencies and other interested stakeholders information about options to facilitate access to services through the use of telehealth delivery methods as specifically outlined in the *SUPPORT for Patients and Communities Act*, but these telehealth delivery methods could also be used in other circumstances such as responding to the COVID-19 public health emergency.

On June 19, 2020, CMS also published the proposed rule *Establishing Minimum Standards in Medicaid State Drug Utilization Review (DUR) and Supporting Value-Based Purchasing for Drugs Covered in Medicaid, Revising Medicaid Drug Rebate and Third Party Liability Requirements*. This proposed rule would amend Medicaid regulation to implement new opioid-related DUR standards that are required of states under the *SUPPORT for Patients and Communities Act*, as well as additional opioid-related DUR standards that CMS is proposing under the authority of the *Social Security Act*. These changes reflect CMS's continued efforts to reduce prescription-related fraud, abuse and misuse and assure that opioid prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results.

Increase provider capacity to treat substance use disorders by implementing Medicaid 5-State Demonstration

The SUD Prevention that Promotes Opioid Recovery and Treatment for *SUPPORT for Patients and Communities Act* authorized a 54-month demonstration project to increase substance use provider capacity. CMS announced the opportunity for State Medicaid Agencies to apply for the planning grants in June 2019. In September 2019, CMS awarded $48.4 million to 15 state Medicaid agencies. Five of the planning grantees will be selected for the 36-month post-planning demonstration period in which they will receive enhanced federal reimbursement for increases in Medicaid expenditures for SUD treatment and recovery services.

Expand Medicaid coverage of services for beneficiaries with substance use disorders

Another step in CMS's multi-pronged strategy to combat the nation's opioid crisis is the Maternal Opioid Misuse model. The model addresses fragmentation in the care of pregnant and postpartum Medicaid beneficiaries with opioid use disorder through state-driven transformation of the delivery system surrounding this vulnerable population. By supporting the coordination of clinical care and the integration of other services critical for health, wellbeing, and recovery, the Maternal Opioid Misuse model has the potential to improve quality of care and reduce costs for mothers and infants.

Additionally, CMS's Integrated Care for Kids model is a child-centered local service delivery and state payment model that aims to reduce expenditures and improve the quality of care for children under 21 years of age covered by Medicaid through prevention, early identification, and treatment of behavioral and physical health needs. The model will empower states and local providers to better address these needs, as well as the impact of opioid addiction through care integration across all types of healthcare providers.

Better Care for Dual Eligibles

Improve quality, reduce costs, and improve the customer experience for people eligible for both Medicare and Medicaid.

Increase the number of dually eligible beneficiaries in integrated care and increase the number of states with one or more widely available integrated care options, or similar models that improve value for dually eligible beneficiaries

In recent years, CMS partnered with states to develop innovative, integrated care and financing approaches. CMS focused on initiatives to better integrate and strengthen access to care for dually eligible individuals and to eliminate unnecessary cost shifting between the Medicare and Medicaid programs. There are a range of approaches to integrating Medicare and Medicaid benefits and/or financing, including through Medicare Advantage Dual Eligible Special Needs Plans, the Programs of All-inclusive Care for the Elderly, and integrated care models and demonstrations such as the Medicare-Medicaid Financial Alignment Initiative.

Improve interoperability by increasing the number of states exchanging eligibility-related files with CMS daily

In March 2020, CMS finalized the *Interoperability and Patient Access Rule* that mandated daily submission of certain Medicare Savings Program payment and dual eligibility status files by April 1, 2022. Currently, states are required to submit these files at least monthly to CMS. Without daily exchanges, CMS lags in its ability to automatically enroll these individuals in Medicare drug plans; deem them automatically eligible for the low income subsidy for Part D premiums, deductibles, and copayments; and terminate or activate state payment of Medicare premiums.

Increasing the frequency of federal-state data exchanges will improve beneficiaries' experience with their Medicare benefits and ensure they are affordable, reduce burden on states and providers to reconcile incorrect payments due to data lags, and improve provider compliance with the prohibition on billing Qualified Medicare Beneficiaries for Medicare Parts A and B cost-sharing.

INNOVATIVE Payment Models

Advance innovative payment structures to move our health care system to one that incentivizes value by rewarding quality and performance, lower program costs, innovation and improved health outcomes.

Increase opportunities for providers to participate in innovative models and payment structures, accept higher levels of risk, and take part in new financial arrangements

CMS is designing innovative payment models to offer clinicians an array of new payment models that reward them for doing the job they were trained to do – spending time caring for patients. By focusing on results, innovative payment and service delivery model tests can be potentially expanded in duration and scope if they are cost neutral or save dollars with improved or neutral outcomes. During FY 2020, CMS continued to test innovative payment models focused on local delivery of health care, where patients and providers determine the best care plan, and providers are held accountable for patients' outcomes.

Medicare-Medicaid Financial Alignment Initiative

In 2019, the demonstrations under the Medicare-Medicaid Financial Alignment Initiative (the Financial Alignment Initiative) accounted for more than 40 percent of integrated care enrollment nationally. Through the Financial Alignment Initiative and related work, we are partnering with states to test demonstrations that integrate primary, acute, and behavioral health care, and long-term services and supports for dually eligible individuals. During FY 2020, there were 11 demonstrations in 10 states, serving over 400,000 dually eligible individuals. We are also partnering with Minnesota on an alternative model testing Medicare and Medicaid administrative alignment activities, building on the longstanding Minnesota Senior Health Options program, and serving nearly 41,000 dually eligible individuals.

Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents

Unnecessary hospitalizations can be disruptive and dangerous for nursing facility residents and costly for Medicare. Through the Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents, we are testing strategies to reduce avoidable hospitalizations for Medicare and Medicaid enrollees who are long-stay residents of nursing facilities.

MODERNIZING CMS

Transform how we currently operate to be more efficient and effective in promoting integration and better collaboration among CMS staff, and to support more effective engagement with our stakeholders.

Invest in our people and ensure we effectively attract, retain, and promote high performers and bring new talent in to fill critical gaps in a timely manner

CMS is committed to maintaining a quality workforce. Over the past year, we have reduced our average hiring time to 35 days which is an almost 40 percent reduction. By improving our administrative processes by removing unnecessary requirements and leveraging technology and automation, CMS is making it easier to fill our jobs of serving program recipients.

Arm our people with up-to-date capabilities, including data and analytics, which will help us reduce errors and regulatory burden, and increase program effectiveness

We are upgrading or developing a new set of organizational capabilities to improve upon advanced analytics, program and performance improvement management, strategic planning, and strategic procurement and vendor management. CMS employees, some of our nation's most dedicated and hardworking public servants, need to be equipped with the proper resources, and empowered to serve our beneficiaries in the most efficient, responsive, and effective way possible.

Continue to ensure our organization reflects how we do business today and the changing needs of our stakeholders, to increase our responsiveness to our customers

In FY 2020, we completed two reorganizations which better aligned CMS employees across the country to better meet customer needs and strengthen our organizational effectiveness. The organizational structure changes better integrate regional office staff into policy development and implementation, places similar responsibilities together so we can harness expertise regardless of location, helps ensure consistency in how we handle issues across the country and creates better service to our stakeholders. The changes also reflect how we do business today and the changing needs of our stakeholders, to increase our responsiveness to our customers and make it easier for the public to engage with us.

OVERVIEW OF FINANCIAL DATA

Sound financial management is an integral part of CMS's efforts to deliver services and administer our programs. CMS maintains strong financial management operations and continues to improve its financial management and reporting processes to provide timely, reliable, and accurate financial information. CMS management and other decision makers use this information to make timely and accurate program and administrative decisions.

The basic financial statements in this report are prepared pursuant to the requirements of the *Government Management Reform Act of 1994*, the *Chief Financial Officers Act of 1990*, and other requirements, including the Office of Management and Budget Circular A-136, *Financial Reporting Requirements*. The responsibility for the financial information integrity included in these statements rests with CMS management. 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, 2020 and 2019, amounts of future economic benefits owned or managed by CMS (assets), amounts owed (liabilities), and amounts that comprise the difference (net position). A Consolidating Balance Sheet by Major Program is provided as additional information. CMS's Consolidated Balance Sheets reported assets of $590.1 billion. The largest asset is the Fund Balance with Treasury of $240.5 billion, most of which is used for Medicaid, CHIP, and Payments to Health Care Trust Funds. The next largest assets are Investments totaling $222.1 billion, which are invested in Treasury Special Issues, special public obligations for exclusive purchase by the Medicare trust funds. Trust fund holdings not necessary to meet current expenditures are invested in interest-bearing obligations of the U.S. or in obligations guaranteed as to both principal and interest by the U.S. In addition, Other Assets are $104.3 billion, mainly for payments made for the COVID-19 Accelerated and Advance Payment (AAP) program. Liabilities of $133.4 billion consist primarily of the Entitlement Benefits Due and Payable of $117.0 billion. CMS's Net Position totals $456.7 billion and reflects primarily the Cumulative Results of Operations for the Medicare trust funds and the unexpended balances for Payments to Health Care Trust Funds, Medicaid and CHIP.

Consolidated Statements of Net Cost

The Consolidated Statements of Net Cost present the actual net cost of CMS's operations by program for the years ended September 30, 2020 and 2019. The three major programs that CMS administers are Medicare,

Medicaid, and CHIP. The majority of CMS's expenses are in these programs. Both Medicare and Medicaid program integrity and fraud and abuse funding are included under the HI trust fund. The net cost of operations under "Other" includes: State Grants and Demonstrations, and Other Health. Program Management expenses are allocated and shown separately under each major program. A Consolidating Statement of Net Cost shows the Medicare funds as Dedicated Collection versus Other Fund components of net cost as additional information. In FY 2020, our total Net Cost of Operations was $1,157.0 billion encompassing program/activity gross costs of $1,275.8 billion and operating gross costs of $4.8 billion, less exchange revenue of $123.6 billion.

Consolidated Statements of Changes in Net Position

The Consolidated Statements of Changes in Net Position present the change in net position (i.e., difference between assets and liabilities) for the years ended September 30, 2020 and 2019. Changes in the Cumulative Results of Operations and Unexpended Appropriations affect CMS's net position balance. Funds From Dedicated Collections are shown in a separate column from Other Funds. The bulk of the change pertains to Appropriations Used of $874.1 billion, which represents the Medicaid and CHIP appropriations, transfers from Payments to the Health Care Trust Funds to HI and SMI, and State Grants and Demonstrations and general fund- financed Program Management appropriations. Payments to the Health Care Trust Funds, Medicaid, and CHIP are financed by general fund appropriations provided by Congress. Employment tax revenue is Medicare's portion of payroll and self-employment taxes collected under the *Federal Insurance Contributions Act and the Self Employment Contributions Act* for the HI trust fund and totaled $295.9 billion.

Combined Statements of Budgetary Resources

The Combined Statements of Budgetary Resources provide information about the availability of budgetary resources, as well as their status for the years ended September 30, 2020 and 2019. An additional Schedule of Budgetary Resources is provided as Required Supplementary Information (RSI) to present budgetary information by program. In this statement, Program Management is shown separately and Other includes State Grants and Demonstrations, Other Health and Medicare and Medicaid program integrity, and fraud and abuse activities. Also, there are no intra-CMS eliminations in this statement.

CMS total budgetary resources were $2,007.3 billion. Obligations of $1,873.4 billion leave unobligated balances of $133.9 billion. Total outlays, net of collections, were $1,786.7 billion. When offset by $532.1 billion relating to collection of premiums and general fund transfers from the Payments to the Health Care Trust Funds, as well as refunds of MAC overpayments, the CMS net outlays were $1,254.6 billion.

OVERVIEW OF SOCIAL INSURANCE DATA

Statement of Social Insurance

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

Actuarial present values are computed under the intermediate set of assumptions specified in the 2020 Annual Report of the Boards of *Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. The projections and analysis in this report do not reflect the potential effects of the COVID-19 pandemic, or the legislation enacted in response to it, on the Medicare program. However, given the uncertainty associated with these impacts, the Trustees stated that it was not possible to adjust the estimates accurately at the time the report was released. As of the date of the financial statements, there is still a considerable amount of uncertainty surrounding these impacts and the projections have not been adjusted.

The SOSI presents the following estimates:

- The present value of future income (income excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future cost of providing benefits to those same individuals;

- The present value of future income to be received from or on behalf of current participants who have not yet attained eligibility age and the future cost of providing benefits to those same individuals;

- The present value of future income less future cost for the closed group, which represents all current participants who attain age 15 or older in the first year of the projection period, plus the assets in the combined HI and SMI trust funds as of the beginning of the valuation period;

- The present value of income to be received from or on behalf of future participants and the cost of providing benefits to those same individuals;

- The present value of future income less future cost for the open group, which represents all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program, plus the assets in the combined HI and SMI trust funds as of the beginning of the valuation period; and

- The present value of future cash flows for all current and future participants over the next 75 years (open group measure) increased from $5.5 trillion, determined as of January 1, 2019, to ($4.8) trillion, determined as of January 1, 2020.

When the combined HI and SMI trust fund assets are included, the present value increases. As of January 1, 2020, the future cash flow for all current and future participants was $(4.5) trillion for the 75-year valuation period. The comparable cash flow for the closed group of participants, including the combined HI and SMI trust fund assets, is $(12.8) 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; thus, the HI trust fund assets have been declining. The following table shows the 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 steadily dropped from 67 percent at the beginning of FY 2016 to 57 percent at the beginning of FY 2020.

TRUST FUND RATIO

Beginning of Fiscal Year[1]

	2016	2017	2018	2019	2020
HI	67%	66%	66%	62%	57%

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 2020 Trustees Report indicate that the HI trust fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2020 Trustees Report, the HI trust fund ratio is estimated to decline steadily until the fund is depleted in calendar year 2026. Assets at the end of calendar year 2019 were $194.6 billion and are expected to decrease steadily until depleted in 2026.

Long-Term Financing

The short-range outlook for the HI trust fund is similar to what was projected last year. The trust fund ratio declines until the fund is depleted in 2026, the same date as projected last year. HI financing is not projected to be sustainable over the long-term with the projected tax rates and expenditure levels. Program cost is expected to exceed total income in all years. When the HI trust fund is exhausted, full benefits cannot be paid on a timely basis. The percentage of expenditures covered by tax revenues is projected to decrease from 90 percent in 2026 to 78 percent in 2044, and then to increase to about 90 percent by the end of the projection period.

The primary reasons for the projected long-term inadequacy of financing under current law relate to the fact that the ratio of the number of workers paying taxes relative to the number of individuals eligible for benefits drops from 3.0 in 2019 to about 2.1 by 2094. In addition, health care costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $4.6 trillion, which is 0.8 percent of taxable payroll and 0.3 percent of Gross Domestic Product (GDP) over the same period. Significant uncertainty surrounds the estimates for the SOSI. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near-term and

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

ultimate assumptions used in the projections. For more information, please refer to the *Required Supplementary Information: Social Insurance* disclosures required by the Federal Accounting Standards Advisory Board.

SMI Trust Fund Solvency

The SMI trust fund consists of two accounts – Part B and Part D. In order to evaluate the financial status of the SMI trust fund, each account needs to be assessed individually, since financing rates for each part are established separately, and their program benefits are quite different in nature.

While differences between the two accounts exist, the financing mechanism for each part is similar in that the financing is determined on a yearly basis. The Part B account is generally financed by premiums and general revenue matching appropriations determined annually to cover projected program expenditures and to provide a contingency for unexpected program variation. The Part D account is financed by premiums, general revenues, and transfers from state governments. Unlike the Part B account, the appropriation for Part D has generally been set such that amounts can be transferred to the Part D account on an as-needed basis; under this process, there is no need to maintain a contingency reserve. In September 2015, a new policy was implemented to transfer amounts from the Treasury into the account 5 business days before the benefit payments to the plans. As a result, the Trustees expect the Part D account to include a more substantial balance at the end of most months to reflect this policy.

Since both the Part B and Part D programs are financed on a yearly basis, from a program perspective, there is no unfunded liability in the short or long-range. Therefore, in this financial statement, the present value of estimated future excess of income over expenditures for current and future participants over the next 75 years is $0. However, from a government-wide perspective, general fund transfers, as well as interest payments to the Medicare trust funds and asset redemption, represent a draw on other federal resources for which there is no earmarked source of revenue from the public. Hence, from a government wide perspective, the corresponding estimate of future income less expenditures for the 75-year projection period is $(40.9) trillion.

Even though from a program perspective the unfunded liability is $0, there is concern over the rapid increase in cost of the SMI program as a percent of GDP. In 2019, SMI expenditures were 2.2 percent of GDP. By 2094, SMI expenditures are projected to grow to 4.5 percent of the GDP.

The following table presents key amounts from our basic financial statements for fiscal year 2018 through 2020.

TABLE OF KEY MEASURES [2]

Dollars in billions

	2020	2019	2018
Net Position (end of fiscal year)			
Assets	**$590.1**	**$502.0**	**$467.3**
Less Total Liabilities	**$133.4**	**$134.2**	**$123.5**
Net Position (assets net of liabilities)	**$456.7**	**$367.8**	**$343.8**
Costs (end of fiscal year)			
Net Costs	**$1,157.0**	**$1,087.3**	**$1,009.1**
Total Financing Sources	**$1,189.5**	**$1,079.0**	**$1,017.7**
Net Change in Cumulative Results of Operations	**$32.5**	**$(8.3)**	**$8.6**
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 (as of 1/1/2020)	**($4,800)**	**$(5,484)**	**$(4,708)**
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 (as of 1/1/2019)	**($5,484)**	**$(4,708)**	**$(3,532)**
Change in present value	**$683**	**$(776)**	**$(1,176)**

2 The table or other singular presentation showing the measures described above. Totals do not necessarily equal the sums of rounded components.

Statement of Changes in Social Insurance Amounts

The Statement of Changes in Social Insurance Amounts reconciles the change (between the current valuation period and the prior valuation period) in the present value of future tax income less future cost for current and future participants (the open group measure) over the next 75 years. This reconciliation identifies those components of the change that are significant and provides reasons for the changes. In general, an increase in the present value of net cash flow represents a positive change (improving financing), while a decrease in the present value of net cash flow represents a negative change (worsening financing).

The present value as of January 1, 2020, decreased by $235 billion due to advancing the valuation date by 1 year and including the additional year 2094, by $1,715 billion due to changes in economic and health care assumptions, and by $453 billion due to changes in the law. However, changes in the projection base and demographic assumptions increased the present value by $399 and $2,687 billion, respectively. The net overall impact of these changes is an increase in the present value of $683 billion.

Required Supplementary Information

As required by Statement of Federal Financial Accounting Standards (SFFAS) 17, *Accounting for Social Insurance (as amended by SFFAS 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 individuals with Medicare (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 *2020 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 are prepared to report the financial position and results of operations of CMS, pursuant to the requirements of 31 U.S.C. section 3515(b). The statements are prepared from the books and records of CMS in accordance with Federal General Accepted Accounting Principles and the formats prescribed by the Office of Management and Budget. Reports used to monitor and control budgetary resources are prepared from the same books and records. The financial statements should be read with the realization that they are for a component of the U.S. Government.

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

MEGAN WORSTELL

I am pleased to present the Centers for Medicare & Medicaid Services' fiscal year (FY) 2020 Agency Financial Report (AFR). We received an unmodified opinion on four of the six principal financial statements; however, as in previous years, the auditors were not able to express an opinion on the Statement of Social Insurance and the Statement of Changes in Social Insurance Amounts due to uncertainty in the long-range assumptions applied in our projection models. CMS remains assured that our projections are fairly presented and properly disclose the purpose of the projections. We believe our results of operations support our responsible financial stewardship of taxpayer dollars. These results were affirmed within the auditor's independent unmodified opinion. At CMS, we are proud of our long-standing focus on internal controls and continuous improvement in this area. No material weaknesses were reported within the auditor's report on internal control over financial reporting.

During FY 2020, we focused our financial resources to achieve CMS's vision by investing in our people, processes, structure, and capabilities. We supported initiatives to transform Medicare and Medicaid into affordable, patient-driven programs that encourage innovation and competition. We invested in tools that permit patient control and provider sharing of secure healthcare data, allowing for better coordination of care and less duplication. To further modernize our programs, CMS continued to address the increasing role of technology in seniors' lives while keeping their data safe, and upgraded key information technology systems. Our pursuit, commitment, and achievement of these objectives have transformed the nation's health care system to now deliver better value and results for the patients we serve.

The profound impact on the health care community of the COVID-19 Public Health Emergency (PHE) did not hinder us from achieving our mission. CMS exercised unprecedented flexibilities in the administration of its Accelerated and Advance Payment Program by issuing over $107 billion in Advance and Accelerated payments to over 45,000 providers and suppliers who experienced disruptions to their billing during the pandemic. These payments helped to provide financial stability to the nation's health care system and allowed providers and suppliers to focus their attention on the care of our most vulnerable citizens during the PHE.

As good fiscal stewards, CMS continues to strive to protect taxpayer dollars; unleash innovations in technology; and modernize and invest in CMS by identifying, implementing and achieving measurable improvements to lower costs, improve performance results, create operating efficiencies, realize financial savings, and enhance customer/stakeholder experiences. Some achievements of this CMS initiative include:

- reducing Medicare fee-for-service improper payment rate, from 9.51 percent in 2017 to 6.27 percent in FY 2020.
- protecting the solvency of the Medicare trust funds by realizing Medicare Secondary Payer savings of $8.93 billion.
- reducing the Medicare appeals backlog by executing settlements of over 6,500 appeals filed by Inpatient Rehabilitation Facilities.
- implementing the Department of the Treasury's electronic invoicing initiative to receive vendor invoices directly into CMS's financial system.
- modernizing CMS's operating plan formulation and budget processes to enhance our financial and budget management oversight of our $2 trillion of budgetary resources.

Investing in our people, processes, and stakeholders ensures that CMS operates more efficiently and effectively as we transform the health care system to focus on better health outcomes for patients and their families. We will continue our work of managing and safeguarding taxpayer dollars by developing processes, such as implementing technology that prevents fraud or improper payments, waste, and abuse.

I am proud of all we have overcome and accomplished this year as well as the hard work of our dedicated employees, partners, and stakeholders in helping to accomplish CMS's mission.

Megan Worstell

MEGAN WORSTELL
CMS Chief Financial Officer
November 2020

> **"INVESTING IN OUR PEOPLE, PROCESSES, AND STAKEHOLDERS** ENSURES THAT CMS OPERATES MORE EFFICIENTLY AND EFFECTIVELY AS WE TRANSFORM THE HEALTH CARE SYSTEM TO FOCUS ON **BETTER HEALTH OUTCOMES FOR PATIENTS AND THEIR FAMILIES.**"

CONSOLIDATED BALANCE SHEETS

as of September 30, 2020 and September 30, 2019

(in millions)

	FY 2020 Consolidated Totals	FY 2019 Consolidated Totals
ASSETS		
Intragovernmental Assets:		
Fund Balance with Treasury *(Note 2)*	$240,476	$170,796
Investments *(Note 3)*	222,134	305,378
Accounts Receivable, Net *(Note 4)*	477	589
TOTAL INTRAGOVERNMENTAL ASSETS	463,087	476,763
Accounts Receivable, Net *(Note 4)*	21,044	23,356
General Property, Plant and Equipment, Net	1,612	1,460
Other Assets (*Note 5)*	104,335	446
TOTAL ASSETS	$590,078	$502,025
LIABILITIES		
Intragovernmental Liabilities:		
Accounts Payable	$1,536	$1,476
Other Intragovernmental Liabilities	1,737	3,403
TOTAL INTRAGOVERNMENTAL LIABILITIES	3,273	4,879
Accounts Payable	928	233
Entitlement Benefits Due and Payable *(Note 6)*	116,935	110,100
Contingencies *(Note 7)*	3,686	10,032
Other Liabilities	8,542	8,989
TOTAL LIABILITIES *(Note 8)*	$133,364	$134,233
NET POSITION		
Unexpended Appropriations–Dedicated Collections *(Note 10)*	$98,116	$57,968
Unexpended Appropriations–Other Funds	78,507	62,316
Cumulative Results of Operations–Dedicated Collections *(Note 10)*	278,725	252,377
Cumulative Results of Operations–Other Funds	1,366	(4,869)
TOTAL NET POSITION - DEDICATED COLLECTIONS *(Note 10)*	376,841	310,345
TOTAL NET POSITION - OTHER FUNDS	79,873	57,447
TOTAL NET POSITION	$456,714	$367,792
TOTAL LIABILITIES AND NET POSITION	$590,078	$502,025

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF NET COST

for the years ended September 30, 2020 and September 30, 2019

(in millions)

	FY 2020 Consolidated Totals	FY 2019 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS GPRA PROGRAMS		
Medicare HI		
Benefit/Program	$323,476	$318,030
Program Management	1,422	1,625
Net Cost Medicare HI	**$324,898**	**$319,655**
Medicare SMI		
Benefit/Program (Part B)	$262,686	$263,511
Benefit/Program (Part D)	78,001	71,324
Program Management	2,428	2,333
Net Cost Medicare SMI	**$343,115**	**$337,168**
Medicaid		
Benefit/Program	$458,584	$411,183
Program Management	133	149
Net Cost Medicaid	**$458,717**	**$411,332**
CHIP		
Benefit/Program	$16,937	$17,470
Program Management	14	15
Net Cost CHIP	**$16,951**	**$17,485**
Other		
Benefit/Program	$12,754	$1,033
Program Management	519	598
Net Cost Other	**$13,273**	**$1,631**
NET COST OF OPERATIONS *(NOTE 9)*	**$1,156,954**	**$1,087,271**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2020

(in millions)

	Funds from Dedicated Collections *(Note 10)*	All Other Funds	FY 2020 Consolidated Total
UNEXPENDED APPROPRIATIONS			
Beginning Balances	**$57,968**	**$62,316**	**$120,284**
Budgetary Financing Sources:			
Appropriations Received	**438,810**	**526,552**	**965,362**
Appropriations Transferred-in/out		**(4,562)**	**(4,562)**
Other Adjustments	**(6,458)**	**(23,906)**	**(30,364)**
Appropriations Used	**(392,204)**	**(481,893)**	**(874,097)**
Total Budgetary Financing Sources	**40,148**	**16,191**	**56,339**
Total Unexpended Appropriations	**$98,116**	**$78,507**	**$176,623**
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	**$252,377**	**$(4,869)**	**$247,508**
Budgetary Financing Sources:			
Appropriations Used	**392,204**	**481,893**	**874,097**
Nonexchange Revenue:			
FICA and SECA Taxes	**295,913**		**295,913**
Interest on Investments	**6,404**	**174**	**6,578**
Other Nonexchange Revenue	**3,971**		**3,971**
Transfers-in/out Without Reimbursement	**(4,125)**	**1,092**	**(3,033)**
Other Financing Sources (Nonexchange):			
Transfers-in/out Without Reimbursement			
Imputed Financing	**12,348**	**5**	**12,353**
Other		**(342)**	**(342)**
Total Financing Sources	**$706,715**	**$482,822**	**$1,189,537**
Net Cost of Operations (Note 9)	**680,367**	**476,587**	**1,156,954**
Net Change	**26,348**	**6,235**	**32,583**
CUMULATIVE RESULTS OF OPERATIONS	**$278,725**	**$1,366**	**$280,091**
NET POSITION	**$376,841**	**$79,873**	**$456,714**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2019

(in millions)

	Funds from Dedicated Collections *(Note 10)*	All Other Funds	FY 2019 Consolidated Total
UNEXPENDED APPROPRIATIONS			
Beginning Balances	**$22,934**	**$65,147**	**$88,081**
Budgetary Financing Sources:			
Appropriations Received	**402,356**	**515,950**	**918,306**
Appropriations Transferred-in/out		**(4,167)**	**(4,167)**
Other Adjustments	**(5,861)**	**(88,552)**	**(94,413)**
Appropriations Used	**(361,461)**	**(426,062)**	**(787,523)**
Total Budgetary Financing Sources	**35,034**	**(2,831)**	**32,203**
Total Unexpended Appropriations	**$57,968**	**$62,316**	**$120,284**
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	**$256,977**	**$(1,227)**	**$255,750**
Budgetary Financing Sources:			
Appropriations Used	**361,461**	**426,062**	**787,523**
Nonexchange Revenue:			
FICA and SECA Taxes	**281,441**		**281,441**
Interest on Investments	**9,435**	**254**	**9,689**
Other Nonexchange Revenue	**3,253**		**3,253**
Transfers-in/out Without Reimbursement	**(3,212)**	**164**	**(3,048)**
Other Financing Sources (Nonexchange):			
Transfers-in/out Without Reimbursement		**115**	**115**
Imputed Financing	**49**	**7**	**56**
Total Financing Sources	**$652,427**	**$426,602**	**$1,079,029**
Net Cost of Operations (Note 9)	**657,027**	**430,244**	**1,087,271**
Net Change	**(4,600)**	**(3,642)**	**(8,242)**
CUMULATIVE RESULTS OF OPERATIONS	**$252,377**	**$(4,869)**	**$247,508**
NET POSITION	**$310,345**	**$57,447**	**$367,792**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENTS OF BUDGETARY RESOURCES *(NOTE 11)*

for the years ended September 30, 2020 and September 30, 2019

(in millions)

	FY 2020 Combined Totals Budgetary	FY 2019 Combined Totals Budgetary
Budgetary Resources:		
Unobligated balance from prior year budget authority, net (discretionary and mandatory)	$139,670	$104,727
Appropriations (discretionary and mandatory)	1,855,924	1,631,744
Borrowing authority (discretionary and mandatory)	2	5
Spending authority from offsetting collections (discretionary and mandatory)	11,733	12,141
TOTAL BUDGETARY RESOURCES	$2,007,329	$1,748,617
Status of Budgetary Resources:		
New Obligations and upward adjustments	$1,873,445	$1,654,043
Unobligated balance, end of year		
Apportioned, unexpired accounts	56,046	39,640
Exempt from Apportionment, unexpired accounts	3	
Unapportioned, unexpired accounts	10,561	29,386
Unexpired unobligated balance, end of year	$66,610	$69,026
Expired unobligated balance, end of year	67,274	25,548
Unobligated balance, end of year (total)	$133,884	$94,574
TOTAL BUDGETARY RESOURCES	$2,007,329	$1,748,617
Outlays, net		
Outlays, net (discretionary and mandatory)	$1,786,681	$1,571,678
Distributed offsetting receipts	(532,083)	(490,978)
AGENCY OUTLAYS, NET (DISCRETIONARY AND MANDATORY)	$1,254,598	$1,080,700

The accompanying notes are an integral part of these statements.

STATEMENT OF SOCIAL INSURANCE

75-Year Projection as of January 1, 2020 and Prior Base Years

(in billions)

		Estimates from Prior Years (unaudited)			
	2020 (unaudited)	**2019**	**2018**	**2017**	**2016**
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 12 and 13)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$12,454	$11,995	$11,323	$10,679	$10,294
SMI Part B	32,165	27,556	24,143	21,641	19,386
SMI Part D	6,975	7,181	7,176	6,929	7,659
Have attained eligibility age (age 65 or over)					
HI	637	559	525	492	455
SMI Part B	5,864	5,232	4,725	4,122	3,660
SMI Part D	1,016	1,052	1,015	958	952
Those expected to become participants					
HI	12,464	11,805	10,959	10,567	9,952
SMI Part B	8,567	6,864	5,586	5,019	4,437
SMI Part D	3,043	3,000	2,932	2,869	3,602
All current and future participants					
HI	25,554	24,359	22,807	21,738	20,701
SMI Part B	46,596	39,652	34,453	30,783	27,484
SMI Part D	11,035	11,232	11,124	10,756	12,213
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 12 and 13)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$20,103	$20,028	$18,604	$17,193	$16,800
SMI Part B	31,819	27,270	23,832	21,392	19,178
SMI Part D	6,975	7,181	7,176	6,929	7,659
Have attained eligibility age (age 65 and over)					
HI	6,073	5,348	5,027	4,539	4,285
SMI Part B	6,194	5,741	5,180	4,531	4,026
SMI Part D	1,016	1,052	1,015	958	952
Those expected to become participants					
HI	4,179	4,467	3,884	3,539	3,437
SMI Part B	8,583	6,641	5,442	4,860	4,281
SMI Part D	3,043	3,000	2,932	2,869	3,602
All current and future participants:					
HI	30,355	29,843	27,515	25,270	24,523
SMI Part B	46,596	39,652	34,453	30,783	27,484
SMI Part D	11,035	11,232	11,124	10,756	12,213
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 12 and 13)					
HI	$(4,800)	$(5,484)	$(4,708)	$(3,532)	$(3,822)
SMI Part B					
SMI Part D					
Additional Information					
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 12 and 13)					
HI	$(4,800)	$(5,484)	$(4,708)	$(3,532)	$(3,822)
SMI Part B					
SMI Part D					
Trust Fund assets at start of period					
HI	$195	$200	$202	$199	$194
SMI Part B	100	96	80	88	68
SMI Part D	9	8	8	8	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 12 and 13)					
HI	$(4,606)	$(5,283)	$(4,506)	$(3,333)	$(3,628)
SMI Part B	100	96	80	88	68
SMI Part D	9	8	8	8	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, 2020 and Prior Base Years

(in billions)

		Estimates from Prior Years (unaudited)			
	2020 (unaudited)	**2019**	**2018**	**2017**	**2016**
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)	$7,517	$6,843	$6,266	$5,572	$5,067
Expenditures	13,284	12,140	11,222	10,027	9,263
Income less expenditures	(5,766)	(5,297)	(4,957)	(4,455)	(4,196)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	51,594	46,731	42,643	39,250	37,339
Expenditures	58,897	54,479	49,612	45,514	43,637
Income less expenditures	(7,303)	(7,748)	(6,970)	(6,264)	(6,298)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(13,069)	(13,045)	(11,926)	(10,719)	(10,493)
Combined Medicare Trust Fund assets at start of period	303	305	290	295	263
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(12,766)	(12,740)	(11,637)	(10,425)	(10,230)
Future Participants:					
Actuarial present value for the 75-year projection period:					
Income (excluding interest)	$24,074	$21,669	$19,477	$18,456	$17,992
Expenditures	15,805	14,108	12,258	11,268	11,320
Income less expenditures	8,269	7,561	7,219	7,187	6,672
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(4,800)	(5,484)	(4,708)	(3,532)	(3,822)
Combined Medicare Trust Fund assets at start of period	303	305	290	295	263
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$(4,497)	$(5,179)	$(4,418)	$(3,237)	$(3,559)

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, 2019 to January 1, 2020

(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 14)*					
As of January 1, 2019	$75,243	$80,727	$(5,484)	$305	$(5,179)
Reasons for change					
Change in the valuation period	2,691	2,926	(235)	(3)	(238)
Change in projection base	444	45	399	2	401
Changes in the demographic assumptions	(1,871)	(4,558)	2,687		2,687
Changes in economic and health care assumptions	7,455	9,170	(1,715)		(1,715)
Changes in law	(778)	(325)	(453)		(453)
Net changes	7,942	7,259	683	(1)	682
As of January 1, 2020	$83,185	$87,986	$(4,800)	$303	$(4,497)
HI: Part A *(Note 14)*					
As of January 1, 2019	$24,359	$29,843	$(5,484)	$200	$(5,283)
Reasons for change					
Change in the valuation period	799	1,034	(235)	(7)	(242)
Change in projection base	(17)	(415)	399	1	400
Changes in the demographic assumptions	(426)	(3,114)	2,687		2,687
Changes in economic and health care assumptions	1,386	3,101	(1,715)		(1,715)
Changes in law	(547)	(94)	(453)		(453)
Net changes	1,195	512	683	(6)	677
As of January 1, 2020	$25,554	$30,355	$(4,800)	$195	$(4,606)
SMI: Part B *(Note 14)*					
As of January 1, 2019	$39,652	$39,652		$96	$96
Reasons for change					
Change in the valuation period	1,449	1,449		3	3
Change in projection base	285	285			
Changes in the demographic assumptions	(1,049)	(1,049)			
Changes in economic and health care assumptions	6,414	6,414			
Changes in law	(154)	(154)			
Net changes	6,944	6,944		3	3
As of January 1, 2020	$46,596	$46,596		$100	$100
SMI: Part D *(Note 14)*					
As of January 1, 2019	$11,232	$11,232		$8	$8
Reasons for change					
Change in the valuation period	444	444			
Change in projection base	176	176		1	1
Changes in the demographic assumptions	(395)	(395)			
Changes in economic and health care assumptions	(345)	(345)			
Changes in law	(77)	(77)			
Net changes	(198)	(198)		1	1
As of January 1, 2020	$11,035	$11,035		$9	$9

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

January 1, 2018 to January 1, 2019

(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 14)*					
As of January 1, 2018	$68,385	$73,092	$(4,708)	$290	$(4,418)
Reasons for change					
Change in the valuation period	2,427	2,628	(201)	7	(193)
Change in projection base	251	451	(200)	8	(193)
Changes in the demographic assumptions	(852)	(879)	27		27
Changes in economic and health care assumptions	5,032	5,435	(402)		(402)
Changes in law					
Net changes	6,858	7,634	(776)	15	(761)
As of January 1, 2019	$75,243	$80,727	$(5,484)	$305	$(5,179)
HI: Part A *(Note 14)*					
As of January 1, 2018	$22,807	$27,515	$(4,708)	$202	$(4,506)
Reasons for change					
Change in the valuation period	748	949	(201)	(5)	(206)
Change in projection base	(100)	100	(200)	4	(197)
Changes in the demographic assumptions	(243)	(270)	27		27
Changes in economic and health care assumptions	1,146	1,548	(402)		(402)
Changes in law					
Net changes	1,552	2,328	(776)	(2)	(778)
As of January 1, 2019	$24,359	$29,843	$(5,484)	$200	$(5,283)
SMI: Part B *(Note 14)*					
As of January 1, 2018	$34,453	$34,453		$80	$80
Reasons for change					
Change in the valuation period	1,232	1,232		13	13
Change in projection base	70	70		3	3
Changes in the demographic assumptions	(507)	(507)			
Changes in economic and health care assumptions	4,404	4,404			
Changes in law					
Net changes	5,199	5,199		16	16
As of January 1, 2019	$39,652	$39,652		$96	$96
SMI: Part D *(Note 14)*					
As of January 1, 2018	$11,124	$11,124		$8	$8
Reasons for change					
Change in the valuation period	447	447		(1)	(1)
Change in projection base	281	281		1	1
Changes in the demographic assumptions	(103)	(103)			
Changes in economic and health care assumptions	(517)	(517)			
Changes in law					
Net changes	108	108			
As of January 1, 2019	$11,232	$11,232		$8	$8

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

Basis of Accounting and Presentation

The financial statements were prepared from CMS's accounting records in accordance with accounting principles generally accepted in the United States (GAAP) and the form and content specified by the Office of Management and Budget (OMB) in OMB Circular A-136, *Financial Reporting Requirements*. GAAP for federal entities are the standards prescribed by the Federal Accounting Standards Advisory Board (FASAB). In accordance with Statement of Federal Financial Accounting Standards (SFFAS) 47, *Reporting Entity*, CMS has included all consolidation entities for which it is accountable in this general purpose federal financial report.

The financial statements have been prepared to report the financial position, net cost, changes in net position, and budgetary resources for all programs administered by CMS. CMS's fiscal year (FY) 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 that, 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. Accounting standards require all reporting entities to disclose that accounting standards allow certain presentations and disclosures to be modified, if needed, to prevent the disclosure of classified information.

Use of Estimates

Financial statements prepared in accordance with GAAP are based on a selection of accounting policies and the application of significant accounting estimates. Some estimates require management to make significant assumptions. Further, the estimates are based on current conditions that may change in the future. Actual results could differ materially from the estimated amounts. The financial statements include information to assist in understanding the effect of changes in assumptions to the related information.

Parent/Child Reporting

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

Funds from Dedicated Collections

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

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

CMS's major funds from dedicated collections include:

Medicare Hospital Insurance Trust Fund – Part A

Section 1817 of the *Social Security Act* established the Medicare Hospital Insurance (HI) trust fund. Benefit payments made by the Medicare contractors for Medicare Part A 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 U.S. Government (general fund) to the HI trust fund based on the amount of wages certified by the Commissioner of Social Security from the Social Security Administration (SSA) records of wages established and maintained by SSA in accordance with wage information reports.

Medicare Supplementary Medical Insurance Trust Fund – Part B

Section 1841 of the *Social Security Act* established the Supplementary Medical Insurance (SMI) trust fund. Benefit payments made by the Medicare contractors for Medicare Part B services, as well as administrative costs, are charged to the SMI trust fund. A portion of CMS payments to Medicare Advantage plans are also charged to this fund. The financial statements include SMI trust fund activities administered by Treasury. The SMI trust fund has permanent indefinite authority.

SMI benefits and administrative expenses are financed primarily by monthly premiums paid by Medicare beneficiaries with matching by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the *Social Security Act* authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as the method to fully compensate the trust fund 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. Medicare also 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 *Patient Protection and Affordable Care Act* (PPACA) provides that beneficiary cost sharing in the Part D coverage gap is reduced for brand-name and generic drugs by 7 percentage points per year until coinsurance is 25 percent by 2020. Part D is considered part of the SMI trust fund and is reported in the SMI 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*. 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. 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.

Payments to the Health Care Trust Funds Appropriation

The *Social Security Act* provides for payments to the HI and SMI trust funds for SMI (e.g., appropriated funds to provide for federal matching of SMI premium collections) and HI (e.g., for the Uninsured and Federal Uninsured Payments). The Act also prescribes that funds covering the Medicare Prescription Drug Benefit and associated administrative costs, retiree drug coverage, reimbursements to the states and Transitional Assistance benefits be transferred from the general fund to the SMI trust fund; this occurs via the Payments to the Health Care Trust Funds account. The *Social Security Act* also prescribes that criminal fines and civil monetary penalties arising from health care cases be transferred to the Health Care Fraud and Abuse Control (HCFAC) account of the HI trust fund as well as payments to support FBI activities related to health

care fraud and abuse activities. There is permanent indefinite authority for the transfer of general funds containing criminal fines and civil monetary penalties to the HCFAC account of the HI trust fund. In addition, funds are provided by the Payments to the Health Care Trust Funds account to cover CMS's administrative costs that are not related to the Medicare program. To prevent duplicative reporting, the Fund Balance, Unexpended Appropriation, Financing Sources and Expenditure Transfers of this appropriation are reported only in the Medicare HI and SMI columns of the financial statements.

There is permanent indefinite authority for the transfer of general funds to the HI trust fund in amounts equal to SECA tax credits and receipts from taxation of Old-Age, Survivors, and Disability Insurance (OASDI) beneficiaries. The Social Security Amendments of 1994, provided for additional tax payments from Social Security OASDI benefits and Tier 1 Railroad Retirement beneficiaries.

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

Medicaid

Medicaid is administered via grant awards, which limit the funds that can be drawn by the states to cover current expenses. 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 PPACA expanded eligibility (based upon a state's choice) for Medicaid to certain low-income adults with the federal government paying 100 percent of claims for those newly eligible under Medicaid expansion for the first three years, phasing down to 90 percent in calendar year (CY) 2020 and beyond (the rate for CY 2018 is 94 percent and for CY 2019 is 93 percent). On March 18, 2020, the President signed into law H.R. 6021, the *Families First Coronavirus Response Act* (FFCRA). This Act provides a temporary 6.2 percentage point increase to each qualifying state and territory's Federal Medical Assistance Percentage (FMAP) effective beginning January 1, 2020 and extending through the last day of the calendar quarter in which the public health emergency declared by the Secretary of HHS for COVID-19, including any extensions, terminates. The increased FMAP was in effect through September 30, 2020.

CHIP

CHIP is administered via grant awards, which limit the funds that can be drawn by the states to cover current expenses.

The *Children's Health Insurance Program Reauthorization Act of 2009* (CHIPRA) established a Child Enrollment Contingency Fund to cover shortfalls in funding for the states. This fund is invested in interest-bearing Treasury securities.

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 PPACA, several new grants were included in the account and the availability of funds for other grants was extended.

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, Exchange, and Other User Fees

This account operates as a revolving fund without fiscal year restriction. Medicare Advantage plans are required to make payments for their share of the estimated costs related to enrollment, dissemination of information, and certain counseling and assistance programs. These user fees are devoted to educational efforts for beneficiaries and outreach partners. The Clinical Laboratory Improvement Amendments of 1988 (CLIA) marked the first comprehensive effort by the federal government to regulate medical laboratory testing. Fees for registration, certificates, and compliance determination of all U.S. clinical laboratories are collected to finance the program. Beginning January 1, 2014, the PPACA requires the collection of a user fee from each issuer offering

coverage through a Federally-facilitated Exchange 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 a based on the CMS cost allocation system. It is reported under the Program Management (administrative) and Other (user fees) columns in the supplemental statements in the Supplementary Information section. Both of these activities are reported as dedicated collections.

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 PPACA 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.

Investments consist of trust fund (Dedicated collections) investments which are investments (plus the accrued interest on investments) held by Treasury. 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. Additionally, investments consist of the CHIP Child Enrollment Contingency Fund investments (net of any accrued amortized or unrealized discounts) also held by Treasury (see Note 3).

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

Benefit Payments are payments made by Medicare contractors, CMS, and state Medicaid agencies to health care providers for their services. CMS recognizes the cost associated with payments in the period incurred and based on entitlement. In accordance with Public Law and existing federal accounting standards, no expense or liability is recorded for any future payment to be made on behalf of current workers contributing to the Medicare HI trust fund.

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

Medicare Premiums Collected are used to help finance benefits and administrative expenses. Premiums collected are for Part A, Part B, Medicare Advantage and Part D.

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

- **Appropriations Used and Federal Matching Contributions** are described in the Medicare Premiums Collected section above. For financial statement purposes, appropriations used are recognized as a financing source as expenses are incurred. A transfer of general funds to the HI trust fund in an amount equal to SECA tax credits is made through the Payments to the Health Care Trust Funds account.

- **Nonexchange Revenues** arise primarily from the exercise of the Government's power to demand payment from the public (e.g., taxes, duties, fines and penalties) but also include donations. Employment tax revenue is the primary source of financing for Medicare's HI program. Interest earned on HI and SMI trust fund investments, as well as on the Child Enrollment Contingency Fund investments, are also reported as nonexchange revenue.

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, Report on Budget Execution and Budgetary Resources. OMB has mandated that CMS report all Medicare cash collections as an offsetting receipt.

Imputed Financing Sources occur when costs are paid out of funds appropriated to other federal entities. For instance, certain legal judgments against CMS are paid from the Judgment Fund maintained by Bureau of Fiscal Service, Treasury. When costs are identifiable to CMS, directly attributable to CMS's operations, and paid by other agencies, CMS recognizes these amounts as imputed costs within the Consolidated Statements of Net Cost and as an imputed financing source on the Consolidated Statement of Changes in Net Position.

The PPACA

The PPACA 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). One of the main programs under CCIIO is the Health Insurance Exchanges (the "Exchanges"). A brief description of the remaining programs is presented below. There were two additional programs - Transitional Reinsurance and Risk Corridors – that are no longer in operation.

Health Insurance Exchanges

Grants have been provided to the states to establish Health Insurance Exchanges. The initial grants were made by HHS to the states "not later than 1 year after the date of enactment." Thus, HHS made the initial grants by March 23, 2011. Subsequent grants were issued by CMS through December 31, 2014, after which time no further grants could be made. All Exchanges were launched on October 1, 2013.

Risk Adjustment Program

The Risk Adjustment program is a permanent program. It applies to non-grandfathered individual and small group plans inside and outside the Exchanges. It provides payments to health insurance issuers that disproportionately attract higher-risk populations (such as individuals with chronic conditions) and transfers funds from plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to protect against adverse selection. States that operate a State-based Exchange are eligible to establish a Risk Adjustment program. States operating a Risk Adjustment program may have an entity other than the Exchange perform this function. CMS operates a Risk Adjustment program for each state that does not operate its own Risk Adjustment program.

NOTE 2:
FUND BALANCE WITH TREASURY

(Dollars in Millions)

	FY 2020	FY 2019
Status of Fund Balances with Treasury:		
Unobligated Balance:		
Available	**$56,049**	**$39,640**
Unavailable	**77,835**	**54,934**
Obligated Balance not yet Disbursed	**174,005**	**149,132**
Non-Budgetary FBWT	**(67,413)**	**(72,910)**
Total Status of Fund Balances with Treasury	**$240,476**	**$170,796**

The Unobligated Balance Available includes $29,812 million ($16,609 million in FY 2019), which is restricted for future use and is not apportioned for current use for PPACA, CHIP, Program Management, and State Grants and Demonstrations.

NOTE 3:

INVESTMENTS

(Dollars in Millions)

FY 2020 **Medicare Investments** ***(Dedicated Collections)***	**Maturity Range**	**Interest Range**	**Value**
HI TF			
Certificates	June 2021	.75%	$25,333
Bonds	June 2022 to June 2029	.75 – 2.875%	108,401
Accrued Interest			566
Total HI TF Investments			**$134,300**
SMI TF			
Certificates	June 2021	.625 – .75%	$25,093
Bonds	June 2023 to June 2034	.75 – 2.875%	62,384
Accrued Interest			357
Total SMI TF Investments			**$87,834**
Total Medicare Investments			**$222,134**

FY 2019 **Medicare Investments** ***(Dedicated Collections)***	**Maturity Range**	**Interest Range**	**Value**
HI TF			
Certificates	June 2020	1.625%	$13,460
Bonds	June 2020 to June 2029	1.875 – 5.125%	185,165
Accrued Interest			1,490
Total HI TF Investments			**$200,115**
SMI TF			
Certificates	June 2020	1.625 – 2.125%	$20,450
Bonds	June 2022 to June 2034	1.875 – 5.000%	84,267
Accrued Interest			546
Total SMI TF Investments			**$105,263**
Total Medicare Investments			**$305,378**

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:

CMS INVESTMENT SUMMARY

(Dollars in Millions)

FY 2020	Medicare (Dedicated Collection)			Consolidated Total
	HI TF	SMI TF	Total	
Certificates	$25,333	$25,093	$50,426	$50,426
Bonds	108,401	62,384	170,785	170,785
Accrued Interest	566	357	923	923
Total Investments	**$134,300**	**$87,834**	**$222,134**	**$222,134**

FY 2019	Medicare (Dedicated Collection)			Consolidated Total
	HI TF	SMI TF	Total	
Certificates	$13,460	$20,450	$33,910	$33,910
Bonds	185,165	84,267	269,432	269,432
Accrued Interest	1,490	546	2,036	2,036
Total Investments	**$200,115**	**$105,263**	**$305,378**	**$305,378**

NOTE 4:

ACCOUNTS RECEIVABLE, NET

(Dollars in Millions)

FY 2020	Accounts Receivable Principal	Interest Receivable	Accounts Receivable Gross	Allowance	Net CMS Receivables
Intragovernmental					
Entity	$477		$477		$477
Total Intragovernmental	$477		$477		$477
With the Public					
Entity					
Medicare FFS	$8,242		$8,242	$(3,626)	$4,616
Medicare Advantage/Prescription Drug Program	7,689		7,689	(5)	7,684
Medicaid	5,359		5,359	(1,038)	4,321
CHIP	204		204		204
Other	4,594		4,594	(395)	4,199
Non-Entity	4	$72	76	(56)	20
Total With the Public	$26,092	$72	$26,164	$(5,120)	$21,044

FY 2019	Accounts Receivable Principal	Interest Receivable	Accounts Receivable Gross	Allowance	Net CMS Receivables
Intragovernmental					
Entity	$589		$589		$589
Total Intragovernmental	$589		$589		$589
With the Public					
Entity					
Medicare FFS	$8,606		$8,606	$(3,502)	$5,104
Medicare Advantage/Prescription Drug Program	9,909		9,909	(5)	9,904
Medicaid	4,943		4,943	(785)	4,158
CHIP	204		204		204
Other	4,381		4,381	(427)	3,954
Non-Entity	4	$72	76	(44)	32
Total With the Public	$28,047	$72	$28,119	$(4,763)	$23,356

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 [restitutions balances for FY 2020 are $2.4 billion (gross) and $74 million (net of allowance) [$2.2 billion (gross) and $67 million (net of allowance) in FY 2019], the recognition of Medicare secondary payer (MSP) accounts receivable, and Exchange activities. Accounts receivable with the public is presented net of an allowance for uncollectible amounts. The allowance is based on past collection experience and an analysis of outstanding balances. For Medicare accounts receivable, the allowance for uncollectible accounts receivable derived this year has been calculated from data based on the agency's collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the past five years. The Medicaid accounts receivable has been recorded at a net realizable value based on a historic analysis of actual recoveries and the rate of disallowances found in favor of the states. The other accounts receivable have been recorded to account for amounts due related to collections for Exchange activities.

NOTE 5:

OTHER ASSETS

(Dollars in Millions)

As of September 30, 2020, CMS has $104,335 million ($446 million in FY 2019) in total other assets, mainly for advance/accelerated payments made for the COVID-19 Accelerated and Advance Payment (AAP) program. The original AAP program was set up to help providers and suppliers who had cash flow concerns due to system issues causing delays in submissions or processing of claims or local emergencies (e.g., hurricanes). On March 30, 2020, the AAP program was expanded based on the language included in the *Coronavirus Aid, Relief, and Economic Security (CARES) Act* for specific providers. Collections of these items will begin in March 2021. There were no prepayments made in 2019 for FY 2019 that would result in a similar advance in the consolidated balance sheets as of September 30, 2019.

NOTE 6:

ENTITLEMENT BENEFITS DUE AND PAYABLE

(Dollars in Millions)

	FY 2020	FY 2019
Medicare FFS	**$49,262**	**$54,752**
Medicare Advantage/Prescription Drug Program	**20,890**	**16,839**
Medicaid	**45,850**	**37,147**
CHIP	**933**	**1,360**
Other		**2**
TOTALS	**$116,935**	**$110,100**

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, 2020 and 2019 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 2020. 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, 2020.

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 based on data from the states' latest audited Comprehensive Annual Financial Report. Each state's estimate is subject to variability due to the variety of programs offered by the respective states and the data required to formulate these estimates. Accordingly, the ultimate outcome of these estimates could vary from the amounts recorded at September 30, 2020 and 2019.

NOTE 7:

CONTINGENCIES

(Dollars in Millions)

The contingencies balance as of September 30, 2020 is $3,686 million ($10,032 million in FY 2019), which includes $3,674 million for Medicaid ($9,859 million in FY 2019) for audit and program disallowances and reimbursement of state plan amendments. Additionally, 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. CMS may owe amounts to providers for previous years' disputed cost report and claims adjustments. 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.

NOTE 8:

LIABILITIES NOT COVERED BY BUDGETARY RESOURCES

(Dollars in Millions)

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 FECA payments. For CMS revolving funds, all liabilities are funded as they occur.

Additionally, the *Balanced Budget Act of 2015* (Section 601) authorized a transfer from the general fund to SMI, to temporarily replace the reduction in Part B premiums for calendar years 2016 and 2017. Section 601 created an "additional premium" charged alongside the normal Part B monthly premiums which will be used to pay back the general fund transfer without interest. These repayments are transferred quarterly. As of September 30, 2020, $1,154 million ($3,152 million in FY 2019) is still owed.

Starting January 1, 2014, the PPACA provides for a permanent Risk Adjustment program and a temporary transitional Reinsurance program administered by CMS. With these programs, amounts may be owed to or due from private health insurers who participate in the Exchange that began on January 1, 2014, as well as the broader individual and small group markets. The Reinsurance program is no longer in operation, however, there are still funds left in the program to be paid to Treasury, and for administrative cost. An accrual has been recorded for this program as of September 30, 2020. The Risk Adjustment program will be administered in a budget neutral manner in any calendar year and collections will not be due and payments will not be made until the year following the calendar year for which the program operates. As of September 30, 2020, accruals were recorded to cover future payments, collections, sequestration, and for one appeal that is still due that pertain to program year 2017 for the Risk Adjustment program, and are reflected on the Other line below.

FY 2020 Intragovernmental	Medicare								
	HI TF	SMI TF	Medicaid	CHIP	Other	Program Mgmt.	Combined Total	Intra-CMS Eliminations	Consolidated Total
Other					$362	$3	$365		$365
Total Intragovernmental					362	3	365		365
Federal Employee and Veterans' Benefits						14	14		14
Other	$5				4,560	60	4,625		4,625
Contingencies	12		$3,674				3,686		3,686
Total Liabilities Not Covered by Budgetary Resources	17		3,674		4,922	77	8,690		8,690
Total Liabilities Covered by Budgetary Resources	69,806	$85,656	45,963	$1,415	3,908	212	206,960	$(82,840)	124,120
Total Liabilities Not Requiring Budgetary Resources	132	380			42		554		554
TOTAL LIABILITIES	$69,955	$86,036	$49,637	$1,415	$8,872	$289	$216,204	$(82,840)	$133,364

FY 2019 Intragovernmental	Medicare								
	HI TF	SMI TF	Medicaid	CHIP	Other	Program Mgmt.	Combined Total	Intra-CMS Eliminations	Consolidated Total
Other					$33	$2	$35		$35
Total Intragovernmental					33	2	35		35
Federal Employee and Veterans' Benefits						14	14		14
Other	$4	$1			5,067	48	5,120		5,120
Contingencies	173		$9,859				10,032		10,032
Total Liabilities Not Covered by Budgetary Resources	177	1	9,859		5,100	64	15,201		15,201
Total Liabilities Covered by Budgetary Resources	78,414	84,884	37,267	$1,360	3,149	150	205,224	$(87,070)	118,154
Total Liabilities Not Requiring Budgetary Resources	158	633			87		878		878
TOTAL LIABILITIES	$78,749	$85,518	$47,126	$1,360	$8,336	$214	$221,303	$(87,070)	$134,233

NOTE 9:

NET COST OF OPERATIONS

(Dollars in Millions)

FY 2020	Medicare		Health			
	HI TF	SMI TF	Medicaid	CHIP	Other	Consolidated Total
BENEFIT/PROGRAM COSTS						
Medicare						
Fee for Service	$190,171	$191,944				$382,115
Medicare Advantage/ Managed Care	135,994	177,826				313,820
Prescription Drug (Part D)		83,758				83,758
Medicaid/CHIP			$458,322	$16,936		475,258
Other					$8,252	8,252
Judgment Fund (Treasury)					12,306	12,306
Bad Debt Expense and Writeoffs	52	18	253		(45)	278
Total Benefit/Program Costs	$326,217	$453,546	$458,575	$16,936	$20,513	$1,275,787
OPERATING COSTS						
Medicare Integrity Program	$1,381					$1,381
Quality Improvement Organizations	464	$175				639
Program Management and Other Expenses	508	1,384	$143	$15	$722	2,772
Total Operating Costs	2,353	1,559	143	15	722	4,792
TOTAL COSTS	$328,570	$455,105	$458,718	$16,951	$21,235	$1,280,579
Less: Exchange Revenues:						
Medicare Premiums	$4,356	$112,961				$117,317
Other Exchange Revenues	8	17	$1		$6,282	6,308
Total Exchange Revenues	4,364	112,978	1		6,282	123,625
Intra-CMS Eliminations	692	988			(1,680)	
TOTAL NET COST OF OPERATIONS	$324,898	$343,115	$458,717	$16,951	$13,273	$1,156,954

NOTE 9:
NET COST OF OPERATIONS *(CONTINUED)*

(Dollars in Millions)

	Medicare		Health			
FY 2019	**HI TF**	**SMI TF**	**Medicaid**	**CHIP**	**Other**	**Consolidated Total**
BENEFIT/PROGRAM COSTS						
Medicare						
Fee for Service	$204,592	$212,311				$416,903
Medicare Advantage/ Managed Care	115,165	149,163				264,328
Prescription Drug (Part D)		76,866				76,866
Medicaid/CHIP			$411,355	$17,470		428,825
Other					$8,847	8,847
Bad Debt Expense and Writeoffs	101	44	(172)		66	39
Total Benefit/Program Costs	$319,858	$438,384	$411,183	$17,470	$8,913	$1,195,808
OPERATING COSTS						
Medicare Integrity Program	$1,342					$1,342
Quality Improvement Organizations	604	$272				876
Program Management and Other Expenses	2,136	1,274	$149	$15	$688	4,262
Total Operating Costs	4,082	1,546	149	15	688	6,480
TOTAL COSTS	$323,940	$439,930	$411,332	$17,485	$9,601	$1,202,288
Less: Exchange Revenues:						
Medicare Premiums	$4,128	$102,627				$106,755
Other Exchange Revenues	4	10			$8,248	8,262
Total Exchange Revenues	4,132	102,637			8,248	115,017
Intra-CMS Eliminations	(153)	(125)			278	
TOTAL NET COST OF OPERATIONS	$319,655	$337,168	$411,332	$17,485	$1,631	$1,087,271

For purposes of financial statement presentation, non-CMS administrative costs are considered expenses to the Medicare trust funds when outlayed by Treasury even though some funds may have been used to pay for assets such as property and equipment. CMS administrative costs have been allocated to programs based on the CMS cost allocation system. Program Management costs allocated to the Medicare program include $2,273 million ($2,248 million in FY 2019) paid to Medicare contractors to carry out their responsibilities as CMS's agents in the administration of the Medicare program.

For reporting purposes, Medicare Part D expense has been reduced by actual and accrued reimbursements made by the states pursuant to the State Phased-Down provision. The FY 2020 Part D expense of $83,758 million ($76,866 million in FY 2019) is net of State reimbursements of $11,003 million ($13,897 million in FY 2019). The gross expense would have been $94,761 million ($90,763 million in FY 2019).

NOTE 10:

FUNDS FROM DEDICATED COLLECTIONS

(Dollars in Millions)

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. Other Non-Medicare includes user fees and program management (administrative) activities. Condensed information showing assets, liabilities, gross cost, exchange and nonexchange revenues and changes in net position appears below.

	Medicare	Other Non-Medicare	Eliminations	Total Dedicated Collections
Balance Sheet as of September 30, 2020				
ASSETS				
Fund Balance with Treasury	$107,525	$7,842		$115,367
Investments	222,134			222,134
Other Assets	191,183	12,282	$(81,414)	122,051
TOTAL ASSETS	$520,842	$20,124	$(81,414)	$459,552
LIABILITIES				
Entitlement Benefits Due and Payable	$70,152			$70,152
Other Liabilities	85,839	$8,134	$(81,414)	12,559
TOTAL LIABILITIES	$155,991	$8,134	$(81,414)	$82,711
Unexpended Appropriations	$97,863	$253		$98,116
Cumulative Results of Operations	266,988	11,737		278,725
TOTAL LIABILITIES AND NET POSITION	$520,842	$20,124	$(81,414)	$459,552
Statement of Net Cost for the year ended September 30, 2020				
Benefit/Program Costs	$779,763	$19,666		$799,429
Operating Costs	37	4,521	$1,680	6,238
Total Costs	$779,800	$24,187	$1,680	$805,667
Less Exchange Revenues	117,317	6,303	1,680	125,300
Net Cost of Operations	$662,483	$17,884		$680,367
Statement of Changes in Net Position for the year ended September 30, 2020				
Net Position, Beginning of Period	$297,880	$12,465		$310,345
Taxes and Other Nonexchange Revenue	306,288			306,288
Other Financing Sources	423,166	17,409		440,575
Net Cost of Operations	662,483	17,884		680,367
Change in Net Position	66,971	(475)		66,496
NET POSITION, END OF PERIOD	$364,851	$11,990		$376,841

NOTE 10:
FUNDS FROM DEDICATED COLLECTIONS (CONTINUED)

(Dollars in Millions)

	Medicare	Other Non-Medicare	Eliminations	Total Dedicated Collections
Balance Sheet as of September 30, 2019				
ASSETS				
Fund Balance with Treasury	$63,442	$7,175		$70,617
Investments	305,378			305,378
Other Assets	93,327	13,459	$(86,036)	20,750
TOTAL ASSETS	**$462,147**	**$20,634**	**$(86,036)**	**$396,745**
LIABILITIES				
Entitlement Benefits Due and Payable	$71,591	$3		$71,594
Other Liabilities	92,676	8,166	$(86,036)	14,806
TOTAL LIABILITIES	**$164,267**	**$8,169**	**$(86,036)**	**$86,400**
Unexpended Appropriations	$57,895	$73		$57,968
Cumulative Results of Operations	239,985	12,392		252,377
TOTAL LIABILITIES AND NET POSITION	**$462,147**	**$20,634**	**$(86,036)**	**$396,745**
Statement of Net Cost for the year ended September 30, 2019				
Benefit/Program Costs	$758,242	$7,439		$765,681
Operating Costs	1,656	4,698	$(278)	6,076
Total Costs	759,898	12,137	(278)	771,757
Less Exchange Revenues	106,755	8,253	(278)	114,730
Net Cost of Operations	**653,143**	**3,884**		**657,027**
Statement of Changes in Net Position for the year ended September 30, 2019				
Net Position, Beginning of Period	$275,348	$4,563		$279,911
Taxes and Other Nonexchange Revenue	294,129			294,129
Other Financing Sources	381,546	11,786		393,332
Net Cost of Operations	**653,143**	**3,884**		**657,027**
Change in Net Position	**22,532**	**7,902**		**30,434**
NET POSITION, END OF PERIOD	**$297,880**	**$12,465**		**$310,345**

NOTE 11:

STATEMENT OF BUDGETARY RESOURCES DISCLOSURES

(Dollars in Millions)

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 of $146,530 million ($223,554 million in FY 2019) are included in Investments on the Balance Sheets. The following table presents trust fund activities and balances for FY 2020 and FY 2019 (in millions):

	FY 2020 Combined Balance	FY 2019 Combined Balance
TRUST FUND BALANCE, BEGINNING	**$223,554**	**$230,855**
Receipts	**745,848**	**695,681**
Less Obligations	**822,872**	**702,982**
Excess (Shortage) of Receipts Over Obligations	**(77,024)**	**(7,301)**
TRUST FUND BALANCE, ENDING	**$146,530**	**$223,554**

Explanations of Differences Between the Combined Statement of Budgetary Resources and the Budget of the United States Government for FY 2019

CMS reconciled the amounts of the FY 2019 column of the SBR to the actual amounts for FY 2019 from the Appendix in the FY 2020 President's Budget for budgetary resources, obligations incurred, offsetting receipts and net outlays (gross outlays less offsetting collections). The Budget with the actual amounts for the current year (FY 2020) will be available at a later date at https://www.whitehouse.gov/omb/budget/.

FY 2019	Budgetary Resources	New Obligations & Upward Adjustments	Distributed Offsetting Receipts	Net Outlays
Combined Statement of Budgetary Resources	**$1,748,617**	**$1,654,043**	**$490,978**	**$1,571,678**
Expired Accounts	**(25,604)**			
Other	**3,656**	**3,658**	**1**	**4,527**
Budget of the US Govt (2019 Actual)	**$1,726,669**	**$1,657,701**	**$490,979**	**$1,576,205**

For the budgetary resources reconciliation, the amount used from the President's Budget was the total budgetary resources available for obligation. The Expired Accounts line included expired authority, recoveries and other amounts included in the Combined SBR that are not included in the President's Budget. The Other line contained in the SBR and also not in the President's Budget for budgetary resources, obligations incurred and net outlays are CMS amounts reported on CDC and OS statements and GTAS adjustments.

Undelivered Orders at the End of the Period

The amount of budgetary resources obligated for undelivered orders totaled $153,730 million ($34,789 million FY19). The FY 2020 Non-Federal amount reflects the advance/accelerated payments made for the COVID-19 AAP program. There were no such payments in FY 2019.

	FY 2020		FY 2019	
	Federal	Non-Federal	Federal	Non-Federal
Undelivered orders (unpaid)	$397	$49,553	$379	$34,182
Undelivered orders (paid)	2	103,778	3	225
Total	$399	$153,331	$382	$34,407

NOTE 12:

STATEMENT OF SOCIAL INSURANCE (UNAUDITED)

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

Actuarial present values are computed under the intermediate set of assumptions specified in the *2020 Annual Report of the Medicare Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and healthcare-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent completed review occurred with the 2016-2017 Technical Review Panel.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. The Trustees' projections are based on the current Medicare laws, regulations, and policies in effect on January 1, 2020 and do not reflect any changes in law or regulation subsequent to that date in accordance with SFFAS 39. They do not reflect the potential effects of the COVID-19 pandemic, which occurred subsequent to January 1, or the legislation enacted in response to it, including i) the *Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020* (Public Law 116-123); ii) the *Families First Coronavirus Response Act* (Public Law 116-127); and iii) the *Coronavirus, Aid, Relief, and Economic Security Act* (Public Law 116-136). However, given the uncertainty associated with these impacts, the Trustees stated that it was not possible to adjust the estimates accurately at the time the report was released. As of the date of the financial statements, there is still a considerable amount of uncertainty surrounding these impacts and the projections have not been adjusted.

In addition, the projections disregard payment reductions that would result from the projected depletion of the Medicare HI trust fund. The present values are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments and administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of *FICA* and *SECA* payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, premiums paid by, or on behalf of, aged uninsured beneficiaries, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and transfers from the general fund of the Treasury. Fees related to brand-name prescription drugs 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.

Actuarial present values of estimated future income (excluding interest) and estimated future expenditures are presented for three different groups of participants: (1) current participants who have not yet attained eligibility age; (2) current participants who have attained eligibility age; and (3) new entrants, those who are expected to become participants in the future. Current participants are the closed group of individuals who are at least age 15 at the start of the projection period and are expected to participate in the program as either taxpayers, beneficiaries, or both.

The SOSI sets forth, for each of these three groups, the projected actuarial present values of all future expenditures and of all future non-interest income for the next 75 years. The SOSI also presents the net present values of future net cash flows, which are calculated by subtracting the actuarial present value of estimated future expenditures from the actuarial present value of estimated future income. The HI trust fund is expected to have an actuarial deficit indicating that, under these assumptions as to economic, demographic, and health care cost trends for the future, HI income is expected to fall short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar deficits because each account is automatically in financial balance every year due to its statutory financing mechanism.

In addition to the actuarial present value of the estimated future excess of income (excluding interest) over expenditures for the open group of participants, the SOSI also sets forth the same calculation for the closed group of participants. The closed group consists of those who, in the starting year of the projection period, have attained retirement eligibility age or have attained ages 15 through 64. In order to calculate the actuarial net present value of the excess of estimated future income over estimated future expenditures for the closed group, the actuarial present value of estimated future expenditures for or on behalf of current participants is subtracted from the actuarial present value of estimated future income (excluding interest) for current participants.

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

To develop projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the trust funds will continue to operate under the law in effect on April 22, 2020, excluding the impact of the legislation enacted in response to the COVID-19 pandemic and disregarding the payment reductions that would result from the projected depletion of the Medicare HI trust fund. In addition, the estimates depend on many economic, demographic, and healthcare-specific assumptions, including changes in per beneficiary health care costs, wages, and the consumer price index (CPI); fertility rates; mortality rates; immigration rates; and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period.

The following table includes the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. The assumptions underlying the 2020 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2020. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions. Similar detailed information for the prior years is publicly available on the CMS website.[1]

TABLE 1:

Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2020

					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[10]
									B	D	
2020	1.69	1,418,000	790.4	1.23	3.50	2.27	2.1	5.2	6.5	-0.7[9]	[11]
2030	1.95	1,326,000	729.4	1.25	3.65	2.40	2.0	6.5	8.3	4.5	2.3
2040	1.95	1,277,000	669.5	1.14	3.54	2.40	1.9	4.4	4.4	4.2	2.3
2050	1.95	1,249,000	616.6	1.12	3.52	2.40	2.0	3.4	3.8	4.4	2.3
2060	1.95	1,236,000	570.1	1.16	3.56	2.40	2.0	3.1	3.7	4.2	2.3
2070	1.95	1,227,000	529.1	1.12	3.52	2.40	1.9	3.4	3.6	4.1	2.3
2080	1.95	1,221,000	492.8	1.11	3.51	2.40	2.0	3.5	3.7	4.2	2.3
2090	1.95	1,218,000	460.5	1.13	3.53	2.40	2.0	3.3	3.6	4.1	2.3

1 Average number of children per woman.

2 Includes legal immigration, net of emigration, as well as other, non-legal, immigration.

3 The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.

4 Difference between percentage increases in wages and the CPI.

5 Average annual wage in covered employment.

6 Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services.

7 The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.

8 These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceuticals). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.

9 Part D cost growth is projected to be negative in 2020 mainly due to higher assumed direct and indirect remuneration.

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

11 The assumption for 2020 is greater than -0.05 and less than 0.05 percent.

1 The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation.

The projections presented in the SOSI are based on various economic and demographic assumptions. The values for each of these assumptions move from recently experienced levels or trends toward long-range ultimate values. Table 2 below summarizes these ultimate values assumed for the current year and the prior 4 years, based on the intermediate assumptions of the respective Medicare Trustees Reports.

TABLE 2:

Significant Ultimate Assumptions Used for the Statement of Social Insurance, FY 2020–2016

					Annual percentage change in: Per beneficiary cost[8]						
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	SMI		Real-interest rate[9]
									B	D	
FY 2020	1.95	1,218,000	460.5	1.13	3.53	2.40	2.0	3.3	3.6	4.1	2.3
FY 2019	2.0	1,218,000	453.5	1.16	3.76	2.60	2.0	3.5	3.6	4.3	2.5
FY 2018	2.0	1,218,000	444.7	1.15	3.75	2.60	2.1	3.4	3.5	4.3	2.7
FY 2017	2.0	1,227,000	438.7	1.15	3.75	2.60	2.0	3.4	3.4	4.3	2.7
FY 2016	2.0	1,228,000	435.1	1.15	3.75	2.60	2.0	3.4	3.4	4.3	2.7

1 Average number of children per woman. The ultimate fertility rate is assumed to be reached in 2027.

2 Includes legal immigration, net of emigration, as well as other, non-legal, immigration. (Beginning with FY 2018 legal immigration is referred to as lawful permanent resident (LPR) immigration, and other, non-legal, immigration is referred to as other-than-LPR immigration.) The ultimate level of net legal immigration is 788,000 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 2090.

3 The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2010, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2090.

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 2090.

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 2090.

6 Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services. The ultimate assumption is reached within the first 10 years of the projection period.

7 The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth. Since the annual rate declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2090.

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 pharmaceuticals). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. Since the annual rate of growth declines gradually during the entire period, no ultimate rate is achieved. The assumption presented is the value assumed in the year 2090.

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 13:

ALTERNATIVE SOSI PROJECTIONS (UNAUDITED)

The Medicare Board of Trustees, in its annual report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results.

Certain features of current law may result in some challenges for the Medicare program. Physician payment update amounts are specified for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. Payment rate updates for most non-physician categories of Medicare providers are reduced by the growth in economy-wide private nonfarm business multifactor productivity although these health providers have historically achieved lower levels of productivity growth. For those providers affected by the productivity adjustments and the specified updates to physician payments, sustaining the price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services and that physician costs will grow at a faster rate than the specified updates. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time.

The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. The Trustees previously estimated that physician payment rates under current law will be lower than they would have been under the sustainable growth rate (SGR) formula by 2048 and will be about 30 percent lower by the end of the projection period. Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term. Overriding the price updates in current law, as lawmakers repeatedly did in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in this report.

To help illustrate and quantify the potential magnitude of the cost understatement, the Trustees asked the Office of the Actuary at CMS to prepare an illustrative Medicare trust fund projection under a hypothetical alternative. This scenario illustrates the impact that would occur if the payment updates that are affected by the productivity adjustments transition from current law to the payment updates assumed for private health plans over the period 2028 to 2042. It also reflects physician payment updates that transition from current law to the increase in the Medicare Economic Index over the same period. Finally, the scenario assumes the continuation of the 5-percent bonuses for qualified physicians in advanced alternative models (advanced APMs) and of the $500-million payments for physicians in the merit-based incentive payment system (MIPS), which are set to expire in 2025.[2] This alternative was developed for illustrative purposes only; the calculations have not been audited; no endorsement of the policies underlying the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation affecting the productivity adjustments and physician updates under Medicare and of the broad range of uncertainty associated with such impacts.

2 The illustrative alternative projections included changes to the productivity adjustments starting with the 2010 annual report, following enactment of the *Affordable Care Act*. The assumption regarding physician payments is being used because the enactment of MACRA in 2015 replaced the SGR with specified physician updates.

Table 3 below contains a comparison of the Medicare 75-year present values of estimated future income and estimated future expenditures under current law with those under the illustrative alternative scenario.

TABLE 3:

Medicare Present Values

(in billions)

	Current law (Unaudited)	Alternative Scenario[1, 2] (Unaudited)
Income		
Part A	$25,554	$25,619
Part B	46,596	52,522
Part D	11,035	11,035
Expenditures		
Part A	30,355	35,543
Part B	46,596	52,522
Part D	11,035	11,035
Income less expenditures		
Part A	(4,800)	(9,924)
Part B	0	0
Part D	0	0

1 These amounts are not presented in the 2020 Trustees Report.

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

The difference between the current-law and illustrative alternative projections is substantial for Parts A and B. All Part A fee-for-service providers and roughly half of Part B fee-for-service providers are affected by the productivity adjustments, so the current-law projections reflect an estimated 1.0-percent reduction in annual cost growth each year for these providers. If the payment updates that are affected by the productivity adjustments were to gradually transition from current law to the payment updates assumed for private health plans, the physician updates transitioned to the Medicare Economic Index, and the 5-percent bonuses paid to qualified physicians in advanced APMs did not expire, as illustrated under the alternative scenario, the estimated present values of Part A would be higher than the current-law projections by roughly 17 percent and Part B expenditures would be higher than the current-law projections by roughly 13 percent. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario, and the present value of Part B income is 13 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

The Part D values are the same under each projection because the services are not affected by the productivity adjustments or the physician updates.

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

NOTE 14:

STATEMENT OF CHANGES IN SOCIAL INSURANCE AMOUNTS (UNAUDITED)

The Statement of Changes in Social Insurance Amounts (SCSIA) reconciles the change (between the current valuation and the prior valuation) in the (1) present value of estimated future income (excluding interest) for current and future participants; (2) present value of estimated future expenditures for current and future participants; (3) present value of estimated future noninterest income less estimated future expenditures for current and future participants (the open-group measure) over the next 75 years; (4) assets of the combined Medicare Trust Funds; and (5) present value of estimated future non-interest income less estimated future expenditures for current and future participants over the next 75 years plus the assets of the combined Medicare Trust Funds. The SCSIA shows the reconciliation from the period beginning on January 1, 2019 to the period beginning on January 1, 2020, and the reconciliation from the period beginning on January 1, 2018 to the period beginning on January 1, 2019. The reconciliation identifies several significant components of the change and provides reasons for the change.

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, change has no impact on the estimated future net cash flow. In order to enhance the presentation, the changes in the present values of estimated future income and estimated future expenditures are presented separately.

The five changes considered in the SCSIA are, in order, as follows:

- 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 SCSIA represent values that are incremental to the prior change. As an example, the present values shown for demographic assumptions, represent the additional effect that these assumptions have, once the effects from the change in the valuation period and projection base have been considered. In general, an increase in the present value of net cash flows represents a positive change (improving financing), while a decrease in the present value of net cash flows represents a negative change (worsening financing).

Assumptions Used for the Statement of Changes in Social Insurance Amounts

The present values included in the SCSIA are for the current and prior years 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 12 summarizes these assumptions for the current year.

Period beginning on January 1, 2019 and ending January 1, 2020

Present values as of January 1, 2019 are calculated using interest rates from the intermediate assumptions of the 2019 Trustees Report. All other present values in this part of the Statement are calculated as present values as of January 1, 2020. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions of the 2019 Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2020 Trustees Report.

Period beginning on January 1, 2018 and ending January 1, 2019

Present values as of January 1, 2018 are calculated using interest rates from the intermediate assumptions of the 2018 Trustees Report. All other present values in this part of the Statement are calculated as present values as of January 1, 2019. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are presented using the interest rates under the intermediate assumptions

of the 2018 Trustees Report. Since interest rates are an economic estimate and all estimates in the table are incremental to the prior change, the estimates of the present values of changes in economic and health care assumptions are calculated using the interest rates under the intermediate assumptions of the 2019 Trustees Report.

Change in the Valuation Period

From the period beginning on January 1, 2019 to the period beginning on January 1, 2020

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2019-93) to the current valuation period (2020-94) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2019, replaces it with a much larger negative net cash flow for 2094, and measures the present values as of January 1, 2020, one year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (was made more negative) when the 75-year valuation period changed from 2019-93 to 2020-94. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming that all values projected in the prior valuation for the year 2019 are realized. The change in valuation period resulted in a slight decrease in the starting level of assets in the combined Medicare Trust Funds. Accordingly, the present value of the estimated future net cash flow, including combined trust fund assets, decreased by $238 billion.

From the period beginning on January 1, 2018 to the period beginning on January 1, 2019

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2018-92) to the current valuation period (2019-93) is measured by using the assumptions for the prior valuation period and extending them, in the absence of any other changes, to cover the current valuation period. Changing the valuation period removes a small negative net cash flow for 2018, replaces it with a much larger negative net cash flow for 2093, and measures the present values as of January 1, 2019, 1 year later. Thus, the present value of estimated future net cash flow (including or excluding the combined Medicare Trust Fund assets at the start of the period) decreased (was made more negative) when the 75-year valuation period changed from 2018-92 to 2019-93. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming that all values projected in the prior valuation for the year 2018 are realized. The change in valuation period resulted in a slight increase in the starting level of assets in the combined Medicare Trust Funds. Accordingly, the present value of the estimated future net cash flow, including combined trust fund assets, decreased by $193 billion.

Change in Projection Base

From the period beginning on January 1, 2019 to the period beginning on January 1, 2020

Actual income and expenditures in 2019 were different from what was anticipated when the 2019 Trustees Report projections were prepared. Part A income and expenditures in 2019 were lower than anticipated based on actual experience. For both Part B and Part D, total income and expenditures were higher than estimated based on actual experience. The net impact of the Part A, B, and D projection base changes is an increase of $401 billion in the present value of the estimated future net cash flow, including combined trust fund assets. Actual experience of the Medicare Trust Funds between January 1, 2019 and January 1, 2020 is incorporated in the current valuation and is more than projected in the prior valuation.

From the period beginning on January 1, 2018 to the period beginning on January 1, 2019

Actual income and expenditures in 2018 were different from what was anticipated when the 2018 Trustees Report projections were prepared. Part A income in 2018 was lower and expenditures were higher than anticipated based on actual experience. For both Part B and Part D, total income and expenditures were higher than estimated based on actual experience. The net impact of the Part A, B, and D projection base changes is a decrease of $193 billion in the present value of the estimated future net cash flow, including combined trust fund assets. Actual experience of the Medicare Trust Funds between January 1, 2018 and January 1, 2019 is incorporated in the current valuation and is more than projected in the prior valuation.

Changes in the Demographic Assumptions

From the period beginning on January 1, 2019 to the period beginning on January 1, 2020

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, 2020), there were two changes to the ultimate demographic assumptions.

- The ultimate total fertility rate was lowered from 2.00 to 1.95 children per woman, reflecting a continued decline in fertility rates since 2007.

- The ultimate disability incidence rate was lowered from 5.2 per thousand exposed in the prior valuation to 5.0 in the current valuation. In addition, near-term assumed disability incidence rates, in the period of transition from recent historical values to the ultimate rates, are somewhat lower in the current valuation than in the prior valuation.

In addition to these ultimate demographic assumption changes, the starting demographic values and the way these values transition to the ultimate assumptions were changed.

- Final birth rate data for 2018 and the first quarter of 2019 indicated somewhat lower birth rates than were assumed in the prior valuation.

- Incorporating 2017 mortality data obtained from the National Center for Health Statistics (NCHS) for ages under 65 in addition to final 2016, preliminary 2017, and preliminary 2018 mortality data from Medicare experience for ages 65 and older resulted in higher death rates for all future years than were projected in the prior valuation.

- The latest valuation included the impact of time to death on Medicare expenditures. Previously, the valuation included only the impact of age and sex on the expenditures.

These changes, especially the time to death assumption lowered Medicare expenditures for the current valuation period, particularly for Part A, and resulted in a large increase in the estimated future net cash flow. The present values of estimated income and expenditures are lower for Parts A, Part B, and Part D. Overall, these changes increased the present value of the estimated future net cash flow by $2,687 billion.

From the period beginning on January 1, 2018 to the period beginning on January 1, 2019

The demographic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2019) 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.

- The numbers of new lawful permanent residents (LPR) for calendar years 2018 and 2019 were assumed to be slightly lower than projected in the prior valuation period, due to recent lower annual refugee ceilings set by the Administration.

- The current valuation incorporated a gradual rise in 2017 and 2018 of other-than-LPR immigrants, reaching the ultimate assumed level in 2019. In contrast, the prior valuation incorporated a surge in the number of other-than-LPR immigrants for years 2016 through 2021.

- Final birth rate data for 2017 indicated slightly lower birth rates than were assumed in the prior valuation.

- Incorporating 2016 mortality data obtained from the NCHS for ages under 65 and 2016 and preliminary 2017 mortality data from Medicare experience for ages 65 and older resulted in higher death rates for all future years than were projected in the prior valuation.

There were two notable changes in demographic methodology:

- Improved the method for projecting fertility rates by better incorporating detailed provisional birth rate data available from NCHS.

- Incorporated more comprehensive Medicare mortality data from CMS.

These changes lowered overall Medicare enrollment for the current valuation period and resulted in a slight increase in the estimated future net cash flow. The present values of estimated income and expenditures are lower for Parts A, Part B, and Part D. Overall, these changes increased the present value of the estimated future net cash flow by $27 billion.

Changes in Economic and Health Care Assumptions

For the period beginning on January 1, 2019 to the period beginning on January 1, 2020

The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

For the current valuation (beginning on January 1, 2020), there were four changes to the ultimate economic assumptions.

- The ultimate rate of price inflation (CPI-W) was lowered by 0.2 percentage point, from 2.6 percent in the prior valuation to 2.4 percent in the current valuation.
- The ultimate average real-wage differential was decreased from 1.21 percentage points in the prior valuation to 1.14 percentage points in the current valuation. Most of this decrease is due to the repeal of the PPACA excise tax, the effect of which is accounted for in the "Changes in Law or Policy" section. However, a small portion is due to faster assumed growth in employer-sponsored group health insurance premiums separate from this repeal.
- The ultimate age-sex-adjusted unemployment rate was reduced from 5.5 percent for the prior valuation to 5.0 percent in the current valuation. At the same time, long-term labor force participation rates were reduced by age and sex for the current valuation, such that projected employment rates remained essentially unchanged from the prior valuation to the current valuation.
- The ultimate real interest rate was lowered by 0.2 percentage point, from 2.5 percent in the prior valuation to 2.3 percent in the current valuation.

In addition to these changes in ultimate assumptions, the starting economic values and the way these values transition to the ultimate assumptions were changed. The most notable change was to include a 0.7 percent

decrease in the estimated level of potential GDP for the fourth quarter of 2019 and thereafter. This and other smaller changes in starting values and near-term growth assumptions combined to decrease the present value of estimated future net cash flows.

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

- Higher projected spending growth for Medicare Advantage beneficiaries.
- Faster projected spending growth for Part B drugs.
- Slower overall drug price increases and higher direct and indirect remuneration.

The net impact of these changes was a decrease in the estimated future net cash flow for total Medicare. For Part A and Part B, these changes increased the present value of estimated future income and expenditures. For Part D, these changes resulted in a decrease in the present value of estimated expenditures (and income). Overall, these changes decreased the present value of the estimated future net cash flow by $1,715 billion.

For the period beginning on January 1, 2018 to the period beginning on January 1, 2019

The economic assumptions used in the Medicare projections are the same as those used for the OASDI and are prepared by the Office of the Chief Actuary at the SSA.

For the current valuation (beginning on January 1, 2019), there were four changes to the ultimate economic assumptions.

- The ultimate annual rate of change in total-economy labor productivity was lowered from 1.68 percent in the prior valuation to 1.63 percent in the current valuation, reflecting an expected slower rate of productivity growth in the long term.
- The difference between the ultimate growth rates for the Consumer Price Index for Urban Wage Earners and Clerical Workers and the GDP implicit price deflator (the "price differential"), was decreased from 0.40 percentage point in the prior valuation to 0.35 percentage point in the current valuation.
- The ultimate average real-wage differential was increased from 1.20 percentage points in the prior valuation to 1.21 percentage points in the current valuation.
- The ultimate real interest rate was lowered by 0.2 percentage point, from 2.7 percent in the prior valuation to 2.5 percent in the current valuation.

In addition to these changes in ultimate assumptions, the starting economic values and the way these values transition to the ultimate assumptions were changed. The most notable change was to include the July 2018 revisions in historical GDP estimated by the Bureau of Economic Analysis of the Department of Commerce. This and other smaller changes in starting values and near-term growth assumptions combined to increase the present value of estimated future net cash flows.

There was one notable change in economic methodology.

- Incorporated more recent projections of disability prevalence in the labor force participation model.

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

- Lower assumed growth in economy-wide productivity, which results in higher payment updates for certain providers.
- Faster projected spending growth for physician-administered drugs under Part B.
- Higher projected drug manufacturer rebates and slower overall drug price increases assumed in the short-range period.

The net impact of these changes was a decrease in the estimated future net cash flow for total Medicare. For Part A and Part B, these changes increased the present value of estimated future income and expenditures. For Part D, these changes resulted in a decrease in the present value of estimated expenditures (and income). Overall, these changes decreased the present value of the estimated future net cash flow by $402 billion.

Changes in Law

For the period beginning on January 1, 2019 to the period beginning on January 1, 2020

Most of the provisions enacted as part of Medicare legislation since the prior valuation date had little or no impact on the program. The following provisions did have a financial impact on the present value of the 75-year estimated future income, expenditures, and net cash flow.

- The *Bipartisan Budget Act of 2019* (Public Law 116-37, enacted on August 2, 2019) included one provision that affects HI and SMI programs.
  - » The sequestration process that is in place should Congress fail to address the budget deficit by certain deadlines is extended by two years, through fiscal years 2028 and 2029.
- The *Further Consolidated Appropriations Act, 2020* (Public Law 116-94, enacted on December 20, 2019) included provisions that affect HI and SMI programs.
  - » The annual fee imposed on certain large health insurer providers, including those furnishing coverage under Medicare Advantage and Medicare Part D, is repealed for calendar years beginning after December 31, 2020.
  - » The excise tax on employer-sponsored group health insurance premiums above a specified level (commonly referred to as the "Cadillac Tax" and provided for by legislation in 2010) is repealed. This excise tax was expected to decrease the average cost of health insurance, thereby increasing the portion of employee compensation subject to the HI payroll tax, over both the short- and long-range projection periods. Although the implementation of this provision has been repeatedly delayed since inception, the 2010-2019 annual reports reflected the assumption that the excise tax would eventually be applied. Therefore, the repeal of this provision decreases the share of employee compensation that will be subject to the HI payroll tax.
  - » The 1.00 floor on the geographic index for physician work is extended through May 22, 2020 (from December 31, 2019).
  - » The clinical laboratory commercial payer data reporting requirement is delayed for 1 year (that is, until calendar year 2021).

The net impact of these changes was a decrease in the estimated future net cash flow for total Medicare. The present values of estimated income and expenditures are lower for Part A, Part B, and Part D. Overall, these changes decreased the present value of the estimated future net cash flow by $453 billion.

For the period beginning on January 1, 2018 to the period beginning on January 1, 2019

The provisions enacted as part of Medicare legislation since the prior valuation date had no measurable impact on program expenditures. For more information on the legislation please see section V.A of the 2019 Medicare Trustees Report.

NOTE 15:
BUDGET AND ACCRUAL RECONCILIATION
(DOLLARS IN MILLIONS)

FY2020	Intra-Government	With the Public	Total
NET COST OF OPERATIONS (SNC)	**$13,298**	**$1,143,656**	**$1,156,954**
Components of net cost not part of the budget outlays			
Property, plant, and equipment Depreciation		$(542)	$(542)
Other		694	694
		$152	$152
Increase/(Decrease) in Assets:			
Accounts receivable		$(2,299)	$(2,299)
Loans receivable		336	336
Other asset - Regulatory Assets		103,553	103,553
		$101,590	$101,590
(Increase)/Decrease in Liabilities:			
Accounts Payable	$3	$(7,530)	$(7,527)
Other liabilities (Salaries and Benefits, Unfunded Leave, Unfunded FECA, Actuarial FECA)	(395)	6,746	6,351
	$(392)	$(784)	$(1,176)
Other Financing Sources:			
Federal employee retirement benefit costs paid by OPM and imputed to the agency	$(47)		$(47)
Transfers out (in) without reimbursement	3,554		3,554
Other imputed finance	(12,306)		(12,306)
	$(8,799)		$(8,799)
Components of the budget outlays that are not part of net cost:			
Other	$(174)	$6,051	$5,877
	$(174)	$6,051	$5,877
Other temporary timing differences			
Other			
NET OUTLAYS	**$3,933**	**$1,250,665**	**$1,254,598**
Related Amounts on the Statement of Budgetary Resources			
Outlays, net			$1,786,681
Distributed offsetting receipts			(532,083)
AGENCY OUTLAYS, NET			**$1,254,598**

FY2019	Intra-Government	With the Public	Total
NET COST OF OPERATIONS (SNC)	$992	$1,086,279	$1,087,271
Components of net cost not part of the budget outlays			
Property, plant, and equipment Depreciation		$(408)	$(408)
Other		432	432
		$24	$24
Increase/(Decrease) in Assets:			
Accounts receivable		$(2,685)	$(2,685)
Loans receivable		(7)	(7)
Other asset - Regulatory Assets	(25)	(3)	(28)
	$(25)	$(2,695)	$(2,720)
(Increase)/Decrease in Liabilities:			
Accounts Payable	$(30)	$(11,017)	$(11,047)
Other liabilities (Salaries and Benefits, Unfunded Leave, Unfunded FECA, Actuarial FECA)	(30)	(1,730)	(1,760)
	$(60)	$(12,747)	$(12,807)
Other Financing Sources:			
Federal employee retirement benefit costs paid by OPM and imputed to the agency	$(56)		$(56)
Transfers out (in) without reimbursement	3,515		3,515
	$3,459		$3,459
Components of the budget outlays that are not part of net cost:			
Other	$(519)	$5,946	$5,427
	$(519)	$5,946	$5,427
Other temporary timing differences			
Other			$46
			$46
NET OUTLAYS	$3,847	$1,076,807	$1,080,700
Related Amounts on the Statement of Budgetary Resources			
Outlays, net			$1,571,678
Distributed offsetting receipts			(490,978)
AGENCY OUTLAYS, NET			$1,080,700

REQUIRED SUPPLEMENTARY INFORMATION

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for over 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 *2020 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 Trustees' projections are based on the current Medicare laws, regulations, and policies in effect on January 1, 2020 and do not reflect any changes in law or regulation subsequent to that date in accordance with SFFAS 39. They do not reflect the potential effects of the COVID-19 pandemic, which occurred subsequent to January 1, or the legislation enacted in response to it. However, given the uncertainty associated with these impacts, the Trustees stated that it was not possible to adjust the estimates accurately at the time the report was released. As of the date of the financial statements, there is still a considerable amount of uncertainty surrounding these impacts and the projections have not been adjusted.

The projections presented here are based on current law, certain features of which may result in some challenges for the Medicare program. Physician payment update amounts are specified for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. These rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. Payment rate updates for most non-physician categories of Medicare providers are reduced by the growth in economy-wide private nonfarm business multifactor productivity[1] although these health providers have historically achieved lower levels of productivity growth. If the health sector cannot transition to more efficient models of care delivery and if the provider reimbursement rates paid by commercial insurers continue to be based on the same negotiated process used to date, then the availability, particularly with respect to physician services, and quality of health care received by Medicare beneficiaries would, under current law, fall over time compared to that received by those with private health insurance.

Incorporated in these projections is the sequestration of non-salary Medicare expenditures as required by the following laws: the *Budget Control Act of 2011* (Public Law 112-25, enacted on August 2, 2011), as amended by the *American Taxpayer Relief Act of 2012* (Public Law 112-240, enacted on January 2, 2013); the Continuing Appropriations Resolution, 2014 (Public Law 113-67, enacted on December 26, 2013); Sections 1 and 3 of Public Law 113-82, enacted on February 15, 2014; the *Protecting Access to Medicare Act of 2014* (Public Law 113-93, enacted on April 1, 2014); the *Bipartisan Budget Act of 2015* (Public Law 114-74, enacted on November 2, 2015); the *Bipartisan Budget Act of 2018* (Public Law 115-123, enacted on February 9, 2018); and the *Bipartisan Budget Act of 2019* (Public Law 116-37, enacted on August 2, 2019). The sequestration reduces benefit payments by 2 percent from April 1, 2013 through March 31, 2029 and by 4 percent from April 1, 2029 through September 30, 2029. Due to sequestration, non-salary administrative expenses are reduced by an estimated 5 to 7 percent from March 1, 2013 through September 30, 2029.

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from current-law provisions that lower increases in Medicare payment rates to most categories of health care providers, but such adjustments would probably not be viable indefinitely without fundamental change in the current delivery system. It is conceivable that providers could improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. For such efforts to be successful in the long range, however, providers would have to generate and sustain unprecedented levels of productivity gains—a very challenging and uncertain prospect.

In view of the factors described above, it is important to note that Medicare's actual future costs are highly uncertain for reasons apart from the inherent

1 For convenience the term *economy-wide private nonfarm business multifactor productivity* will henceforth be referred to as *economy-wide productivity*.

challenges in projecting health care cost growth over time. The expenditure projections reflect the cost-reduction provisions required under current law. In addition, the Trustees reference in their report an illustrative alternative scenario, which assumes that (i) there would be a transition from current-law[2] payment updates for providers affected by the economy-wide productivity adjustments to payment updates that reflect adjustments for health care productivity; (ii) the average physician payment updates would transition from current law[3] to payment updates that reflect the Medicare Economic Index; and (iii) the 5-percent bonuses for qualified physicians in advanced alternative payment models (advanced APMs) and the $500-million payments for physicians in the merit-based incentive payment system (MIPS) would continue indefinitely rather than expire in 2025. The difference between the illustrative alternative and the current-law projections continues to demonstrate that the long-range costs could be substantially higher than shown throughout much of the report if the cost-reduction measures prove problematic and new legislation scales them back.

Additional information on the current-law and illustrative alternative projections is provided in Note 13 in these financial statements, in section 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 the CMS website.

ACTUARIAL PROJECTIONS

Long–Range Medicare Cost Growth Assumptions

Beginning with the 2013 report, the Trustees used the statutory price updates and the volume and intensity assumptions from the "factors contributing to growth" model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period.[4] The Trustees assume that the productivity reductions to Medicare payment rate updates will reduce volume and intensity growth by 0.1 percent below the factors model projection.[5]

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

Medicare payment rates for most non-physician provider categories are 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. These updates are then reduced by the 10-year moving average increase in economy-wide productivity, which the Trustees assume will be 1.0 percent per year over the long range. The different statutory provisions for updating payment rates require the development of separate long-range Medicare cost growth assumptions for four categories of health care provider services:

2 Medicare's annual payment rate updates for most categories of provider services would be reduced below the increase in providers' input prices by the growth of economy-wide productivity (1.0 percent over the long range).

3 The law specifies physician payment rate updates of 0.75 percent or 0.25 percent annually thereafter for physicians in advanced alternative payment models (advanced APMs) or the merit-based incentive payment system (MIPS), respectively. These updates are notably lower than the projected physician cost increases, which are assumed to average 2.05 percent per year in the long range.

4 This assumed increase in the average expenditures per beneficiary excludes the impacts of the aging of the population, changes in the gender composition of the Medicare population, and changes in the distribution of the Medicare population on the basis of proximity to death, as the Trustees estimated these factors separately. For convenience, the increase in Medicare expenditures per beneficiary, before consideration of demographic impacts, is referred to as the Medicare cost growth rate.

5 The Trustees' methodology is consistent with Finding III-2 and Recommendation III-3 of the 2010-2011 Medicare Technical Review Panel (final report available here) and with Finding 3-2 of the 2016-2017 Medicare Technical Review Panel (final report available here).

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 cost growth rates for these provider services start at 3.8 percent in 2044, or GDP plus 0.1 percent, declining gradually to 3.3 percent in 2094, or GDP minus 0.3 percent.

ii. Physician services

Payment rate updates are 0.75 percent per year for those qualified physicians assumed to be participating in advanced APMs and 0.25 percent for those assumed to be participating in MIPS. The year-by-year cost growth rates for physician payments are assumed to be 3.3 percent in 2044, or GDP minus 0.4 percent, declining to 2.8 percent in 2094, or GDP minus 0.8 percent.

iii. Certain SMI Part B services that are updated annually by the Consumer Price Index (CPI) increase less the increase in economy-wide productivity

Such services include durable medical equipment that is not subject to competitive bidding,[6] care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the year-by-year cost growth rates for these services to be 3.0 percent in 2044, or GDP minus 0.7 percent, declining to 2.6 percent in 2094, or GDP minus 1.0 percent.

iv. All other Medicare services, for which payments are established based on market processes, such as prescription drugs provided through Part D and the remaining Part B services

These Part B outlays constitute an estimated 33 percent of total Part B expenditures in 2029 and consist mostly of payments for laboratory tests, physician-administered drugs, and small facility services. Medicare payments to Part D plans are based on a competitive-bidding process and are not affected by the productivity adjustments. Similarly, payments for the other Part B services are based on market factors.[7] The long-range cost growth rates for Part D and these Part B services are assumed to equal the growth rates as determined from the factors model. The corresponding year-by-year cost growth rates for these services are 4.4 percent in 2044, or GDP plus 0.7 percent, declining to 4.1 percent by 2094, or GDP plus 0.5 percent.

In addition, these long-range cost growth rates must be modified to reflect demographic impacts. In the 2019 report and prior reports, these impacts reflected the changing distribution of Medicare enrollment by age and sex. For the 2020 report, these effects are being modified to estimate not only the changing distribution of Medicare enrollment by age and sex but also the beneficiary's proximity to death, which is referred to as a time-to-death (TTD) adjustment. The TTD adjustment reflects the fact that the closer an individual is to death, the higher his or her health care spending is. Thus, as mortality rates improve and a smaller portion of the Medicare population is likely to die at any given age, the effect of individuals getting older and spending more on health care is offset somewhat. For the 2020 report, inclusion of the TTD adjustment results in demographic impacts that are smaller than those in the 2019 report.[8] This is particularly the case for Part A services—such as inpatient hospital, skilled nursing, and home health services—for which the distribution of spending is more concentrated in the period right before death.[9] For Part B services that are less acute, the incorporation of the TTD adjustment has a smaller effect. Finally, this demographic adjustment has significantly less of an impact on Part D costs because the incidence of prescription drug use is more evenly distributed by age and TTD.

After combining the rates of growth from the four long-range assumptions, the weighted average cost growth rate for Part B is 3.9 percent in 2044, or GDP plus 0.2 percent, declining to 3.7 percent by 2094, or GDP plus 0.1 percent. When Parts A, B, and D are combined, the weighted average cost growth rate for Medicare is 4.0 percent, or GDP plus 0.3 percent in 2044, declining to 3.7 percent, or GDP plus 0.1 percent by 2094.

6 The portion of durable medical equipment that is subject to competitive bidding is included with all other Medicare services since the price is determined by a competitive bidding process. For more information on the bidding process, see section IV.B of the 2020 Medicare Trustees Report.

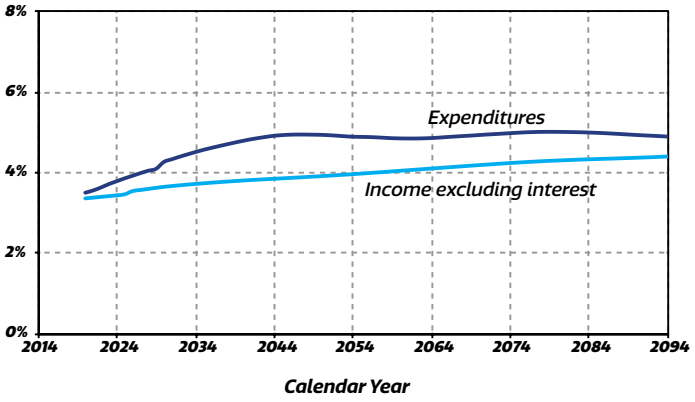
7 For example, physician-administered Part B drugs are reimbursed at the level of the average sales price in the market plus 6 percent.

8 More information on the TTD adjustment is available at the CMS website.

9 The one exception is for hospice services, which previously did not reflect changing demographics. The inclusion of an age and sex adjustment in the 2020 report has a larger impact in raising hospice spending—particularly during the period when the baby boom generation reaches older ages—than does the TTD adjustment in lowering such spending.

CHART 1

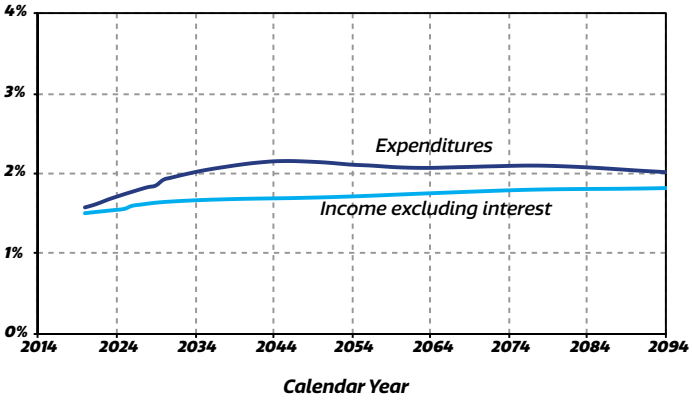
HI Expenditures and Income Excluding Interest as a Percentage of Taxable Payroll // 2020 – 2094



Source: CMS/OACT

CHART 2

HI Expenditures and Income Excluding Interest as a Percentage of GDP // 2020 – 2094



Source: CMS/OACT

HI Cash Flow as a Percentage of Taxable Payroll

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

Chart 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected HI cost rates shown in the 2020 report are lower than those from the 2019 report for nearly all years largely because of lower expenditures attributable to lower-than-projected 2019 spending and the incorporation of time-to-death into the demographic factors used in the projection model.

Since the standard HI payroll tax rates are not scheduled to change in the future under current law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. In addition, starting in 2013, high-income workers pay an additional 0.9 percent of their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns). Because income thresholds for determining eligibility for the additional HI tax are not indexed, over time an increasing proportion of workers will become subject to a higher 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; this result will occur because the income thresholds determining taxable benefits are not indexed for price inflation and because the income tax brackets are indexed to the chained CPI (C-CPI-U), which increases at a slower rate than average wages.[10] Thus, as chart 1 shows, the income rate is expected to gradually increase over current levels.

In 2020 and beyond, as indicated in chart 1, the cost rate is projected to rise, primarily due to the continued retirements of those in the baby boom generation and partly due to an acceleration of health services cost growth. This cost rate increase is moderated by the accumulating effect of the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average of 0.7 percent through 2029 and 1.0 percent thereafter. Under the illustrative alternative scenario, the HI cost rate would be 5.3 percent in 2045 and 7.3 percent in 2094.

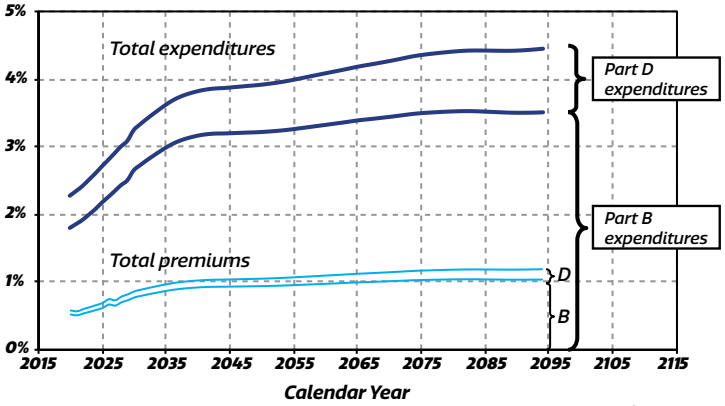
HI and SMI Cash Flow as a Percentage of GDP

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.

10 After the 10th year of the projection period, income tax brackets are assumed to rise with average wages, rather than with the C-CPI-U as specified in the Internal Revenue Code. As a result of this assumption, income from the taxation of Social Security benefits increases at a similar rate as, rather than significantly faster than, taxable payroll. See section V.C7 of the 2020 Old-Age, Survivors, and Disability Insurance Trustees Report for more detailed information on the projection of income from taxation of Social Security benefits.

CHART 3

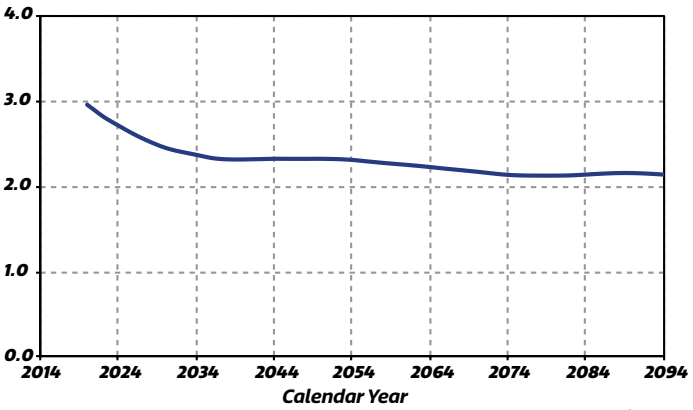
SMI Expenditures and Premiums as a Percentage of GDP // 2020 – 2094



Source: CMS/OACT

CHART 4

Number of Covered Workers per HI Beneficiary // 2020 – 2094



Source: CMS/OACT

HI

Chart 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2019, the expenditures were $328.3 billion, which was 1.5 percent of GDP. As chart 2 illustrates, this percentage is projected to increase steadily until about 2045 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 3.0 percent in 2094.

SMI

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

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

In 2019, SMI expenditures were $467.9 billion, or about 2.2 percent of GDP. Under current law, they would grow to about 3.9 percent of GDP within 25 years and to 4.5 percent by the end of the projection period, as demonstrated in chart 3. Under the illustrative alternative, total SMI expenditures in 2094 would be 5.5 percent of GDP.

To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time but at a slower rate compared to the last 10 years. Average per beneficiary costs for Part B and Part D benefits are projected to increase after 2019 by about 4.2 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate. The special State payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the State payments are also expected to increase faster than GDP.

Worker-to-Beneficiary Ratio

HI

Another way to evaluate the long-range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 4 illustrates this ratio over the next 75 years. For the most part, current workers pay for current benefits. The relatively smaller number of persons born after the baby boom will therefore finance the retirement of the baby boom generation.

In 2019, every beneficiary had about 3.0 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.5 workers for each beneficiary, as indicated in chart 4. The projected ratio continues to decline until there are only 2.1 workers per beneficiary by 2094.

TABLE 1

Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	–1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures (in billions)	$3,879	–$4,800	–$18,727

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 current law. In addition, the estimates depend on many economic and demographic assumptions. Because of revisions to these assumptions, due to either changed conditions or updated information, estimates sometimes change substantially compared to those made in prior years. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty.

To illustrate the sensitivity of the long-range projections and determine the impact on the HI actuarial present values, six of the key assumptions were varied individually.[11] The assumptions varied are the health care cost factors, real-wage differential, CPI, real-interest rate, fertility rate, and net immigration.[12]

For this analysis, the intermediate economic and demographic assumptions in the *2020 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, 2020 and are based on estimates of income and expenditures during the 75-year projection period.

Charts 5 through 10 show the present value of the estimated net cash flow for each assumption varied. Generally, under all three scenarios, the present values decrease through the first 25 to 30 years of the projection period, at which point they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process for computing present values, which is used to help interpret the net cash flow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

Health Care Cost Factors

Table 1 shows the net present value of cash flow during the 75-year projection period under three alternative assumptions for the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, relative to taxable payroll, will be 1 percent slower than the intermediate assumptions, the same as the intermediate assumptions, and 1 percent faster than the intermediate assumptions. In each case, the taxable payroll will be the same as assumed for the intermediate projections.

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $8,680 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 $13,927 billion.

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

This assumption has a dramatic impact on projected HI cash flow. The present value of the net cash flow under the ultimate growth rate assumption of 1 percentage point lower than the intermediate assumption actually becomes a surplus due to the improved financial outlook

11 Sensitivity analysis is not done for Parts B or D of the SMI trust fund due to the financing mechanism for each account. Any change in assumptions would have a negligible impact on the net cash flow, since the change would affect income and expenditures equally.

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

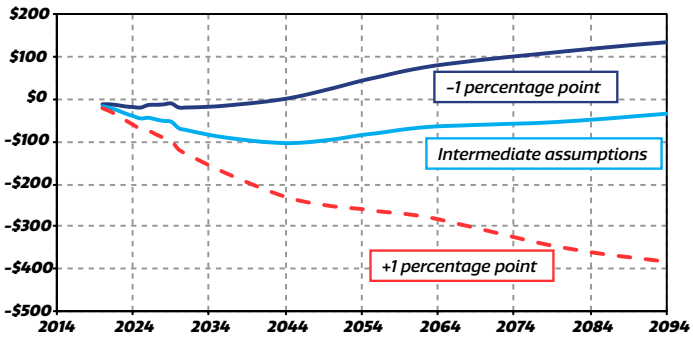
TABLE 2

Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions

Ultimate percentage increase in wages – CPI	2.92 – 2.40	3.54 – 2.40	4.16 – 2.40
Ultimate percentage increase in real-wage differential	0.52	1.14	1.76
Income minus expenditures (in billions)	–$6,493	–$4,800	–$1,952

CHART 5

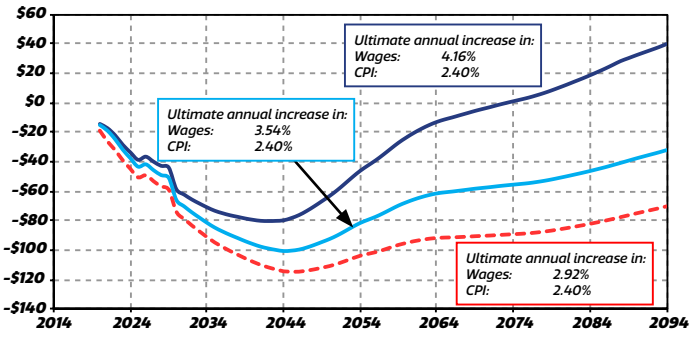
Present Value of HI Net Cash Flow with Various Health Care Cost Factors // 2020 – 2094 *(in billions)*



Source: CMS/OACT

CHART 6

Present Value of HI Net Cash Flow with Various Real-Wage Assumptions // 2020 – 2094 *(in billions)*



Source: CMS/OACT

for the HI trust fund as a result of the cost-reduction provisions required under current law. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As chart 5 indicates, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs.

Real-Wage Differential

Table 2 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.52, 1.14, and 1.76 percentage points.[13] In each case, the assumed ultimate annual increase in the CPI is 2.4 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 2.92, 3.54, and 4.16 percent, respectively.

As indicated in table 2, for a half-point increase in the ultimate real-wage differential assumption, the deficit—expressed in present-value dollars—decreases by approximately $2,297 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $1,365 billion.

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

Faster real-wage growth results in smaller HI cash flow deficits, when expressed in present-value dollars, as demonstrated in chart 6. 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 cost-reduction provisions depends critically on the sustainability of the lower Medicare price updates for hospitals and other HI providers. Sustaining these price reductions will be challenging for health care providers, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services.

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

TABLE 3

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

Ultimate percentage increase in wages – CPI	4.14 – 3.00	3.54 – 2.40	2.94 – 1.80
Income minus expenditures (in billions)	–$3,507	–$4,800	–$6,426

TABLE 4

Present Value of Estimated HI Income Less Expenditures under Various Real-Interest Assumptions

Ultimate real-interest rate	1.8 percent	2.3 percent	2.8 percent
Income minus expenditures (in billions)	–$5,566	–$4,800	–$4,130

Consumer Price Index

Table 3 illustrates the net present value of cash flow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 3.0, 2.4, and 1.8 percent. In each case, the assumed ultimate real-wage differential is 1.14 percent, which yields ultimate percentage increases in average annual wages in covered employment of 4.14, 3.54, and 2.94 percent, respectively.

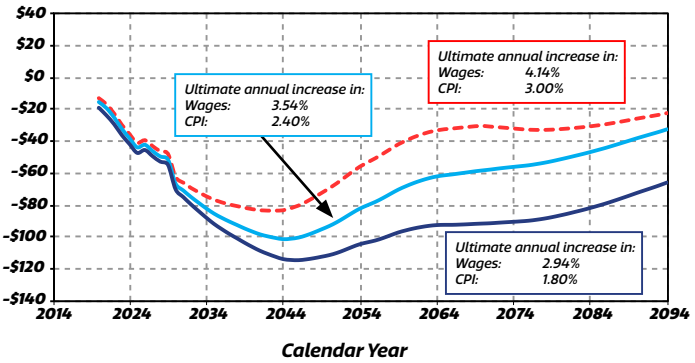
Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.0 percent, the deficit decreases by $1,293 billion. On the other hand, if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by $1,625 billion.

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

This assumption has a small impact when the cash flow is expressed as present values, as chart 7 indicates. The projected present values of HI cash flow are relatively insensitive to the assumed level of general price inflation because price inflation has about the same proportionate effect on income as it does on costs. In present value terms, a smaller deficit is the result under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios; under high-inflation conditions, however, the present value of HI income increases as more people become subject to the additional 0.9-percent HI tax rate required 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.

CHART 7

Present Value of HI Net Cash Flow with Various CPI-Increase Assumptions // 2020– 2094 *(in billions)*



Source: CMS/OACT

Real-Interest Rate

Table 4 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate annual real-interest assumptions: 1.8, 2.3, and 2.8 percent. In each case, the assumed ultimate annual increase in the CPI is 2.4 percent, which results in ultimate annual yields of 4.2, 4.7, and 5.2 percent, respectively.

As demonstrated in table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $145 billion.

Chart 8, on the following page, illustrates projections of the present value of the estimated net cash flow under the three alternative real-interest assumptions presented in table 4.

The projected HI cash flow when expressed in present values is fairly sensitive to the interest assumption, as shown in chart 8. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI trust fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2026.

TABLE 5

Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate fertility rate[1]	1.75	1.95	2.15
Income minus expenditures (in billions)	−$5,449	−$4,800	−$4,142

[1] The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year and if she were to survive the entire childbearing period.

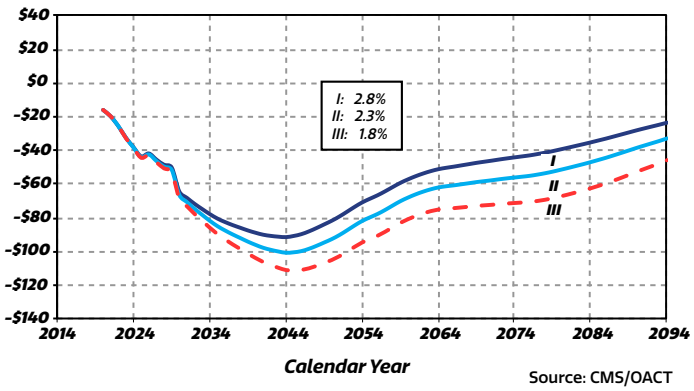
TABLE 6

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

Average annual net immigration	946,000	1,261,000	1,598,000
Income minus expenditures (in billions)	−$5,093	−$4,800	−$4,490

CHART 8

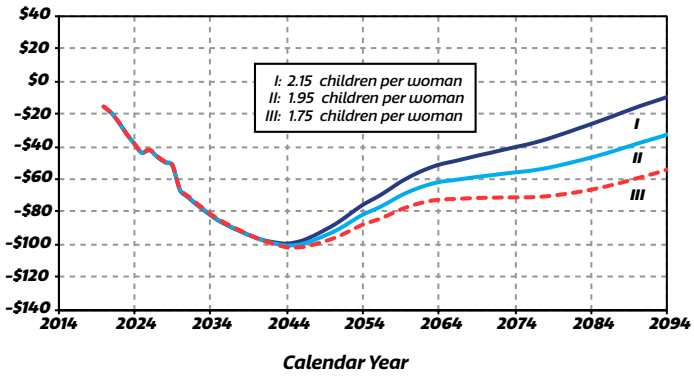
Present Value of HI Net Cash Flow with Various Real-Interest Rate Assumptions // 2020 – 2094 *(in billions)*



Source: CMS/OACT

CHART 9

Present Value of HI Net Cash Flow with Various Ultimate Fertility Rate Assumptions // 2020 – 2094 *(in billions)*



Source: CMS/OACT

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

Fertility Rate

Table 5 shows the net present value of cash flow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.75, 1.95, and 2.15 children per woman.

As table 5 demonstrates, for an increase of 0.2 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $655 billion.

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

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

Net Immigration

Table 6 illustrates the net present value of cash flow during the 75-year projection period under three alternative average annual net immigration assumptions: 946,000 persons, 1,261,000 persons, and 1,598,000 persons per year.

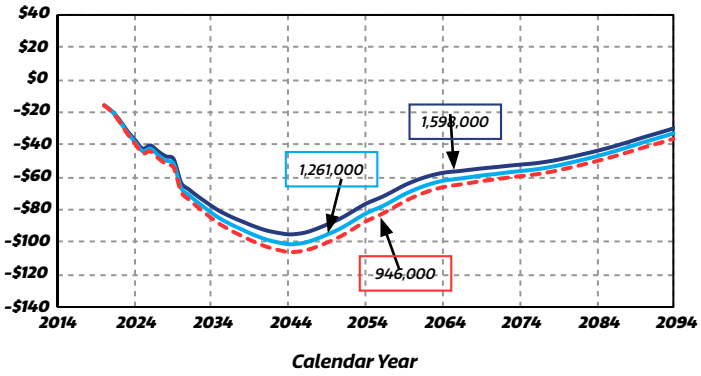
As indicated in table 6, if the average annual net immigration assumption is 946,000 persons, the deficit—expressed in present-value dollars—increases by $292 billion. Conversely, if the assumption is 1,598,000 persons, the deficit decreases by $310 billion.

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

Higher net immigration results in smaller HI cash flow deficits, as demonstrated 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.

CHART 10

Present Value of HI Net Cash Flow with Various Net Immigration Assumptions // 2020 – 2094 *(in billions)*



Source: CMS/OACT

Trust Fund Finances and Sustainability

HI

The short-range financial outlook for the HI trust fund is similar to the projections in last year's annual report. The estimated depletion date for the HI trust fund is 2026, the same as in the 2019 report. As in past years, the Trustees have determined that the fund is not adequately financed over the next 10 years. HI income is projected to be lower than last year's estimates due to lower payroll taxes. HI expenditures are projected to be lower than last year's estimates because of lower-than-projected 2019 spending, lower projected provider payment updates, and incorporation of time-to-death into the demographic factors used in the projection model. Partially offsetting this decrease in expenditures is higher projected spending growth for Medicare Advantage beneficiaries.

HI expenditures exceeded income each year from 2008 through 2015. In 2016 and 2017, however, there were fund surpluses amounting to $5.4 billion and $2.8 billion, respectively. In 2018 and 2019, expenditures again exceeded income, with trust fund deficits of $1.6 billion and $5.8 billion, respectively. The Trustees project deficits in all future years until the trust fund becomes depleted in 2026. If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs. Beneficiary access to health care services would rapidly be curtailed. To date, Congress has never allowed the HI trust fund to become depleted.

The HI trust fund remains out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require significant increases in revenues and/or reductions in benefits. Policy makers should determine effective solutions to ensure the financial integrity of HI in the long term and should also consider the likelihood that the price adjustments in current law may prove difficult to adhere to fully and may require even more changes to address this challenge.

SMI

The SMI trust fund will remain adequate, both in the near term and into the indefinite future, because of the automatic financing established for Parts B and D. There is no provision in the law for transferring assets between the Part D and Part B accounts; therefore, it is necessary to evaluate each account's financial adequacy separately.

The nature of the financing for both parts of SMI is similar in that the law establishes a mechanism by which income from the Part B premium and the Part D premium, and the corresponding general revenue transfers for each part, are sufficient to cover the following year's estimated expenditures. Accordingly, each account within SMI is automatically in financial balance under current law. Such financing, however, would have to increase faster than the economy to cover expected expenditure growth. A critical issue for the SMI trust fund is the impact of the rapid growth of SMI costs, which places steadily increasing demands on beneficiaries and taxpayers.

Medicare Overall

Federal law requires that the Board of Trustees issue a determination of excess general revenue Medicare funding if they project that under current law the difference between program outlays and dedicated financing sources[14] will exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2020-2026). For the 2020 Medicare Trustees Report, this difference is expected to exceed 45 percent of total expenditures in fiscal year 2021, and therefore the Trustees are issuing this determination. Since this determination was made last year as well, this year's determination triggers a Medicare funding warning, which (i) requires the President to submit to Congress proposed legislation to respond to the warning within 15 days after the submission of the Fiscal Year 2022 Budget and (ii) requires Congress to consider the legislation on an expedited basis. Such funding warnings were previously issued in each of the 2007 through 2013 reports and in the 2018 and 2019 reports. To date, elected officials have not enacted legislation responding to these funding warnings.

The projections shown continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the projected depletion of the HI trust fund, this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures. Furthermore, if the growth in Medicare costs is comparable to growth under the illustrative alternative projections, then policy reforms will have to address much larger financial challenges than those assumed under current law. In their 2020 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."

14 Dedicated Medicare financing sources used in this year's determination include HI payroll taxes; income from taxation of Social Security benefits; State transfers for the prescription drug benefit; premiums paid under Parts A, B, and D; fees allocated to Part B related to brand-name prescription drugs; and any gifts received by the Medicare trust funds.

COMBINING STATEMENT OF BUDGETARY RESOURCES

for the year ended September 30, 2020

(in millions)

	Medicare			Payments to Trust Funds	Medicaid	CHIP	Other	Program Management	Combined Total
	HI TF	SMI TF	Part D						
BUDGETARY RESOURCES:									
Unobligated balance from prior year budget authority, net (discretionary and mandatory)	$693	$1,130	$4	$56,217	$50,457	$21,775	$7,648	$1,746	$139,670
Appropriations (discretionary and mandatory)	403,700	417,349	89,744	438,608	462,991	25,428	17,901	203	1,855,924
Borrowing authority (discretionary and mandatory)							2		2
Spending authority from offsetting collections (discretionary and mandatory)			3,659		1,292		2,032	4,750	11,733
TOTAL BUDGETARY RESOURCES	$404,393	$418,479	$93,407	$494,825	$514,740	$47,203	$27,583	$6,699	$2,007,329
STATUS OF BUDGETARY RESOURCES:									
New Obligations and upward adjustments	$404,393	$418,479	$93,407	$407,385	$514,429	$18,559	$11,661	$5,132	$1,873,445
Unobligated balance, end of year									
Apportioned, unexpired accounts				31,223		11,501	12,924	398	56,046
Exempt from Apportionment, unexpired accounts							3		3
Unapportioned, unexpired accounts					311	7,645	2,601	4	10,561
Unexpired unobligated balance, end of year				31,223	311	19,146	15,528	402	66,610
Expired unobligated balance, end of year				56,217		9,498	394	1,165	67,274
Unobligated balance, end of year (total)				87,440	311	28,644	15,922	1,567	133,884
TOTAL BUDGETARY RESOURCES	$404,393	$418,479	$93,407	$494,825	$514,740	$47,203	$27,583	$6,699	$2,007,329
OUTLAYS, NET:									
Outlays, net (discretionary and mandatory)	$407,738	$419,999	$89,646	$388,522	$455,176	$16,881	$8,743	$(24)	$1,786,681
Distributed offsetting receipts	(42,602)	(489,119)				(174)	(188)		(532,083)
AGENCY OUTLAYS, NET (DISCRETIONARY AND MANDATORY)	$365,136	$(69,120)	$89,646	$388,522	$455,176	$16,707	$8,555	$(24)	$1,254,598

SUPPLEMENTARY INFORMATION

Consolidating Balance Sheet

Consolidating Statement of Net Cost

Consolidating Statement of Changes in Net Position

CONSOLIDATING BALANCE SHEET

as of September 30, 2020

(in millions)

	Medicare		Health				Combined Totals	Intra-CMS Eliminations	Consolidated Totals
	HI TF	SMI TF	MEDICAID	CHIP	Other	Program Management			
ASSETS									
Intragovernmental Assets:									
Fund Balance with Treasury	$1,675	$105,850	$69,757	$41,854	$20,895	$445	$240,476		$240,476
Investments	134,300	87,834					222,134		222,134
Accounts Receivable, Net	33,771	41,299	1,084		1,999	5,164	83,317	$(82,840)	477
Total Intragovernmental Assets	169,746	234,983	70,841	41,854	22,894	5,609	545,927	(82,840)	463,087
Accounts Receivable, Net	843	11,457	4,321	204	4,217	2	21,044		21,044
General Property, Plant & Equipment, Net	173				486	953	1,612		1,612
Other Assets	64,956	38,684	30		583	82	104,335		104,335
TOTAL ASSETS	$235,718	$285,124	$75,192	$42,058	$28,180	$6,646	$672,918	$(82,840)	$590,078
LIABILITIES									
Intragovernmental Liabilities:									
Accounts Payable	$38,966	$45,042	$2		$1	$23	$84,034	$(82,498)	$1,536
Other Intragovernmental Liabilities	1	1,154			913	11	2,079	(342)	1,737
Total Intragovernmental Liabilities	38,967	46,196	2		914	34	86,113	(82,840)	3,273
Accounts Payable	65	79	85	$482	82	135	928		928
Entitlement Benefits Due and Payable	30,771	39,381	45,850	933			116,935		116,935
Contingencies	12		3,674				3,686		3,686
Other Liabilities	140	380	26		7,876	120	8,542		8,542
TOTAL LIABILITIES	$69,955	$86,036	$49,637	$1,415	$8,872	$289	$216,204	$(82,840)	$133,364
NET POSITION									
Unexpended Appropriations-Dedicated Collections	$1,048	$96,815			$58	$195	$98,116		$98,116
Unexpended Appropriations-Other Funds			$24,907	$39,949	13,651		78,507		78,507
Cumulative Results of Operations-Dedicated Collections	164,715	102,273			5,575	6,162	278,725		278,725
Cumulative Results of Operations-Other Funds			648	694	24		1,366		1,366
Total Net Position - Dedicated Collections	165,763	199,088			5,633	6,357	376,841		376,841
Total Net Position - Other Funds			25,555	40,643	13,675		79,873		79,873
TOTAL NET POSITION	$165,763	$199,088	$25,555	$40,643	$19,308	$6,357	$456,714		$456,714
TOTAL LIABILITIES AND NET POSITION	$235,718	$285,124	$75,192	$42,058	$28,180	$6,646	$672,918	$(82,840)	$590,078

CONSOLIDATING STATEMENT OF NET COST

for the year ended September 30, 2020

(in millions)

	Program	Program Management	Intra-CMS Eliminations	Total
Medicare HI				
Benefit/Program Expenses	$326,217			$326,217
Operating Expenses	923	$1,430	$692	3,045
Total Cost	327,140	1,430	692	329,262
Less: Exchange Revenues	(4,356)	(8)		(4,364)
Net Cost Medicare HI	$322,784	$1,422	$692	$324,898
Medicare SMI				
Benefit/Program Expenses (Part B)	$369,788			$369,788
Benefit Expenses (Part D)	83,758			83,758
Operating Expenses	(886)	$2,445	$988	2,547
Total Cost	452,660	2,445	988	456,093
Less: Exchange Revenues	(112,961)	(17)		(112,978)
Net Cost Medicare SMI	$339,699	$2,428	$988	$343,115
Medicaid				
Benefit/Program Expenses	$458,575			$458,575
Operating Expenses	9	$134		143
Total Cost	458,584	134		458,718
Less: Exchange Revenues		(1)		(1)
Net Cost Medicaid	$458,584	$133		$458,717
CHIP				
Benefit/Program Expenses	$16,936			$16,936
Operating Expenses	1	$14		15
Total Cost	16,937	14		16,951
Less: Exchange Revenues				
Net Cost CHIP	$16,937	$14		$16,951
Other				
Program Expenses	$20,513			$20,513
Operating Expenses	198	$524		722
Total Cost	20,711	524		21,235
Less: Exchange Revenues	(6,277)	(5)	$(1,680)	(7,962)
Net Cost Other	$14,434	$519	$(1,680)	$13,273
NET COST OF OPERATIONS	$1,152,438	$4,516		$1,156,954

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2020

(in millions)

	Dedicated Collections					All Other Funds				
	Medicare		Health		Total Funds From Dedicated Collections	Health (Other Funds)			Total All Other Funds	Consolidated Total
	HI TF	SMI TF	Other	Program Management		Medicaid	CHIP	Other		
UNEXPENDED APPROPRIATIONS										
Beginning Balances	$1,008	$56,887	$68	$5	$57,968	$25,541	$31,631	$5,144	$62,316	$120,284
Budgetary Financing Sources:										
Appropriations Received	29,097	409,510		203	438,810	487,683	28,440	10,429	526,552	965,362
Appropriations Transferred-in/out						(4,562)			(4,562)	(4,562)
Other Adjustments		(6,458)			(6,458)	(20,115)	(3,185)	(606)	(23,906)	(30,364)
Appropriations Used	(29,057)	(363,124)	(10)	(13)	(392,204)	(463,640)	(16,937)	(1,316)	(481,893)	(874,097)
Total Budgetary Financing Sources	40	39,928	(10)	190	40,148	(634)	8,318	8,507	16,191	56,339
Total Unexpended Appropriations	$1,048	$96,815	$58	$195	$98,116	$24,907	$39,949	$13,651	$78,507	$176,623
CUMULATIVE RESULTS OF OPERATIONS										
Beginning Balances	$160,976	$79,009	$6,479	$5,913	$252,377	$(5,700)	$520	$311	$(4,869)	$247,508
Budgetary Financing Sources:										
Appropriations Used	29,057	363,124	10	13	392,204	463,640	16,937	1,316	481,893	874,097
Nonexchange Revenue:										
FICA and SECA Taxes	295,913				295,913					295,913
Interest on Investments	4,372	2,032			6,404		174		174	6,578
Other Nonexchange Revenue	832	3,139			3,971					3,971
Transfers-in/out Without Reimbursement	(3,654)	(5,332)	145	4,716	(4,125)	1,292		(200)	1,092	(3,033)
Other Financing Sources (Nonexchange):										
Imputed Financing	3		12,309	36	12,348			5	5	12,353
Other								(342)	(342)	(342)
Total Financing Sources	$326,523	$362,963	$12,464	$4,765	$706,715	$464,932	$17,111	$779	$482,822	$1,189,537
Net Cost of Operations	322,784	339,699	13,368	4,516	680,367	458,584	16,937	1,066	476,587	1,156,954
Net Change	3,739	23,264	(904)	249	26,348	6,348	174	(287)	6,235	32,583
Cumulative Results of Operations	$164,715	$102,273	$5,575	$6,162	$278,725	$648	$694	$24	$1,366	$280,091
Net Position	$165,763	$199,088	$5,633	$6,357	$376,841	$25,555	$40,643	$13,675	$79,873	$456,714

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

November 6, 2020

TO: Seema Verma, M.P.H.
Administrator
Centers for Medicare & Medicaid Services

FROM: Amy J. Frontz
Deputy Inspector General for Audit Services

Amy Frontz

Digitally signed by AMY FRONTZ
Date: 2020.11.06 09:32:25 -05'00'

SUBJECT: *Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2020*, A-17-20-53000

This memorandum transmits the independent auditors' reports on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2020 financial statements, internal control over financial reporting, 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, 2020 and 2019, 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, 2020, and related statement of changes in social insurance amounts. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 19-03, *Audit Requirements for Federal Financial Statements*.

Results of the Independent Audit

Based on its audit, Ernst & Young found that the FY 2020 CMS consolidated balance sheets and the related consolidated statements of net cost and changes in net position and combined statement of budgetary resources were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. Ernst & Young was unable to obtain sufficient audit evidence for the amounts presented in the statements of social insurance as of January 1, 2020, 2019, 2018, 2017, and 2016, and the related statements of changes in social

insurance amounts for the periods ended January 1, 2020 and 2019. As a result, 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*, Ernst & Young identified significant deficiencies in CMS's financial reporting processes and information systems controls:

- *Financial Reporting Processes*—Ernst & Young noted that CMS continues its efforts to enhance internal controls as part of the financial reporting processes. Weaknesses in oversight of the Medicaid program included limitations with the utilization of claims data for financial accounting and reporting. Also, the process to perform a detailed claims-level look-back analysis related to the Entitlement Benefits Due and Payable accrual, which would determine the reasonableness of the various State calculations of the incurred but not reported liability, should be further developed.

  Ernst & Young also identified weaknesses in the following areas: formula errors in the spreadsheets used in the preparation of the statement of social insurance which were not detected by the organization's monitoring and review function, and improper payments. These deficiencies collectively represent a significant deficiency in internal control.

- *Information Systems Controls*—Ernst & Young noted that deficiencies continue to be identified in implementing and monitoring access controls for CMS's information systems. While CMS has made progress in implementing greater oversight and uniformity in the design and operation of CMS' IT controls, CMS continues to encounter challenges in monitoring its own and its contractor's adherence to CMS's established information systems control standards and processes. The deficiencies found continue to constitute a significant deficiency in internal control.

Ernst & Young identified several instances of noncompliance with laws and other matters. During FY 2020, CMS was not in full compliance with the requirements of the Payment Integrity Information Act of 2019 (P.L. No. 116-117). Notably, the Medicaid program and the Children's Health Insurance Program (CHIP) reported error rates in excess of 10 percent. Neither the Medicaid program nor CHIP had an error rate target for FY 2020. CMS is currently in process of incorporating a new eligibility measurement process, which would defer the establishment of error rate reduction targets until a baseline measurement was in place.

CMS was not in compliance with section 6411 of the Affordable Care Act.[1] CMS had not yet implemented recovery activities for the identified improper payments for the Medicare Advantage (Part C) program. CMS management was notified during FY 2020 that it may have potential violations of the Federal Acquisition Regulation related to contracting matters and was notified during FY 2019 that it may have potential violations of the Antideficiency Act related to

[1] The Patient Protection and Affordable Care Act (P.L. No. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. No. 111-152) are collectively referred to as the Affordable Care Act.

certain contract obligations for fiscal years 2014 and 2015. Ernst & Young disclosed no other instances of noncompliance that are required to be reported under *Government Auditing Standards* and OMB Bulletin 19-03.

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, including that related to the review of internal controls over financial reporting;
- reviewing the auditors' reports; and
- reviewing CMS's "Management Discussion and Analysis," "Financial Statements and Footnotes," "Required Supplementary Information," "Supplementary Information," and "Other Information."

Ernst & Young is responsible for the attached reports and the conclusions expressed in those 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 Carla J. Lewis, Acting Assistant Inspector General for Audit Services, at (202) 205-9125 or Carla.Lewis@oig.hhs.gov. Please refer to report number A-17-20-53000.

Attachment

cc:
Jennifer Moughalian
Acting Assistant Secretary for Financial Resources
and Acting Chief Financial Officer

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

Jennifer Main
Chief Operating 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, 2020 and 2019, 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 also engaged to audit the sustainability financial statements, which comprise the statements of social insurance as of January 1, 2020, 2019, 2018, 2017, and 2016, the related statements of changes in social insurance amounts for the periods ended January 1, 2020 and 2019, and the related notes to the sustainability 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, 2020, 2019, 2018, 2017, and 2016, the related statements of changes in social insurance amounts for the periods ended January 1, 2020 and 2019, 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 (OMB) Bulletin No. 19-03, *Audit Requirements for Federal Financial Statements*. Those standards and OMB Bulletin No. 19-03 require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

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

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions on the consolidated balance sheets as of September 30, 2020 and 2019, 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 12 to the financial statements, the statement of social insurance presents the actuarial present value of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds' estimated future income to be received from or on behalf of the participants and estimated future expenditures to be paid to or on behalf of participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. The sustainability financial statements are intended to aid users in assessing whether future resources will likely be sufficient to sustain public services and to meet obligations as they come due. The statements of social insurance and changes in social insurance amounts are based on income and benefit formulas in current law and assume that scheduled benefits will continue after any related trust funds are exhausted. The sustainability financial statements are not forecasts or predictions. The sustainability financial statements are not intended to imply that current policy or law is sustainable. 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

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the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act (MACRA).

With respect to the estimates for the social insurance program presented as of January 1, 2020, 2019, 2018, 2017, and 2016, the current-law expenditure projections reflect the physicians' payment levels expected under the MACRA payment rules and the ACA-mandated reductions in other Medicare payment rates. Management has developed an illustrative alternative scenario and projections intended to quantify the potential understatement of projected Medicare costs to the extent that certain payment provisions were not fully implemented in all future years. The range of the social insurance liability estimates in the scenarios is significant. As described in Note 13, 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 and that physician costs will grow at a faster rate than the specified updates. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. Absent a change in the health care delivery system or level of update by subsequent legislation, access to Medicare-participating providers may become a significant issue in the long term under current law. Overriding the price updates in current law, as lawmakers repeatedly did in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in this report. 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, 2020, 2019, 2018, 2017, and 2016, and the related statements of changes in social insurance amounts for the periods ended January 1, 2020 and 2019.

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, 2020, 2019, 2018, 2017, and 2016, and the related changes in the social insurance program for the periods ended January 1, 2020 and 2019.

Opinion

In our opinion, the consolidated balance sheets, consolidated statements of net cost and changes in net position, and combined statements of budgetary resources referred to above present fairly, in all material respects, the financial position of CMS as of September 30, 2020 and 2019, and its net cost, changes in net position, and budgetary resources for the years then ended in conformity with U.S. generally accepted accounting principles.

Other Matters

Required Supplementary Information

U.S. generally accepted accounting principles require that Management's Discussion and Analysis and Required Supplementary Information as identified on CMS' Annual Financial Report Table of Contents be presented to supplement the financial statements. Such information, although not a part of the 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 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 financial statements, and other knowledge we obtained during our audit of the financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Supplementary and Other Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise CMS' financial statements. The Supplementary Information is presented for purposes of additional analysis and is not a required part of the 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 financial statements. Such information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the 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 financial statements as a whole.

The Other Information has not been subjected to the auditing procedures applied in the audit of the 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 6, 2020, on our consideration of CMS' internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant

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agreements and other matters. The purpose of those reports is solely 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 effectiveness of CMS' 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 6, 2020

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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. 19-03, *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, 2020 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 sustainability financial statements, which comprise the statement of social insurance as of January 1, 2020, and the related statement of changes in social insurance amounts for the period ended January 1, 2020, and have issued our report thereon dated November 6, 2020. 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, 2020 and the related statement of changes in social insurance amounts for the period ended January 1, 2020.

Compliance and Other Matters

In connection with our audit of the financial statements of CMS, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements, noncompliance with which could have a direct and material effect on the financial statements, as well as the requirements referred to in the *Federal Financial Management Improvement Act of 1996* (FFMIA) (P.L.104-208). 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 disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 19-03, as described below:

The *Payment Integrity Information Act of 2019 (*P.L.116-117) (hereinafter, the "Act") requires 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

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improper payment rates for each of its high-risk programs, or components of such programs, it is not in full compliance with the Act. The Medicaid and CHIP improper payment rates exceeded the statutorily required maximum of 10 percent. In addition, CMS was not in full compliance with Section 6411 of the *Affordable Care Act* as CMS had not yet implemented recovery activities of the identified improper payments for the Medicare Advantage (Part C) program.

During FY 2020, CMS management was notified that it may have potential violations of the Federal Acquisition Regulation related to contracting matters. In addition, CMS management was notified in the prior fiscal year that it may have potential violations of the *Anti-Deficiency Act* related to certain contract obligations related to fiscal years 2014 and 2015.

CMS' Response to Findings

CMS' response to the findings identified in our audit are described in their letter dated November 6, 2020. 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 6, 2020

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

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

We have audited, in accordance with auditing standards generally accepted in the United States and the standards applicable to financial statement audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States and Office of Management and Budget (OMB) Bulletin No. 19-03, *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, 2020 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 sustainability financial statements, which comprise the statement of social insurance as of January 1, 2020, and the related statement of changes in social insurance amounts for the period ended January 1, 2020, and have issued our report thereon dated November 6, 2020. 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, 2020 and the related statement of changes in social insurance amounts for the period ended January 1, 2020.

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) as a basis for designing 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 CMS' internal control. We did not consider 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 preparing performance information and ensuring efficient operations.

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

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corrected, on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

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

Significant Deficiencies

Financial Reporting Processes

Financial management in the Federal government requires accountability of financial and program managers for financial results of actions taken, control over the Federal government's financial resources and protection of Federal assets. To enable these requirements to be met, financial management systems and internal controls must be in place to process and record financial events effectively and efficiently and to provide complete, timely, reliable and consistent information for decision-makers and the public. CMS is a very large organization that is responsible for the management of complex programs that are continuing to increase in scope and size. CMS is entrusted with the lead role in overseeing health services in the United States. Financial reporting of the cost of health programs and the oversight role is important as the country continues to make decisions about this critical mission.

CMS relies on a decentralized organization and a high number of 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).

As CMS continues its efforts to enhance internal controls, the following areas identified in the current year audit merit continued focus as part of the financial reporting processes significant deficiency.

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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.

CMS previously completed implementation of the Transformed-Medicaid Statistical Information System (T-MSIS). T-MSIS modernizes and enhances the way states submit operational data about beneficiaries, providers, health plans, claims and encounters. Although operational data is currently available, information contained within T-MSIS requires additional verification before it would be considered reliable to utilize in the financial accounting and reporting for Medicaid. CMS should evaluate whether financial reporting risks can be addressed by using T-MSIS data to identify outliers and unusual or unexpected results that demonstrate abnormalities in state-related Medicaid expenditures. Given the claims level detail is not yet considered reliable for financial accounting and reporting, CMS is unable to perform a claims-level detailed look-back analysis for the Medicaid Entitlement Benefits Due and Payable (EBDP) to determine the reasonableness of the various state calculations of incurred (unpaid claims) but not reported liability. The Medicaid EBDP is a significant liability on the FY 2020 financial statements and is subject to volatility based on the complexity and judgement required in establishing this estimate. From time to time, claim processing cycle changes, such as a claims inventory buildup, may arise. As such, the lack of detailed claims data limits the ability to detect this type of situation on a timely basis or consider the potential volatility from this occurrence.

Despite the implementation of T-MSIS, CMS must continue to evaluate and improve the quality and completeness of data reported by the states in T-MSIS before a claims level detailed look-back analysis for Medicaid EBDP can be suitably relied upon. Until further analysis is developed and performed to verify the reliability of T-MSIS data, there remains a risk that potential updates to CMS' analysis will not be reflected in CMS' financial statements in a timely manner.

Statements of Social Insurance

The Statements of Social Insurance (SOSI) for CMS presents a long-term projection of the present value of the benefits to be paid for the closed and open groups of existing and future participants of the Medicare social insurance programs less the inflows to be received from, or on behalf of, those same individuals. The SOSI models are complex, 75-year projections that contain a high degree of estimation. The models and their results are heavily reviewed by actuaries and others within CMS. The veracity of the underlying data remains critical to the accuracy of the model, and as a result the reviews of the underlying data is robust, in line with CMS' policies and procedures. As part of this review, the input into the spreadsheet is checked against the original data sources to ensure that no input errors have been made. In addition, output data, including those that are generated from updating and running any macro in the spreadsheet, are checked by the reviewer.

These checks include a comparison to the results from the year before and testing of the formulas that are part of the spreadsheet or macro, to ensure that the projection output from the program is as expected and reasonable. In the current year, CMS incorporated changes to key assumptions and certain aspects of its methodology in the SOSI projection, resulting in changes to the inputs, formulas and macros, and outputs of certain spreadsheets. The extent of those changes was significant and the majority of those changes were implemented without issue; however, during our procedures, formula errors associated with certain of the changes were identified that were not detected by the organization's monitoring and review function, and accordingly, the related control was not functioning as designed.

Improper Payments

The nature and volume of its expenditures present a substantial challenge to CMS in the quantification, evaluation and remediation of improper payments. Health insurance claims represent the vast majority of the CMS payments. These payments are complex and involve the evaluation of the program eligibility of both the recipient of the services and of the health provider, oversight of the medical necessity of each covered treatment and concurrence with the cost to be paid, some of which is based on complex financial formulas and/or coding decisions. CMS has developed sophisticated sampling processes for estimating improper payment rates in the high-risk CMS programs of Medicare Fee-for-Service (FFS), Medicare Advantage, Medicare Prescription Drugs, Medicaid and CHIP.

CMS builds time into their processes to allow all payments sampled for review sufficient time to allow for appeals of the errors and submission of additional documentation by the claimant. CMS believes that expediting the improper payment 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. Allowing the maximum amount of time for this development causes the processes to be completed very near the required annual reporting deadline. CMS remains committed to achieving reductions in improper payment rates. As a result, improper payment rates declined for Medicare FFS and Medicare Part C. Part D saw a slight increase from the prior year's estimate, however the improper payment rate remains low. For Medicaid and CHIP, CMS reintegrated the eligibility component of the measurement in 2019, resulting in an increase in the improper payment rates; however, the 2020 rates are not comparable to the prior year as a result of this reintegration of the new eligibility component which contributed to a further increase in the Medicaid and CHIP error rates in 2020. Rates between years will not be comparable until a baseline is established in 2021, when all states have been measured under the new eligibility requirements. CMS has specific initiatives underway to address these new results.

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Recommendations

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

- Continue to enhance the data analyses on Medicaid claims level data to develop robust analytical procedures and measures against benchmarks to monitor and identify risks associated with the financial accounting and reporting of the Medicaid program.

- 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 $45.9 billion liability.

- Continue to adhere to established policies and procedures to ensure that the SOSI model methodology and related calculation and estimates are reviewed at a level of sufficient precision. When significant changes are made, such as changes to the methodology or key assumptions, management should require an enhanced review specific to these changes.

- Consider additional opportunities to further reduce improper payments which are consistent with the organization's objectives of improving payment accuracy levels.

Information Systems Controls

Information systems controls are a critical component of the Federal government's operations to manage the integrity, confidentiality and reliability of its programs and activities and assist with reducing the risk of errors, fraud or other illegal acts. The nature, size and complexity of CMS' operations require the organization to administer its programs under a decentralized business model by using numerous geographically dispersed contractors operating complex and extensive information systems.

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

Controls over System Access and Information Security Controls

CMS has a large number of users required to have access to CMS systems in order to process claims and to support beneficiaries in a timely and effective manner. Accordingly, properly implemented system access controls, including user and system account management and monitoring of system access, are critical to preventing and detecting unauthorized usage of CMS information resources and program and data files. Without maintaining an appropriate level of access controls within CMS systems, the integrity of CMS' information resources could be compromised. Additionally, information systems security controls are vital to safeguard the

confidentiality, integrity and availability of data. As a result of evolving threats to information systems, continuous monitoring and scanning of security baselines is essential in identifying vulnerabilities and misconfiguration of system controls that could be exploited if they remain un-remediated.

Deficiencies continued to be identified in the implementation and monitoring of controls, including controls over privileged access to the CMS information systems and system misconfigurations. Examples included:

- Procedures for the removal of users who no longer required access were not consistently followed.
- Monitoring of privileged access for key applications and underlying IT infrastructure was not performed, or evidence of such monitoring activity was not retained.
- System configurations were not compliant with CMS requirements. These include settings to disable inactive accounts and password requirements.
- Security baseline configuration scans for the general leger system were not performed for part of the fiscal year.
- An expedited change to the general ledger system was implemented without obtaining all appropriate approvals.

Appropriate consideration of the design of controls over access and monitoring of access as well as information security controls is essential to provide a suitable framework for subsequent implementation and operation of the controls. Without adequate controls over managing access to critical systems and monitoring of information systems security controls, the risk of errors, fraud or other illegal acts is increased.

Governance Over Implementation of Information Systems Control Standards and Processes

While progress has been made towards implementing greater oversight and uniformity in the design and operation of CMS' IT controls, CMS continues to encounter challenges with monitoring their own and contractors' adherence to their established information systems control standards and processes, particularly as it relates to the organization's access monitoring controls. Further, the oversight of the information systems control standards and processes is performed by multiple business units within CMS Headquarters, such as the Office of Information Technology (OIT), Office of Financial Management (OFM), and the Center for Medicare (CM). The multiple business units involved in oversight activities heighten CMS' inability to enforce enterprise-wide risk management strategy, and overall integrity of its Medicare systems and other enterprise-wide systems.

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Deficiencies continued to be identified, similar to previous years, in the contractors' implementation and CMS' monitoring of compliance with CMS' information systems control standards and processes, which included:

- CMS' risk management strategy is decentralized and lacks an enterprise viewpoint, which has resulted in several vulnerabilities related to system configurations with the CMS information systems. The remediation, mitigation of risks, or monitoring of these vulnerabilities was not performed or not performed timely.

- The distributed nature of CMS' IT environment has resulted in the identification of control deficiencies stemming from inadequate implementation of controls related to access, security management and system configuration. Deficiencies related to these control areas were consistently noted within the OMB A-123 and OIG audit reports. Commonality in access, security management and system configuration control deficiencies across the business units indicates monitoring and oversight is an enterprise level risk for which standardized processes should be developed to allow the varying IT environments to implement common access controls.

Without sufficient and consistent oversight by CMS Headquarters to monitor and enforce compliance with its established information security and configuration management policies and procedures, Medicare systems and other enterprise-wide systems may be susceptible to error, fraud, and/or security vulnerabilities that may impact claims processing and financial reporting.

Recommendations

CMS should continue to improve the operating effectiveness of information security controls including access controls, to ensure that:

- Relevant CMS guidance is followed for the removal of users to all systems, security configurations, and configuration management.

- Privileged access for key applications and the underlying IT infrastructure is monitored to detect and correct unauthorized access or activities, and evidence of such monitoring activities is retained. Specific to the governance over implementation of information systems controls standards and processes, CMS should continually assess the governance and oversight across its organizational units charged with responsibility for the information security of its systems and data at both Headquarters and the CMS Medicare FFS contractors. As such, an approach will require continued and active communication and integration of efforts by the OFM, OIT and CM.

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

- Enhanced risk management procedures and practices that focus on the role of the IT system within the enterprise and a clear definition of responsibilities associated with the oversight and implementation of controls to address identified risks.

- Ensuring that remediation of findings identified as a part of OIG and OMB A-123 audits including tests performed on CMS and its Medicare contractors' IT operations is performed timely.

CMS' Response to Findings

CMS' response to the findings identified in our audit are described in the accompanying letter dated November 6, 2020. CMS' response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and the results of that testing, and not to provide an opinion on the effectiveness of 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 6, 2020

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT

November 6, 2020

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

Dear Sir/Madame:

This letter is in response to your audit report on the Centers for Medicare & Medicaid Services' (CMS) fiscal year 2020 financial statements and annual Agency Financial Report. We have reviewed your report and are pleased to receive an unmodified opinion on our Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position, and the Combined Statement of Budgetary Resources.

I understand that you are still not able to express an opinion on the Statement of Social Insurance (SOSI) and the Statement of Changes in Social Insurance Amounts due to the uncertainty of the long-range assumptions used in the model. CMS has properly disclosed and documented the nature and uncertainty surrounding these projections and remains assured that our SOSI model projections are fairly presented. We remain fully committed to continuing our partnership with you to find a solution to reporting the SOSI projections that will allow auditors to opine on these statements in the future.

We acknowledge that your audit identified no material weaknesses in our internal controls and reported two significant internal control deficiencies in our financial reporting processes and information systems. CMS has already begun implementing corrective action plans that will assist us in resolving the deficiencies noted by the auditors. These corrective action plans will also aide us in strengthening our internal controls.

CMS understands the tremendous undertaking it is to audit financial statements with complex programs such as ours, especially during a public health emergency. We thank you and your audit team for your continued diligence and professionalism in completing this year's annual financial statement audit.

Sincerely,

Megan Worstell

Megan Worstell
Chief Financial Officer

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OTHER INFORMATION

Summary of Federal Managers' Financial Integrity Act Report and OMB Circular No. A-123, Management's Responsibility for Enterprise Risk Management and Internal Control // Improper Payments

SUMMARY OF FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT REPORT AND OMB CIRCULAR NO. A–123, MANAGEMENT'S RESPONSIBILITY FOR ENTERPRISE RISK MANAGEMENT AND INTERNAL CONTROL

CMS assesses its internal controls through: (1) management self-assessments, including annual tests of security controls; (2) Office of Management and Budget (OMB) Circular A-123, Appendix A self-assessments; (3) Office of Inspector General (OIG) audits, and Government Accountability Office (GAO) audits and High-Risk reports; (4) Statement on Standards for Attestation Engagements (SSAE) 18 internal control audits; (5) evaluations and tests of Medicare contractor controls conducted pursuant to section 912 of the *Medicare Modernization Act*; (6) the annual Chief Financial Officers (CFO) Act audit; (7) security assessment and authorization of systems; and (8) Department Enterprise Risk Management efforts. As of September 30, 2020, the internal controls and financial management systems of CMS provided reasonable assurance that the objectives of the *Federal Managers' Financial Integrity Act of 1982* (FMFIA) were achieved with the exception of two instances of non-compliance described below.

OMB Circular No. A–123 Statement of Assurance

CMS management is responsible for managing risks and maintaining effective internal control to meet the objectives of Sections 2 and 4 of the FMFIA. These objectives are to ensure: (1) effective and efficient operations, (2) reliable reporting, and (3) compliance with applicable laws and regulations.

CMS conducted its assessment of risk and internal control in accordance with OMB Circular A-123, Management's Responsibility for Enterprise Risk Management and Internal Control. Based on the results of the assessment, CMS provides reasonable assurance that internal controls over operations, reporting, and compliance were operating effectively as of September 30, 2020, with the exception of material non-compliances with: the *Payment Integrity Information Act of 2019* (PIIA), signed into law on March 2, 2020 (hereafter referenced as PIIA); and Section 6411 of the PPACA.

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 substantially comply with Federal financial management systems requirements, Federal accounting standards, and the United States Standard General Ledger at the transaction level. CMS conducted its evaluation of financial management systems for compliance with FFMIA in accordance with OMB Circular A-123, Appendix D. Based on the results of this assessment, CMS provides reasonable assurance that its overall financial management systems substantially comply with FFMIA and substantially conform to the objectives of FMFIA, Section 4.

Noncompliance – Actions and Accomplishments

CMS did not fully comply with the requirements of the PIIA, and section 6411 of the PPACA. CMS has developed several corrective actions to reduce improper payments. 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.

CMS's fiscal year (FY) 2020 PIIA non-compliance stems from the following:

1. The Medicaid improper payment rate was 21.36 percent, higher than the 10 percent PIIA required threshold.

2. The FY 2020 Children's Health Insurance Program (CHIP) improper payment rate was 27.00 percent, higher than the 10 percent PIIA required threshold.

CMS has taken, and continues to take a number of actions outlined in the FY 2020 Agency Financial Report (AFR). CMS continues its efforts to comply with the requirements of the PIIA and OMB's implementing guidance.

With regard to compliance with section 6411 of the PPACA concerning development of the Medicare Part C Recovery Audit Contractor (RAC) program, as part of the A-19 process, CMS is seeking to remove authority requiring CMS to expand the recovery audit program to Medicare Parts C and D programs. In 2015, CMS issued a Request for Information on the proposal to put the Risk Adjustment Data Validation (RADV) audits under the purview of a Medicare Part C RAC. The primary corrective action on Part C payment error has been the

RADV audits. RADV verifies that diagnoses submitted by MA organizations for risk adjusted payment are supported by medical record documentation. In the responses to the Request for Information, the MA industry expressed concerns of burden related to the high overturn rate in the early experience of the Parts A and B RAC programs. Additionally, potential RAC vendors expressed concerns with the unlimited delay in the contingency payment due to time frames not being established for appeal decisions in the MA appeal process (42 C.F.R. § 423.2600). Also, despite their success in Medicare FFS, RACs have found Medicare Part C to be an unattractive business model because of differing payment structures and a narrow scope of payment error.

To more efficiently use program integrity resources, the FY 2021 budget included a proposal to remove the requirement for HHS to expand the RAC program to Medicare Part C and requires plan sponsors to report fraud and abuse incidents and corrective actions.

CMS believes that the functions of the Part C RAC are currently being performed by the RADV program. The RADV program is currently operational with the support of contractors that the government has procured. An updated RADV methodology that addresses recommendations in GAO audit report GAO 16-76 includes targeting payment errors using historical payment error data. CMS expects to receive audit findings in the first quarter of FY 2021. The proposal included in the FY 2021 budget creates programmatic and administrative efficiencies while strengthening fraud and abuse reporting. Although OMB approved the FY 2021 budget, Congress has not acted on the proposal.

IMPROPER PAYMENTS

PIIA includes requirements for identifying programs susceptible to significant improper payments, annually reporting estimates of improper payments, and implementing corrective actions to reduce improper payments. PIIA defines improper payments as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments). Improper payments also include payments to ineligible recipients, payments for ineligible services, duplicate payments, payments for services not received, as well as payments that are lacking sufficient documentation to determine if proper. Since FY 2012, CMS has complied with OMB's implementing guidance and instituted comprehensive processes that measure the payment error rates for the Medicare FFS, Medicare Part C, Medicare Prescription Drug (Medicare Part D), Medicaid, and CHIP programs. However, in response to the COVID-19 Public Health Emergency (PHE), CMS exercised its enforcement discretion to adopt a temporary policy to suspend all improper payment-related engagement/communication with providers and states between March 2020 and August 2020. To minimize burden on providers and states, CMS modified the improper payment statistical methodologies to be able to timely report rates in the FY 2020 AFR based on data already collected at the time of the PHE or that providers or states voluntarily submitted. With the modified methodologies, CMS will still meet the regulatory national-level precision requirements that the rates are +/- 3 percentage points at a 95 percent confidence interval[1].

CMS FY 2020 AFR improper payment data reported does not represent payments that occurred during the COVID-19 PHE period but represent payments submitted July 1, 2018 –June 30, 2019 for the Comprehensive Error Rate Testing (CERT) and Payment Error Rate Measurement (PERM) programs and Calendar Year 2018 for Medicare Parts C and D programs.

Medicare FFS

CMS measures the national Medicare FFS improper payment rate annually, through the CERT program. The Medicare FFS measurement methodology remains the same since FY 2012. The estimated percentage of Medicare FFS dollars paid correctly was 93.73 percent. This means Medicare paid an estimated $385.10 billion correctly in FY 2020.

The CERT program estimates the Medicare FFS payment accuracy rate by reviewing claims and the submitted medical records. These reviews uncover causes of improper payments including insufficient documentation and lack of medical necessity. To achieve an even greater payment accuracy rate, CMS must focus its corrective actions on specific areas that are most vulnerable to improper payments.

The national Medicare FFS estimated improper payment rate for FY 2020 is 6.27 percent or $25.74 billion in gross improper payments. Improper payments for hospital outpatient, inpatient rehabilitation facility (IRF), skilled nursing facility (SNF), and home health claims were the major contributing factors to the FY 2020 Medicare FFS improper payment rate. While the factors contributing

1 Due to CMS's temporary policy to stop documentation requests to providers as a result of the PHE for COVID-19 pandemic, the Medicare Part C Improper Payment Measurement medical record submission did not follow the same pattern as in previous years. As a result CMS had to make significant changes to the sampling and estimation plan for FY 2020 Medicare Part C improper payment reporting. This impacted CMS's ability to set an aggressive yet realistic out-year target given the situation with the current year data as compared to prior years data. OMB allows for this exception for not reporting out-year targets in the OMB Circular A-123 Appendix C.

to improper payments are complex and vary by year, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors.

CMS uses data from the CERT program and other sources of information to address improper payments in Medicare FFS through various corrective actions, such as policy clarifications and simplifications, when appropriate, as well as targeted probe and educate reviews, which include more individualized education through smaller probe reviews, followed by specific education based on the findings of these reviews. CMS is also continuing prior authorization initiatives, as appropriate, which help to make sure that applicable coverage, payment, and coding rules are met before services are rendered while ensuring access to and quality of care. CMS has developed a number of preventative measures for specific service areas with high improper payment rates. CMS believes implementing targeted corrective actions in these areas will prevent and reduce improper payments in these areas and reduce the overall improper payment rate.

Medicare Advantage and Prescription Drugs

CMS has reported a Part C payment error rate since FY 2008. The Part C error rate measures improper payments made to Medicare Advantage (MA) contracts based on diagnoses submitted by MA organizations for payment (or risk adjustment error). The Part C payment error rate was 6.78 percent for the FY 2020 reporting period.

The Part D payment error estimate measures payment errors related to prescription drug event data. The Part D improper payment error rate was 1.15 percent for the FY 2020 reporting period.

Medicaid and CHIP

Medicaid and CHIP are susceptible to erroneous payments as well. Thus, the federal government and the states both have a strong financial interest in ensuring that claims are paid accurately. Through PERM, CMS measures three areas of Medicaid and CHIP: FFS claims, managed care payments, and eligibility determinations. PERM uses a 17-states-per-year, 3-year rotation to produce and report national program improper payment rates.

Between FY 2015 and FY 2018, states were not measured on the eligibility PERM component as states worked to come into compliance with new PPACA eligibility requirements. In 2019, the PERM program integrated these new PPACA Medicaid and CHIP eligibility requirements in the eligibility review methodology. CMS resumed the eligibility review component measurement under the PERM final rule (82 FR 31158, July 5, 2017) for the first cycle of 17 states and reported an updated national eligibility improper payment estimate for FY 2019. In FY 2020, CMS is reporting an updated national eligibility improper payment estimate including the first two cycles of states and a proxy eligibility rate estimate for the remaining 17 states that have not yet been measured. CMS will complete the measurement of all states and establish a baseline in FY 2021, when all three cycles are measured under the new eligibility review component.

The national Medicaid improper payment rate reported for FY 2020 is 21.36 percent or $86.49 billion in improper payments based on measurements conducted in FYs 2018, 2019, and 2020[2]. The national component improper payment rates are: Medicaid FFS: 16.84 percent; Medicaid managed care: 0.06 percent; Medicaid eligibility: 14.94 percent. The national CHIP improper payment rate reported for FY 2020 is 27.00 percent or $4.78 billion in improper payments based on measurements conducted in FYs 2018, 2019, and 2020. The national component improper payment rates are: CHIP FFS: 14.15 percent; CHIP managed care: 0.49 percent; CHIP eligibility: 23.53 percent.

The majority of Medicaid and CHIP improper payments are a result of eligibility errors discovered through the reintegration of the PERM eligibility component, as mentioned above. A federal contractor[3] conducts the eligibility measurement, allowing for consistent insight into the accuracy of Medicaid and CHIP eligibility determinations and increased oversight of identified vulnerabilities. Based on the measurement of the first two cycles of states, eligibility errors are mostly due to insufficient documentation to affirmatively verify eligibility or non-compliance with eligibility redetermination requirements. The majority of the insufficient documentation errors represent both situations where:

2 There were accuracy concerns with the 2018 improper payment estimate due to issues with a portion of the Medicaid and CHIP reviews for PERM Cycle 3 states. Prior to reporting in the AFR, CMS ran scenarios for what the national improper payment rate would be if all reviews in question were considered errors or all were considered correct. In these extreme scenarios, the 2018 national rate would swing by +/- 0.33 percent, well within the estimate's confidence interval. Due to the PERM methodology, which utilizes three cycles to combine to the overall Medicaid and CHIP rates, these concerns also have an impact on the 2019 and 2020 rates, until the same cycle of states is measured again and reported in 2021. The 2019 rate would swing by +/- 0.27 percent based on these concerns, again well within the estimate's confidence interval. The 2020 rate would swing by +/- 0.22 percent based on these concerns.

3 Prior to FY 2014, the eligibility component was reviewed and self-reported by the states to CMS for national improper payment reporting.

- The required verification of eligibility data, such as income, was not done at all, and
- Where there is indication that the eligibility verification was initiated but there was no documentation to validate the verification process was completed.

The CHIP improper payment rate was also driven by claims where the beneficiary was inappropriately deemed eligible for CHIP, but was eligible for Medicaid. Additionally, state non-compliance with provider screening, enrollment, and National Provider Identifier (NPI) requirements is a major contributor to the Medicaid and CHIP improper payment rates.

CMS works closely with states to develop state-specific corrective action plans to reduce improper payments. All states are responsible for implementing, monitoring, and evaluating the effectiveness of their plans, with assistance and oversight from CMS.

Additional information on the Medicare FFS, Medicare Part C, Medicare Part D, Medicaid, and CHIP improper payments can be found in the HHS FY 2020 AFR and CMS websites.

Exchanges

While a FY 2016 risk assessment concluded that the Advance Premium Tax Credit (APTC) program is susceptible to significant improper payments, the program is not yet reporting improper payment estimates for FY 2020. CMS is committed to implementing an improper payment measurement program as required by PIIA. As with similar CMS programs, developing an effective and efficient improper payment measurement program requires multiple, time-intensive steps including contractor procurement, development of measurement policies, procedures, and tools, and extensive pilot testing to ensure an accurate improper payment estimate. CMS will continue to monitor and assess the program for changes and adapt accordingly. In FYs 2017 through 2020 CMS conducted development and piloting activities for the APTC improper payment measurement program and will continue these activities in FY 2021. CMS will continue to update the AFR with the measurement program development status until the reporting of the improper payment estimate.

GLOSSARY

A

Accountable Care Organizations (ACO): A group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) who work together to coordinate care for the patients they serve.

Accrual Accounting: A system of accounting in which revenues are recorded when earned and expenses are recorded when goods are received or services are performed, even though the actual receipt of revenues and payment for goods or services may occur, in whole or in part, at a different time.

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. CMS administrative costs are the costs of operating CMS (e.g., salaries, expenses, facilities, equipment, rent and utilities). These costs are accounted for in the Program Management account.

Advance Premium Tax Credit (APTC): Payment amounts calculated by the Exchange and paid to an eligible consumer's insurance company on the consumer's behalf to lower the consumer's out-of-pocket cost for health insurance premiums. The amount the consumer is eligible for is based on the cost of the second lowest silver plan available through the applicable Exchange and the consumer's estimated annual household income compared to the Federal poverty line. Consumers that receive the benefit of APTC payments must file a tax return to reconcile the amount of APTC payments with the amount of the actual premium tax credit they are eligible.

American Recovery and Reinvestment Act of 2009 (ARRA): An economic stimulus package enacted by the 111th U.S. Congress in February 2009. This act of Congress was based largely on proposals made by the President and was intended to stimulate 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 of the BBA provided for the Children's Health Insurance Program, Medicare + Choice (currently known as the Medicare Advantage program), and expansion of preventive benefits.

Benefit Payments: Expenses accrued or funds outlaid for services delivered to beneficiaries.

C

Chief Financial Officers Act of 1990 (CFO Act): Designated a Chief Financial Officer in each executive department and each major executive agency in the federal government. It provides for production of complete, reliable, timely, and consistent financial information for use by the executive branch of the government and the Congress in the financing, management, and evaluation of federal programs.

Children's Health Insurance Program (CHIP) (also known as Title XXI): CHIP (previously known as the State Children's Health Insurance Program, or SCHIP) was originally created in 1997 as Title XXI of the *Social Security Act*. CHIP is a state and federal partnership that targets uninsured children and pregnant women in families with incomes too high to qualify for Medicaid, but often too low to afford private coverage.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA): CHIPRA extended and expanded CHIP, which was enacted as part of the 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 an applicable certificate in effect.

Consumer Operated and Oriented Plan Program (CO-OP): The *Patient Protection and Affordable Care Act* calls for the establishment of the CO-OP Program, which fosters the creation of qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets.

Cost-Sharing Reduction (CSR) Payment: Payments to health insurance issuers on the Exchange on behalf of eligible insured individuals that lower the amount consumers pay for deductibles, copayments, and coinsurance. Eligibility is limited to those in silver plans receiving APTCs and is based on the amount of household income for the insured compared to the poverty line. These payments to issuers ceased starting in Fiscal Year 2018 in light of a legal opinion from the Attorney General of the U.S. that a valid appropriation does not exist for CSR payments. However, issuers are still required by law to reduce cost-sharing for eligible enrollees.

D

Deficit Reduction Act of 2005: The *Deficit Reduction Act* restrains federal spending for entitlement programs (i.e., Medicare and Medicaid) while ensuring that Americans who rely on these programs continue to get needed care. Provisions of the act require wealthier seniors to pay higher premiums for their Medicare coverage; a restraint on Medicaid spending by reducing federal overpayment for prescription drugs so that taxpayers do not pay inflated markups; and 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 to determine if such projects/pilots should be continued or expanded to meet the health care needs of the nation. Demonstrations are used to evaluate the effects and impact of various health care initiatives and the cost implications to the public.

Disproportionate Share Hospital (DSH): A hospital with a disproportionately large share of low-income patients. Under Medicaid, states augment payment to these hospitals. Medicare inpatient hospital payments are also adjusted for this added burden.

Durable Medical Equipment (DME): Purchased or rented items such as iron lungs, oxygen tents, hospital beds, and wheelchairs used in the patient's home, as well as blood glucose monitors for individuals with diabetes. DME is equipment which: (1) can withstand

repeated use; (2) has an expected life of at least 3 years if classified as DME after January 1, 2012; (3) is primarily and customarily used to serve a medical purpose; (4) generally is not useful to a person in the absence of an illness or injury; and (5) is appropriate for use in the home.

E

End Stage Renal Disease: Permanent kidney failure requiring dialysis or a transplant.

Exchanges: A mechanism for facilitating the purchase of Qualified Health Plans and evaluating eligibility for APTCs and CSRs. (See Health Insurance Exchanges for additional information).

Expenditure: Budgeted funds that are actually spent. When used in the discussion of the Medicaid program, expenditure refers to funds actually spent as reported by the states.

Expense: An outlay or an accrued liability for services incurred in the current period.

F

Federal Financial Management Improvement Act of 1996 (FFMIA): Requires agencies to have financial management systems that substantially comply with 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 Insurance Contribution Act (FICA) Payroll Tax: Medicare's share of FICA is used to fund the Hospital Insurance (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 of 1982 (FMFIA): Requires agencies to establish internal control and financial systems that provide reasonable assurance of achieving control objectives, including the effectiveness and efficiency of operations; compliance with laws and regulations; and reliability of financial reporting. FMFIA requires agency heads to conduct an annual evaluation and report on the adequacy of internal control systems.

Fee-for-Service: A system of health care payment in which a provider is paid separately for each particular service rendered.

G

Government Performance and Results Act Modernization Act of 2010 (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 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 that the strategic plan is available.

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

H

Healthcare Fraud Prevention Partnership (HFPP): Voluntary public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations.

***Health Information Technology for Economic and Clinical Health Act* (HITECH):** ARRA includes the *HITECH Act*, which established programs under Medicare and Medicaid to incentivize the meaningful use of certified electronic health record technology among eligible professionals, hospitals, and critical access hospitals.

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

Health Insurance Exchanges: A mechanism for facilitating the purchase of Qualified Health Plans and evaluating eligibility for APTCs and CSRs. States can establish their own Exchange or the federal government can operate an Exchange on their behalf.

I

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

Internal Control: Process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved. Management's tools, such as the organization's policies and procedures, that help program and financial managers achieve results and safeguard the integrity of their programs. Such controls include program, operational, and administrative areas, as well as accounting and financial management.

M

Material Weakness: A deficiency, or combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented or detected and corrected on a timely basis.

Medicaid: A joint federal and state program that helps with medical costs for persons with limited income and resources.

Medicare: The federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): Legislation passed to strengthen Medicare, extend CHIP, and make numerous other improvements to the health care system.

Medicare Administrative Contractor (MAC): A private entity that CMS contracts with under section 1874A of the *Social Security Act*, as added by the *Medicare Prescription Drug Improvement and Modernization Act of 2003* (MMA). 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 DME.

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, promotes the integrity of the Medicare program, as specified in Section 1893 of the *Social Security Act*.

Medical Loss Ratio: Requires health insurance companies to spend 80 to 85 percent of premium dollars on medical care and health care quality improvement, rather than on administrative costs. When they do not, health insurance companies are required to provide a rebate to their customers.

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 that established a new Medicare program (Medicare Part D) to provide a prescription drug benefit. 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): Also known as Medicare Part D. An optional prescription drug benefit created by the MMA for individuals with Medicare who are entitled to benefits under Part A or enrolled in Part B. Eligible individuals have the opportunity to enroll in either a stand-alone

prescription drug plan to supplement their traditional Medicare coverage, or in a MA prescription drug plan, which integrates basic medical coverage with added prescription drug coverage. Individuals who qualify for both Medicare and Medicaid (full-benefit dual-eligible) are automatically enrolled in the Part D program; assistance with premiums and cost sharing is available to full-benefit dual-eligible and other qualified low-income individuals.

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 Medicare.

N

2019 Novel Coronavirus Disease (COVID-19): A new coronavirus that has not been previously identified. On February 11, 2020, the World Health Organization announced an official name for the disease causing the 2019 novel coronavirus outbreak, first identified in Wuhan China.

O

Obligation: Legal requirement to pay funds.

OMB Circular A-123, Management's Responsibility for Enterprise Risk Management and Internal Control: 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 FMFIA.

Outlay: Budgeted funds actually spent. When used in the discussion of the Medicaid program, outlays refer to amounts advanced to the states for Medicaid benefits.

P

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

Part B: The part of Medicare that pays physician and supplier claims, also referred to as Medicare Supplementary Medical Insurance or "SMI."

Patient Protection and Affordable Care Act (PPACA) (P.l. 111-148): A federal statute enacted in 2010 to drive health insurance reforms. The law requires insurers to accept all legal applicants, to cover a specific list of benefits, and to charge the same rates regardless of pre-existing conditions.

Payment Integrity Information Act of 2019 (PIIA): A law that requires government agencies to identify, report, and reduce improper payments in the government's programs and activities. The implementation guidance in Appendix C of the OMB Circular A-123 requires executive branch agency heads to review their programs and activities annually and identify those that may be susceptible to significant improper payments.

Payment Safeguards: Activities to prevent and recover inappropriate Medicare benefit payments, including MSP, medical review/utilization review provider audits, and fraud and abuse detection.

Public Health Emergency (PHE): The need for health care [medical] services to respond to a disaster, significant outbreak of an infectious disease, bioterrorist attack, or other significant or catastrophic event.

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

Program Management: The CMS operational account which supplies CMS with the resources to administer Medicare, the federal portion of Medicaid, and other CMS responsibilities. The components of Program Management are program operations, survey and certification, research, and federal administrative costs.

Provider: A health care professional or organization that provides medical services.

Q

Qualified Health Plans (QHPs): Certified health insurance plans that meet minimum standards for health benefit coverage, as required by the PPACA.

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.

Quality Payment Program (QPP): Established by MACRA, which repeals the sustainable growth rate formula and streamlines multiple quality reporting programs into a new Merit-based Incentive Payment System. Under the QPP, incentive payments are provided to clinicians for their participation in Advanced Alternative Payment Models or the Merit-based Incentive Payment System. Clinicians can choose how they want to participate based on their practice size, specialty, location, or patient population.

R

Recipient: An individual covered by the Medicaid program. Also referred to as a beneficiary.

Retiree Drug Subsidy (RDS) Program: The RDS is one of several options available under Medicare that is designed to encourage employers and unions to continue to provide high-quality prescription drug coverage to their retirees.

Revenue: An inflow of resources that the government earns, demands, or receives by donation. Resources arise when the government entity provides goods and services, or from the government's power to demand payments from the public (e.g., taxes, duties, fines, and penalties).

Risk Adjustment (private health insurance market): The risk adjustment program is designed to protect issuers that attract a high-risk population, such as those with chronic conditions. Under this program, money is transferred from issuers with lower-risk enrollees to issuers with higher-risk enrollees. This is a state-based program that applies to non-grandfathered plans in the individual and small group markets, inside and outside of the Exchanges.

Risk Corridors: The risk corridor program provided issuers of QHPs in the individual and small group markets additional protection against uncertainty in claims costs during the first three years of the Exchange. This program, modeled after a similar program used in the Medicare prescription drug benefit, encouraged issuers to keep their rates stable as they adjusted to the new health insurance reforms in the early years of the Exchanges.

S

Self–Employment Contribution Act (SECA) Payroll Tax: A tax on self-employed individuals of 2.9% of taxable net income, with no limitation. Medicare's share of SECA is used to fund the HI Trust Fund.

Significant Deficiency: 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.

Statement on Standards for Attestation Engagements 18 (SSAE 18): For the purposes of CMS, a report on the internal controls of a servicing organization issued by an independent public accountant in accordance with standards promulgated by the American Institute of Certified Public Accountants (AICPA). The AICPA SSAE 18 defines the professional standards to assess the internal controls at a service organization.

Supplementary Medical Insurance (SMI) (Part B): The part of Medicare that pays physician services, outpatient hospital services, other related medical and health services for voluntarily insured aged and disabled individuals as well as private plans to provide prescription drug coverage. The prescription drug benefit is funded through the SMI Trust Fund.

Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act: Legislation that includes Medicaid, Medicare, and public health reforms to combat the opioid crisis by advancing treatment and recovery initiatives, improving prevention, protecting communities, and bolstering efforts to combat illicit synthetic drugs.

T

Transitional Reinsurance Program: The transitional reinsurance program stabilized premiums in the individual market inside and outside of the Exchanges. The transitional reinsurance program collected contributions from contributing entities to fund reinsurance payments to issuers of non-grandfathered, PPACA-compliant reinsurance-eligible individual market plans, the administrative costs of operating the reinsurance program, and the General Fund of the U. S. Government for the 2014, 2015, and 2016 benefit years.

21st Century Cures Act (Cures Act): Legislation which promotes and funds the acceleration of research into preventing and curing serious illnesses, accelerates drug and medical device development, attempts to address the opioid abuse crisis, and tries to improve mental health service delivery. The act includes a number of provisions that push for greater interoperability, adoption of electronic health records and support for human services programs.

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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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