U.S. Department of Health and Human Services

CMS Financial Report

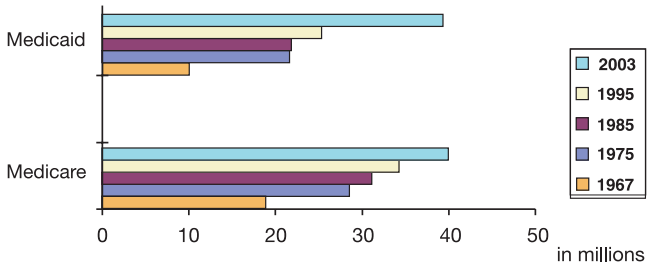
Fiscal Year 2003

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

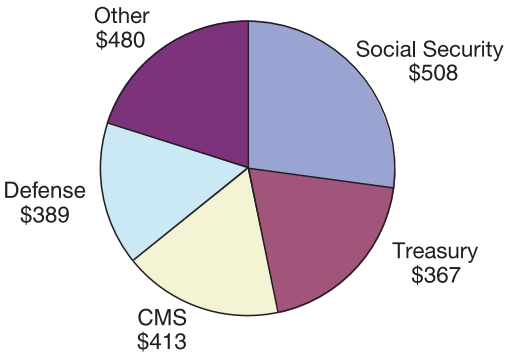
The Centers for Medicare & Medicaid Services At a Glance

The **CMS** is one of the largest purchasers of health care in the world. The Medicare, Medicaid, and State Children's Health Insurance programs that we administer provide health care for one in four Americans. Medicare enrollment has increased from 19 million beneficiaries in 1966 to 41 million beneficiaries. Medicaid enrollment has increased from 10 million beneficiaries in 1967 to over 41 million beneficiaries.

2003 Program Enrollment



2003 Federal Outlays



Source: U.S. Treasury

$ in billions

The **CMS** outlayed $413.4 billion (net of offsetting receipts and Payments to the Health Care Trust Funds) in fiscal year (FY) 2003, 19 percent of total Federal outlays. The only agency that outlayed more is the Social Security Administration.

The **CMS** has approximately 4,600 Federal employees, but does most of its work through third parties. The CMS and its contractors process over one billion Medicare claims annually, monitor quality of care, provide States with matching funds for Medicaid benefits, and develop policies and procedures designed to give the best possible service to beneficiaries. We also assure the safety and quality of medical facilities, provide health insurance protection to workers changing jobs, and maintain the largest collection of health care data in the United States.

CMS and Its Partners

	Employees
CMS	4,600
State Medicaid/SCHIP	34,000
Medicare Contractors	21,100
State Surveyors	6,000
Quality Improvement Orgs.	2,200

Administrator

Washington, DC 20201

A Message from the Administrator

As events on the national and international scene demonstrate that change is ever present in our lives, we can be assured of at least one constant—health care security for over 80 million beneficiaries through Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). The Centers for Medicare & Medicaid Services (CMS) Financial Report for Fiscal Year (FY) 2003 indicates how CMS managed outlays of over $413 billion to provide high quality services for our Nation's beneficiaries.

We have made tremendous strides over the past year and the months ahead of us will bring additional challenges. The President continues his commitment to modernize and reform Medicare in ways that will provide more health care options and better choices for our seniors and people with disabilities. This summer both the House and Senate passed bills that move us forward in that effort. Negotiations toward a final bill will continue into the fall and CMS will work closely with lawmakers to bring the best possible bill to the President's desk.

This year we have an opportunity to raise the bar of commitment to our beneficiaries by making the most profound changes to Medicare and Medicaid since their inception 38 years ago. We will work with Congress to make both programs more modern, flexible, and responsive to the needs of the people who depend upon them and the states that administer them.

The CMS has taken many steps toward improving Medicare, for instance, by focusing on the quality of care beneficiaries receive. We have been focusing on health care quality since Secretary Thompson launched the Quality Initiative in November 2001. The initiative aims to empower consumers by giving them facility-specific information with which to make better choices and to encourage providers to improve their services. We began with nursing homes in 2002 and have expanded to home health agencies and hospitals.

In the Medicaid program, we have taken a number of steps to allow states greater ability to design health insurance programs to meet the health care needs of their low-income populations. We have become more responsive to their request for waivers as well. Since January 2001, CMS has approved nearly 3,200 State Plan Amendments and waivers that have expanded eligibility to more than 2.2 million people and enhanced benefits for about 7.1 million people. While providing health care services to people in need, we have also made the Medicaid program more responsive to the needs of states.

The future presents many challenges, but I am confident that CMS and its partners will continue our focus on providing the best health care possible for our Nation's beneficiaries.

Thomas A. Scully
November 2003

Acting Deputy Administrator
Baltimore, MD 21244-1850

A Message from the Acting Deputy Administrator

As CMS' Acting Deputy Administrator, I am pleased to join the Administrator and the CFO in presenting CMS' Financial Report for FY 2003. Our mission is to assure health care security for beneficiaries. For CMS, this has resulted in a strengthened Agency commitment to beneficiaries as the ultimate focus of all CMS activities, expenditures, and policies.

The President's Management Agenda gave us an opportunity to develop initiatives to vigorously move the Agency forward with a focus on five primary objectives: integrating budget performance; enhancing strategic management of human capital; increasing competitive sourcing; improving financial performance; and expanding electronic government. Consistent with the President's Management Agenda and the Department's Strategic Plan, CMS' initiatives include process reengineering efforts, improved methods of working and management initiatives that will enable the Agency to implement its long-term goals and objectives.

In FY 2003, we continued our national ad campaign, which assists beneficiaries and their caregivers to become active and informed participants in their health care decisions. We continue to implement new and expanded services to make it easier than ever for Medicare beneficiaries to learn about their health care choices. We strive to encourage choice in the Medicare beneficiary community for medical coverage while maintaining high-quality care and ensuring fairness of the program to its beneficiaries.

Additionally, we implemented initiatives that strengthen our commitment to the fiscal integrity of our programs. Improving financial performance is a top management priority at CMS. We have made significant improvements especially in the areas of timeliness and reliability of financial data, and accountability of public funds. We continue to focus our priorities on paying the right amount to legitimate providers for covered, reasonable and necessary services. The CMS continues to be a pioneer in the field of identifying, quantifying, and working to reduce payments error rates in the Medicare fee-for-service program, as well as in the Medicaid and SCHIP programs.

I take great pride in the many achievements we have accomplished in FY 2003. We have identified a set of meaningful, outcome-oriented performance goals that speak to fundamental program purposes and to the Agency's role as a steward of taxpayer dollars. Results from performance measurement provides us with a wealth of information about the success of CMS' programs and activities, and CMS uses performance information to identify opportunities for improvement and to shape its programs. We look forward to meeting the challenges posed by our performance goals and are optimistic about our ability to achieve them.

Leslie V. Norwalk
November 2003

A Message from the Chief Financial Officer

As the Chief Financial Officer (CFO), I am pleased to present the CMS Financial Report for FY 2003. This report documents the steady progress that our Agency has made in achieving our financial management goals. As CFO, I have an obligation to build on the successes of the past and position the Agency for continued financial management excellence. Among the many initiatives achieved in FY 2003 that validate this success are:

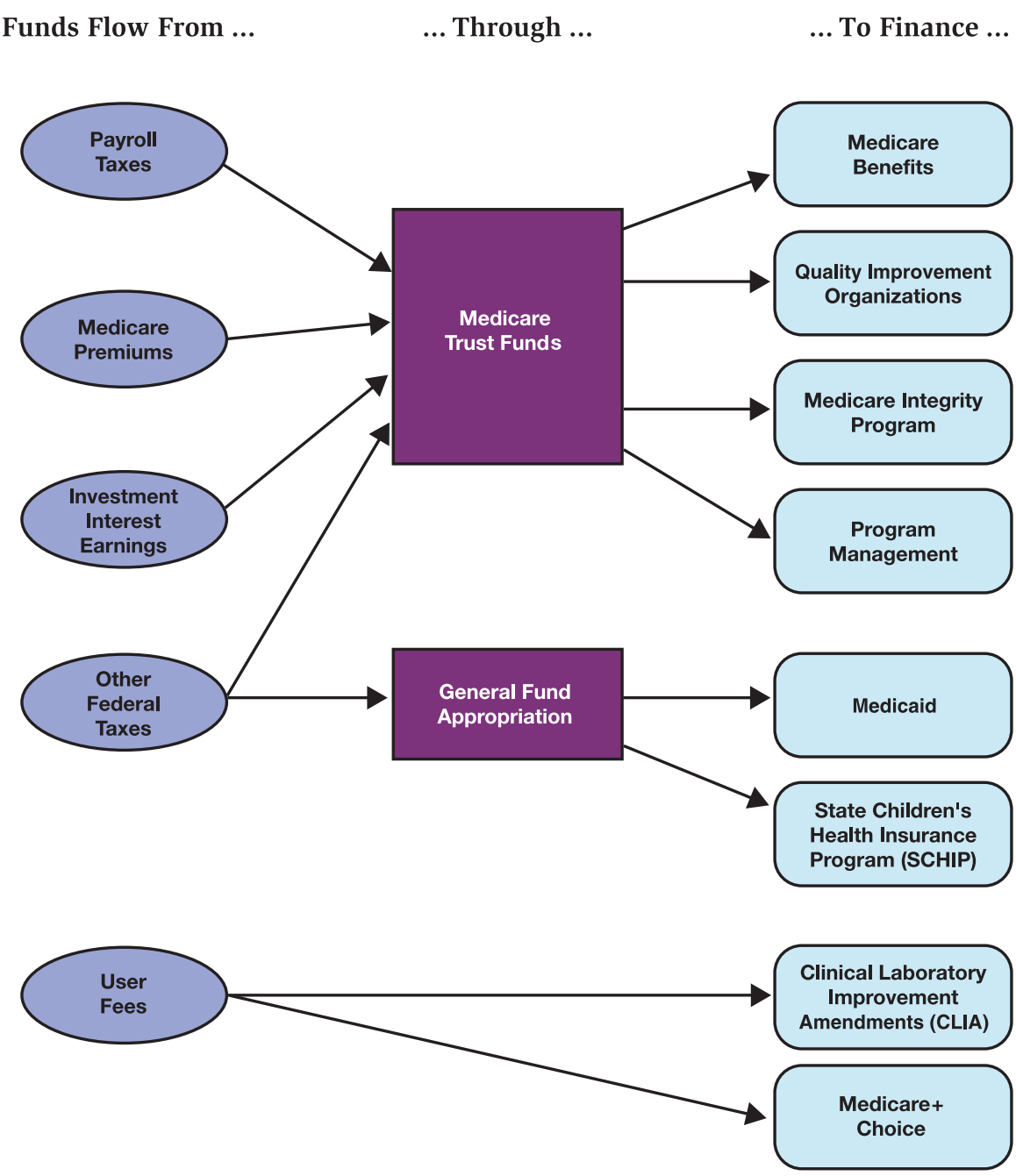
- We received an unqualified audit opinion on our financial statements for the fifth consecutive year.
- We began testing the Healthcare Integrated General Ledger Accounting System (HIGLAS) at two pilot Medicare contractors in October 2003. The HIGLAS is a key element of our strategic vision to implement a complete, financial management system that integrates CMS accounting systems with those of our Medicare contractors.
- We fully implemented the Comprehensive Error Rate Testing (CERT) program that produces a national Medicare fee-for-service paid claims error rate, and provider-type, contractor and specialty specific error rates. I believe the implementation of CERT provides the best tool to perform a more robust analysis of the data to allow us to resolve the root cause of errors identified.
- As part of our financial management oversight, we conducted internal controls and accounts receivable reviews at 24 Medicare contractors to provide assurance that their reported information is accurate, reliable, and uniform. We continue to implement initiatives to address four key financial oversight areas of Corrective Action Plans, Cash Reconciliation, Trend Analysis, and Internal Controls.
- We also continued to make substantive progress in the successful implementation of the Debt Collection Improvement Act by referring an additional $718 million of delinquent debt for collection to the Department of Treasury.
- We maintained a high quality in our financial management processes and are able to prepare our report on an accelerated timeframe—a full year before an Office of Management and Budget (OMB) requirement. We met this daunting task through cooperation with our partners, including the Medicare contractors, without sacrificing the integrity of the data that we report in CMS' financial statements.

The magnitude and complexity of the programs that we administer demand that we continue to strengthen financial management. Building on these accomplishments and using issues identified in the CFO audit as a guide, we will publish a FY 2004 CFO

Comprehensive Plan that ensures a continued emphasis on financial management. We remain committed to the improvement of our financial operations, so that we can fulfill our stewardship responsibilities and maintain the highest level of accountability for the management of the Agency's financial resources.

Timothy Hill
November 2003

Financing of CMS Programs and Operations



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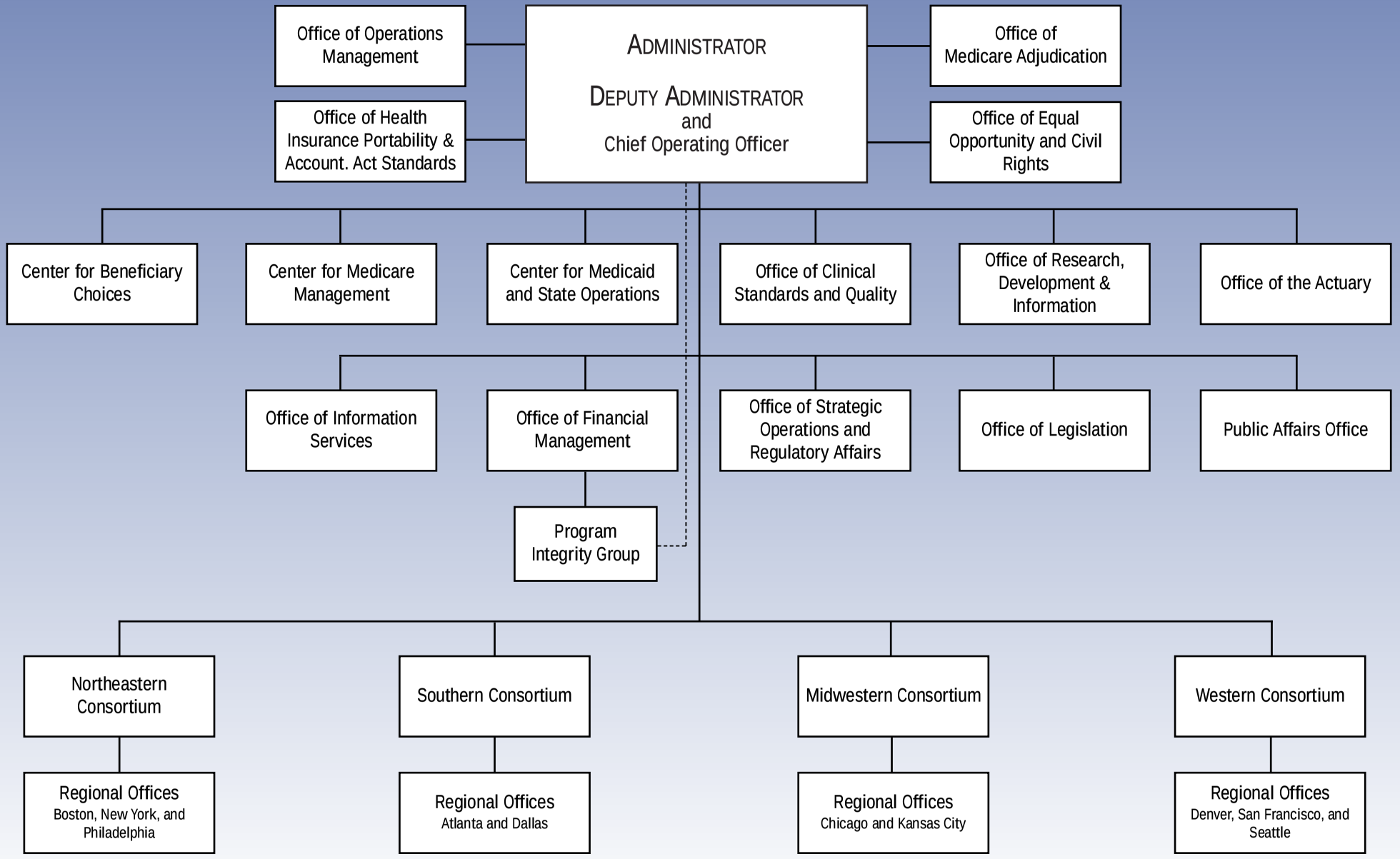
Approved Structure
As of November 2003

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES



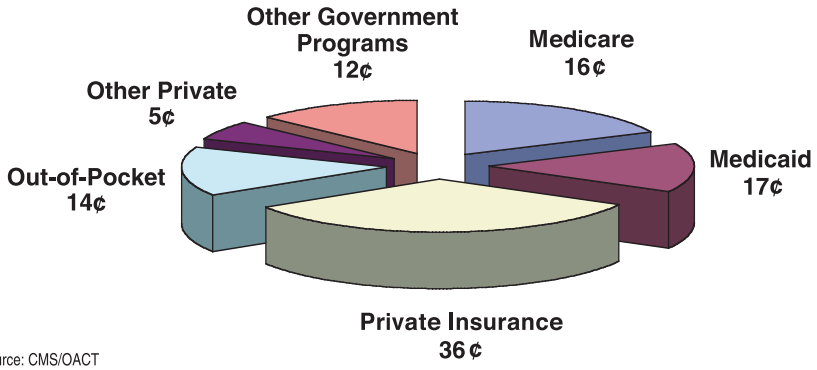
Management's Discussion and Analysis

OVERVIEW

The Centers for Medicare & Medicaid Services (CMS), a component of the Department of Health and Human Services (HHS), administers Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and the Clinical Laboratory Improvement Amendments (CLIA). Along with the Departments of Labor and Treasury, CMS also implements the insurance reform provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The CMS is one of the largest purchasers of health care in the world. Based on the latest projections, Medicare and Medicaid (including State funding), represent 33 cents of every dollar spent on health care in the United States (U.S.)—or looked at from three

The Nation's Health Care Dollar 2003



Source: CMS/OACT

different perspectives, 61 cents of every dollar spent on nursing homes, 47 cents of every dollar received by U.S. hospitals, and 27 cents of every dollar spent on physician services.

The CMS **outlays** totaled $413.4 billion (net of offsetting receipts and Payments to the Health Care Trust Funds) in FY 2003. Our **expenses** totaled $444.7 billion, of which $2.4 billion (less than 1 percent) were administrative expenses.

Expenses are computed using the accrual basis of accounting that recognizes costs when incurred and revenues when earned regardless of the timing of cash received or disbursed. Expenses include the effect of accounts receivable and accounts payable on determining the net cost of operations. **Outlays** refer to cash disbursements made to liquidate an expense regardless of the fiscal year the expense was incurred.

We establish policies for program eligibility and benefit coverage, process over one billion Medicare claims annually, provide States with funds for Medicaid and SCHIP, ensure quality of health care for beneficiaries, and safeguard funds from fraud, waste, and abuse. Of our approximately 4,600 Federal employees, about 1,600 work in 10 regional offices (ROs) around the country to provide direct services to Medicare contractors, State agencies, health care providers, beneficiaries, and the general public. Approximately 3,000 of our employees work in Baltimore, MD and Washington, DC, where they provide funds to Medicare contractors; write policies and regulations; set payment rates; safeguard the fiscal integrity of the Medicare and Medicaid programs to ensure that benefit payments for medically necessary services are paid correctly the first time; recover improper payments; assist law enforcement agencies in the prosecution of fraudulent activities; monitor contractor performance; develop and implement customer service improvements; provide education and outreach activities to beneficiaries and Medicare providers, survey hospitals, nursing homes, labs, home health agencies and other health care facilities; work with State insurance companies; and assist States and Territories with Medicaid and SCHIP. We also maintain the Nation's largest collection of health care data and provide technical assistance to the Congress, the Executive Branch, universities, and other private sector researchers.

Many important activities are also handled by third parties: (1) an estimated 34,000 State employees administer Medicaid and SCHIP; (2) 21,100 employees at 50 Medicare contractors (27 fiscal intermediaries, 19 carriers, and 4 Durable Medical Equipment Regional Carriers (DMERCs)) process Medicare claims, provide technical assistance to providers and service beneficiaries' needs, including premium billing, and respond to inquiries; (3) 6,000 State employees inspect hospitals, nursing homes, and other facilities to ensure that health and safety standards are met; and (4) 2,200 employees at 53 Quality Improvement Organizations (QIOs) conduct a wide variety of quality improvement programs to ensure quality of care provided to Medicare beneficiaries.

PROGRAMS

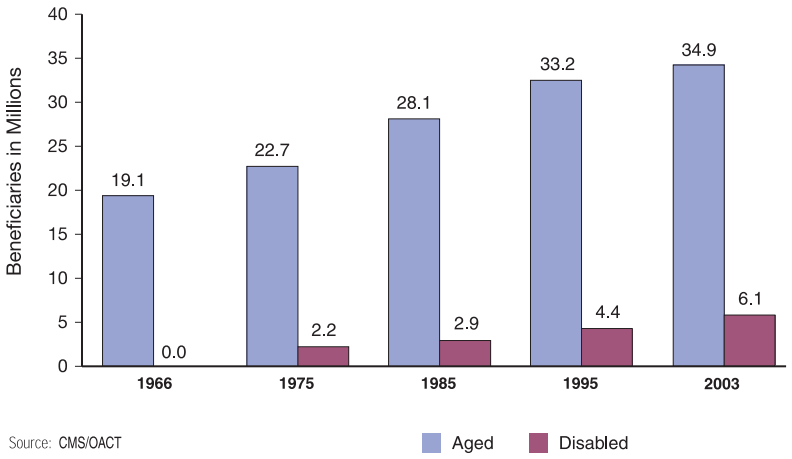
Medicare

Introduction

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

Medicare processes over one billion fee-for-service (FFS) claims a year, is the nation's largest purchaser of managed care, and accounts for almost 13 percent of the Federal Budget. Medicare is a combination of three programs: Hospital Insurance, Supplementary Medical Insurance, and Medicare+Choice. Since 1966, Medicare enrollment has increased from 19 million to approximately 41 million beneficiaries.

Medicare Enrollment



Source: CMS/OACT

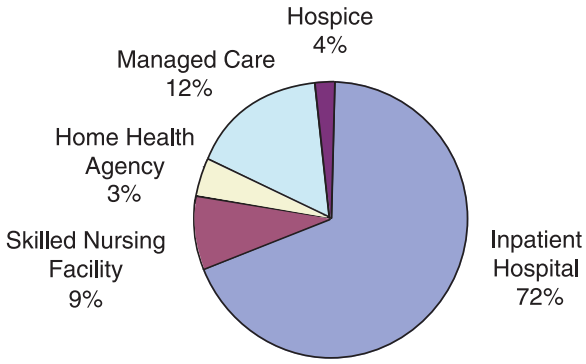
The President's FY 2003 budget included a framework for improving and modernizing the Medicare program, which included adding a drug benefit. During the summer, both the House and the Senate passed legislation that generally was consistent with the President's plan. This effort would result in the largest change to the Medicare program since its enactment in 1965.

Hospital Insurance

Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or

Railroad Retirement benefits. The HI program pays for hospital, skilled nursing facility, home health, and hospice care and is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the HI trust fund, and invested in U.S. Treasury securities.

HI Medicare Benefit Payments



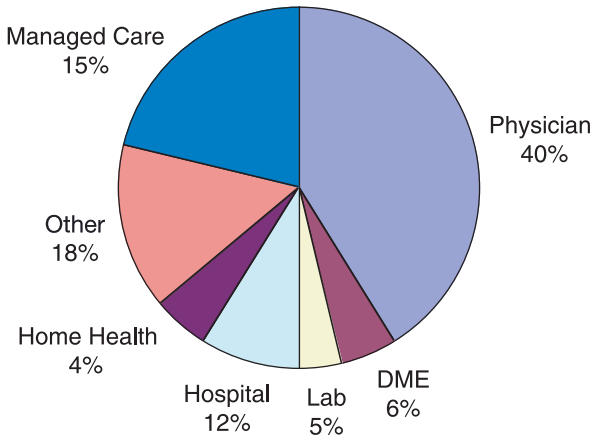
Source: CMS/OACT

Based on estimates from the Mid-Session Review of the FY 2004 President's budget, inpatient hospital spending accounted for 72 percent of HI benefits outlays. Managed care spending comprised 12 percent of total HI outlays. During FY 2003, HI benefit outlays grew by 6.5 percent. The HI benefit outlays per enrollee are projected to increase by 5.3 percent to $3,785.

Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI or Medicare Part B, is available to nearly all people aged 65 and over, the disabled, and people with ESRD who are entitled to Part A benefits. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy, and other services not covered by HI. The SMI coverage is optional and beneficiaries are subject to monthly premium payments. About 95 percent of HI enrollees elect to enroll in SMI.

SMI Medicare Benefit Payments



Source: CMS/OACT

The SMI program is financed primarily by transfers from the general fund of the U.S. Treasury and by monthly premiums paid by beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the SMI trust fund, and invested in U.S. Treasury securities.

Also based on estimates, during FY 2003, SMI benefit outlays grew by 8.8 percent. Physician services, the largest component of SMI, accounted for 40 percent of SMI benefit outlays. The SMI benefit outlays per enrollee are projected to increase 7.4 percent to $3,059.

Medicare+Choice

The Balanced Budget Act of 1997 (BBA) created the Medicare+Choice (M+C) program, which was designed to provide more health care coverage choices for Medicare beneficiaries. Those who are entitled because of age (65 or older) or disability may choose to join an M+C plan if they are entitled to Part A and enrolled in Part B, if there is a plan available in their area. Those who are entitled to Medicare because of ESRD may join an M+C plan only under special circumstances.

Medicare beneficiaries have long had the option to choose to enroll in prepaid health care plans that participate in Medicare instead of receiving services under traditional FFS arrangements. Managed care organizations have their own providers or a network of contracting health care providers who agree to provide health care services for health maintenance organizations (HMO) or prepaid health organizations' members. Managed care organizations currently serve Medicare beneficiaries through coordinated care plans, which include HMOs, point-of-service (POS) plans offered by HMOs, preferred provider organizations (PPOs), and provider-sponsored organizations (PSOs). Under M+C, beneficiaries may also choose to join a private FFS plan that is available in twenty-five States. Managed care demonstration projects, as well as cost and Health Care Prepayment Plans (HCPPs) options, also exist.

All M+C plans are paid a per capita premium, assume full financial risk for all care provided to Medicare beneficiaries, and must provide all Medicare covered services. Many M+C plans offer additional services such as prescription drugs, vision and dental benefits to beneficiaries. Cost contractors are paid a pre-determined monthly amount per beneficiary based on a total estimated budget. Adjustments to that payment are made at the end of the year for any variations from the budget. Cost plans must provide all Medicare-covered services, but do not always provide the additional services that some risk M+C plans offer. The HCPPs are paid in a manner similar to cost contractors, but cover only non-institutional Part B Medicare services. Section 1876 cost-based contractors and HCPPs, with certain limited exceptions, phase out under the BBA provisions.

Managed care outlays are estimated to be $36.4 billion of the total $271.2 billion in Medicare benefit payment outlays in FY 2003.

Medicaid

Introduction

Medicaid is the means-tested health care program for low-income Americans, administered by CMS in partnership with the States. Enacted in 1965 as title XIX of the Social Security Act, Medicaid was originally legislated to provide medical assistance to recipients of cash assistance. Over the years, Congress incrementally expanded Medicaid

well beyond the traditional population of the low-income elderly and the blind and disabled. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including poor families, the disabled, and persons with developmental disabilities requiring long-term care. The average enrollment for Medicaid was estimated at 41.4 million in FY 2003, about 14 percent of the U.S. population. Nearly 7 million people are dually eligible, that is, covered by both Medicare and Medicaid.

The CMS provides matching payments to States and Territories to cover the Medicaid program and related administrative costs. State medical assistance payments are matched according to a formula relating each State's per capita income to the national average. In FY 2003, the Federal matching rate for Medicaid program costs among the States ranged from 50 to 77 percent, with a national average of 57 percent. Federal matching rates for various State and local administrative costs are set by statute, and in FY 2003 averaged 55 percent. Medicaid payments are funded by Federal general revenues provided to CMS through the annual Labor/HHS/Education appropriations act. There is no cap on Federal matching payments to States, except with respect to the disproportionate share program and payments to Territories.

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

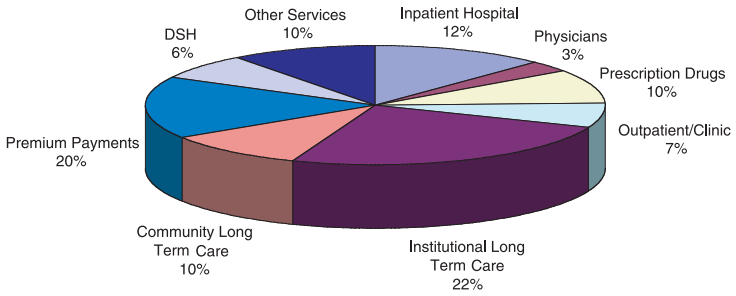
Medicaid is the largest single source of payment for health care services for persons with Acquired Immune Deficiency Syndrome (AIDS). Medicaid now serves over 50 percent of all AIDS patients and pays for the health care costs of most of the children and infants with AIDS. Medicaid spending for AIDS care and treatment in FY 2003 is estimated to be about $8.5 billion in Federal and State funds. In addition, the Medicaid programs of all 50 States and the District of Columbia provide coverage of all drugs approved by the Food and Drug Administration for treatment of AIDS.

Payments

Under Medicaid, State payments for both medical assistance payments (MAP) and administrative (ADM) costs are matched with Federal funds. In FY 2003, State and Federal ADM gross outlays are estimated at $15 billion, about 5.3 percent of the gross Medicaid outlays. State and Federal MAP gross outlays are estimated at $265.6 billion or 95 percent of total Medicaid gross outlays, an increase of 8.6 percent over FY 2002. Thus, State and Federal MAP and ADM outlays for FY 2003 totaled $280.9 billion. The CMS share of Medicaid expenses totaled $163.8 billion in FY 2003.

Medicaid Medical Assistance Payments
FY 2003

Total Payments = $267 billion



Source: CMS/OACT

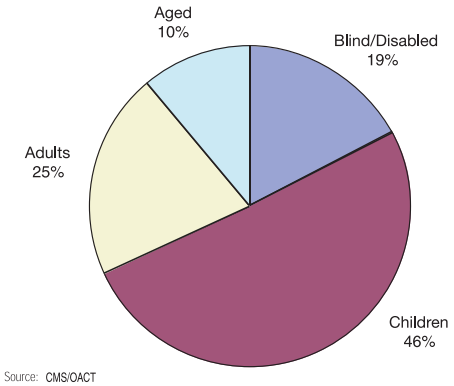
Enrollees

Children comprise nearly half of Medicaid enrollees, but account for only 17 percent of Medicaid outlays. In contrast, the elderly and disabled comprise 29 percent of Medicaid enrollees, but accounted for 65 percent of program spending. The elderly and disabled use more expensive services in all categories, particularly nursing home services.

Service Delivery Options

Many States are pursuing managed care as an alternative to the FFS system for their Medicaid programs. Managed health care provides several advantages for Medicaid beneficiaries, such as enhanced continuity of care, improved preventive care, and prevention of duplicative and contradictory treatments and/or medications. Most States have taken advantage of waivers provided by CMS to introduce managed care plans tailored to their State and local needs, and 47 States now offer a form of managed care. The number of Medicaid beneficiaries enrolled in managed care has grown from slightly under 15 percent in 1993 to over 57 percent in 2002.

2003 Medicaid Enrollees



Source: CMS/OACT

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

1) State health reform waivers—Section 1115 of the Social Security Act provides broad discretion to waive certain provisions of

Medicaid law for experimental, pilot, or demonstration projects. In August 2001, the President announced a section 1115 initiative, known as Health Insurance Flexibility and Accountability, to increase health insurance coverage by coordinating available Medicaid and SCHIP funding with private insurance options.

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

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

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

State Children's Health Insurance

The State Children's Health Insurance Program (SCHIP) was created through the BBA to address the fact that nearly 11 million American children—one in seven—were uninsured and therefore at increased risk for preventable health problems. Many of these children were in working families that earned too little to afford private insurance on their own, but too much to be eligible for Medicaid. Congress and the Administration agreed to set aside nearly $40 billion over ten years, beginning in FY 1998, to create SCHIP—the largest health care investment in children since the creation of Medicaid in 1965. These funds cover the cost of insurance, reasonable costs for administration, and outreach services to get children enrolled. To make sure that funds are used to cover as many children as possible, funds must be used to cover previously uninsured children, and not to replace existing public or private coverage. Important cost-sharing protections were also established so families would not be burdened with out-of-pocket expenses they could not afford.

The statute sets the broad outlines of the program's structure, and establishes a partnership between the Federal and State governments. States are given broad flexibility in tailoring programs to meet their own circumstances. States can create or expand their own separate insurance programs, expand Medicaid, or combine both approaches. States can choose among benchmark benefit packages, develop a benefit package that is actuarially equivalent to one of the benchmark plans, use the Medicaid benefit package, or a combination of these approaches.

States also have the opportunity to set eligibility criteria regarding age, income, and residency within broad Federal guidelines. The Federal role is to ensure that State programs meet statutory requirements that are designed to ensure meaningful coverage under the program.

We work closely with States, Congress, and other Federal agencies to meet the challenge of implementing this program, while at the same time approving State plan amendments as quickly as possible. The CMS provides extensive guidance and interim instructions so States can further develop their plans and use Federal funds to insure as many children as possible. Since September 30, 1999, all 50 States, the District of Columbia, and the Territories had approved child health plans. Of these, 19 are Medicaid expansions, 19 are separate State Child Health plans, and 18 are combination plans. In addition, 170 amendments and 13 section 1115 waivers have been approved that provide SCHIP funds to States to cover pregnant women and parents of children enrolled in Medicaid or SCHIP.

Other Activities

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

Survey and Certification Program

We are responsible for assuring the safety and quality of medical facilities, laboratories, providers, and suppliers by setting standards, conducting inspections, certifying providers as eligible for program payments, and ensuring that corrective actions are taken where deficiencies are found. The survey and certification program is designed to ensure that providers and suppliers comply with Federal health, safety, and program standards. We administer agreements with State survey agencies to conduct onsite facility inspections. Funding is provided through the Program Management and the Medicaid appropriations. Only certified providers, suppliers, and laboratories are eligible for Medicare or Medicaid payments. Currently, CMS Survey and Certification staff oversee compliance with Medicare health and safety standards in over 241,000 medical facilities of different types, including hospitals, laboratories, nursing homes, home health agencies, hospices, and end stage renal disease facilities.

Clinical Laboratory Improvement Program

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) expanded survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing specimens from the human body. We regulate all laboratory testing (whether provided to beneficiaries of CMS programs or to others) including those in physicians' offices. In partnership with the States, we certify and inspect more than 15,000 laboratories each year. The CLIA program is a 100 percent user-fee financed program. The CLIA program is jointly operated by three HHS components: (1) CMS provides financial management of the program, contracts with surveyors to

inspect labs, and offers general administrative support, (2) The Centers for Disease Control and Prevention (CDC) provides research support, and (3) The Food and Drug Administration (FDA) oversees test categorization.

Quality of Care

Through QIOs, ESRD Networks, State agencies, and others, CMS collaborates with health care providers and suppliers to promote the improved health status of Medicare and Medicaid beneficiaries in both FFS and managed care settings. These collaborative projects often employ a sequential process that includes setting priorities, collecting and analyzing data, identifying opportunities to improve care, establishing performance expectations, and selecting and managing one or more improvement strategies. One of the tools for improving patient care is the development and dissemination of quality indicators and the publication of performance information.

In November 2001, Secretary Thompson announced the Quality Initiative, his commitment to assure quality health care for all Americans through accountability and public disclosure. The initiative aims to (a) empower consumers with quality of care information to make more informed decisions about their health care, and (b) stimulate and support providers and clinicians to improve the quality of health care. The Quality Initiative was launched nationally in November 2002 for nursing homes (the Nursing Home Quality Initiative or NHQI), and is being expanded to the nation's home health care agencies (the Home Health Quality Initiative or HHQI) and hospitals in 2003.

The CMS initiated the NHQI to continue to improve quality of care in nursing homes. Working with measurement experts, the National Quality Forum, and a diverse group of nursing home industry stakeholders, CMS adopted a set of improved nursing home quality measures. Following pilot testing in November 2002, CMS released quality of care information for nearly 17,000 nursing homes in all 50 states, the District of Columbia, and some U.S. Territories on **www.medicare.gov**. They are important to consumers, are accurate (reliable, valid, and risk adjusted), can be used to show ways in which facilities are different from one another, and can be influenced by the provision of high quality care by nursing home staff. The quality measures are just one more piece of the information available to help consumers make informed decisions about their nursing home care. The measures are also intended to motivate nursing homes to improve their care and to inform discussions about quality between consumers and clinicians.

The HHQI combines new information for consumers about the quality of care provided by home health agencies with important resources available to improve the quality of home health care. In 2003 CMS is publishing on **www.medicare.gov** a set of home health quality measures on every Medicare-certified home health agency in the United States. The quality measures are an additional resource to help consumers compare the quality of care provided by home health agencies. The quality measures are also intended to motivate home health agencies to improve care and to inform discussions about quality between consumers and clinicians.

We are conducting a similar initiative for hospital quality, although because there are many technical details to be resolved, there are a number of complementary developmental activities at this time. We are working in three states (Maryland, New York, and Arizona) to pilot test a patient perception of care survey and consumer messages about quality. We are working with the Department of Public Health in Connecticut to help them implement a state mandate for public reporting of hospital quality in a way that makes it consistent with Federal efforts. The CMS is part of a large national public-private partnership in which hospitals are volunteering to publicly report clinical and 'patient perception' measures. These will be reported on **www.cms.hhs.gov** in 2003, and migrated to **www.medicare.gov** in 2004. We are also launching a 'pay for performance' demonstration project to test additional measures for public reporting and the role of bonus payments as incentives for improvement in quality.

In addition, as we revise our conditions of participation or conditions of coverage for providers and suppliers, we are focusing on outcome-based requirements that focus on the patient. We continue to believe that providers and suppliers must ensure that there is an effective quality assessment and performance improvement program to evaluate the provision of patient care.

Coverage Policy

In today's health care market, every insurer and health care purchaser must deal with coverage policy. We established a process that provides current information on coverage issues on the CMS coverage Web site and also facilitates input from all stakeholders, including beneficiaries, through the Medicare Coverage Advisory Committee (MCAC). The MCAC holds open meetings and includes consumer and industry members. We also rely on state-of-the-art technology assessment and support from other Federal agencies, as well as considerable staff expertise.

Medicare is a leader in evidence-based decision making for coverage policy. Our own extensive payment data contain additional useful information that is used by the Agency for Healthcare Research and Quality (AHRQ) and others for assessing the effectiveness of a variety of medical treatments.

Insurance Oversight and Data Standards

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

We are responsible for implementing and enforcing most of the HIPAA's administrative simplification provisions, which are aimed at streamlining healthcare administration and at reducing administrative costs. The HIPAA requires HHS to adopt national uniform standards for the electronic transmission of certain health information. As a result, "covered entities" such as health care providers, health plans, billing services and other business partners, who do business electronically, must use the same health care transactions, code sets, and identifiers. Although HIPAA does not mandate the collection or electronic transmission of any health information, it does require that adopted standards be used for any electronic

transmission of specified transactions, including claims payment, remittance advice, and coordination of benefits. The HIPAA also requires that patients' personal health information must be more securely guarded and more carefully handled while it is being used by health care providers and health plans. In response, CMS issued a regulation outlining the administrative, technical, and physical safeguards required to protect confidentiality, integrity, and access of protected health care information. We are also responsible for implementing HIPAA's requirements for health care providers, health plans, and employers to have standard identifiers for use on standard transactions.

As a result of the insurance reform provisions of HIPAA, CMS has assumed a new role in relation to State regulation of health insurance and health coverage. We work with the State Insurance Commissioners' offices, the U.S. Department of Labor, and the Internal Revenue Service to implement these provisions. The common goal is to improve access to the group and individual health insurance markets for certain eligible individuals who move from job to job, or who lose their group health insurance coverage and must purchase coverage in the individual insurance market. These new consumer protections affect an estimated 160 million individuals.

PERFORMANCE GOALS

The passage of the Government Performance and Results Act (GPRA) in 1993 mandated that agencies have strategic plans, annual performance plans (APP), and reports that make them accountable stewards of public programs. The CMS has embraced that charge and has emphasized the themes of accountability, stewardship, and a renewed focus on the customer with its mission to "assure health care security for beneficiaries" with its strategic goals and performance goals.

Our approach to performance measurement under GPRA is to develop goals that are representative of our vast responsibilities. The APP describes CMS performance goals and their linkage to longer-term strategic goals and to the budget. It includes the steps to accomplish each performance goal, and establishes a method and data source for measuring and reporting.

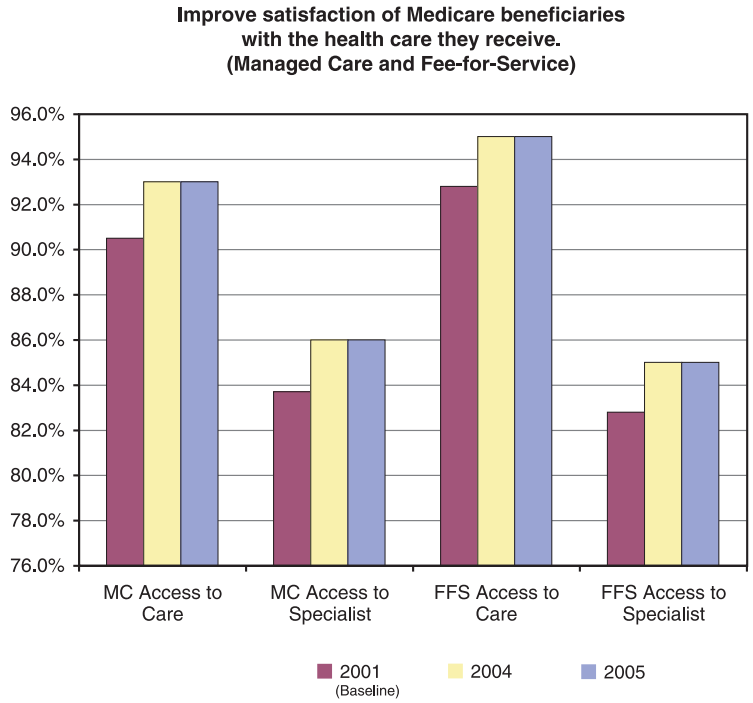
Our performance goals also reinforce the President's Management Agenda (PMA). For example, the PMA objective to improve financial performance is reflected by our goal to reduce the percentage of improper payments made under the Medicare fee-for-service program. Performance goals are also key to the Office of Management & Budget's Program Assessment Rating Tool (PART) and support the PMA objective of integrating budget and performance.

The FY 2003 APP includes 36 goals for CMS programs that highlight major program areas and budget categories. It reflects key Administration and CMS priorities for the next several years. Our performance goals reflect a sensitivity to customer needs and an awareness that meeting those needs will require flexibility and imagination, as well as sound business sense.

In the following sections, we highlight a few of our key FY 2003 performance goals and outcomes. Our progress on the remaining 33 goals will be submitted with the Annual Performance Report along with the President's budget request for FY 2005.

Medicare

Beneficiaries are Medicare's primary customers. One of CMS' primary goals is to assure satisfaction in the experiences beneficiaries have in accessing care for illness and injuries when needed, including their access to care of specialists. In response to the need to



standardize the measurement of and monitor beneficiaries' experience and satisfaction with the care they receive through Medicare, CMS developed a series of data collection activities under the Consumer Assessment Health Plans Surveys (CAHPS). The CMS fields these surveys annually to representative samples of beneficiaries enrolled in each Medicare managed care plan as well as those enrolled in the original Medicare fee-for-service (FFS) plan. The CMS provides comparable sets of specific performance measures collected in CAHPS to Quality Improvement Organizations (QIOs), health plans, and beneficiaries through various means, including the National ***Medicare & You*** Education Program (NMEP).

The CMS' multi-year efforts to improve beneficiary satisfaction with the health care they receive apply to both managed care and FFS. In an effort to capture more complete information for the managed care portion, data from a managed care disenrollee survey is combined with survey data from current managed care enrollees. Baselines and targets were recalculated in CY 2000 to reflect this change. In order for the increase to be statistically significant, these are long-term targets with reports due at the end of the 5-year period.

Our FY 2003 target of directing efforts to improve beneficiary satisfaction in both FFS and managed care is being met by continuing to collect and share CAHPS information from beneficiaries with health plans, QIOs, and beneficiaries.

Reduce the Percentage of Improper Payments Made Under the Medicare Fee-for-Service Program

One of CMS' key goals is to pay claims properly the first time. This means paying the right amount to legitimate providers for covered services provided to eligible beneficiaries. Paying claims right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars.

Prior to FY 2003, the OIG estimated the amount of the improper payments for Medicare claims included in the ***CMS Financial Report***. Beginning in FY 2003, this activity was assumed by CMS with the intention of expanding the number of claims sampled in order to obtain more detailed information to better identify and correct payment problems.

The 2003 ***CMS Financial Report*** includes estimates from the results of two programs used by CMS: the Comprehensive Error Rate Testing (CERT) program with a sample of 70,567 claims; and the Hospital Payment Monitoring Program (HPMP) with a sample of 57,775 discharges. The CERT program implements a new sampling and review methodology (for non-PPS inpatient hospital claims) that provides estimates of the national error rate with tighter precision. In addition, it employs independent reviewers to make determinations for 70,567 claims providing estimates of error rates by contractor, by service type, and by provider type.

These programs provide CMS with a much more rigorous set of data to manage our contractors, identify and prevent errors, and educate providers who bill our programs. As a result of the 2003 programs, we believe that the paid claims error rate remains at about the same rate as last year. Our analysis determined an adjusted paid claims error rate of 5.8 percent, or $11.6 billion, compared to an unadjusted 9.8 percent rate ($19.6 billion). The unadjusted rate reflected an unusually high non-response rate because every non-response was treated as an error (54.7% of errors were due to non-responses). We believe the high non-response rate was due to the impact of HIPAA privacy rules, record requests made by an unfamiliar entity, and like the OIG in the first year they calculated the error rate, general difficulties in getting providers to follow-up on record requests. We adjusted the error rate using a conservative non-response estimate based on the OIG's average non-response rate of 12 percent for the past 7 years.

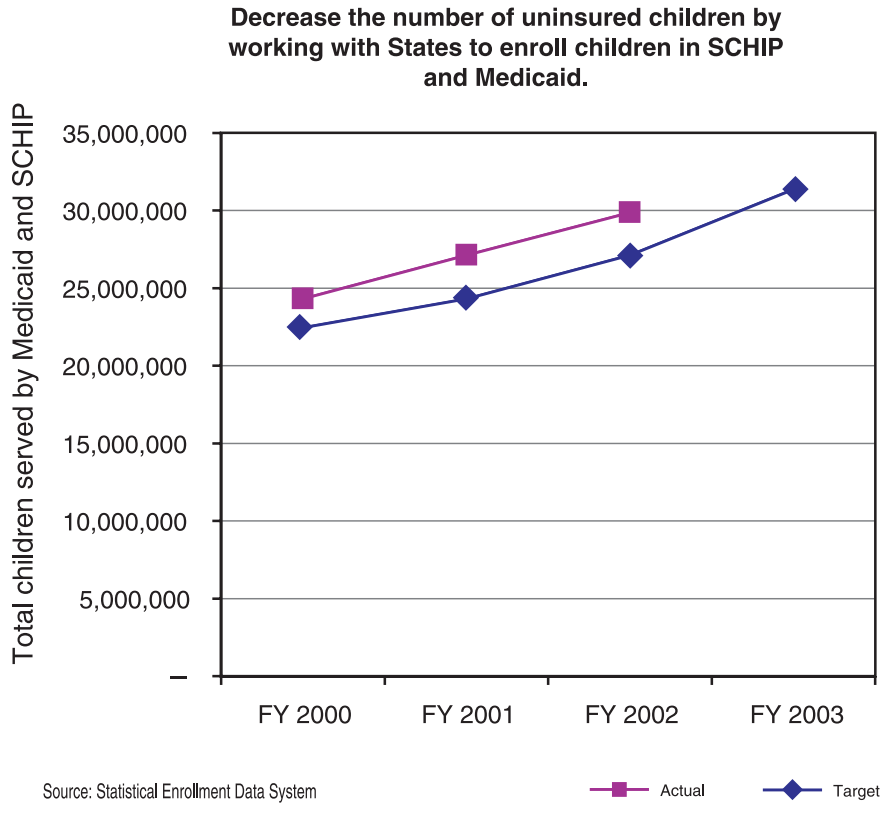
For the first time CMS can use the Medicare error rate to show where it is overpaying or underpaying claims, and for what categories of service. Now that CMS has detailed error rates, it can aggressively target its efforts to fix problems they indicate.

The CMS has taken a number of steps to minimize the non-response problem in the future. For example, CMS has revised the letters requesting medical records by clarifying the role of the error calculation contractor, explaining that it is not a HIPAA compliance violation to submit records to the error calculation contractor, and allowing providers to fax records. As a result, adjustments for non-response should not be necessary for FY 2004.

The CMS is working with the contractors that pay Medicare claims and the QIOs on aggressive efforts to lower the paid claims error rate, including: (1) developing a tool that generates state-specific hospital billing reports to help QIOs analyze administrative claims data, (2) increasing and refining one-on-one educational contacts with providers found to be billing in error, and (3) developing projects with the QIOs addressing state-specific admissions necessity and coding concerns, as well as conducting surveillance and monitoring of inpatient payment error trends by error type.

In addition, CMS has directed the Medicare contractors to develop local efforts to lower the error rate by developing plans that address the cause of the errors, the steps they are taking to fix the problems, and other recommendations that will ultimately lower the error rate. The CERT program is an important new tool in monitoring contractor performance. It will provide CMS with the fundamental structure to hold the fee-for-service contractors accountable for the services they provide as CMS moves to performance-based contracting from simply paying contractors to process Medicare claims.

Medicaid and SCHIP



The SCHIP and Medicaid programs have made an unprecedented investment to improve the quality of life for millions of vulnerable, uninsured, low-income children. Through title XXI of the Social Security Act, States were given the option to expand their Medicaid program, establish a separate SCHIP, or use a combination of both. The CMS' goal is to increase the number of children (up to age 19 for SCHIP; age 21 for Medicaid) who are enrolled in regular Medicaid or SCHIP. During FY 2002, there were approximately 30 million children enrolled in SCHIP and Medicaid, which is about 2,750,000 over the previous year's level.

When CMS first implemented this GPRA enrollment goal, the objective was to enroll five million children in the program by FY 2005. Based on this objective, we set our initial targets to increase enrollment by one million over the previous year. Because we have exceeded this goal and are now seeing States face fiscal challenges that may affect program outreach and enrollment, we are unsure about future projections and have decided to set our FY 2003 target to increase enrollment by five percent over the previous year. We expect FY 2003 data in early CY 2004.

FINANCIAL ACCOMPLISHMENTS AND STATEMENT HIGHLIGHTS

For the fifth consecutive year, we received an unqualified audit opinion on our financial statements from the auditors, indicating that our financial statements are fairly presented in all material respects. Of particular significance, we achieved such a milestone under a greatly accelerated timeline—more than two months earlier than last year. Our strategic vision for financial management is: To develop and maintain a strong financial management operation to meet the changing requirements and challenges of the twenty-first century as we continue to safeguard the assets of the Medicare trust funds. To accomplish this vision, our four key financial management objectives are to: (1) improve financial reporting, guidance, and contractor oversight by providing timely, reliable, and accurate financial information so that CMS management and other decision makers make timely and accurate program and administrative decisions, (2) design and implement effective financial management systems that comply with the Federal Financial Management Improvement Act (FFMIA), (3) improve debt collection and internal accounting operations, and (4) validate key financial data to ensure its accuracy and reliability.

CFO Audit

We received our first unqualified audit opinion on our financial statements in FY 1999. While obtaining an unqualified opinion remains an important goal, we continue to make financial management improvements. For example, we have improved internal controls and the underlying financial reporting processes to ensure that we can generate accurate financial data on an on-going and timely basis. However, our auditors have concerns over some aspects of contractor financial reporting. One of the major issues remaining is the status of accounts receivable, most of which are maintained on our behalf by our fiscal intermediaries (FI) and carriers. These organizations, commonly referred to as Medicare contractors, have contracted with CMS to administer the day-to-day operations of the Medicare program. They pay claims, audit provider cost reports, and establish and collect overpayments. Because the systems used by the Medicare contractors have not always produced data that were adequately supported, our auditors have had difficulty validating their accounts receivable balances.

Accounts Receivable

To continue receiving an unqualified opinion, our financial statements have to properly reflect accounts receivable at their true economic value based on provisions provided within the Office of Management and Budget Circular A-129, ***Managing Federal Credit Programs.*** Medicare accounts receivable consist primarily of provider and beneficiary overpayments, and Medicare Secondary Payer (MSP) receivables of paid claims that we subsequently determined that Medicare should have been the secondary rather than the primary payer.

We continue to use independent certified public accountants (CPAs) to review Medicare contractor accounts receivable balances in order to validate the receivable amounts reported to CMS and the adequacy of their internal controls. For FY 2003, the consultants conducted reviews at 15 Medicare contractors, which comprised about 80 percent of the accounts receivable balance reflected in last year's financial statements. Additionally, the scope of these reviews included the timely implementation of Medicare contractors' financial management corrective action plans (CAPs).

The reviews disclosed a total of $98.3 million errors (principal only) ($91.1 million non-MSP and $7.2 million MSP) resulting in the accounts receivable being overstated by $11.6 million ($5.0 million non-MSP and $6.6 million MSP). These amounts continue to indicate significant progress and reflect our enduring commitment to generate accurate financial statements.

While we have made significant improvements in financial reporting, our auditors continue to report a material weakness in the financial systems, analyses, and oversight area. Our long-term solution to this material weakness is the Healthcare Integrated General Ledger Accounting System (HIGLAS). The HIGLAS will provide CMS with an integrated financial management system that conforms to government-wide

requirements and will strengthen management of Medicare accounts receivable. Until this system is implemented, we will compensate for the lack of a modernized system through other means.

Debt Management

We collect the majority of our debt because most overpayments are recognized timely, thus allowing future claims to be offset against current overpayments. Debts that are over 180 days delinquent are subject to the Debt Collection Improvement Act (DCIA). Under the DCIA, Federal agencies are required to refer all eligible debts over 180 days delinquent to the Department of Treasury (Treasury) for cross-servicing and/or Treasury Offset Program (TOP). Debts referred to the TOP are housed in the National Interactive Database and matched to the Federal payments for potential offset. Debts referred for cross-servicing, which is the other primary collection tool used by the Treasury's Financial Management Service, can have a variety of collection activities, including sending additional demand letters, referring debts to the TOP, referring debts to private collection agencies, negotiating repayment agreements, and eventually referring some debts to the Department of Justice for litigation, if necessary. The HHS Program Support Center (PSC) serves as the Debt Collection Center (DCC) for all CMS debts. The majority of all CMS debts (MSP and non-MSP) are referred to Treasury, via the PSC, for cross-servicing and referral to TOP.

Our debt referral process encompasses all Medicare contractors, CO, and ROs, who forward demand letters to the delinquent debtors and input the debt information into our Debt Collection System (DCS) to transmit the debt electronically to the PSC for referral to Treasury. During FY 2003, we referred approximately $700 million of delinquent debt to Treasury for cross-servicing and TOP. This brought our total gross delinquent debt referred to approximately $6.2 billion, which is about 96 percent of the total net eligible to be referred. Our goal is to have 100 percent of our eligible delinquent debt referred to Treasury for cross-servicing and TOP by the end of the first quarter of FY 2004.

Medicare Contractor Oversight

Medicare contractors administer the day-to-day operations of the Medicare program by paying claims, auditing provider cost reports, and establishing and collecting overpayments. As part of these activities, Medicare contractors are required to maintain a vast array of financial data. Due to the materiality of this data, we must have assurances as to its validity and accuracy.

In FY 2002, the financial statement auditors reported that CMS continued to build upon prior efforts to improve its oversight of Medicare contractors and that it should continue to enhance its review of information included in its financial statements. Progress in these areas is ongoing through the workgroups comprised of CO and RO

consortia staff that address the areas identified by auditors: follow up on CAPs, reconciliations of funds expended to paid claims, trend analysis, and internal controls. The workgroups have defined CO and RO roles and responsibilities, and developed national strategic plans to strengthen our Medicare contractor financial management oversight.

Corrective Action Plans

The CMS conducts various financial management and electronic data processing (EDP) audits and reviews performed by the OIG, GAO, independent CPA firms, and CMS RO and CO staff to provide reasonable assurance that Medicare contractors have developed and implemented sound internal controls. The results of these reviews indicate whether the contractors' internal controls are operating as designed and identify existing deficiencies. Correcting these deficiencies is essential to improve financial management. Therefore, audit resolution remains a top priority at CMS. Medicare contractors, ROs, and CO components are required to prepare an initial CAP, which describes activities to correct all identified findings. Additionally, quarterly updates to the CAPs are required. The CMS reviews all initial CAPs and quarterly CAP updates for adequacy.

During FY 2003, the CMS CAP Workgroup revised the manual policies and procedures for the reporting and implementation of CAPs by the Medicare contractors to provide additional clarification regarding the submission of the "Universal CAP Report" that was developed in FY 2002. The CAP report consolidates all findings identified during CFO initiated audits, SAS 70 reviews, and reviews of accounts receivable balances. It also standardizes the format of CAP submissions and facilitates CMS' monitoring responsibilities of these reports. Training on the changes to our procedures was provided during our annual CFO training conferences. Furthermore, we are completing the development of a CAP database that will enable us to monitor the implementation of the CAPs more efficiently, analyze recurring findings, and generate reports based on select criteria. Designated CO and RO staff will have access to the system, thereby eliminating the need for the creation of multiple spreadsheets to be manually created and updated.

The CAP Workgroup also developed a CAP review protocol for CO and RO staff. This protocol provides a consistent step-by-step approach for following up on and resolving open financial findings. The protocol includes a standard closeout letter to report the results of the review and recommendation for CAP closure.

We also used independent CPA firms to conduct CAP follow-up reviews during the SAS 70 reviews and accounts receivable agreed upon procedure reviews that were performed in FY 2003.

CMS-1522 Reconciliations

On a monthly basis, Medicare contractors perform a reconciliation of their Form CMS-1522 Funds Expended Report to their paid claims or system reports. Although contractors are required to submit this reconciliation to CMS each month, the financial

statement auditors continue to identify this area as a material weakness during the annual CFO audit.

During FY 2003, the CMS-1522 Cash Reconciliation Workgroup worked with the Office of Inspector General and issued reconciliation procedures to Medicare contractors who process and pay claim under the Fiscal Intermediary Shared System (FISS) and Multi-Carrier System (MCS). The detailed procedures require Medicare contractors to reconcile, on a monthly basis, total funds expended by CMS to the corresponding Medicare claims that have been submitted and paid. The System Maintainers are currently programming system changes and the procedures are anticipated to be effective January 2004.

The CMS selected and performed reviews at 11 Medicare contractor locations during FY 2003. Teams consisting of CMS RO and CO staff completed the reviews. During FY 2004, the workgroup will continue to perform reviews of the Form CMS-1522 reporting and reconciliation processes at a sample of contractors.

Trend Analysis

We continue to enhance our analytical tools to provide the steps to identify potential errors, unusual variances, system weaknesses or inappropriate patterns of financial data accumulation. The Trend Analysis Workgroup has revised policies and updated procedures for performing trend analysis of critical financial related data, such as accounts receivable and quarterly financial statements, reported by CMS and our Medicare contractors. These tools allow us to perform more extensive data analyses and determine the need for additional actions to ensure that problems are adequately resolved.

To ensure that accounts receivable balances reported are reasonable, Medicare contractors are required to perform trend analysis on a quarterly basis and maintain documentation supporting it. During the annual CFO training conferences, the workgroup provides trend analysis training to the Medicare contractors. Additionally, the workgroup provides training to CO and RO staff on the review procedures that are used to review the adequacy of Medicare contractors' quarterly trending analysis submissions.

Internal Controls

To continue our emphasis on the importance of internal controls, the Certification Package on Internal Controls (CPIC) Workgroup continued to develop and communicate a heightened awareness of internal controls within the Medicare contractor community. In FY 2003, members of the CPIC workgroup tested the CPIC protocol review at four Medicare contractors for the FY 2002 CPIC submission. The workgroup also updated manual instructions that provide guidelines and policies to the Medicare contractors to enable them to strengthen their internal control procedures. This included

the annual update of the control objectives. The past several years have confirmed a need for a structured internal control strategy and process for CMS. In the past, we have been criticized for not providing a level of assurance that Medicare contractors had adequate systems of internal controls that were in place and operating efficiently. We believe the procedures and methods set forth in this manual will alleviate the problems and weaknesses for which the program has been cited.

Additionally, we require all Medicare contractors to submit an annual CPIC on their Medicare operations by October 15 of each FY. In the CPIC, contractors are required to report their material weaknesses identified during the FY. They are also required to maintain an internal list of reportable conditions. We require CAPs for all material weaknesses reported in the CPICs. During FY 2003, we also contracted with CPA firms to conduct SAS 70 internal control reviews of 24 Medicare contractors. The reviews indicated that 22 Medicare contractors reviewed had one or more exceptions. To ensure that the exceptions are properly addressed in a timely manner, we requested the contractors to develop and submit CAPs. For FY 2004, we will continue to perform these SAS 70 reviews and monitor contractors' progress for implementing their CAPs.

Financial Management and Reporting

To achieve accurate financial reporting and reliable internal controls, we have identified the following areas as significant.

Budget Execution

We continue to improve our budget execution for the Program Management Appropriation. The Financial Management Investment Board (FMIB), comprised of senior staff representing each CMS component, recommends allocations of resources in support of our priorities. The CMS Deputy Administrator/Chief Operating Officer makes the final operating plan allocations. In addition, we establish lapse targets for each Program Management allotment, and manage funds aggressively to meet those targets. This ensures available funds are identified timely and allocated to fund our priorities.

Guidance to Medicare Contractors

Medicare contractors provide much of the financial data CMS uses to manage the Medicare program. It is vital that they manage resources effectively and report accurate financial data. Therefore, we have continued to hold Medicare contractors accountable for improved financial management. We do so by requiring them to fix all deficiencies identified by the annual CFO audits and reviews and to report to us on a quarterly basis on their progress.

During FY 2003, we continued to revise and issue Medicare contractor financial reporting instructions. These instructions include revising policies regarding the calculation of the allowance for uncollectible accounts, recognizing and reporting non-MSP and MSP currently not collectible (CNC) debt, and recognizing and reporting claims

accounts receivable. In addition, revisions were made to the format of the financial reports to enable Medicare contractors to provide more detailed financial data.

We also revised and clarified financial reporting and debt collection policies and procedures based on findings from CFO audits, oversight reviews, and SAS 70 internal control reviews. The evaluation of findings resulting from these reviews allows us to perform risk analysis and profiling of Medicare contractors to determine where our resources should be focused and where additional guidance is needed. Additionally, we clarified our guidance requiring Medicare contractors to perform trend analysis procedures of its Medicare accounts receivable balances on a quarterly basis. Our goal is to continue to improve the consistency of information provided by the Medicare contractors.

We conducted two national training conferences for the Medicare contractors and ROs. We presented our revised policies and procedures for financial reporting and trend analysis, and also emphasized the importance of debt referral and internal controls documentation. With assurances that data is valid and complete, we have greater confidence in the accuracy and reliability of the financial information reported.

Our Medicare contractor financial management manual provides guidance on budget preparation and execution, overpayments, debt collection, accounts receivable, contractor financial reports, and enhances contractors' ability to map their internal control environment, and assists us in the development of training on internal control requirements. The manual is Internet-accessible.

Financial Reporting

In FY 2003, we continued to improve our financial statement reporting process within CO. All financial data, including data provided by Treasury and other Federal agencies, was included in our general ledger. This facilitated the preparation of the financial statements by eliminating manual entries into spreadsheets to determine necessary adjustments. It also provided the auditors with a clearer audit trail.

We continued preparing automated formatted financial statements produced directly from the Financial Accounting and Control System (FACS). This enabled the system to produce an audit trail documenting manual adjustments made to accounts that affect the financial statements. We also produced interim financial statements for the quarters ending December 31, 2002, March 31, 2003, and June 30, 2003, and, for the sixth consecutive year, submitted our financial statements through the automated financial statement system implemented by HHS.

We have also complied with Treasury's November 2003 reporting requirement for the Federal Agencies Centralized Trial Balance System (FACTS) II and the January 2003 reporting requirements for FACTS I. We continued to improve the operation of FACS by programming and implementing numerous accounting enhancements. These changes ensured that we met new program and Treasury requirements, as well as improved our administrative and accounting operations.

Medicare Secondary Payer

Our efforts in the MSP area saved the Medicare trust funds approximately $4.6 billion dollars in FY 2003. In addition, the MSP area has been actively pursuing delinquent debts owed the Medicare Program as a result of the enactment of the DCIA.

The CMS continues to pursue Voluntary Data Sharing Agreements (VDSAs) with insurers and large employers to secure health care coverage information on working enrollees and dependents. Current participation (52 insurers and large employers) in the VDSA process represents over 40 percent of the Medicare beneficiary population. Of these, 10 were signed in FY 2003 including, among others, the Office of Personnel Management, the largest Federal employer in the U.S. Active negotiations continue with a dozen other large employers and insurers, and we are in technical discussion with an estimated 20 other interested entities.

Other Initiatives

For the past several years, the number of unsettled managed care cost reports has been decreasing. The total backlog of unsettled managed care cost reports at the close of 2003 was 133. Disallowances resulting from FY 2003 settlement activity amounted to about $50 million. We have historically experienced a rate of return of about 22 to 1. For FY 2003, we had a rate of return of 20 to 1. The remaining backlog of unsettled managed care cost reports still represents a challenge to CMS because these cost reports have critical issues that must be resolved with Managed Care Organizations (MCOs). Therefore, it is projected that settlement activity will remain stable in the future fiscal years.

We also made important accomplishments in our administrative payment areas. We continued to pay all of our administrative payments on time in accordance with the Prompt Payment Act. Over 97 percent of our vendor reimbursements and virtually 100 percent of our travel reimbursements are made electronically.

Healthcare Integrated General Ledger Accounting System

Although our CFO auditors have found that Medicare contractors' claims processing systems are operating effectively in paying claims, they were not designed to meet the requirements of a dual entry, general ledger accounting system. As a result, they do not meet the provisions of the FFMIA. Therefore, a key element of our strategic vision is to acquire an FFMIA-compliant financial management system that will include all Medicare contractors. This project is called the Healthcare Integrated General Ledger Accounting System (HIGLAS). As part of this effort, CMS will replace the FACS, which accumulates all of the CMS financial activities, both programmatic and administrative, in its general ledger.

Following the guidance of OMB Circular A-130, ***Management of Federal Information Resources***, we acquired a commercial-off-the-shelf (COTS) product for HIGLAS. IBM is the systems integrator. Oracle Corporation and Electronic Data Systems

are providing the financial accounting software and application service provider services, respectively. Implementing an integrated general ledger program will give CMS enhanced oversight of contractor accounting systems and provide high quality, timely data for decision-making and performance measurement.

The HIGLAS project began with a pilot program with one Medicare contractor (Palmetto Government Benefit Administrators) that processes primarily hospital and other institutional claims, and another Medicare contractor (Empire Blue Cross Blue Shield) that processes primarily physician and supplier claims. The pilot phase will reengineer the accounting business process of the Medicare contractors to support the accounting software.

Once completed, the system will be thoroughly tested to ensure it works correctly and can handle the large volume of financial transactions generated by the Medicare program before a final decision is made to install the accounting system for Medicare and all its contractors. Full implementation is projected for the end of FY 2007.

The new system will also strengthen management of Medicare accounts receivable and allow more timely and effective collection activities on outstanding debts. These improvements in financial reporting by CMS and its contractors are essential to retaining an unqualified opinion on our financial statements, meeting the requirements of key Federal legislation, and safeguarding government assets.

Financial Statement Highlights

Consolidated Balance Sheet

The Consolidated Balance Sheet presents amounts of future economic benefits owned or managed by CMS (assets), amounts owed (liabilities), and amounts that comprise the difference (net position). The CMS Consolidated Balance Sheet shows $314.9 billion in assets. The bulk of these assets are in the Trust Fund Investments totaling $280.3 billion, which are invested in U.S. Treasury Special Issues, special public obligations for exclusive purchase by the Medicare trust funds. Trust fund holdings not necessary to meet current expenditures are invested in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. The next largest asset is the Fund Balance with Treasury of $18.5 billion, most of which is for Medicaid and SCHIP. Liabilities of $48.9 billion consist primarily of the Entitlement Benefits Due and Payable of $48.1 billion. The CMS net position totals $266.0 billion and reflects the cumulative results of the Medicare trust fund investments and the unexpended balance for SCHIP.

Consolidated Statement of Net Cost

The Consolidated Statement of Net Cost shows a single amount—the actual net cost of CMS operations for the period by program. The three major programs that CMS administers are Medicare, Medicaid, and SCHIP. The majority of CMS expenses are allocated to these programs.

Total Benefit Payments were $441.1 billion for FY 2003. Administrative Expenses were $2.4 billion, less than 1 percent of total net Program/Activity Costs of $416.2 billion.

The net cost of the Medicare program including benefit payments, Quality Improvement Organizations, Medicare Integrity Program spending, and administrative costs, was $250.1 billion. The HI total costs of $154.2 billion were offset by $1.6 billion in premiums. The SMI total costs of $124.3 billion were offset by premiums of $26.8 billion. Medicaid total costs of $161.7 billion represent expenses incurred by the States and Territories that were reimbursed by CMS during the fiscal year, plus accrued payables. The SCHIP total costs were $4.4 billion.

Consolidated Statement of Changes in Net Position

The Consolidated Statement of Changes in Net Position shows the net cost of operations less financing sources other than exchange revenues, and the net position at the end of period. The line, Appropriations Used, represents the Medicaid appropriations used of $161.4 billion, $89.9 billion in transfers from Payments to Health Care Trust Funds to HI and SMI, SCHIP appropriations of $4.4 billion, and Ticket to Work appropriations of $14 million. Medicaid and SCHIP are financed by a general fund appropriation provided by Congress. Employment tax revenue is Medicare's portion of payroll and self-employment taxes collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA) for the HI trust fund totaling $149.8 billion. The Federal matching contribution is income to the SMI program from a general fund appropriation (Payments to Health Care Trust Funds) of $84.3 billion, that matches monthly premiums paid by beneficiaries.

Combined Statement of Budgetary Resources

The Combined Statement of Budgetary Resources provides information about the availability of budgetary resources, as well as their status at the end of the year. The CMS total budgetary resources were $545.2 billion. Obligations of $544.7 billion leave unobligated balances of $511 million (of which $204 million is not available). Total outlays were $531.7 billion. When offset by $28.4 billion relating to collection of premiums, the net outlays were $503.3 billion. When further offset by the $89.9 billion in the Payments to Health Care Trust Funds, the net outlays to the public were $413.4 billion.

Consolidated Statement of Financing

The Consolidated Statement of Financing is a reconciliation of the preceding statements. Accrual-based measures used in the Consolidated Statement of Net Cost differ from the obligation-based measures used in the Combined Statement of Budgetary Resources, especially in the treatment of liabilities. A liability not covered by budgetary resources may not be recorded as a funded liability in the budgetary accounts of CMS' general ledger, which supports the Report on Budget Execution and Budgetary Resources (SF 133) and the Combined Statement of Budgetary Resources. Therefore, these liabilities

are recorded as contingent liabilities on the general ledger. Based on appropriation language, they are considered "funded" liabilities for purposes of the Consolidated Balance Sheet, Consolidated Statement of Net Cost, and Consolidated Statement of Changes in Net Position. A reconciling item has been entered on the Consolidated Statement of Financing.

Required Supplementary Stewardship Information (RSSI)

As required by the Statement of Federal Financial Accounting Standards (SFFAS) Number 17, CMS has included information about the Medicare trust funds—HI and SMI. The RSSI 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 ***2003 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 financial statements have been prepared to report the financial position and results of operations of CMS, pursuant to the requirements of 31 U.S.C. 3515(b) and the Chief Financial Officers Act of 1990 (P.L. 101-576).

While these financial statements have been prepared from CMS' general ledger and subsidiary reports and supplemented with financial data provided by the U.S. Treasury in accordance with the formats prescribed by OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources that are prepared from the same books and records. These statements use accrual accounting, and some amounts shown will differ from those in other financial documents, such as the ***Budget of the U.S. Government*** and the annual report of the Boards of Trustees for HI and SMI, which are presented on a cash basis. The statements should be read with the realization that they are for a component of the United States government, a sovereign entity. One implication of this is that liabilities cannot be liquidated without legislation that provides resources to do so. The accuracy and propriety of the information contained in the principal financial statements and the quality of internal control rests with management.

Principal Statements and Notes

CONSOLIDATED BALANCE SHEET
As of September 30, 2003 and 2002
(in millions)

	FY 2003 Consolidated Totals	FY 2002 Consolidated Totals
ASSETS		
Intragovernmental Assets:		
Fund Balance with Treasury ***(Note 2)***	$18,536	$19,182
Trust Fund Investments ***(Note 3)***	280,300	271,933
Accounts Receivable, Net ***(Note 4)***	700	634
Other Assets:		
Anticipated Congressional Appropriation ***(Note 5)***	11,830	10,399
Other	3	
Total Intragovernmental Assets	**311,369**	**302,148**
Cash and Other Monetary Assets	843	375
Accounts Receivable, Net ***(Note 6)***	2,620	3,612
General Property, Plant and Equipment, Net	13	9
Other	72	54
TOTAL ASSETS	**$314,917**	**$306,198**
LIABILITIES ***(Note 9)***		
Intragovernmental Liabilities:		
Accounts Payable	$246	$224
Accrued Payroll and Benefits	3	5
Other Intragovernmental Liabilities ***(Note 7)***	233	312
Total Intragovernmental Liabilities	**482**	**541**
Federal Employee and Veterans' Benefits	11	10
Entitlement Benefits Due and Payable ***(Note 8)***	48,123	44,576
Accrued Payroll and Benefits	46	56
Other Liabilities ***(Note 7)***	256	212
TOTAL LIABILITIES	**48,918**	**45,395**
NET POSITION		
Unexpended Appropriations	13,441	14,096
Cumulative Results of Operations	252,558	246,707
TOTAL NET POSITION	**$265,999**	**$260,803**
TOTAL LIABILITIES AND NET POSITION	**$314,917**	**$306,198**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF NET COST
For the Years Ended September 30, 2003 and 2002
(in millions)

	FY 2003 Consolidated Totals	FY 2002 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS		
GPRA Programs		
Medicare	$250,074	$231,132
Medicaid	161,721	150,101
SCHIP	4,360	3,662
Net Cost - GPRA Programs	**416,155**	**384,895**
Other Activities		
CLIA	33	19
Ticket to Work Incentive	14	9
Other	(4)	1
Net Cost - Other Activities	**43**	**29**
NET COST OF OPERATIONS ***(Note 10)***	**$416,198**	**$384,924**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION
For the Years Ended September 30, 2003 and 2002
(in millions)

	FY 2003		FY 2002	
	Cumulative Results of Operations	Unexpended Appropriations	Cumulative Results of Operations	Unexpended Appropriations
BEGINNING BALANCES	**$246,707**	**$14,096**	**$223,382**	**$11,674**
Budgetary Financing Sources:				
Appropriations Received		261,307		247,188
Appropriations Transferred-in/out		(1,167)		(1,050)
Other Adjustments ***(Note 11)***		(5,143)		(4,348)
Appropriations Used	255,652	(255,652)	239,368	(239,368)
Nonexchange Revenue ***(Note 12)***	167,200		169,828	
Transfers-in/out Without Reimbursement ***(Note 13)***	(836)		(976)	
Other Financing Sources:				
Imputed Financing from Costs Absorbed by Others	33		29	
TOTAL FINANCING SOURCES	**422,049**	**(655)**	**408,249**	**2,422**
NET COST OF OPERATIONS	**416,198**		**384,924**	
ENDING BALANCES	**$252,558**	**$13,441**	**$246,707**	**$14,096**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENT OF BUDGETARY RESOURCES
For the Years Ended September 30, 2003 and 2002

(in millions)

	FY 2003 Combined Totals	FY 2002 Combined Totals
Budgetary Resources:		
Budget authority:		
Appropriations received	$547,308	$532,604
Net transfers	(1,162)	(1,050)
Unobligated balance:		
Beginning of period	3,358	400
Net transfers, actual	(5)	
Spending authority from offsetting collections:		
Earned:		
Collected	65	93
Receivable from Federal sources		(26)
Change in unfilled customer orders:		
Advance received	(4)	5
Without advance from Federal sources	6	
Transfers from trust funds	2,645	2,388
SUBTOTAL	**2,712**	**2,460**
Recoveries of prior year obligations	7,228	7,256
Temporarily not available pursuant to Public Law	(7,674)	(28,031)
Permanently not available	(6,589)	(3,582)
TOTAL BUDGETARY RESOURCES	**$545,176**	**$510,057**
Status of Budgetary Resources:		
Obligations incurred: ***(Note 15)***		
Direct	$544,589	$506,602
Reimbursable	76	97
SUBTOTAL	**544,665**	**506,699**
Unobligated balance:		
Apportioned	307	3,151
Unobligated balance not available	204	207
TOTAL STATUS OF BUDGETARY RESOURCES	**$545,176**	**$510,057**
Relationship of Obligations to Outlays:		
Obligated balance, net, beginning of period	$17,901	$18,587
Obligated balance, net, end of period:		
Accounts receivable	(1,185)	(1,144)
Unfilled customer orders from Federal sources	(6)	
Undelivered orders	11,842	12,552
Accounts payable	10,296	6,493
Outlays:		
Disbursements	534,343	499,832
Collections	(2,664)	(2,163)
SUBTOTAL	**531,679**	**497,669**
LESS: OFFSETTING RECEIPTS	**28,432**	**25,951**
NET OUTLAYS	**$503,247**	**$471,718**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF FINANCING
For the Years Ended September 30, 2003 and 2002
(in millions)

	FY 2003 Consolidated Totals	FY 2002 Consolidated Totals
RESOURCES USED TO FINANCE ACTIVITIES:		
Budgetary Resources Obligated:		
Obligations incurred	$544,665	$506,699
Less: Spending authority from offsetting collections and recoveries	9,940	9,716
Obligations net of offsetting collections and recoveries	534,725	496,983
Less: Offsetting receipts	28,432	25,951
NET OBLIGATIONS	**506,293**	**471,032**
Other Resources:		
Imputed financing from costs absorbed by others	33	29
NET OTHER RESOURCES USED TO FINANCE ACTIVITIES	**33**	**29**
TOTAL RESOURCES USED TO FINANCE ACTIVITIES	**$506,326**	**$471,061**
RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS:		
Change in budgetary resources obligated for goods, services and benefits ordered but not yet provided	$(689)	$(451)
Resources that fund expenses recognized in prior periods	39,526	39,196
Resources that finance the acquisition of assets	8	
Other resources or adjustments to net obligated resources that do not affect net cost of operations	94,490	87,220
TOTAL RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS	**133,335**	**125,965**
TOTAL RESOURCES USED TO FINANCE THE NET COST OF OPERATIONS	**$372,991**	**$345,096**
COMPONENTS OF THE NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD:		
Components Requiring or Generating Resources in Future Periods:		
Accrued unfunded entitlement benefit costs	$39,326	$39,526
Liability for unmatched SMI premiums ***(Note 5)***	3,381	
Increase in annual leave liability	1	1
(Increase) in exchange revenue receivable from the public	1,289	749
Other	1	
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL REQUIRE OR GENERATE RESOURCES IN FUTURE PERIODS	**43,998**	**40,276**
Components Not Requiring or Generating Resources:		
Depreciation and amortization	4	4
Other	(795)	(452)
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES	(791)	(448)
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD	**43,207**	**39,828**
NET COST OF OPERATIONS	**$416,198**	**$384,924**

The accompanying notes are an integral part of these statements.

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity

The CMS is a separate financial reporting entity of HHS. The financial statements have been prepared to report the financial position and results of operations of CMS, as required by the Chief Financial Officers Act of 1990. The statements were prepared from CMS' accounting records in accordance with accounting principles generally accepted in the United States (GAAP) and the form and content specified by the Office of Management and Budget (OMB) in OMB Bulletin 01-09. As discussed later in this Note, OMB has exempted CMS from certain requirements of OMB Circular No. A-11 regarding obligations incurred and recoveries of prior year obligations.

The financial statements cover all the programs administered by CMS. The programs administered by CMS are shown in two categories, Medicare and Health. The Medicare programs include:

Medicare Hospital Insurance (HI) Trust Fund

Medicare contractors are paid by CMS to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI trust fund. The CMS payments to managed care plans are also charged to this fund. The financial statements include HI trust fund activities administered by the Department of the Treasury (Treasury). This trust fund has permanent indefinite authority.

Medicare Supplementary Medical Insurance (SMI) Trust Fund

Medicare contractors are paid by CMS to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end stage renal disease (ESRD), rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI trust fund. The CMS payments to managed care plans are also charged to this fund. The financial statements include SMI trust fund activities administered by Treasury. This trust fund has permanent indefinite authority.

Medicare Integrity Program (MIP)

The Health Insurance Portability and Accountability Act, Public Law 104-191, established the MIP and codified the program integrity activities previously known as “payment safeguards.” This account is also called the Health Care Fraud and Abuse Control (HCFAC) Program, or simply “Fraud and Abuse.” The CMS contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews, cost report audits, and the education of providers and beneficiaries with respect to payment integrity and benefit quality assurance issues. The MIP is funded by the HI trust fund.

Payments to the Health Care Trust Funds Appropriation

The Social Security Act provides for payments to the HI and SMI trust funds for SMI (appropriated funds to provide for Federal matching of SMI premium collections) and HI (for the Uninsured and Federal Uninsured Payments). In addition, funds are provided by this appropriation to cover the Medicaid program's share of CMS’ administrative costs. 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.

Permanent Appropriations

A transfer of general funds to the HI trust fund in amounts equal to Self-Employment Contribution Act (SECA) tax credits and the increase to the tax payment from Old Age Survivors and Disability Insurance (OASDI) beneficiaries is made through 75X0513 and 75X0585, respectively. The Social Security Amendments of 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989. The amounts reported in FY 2003 are adjustments for late or amended tax returns. The Social Security Amendments of 1994, provided for additional tax payments from Social Security and Tier 1 Railroad Retirement beneficiaries.

The Health programs include:

Medicaid

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

The State Children's Health Insurance Program (SCHIP)

SCHIP, included in the Balanced Budget Act of 1997 (BBA), was designed to provide health insurance for children, many of whom come from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. The BBA set aside funds for ten years to provide this new insurance coverage. The grant awards, prepared at the beginning of each quarter and amended as necessary, are based on a State approved plan to implement SCHIP. At the end of each quarter, States report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by CMS for the difference between approved expenses reported for the period and the grant awards previously issued.

The Ticket to Work and Work Incentives Improvement Program

The Ticket to Work and Work Incentives Improvement Act of 1999, Public Law 106-170, established two grant programs. The Act provides funding for Medicaid infrastructure grants to support the design, establishment and operation of State infrastructures to help working people with disabilities purchase health coverage through Medicaid. The Act also provides funding for States to establish Demonstrations to Maintain Independence and Employment, which will provide Medicaid benefits and services to working individuals who have a condition that, without medical assistance, will result in disability.

Health Maintenance Organization (HMO) Loan and Loan Guarantee Fund

The HMO Loan and Loan Guarantee Fund was originally established to provide working capital to HMOs during their initial period of operations and to guarantee loans made by private lenders to HMOs. The last loan commitments were made in FY 1983. Direct loans to HMOs were sold, with a guarantee, to the Federal Financing Bank (FFB). The FFB purchase proceeds were then used as capital for additional direct loans. Therefore, the fund operates as a revolving fund. Currently, CMS collects principal and interest payments from HMO borrowers, and, in turn, pays the FFB.

Program Management User Fees: Medicare+Choice, Clinical Laboratory Improvement Program, and Other User Fees

This account operates as a revolving fund without fiscal year restriction. The BBA established the Medicare+Choice program that requires managed care plans to make payments for their share of the estimated costs related to enrollment, dissemination of information, and certain counseling and assistance programs. These user fees are devoted to educational efforts for beneficiaries and outreach partners. The Clinical Laboratory Improvement Amendments of 1988 (CLIA) marked the first comprehensive effort by the Federal government to regulate medical laboratory testing. The CMS and the Public Health Service share

responsibility for the CLIA program, with CMS having the lead responsibility for financial management. Fees for registration, certificates, and compliance determination of all U.S. clinical laboratories are collected to finance the program. Other user fees are charged for certification of some nursing facilities and for sale of the data on nursing facilities surveys. 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 Medicaid program's share of CMS administrative costs (see Note 13). User fees collected from managed care plans seeking Federal qualification and funds received from other federal agencies to reimburse CMS for services performed for them are credited to the Program Management Appropriation.

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

Basis of Presentation

The financial statements have been prepared to report the financial position and results of operations of CMS, pursuant to the requirements of 31 U.S.C. 3515(b), the Chief Financial Officers Act of 1990 (P.L. 101-576), as amended by the Government Management Reform Act of 1994.

These financial statements have been prepared from the CMS general ledger in accordance with GAAP and the formats prescribed by the OMB Bulletin 01-09. Some amounts shown will differ from those in other financial documents, such as the ***Budget of the U.S. Government*** and the annual report of the Boards of Trustees for HI and SMI, which are presented on a cash basis.

Basis of Accounting

The CMS uses the Government's Standard General Ledger account structure and follows accounting policies and guidelines issued by HHS. The financial statements are prepared on an accrual basis. Individual accounting transactions are recorded using both the accrual basis and cash basis of accounting. Under the accrual method, expenses are recognized when resources are consumed, without regard to the payment of cash. Under the cash method, expenses are recognized when cash is outlayed. The CMS follows standard budgetary accounting principles that facilitate compliance with legal constraints and controls over the use of Federal funds.

The CMS uses the cash basis of accounting in the Medicare program to record benefit payments disbursed during the fiscal year, supplemented by the accrual method to estimate the value of benefit payments incurred but not yet paid as of the fiscal year end. Revenues are also recognized both when earned (without regard to receipt of cash) and, in the case of HI and SMI premiums, when collected. Employment taxes earmarked for the Medicare program are recorded on a cash basis.

The CMS uses the cash basis of accounting in the Medicaid and SCHIP programs to record funds paid to the States during the fiscal year, supplemented by the accrual method to estimate the value of expenses (net of recoveries) not yet reported to CMS as of the end of the fiscal year.

Balance Sheet

The Balance Sheet presents amounts of future economic benefits owned or managed by CMS (assets), amounts owed (liabilities), and amounts which comprise the difference (net position). The major components are described below.

Assets

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

Trust Fund Investments are investments (plus the accrued interest on investments) held by Treasury. Sections 1817 for HI and 1841 for SMI

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

Accounts Receivable, Net consists of amounts owed to CMS by other Federal agencies and the public. Amounts due are presented net of an allowance for uncollectible accounts.

Medicare Secondary Payer (MSP) Accounts Receivable (A/R) consists of amounts owed to Medicare by insurance companies, employers, beneficiaries, and/or providers for payments made by Medicare that should have been paid by the primary payer. Receipts are transferred to the HI or SMI trust fund upon collection. Amounts due are presented net of an allowance for uncollectible accounts. The allowance for uncollectible accounts is based on past collection experience and an analysis of the outstanding balances.

Medicare Non-MSP A/R consists of amounts owed to Medicare by medical providers and others because Medicare made payments that were not due, for example, excess payments that were determined to have been made once provider cost reports were audited. Non-MSP A/R represent entity receivables and, once collected, are transferred to the HI or SMI trust fund. Amounts due are presented net of an allowance for uncollectible accounts. The allowance for uncollectible accounts is based on past collection experience and an analysis of the outstanding balances.

Cash and Other Monetary Assets are the total amount of time account balances at the Medicare contractor commercial banks. The Checks Paid Letter-of-Credit method is used for reimbursing Medicare contractors for the payment of covered Medicare services. Medicare contractors issue checks against a Medicare Benefits account maintained at commercial banks. In order to compensate commercial banks for handling the Medicare Benefits accounts, Medicare funds are deposited into non-interest-bearing time accounts. The earnings allowances on the time accounts are used to reimburse the commercial banks.

Property, Plant and Equipment (PP&E) are recorded at full cost of purchase, including all costs incurred to bring the PP&E to a form and location suitable for its intended use, net of accumulated depreciation. All PP&E with an initial acquisition cost of $25,000 or more and an estimated useful life of 2 years or greater is capitalized. The PP&E is depreciated on a straight-line basis over the estimated useful life of the asset. Normal maintenance and repair costs are expensed as incurred.

Liabilities

Liabilities represent amounts owed by CMS. In accordance with Public Law and existing Federal accounting standards, no liability is recorded for any future payment to be made on behalf of current workers contributing to the Medicare HI trust fund.

Liabilities covered by available budgetary resources include (1) new budget authority, (2) spending authority from offsetting collections, (3) recoveries of unexpired budget authority, (4) unobligated balances of budgetary resources at the beginning of the year, and (5) permanent indefinite appropriation or borrowing authority.

Liabilities not covered by budgetary resources are incurred when funding has not yet been made available through Congressional appropriations or current earnings. The CMS recognizes such liabilities for employee annual leave earned but not taken, amounts billed by the Department of Labor for Federal Employee's Compensation Act (FECA) payments, and for portions of the Entitlement Benefits Due and Payable liability for which no obligations have been incurred. For CMS revolving funds, all liabilities are funded as they occur.

Accounts Payable consists of amounts due for goods and services received, progress in contract performance, interest due on accounts payable, and other miscellaneous payables.

Federal Employee and Veterans' Benefits consist of the actuarially-determined estimate of future benefits earned by Federal employees and Veterans, but not yet due and payable. These costs include pensions, other retirement benefits, and

other post-employment benefits. These benefits programs are normally administered by the Office of Personnel Management (OPM) and not by CMS.

Entitlement Benefits Due and Payable represents the liability for Medicare and Medicaid medical services incurred but not paid as of September 30. The Medicare liability is developed by the Office of the Actuary (OACT) and includes (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 FY 2003 but paid in FY 2004, and (e) an estimate of retroactive settlements of cost reports submitted to the Medicare contractors by health care providers. OMB has exempted CMS from the Circular No. A-11 requirement to report obligations for the Medicare Entitlement Benefits Due and Payable when the liability is incurred. Therefore, for budgetary purposes, obligations for the Medicare Entitlement Benefits Due and Payable are recorded at the time the Medicare contractors' banks request reimbursement for checks presented for payment, in an amount equal to the payments, rather than recording the obligation when the liability is incurred.

The Medicaid estimate represents the net of unreported expenses incurred by the States less amounts owed to the States for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases. The FY 2003 estimate was developed based on historical relationships between prior Medicaid net payables and current Medicaid activity. The FY 2002 estimate is based on information provided by the States.

Accrued Payroll and Benefits consist of Federal Employee's Compensation Act (FECA) payments due to the Department of Labor and the estimated liability for salaries, wages, funded annual leave and sick leave that has been earned but is unpaid.

Other Liabilities are the retirement plans utilized by CMS employees; the Civil Service Retirement System (CSRS) or the Federal Employees Retirement System (FERS). Under CSRS, CMS makes matching contributions equal to 7 percent of pay. The CMS does not report CSRS assets, accumulated plan benefits, or unfunded liabilities, if any, applicable to its employees. Reporting such amounts is the responsibility of OPM.

Most employees hired after December 31, 1983 are automatically covered by FERS. A primary feature of FERS is that it offers a savings plan to which CMS is required to contribute 1 percent of pay and to match employee contributions up to an additional 4 percent of pay. For employees covered by FERS, CMS also contributes the employer's matching share of Social Security taxes.

Net Position

Net Position contains the following components:

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

Cumulative Results of Operations represent the net results of operations since the inception of the program plus the cumulative amount of prior period adjustments.

Statement of Net Cost

The Statement of Net Cost shows only a single dollar amount: the actual net cost of CMS' operations for the period by program. Under Government Performance and Results Act (GPRA), CMS is required to identify the mission of the agency and develop a strategic plan and performance measures to show that desired outcomes are being met. The three major programs that CMS administers are: Medicare, Medicaid, and SCHIP. The bulk of CMS' expenses are allocated to these programs. The MIP is included in Medicare. The costs related to the Program Management Appropriation are cost-allocated to all three major components. The net cost of operations of the CLIA program and other programs are shown separately under "Other Activities."

Although the following terms do not appear in the Statement of Net Cost, they are an integral part in the calculation of a program's net cost of operations:

Program/Activity Costs represent the gross costs or expenses incurred by CMS for all activities.

Benefit Payments are payments by Medicare contractors, CMS, and Medicaid State agencies to health care providers for their services.

Administrative Expenses represent the costs of doing business by CMS and its partners.

Exchange Revenues (or earned revenues) arise when a Government entity provides goods and services to the public or to another Government entity for a fee.

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

Net Cost of Operations is the difference between the program's gross costs and its related exchange revenues.

Statement of Changes in Net Position

The Statement of Changes in Net Position (SCNP) reports the change in net position during the fiscal year that occurred in the two components of net position: Cumulative Results of Operations and Unexpended Appropriations. The SCNP comprises the following major line items:

Prior Period Adjustments are either corrections of errors or changes in accounting principles with retroactive effect that increase or decrease net position.

Budgetary Financing Sources display financing sources and nonexchange revenue that are also budgetary resources, as reported on the Statement of Budgetary Resources.

Appropriations Received show the amounts of appropriations received in the current fiscal year.

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

Appropriations Used and Federal Matching Contributions are described in the Medicare Premiums section above. For financial statement purposes, appropriations used are recognized as a financing source as expenses are incurred. A transfer of general funds to the HI trust fund in an amount equal to SECA tax credits is made through the Payments to the Health Care Trust Funds Appropriation. The Social Security Amendments of 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989.

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 FICA and SECA. Employees and employers were both required to contribute 1.45 percent of earnings, with no limitation, to the HI trust fund. Self-employed individuals contributed the full 2.9 percent of their net income.

Transfers-in/Transfers-out report the transfers of funds between CMS programs or between CMS and other Federal agencies. Examples include transfers made from CMS' Payment to the Health Care Trust Fund appropriation to the HI and SMI trust funds and the transfers between the HI and SMI trust funds and CMS' Program Management appropriation.

Statement of Budgetary Resources

The Statement of Budgetary Resources provides information about the availability of budgetary resources as well as their status at the end of the year. Budgetary Statements were developed for each of the budgetary accounts. In this statement, the Program Management and the Program Management User Fee accounts are combined and are not allocated back to the other programs. Also, there are no intra-CMS eliminations in this statement.

Unobligated Balances—beginning of period represent funds available. These funds are primarily HI and SMI trust fund balances invested by the Treasury.

Budget Authority represents the funds available through appropriations, direct spending authority, obligations limitations, unobligated balances at the beginning of the period or

transferred in during the period, spending authority from offsetting collections, and any adjustments to budgetary authority.

Obligations Incurred consist of expended authority and the change in undelivered orders. OMB has exempted CMS from the Circular No. A-11 requirement to report the recoveries of prior year obligations separately on the SF-133. Furthermore, current system limitations prevent CMS from reporting the recoveries of prior year obligations. Therefore, recoveries of prior year obligations have not been reported separately within the financial statements.

Adjustments are increases or (decreases) to budgetary resources. Increases include recoveries of prior year obligations; decreases include budgetary resources temporarily not available, rescissions, and cancellations of expired and no-year accounts.

Statement of Financing

The Statement of Financing is a reconciliation of the preceding statements. Accrual-based measures used in the Statement of Net Cost differ from the obligation-based measures used in the Statement of Budgetary Resources, especially in the treatment of liabilities. A liability not covered by budgetary resources may not be recorded as a funded liability in the budgetary accounts of CMS' general ledger, which supports the Report on Budget Execution (SF-133) and the Statement of Budgetary Resources. Therefore, these liabilities are recorded as contingent liabilities on the general ledger. Based on appropriation language, they are considered "funded" liabilities for purposes of the Balance Sheet, Statement of Net Cost and Statement of Changes in Net Position. A reconciling item has been entered on the Statement of Financing, which has been prepared on a consolidated basis, except for the budgetary information used to calculate net obligations (budgetary resources), which must be presented on a combined basis.

Use of Estimates in Preparing Financial Statements

Preparation of financial statements in accordance with Federal accounting standards requires CMS to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results may differ from those estimates.

Intra-Governmental Relationships and Transactions

In the course of its operations, CMS has relationships and financial transactions with numerous Federal agencies. For example, CMS interacts with the Social Security Administration (SSA) and Treasury. The SSA determines eligibility for Medicare programs, and also allocates a portion of Social Security benefit payments to the Medicare Part B trust fund for Social Security beneficiaries who elect to enroll in the Medicare Part B program. The Treasury receives the cumulative excess of Medicare receipts and other financing sources, and issues interest-bearing securities in exchange for the use of those monies. At the Government-wide level, the assets related to the trust funds on CMS' financial statements and the corresponding liabilities on the Treasury's financial statements are eliminated.

Comparative Data

In accordance with OMB Bulletin 01-09 CMS has presented comparative Consolidated Balance Sheets, Consolidated Statements of Net Cost, Consolidated Statements of Changes in Net Position, Combined Statements of Budgetary Resources, Consolidated Statements of Financing and Notes to the Financial Statements.

Reclassifications

Certain FY 2002 balances have been reclassified to conform to FY 2003 financial statement presentations, the effect of which is immaterial.

Estimation of Obligations Related to Canceled Appropriations

As of September 30, 2003, CMS has canceled over $136 million in cumulative obligations to FY 1997 and prior years in accordance with the National Defense Authorization Act of Fiscal Year 1991 (P.L. 101-150). Based on the payments made in FYs 1999 through 2003 related to canceled appropriations, CMS anticipates an additional $1.5 million will be paid from current year funds for canceled obligations.

NOTE 2:

FUND BALANCES *(Dollars in Millions)*

FY 2003	Consolidated Totals
FUND BALANCES:	
Trust Funds	
HI Trust Fund Balance *(1)*	$(206)
SMI Trust Fund Balance *(1)*	(178)
Revolving Funds	
HMO Loan *(2)*	10
CLIA *(2)*	116
Appropriated Funds	
Medicaid	8,788
SCHIP	9,754
TWI *(2)*	234
Other Fund Types	
CMS Suspense Account *(2)*	5
Program Management Reimbursables *(2)*	13
TOTAL FUND BALANCES	**$18,536**
STATUS OF FUND BALANCES WITH TREASURY:	
Unobligated Balance	
Available	$307
Unavailable	(2,702)
Obligated Balance not yet Disbursed	20,931
TOTAL STATUS OF FUND BALANCES WITH TREASURY	**$18,536**

(1) The portions of the HI and SMI fund balances comprising the remaining fund balance in the Payments to the Health Care Trust Funds appropriation are not available for use by the trust funds. The respective amounts are $45 million in HI and no remaining fund balance in SMI (see Note 5).

(2) These fund balances are reported in the Supplementary Information section under the "All Others" column of the Consolidating Balance Sheet.

FY 2002	Consolidated Totals
FUND BALANCES:	
Trust Funds	
HI Trust Fund Balance *(1)*	$162
SMI Trust Fund Balance *(1)*	2,763
Revolving Funds	
HMO Loan *(2)*	11
CLIA *(2)*	129
Appropriated Funds	
Medicaid	5,040
SCHIP	10,933
TWI *(2)*	117
Other Fund Types	
CMS Suspense Account *(2)*	11
Program Management Reimbursables *(2)*	16
TOTAL FUND BALANCES	**$19,182**
STATUS OF FUND BALANCES WITH TREASURY:	
Unobligated Balance	
Available	$3,152
Unavailable	(1,872)
Obligated Balance not yet Disbursed	17,902
TOTAL STATUS OF FUND BALANCES WITH TREASURY	**$19,182**

(1) The portions of the HI and SMI fund balances comprising the remaining fund balance in the Payments to the Health Care Trust Funds appropriation are not available for use by the trust funds. The respective amounts are $3 million in HI and $3,014 million in SMI.

(2) These fund balances are reported in the Supplementary Information section under the "All Others" column of the Consolidating Balance Sheet.

NOTE 3: TRUST FUND INVESTMENTS, NET *(Dollars in Millions)*

Medicare Investments

FY 2003	Maturity Range	Interest Range	Value
HI			
Certificate	June 2004	4 1/2%	$2,948
Bonds	June 2004 to June 2018	3 1/2 - 8 3/4%	248,375
Accrued Interest			3,657
TOTAL HI INVESTMENTS			**$254,980**
SMI			
Bonds	June 2008 to June 2016	5 1/4 - 7 1/4%	$24,921
Accrued Interest			399
TOTAL SMI INVESTMENTS			**$25,320**
TOTAL MEDICARE INVESTMENTS			**$280,300**

FY 2002	Maturity Range	Interest Range	Value
HI			
Certificate	June 2003	4 3/8%	$3,385
Bonds	June 2003 to June 2017	5 1/4 - 9 1/4%	225,521
Accrued Interest			3,597
TOTAL HI INVESTMENTS			**$232,503**
SMI			
Certificate	June 2003	4 3/8%	$1,179
Bonds	June 2004 to June 2016	5 1/4 - 8 3/4%	37,626
Accrued Interest			625
TOTAL SMI INVESTMENTS			**$39,430**
TOTAL MEDICARE INVESTMENTS			**$271,933**

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

NOTE 4: INTRAGOVERNMENTAL ACCOUNTS RECEIVABLE, NET *(Dollars in Millions)*

FY 2003

	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
Expenditure Transfer-in	$355	$4,102	$88	$3	$19	$4,567	$(4,567)	
Nonexpenditure Transfer-in	1,193	349				1,542	(1,542)	
Railroad Retirement Principal	406					406		$406
Military Service Contribution	147					147		147
Interest on OASDI FY 2001 Warrant	147					147		147
TOTAL INTRAGOVERNMENTAL ACCOUNTS RECEIVABLE, NET	**$2,248**	**$4,451**	**$88**	**$3**	**$19**	**$6,809**	**$(6,109)**	**$700**

FY 2002

	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
Expenditure Transfer-in	$323	$690	$87	$3	$41	$1,144	$(1,144)	
Nonexpenditure Transfer-in	462	260				722	(722)	
Railroad Retirement Principal	412					412		$412
Military Service Contribution	123					123		123
Interest on OASDI FY 2001 Warrant	99					99		99
TOTAL INTRAGOVERNMENTAL ACCOUNTS RECEIVABLE, NET	**$1,419**	**$950**	**$87**	**$3**	**$41**	**$2,500**	**$(1,866)**	**$634**

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 Sheet.

NOTE 5: ANTICIPATED CONGRESSIONAL APPROPRIATION

The CMS has recorded $11,830 million in anticipated Congressional appropriations ($10,399 in FY 2002) to cover liabilities incurred as of September 30 by the Medicaid program and the Payments to the Health Care Trust Funds, as discussed below:

Medicaid

Beginning in FY 1996, CMS has accrued an expense and liability for Medicaid claims incurred but not reported (IBNR) as of September 30. In FY 2003, the IBNR expense exceeded the available unexpended Medicaid appropriations in the amount of $8,449 million ($10,399 in FY 2002). A review of appropriation language by CMS' Office of General Counsel (OGC) has resulted in a determination that the Medicaid appropriation's indefinite authority provision allows for the entire IBNR amount to be reported as a funded liability. Consequently, CMS has recorded a $8,449 million anticipated appropriation in FY 2003 ($10,399 in FY 2002) for IBNR claims that exceed the available appropriation.

Payments to the Health Care Trust Funds

The SMI program is financed primarily by the general fund appropriation, Payments to the Health Care Trust Funds, and by monthly premiums paid by beneficiaries. Section 1844 of the Social Security Act authorizes funds to be appropriated from the general fund to match premiums payable and deposited in the Trust Fund. Section 1844 also outlines the ratio for the match and the method to make the trust funds whole if insufficient funds are available in the appropriation to match all SMI premiums received in the fiscal year.

The appropriated amount is an estimate calculated annually by CMS' OACT and can be insufficient in any particular fiscal year. In FY 2003, the estimate was insufficient and the matching ceased prior to the close of the fiscal year. At September 30 approximately $3,334.6 million should have been matched to premiums paid by beneficiaries. OACT calculated an additional $46.4 million in interest on the unmatched amount, leaving a cumulative liability of $3,381 million owed to SMI. When this occurs, Section 1844 allows for a reimbursement to be made to the SMI Trust Fund from the Payments to the Health Care Trust Funds appropriation enacted for the following year. Consequently, CMS has recorded a $3,381 million anticipated appropriation in FY 2003 for the amount of the unmatched SMI premiums. Although the actual transfer of funds will occur in FY 2004, CMS has reported the $3,381 million as revenues earned in FY 2003.

In addition, the $3,381 million in unmatched SMI premiums is reported as a liability "requiring or generating resources in future periods" on the Consolidated Statement of Financing.

NOTE 6: ACCOUNTS RECEIVABLE, NET *(Dollars in Millions)*

FY 2003	Medicare HI	Medicare SMI	Medicaid	All Others	Consolidated Total
Provider & Beneficiary Overpayment					
Accounts Receivable Principal	$2,663	$1,299		$462	$4,424
Less: Allowance for Uncollectible Accounts Receivable	(1,524)	(907)		(439)	(2,870)
Accounts Receivable, Net	1,139	392		23	1,554
Medicare Secondary Payer (MSP)					
Accounts Receivable Principal	103	58		30	191
Less: Allowance for Uncollectible Accounts Receivable	(56)	(34)		(27)	(117)
Accounts Receivable, Net	47	24		3	74
CMPs & Other Restitutions					
Accounts Receivable Principal	129	319		1	449
Less: Allowance for Uncollectible Accounts Receivable	(123)	(294)		(1)	(418)
Accounts Receivable, Net	6	25			31
Fraud and Abuse					
Accounts Receivable Principal	116	139			255
Less: Allowance for Uncollectible Accounts Receivable	(114)	(137)			(251)
Accounts Receivable, Net	2	2			4
Managed Care					
Accounts Receivable Principal	2	4		2	8
Less: Allowance for Uncollectible Accounts Receivable	(1)	(3)			(4)
Accounts Receivable, Net	1	1		2	4
Medicare Premiums					
Accounts Receivable Principal	144	338			482
Less: Allowance for Uncollectible Accounts Receivable	(40)	(37)			(77)
Accounts Receivable, Net	104	301			405
Audit Disallowances					
Accounts Receivable Principal	4	8	$1,123		1,135
Less: Allowance for Uncollectible Accounts Receivable	(1)	(2)	(593)		(596)
Accounts Receivable, Net	3	6	530		539
Other Accounts Receivable					
Accounts Receivable Principal			53	20	73
Less: Allowance for Uncollectible Accounts Receivable			(44)	(20)	(64)
Accounts Receivable, Net			9		9
TOTAL ACCOUNTS RECEIVABLE PRINCIPAL	**$3,161**	**$2,165**	**$1,176**	**$515**	**$7,017**
Less: Allowance for Uncollectible Accounts Receivable	(1,859)	(1,414)	(637)	(487)	(4,397)
TOTAL ACCOUNTS RECEIVABLE, NET	**$1,302**	**$751**	**$539**	**$28**	**$2,620**

FY 2002	Medicare HI	Medicare SMI	Medicaid	All Others	Consolidated Total
Provider & Beneficiary Overpayment					
Accounts Receivable Principal	$3,472	$1,642		$621	$5,735
Less: Allowance for Uncollectible Accounts Receivable	(1,920)	(1,085)		(571)	(3,576)
Accounts Receivable, Net	1,552	557		50	2,159
Medicare Secondary Payer (MSP)					
Accounts Receivable Principal	34	13		2	49
Less: Allowance for Uncollectible Accounts Receivable	(6)	(1)		—	(7)
Accounts Receivable, Net	28	12		2	42
CMPs & Other Restitutions					
Accounts Receivable Principal	111	324		2	437
Less: Allowance for Uncollectible Accounts Receivable	(102)	(236)		(2)	(340)
Accounts Receivable, Net	9	88			97
Fraud and Abuse					
Accounts Receivable Principal	114	128			242
Less: Allowance for Uncollectible Accounts Receivable	(112)	(125)			(237)
Accounts Receivable, Net	2	3			5
Managed Care					
Accounts Receivable Principal	1	8		3	12
Less: Allowance for Uncollectible Accounts Receivable	—	(3)		(3)	(6)
Accounts Receivable, Net	1	5			6
Medicare Premiums					
Accounts Receivable Principal	151	337			488
Less: Allowance for Uncollectible Accounts Receivable	(40)	(37)			(77)
Accounts Receivable, Net	111	300			411
Audit Disallowances					
Accounts Receivable Principal		1	$1,430		1,431
Less: Allowance for Uncollectible Accounts Receivable		—	(539)		(539)
Accounts Receivable, Net		1	891		892
Other Accounts Receivable					
Accounts Receivable Principal			32	10	42
Less: Allowance for Uncollectible Accounts Receivable			(32)	(10)	(42)
Accounts Receivable, Net					
TOTAL ACCOUNTS RECEIVABLE PRINCIPAL	**$3,883**	**$2,453**	**$1,462**	**$638**	**$8,436**
Less: Allowance for Uncollectible Accounts Receivable	(2,180)	(1,487)	(571)	(586)	(4,824)
TOTAL ACCOUNTS RECEIVABLE, NET	**$1,703**	**$966**	**$891**	**$52**	**$3,612**

Medicare accounts receivable are primarily composed of provider and beneficiary overpayments, and MSP overpayments. The MSP receivables are composed of paid claims in which Medicare should have been the secondary rather than the primary payer. Claims that have been identified to a primary payer are included in the MSP receivable amount. Accounts receivable data were primarily obtained from data provided by the Medicare contractors.

Currently Not Reportable/Currently Not Collectible Debt

In FY 1999, CMS implemented a number of policy changes in the reporting of delinquent accounts receivable. Provisions within the Office of Management and Budget (OMB) Circular A-129, ***Managing Federal Credit Programs***, allow an agency to move certain uncollectible delinquent debts into memorandum entries, which removes the receivable from the financial statements. The policy provides for certain debts to be written off closed without any further collection activity or reclassified as Currently Not Reportable. (This is also referred to as Currently Not Reportable/Collectible). This category of debt will continue to be referred for collection and litigation, but will not be reported on the financial statements because of the unlikelihood of collecting it. While these debts are not reported on the financial statements, the Currently Not Reportable/Collectible process permits and requires the use of collection tools of the Debt Collection Improvement Act of 1996. This allows delinquent debt to be worked until the end of its statutory collection life cycle.

In FY 2003, CMS continued the implementation of this policy and again performed analyses of its accounts receivable. CMS also continued to manage this debt by referring a significant portion of debt to Treasury for offset and cross-servicing in accordance with the Debt Collection Improvement Act of 1996.

Recognition of MSP Accounts Receivable

MSP accounts receivable are recorded on the financial statements as of the date the MSP recovery demand letter is issued. However, the MSP accounts receivable ending balance reflects an adjustment for expected reductions to group health plan accounts receivable for situations where CMS receives valid documented defenses to its recovery demands.

Write Offs and Adjustments

The implementation of the revised policies and other initiatives undertaken in recent fiscal years resulted in significant adjustments and write offs made to CMS' accounts receivable balance. CMS' financial reporting reflected additional adjustments, resulting from the validation and reconciliation efforts performed, revised policies and supplemental guidance provided by CMS to the Medicare contractors. The accounts receivable ending balance continues to reflect adjustments for accounts receivable which have been reclassified as Currently Not Reportable debt.

The allowance for uncollectible accounts receivable derived this year has been calculated from data based on the agency's collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the past five years. The Medicaid accounts receivable has been recorded at a net realizable value based on an historic analysis of actual recoveries and the rate of disallowances found in favor of the States. Such disallowances are not considered bad debts; the States elect to retain the funds until final resolution.

Non-entity Assets

Assets are either "entity" (the reporting entity holds and has authority to use the assets in its operations) or "non-entity" (the reporting agency holds but does not have authority to use in its operations). Before FY 2000 CMS reported its entity and non-entity assets in separate sections of the balance sheet. Since FY 2000 CMS has reported its entity and non-entity assets in a single combined section.

The only non-entity assets on CMS' Consolidating Balance Sheet are receivables for interest and penalties, net for the amount of $28 million ($51 million in FY 2002). The accrued interest associated with Provider and Beneficiary, MSP and Managed Care overpayments appear under All Others.

NOTE 7: OTHER LIABILITIES *(Dollars in Millions)*

FY 2003	Medicare HI	Medicare SMI	Medicaid	All Others	Consolidated Total
Intragovernmental:					
Uncollected Revenue due Treasury	$45	$112		$28	$185
Other	16	26	$3	3	48
TOTAL OTHER INTRAGOVERNMENTAL LIABILITIES	**$61**	**$138**	**$3**	**$31**	**$233**
Deferred Revenue	$59	$188			$247
Suspense Account Deposit Funds				$5	5
Other	3			1	4
TOTAL OTHER LIABILITIES	**$62**	**$188**		**$6**	**$256**

FY 2002	Medicare HI	Medicare SMI	Medicaid	All Others	Consolidated Total
Intragovernmental:					
Uncollected Revenue due Treasury	$68	$150		$51	$269
Other	9	15	$2	17	43
TOTAL OTHER INTRAGOVERNMENTAL LIABILITIES	**$77**	**$165**	**$2**	**$68**	**$312**
Deferred Revenue	$43	$150			$193
Suspense Account Deposit Funds				$11	11
Other	5	3			8
TOTAL OTHER LIABILITIES	**$48**	**$153**		**$11**	**$212**

CMS routinely receives premium payments on behalf of select categories of beneficiaries from third parties. In some instances, the payments received exceed the amount billed. As of the end of the accounting period, the excess collections are reported as deferred revenue received that will be applied against the next month's premium bill.

Potential Liability

The CMS routinely processes and settles cost reports and payment issues for institutional providers and healthcare insurers. As part of this process, some providers/insurers have filed suits challenging the amount of reimbursement to which they claim entitlement. CMS cannot reasonably estimate the probability of the providers successfully winning their suits or the exact amount of the potential loss to the Medicare trust funds.

In the opinion of management, the resolution of these matters will not have a material impact on the results of operations and financial condition of CMS.

NOTE 8: ENTITLEMENT BENEFITS DUE AND PAYABLE *(Dollars in Millions)*

FY 2003	Medicare				Consolidated
	HI	SMI	Total	Medicaid	Total
Medicare Benefits Payable *(1)*	$14,949	$15,289	$30,238		$30,238
Demonstration Projects and HMO Benefits	58	43	101		101
Medicaid Benefits Payable *(2)*				$17,500	17,500
Medicaid Audit/Program Disallowances *(3)*				284	284
TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE	**$15,007**	**$15,332**	**$30,339**	**$17,784**	**$48,123**

FY 2002	Medicare				Consolidated
	HI	SMI	Total	Medicaid	Total
Medicare Benefits Payable *(1)*	$14,074	$14,106	$28,180		$28,180
Demonstration Projects and HMO Benefits	32	24	56		56
Medicaid Benefits Payable *(2)*				$16,048	16,048
Medicaid Audit/Program Disallowances *(3)*				292	292
TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE	**$14,106**	**$14,130**	**$28,236**	**$16,340**	**$44,576**

(1) Medicare benefits payable consists of a $30.2 billion estimate ($28.2 billion in FY 2002) by CMS' Office of the Actuary of Medicare services incurred but not paid, as of September 30, 2003. The liability represents (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (d) periodic interim payments for 2003 that were paid in 2004 and (e) an estimate of retroactive settlements of cost reports.

(2) Medicaid benefits payable of $17.5 billion ($16.0 billion in FY 2002) is an estimate of the net Federal share of expenses that have been incurred by the States but not yet reported to CMS as of September 30, 2003.

(3) Medicaid audit and program disallowances of $284 million ($292 million in FY 2002) are contingent liabilities that have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the States. In all cases, the funds have been returned to CMS. CMS will be required to pay these amounts if the appeals are decided in the favor of the States. In addition, certain amounts for payment have been deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. CMS defers the payment of these claims until the State provides additional supporting data. Based on historical data, CMS expects to eventually pay approximately 21.5 percent (21.7 percent in FY 2002) of total contingent liabilities. Therefore, of the total contingent liabilities of $1,324 million ($1,342 million in FY 2002), CMS expects to pay approximately $284 million ($292 million in FY 2002).

Note that the entire Medicare and a portion of the Medicaid Entitlement Benefits Due and Payable are not covered by budgetary resources. Refer to Note 9 for the classification between the covered and not covered portions of these liabilities.

Appeals at the Provider Reimbursement Review Board

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. As of September 30, 2002, there were 8,938 (10,142 in FY 2001) PRRB cases under appeal. A total of 1,622 (2,138 in FY 2002) new cases were filed in FY 2003. The PRRB rendered decisions on 66 (50 in FY 2002) cases in FY 2003 and 2,860 (3,292 in FY 2002) additional cases were dismissed, withdrawn or settled prior to an appeal hearing. The PRRB gets no information on the value of these cases that are settled prior to a hearing. Since data is available for only the 66 cases that were decided in FY 2003, a reasonable liability estimate cannot be projected for the value of the 7,634 (8,938 in FY 2002) cases remaining on appeal as of September 30, 2003. As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

NOTE 9:
LIABILITIES NOT COVERED BY BUDGETARY RESOURCES *(Dollars in Millions)*

FY 2003	Medicare HI	Medicare SMI	Medicaid	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
Intragovernmental:							
Accrued Payroll and Benefits	$1	$2			$3		$3
Liability for Unmatched SMI Premiums		3,381			3,381	$(3,381)	
TOTAL INTRAGOVERNMENTAL	**$1**	**$3,383**			**$3,384**	**$(3,381)**	**$3**
Entitlement Benefits Due and Payable	$15,007	$15,332	$8,987		$39,326		$39,326
Federal Employee and Veterans' Benefits	3	7	1		11		11
Accrued Payroll and Benefits	9	20	1		30		30
TOTAL LIABILITIES NOT COVERED BY BUDGETARY RESOURCES	**$15,020**	**$18,742**	**$8,989**		**$42,751**	**$(3,381)**	**$39,370**
TOTAL LIABILITIES COVERED BY BUDGETARY RESOURCES	**$1,879**	**$1,558**	**$8,802**	**$37**	**$12,276**	**$(2,728)**	**$9,548**
TOTAL LIABILITIES	**$16,899**	**$20,300**	**$17,791**	**$37**	**$55,027**	**$(6,109)**	**$48,918**

FY 2002	Medicare HI	Medicare SMI	Medicaid	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
Intragovernmental:							
Accrued Payroll and Benefits	$1	$3		$1	$5		$5
TOTAL INTRAGOVERNMENTAL	**$1**	**$3**		**$1**	**$5**		**$5**
Entitlement Benefits Due and Payable	$14,106	$14,130	$11,290		$39,526		$39,526
Federal Employee and Veterans' Benefits	3	7			10		10
Accrued Payroll and Benefits	9	18	2		29		29
TOTAL LIABILITIES NOT COVERED BY BUDGETARY RESOURCES	**$14,119**	**$14,158**	**$11,292**	**$1**	**$39,570**		**$39,570**
TOTAL LIABILITIES COVERED BY BUDGETARY RESOURCES	**$1,172**	**$1,387**	**$5,053**	**$79**	**$7,691**	**$(1,866)**	**$5,825**
TOTAL LIABILITIES	**$15,291**	**$15,545**	**$16,345**	**$80**	**$47,261**	**$(1,866)**	**$45,395**

Liabilities not covered by budgetary resources are incurred when funding has not yet been made available through Congressional appropriations or current earnings. The CMS recognizes such liabilities for employee annual leave earned but not taken, amounts billed by the Department of Labor for Federal Employee's Compensation Act (FECA) payments, and for portions of the Entitlement Benefits Due and Payable liability for which no obligations have been incurred. For CMS revolving funds, all liabilities are funded as they occur.

NOTE 10:
NET COST OF OPERATIONS *(Dollars in Millions)*

FY 2003	Medicare HI	Medicare SMI	Total Medicare	Medicaid	SCHIP	All Others	Consolidated Totals
PROGRAM/ACTIVITY COSTS							
Medicare							
Fee for Service	$133,183	$105,662	$238,845				$238,845
Managed Care	19,269	17,132	36,401				36,401
Medicaid/SCHIP/TWI				$161,480	$4,355	$14	165,849
CLIA						90	90
TOTAL PROGRAM/ACTIVITY COSTS	**$152,452**	**$122,794**	**$275,246**	**$161,480**	**$4,355**	**$104**	**$441,185**
OPERATING COSTS							
Medicare Integrity Program	$1,023		$1,023				$1,023
Quality Improvement Organizations	280	$70	350				350
Bad Debt Expense and Writeoffs	(321)	(73)	(394)	$66			(328)
Reimbursable Expenses	2	5	7	1		$(4)	4
Administrative Expenses	754	1,444	2,198	169	$5		2,372
Depreciation and Amortization	1	2	3				3
Imputed Cost Subsidies	10	21	31	2			33
Other Expenses	17	33	50	3			53
TOTAL OPERATING COSTS	**$1,766**	**$1,502**	**$3,268**	**$241**	**$5**	**$(4)**	**$3,510**
TOTAL COSTS	**$154,218**	**$124,296**	**$278,514**	**$161,721**	**$4,360**	**$100**	**$444,695**
LESS: EXCHANGE REVENUES:							
Medicare Premiums Collected	$1,598	$26,834	$28,432				$28,432
CLIA Revenues						$57	57
Other Exchange Revenues	4	4	8				8
TOTAL EXCHANGE REVENUES	**$1,602**	**$26,838**	**$28,440**			**$57**	**$28,497**
TOTAL NET COST OF OPERATIONS	**$152,616**	**$97,458**	**$250,074**	**$161,721**	**$4,360**	**$43**	**$416,198**

FY 2002	Medicare HI	Medicare SMI	Total Medicare	Medicaid	SCHIP	All Others	Consolidated Totals
PROGRAM/ACTIVITY COSTS							
Medicare							
Fee for Service	$129,246	$91,367	$220,613				$220,613
Managed Care	17,847	15,942	33,789				33,789
Medicaid/SCHIP/TWI				$149,371	$3,656	$8	153,035
CLIA						78	78
TOTAL PROGRAM/ACTIVITY COSTS	**$147,093**	**$107,309**	**$254,402**	**$149,371**	**$3,656**	**$86**	**$407,515**
OPERATING COSTS							
Medicare Integrity Program	$968		$968				$968
Quality Improvement Organizations	244	$71	315				315
Bad Debt Expense and Writeoffs	(895)	134	(761)	$548			(213)
Reimbursable Expenses						$2	2
Administrative Expenses	694	1,398	2,092	176	$6	1	2,275
Depreciation and Amortization	1	2	3				3
Imputed Cost Subsidies	9	18	27	2			29
Other Expenses	14	30	44	4			48
TOTAL OPERATING COSTS	**$1,035**	**$1,653**	**$2,688**	**$730**	**$6**	**$3**	**$3,427**
TOTAL COSTS	**$148,128**	**$108,962**	**$257,090**	**$150,101**	**$3,662**	**$89**	**$410,942**
LESS: EXCHANGE REVENUES:							
Medicare Premiums Collected	$1,524	$24,427	$25,951				$25,951
CLIA Revenues						$59	59
Other Earned Revenues	7		7			1	8
TOTAL EXCHANGE REVENUES	**$1,531**	**$24,427**	**$25,958**			**$60**	**$26,018**
TOTAL NET COST OF OPERATIONS	**$146,597**	**$84,535**	**$231,132**	**$150,101**	**$3,662**	**$29**	**$384,924**

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. In this regard, the SSA reported $62.0 million ($70.7 million in FY 2002) of Property and Equipment, Net attributable to the Medicare program as of September 30, 2003. This amount is not included in CMS' Consolidating Balance Sheet as assets related to the Medicare program. However, funds withdrawn from the trust funds by SSA during FY 2003 to pay for this activity are reported as Transfers-out in the Statement of Changes in Net Position. The SSA administrative costs are reported to CMS by Treasury. These expenses are also reported by SSA on their FY 2003 Annual Financial Statement. The CMS administrative costs have been allocated to the Medicare, Medicaid, SCHIP and TWI programs based on the CMS cost allocation system. Administrative costs allocated to the Medicare program include $1.2 billion ($1.1 billion in FY 2002) paid to Medicare contractors to carry out their responsibilities as CMS' agents in the administration of the Medicare program.

NOTE 11: BUDGETARY FINANCING SOURCES: OTHER ADJUSTMENTS *(Dollars in Millions)*

FY 2003	Medicare HI	Medicare SMI	Medicaid	SCHIP	Other	Consolidated Total
Unexpended Appropriations						
Withdrawal of Expired or Canceled Year Authority	$(3)	$(3,015)			$(2)	$(3,020)
Net Change in Anticipated Congressional Appropriation		3,381	$(1,951)			1,430
Return of Indefinite Authority			(1,347)			(1,347)
Redistribution of SCHIP				$(2,206)		(2,206)
TOTAL OTHER ADJUSTMENTS	**$(3)**	**$366**	**$(3,298)**	**$(2,206)**	**$(2)**	**$(5,143)**

FY 2002	Medicare HI	Medicare SMI	Medicaid	SCHIP	Consolidated Total
Unexpended Appropriations					
Reversal of Accrual of FY 2001 Income Tax on OASDI	$(2,630)				$(2,630)
Reversal of Accrual of FY 2001 Federal Matching Contributions		$(1,592)			(1,592)
Net Increase in Anticipated Congressional Appropriation			$3,455		3,455
Withdrawal of Appropriation	(2)		(760)		(762)
Redistribution of SCHIP FY 1999 Appropriation				$(2,819)	(2,819)
TOTAL OTHER ADJUSTMENTS	**$(2,632)**	**$(1,592)**	**$2,695**	**$(2,819)**	**$(4,348)**

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

NOTE 12: TAXES AND OTHER NON-EXCHANGE REVENUE *(Dollars in Millions)*

FY 2003	Medicare HI	Medicare SMI	Consolidated Total
FICA Tax Receipts	$139,934		$139,934
SECA Tax Receipts	9,905		9,905
Trust Fund Investment Interest	14,846	$2,220	17,066
Interest on FY 2001 OASDI Warrant	48		48
Criminal Fines	2		2
Civil Monetary Penalties and Damages	233		233
Administrative Fees	7		7
Other Income	2	3	5
TAXES AND OTHER NON-EXCHANGE REVENUE	**$164,977**	**$2,223**	**$167,200**

FY 2002	Medicare HI	Medicare SMI	Consolidated Total
FICA Tax Receipts	$141,990		$141,990
SECA Tax Receipts	10,038		10,038
Trust Fund Investment Interest	14,127	$2,837	16,964
Interest on FY 2001 OASDI Warrant	67		67
Criminal Fines	430		430
Civil Monetary Penalties and Damages	326		326
Administrative Fees	10		10
Other Income	1	2	3
TAXES AND OTHER NON-EXCHANGE REVENUE	**$166,989**	**$2,839**	**$169,828**

For periods after December 31, 1993, employees and employers are each required to contribute 1.45 percent of employees' wages, and self-employed persons are required to contribute 2.90 percent of net income, with no limitation, to the HI trust fund. The Social Security Act requires the transfer of these contributions from the General Fund of Treasury to the HI trust fund based on the amount of wages certified by the Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 as the basis for conducting quarterly certification of regular wages.

NOTE 13:
OTHER TRANSFERS-IN/OUT *(Dollars in Millions)*

FY 2003

Transfers-in Without Reimbursement	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
Medicare Benefit Transfers	$151,529	$121,767				$273,296	$(273,296)	
Transfers to HCFAC	1,052					1,052	(1,052)	
Federal Matching Contributions		84,286				84,286	(84,286)	
Allocation to CMS Programs	771	1,577	$176	$5	$3	2,532	(2,532)	
Fraud and Abuse Appropriation	114					114	(114)	
Transfer-Uninsured Coverage	393					393	(393)	
Prog. Mngmt. Admin. Expense *(1)*	120					120	(120)	
Military Service Contribution	28	4				32		$32
Income Tax OASDI Benefits *(2)*	8,318					8,318	(8,318)	
Railroad Retirement Principal	389					389		389
Medicaid Part B Premiums			112			112	(112)	
Gifts and Miscellaneous	2					2		2
TOTAL TRANSFERS-IN	**$162,716**	**$207,634**	**$288**	**$5**	**$3**	**$370,646**	**$(370,223)**	**$423**

FY 2003

Transfers-out Without Reimbursement	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
SSA Administrative Expenses	$(601)	$(635)				$(1,236)		$(1,236)
Medicare Benefit Transfers	(151,529)	(121,767)				(273,296)	$273,296	
Transfers to HCFAC	(1,052)					(1,052)	1,052	
Federal Matching Contributions		(84,286)				(84,286)	84,286	
Transfers to Program Management	(854)	(1,678)				(2,532)	2,532	
Fraud and Abuse Appropriation	(114)					(114)	114	
Transfer-Uninsured Coverage	(393)					(393)	393	
Prog. Mngmt. Admin. Expense *(1)*	(120)					(120)	120	
Income Tax OASDI Benefits *(2)*	(8,318)					(8,318)	8,318	
Medicaid Part B Premiums		(112)				(112)	112	
Office of the Secretary	(6)	(3)				(9)		(9)
Payment Assessment Commission	(5)	(4)				(9)		(9)
Railroad Retirement Board		(5)				(5)		(5)
TOTAL TRANSFERS-OUT	**$(162,992)**	**$(208,490)**				**$(371,482)**	**$370,223**	**$(1,259)**
TOTAL TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT	**$(276)**	**$(856)**	**$288**	**$5**	**$3**	**$(836)**		**$(836)**

FY 2002

Transfers-in Without Reimbursement	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
Medicare Benefit Transfers	$145,722	$107,322				$253,044	$(253,044)	
Transfers to HCFAC	1,235					1,235	(1,235)	
Federal Matching Contributions		76,726				76,726	(76,726)	
Allocation to CMS Programs	692	1,481	$188	$6	$19	2,386	(2,386)	
Fraud and Abuse Appropriation	101					101	(101)	
Transfer-Uninsured Coverage	442					442	(442)	
Prog. Mngmt. Admin. Expense *(1)*	202					202	(202)	
Military Service Contribution	41	40				81		$81
Income Tax OASDI Benefits *(2)*	8,316					8,316	(8,316)	
Railroad Retirement Principal	373					373		373
Medicaid Part B Premiums			2			2	(2)	
Gifts and Miscellaneous	1	1				2		2
TOTAL TRANSFERS-IN	**$157,125**	**$185,570**	**$190**	**$6**	**$19**	**$342,910**	**$(342,454)**	**$456**

FY 2002

Transfers-out Without Reimbursement	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
SSA Administrative Expenses	$(706)	$(700)				$(1,406)		$(1,406)
Medicare Benefit Transfers	(145,722)	(107,322)				(253,044)	$253,044	
Transfers to HCFAC	(1,235)					(1,235)	1,235	
Federal Matching Contributions		(76,726)				(76,726)	76,726	
Transfers to Program Management	(890)	(1,496)				(2,386)	2,386	
Fraud and Abuse Appropriation	(101)					(101)	101	
Transfer-Uninsured Coverage	(442)					(442)	442	
Prog. Mngmt. Admin. Expense *(1)*	(202)					(202)	202	
Income Tax OASDI Benefits *(2)*	(8,316)					(8,316)	8,316	
Medicaid Part B Premiums		(2)				(2)	2	
Office of the Secretary	(8)	(5)				(13)		(13)
Payment Assessment Commission	(5)	(3)				(8)		(8)
Railroad Retirement Board		(5)				(5)		(5)
TOTAL TRANSFERS-OUT	**$(157,627)**	**$(186,259)**				**$(343,886)**	**$342,454**	**$(1,432)**
TOTAL TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT	**$(502)**	**$(689)**	**$190**	**$6**	**$19**	**$(976)**		**$(976)**

(1) During FY 2003, the Payments to the Health Care Trust Funds appropriation paid the HI trust fund $120 million ($202 million in FY 2002) to cover the Medicaid, SCHIP and TWI programs' share of CMS' administrative costs.

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

Funds are obtained from the HI and SMI trust funds as cash is needed to pay for Program Management appropriation expenses. During FY 2003, a total of $2,491 million ($1,953 million in FY 2002) was obtained from the trust funds to cover cash outlays. Of this amount, $1,851 million ($1,674 million in FY 2002) was needed to pay for expenses incurred against current year obligations and $640 million ($279 million in FY 2002),of which $16 million ($16 million in FY 2002) was transferred to the CLIA program, was needed for expenses incurred against prior year obligations.

Federal Matching Contributions

SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. The monthly SMI premium per beneficiary was $54.00 from October 2002 through December 2002 and $58.70 from January 2003 through September 2003. Premiums collected from beneficiaries totaled $26.8 billion ($24.4 billion in FY 2002) and were matched by a $84.3 billion ($76.7 billion in FY 2002) contribution from the Federal government.

NOTE 14:

GROSS COST AND EXCHANGE REVENUE BY BUDGET FUNCTIONAL CLASSIFICATION *(Dollars in Millions)*

FY 2003	Medicare	Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Intragovernmental Costs	$443	$36	$479		$479
With the Public	278,071	166,145	444,216		444,216
Gross Cost	278,514	166,181	444,695		444,695
Less: Exchange Revenue	(28,440)	(57)	(28,497)		(28,497)
NET COST	**$250,074**	**$166,124**	**$416,198**		**$416,198**

FY 2002	Medicare	Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Intragovernmental Costs	$254	$25	$279		$279
With the Public	256,836	153,827	410,663		410,663
Gross Cost	257,090	153,852	410,942		410,942
Less: Exchange Revenue	(25,958)	(60)	(26,018)		(26,018)
NET COST	**$231,132**	**$153,792**	**$384,924**		**$384,924**

NOTE 15:
STATEMENT OF BUDGETARY RESOURCES DISCLOSURES *(Dollars in Millions)*

The amounts of direct and reimbursable obligations incurred against amounts apportioned under Category A, Category B and Exempt from Apportionment are shown below:

FY 2003	Direct	Reimbursable	Combined Totals
Category A	$16,679	$71	$16,750
Category B	523,948	5	523,953
Exempt	3,962		3,962
TOTAL	**$544,589**	**$76**	**$544,665**

FY 2002	Direct	Reimbursable	Combined Totals
Category A	$19,474	$95	$19,569
Category B	483,266	2	483,268
Exempt	3,862		3,862
TOTAL	**$506,602**	**$97**	**$506,699**

Legal Arrangements Affecting Use of Unobligated Balances

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Statement of Budgetary Resources. The portion of trust fund receipts collected in the fiscal year that exceeds the amount needed to pay benefits and other valid obligations in that fiscal year is precluded by law from being available for obligation. This excess of receipts over obligations is reported as Temporarily Not Available Pursuant to Public Law in the Statement of Budgetary Resources and, therefore, is not classified as budgetary resources in the fiscal year collected. However, all such excess receipts are assets of the trust funds and currently become available for obligation as needed. The entire trust fund balances in the amount of $273,294 million ($265,620 million in FY 2002) as of September 30, 2003 are included in Investments on the Balance Sheet. The following table presents trust fund activities and balances for FY 2003 and FY 2002 (in millions):

FY 2003	Combined Balances
TRUST FUND BALANCES, BEGINNING	**$265,620**
Receipts	285,984
Less Obligations	277,258
Less Transfers	1,052
Excess of Receipts Over Obligations	7,674
TRUST FUND BALANCES, ENDING	**$273,294**

FY 2002	Combined Balances
TRUST FUND BALANCES, BEGINNING	**$237,589**
Receipts	285,416
Less Obligations	256,392
Less Transfers	993
Excess of Receipts Over Obligations	28,031
TRUST FUND BALANCES, ENDING	**$265,620**

Required Supplementary Stewardship Information

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for almost four decades. A brief description of the provisions of Medicare's Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds is included on pages 3–5 of this financial report.

The required supplementary stewardship information (RSSI) contained in this section is presented in accordance with the requirements of the Federal Accounting Standards Advisory Board (FASAB). Included are a description of the long-term sustainability and financial condition of the program and a discussion of trends revealed in the data.

RSSI material is generally drawn from the ***2003 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.

Printed copies of the Trustees Report may be obtained from CMS' Office of the Actuary (410-786-6386). The report is also available online at **www.cms.hhs.gov/publications/trusteesreport/default.asp**.

Please note that the 2003 Trustees Report for Medicare (issued March 17, 2003) was used as the source document for this FY 2003 CFO Financial Report. We anticipate that the Government-wide financial statement report for FY 2003 (expected to be issued March 31, 2004) will contain updated information from the 2004 Trustees Report (which is expected to be issued on or near March 15, 2004). Thus, some data related to the Medicare trust funds contained in this FY 2003 CFO Financial Report may differ from that contained in the FY 2003 ***Financial Report of the United States Government.***

ACTUARIAL PROJECTIONS

Cashflow in Nominal Dollars

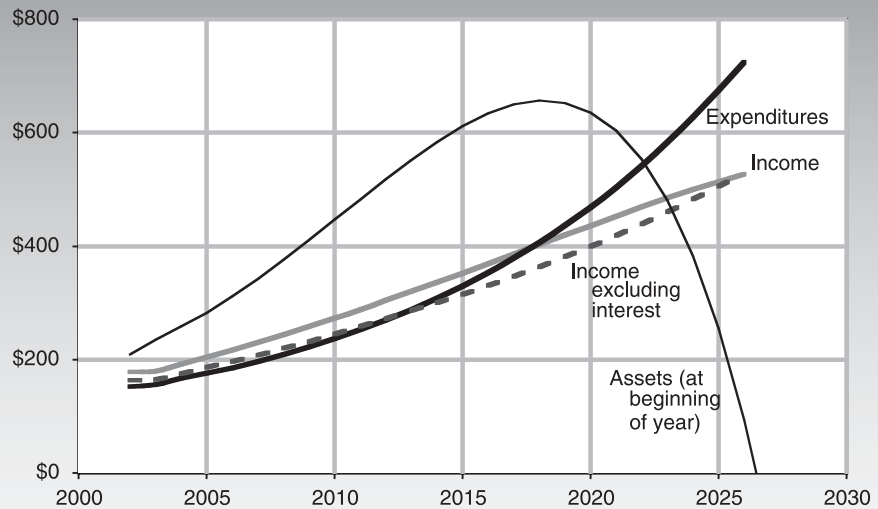
Using nominal dollars[1] for short-term projections paints a reasonably clear picture of expected performance with particular attention on cashflow and trust fund balances. Over longer periods, however, the changing value of the dollar can complicate efforts to compare dollar amounts in different periods and can create severe barriers to interpretation, since projections must be linked to something that the mind can comprehend in today's experience.

For this reason, long-range (75-year) Medicare projections in nominal dollars are seldom used and are not presented here. Instead, nominal-dollar estimates for the HI trust fund are displayed only through the projected date of depletion, currently the year 2026. Estimates for SMI are presented only for the next 10 years, primarily due to the fact that under present law, the SMI trust fund is automatically in financial balance every year.

HI

Chart 1 shows the actuarial estimates of HI income, expenditures, and assets for each of the next 24 years, in nominal dollars. Income includes payroll taxes, income from the taxation of Social Security benefits, interest earned on the U.S. Treasury securities held by the trust fund, and other miscellaneous revenue. Expenditures include benefit payments and administrative expenses. The estimates are for the "open group" population—all persons who will participate during the period as either taxpayers or beneficiaries, or both—and consist of payments from, and on behalf of, employees now in the workforce, as well as those who will enter the workforce over the next 24 years. The estimates also include expenditures attributable to these current and future workers, in addition to current beneficiaries.

Chart 1—HI Income, Expenditures, and Assets 2002-2026
(In billions)



Source: CMS/OACT

[1] Dollar amounts that are not adjusted for inflation or other factors are referred to as "nominal."

As chart 1 shows, under the intermediate assumptions HI expenditures would begin to exceed income including interest in 2018 and income excluding interest in 2013. This situation is due in part to the attainment of Medicare eligibility, starting in 2011, of those born during the 1946-1964 baby boom. It also arises as a result of health cost increases that are expected to continue to grow faster than workers' earnings. Beginning in 2018, the trust fund would start redeeming trust fund assets; in 2026, the assets would be depleted.

The projected year of depletion of the trust fund is very sensitive to assumed future economic and other trends. Under less favorable conditions the cash flow could turn negative much earlier and thereby accelerate asset exhaustion. On the other hand, more favorable conditions could delay the date of asset exhaustion.

By law, Medicare trust fund assets are invested in special U.S. Treasury Securities, which earn interest while Treasury uses those cash resources for other Federal purposes. During times of Federal "on-budget" surpluses, this process reduces the Federal debt held by the public. In times of Federal budget deficits, Medicare surpluses reduce the amount that must be borrowed from the public to finance those deficits. The trust fund assets are claims on the Treasury that, when redeemed, will have to be financed by raising taxes, borrowing from the public, or reducing other Federal expenditures. (When the assets are financed by borrowing, the effect is to defer today's costs to later generations who will ultimately repay the funds being borrowed for today's Medicare beneficiaries.) The existence of large trust fund balances, therefore, represents an important obligation of the Government to pay future Medicare benefits but does not necessarily make it easier for the Government to pay those benefits.

SMI

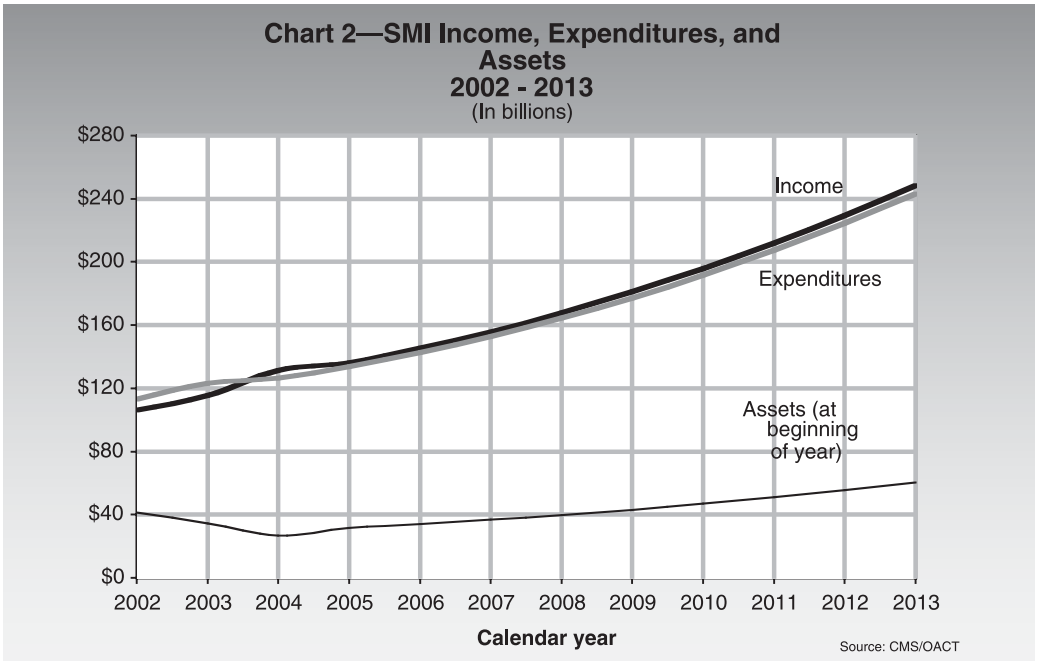
Chart 2 shows the actuarial estimates of SMI income, expenditures, and assets for each of the next 10 years, in nominal dollars. Whereas HI estimates are displayed through the year 2026, SMI estimates cover only the next 10 years, as SMI differs fundamentally from HI in regard to the way it is financed. In particular, SMI financing is not at all based on payroll taxes but instead on monthly premiums and income from the general fund of the U.S. Treasury—both of which are established annually to cover the following year's expenditures. Estimates of SMI income and expenditures, therefore, are virtually the same, as illustrated in chart 2, and so are not shown in nominal dollars separately beyond 10 years.

Income includes monthly premiums paid by, or on behalf of, beneficiaries, transfers from the general fund of the U.S. Treasury, and interest earned on the U.S. Treasury securities held by the trust fund.[2] Chart 2 displays only total income; it does not represent income excluding interest. The difference between the two is not visible graphically since interest is not a significant source of income.[3] Expenditures include benefit payments as well as administrative expenses.

[2] In the financial statements for CMS, Medicare income and expenditures are shown from a "trust fund perspective." All sources of income to the trust funds are reflected, and the actuarial projections can be used to assess the financial status of each trust fund. Corresponding estimates for Medicare and other Federal social insurance programs are also shown in the annual ***Financial Report of the United States Government***, also known as the consolidated financial statement. On a consolidated basis, the estimates are shown from a "Federal budget perspective." In particular, certain categories of trust fund income—primarily interest payments and SMI general revenues—are excluded because they represent intragovernmental transfers, rather than revenues received from the public. Thus, the consolidated financial statement focuses not on the financial status of individual trust funds, but on the overall balance between revenues and outlays for the Federal budget. Each perspective is appropriate and useful for its intended purpose.

[3] Interest income is generally about 3 percent of total SMI income.

As chart 2 indicates, SMI income is very close to expenditures. As noted earlier, this is due to SMI's financing mechanism. Under present law, SMI is automatically in financial balance every year, regardless of future economic and other conditions.

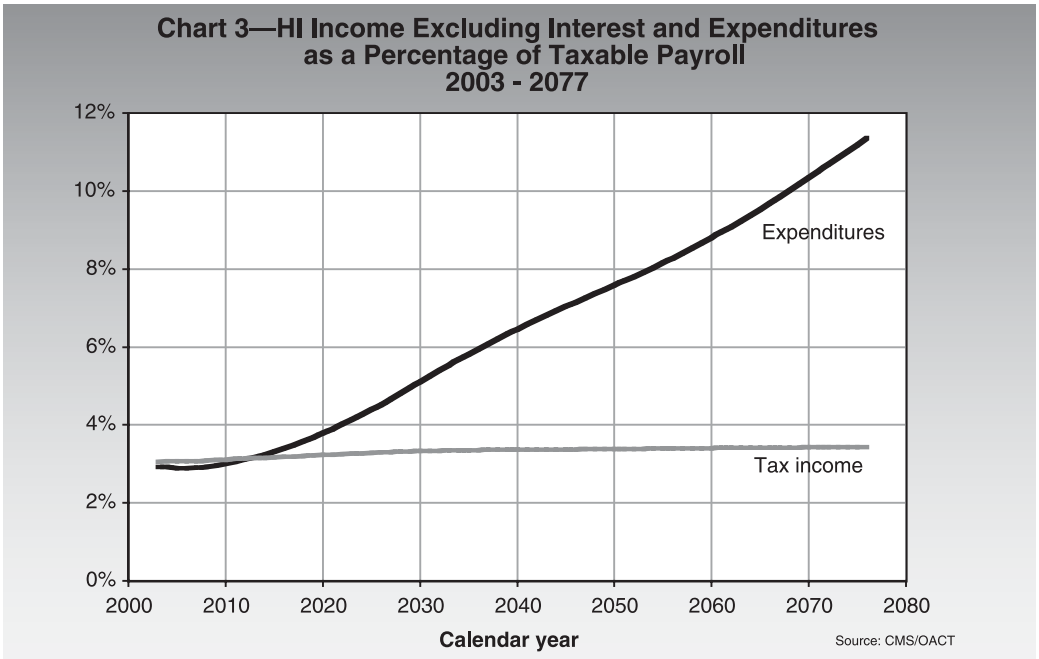


HI Cashflow as a Percent of Taxable Payroll

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

Chart 3 illustrates income excluding interest and expenditures as a percentage of taxable payroll over the next 75 years. As it was in the 2001and 2002 reports, the per beneficiary long-range growth in the 2003 report is assumed to be the level of per capita gross domestic product (GDP) growth plus 1 percentage point—reflecting an expectation that the impact of advances in medical technology on health care costs will continue, both in Medicare and in the health sector as a whole.

Since HI payroll tax rates are not scheduled to change in the future under present law, payroll tax income as a percentage of taxable payroll will remain constant at 2.90 percent. Income from taxation of benefits will increase only gradually as a greater proportion of Social Security beneficiaries become subject to such taxation over time. Thus, as chart 3 shows, the income rate is not expected to increase significantly over current levels. On the other hand, expenditures as a percentage of taxable payroll sharply escalate—in part due to health care cost increases that exceed wage growth, but also due to the attainment of Medicare eligibility of those born during the 1946-1964 baby boom.



HI and SMI Cashflow as a Percent of GDP

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

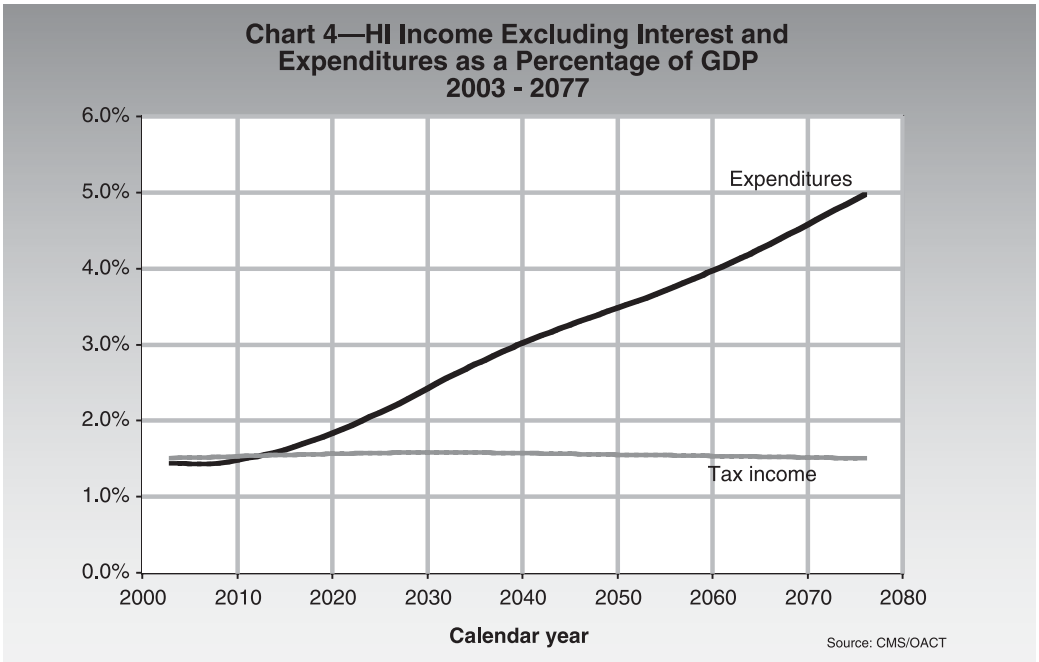
HI

Chart 4 shows HI income excluding interest and expenditures over the next 75 years expressed as a percentage of GDP. In 2002, the expenditures were $152.5 billion, which was 1.5 percent of GDP. Following slight reductions over the next 5 years, this percentage is projected to increase steadily throughout the remainder of the 75-year period.

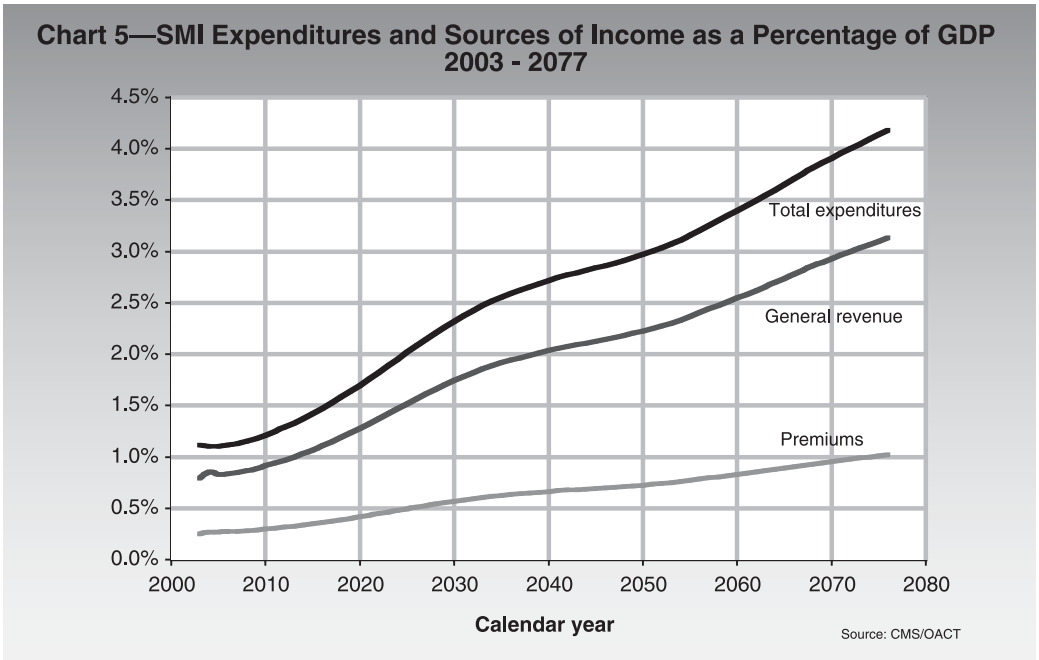
SMI

Because of the SMI 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 5 shows SMI expenditures over the next 75 years expressed as a percentage of GDP. In 2002, SMI expenditures were $113.2 billion, which was 1.1 percent of GDP. After 2005, this percentage is projected to increase steadily, reflecting growth in the volume and intensity of services provided per beneficiary throughout the projection period, together with the effects of the baby boom eligibility for retirement.



In the SMI expenditure projections, as in those for HI, the per beneficiary long-range growth rate is assumed to equal per capita GDP growth plus 1 percentage point. The growth rates are estimated year by year for the next 12 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 13 to 25 is assumed to grade smoothly into the long-range assumptions.

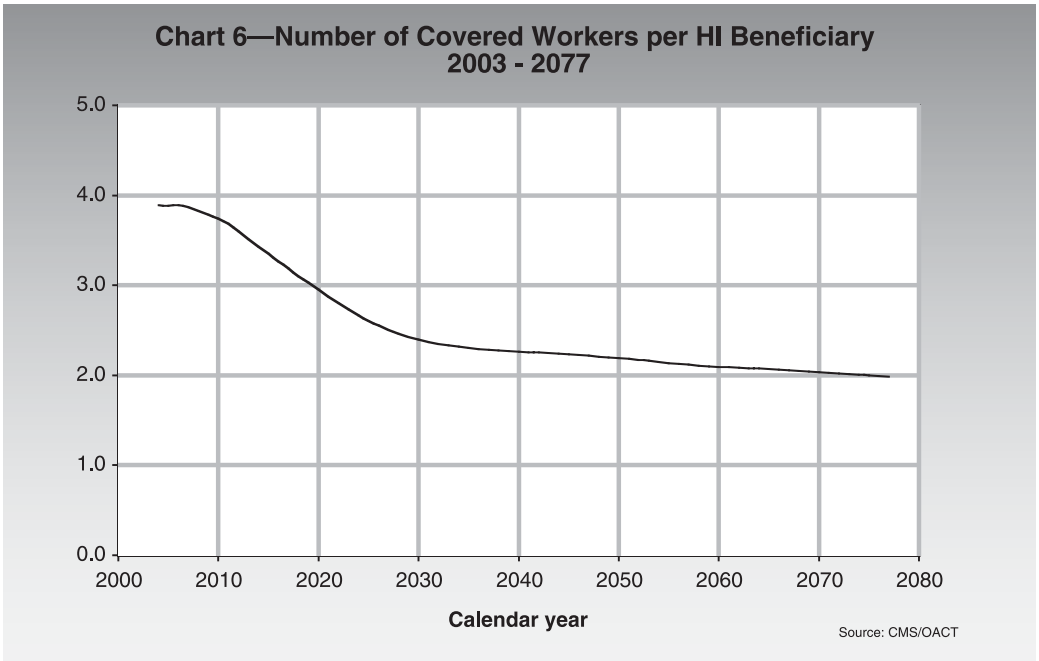


Also shown in chart 5 are SMI general revenue transfers and premium income expressed as a percentage of GDP.[4] Under present law, premiums will cover roughly 25 percent of total expenditures. As indicated, both sources of revenue would increase more rapidly than the GDP over time, to match the faster growth rates for SMI expenditures.

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 6 illustrates this ratio over the next 75 years. For the most part, current benefits are paid for by current workers. The retirement of the baby boom generation will therefore be financed by the relatively smaller number of persons born after the baby boom. In 2002, every beneficiary had almost 4.0 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.4 workers per beneficiary. The projected ratio continues to decline until there are just 2.0 workers per beneficiary in 2077.



ACTUARIAL PRESENT VALUES

Projected future expenditures can be summarized by computing an "actuarial present value." This value represents the lump-sum amount that, if invested today in trust fund

[4] See footnote 2 regarding the treatment of SMI general revenue income in the consolidated financial statement of the U.S. government.

securities, would be just sufficient to pay each year's expenditures over the next 75 years, with the fund being drawn down to zero at the end of the period. Similarly, future revenues (excluding interest) can be summarized as a single, equivalent amount as of the current year.

Actuarial present values are calculated by discounting the future annual amounts of non-interest income and expenditures at the assumed rates of interest credited to the HI and SMI trust funds. Present values are computed as of the beginning of the 75-year projection period for three different groups of participants: current workers and other individuals who have not yet attained eligibility age; current beneficiaries who have attained eligibility age; and new entrants, or those who are expected to become participants in the future.

Table 1 sets forth, for each of these three groups, the actuarial present values of all future HI and SMI expenditures and all future non-interest income for the next 75 years. Also shown is the net present value of cashflow, which is calculated by subtracting the actuarial present value of future expenditures from the actuarial present value of future income.

TABLE 1
Actuarial Present Values of Hospital Insurance and Supplementary Medical Insurance Revenues and Expenditures: 75-year Projection as of January 1, 2003
(In billions)

	HI				SMI[2]			
Actuarial present value[1] of estimated future income (excluding interest) received from or on behalf of:	**2003**	**2002**	**2001**	**2000**	**2003**	**2002**	**2001**	**2000**
Current participants[3] who, at the start of projection period:								
Have not yet attained eligibility age (ages 15-64)	$4,510	$4,408	$4,136	$3,757	$8,796	$7,423	$7,378	$6,109
Have attained eligibility age (age 65 and over)	128	125	113	97	1,160	1,008	1,032	934
Those expected to become participants (under age 15)	3,773	3,753	3,507	3,179	2,817	2,402	2,370	1,616
All current and future participants	**$8,411**	**$8,286**	**$7,757**	**$7,033**	**$12,773**	**$10,833**	**$10,780**	**$8,659**
Actuarial present value[1] of estimated future expenditures[4] paid to or on behalf of:								
Current participants[3] who, at the start of projection period:								
Have not yet attained eligibility age (ages 15-64)	$10,028	$9,195	$8,568	$6,702	$8,845	$7,463	$7,415	$6,094
Have attained eligibility age (age 65 and over)	1,897	1,747	1,693	1,681	1,306	1,132	1,159	1,051
Those expected to become participants (under age 15)	2,653	2,470	2,225	1,349	2,622	2,238	2,206	1,514
All current and future participants	**$14,577**	**$13,412**	**$12,487**	**$9,732**	**$12,773**	**$10,833**	**$10,780**	**$8,659**
Actuarial present value[1] of estimated future income (excluding interest) less expenditures	-6,166	-5,126	-4,730	-2,700	0	0	0	0
Trust fund assets at start of period	235	209	177	141	34	41	44	45
Assets at start of period plus actuarial present value[1] of estimated future income (excluding interest) less expenditures	**-$5,931**	**-$4,917**	**$-4,553**	**$-2,558**	**$34**	**$41**	**$44**	**$45**

[1] Present values are computed on the basis of the intermediate set of economic and demographic assumptions specified in the Report of the Boards of Trustees for the year shown and over the 75-year projection period beginning January 1 of that year.

[2] SMI income includes premiums paid by beneficiaries and general revenue contributions made on behalf of beneficiaries. See footnote 2 on page 57 concerning treatment of SMI general revenues in the consolidated financial statement of the U.S. government.

[3] Current participants are the "closed group" of individuals age 15 and over at the start of the period. The projection period for these current participants would theoretically cover all of their working and retirement years, a period that could be greater than 75 years in some instances. As a practical matter, the present values of future income and expenditures from/for current participants beyond 75 years are not material. The projection period for new entrants covers the next 75 years.

[4] Expenditures include benefit payments and administrative expenses.

Note: Totals do not necessarily equal the sums of rounded components.

As shown in table 1, the HI trust fund has an actuarial deficit of more than $5.9 trillion over the 75-year projection period, as compared to more than $4.9 trillion in the 2002 financial report. SMI, on the other hand, does not have similar problems because it is automatically in financial balance every year due to its financing mechanism.[5]

The existence of a large actuarial deficit for the HI trust fund indicates that, under reasonable assumptions as to economic, demographic, and health cost trends for the future, HI income is expected to fall substantially short of expenditures in the long range. Although the deficits are not anticipated in the immediate future, as indicated by the preceding cash-flow projections, they nonetheless pose a serious financial problem for the HI trust fund.

A figure as large as $5.9 trillion can be difficult to interpret without some relative basis of comparison. To put this number in perspective, it is helpful to consider that the present value of future taxable payroll over the same 75-year period is estimated to be $256 trillion in the 2003 Trustees Report. Thus, the $5.9-trillion deficit represents approximately 2.3 percent of future taxable payroll.

It is important to note that no liability has been recognized on the balance sheet for future payments to be made to current and future program participants beyond the existing "incurred but not reported" Medicare claim amounts as of September 30, 2003. This is because Medicare is accounted for as a social insurance program rather than a pension program. Accounting for a social insurance program recognizes the expense of benefits when they are actually paid, or are due to be paid, because benefit payments are primarily nonexchange transactions and, unlike employer-sponsored pension benefits for employees, are not considered deferred compensation. Accrual accounting for a pension program, by contrast, recognizes retirement benefit expenses as they are earned so that the full actuarial present value of the worker's expected retirement benefits has been recognized by the time the worker retires.

ACTUARIAL ASSUMPTIONS AND SENSITIVITY ANALYSIS

In order to make projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that the trust funds will continue under present law. In addition, the estimates depend on many economic and demographic assumptions, including changes in wages and the consumer price index (CPI), fertility 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.

[5] As noted in footnote 2 on page 57, the actuarial deficit is calculated from a *trust fund perspective*, reflecting all sources of income and expenditures to or from the HI and SMI trust funds. If, instead, a *budget perspective* is considered, as used in the consolidated financial statement, one would compare Medicare outlays to the public with revenues received directly from the public. On this basis, transfers to the SMI trust fund from the general fund of the Treasury would be excluded, with the result that the present value of projected SMI expenditures through 2077 would exceed the present value of projected SMI premium revenue alone by $9.6 trillion. When added to the corresponding differential for HI, the present value of expenditures for the Medicare program overall is projected to exceed receipts from the public by $15.8 trillion. This *budget impact* reflects both (i) the cost to the Federal budget of SMI general revenues provided under current law and (ii) the amount that HI revenues would have to be increased to enable HI benefits to be paid at their currently scheduled level—for which there is no provision in current law.

Table 2 shows some of the underlying assumptions used in the projections of Medicare spending displayed in this section. Further details on these assumptions are available in the Social Security and Medicare Trustees Reports for 2003. In practice, a number of 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 utilization, volume, and intensity of each type of service. The per beneficiary cost increases displayed in table 2 reflect the overall impact of these more detailed assumptions.

TABLE 2
Medicare Assumptions

					Annual percentage change in:				
	Fertility rate[1]	Net immigration	Real wage differential[2]	Wages	CPI	Real GDP	Per beneficiary cost[3] HI	SMI	Real Interest rate[4]
2003	2.04	1,200,000	1.6	3.9	2.3	2.9	2.0	5.5	2.8
2005	2.03	1,150,000	1.6	4.3	2.7	3.5	3.3	4.2	3.5
2010	2.01	1,025,000	1.2	4.2	3.0	2.5	4.2	5.7	2.9
2020	1.98	950,000	1.1	4.1	3.0	1.9	4.3	5.4	2.9
2030	1.95	900,000	1.1	4.1	3.0	1.9	5.9	5.5	2.9
2040	1.95	900,000	1.1	4.1	3.0	1.9	5.9	5.2	2.9
2050	1.95	900,000	1.1	4.1	3.0	1.8	5.2	4.9	2.9
2060	1.95	900,000	1.1	4.1	3.0	1.8	5.4	5.4	2.9
2070	1.95	900,000	1.1	4.1	3.0	1.8	5.5	5.2	2.9
2077	1.95	900,000	1.1	4.1	3.0	1.8	5.3	5.1	2.9

[1] Average number of children per woman.
[2] Difference between percentage increases in wages and the CPI.
[3] See text for nature of this assumption.
[4] Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

Estimates made in prior years have sometimes changed substantially because of revisions to the assumptions, which are due either to changed conditions or to more recent experience. 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. In order to illustrate the magnitude of the sensitivity of the long-range projections, six of the key assumptions were varied individually to determine the impact on the HI actuarial present values and net cashflows.[6] The assumptions varied are the fertility rate, net immigration, real-wage differential, CPI, real-interest rate, and health care cost factors.[7]

[6] Sensitivity analysis is not done for the SMI trust fund due to its financing mechanism. Any change in assumptions would have no impact on the net cashflow, since the change would affect income and expenditures equally.

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

For this analysis, the intermediate economic and demographic assumptions in the ***2003 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, 2003 and are based on estimates of income and expenditures during the 75-year projection period.

Charts 7 through 12 show the net annual HI cashflow in nominal dollars and the present value of this net cashflow for each assumption varied. In most instances, the charts depicting the estimated net cashflow indicate that, after increasing in the early years, net cashflow decreases steadily through 2026 under all three scenarios displayed. On the present value charts, the same pattern is evident, though the magnitudes are lower because of the discounting process used for computing present values.

Fertility Rate

Table 3 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.7, 1.95, and 2.2 children per woman.

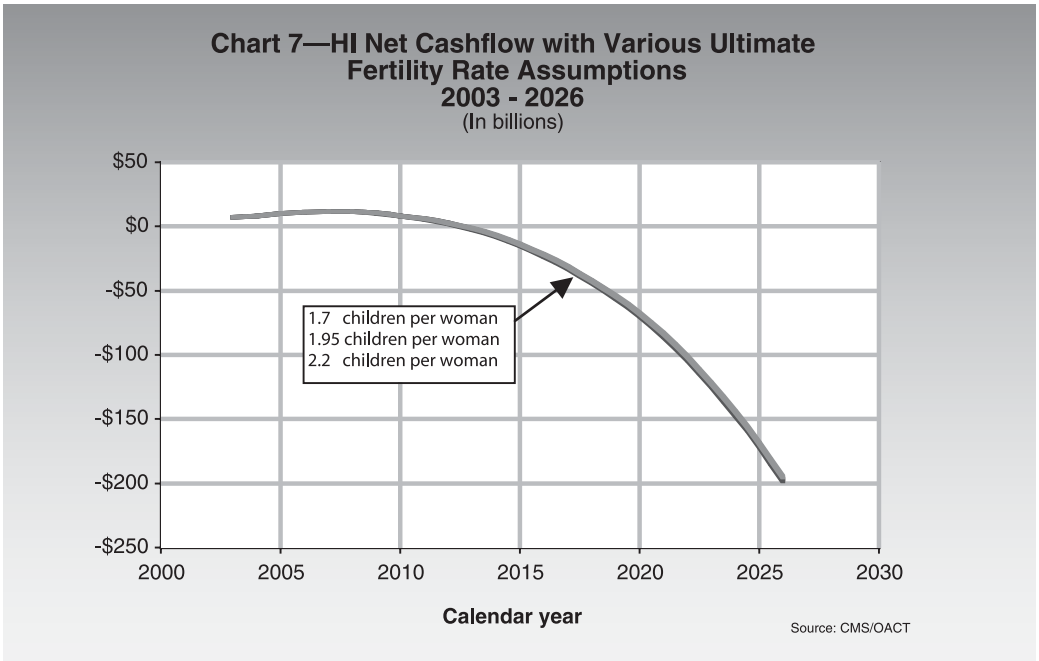
TABLE 3
Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate fertility rate[1]	1.7	1.95	2.2
Income minus expenditures *(in billions)*	-$6,323	-$6,166	-$6,014

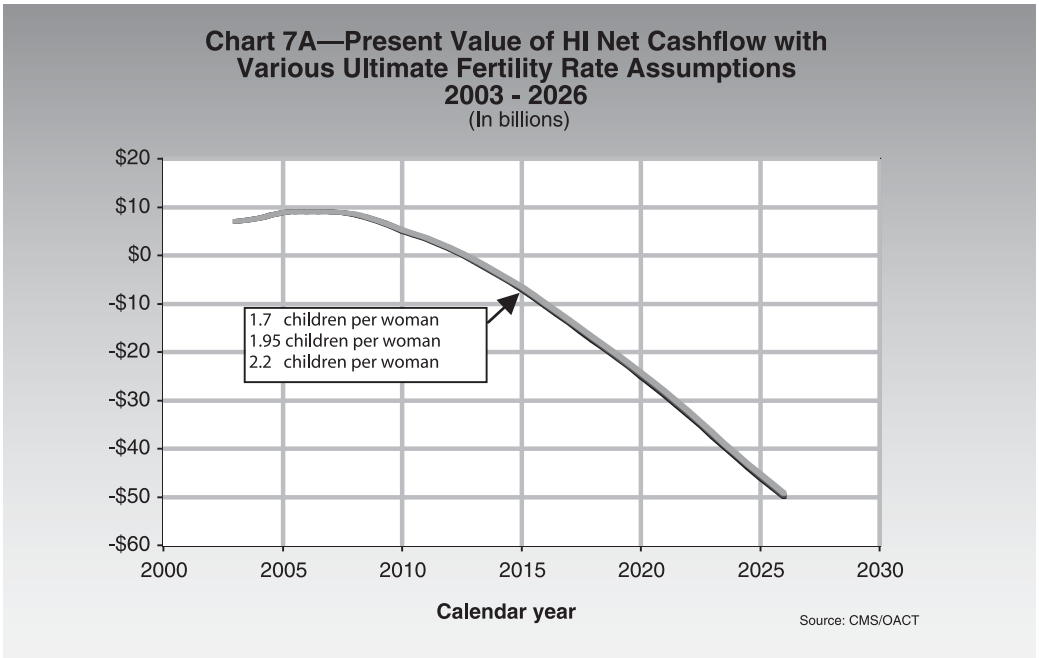
[1] The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year, and if she were to survive the entire childbearing period.

As table 3 demonstrates, for every increase of 0.25 in the assumed ultimate fertility rate, the projected deficit of income over expenditures decreases by approximately $150 billion.

Charts 7 and 7A show projections of the net cashflow under the three alternative fertility rate assumptions presented in table 3.



As charts 7 and 7A indicate, the fertility rate assumption has only a negligible impact on projected HI cashflows over the next 30 years. This is because higher fertility in the first year does not affect the labor force until roughly 20 years have passed (increasing HI payroll taxes slightly) and has virtually no impact on the number of beneficiaries within this period. Over the full 75-year period, the changes are somewhat greater, as illustrated by the present values in table 3.



Net Immigration

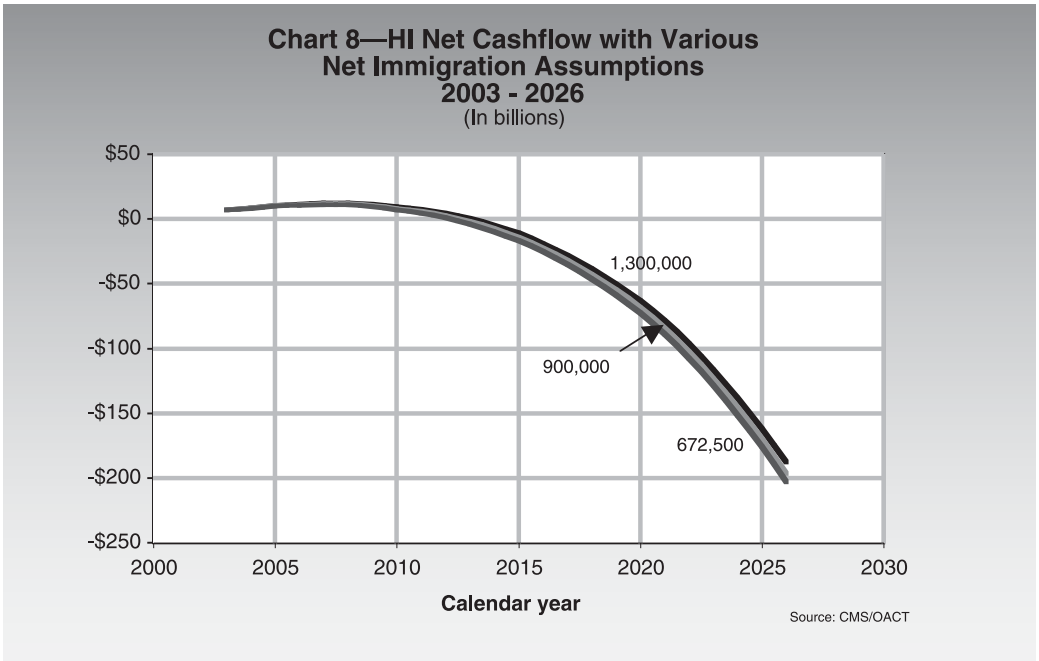
Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative net immigration assumptions: 672,500 persons, 900,000 persons, and 1,300,000 persons per year.

TABLE 4
Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

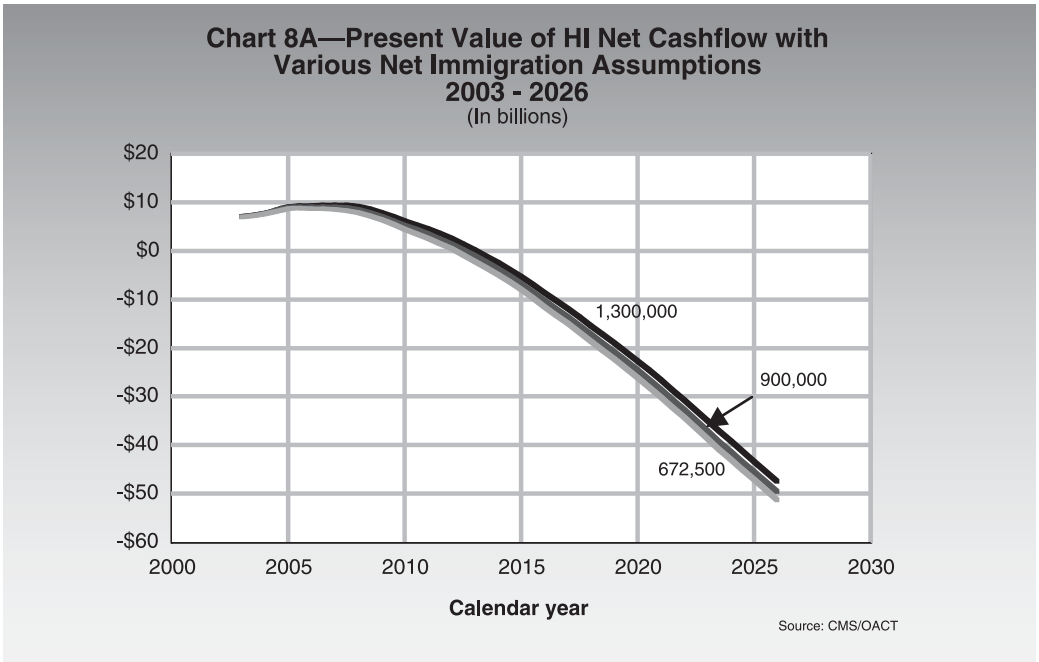
Ultimate net immigration	672,500	900,000	1,300,000
Income minus expenditures *(in billions)*	-$6,379	-$6,166	-$5,849

As shown in table 4, for every increase of 100,000 persons on the ultimate net immigration assumption, the deficit of income over expenditures decreases by nearly $100 billion.

Charts 8 and 8A show projections of the net cashflow under the three alternative net immigration assumptions presented in table 4.



As charts 8 and 8A indicate, this assumption has an impact on projected HI cashflow starting almost immediately. Because immigration tends to occur among younger individuals, the number of covered workers is affected immediately, while the number of beneficiaries is affected much less quickly. Nonetheless, variations in net immigration result in fairly small differences in cashflow.



Real-Wage Differential

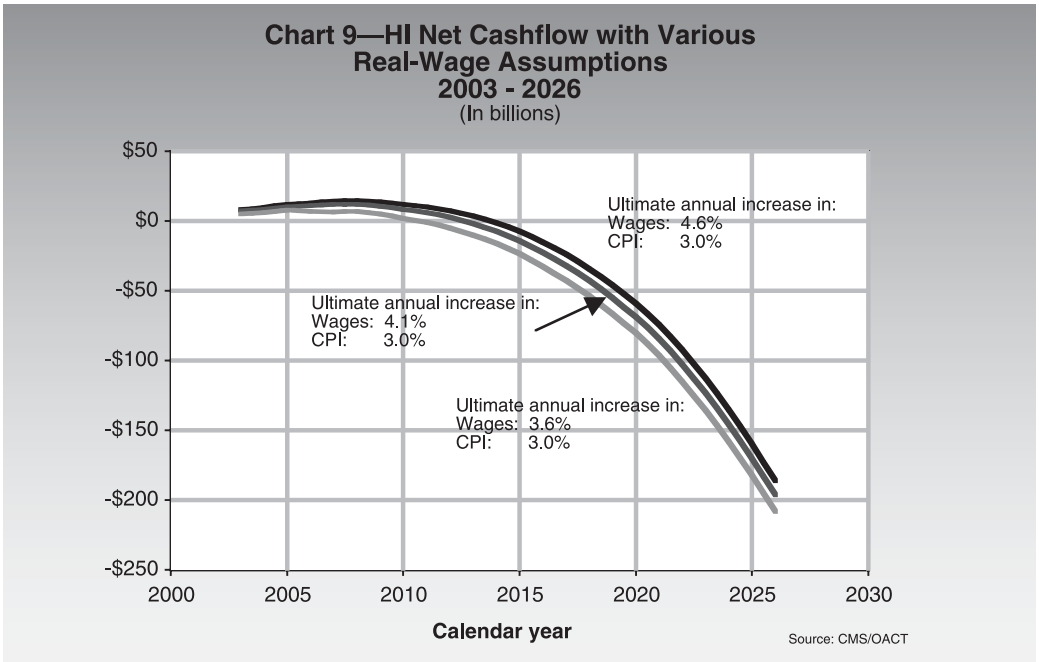
Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.6, 1.1, and 1.6 percentage points. In each case, the CPI is assumed to be 3.0 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.6, 4.1, and 4.6 percent, respectively.

TABLE 5
Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions

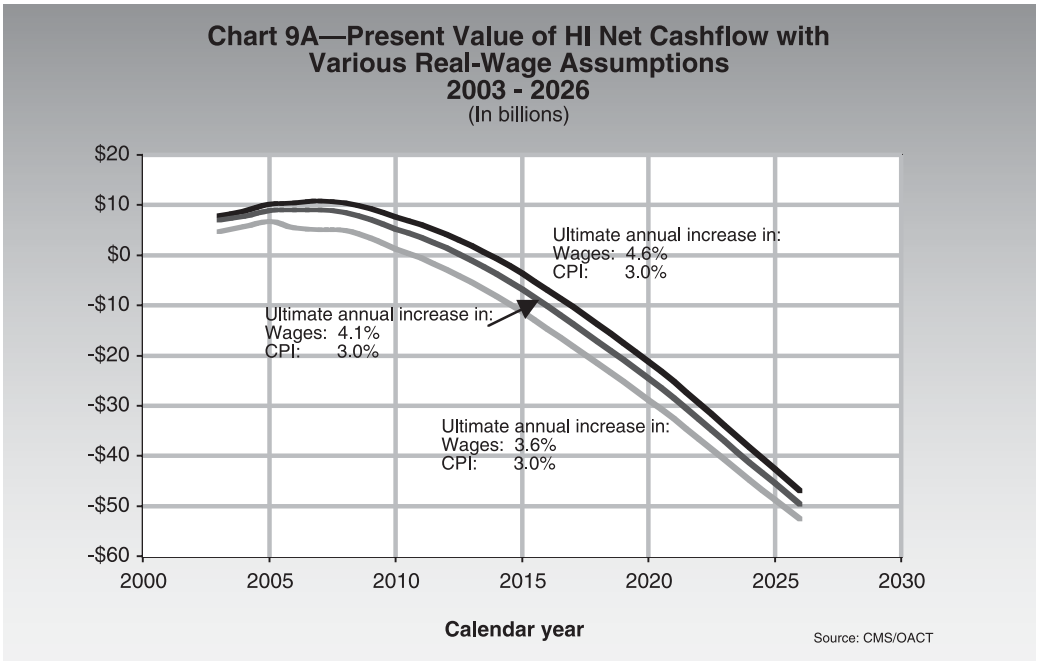
Ultimate percentage increase in wages - CPI	3.6 - 3.0	4.1 - 3.0	4.6 - 3.0
Ultimate percentage increase in real-wage differential	0.6	1.1	1.6
Income minus expenditures *(in billions)*	-$6,538	-$6,166	-$5,816

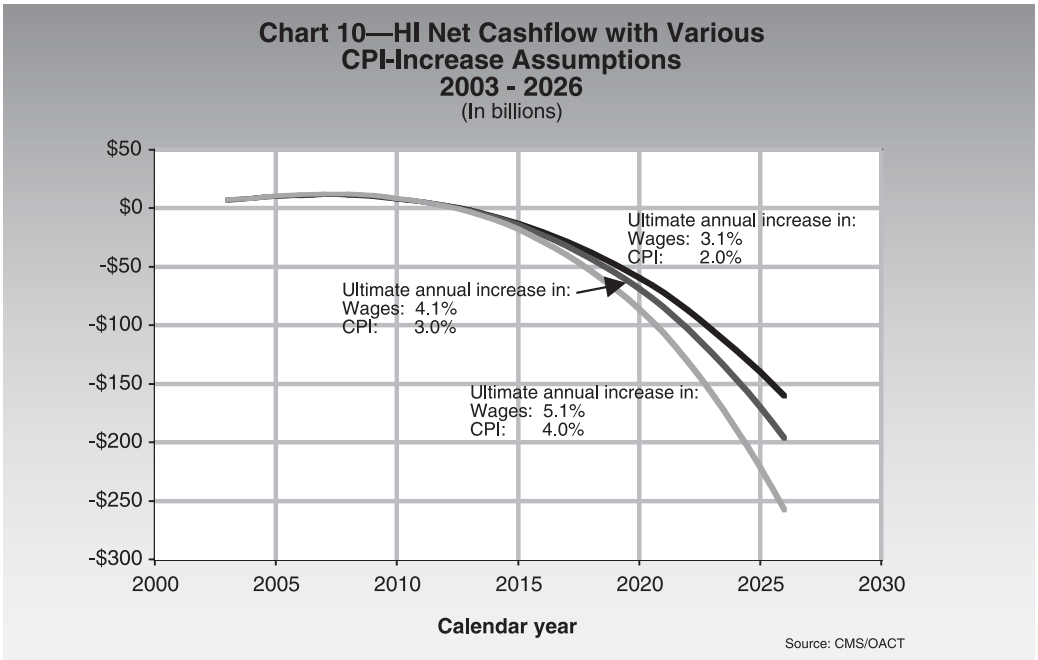
Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.6, 1.1, and 1.6 percentage points. In each case, the CPI is assumed to be 3.0 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.6, 4.1, and 4.6 percent, respectively.

As indicated in table 5, for every half-point increase in the ultimate real-wage differential assumption, the deficit of income over expenditures decreases by approximately $360 billion.



As charts 9 and 9A indicate, this assumption has a fairly large impact on projected HI cashflow very early in the projection period. Higher real-wage differential assumptions immediately increase both HI expenditures for health care and wages for all workers. Though there is a full effect on wages and payroll taxes, the effect on benefits is only partial, since not all health care costs are wage-related.





Consumer Price Index

Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 2.0, 3.0, and 4.0 percent. In each case, the ultimate real-wage differential is assumed to be 1.1 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.1, 4.1, and 5.1 percent, respectively.

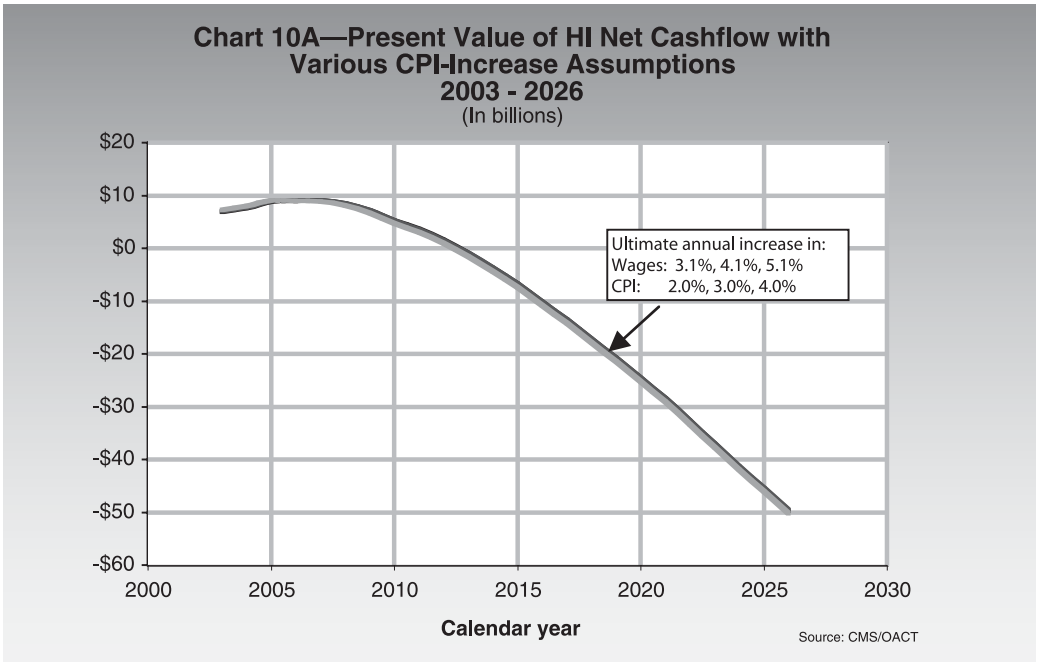
TABLE 6
Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

Ultimate percentage increase in wages - CPI	3.1 - 2.0	4.1 - 3.0	5.1 - 4.0
Income minus expenditures *(in billions)*	-$6,189	-$6,166	-$6,182

Table 6 demonstrates that for every 1-point change in the ultimate CPI-increase assumption, the deficit of income over expenditures changes by approximately $20 billion.

Charts 10 and 10A show projections of the net cashflow under the three alternative CPI rate-of-increase assumptions presented in table 6.

As charts 10 and 10A indicate, this assumption has a large impact on projected HI cashflow in nominal dollars but only a negligible impact when the cashflow is expressed as present values. The relative insensitivity of the projected present values of HI cashflow to different levels of general inflation occurs because inflation tends to affect both income and costs equally. In nominal dollars, however, a given deficit “looks bigger”



under high-inflation conditions but is not significantly different when it is expressed as a present value or relative to taxable payroll. This sensitivity test serves as a useful example of the limitations of nominal-dollar projections over long periods.

Real-Interest Rate

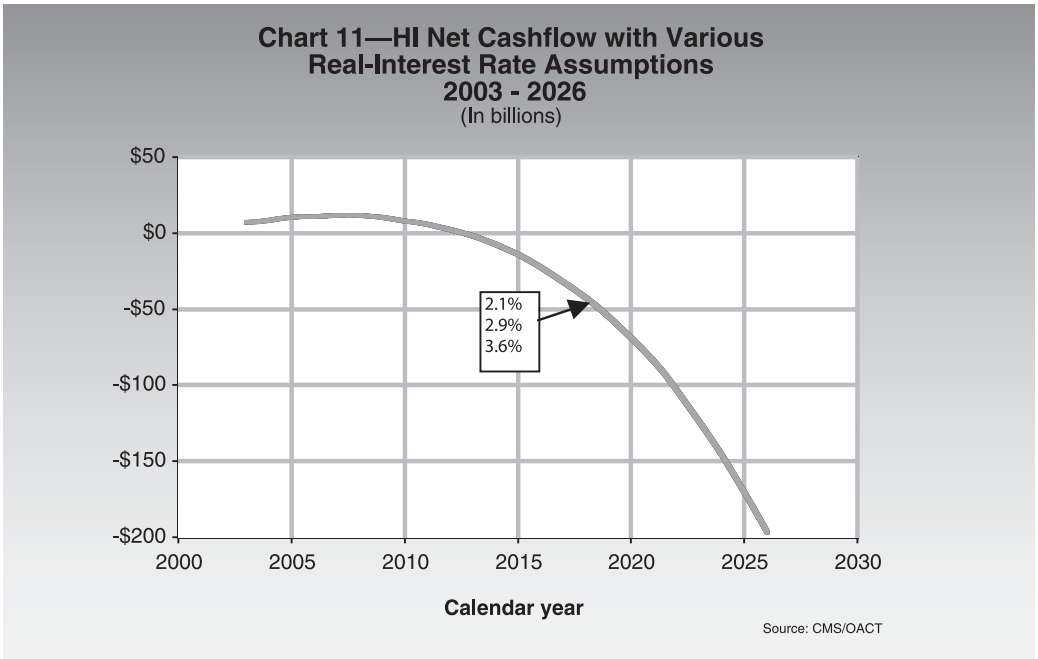
Table 7 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.1, 2.9, and 3.6 percent. In each case, the ultimate annual increase in the CPI is assumed to be 3.0 percent, resulting in ultimate annual yields of 5.1, 5.9, and 6.6 percent, respectively.

TABLE 7
Present Value of Estimated HI Income Less Expenditures under Various Real-Interest Assumptions

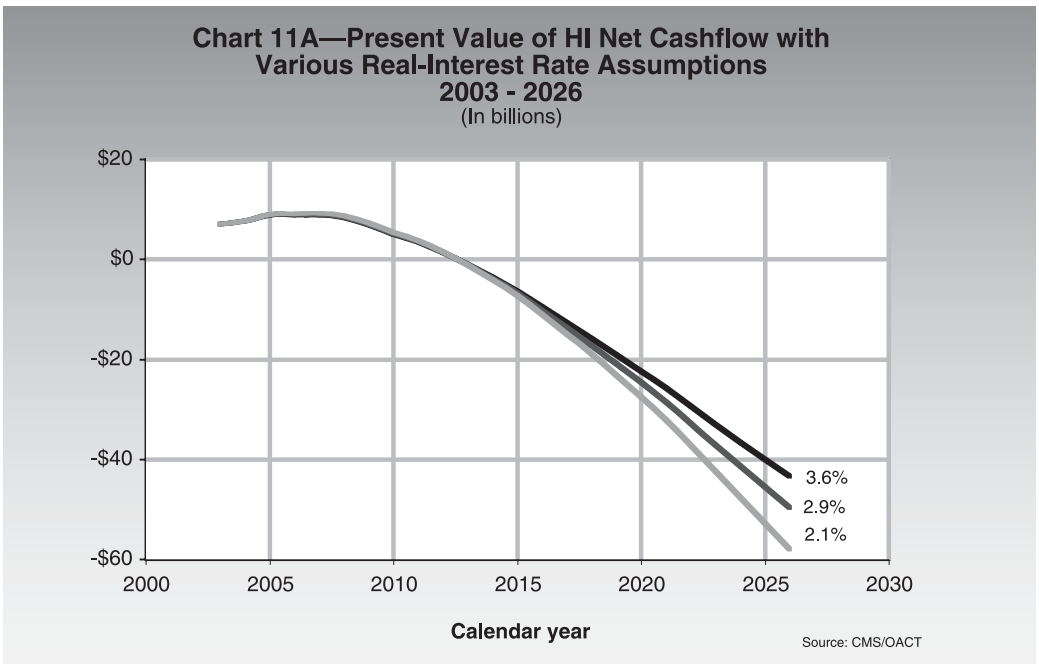
Ultimate real-interest rate	2.1 %	2.9 %	3.6 %
Income minus expenditures *(in billions)*	-$8,962	-$6,166	-$4,501

As illustrated in table 7, for every increase of 0.1 in the ultimate real-interest rate percentage, the deficit of income over expenditures decreases by approximately $300 billion.

Charts 11 and 11A show projections of the net cashflow under the three alternative real-interest assumptions presented in table 7.



As shown in charts 11 and 11A, the present values of the net cashflow are more sensitive to the interest assumption than is the nominal net cashflow. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI trust fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2026. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), and the overall net present value is smaller.



Health Care Cost Factors

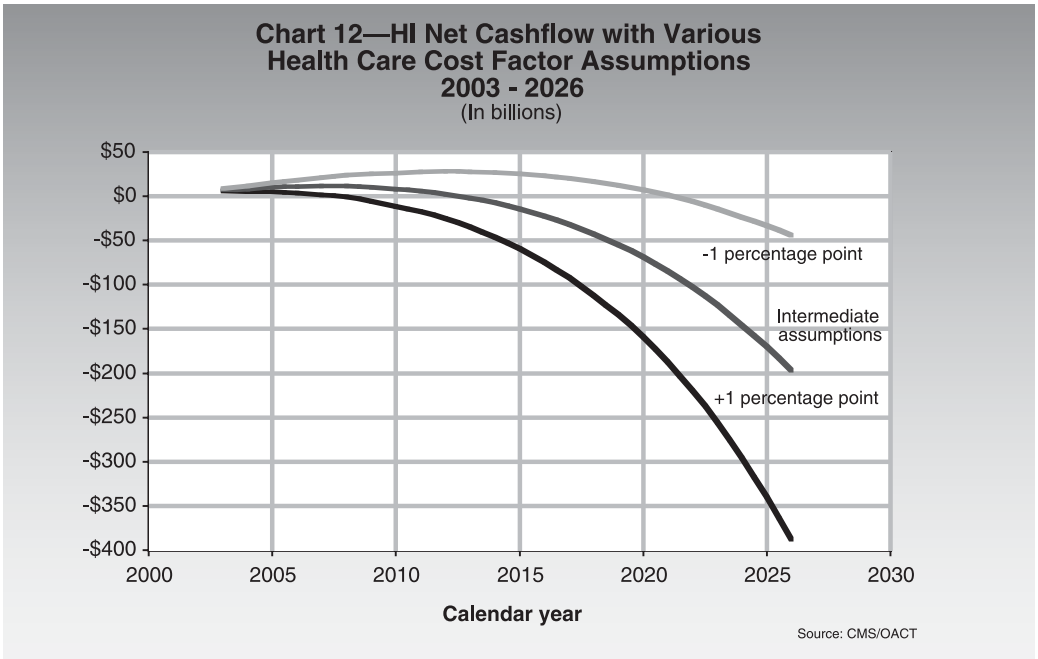
Table 8 shows the net present value of cashflow during the 75-year projection period under three alternative assumptions of the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, relative to taxable payroll, will be 1 percent slower than the intermediate assumptions, the same as the intermediate assumptions, and 1 percent faster than the intermediate assumptions. In each case, the taxable payroll will be the same as that which was assumed for the intermediate assumptions.

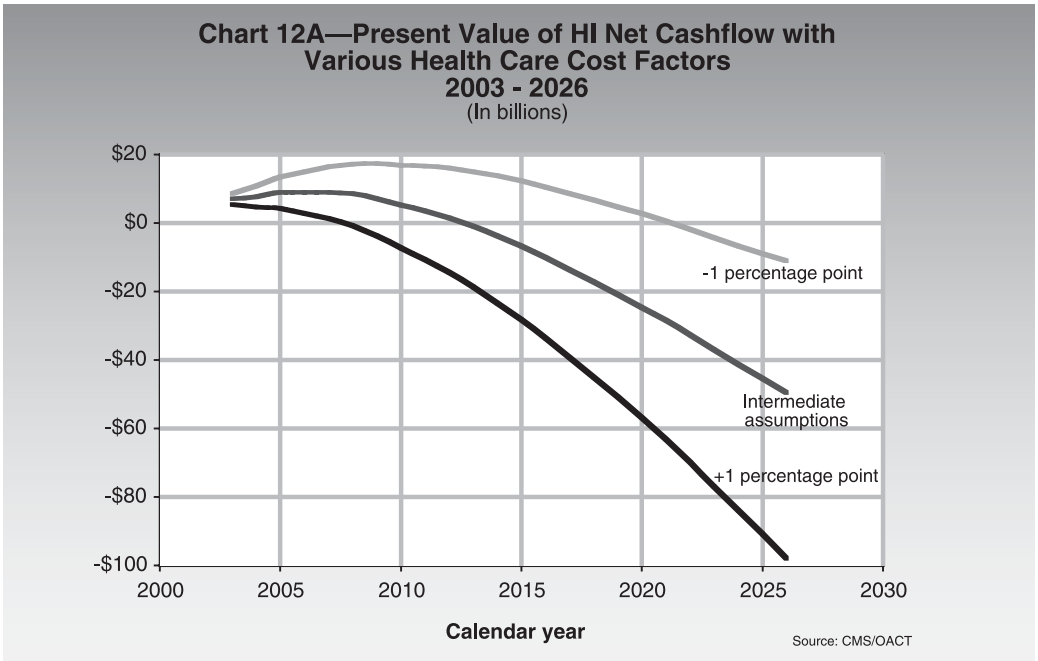
TABLE 8
Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	-1 percentage point	Intermediate assumptions	+ 1 percentage point
Income minus expenditures *(in billions)*	-$1,583	-$6,166	-$13,684

Table 8 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit of income over expenditures decreases by $4,583 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases more substantially, by $7,518 billion.

Charts 12 and 12A show projections of the net cashflow under the three alternative annual growth rate assumptions presented in table 8.





This assumption has a dramatic impact on projected HI cashflow. The assumptions analyzed thus far have affected HI income and costs simultaneously. However, 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 charts 12 and 12A indicate, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs versus taxable payroll.

TRUST FUND FINANCES AND SUSTAINABILITY

HI

The HI trust fund is substantially out of financial balance in the long range. Under the Medicare Trustees' intermediate assumptions, income from all sources is projected to continue to exceed expenditures for the next 15 years but to fall short by steadily increasing amounts in 2018 and later. These shortfalls can be met by increasingly drawing on interest payments on invested assets and the redemption of those assets, but only until 2026 when assets would be exhausted. In the absence of corrective legislation, a depleted trust fund would initially produce payment delays, but very quickly lead to a curtailment of health care services to beneficiaries.

Bringing the HI trust fund into actuarial balance over the next 75 years under the intermediate assumptions would require very substantial increases in revenues and/or reductions in benefits. These changes are needed in part as a result of the impending retirement of the baby boom generation.

SMI

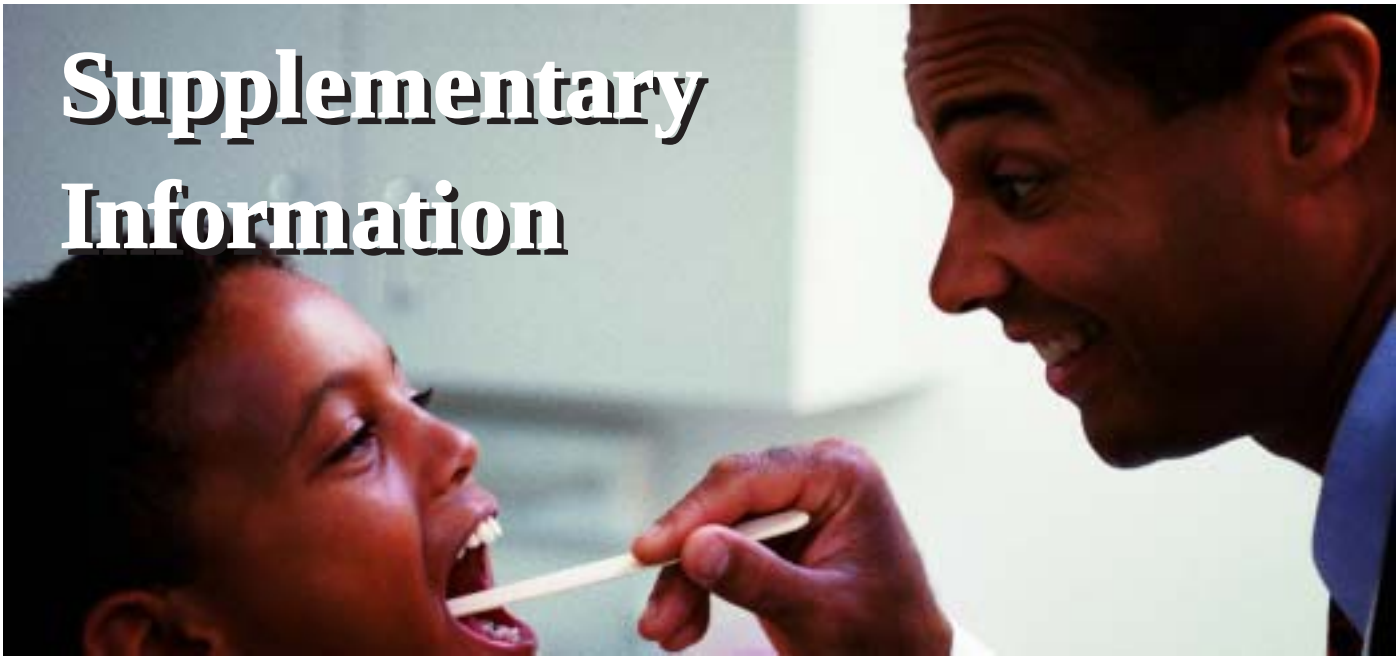
The financing established for the SMI trust fund for calendar year 2003, along with a portion of trust fund assets, is estimated to be sufficient to cover expenditures for that year and to still preserve an adequate contingency reserve in the fund. Moreover, for all future years, trust fund income is projected to equal expenditures—but only because beneficiary premiums and government general revenue contributions are set to meet expected costs each year. However, a critical issue for the SMI trust fund is the impact of the past and expected rapid growth of SMI costs, which place steadily increasing demands on beneficiaries and society at large.

The SMI trust fund's automatic financing provisions prevent crises such as those faced in the mid-1990s by the HI trust fund, the assets of which were projected to be exhausted in the near future. As a result, there has been substantially less attention directed toward the financial status of the SMI trust fund than to the HI trust fund—even though SMI expenditures have increased faster than HI expenditures in most years and are expected to continue to do so for a number of years in the future.

Medicare Overall

The projections shown in this section continue to demonstrate the need for the Administration and the Congress to address the financial challenges facing Medicare—both the long-range financial imbalance facing the HI trust fund and the continuing problem of rapid growth in SMI expenditures. In their 2003 annual report to Congress, the Medicare Boards of Trustees emphasize the seriousness of these concerns and urge the nation's policy makers to take "effective and decisive action…to build upon the strong steps taken in recent reforms." They also state: "Consideration of further reforms should occur in the relatively near future."

Supplementary Information



CONSOLIDATING BALANCE SHEET
As of September 30, 2003

(in millions)

	MEDICARE			HEALTH			Combined	Intra-CMS	Consolidated
	HI	SMI	Total	Medicaid	SCHIP	All Others	Totals	Eliminations	Totals
ASSETS									
Intragovernmental Assets:									
Fund Balance with Treasury	$(206)	$(178)	$(384)	$8,788	$9,754	$378	$18,536		$18,536
Trust Fund Investments	254,980	25,320	280,300				280,300		280,300
Accounts Receivable, Net	2,248	4,451	6,699	88	3	19	6,809	$(6,109)	700
Other Assets:									
Anticipated Congressional Appropriation		3,381	3,381	8,449			11,830		11,830
Other	1	2	3				3		3
Total Intragovernmental Assets	**257,023**	**32,976**	**289,999**	**17,325**	**9,757**	**397**	**317,478**	**(6,109)**	**311,369**
Cash & Other Monetary Assets	214	629	843				843		843
Accounts Receivable, Net	1,302	751	2,053	539		28	2,620		2,620
General Property, Plant & Equipment, Net	4	8	12	1			13		13
Other	26	36	62	4		6	72		72
TOTAL ASSETS	**$258,569**	**$34,400**	**$292,969**	**$17,869**	**$9,757**	**$431**	**$321,026**	**$(6,109)**	**$314,917**
LIABILITIES									
Intragovernmental Liabilities:									
Accounts Payable	$1,750	$4,605	$6,355				$6,355	$(6,109)	$246
Accrued Payroll and Benefits	1	2	3				3		3
Other Intragovernmental Liabilities	61	138	199	$3		$31	233		233
Total Intragovernmental Liabilities	**1,812**	**4,745**	**6,557**	**3**		**31**	**6,591**	**(6,109)**	**482**
Federal Employee & Veterans' Benefits	3	7	10	1			11		11
Entitlement Benefits Due & Payable	15,007	15,332	30,339	17,784			48,123		48,123
Accrued Payroll & Benefits	15	28	43	3			46		46
Other Liabilities	62	188	250			6	256		256
TOTAL LIABILITIES	**16,899**	**20,300**	**37,199**	**17,791**		**37**	**55,027**	**(6,109)**	**48,918**
NET POSITION									
Unexpended Appropriations	45	3,380	3,425		$9,755	261	13,441		13,441
Cumulative Results of Operations	241,625	10,720	252,345	78	2	133	252,558		252,558
TOTAL NET POSITION	**$241,670**	**$14,100**	**$255,770**	**$78**	**$9,757**	**$394**	**$265,999**		**$265,999**
TOTAL LIABILITIES & NET POSITION	**$258,569**	**$34,400**	**$292,969**	**$17,869**	**$9,757**	**$431**	**$321,026**	**$(6,109)**	**$314,917**

SUPPLEMENTARY INFORMATION

CONSOLIDATING STATEMENT OF NET COST
For the Year Ended September 30, 2003
(in millions)

	MEDICARE			HEALTH			Combined	Intra-CMS	Consolidated
	HI	SMI	Total	Medicaid	SCHIP	All Others	Totals	Eliminations	Totals
NET PROGRAM/ACTIVITY COSTS									
GPRA Programs									
Medicare	$152,616	$97,458	$250,074				$250,074		$250,074
Medicaid				$161,721			161,721		161,721
SCHIP					$4,360		4,360		4,360
NET COST—GPRA PROGRAMS	**152,616**	**97,458**	**250,074**	**161,721**	**4,360**		**416,155**		**416,155**
Other Activities									
CLIA						$33	33		33
Ticket to Work Incentive						14	14		14
Other						(4)	(4)		(4)
NET COST—OTHER ACTIVITIES						**43**	**43**		**43**
NET COST OF OPERATIONS	**$152,616**	**$97,458**	**$250,074**	**$161,721**	**$4,360**	**$43**	**$416,198**		**$416,198**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2003
(in millions)

	MEDICARE			HEALTH			Consolidated
	HI	SMI	Total	Medicaid	SCHIP	All Others	Totals
CUMULATIVE RESULTS OF OPERATIONS							
Beginning Balances	$220,585	$25,885	$246,470	$76	$2	$159	$246,707
Budgetary Financing Sources:							
Appropriations Used	8,945	80,905	89,850	161,433	4,355	14	255,652
Nonexchange Revenue	164,977	2,223	167,200				167,200
Transfers-in/out Without Reimbursement	(276)	(856)	(1,132)	288	5	3	(836)
Other Financing Sources:							
Imputed Financing from Costs Absorbed by Others	10	21	31	2			33
TOTAL FINANCING SOURCES	**173,656**	**82,293**	**255,949**	**161,723**	**4,360**	**17**	**422,049**
NET COST OF OPERATIONS	**152,616**	**97,458**	**250,074**	**161,721**	**4,360**	**43**	**416,198**
ENDING BALANCES	**$241,625**	**$10,720**	**$252,345**	**$78**	**$2**	**$133**	**$252,558**
UNEXPENDED APPROPRIATIONS							
Beginning Balances	$3	$3,014	$3,017		$10,934	$145	$14,096
Budgetary Financing Sources:							
Appropriations Received	8,990	80,905	89,895	$165,898	5,382	132	261,307
Appropriations Transferred-in/out				(1,167)			(1,167)
Other Adjustments	(3)	366	363	(3,298)	(2,206)	(2)	(5,143)
Appropriations Used	(8,945)	(80,905)	(89,850)	(161,433)	(4,355)	(14)	(255,652)
TOTAL FINANCING SOURCES	**42**	**366**	**408**		**(1,179)**	**116**	**(655)**
ENDING BALANCES	**$45**	**$3,380**	**$3,425**		**$9,755**	**$261**	**$13,441**

COMBINING STATEMENT OF BUDGETARY RESOURCES (Required)
For the Year Ended September 30, 2003

(in millions)

	MEDICARE HI	MEDICARE SMI	HCFAC	Payments to Trust Funds	Program Mgmt.	Medicaid	SCHIP	Ticket to Work	HMO Loan	Combined Totals
Budgetary Resources:										
Budget Authority:										
Appropriations received	$175,804	$110,180		$89,895	$17	$165,898	$5,382	$132		$547,308
Net transfers	(1,052)		$1,057			(1,167)				(1,162)
Unobligated Balance:										
Beginning of period			44	3,017	204			82	$11	3,358
Net transfers, actual			(5)							(5)
Spending authority from offsetting collections:										
Earned:										
Collected			3		62					65
Change in unfilled customer orders:										
Advance received					(4)					(4)
Without advance from Federal sources					6					6
Transfers from trust funds					2,533	112				2,645
SUBTOTAL			**3**		**2,597**	**112**				**2,712**
Recoveries of prior year obligations			117		290	4,445	2,376			7,228
Temporarily not available pursuant to Public Law	(21,699)	14,025								(7,674)
Permanently not available				(3,017)	(19)	(1,347)	(2,206)			(6,589)
TOTAL BUDGETARY RESOURCES	**$153,053**	**$124,205**	**$1,216**	**$89,895**	**$3,089**	**$167,941**	**$5,552**	**$214**	**$11**	**$545,176**
Status of Budgetary Resources:										
Obligations Incurred:										
Direct	$153,053	$124,205	$1,179	$89,850	$2,796	$167,941	$5,545	$20		$544,589
Reimbursable			5		71					76
SUBTOTAL	**153,053**	**124,205**	**1,184**	**89,850**	**2,867**	**167,941**	**5,545**	**20**		**544,665**
Unobligated Balance:										
Apportioned			5	45	56		7	194		307
Unobligated Balance not available			27		166				$11	204
TOTAL STATUS OF BUDGETARY RESOURCES	**$153,053**	**$124,205**	**$1,216**	**$89,895**	**$3,089**	**$167,941**	**$5,552**	**$214**	**$11**	**$545,176**
Relationship of Obligations to Outlays:										
Obligated Balance, net, beginning of period	$968	$922	$213		$(219)	$5,049	$10,934	$34		$17,901
Obligated Balance, net, end of period:										
Accounts receivable					(1,185)					(1,185)
Unfulfilled customer orders from Federal sources					(6)					(6)
Undelivered orders	671	197	243		944		9,748	39		11,842
Accounts payable	557	875	7		60	8,797				10,296
Outlays:										
Disbursements	152,793	124,055	1,030	$89,850	2,497	159,748	4,355	15		534,343
Collections			(3)		(2,549)	(112)				(2,664)
SUBTOTAL	**152,793**	**124,055**	**1,027**	**89,850**	**(52)**	**159,636**	**4,355**	**15**		**531,679**
LESS: OFFSETTING RECEIPTS	**1,598**	**26,834**								**28,432**
NET OUTLAYS	**$151,195**	**$97,221**	**$1,027**	**$89,850**	**$(52)**	**$159,636**	**$4,355**	**$15**		**$503,247**

SUPPLEMENTARY INFORMATION

GROSS COST AND EXCHANGE REVENUE (Required)
For the Year Ended September 30, 2003
(in millions)

PROGRAM/ACTIVITY	INTRAGOVERNMENTAL						WITH THE PUBLIC		Consolidated
	Gross Cost			Less: Exchange Revenue			Gross	Less:	Net Cost of
	Combined	Eliminations	Consolidated	Combined	Eliminations	Consolidated	Cost	Exchange	Operations
NET PROGRAM/ACTIVITY COSTS									
GPRA Programs									
Medicare									
HI	$332		$332	$2		$2	$153,886	$1,600	$152,616
SMI	111		111	4		4	124,185	26,834	97,458
Medicaid	12		12				161,709		161,721
SCHIP	1		1				4,359		4,360
SUBTOTAL	**456**		**456**	**6**		**6**	**444,139**	**28,434**	**416,155**
Other Activities									
CLIA	23		23				67	57	33
TWI							14		14
Other							(4)		(4)
SUBTOTAL	**23**		**23**				**77**	**57**	**43**
PROGRAM/ACTIVITY TOTALS	**$479**		**$479**	**$6**		**$6**	**$444,216**	**$28,491**	**$416,198**

CONSOLIDATED INTRAGOVERNMENTAL BALANCES (Required)
For the Year Ended September 30, 2003
(in millions)

	*TFM Dept. Code	Fund Bal. with Treasury	Investments	Accounts Receivable	Other
INTRAGOVERNMENTAL ASSETS					
Agency					
Department of the Treasury	20, 99	$18,536	$280,300	$147	$11,830
Department of Commerce	13				3
Department of Defense	17, 21 57, 97			147	
Railroad Retirement Board	60			406	
		$18,536	**$280,300**	**$700**	**$11,833**

	*TFM Dept. Code	Accounts Payable	Environmental & Disposal Costs	Accrued Payroll & Benefits	Other
INTRAGOVERNMENTAL LIABILITIES					
Agency					
Department of Labor	16			$2	
Department of the Treasury	20, 99				$184
Office of Personnel Management	24			1	
Social Security Administration	28	$246			
General Services Administration	47				13
Department of Health and Human Services	75				1
All Other Federal Agencies					35
		$246		**$3**	**$233**

	*TFM Dept. Code	Earned Revenue	Gross Cost	Non-exchange Revenue Transfers-in	Transfers-out
INTRAGOVERNMENTAL REVENUES & EXPENSES					
Agency					
Department of Justice	15	$1	$114		
Department of Labor	16		2		
Department of the Treasury	20, 99		2		
Department of Defense	17, 21 57, 97			$32	
Office of Personnel Management	24		83		
Social Security Administration	28			2	$(1,236)
General Services Administration	47		45		
Railroad Retirement Board	60			389	(5)
Department of Transportation	69				
Department of Health and Human Services	75	4	193		(9)
Department of Housing and Urban Development	86	1			
All Other Federal Agencies			40		(9)
		$6	**$479**	**$423**	**$(1,259)**

* Treasury Financial Manual

Audit Opinion

Department of Health and Human Services

CENTERS FOR MEDICARE & MEDICAID SERVICES

NOV - 7 2003

TO: Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

FROM: Dara Corrigan
Acting Principal Deputy Inspector General

SUBJECT: Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2003 (A-17-03-03003)

The attached final report presents the results of the audit of the fiscal year (FY) 2003 financial statements of the Centers for Medicare & Medicaid Services (CMS). We contracted with PricewaterhouseCoopers LLP (PWC), an independent certified public accounting firm, to perform the CMS audit, which supports the Office of Inspector General's Departmentwide audit in accordance with the Government Management Reform Act of 1994.

The audit objectives were to determine whether (1) the CMS consolidated balance sheets as of September 30, 2003 and 2002 and the related consolidated statement of net costs, consolidated statement of changes in net position, combined statement of budgetary resources, and consolidated statement of financing for the FYs then ended were presented fairly in all material respects; (2) CMS internal controls provided reasonable assurance that transactions were properly recorded and accounted for to permit the preparation of reliable financial statements; and (3) CMS complied with laws and regulations that could have a direct and material effect on the financial statements.

We evaluated the nature, timing, and extent of the work; monitored progress throughout the audit; reviewed PWC's documentation; evaluated the key judgments; performed independent tests of the accounting records; met with PWC partners and staff members and with CMS officials; and performed other procedures we deemed appropriate. We conducted our work in accordance with auditing standards generally accepted in the United States.

We concur with PWC's report, which indicated the following:

- The financial statements referred to above present fairly, in all material respects, the financial position of CMS and its net costs, changes in net position, budgetary resources, and financing as of September 30, 2003 and 2002 in conformity with accounting principles generally accepted in the United States.

- Certain matters involving internal controls over financial reporting were reportable, two of which were deemed to be material weaknesses under standards issued by the American Institute of Certified Public Accountants.

- CMS's financial management systems were not substantially compliant with certain requirements of the Federal Financial Management Improvement Act of 1996.

We commend CMS for sustaining the unqualified audit opinion first issued on the FY 1999 financial statements and for meeting the accelerated FY 2003 reporting deadline. Although CMS has continued to make progress in providing reliable financial information, the agency remains impaired by the absence of a fully integrated financial management system to accumulate, analyze, and report financial information in a timely manner. As discussed in the auditor's report on internal controls, material weaknesses remain in financial systems, analyses, and oversight and in Medicare electronic data processing (EDP) controls.

Financial Systems, Analyses, and Oversight. As reported in FY 2002 and continuing in FY 2003, the Medicare contractors relied on a combination of claims processing systems, personal-computer-based software applications, and other ad hoc systems to prepare information for CMS. Reliance on such systems increased the risk that the reported information could be inconsistent, incomplete, or inaccurate. In addition, CMS's oversight of the Medicare contractors and monitoring of accounts receivable activities remained a weakness. CMS should continue to enhance its oversight of information included in the financial statements, and the regional offices should ensure that the contractors' financial data are reliable, accurate, and complete.

Further, CMS was unable to provide documentation on its review and approval process for managed care applications. Additionally, CMS regional offices did not maintain sufficient documentation on monitoring managed care plans, and existing documentation was not consistent among the regional offices. These weaknesses increased the risk that a plan could be inappropriately accepted into, or allowed to continue participation in, the Medicare program.

Medicare Electronic Data Processing Controls. To administer the Medicare program and to process and account for Medicare expenditures, CMS relies on extensive, interdependent EDP operations at its central office and Medicare contractor sites. Adequate internal controls over these operations are essential to ensuring the integrity, confidentiality, and reliability of critical data and reducing the risk of errors, fraud, and other illegal acts. In FY 2003, numerous EDP general control weaknesses continued to be found at the Medicare contractors and the CMS central office. Some contractors did not have an overall entity-wide security program, and almost all contractor sites had significant weaknesses in their plans. Other noted weaknesses increased the risk of (1) unauthorized access to and disclosure of sensitive information, (2) malicious changes that could interrupt data processing or destroy files, (3) improper Medicare payments, and (4) disruption of critical operations.

CMS's comments on the draft of the attached report have been incorporated where appropriate. Officials in your office concurred with the recommendations and are in the process of taking corrective action.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me or have your staff call Joseph E. Vengrin, Assistant Inspector General for Financial Management Audits, at (410) 786-7103 or through e-mail at jvengrin@oig.hhs.gov. To facilitate identification, please refer to report number A-17-03-03003 in all correspondence.

Attachment

cc:
Kerry N. Weems
Acting Assistant Secretary for
Budget, Technology, and Finance

George H. Strader
Deputy Assistant Secretary, Finance

PRICEWATERHOUSECOOPERS

PricewaterhouseCoopers LLP
Suite 800W
1301 K St., N.W.
Washington DC 20005-3333
Telephone (202) 414 1000
Facsimile (202) 414 1301

Report of Independent Auditors

To the Administrator of the Centers for Medicare & Medicaid Services and
the Inspector General of the Department of Health and Human Services

We have audited the accompanying consolidated balance sheet of the Centers for Medicare and Medicaid Services (CMS) and its components as of September 30, 2003, and the related consolidated statements of net cost, of changes in net position and of financing, and the combined statement of budgetary resources for the year then ended. These financial statements are the responsibility of the CMS' management. Our responsibility is to express an opinion on these financial statements based on our audit. We did not audit the financial statements of the Health Programs which are a major subset of the CMS administered programs, which statements reflect total combined assets of $28,057 million and total combined net costs of $166,081 million, as of and for the year ended September 30, 2003. Those statements and financial information were audited by other auditors whose report thereon has been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for the Health Programs, is based solely on the report of the other auditors. The consolidated and combined financial statements of the CMS as of September 30, 2002, and for the year then ended were audited by other auditors whose report dated December 10, 2002, expressed an unqualified opinion on those statements.

We conducted our audit 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 No. 01-02, *Audit Requirements for Federal Financial Statements*. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit and the report of other auditors provides a reasonable basis for our opinion.

In our opinion, based on our audit and the report of other auditors, the consolidated and combined financial statements referred to above and appearing on pages 27 through 54 of this financial report, present fairly, in all material respects, the financial position of the CMS, as of

September 30, 2003, and their net cost, changes in net position, budgetary resources, and reconciliation of net cost to budgetary resources for the fiscal year then ended in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 1 to the financial statements, the Office of Management and Budget has exempted the CMS from certain requirements of OMB Circular No. A-11, *Preparation, Submission and Execution of the Budget*, for fiscal years 2003 and prior. Specifically, for the Medicare program, the CMS is exempted from reporting Medicare entitlements due and payable as obligations in the statement of budgetary resources and from reporting recoveries of prior year obligations on the statement of budgetary resources.

Our audit was conducted for the purpose of forming an opinion on the consolidated and combined financial statements of CMS taken as a whole. The required supplementary information, schedule of budgetary resources, included on page 78 of the financial report, is not a required part of the consolidated and combined financial statements but is supplementary information required by OMB Bulletin No. 01-09. This information, and the consolidating information included on pages 76 and 77 of this financial report are presented for purposes of additional analysis of the consolidated and combined financial statements rather than to present the financial position, changes in net position, budgetary resources and reconciliation of net cost to budgetary resources of the individual the CMS programs. Such information has been subjected to the auditing procedures applied in the audit of the consolidated and combined financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated and combined financial statements taken as a whole.

The required supplementary information included on pages i to viii, 1 to 26, and 79 of this financial report and the required supplementary stewardship information included on pages 55 to 75 of this financial report, are not required parts of the financial statements but are supplementary information required by OMB Bulletin No. 01-09 and the Federal Accounting Standards Advisory Board. We have applied certain limited procedures to such information, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit the information and express no opinion on it.

The other accompanying information included on pages 80 to 83 and 101 to the end of this financial report, are presented for purposes of additional analysis and are not a required part of the financial statements. Such information has not been subjected to the auditing procedures applied in the audit of the consolidated and combined financial statements and, accordingly, we express no opinion on it.

PRICEWATERHOUSECOOPERS

Report of Independent Auditors

In accordance with *Government Auditing Standards*, we have also issued a report dated November 7, 2003 on our consideration of the CMS' internal control and a report dated November 7, 2003 on its compliance with laws and regulations. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

PricewaterhouseCoopers LLP

November 7, 2003

PRICEWATERHOUSECOOPERS

PricewaterhouseCoopers LLP
Suite 800W
1301 K St., N.W.
Washington DC 20005-3333
Telephone (202) 414 1000
Facsimile (202) 414 1301

Report of Independent Auditors on Compliance with Laws and Regulations

To the Administrator of the Centers for Medicare & Medicaid Services and
the Inspector General of the Department of Health and Human Services

We have audited the accompanying consolidated balance sheets of the Centers for Medicare and Medicaid Services (CMS) and its components as of September 30, 2003, and the related consolidated statements of net cost, of changes in net position and of financing, and the combined statement of budgetary resources for the year then ended and have issued a report thereon dated November 7, 2003. We conducted our audit 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 No. 01-02, *Audit Requirements for Federal Financial Statements.*

We did not audit the financial statements of the Health Programs which are a major subset of the CMS administered programs, which statements reflect total combined assets of $28,057 million and total combined net costs of $166,081 million, as of and for the year ended September 30, 2003. Those statements were audited by other auditors whose report thereon has been furnished to us, and our report on the CMS' compliance with laws and regulations herein, insofar as it relates to Health Programs is based solely on the report of the other auditors.

Management of the CMS is responsible for compliance with laws and regulations applicable to the CMS. As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we and other auditors performed tests of the CMS' compliance with certain provisions of laws and regulations, non-compliance with which could have a direct and material effect on the determination of financial statement amounts and certain other laws and regulations specified in OMB Bulletin No. 01-02, including the requirements referred to in the Federal Financial Management Improvement Act of 1996 (FFMIA). However, the objective of our audit of the financial statements was not to provide an opinion on overall compliance with such provisions and, accordingly, we do not express such an opinion.

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Report of Independent Auditors on Compliance with Laws and Regulations

The results of our and other auditors' tests of the CMS' compliance with the provisions of laws and regulations described in the preceding paragraph, exclusive of FFMIA, disclosed no instances of non-compliance that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 01-02.

Under FFMIA, we are required to report whether the CMS' financial management systems substantially comply with (1) the Federal financial management systems requirements, (2) the applicable Federal accounting standards, and (3) the United States Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA section 803(a) requirements. The results of our tests disclosed instances, noted in the following paragraph, where the CMS' financial management systems did not substantially comply with the FFMIA requirements.

We reported that the CMS has material weaknesses related to (1) internal controls surrounding Financial Systems, Analyses and Oversight as well as (2) internal controls surrounding Electronic Data Processing for the Medicare program. We believe that these matters, taken together, represent substantial non-compliance with the Federal financial management system requirements under FFMIA. Further details surrounding these findings, together with our recommendations for corrective action have been reported separately to the CMS in our report on internal control dated November 7, 2003.

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

PricewaterhouseCoopers LLP

November 7, 2003

PRICEWATERHOUSECOOPERS

PricewaterhouseCoopers LLP
Suite 800W
1301 K St., N.W.
Washington DC 20005-3333
Telephone (202) 414 1000
Facsimile (202) 414 1301

Report of Independent Auditors on Internal Control

To the Administrator of the Centers for Medicare & Medicaid Services and
the Inspector General of the Department of Health and Human Services

We have audited the accompanying consolidated balance sheet of the Centers for Medicare and Medicaid Services (CMS) and its components as of September 30, 2003, and the related consolidated statements of net cost, of changes in net position and of financing, and the combined statement of budgetary resources for the year then ended and have issued a report thereon dated November 7, 2003. We conducted our audit 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 No. 01-02, *Audit Requirements for Federal Financial Statements*.

We did not audit the financial statements of the Health Programs which are a major subset of the CMS administered programs, which statements reflect total combined assets of $28,057 million and total combined net costs of $166,081 million, as of and for the year ended September 30, 2003. Those statements were audited by other auditors whose report thereon has been furnished to us, and our report on the CMS' internal control over financial reporting herein, insofar as it relates to the Health Programs, is based solely on the report of the other auditors.

Management of the CMS is responsible for establishing and maintaining effective internal control. The objectives of internal control are to provide management with reasonable, but not absolute, assurance that: (a) transactions be properly recorded, processed, and summarized to permit the preparation of the consolidated and combined financial statements in accordance with Federal accounting standards and the safeguarding of assets against loss from unauthorized acquisition, use or disposition and (b) transactions are executed in accordance with (i) laws governing the use of budget authority and other laws and regulations that could have a direct and material effect on the consolidated financial statements and (ii) any other laws, regulations and government wide policies identified in OMB Bulletin No. 01-02.

In planning and performing our audit we considered the CMS' internal control over financial reporting by obtaining an understanding of the CMS' internal control, determined whether internal control had been placed in operation, assessed control risk, and performed tests of

control in order to determine our auditing procedures for the purpose of expressing our audit opinion on the financial statements. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 01-02. We did not test all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982, such as those controls relevant to ensuring efficient operations. The objective of our audit was not to provide assurance on internal control. Consequently, we do not provide an opinion on internal control.

In addition, we considered the CMS' internal control over Required Supplementary Stewardship Information by obtaining an understanding of the CMS' internal control, determined whether these internal controls had been placed in operation, assessed control risk, and performed tests of controls as required by OMB Bulletin No. 01-02 and not to provide assurance on these internal controls. Accordingly, we do not provide an opinion on such controls.

Finally, with respect to internal control related to performance measures reported on pages 11 to 23, we obtained an understanding of the design of significant internal controls relating to the existence and completeness assertions, as required by OMB Bulletin No. 01-02. Our procedures were not designed to provide assurance on internal control over reported performance measures, and, accordingly, we do not provide an opinion on such controls.

Our consideration of the internal control over financial reporting would not disclose all matters in the internal control over financial reporting that might be reportable conditions. Under standards issued by the American Institute of Certified Public Accountants, reportable conditions are matters coming to our attention relating to significant deficiencies in the design or operation of the internal control that, in our judgment could adversely affect the agency's ability to record, process, summarize, and report financial data consistent with the assertions by management in the financial statements. Material weaknesses are reportable conditions in which the design or operation of one of more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Because of inherent limitations in internal controls, misstatements, losses, or noncompliance may nevertheless occur and not be detected. However, we noted certain matters involving the internal control that we consider to be material weaknesses.

Material Weaknesses

Financial Systems, Analyses and Oversight (Repeat Condition)

Over the past year, CMS has made significant progress in addressing the financial systems, analyses and oversight weaknesses noted during fiscal year 2002:

- The CMS referred an additional $700 million in delinquent debt to Treasury, which brings the total referrals to approximately 96% of all eligible debt.
- The CMS continued the use of workgroups comprised of central office and regional office consortia staff to serve as subject matter experts responsible for addressing four key areas: follow up on corrective action plans (CAPs), reconciliation of funds expended to paid claims, trend analyses, and internal controls.
- The CMS CAP Workgroup revised the manual policies and procedures for the reporting and implementation of CAPs by the Medicare contractors to provide additional clarification regarding the submission of the "Universal CAP Report" that was developed in FY 2002.
- The CMS-1522 Cash Reconciliation Workgroup worked with the Office of Inspector General and issued reconciliation procedures to Medicare contractors who process and pay claims under the Fiscal Intermediary Standard System (FISS) and Multi-Carrier System (MCS).
- The CMS continued performing Statement on Auditing Standards (SAS) 70 reviews documenting and assessing internal controls at Medicare contractor sites. These reviews include assessing contractors' progress in implementing corrective actions for prior reviews.

In addition, the CMS continued to make progress toward the implementation of Healthcare Integrated General Ledger Accounting System (HIGLAS). Some of the achievements for the current year include:

- Putting the technical infrastructure in place to pay HIGLAS claims at two of the largest contractors.
- Developing functional and technical solutions and a testing protocol so that the initial functionality of the HIGLAS system can be tested at two of the largest contractors.

However, while progress has been made during the current year, we continued to note significant weaknesses regarding the CMS' financial systems, analyses and oversight.

Lack of Integrated Financial Management System

The CMS' financial management systems are not compliant with the Federal Financial Management Improvement Act of 1996 (FFMIA). FFMIA requires agencies to implement and maintain financial management systems that comply with Federal financial management systems requirements as defined by the Joint Financial Management Improvement Program (JFMIP). More specifically, FFMIA requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems. The lack of an integrated financial management system continues to impair the CMS' and the Medicare contractors' abilities to efficiently and effectively support and analyze accounts receivable and other financial reports.

For example, Medicare contractors currently rely on a combination of claims processing systems, personal computer based software applications and other ad hoc systems to tabulate, summarize and prepare information presented to the CMS on the 750 – Statement of Financial Position Reports and the 751 – Status of Accounts Receivable Reports. These reports are the primary basis for the accounts receivable amounts reported within the financial statements. Because the CMS, and the CMS contractors, do not have a JFMIP compliant financial management system, the preparation of the 750/751 reports, and the review and monitoring of individual accounts receivable are dependent on labor intensive manual processes subject to the increased risk of inconsistent, incomplete or inaccurate information being submitted to the CMS. Likewise the reporting mechanism used by the CMS contractors to reconcile and report funds expended, the 1522 – Monthly Contractor Financial Report, are heavily dependent on inefficient, labor intensive, manual processes, subject to the increased the risk of inconsistent, incomplete, or inaccurate information being submitted to the CMS.

Financial Analyses and Reporting--Medicare Contractors

Our overall results identified improvements regarding the CMS' oversight of the Medicare contractors, however continuing weaknesses impact the CMS' ability to analyze and accurately report financial information in a timely basis.

The CMS has self-reported that during the fiscal year a total of $98.3 million in errors were discovered by certified public accountants hired by the CMS to review accounts receivable transactions processed by the CMS contractors. Collectively, these errors resulted in an overstatement of accounts receivable of $11.6 million, which was corrected by CMS. These errors were attributable in part to the following internal control findings identified through procedures utilized by the CMS to manage the CMS contractors:

- Contractors were not sending demand letters in a timely manner as required by existing policy and procedures.
- Contractors were not maintaining adequate audit trails for Medicare Secondary Payor recoveries.
- Contractors were not implementing policies and procedures to accurately refer debt to Treasury for collection.
- Contractors were not maintaining adequate documentation to support the classification, accumulation or reporting of accounts receivable.
- Contractors were not accurately calculating interest on outstanding accounts receivable.

During our testing of accounts receivable at nine CMS contractors, we noted other indicators of control weaknesses which are also attributable to the previously discussed system weaknesses. The manual processes that the CMS and the contractors have implemented to track and report accounts receivable are inefficient and labor intensive, subject to the type of internal control findings noted below:

- At one contractor, credit balances owed to providers were inappropriately offset against valid accounts receivable due from other providers.
- At one contractor, cash received but not applied against a corresponding account receivable, was inappropriately excluded from the 750/751 report.
- At three contractors, documentation to support the application of cash against existing accounts receivable was not maintained.
- At one contractor, the detailed accounts receivable reports could not be reconciled to the aging of accounts receivable reported on the 750/751 reports.
- At one contractor, the periodic interim payment receivable balances could not be reconciled to the supporting documentation.
- At one contractor, the allowance for doubtful accounts was understated due to the fact that the contractor had failed to accurately report the corresponding accounts receivable balance.
- At one contractor, cash received was not applied against existing accounts receivable in a timely manner.

The regional offices are responsible for reviewing various reports submitted by the Medicare contractors. During our audit, we noted that the regional offices were not completing the required reviews in a timely manner; specifically we noted that in one of the two regional offices visited, the review and approval of the *Currently Not Collectible* (CNC) reports was not completed in a timely manner for MSP debt. Furthermore, we noted instances when the CNC debt being approved for write-off should have been written off during the previous fiscal

year, indicating that the previous reviews may not have been completed in accordance with the CMS policies and procedures.

Ensuring that policies and procedures are consistently implemented and ensuring the availability of documentation used to support management decisions is a requirement of OMB A-123 and GAO's internal control standards.

Recommendations

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

- Establish an integrated financial management system for use by Medicare contractors and the CMS' central and regional offices to promote consistency and reliability in recording and reporting financial information, including accounts receivable and claim activity. Additionally, CMS should continue its efforts to promote uniform reporting procedures by the Medicare contractors.

- Continue to refine procedures to provide a mechanism for the CMS central and regional offices to monitor contractors' activities and enforce compliance with the CMS financial management procedures. This may include obtaining detailed subsidiary ledgers and related support from contractors for the CMS regional and central offices; reviewing subsidiary ledgers for reasonableness and reviewing reconciliations prepared by the contractors on a periodic basis.

Managed Care Organization Oversight

PwC requested the CMS Central Office to provide a complete set of the formal policies and procedures utilized throughout fiscal year 2003 to process, approve and accept the applications for managed care organizations applying to join the Managed Care program. CMS provided PwC with various versions of the requested policy guidance, but was unable to provide a complete set of the formal policies and procedures utilized throughout fiscal year 2003. Having this type of documentation readily available is a requirement of OMB Circular No. A-123, *Management Accountability and Control*, and a requirement of GAO's *Standards for Internal Control in the Federal Government*. The inability of the CMS to readily provide a comprehensive set of the guidance used throughout fiscal year 2003 increases the risk of inappropriately accepting a managed care organization into this program.

During our testing, we requested that the CMS provide the supporting documentation for applications which were processed and approved during the current fiscal year. Due in part to the lack of formalized guidance discussed in the proceeding paragraph, the CMS Central Office was unable to provide to PwC consistently completed documentation to support the CMS' acceptance of managed care organizations into the Managed Care program. For example, PwC requested that the CMS provide documented evidence regarding items, such as state licensure. Having this type of documentation readily available for audit is a requirement of OMB A-123 and GAO's internal control standards.

The CMS was unable to provide to PwC sufficient documentation to evidence the on-going monitoring of managed care organizations by the regional offices in accordance with the CMS policies and procedures provided to PwC during the audit. Internal documentation maintained by the CMS noted that the managed care organization had "met" the required element, but documentation to evidence how the particular element was met was unavailable for review during our audit. Furthermore, we noted other inconsistencies regarding the documentation that was available for review. For example, we noted that some regions maintained worksheets and other documents to evidence the reviews. However, other regions did not maintain this same type of evidence to support the reviews.

Recommendations

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

- Establish and implement formal policies and procedures for the approval of applications of organizations into the Managed Care program.

- Ensure that existing policies and procedures for the on-going monitoring of organizations within the Managed Care program are consistently implemented and that the monitoring of these organizations is documented in accordance with appropriate standards and guidelines.

Medicare Electronic Data Processing (Repeat Condition)

Background and Scope of Review

The CMS relies on extensive information systems operations at its central office and Medicare contractor sites to administer the Medicare program and to process and account for Medicare

expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality and reliability of the Medicare data and to reduce the risk of errors, fraud and other illegal acts.

Our internal control testing covered both general and application controls. General controls involve organizational security plans, referred to as entity-wide security plans (EWSP), access controls (physical and logical), application development and program change controls, segregation of duties, operating systems software for servers and mainframe platforms, and service continuity plans and testing. General controls provide the foundation to ensure the integrity of application systems and combined with application level controls are essential to ensure proper processing of transactions and integrity of stored data. Application controls include controls over input, processing of data, and control over output from CMS application systems.

Our audits included general controls at 17 sites: the CMS central office and 16 Medicare contractors. We reviewed application controls at the CMS central office for several systems integral to Medicare financial information. We also reviewed application controls at six of the Medicare contractors which included the Fiscal Intermediary Standard System (FISS), the Viable Processing Systems (VIPS) and Viable Medicare System (VMS), the Arkansas Part A Standard System (APASS), the Multi Carrier System (MCS) and the Common Working File (CWF) System. Our audit also relied on the work and findings of the SAS 70 reviews for the 16 Medicare contractors audited.

Further, we conducted vulnerability reviews of network controls at 16 of the sites audited. The vulnerability reviews included both external and internal penetration testing and network vulnerability assessments, including security configurations of network servers. Both the scope of the vulnerability testing and the number of sites tested were significantly expanded this year.

A number of general and application control findings were identified which is consistent with that found in prior years. Additionally, our vulnerability testing noted numerous security settings/controls that required enhancement. The majority of weaknesses were noted at the Medicare contractors, rather than the CMS central office. Our procedures disclosed no evidence of actual system compromise of security; however, we consider the cumulative effect of the weaknesses noted to comprise a material weakness to CMS.

Entity-wide Security Program (EWSP) - These programs provide the foundation for the security culture and awareness of the organization. A sound EWSP is the cornerstone to ensure effective security controls throughout the organization. Our audit noted several

contractor locations for which an emphasis on a robust and true entity-wide security program was not in existence. In these locations, security was treated as a directive, rather than a cultural norm that guides daily activities. As a result, numerous weaknesses were noted in the areas of access and systems software controls. An overriding factor in the pervasiveness of poor security controls was that these sites had designated security administration duties to personnel who did not possess the proper background and education to perform their job requirements and that other resources were only minimally directed to security programs, training and understanding. We also noted instances where security administration duties were improperly segregated from the duties of application programming. We also noted numerous sites that did not have an overall EWSP in place. Security controls cannot be effective without a robust, detailed EWSP that is fully sponsored and practiced by the senior management of the contractor sites. Robust plans require proper training and understanding and include security personnel with proper background and education to ensure the function of the program.

Logical and Physical Access Controls – Access controls ensure that critical systems assets are physically protected from unauthorized access and that logical controls provide assurance that only authorized personnel may access data and programs maintained on systems. Our audit noted findings regarding physical and logical access during our controls testing. Further, our vulnerability testing noted a large number of security settings/controls that required enhancement. Our external penetration testing was successful at multiple sites, primarily caused by poor or non-existent security settings resulting from the lack of sufficient security configuration standards for the network computers tested. Our testing of access controls also noted that we were easily able to bypass security controls without prior knowledge of the systems tested and that numerous security weaknesses existed that would allow internal users to easily access sensitive systems, program and data without proper authorization. Our review did not disclose any exploitation of critical systems tested.

The lack of specific guidance for computer security configuration settings and effective entity-wide security programs, administered by personnel with proper knowledge and experience, prevents contractors from providing adequate security controls that would ensure that only properly authorized personnel access sensitive CMS data and programs.

Application Security, Development and Program Change Controls – Application security, development and program change controls provide assurance that programs are developed with standards that ensure their effectiveness, efficiency, accuracy, security and maintenance and that only authorized and properly tested programs are implemented for production use. Our audit noted that contractor processing sites have the ability to turn on and off front-end edits in the FISS system. This issue presents an important area of concern because the ability

to negate system edits degrades the ability to ensure that only proper data is introduced into these systems and ultimately, the CWF and the National Claims History (NCH) System. We also noted that application changes are being implemented without complete testing and that application change control procedures were not followed at several sites, including the CMS central office. We also noted several sites at which application programmers have the ability to directly update production source code for applications thereby bypassing application change controls.

Systems Software – Systems software is a set of computer programs designated to operate and control the processing activities for all applications processed on a specific computer, including network servers, mainframe systems, and personal computers. Controls over access to, and use of, such software are especially critical. Our audits noted numerous findings during our general controls testing for systems software system settings/controls for network servers that required enhancement.

- **Changes to systems software –** Our audit noted that systems software change procedures and/or controls were not in place or consistently followed at many of the sites tested. Failure to control systems software changes can seriously impact the security and effectiveness of data and operations because systems software provides the foundation to operate all of the computers used.

- **Access to systems software programs and files –** Our audit noted numerous instances of poor password controls that could allow unauthorized access to systems software programs and files. Findings were noted regarding systems software on mainframe, Windows, Unix, firewall and router servers audited. The lack of security configuration standards contributes to the weaknesses noted and the ability of our external penetration teams to penetrate multiple sites tested.

Service Continuity Planning and Testing – Service continuity relates to the readiness of a site in the case of a system outage or event that disrupts normal processing of operations. Without approved, documented, and tested business and system continuity plans, there is no assurance that normal operations may be recovered efficiently and timely.

- **Incomplete and/or inadequately tested plans** - Our audit noted findings related to incomplete plans or inadequate testing at both contractor sites and at the CMS central office. Failure to ensure complete, tested and viable plans could severely impact CMS processing operations.

Overall Conclusion - During FY 2003, CMS made progress by issuing the Acceptable Risk Safeguards document. This document provides much greater specificity on security standards

and will complement the Business Partners Systems Security Manual previously provided as guidance to the contractors. CMS has also continued its programs to review the contractors through SAS 70 audits, an extensive contractor self-assessment program and reporting process and greater central oversight by contractor management. Additionally, CMS has requested and received system security plans from its contractors and has a promising certification and accreditation program initiative featuring system vulnerability assessments. However, the number of findings documented during our audit indicates that improvements are still needed.

Efforts to address the findings noted within budgetary constraints are challenged by the decentralized nature of Medicare operations and the complexity of fee-for-service processing. CMS has indicated the President's budget for FY 04 includes a funding request for IT modernization. According to CMS officials, its modernization program represents a longer term solution to simplify the application software code and change controls needed for more robust security. CMS has also stated its contractor reform initiative, including data center consolidation, will shorten the security perimeter by reducing the number of contractors and data centers.

Recommendations

We recommend that the CMS continue to strengthen controls over Medicare electronic data processing. Specifically,

- That the CMS management provide additional guidance to the contractors through the issuance of a centralized set of specific security models for all platforms used in the CMS system (central office, contractors and maintainers). The security standards should clearly outline the required control settings and parameters suggested to ensure that each platform is properly secured for use. Adoption of server security models set by NSA and/or NIST and the DoD for mainframe systems is highly recommended.

- That the CMS management develop and implement policies and procedures to monitor compliance with the security models for all platforms maintained within the CMS central office, the CMS contractor sites and the maintainer sites.

* * * * * * *

We also identified other less significant matters that will be reported to the CMS management in a separate consolidated management recommendation letter.

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Report of Independent Auditors on Internal Control

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

PricewaterhouseCoopers LLP

November 7, 2003

Other Congressional Reports

FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT

The Federal Managers' Financial Integrity Act (FMFIA) requires executive agencies to report annually if: (1) they have reasonable assurance that their management controls protect their programs and resources from fraud, waste, and mismanagement, and if any material weaknesses exist in their controls, and (2) their financial management systems conform with Federal financial management systems requirements.

The CMS assesses its management controls and financial management systems through: (1) management control reviews, (2) management self-certifications, (3) Office of Inspector General (OIG) audits, (4) the CFO financial audit, (5) other review mechanisms, such as Statement on Auditing Standards No. 70 (SAS 70) internal control reviews, and (6) certification and accreditation of systems. As of September 30, 2003, the management controls and financial management systems of CMS provided reasonable assurance that the objectives of FMFIA were achieved. However, two material weaknesses (repeated from prior years) existed and a noncompliance was identified.

Material Weakness 1: Financial Systems, Analyses, and Oversight

The Medicare contractors continue to make improvements in maintaining supporting records for Medicare activities and year-end accounts receivable balances. However, because the contractors lack a formal, integrated accounting system to accumulate and report financial information, they use ad hoc, labor-intensive reports, which increases the risk of material misstatement or omission. In addition, Medicare contractor controls over accounts receivable continue to need improvement.

We continue to contract with Independent Public Accountants to test financial management internal controls and to analyze accounts receivable at Medicare contractors. The CMS workgroups serve as subject matter experts responsible for addressing four key areas: follow up on CAPs, reconciliations of funds expended to paid claims, trend analysis, and internal controls. As CMS progresses toward its long-term goal of developing an integrated general ledger system, we continue to provide training to the Medicare contractors to promote a uniform method of reporting and accounting for accounts receivable and related financial data.

Material Weakness 2: Medicare Electronic Data Processing (EDP) Controls

We rely on extensive EDP operations at CMS and the Medicare contractors to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality, and reliability of critical data while reducing the risk of errors, fraud, and other illegal acts. The material weakness for Medicare EDP controls is very complex and requires time and resources. The CMS has made substantial investment and progress in strengthening security at the Medicare contractors. The strategy in eliminating the material weakness is rooted in the CMS modernization initiative that will further improve our security posture.

We continue to make progress toward resolving this issue. The CMS Security Requirements adhere to guidelines in the Office of Management and Budget Circular A-130 and implement effective control procedures. We have implemented numerous safeguards in the core security requirements areas of access control, system software, segregation of duties, and service continuity. We also developed an entity-wide security program for all significant production applications and related users. We have developed a program to formally have all of our systems certified and accredited by the end of FY 2005.

Noncompliance

The CMS financial management systems—because they are not integrated—do not conform to government-wide requirements. We have implemented a comprehensive plan to bring our financial systems into compliance. Specifically, we have initiated steps to implement an integrated general ledger system known as HIGLAS for the Medicare contractors, regional and central offices. The HIGLAS will integrate our current financial systems with the Medicare contractors' three existing standard claims processing systems. In addition, the current mainframe-based financial system will be replaced by HIGLAS, a web-based system. The HIGLAS is expected to be fully operational by 2007.

MEDICARE'S VALIDATION PROGRAM FOR JCAHO ACCREDITED HOSPITALS

Introduction

Section 1865 of the Social Security Act (the Act) provides that hospitals accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) are deemed to meet the Medicare Conditions of Participation (CoPs). While JCAHO-accredited hospitals are not subject to routine Medicare surveys by the State survey agencies, subsection 1864(c) of the Act authorizes the Secretary to enter into an agreement with any such State agency to survey JCAHO-accredited hospitals on a selective sample basis, or in response to allegations of significant deficiencies which, if substantiated, would adversely affect the health and safety of patients. The Act further requires, at section 1875, the Secretary to include an evaluation of the JCAHO accreditation process for hospitals in an annual report to Congress. This evaluation is referred to as the hospital validation program.

The purpose of the hospital validation program is to determine if the JCAHO accreditation process provides a reasonable assurance that accredited hospitals are in compliance with the statutory requirements set forth at subsection 1861(e) of the Act for participation in the Medicare program as hospitals. In FY 2002, CMS randomly selected approximately 5 percent of all JCAHO-accredited hospitals to receive a validation survey. For FY 2003, the number of hospitals selected to receive a validation survey will decrease to approximately 1 percent of all JCAHO-accredited hospitals.

The JCAHO accreditation survey assesses a hospital's compliance with the JCAHO standards. Following the completion of an on-site survey, the JCAHO makes an accreditation decision. The accreditation decisions include: accreditation, accreditation with requirements for improvement (formerly accreditation with Type I recommendations), conditional accreditation, and accreditation denied.[1] Accreditation means that the hospital meets all JCAHO standards and requirements. Accreditation with requirements for improvement means that the hospital is granted accreditation with the assurance that the identified recommendations for improvement are corrected. The JCAHO requires hospitals with requirements for improvement to submit a written progress report or undergo a follow-up survey. Conditional accreditation results when a hospital is not in substantial compliance with JCAHO standards, but is believed to be capable of

[1] JCAHO accreditation decisions also include preliminary denial of accreditation and provisional accreditation. [The CMS does not recognize provisional accreditation for deeming.] The JCAHO considers all hospitals to be 'accredited' except those that are not accredited. The CMS currently accepts the JCAHO definition for deeming purposes.

achieving acceptable compliance within a stipulated time period. Findings of correction, which serve as the basis for further consideration of awarding full accreditation, must be demonstrated through a short-term follow-up survey. Table 1 summarizes the JCAHO accreditation decisions for Medicare-approved hospitals receiving a triennial survey in fiscal years 2001 and 2002.

TABLE 1
JCAHO Accreditation Decisions,
Medicare-Approved Hospitals Surveyed in FY 2001 and FY 2002

Accreditation Decisions	**No. Hospitals in 2001** *(Percent)*	**No. Hospitals in 2002** *(Percent)*
Accreditation	167 (10.8)	257 (16.7)
Accreditation with Requirements for Improvement	1349 (87.3)	1306 (82.7)
Conditional Accreditation	28 (1.8)	14 (0.9)
Preliminary Denial of Accreditation	1 (0.06)	1 (0.06)
Accreditation Denied	0 (0)	1 (0.06)
Total Surveyed	1545 (100)	1578 (100)

Sample Validation Surveys

A total of 205 sample validation surveys were performed in JCAHO-accredited hospitals during FY 2002. The validation sample includes the following categories:

1. Traditional surveys
2. Focused surveys
3. Conditional surveys

The traditional validation survey is a full survey in which the hospital is evaluated for compliance with all Medicare CoPs. The traditional survey is the "look behind" method historically used by CMS for validation surveys and is conducted within 60 days following the hospital's JCAHO accreditation survey. There were 112 traditional validation surveys conducted during FY 2002.

The focused validation survey is designed to evaluate a hospital's ability to maintain compliance with the Medicare requirements between JCAHO accreditation surveys. Focused surveys are conducted between 60 days and six months following the hospital's JCAHO accreditation survey and examine specific standards of national or regional interest to CMS. The focused areas for FY 2002 were the Medicare CoPs for Patients' Rights, Nursing Services, Pharmaceutical Services and Quality Assurance as it pertains to pharmaceutical services and medication administration. A total of 89 focused surveys were conducted in FY 2002.

The conditional validation survey is a full survey conducted at a hospital that has received a conditional accreditation decision as a result of their JCAHO accreditation survey. The State agency performs the survey approximately six to eight months following the JCAHO survey. There were four conditional validation surveys conducted during FY 2002.

Validation Survey Findings

In FY 2002, a total of 205 JCAHO-accredited hospitals received a validation survey. Table 2 presents the number of validation surveys performed, along with the compliance determinations (i.e., if the results of a validation survey showed noncompliance with one or more CoPs, the hospital was 'out of compliance'). A hospital may have had deficiencies of a lesser severity (e.g., standard level) and still be considered in compliance. This table also includes a comparison of the compliance pattern between validation surveys of accredited hospitals and routine surveys of non-accredited hospitals.

TABLE 2
Compliance Determinations of Validation and Non-Accredited Hospital Surveys, FY 2002

Survey Type	No. Hospitals Out of Compliance *(Percent)*	No. Hospitals In Compliance *(Percent)*	Total
Sample Validations	41 (20.0)	164 (80.0)	205
Routine Non-Accredited	53 (18.9)	227 (81.1)	280

Table 3 presents compliance determinations for JCAHO-accredited hospitals by category of validation survey for FY 2002.

TABLE 3
JCAHO-Accredited Hospitals Out of Compliance by Validation Survey Category for FY 2002

Survey Type	No. Hospitals Out of Compliance	No. Hospitals In Compliance	Total
Traditional	35	77	112
Focused	6	83	89
Conditional	1	3	4

The three health and safety CoPs found out of compliance most frequently for the 205 validation surveys performed in FY 2002 are shown in table 4. The three CoPs found out of compliance most frequently for the 280 non-accredited hospitals surveyed in FY 2002 are shown for comparison.

TABLE 4
Most Frequently Cited Conditions of Participation During Surveys, FY 2002

Accredited Hospitals	Frequency	Non-Accredited Hospitals	Frequency
1 Physical Environment *(Includes Life Safety Code)*	25	Physical Environment *(Includes Life Safety Code)*	20
2 Patients' Rights	8	Quality Assurance	17
3 Quality Assurance	7	Governing Body	16

Allegation Surveys

In addition to sample validation surveys, CMS conducts substantial allegation (complaint) surveys on JCAHO-accredited hospitals. The CMS evaluates each complaint received on an accredited hospital. Based on that evaluation, if CMS believes that the hospital may have a CoP out of compliance, CMS will then authorize the State agency to conduct a substantial allegation survey.

In FY 2002, 2,933 allegation surveys of JCAHO-accredited hospitals were conducted with 100 found out of compliance with one or more CoPs. This means that 3 percent of the allegation surveys were substantiated by findings of non-compliance. Also, 338 allegation surveys of non-accredited hospitals were conducted with 34 found out of compliance with one or more CoPs. This means 10 percent of the allegation surveys in non-accredited hospitals were substantiated by findings of non-compliance at the CoP level. Table 5 summarizes the most frequently cited CoPs found during allegation surveys of accredited and non-accredited hospitals.

TABLE 5
Most Frequently Cited Conditions of Participation During Allegation Surveys, 2002

ACCREDITED HOSPITALS		NON-ACCREDITED HOSPITALS	
Condition Not Met	**Frequency**	**Condition Not Met**	**Frequency**
1 Nursing Services	47	Patients' Rights	12
2 Quality Assurance	32	Infection Control	7
3 Patients' Rights Governing Body	24	Nursing Services Quality Assurance	6

Disparity Rate

The rate of disparity is the percentage of sample validation surveys for which a State survey agency finds noncompliance with one or more Medicare conditions and no comparable condition level deficiency was cited by the accreditation organization, where it is reasonable to conclude that the deficiencies were present at the time of the accreditation organization's most recent survey.

Of the 112 traditional validation surveys performed in JCAHO-accredited hospitals in FY 2002, the State survey agencies found non-compliance with one or more conditions in 35 hospitals. Comparison of the JCAHO-accreditation survey reports with the validation survey reports for these hospitals revealed that in 25 of the 35 hospitals, the accreditation survey did not identify deficiencies comparable to the condition level deficiencies cited by the State agency surveyors. This equals an overall disparity rate of 22 percent, a decrease from a disparity rate of 24 percent in FY 2001. Consistent with FY 2001, Life Safety Code (LSC) deficiencies account for more than 50 percent of the overall disparity rate.

The calculation of the disparity rate for FY 2002 includes only the universe of traditional validation surveys performed (112) by the State survey agencies. While the small number of focused surveys in FY 2001 was included in last year's disparity rate calculation, we did not include the findings from the 89 focused surveys and the four conditional surveys performed in the calculation of this year's disparity rate. We believe that calculating the rate of disparity using a large number of focused surveys would not be consistent with the regulatory definition for rate of disparity and would provide an inaccurate representation of the JCAHO performance.

The focused validation survey, designed to evaluate a hospital's ability to maintain compliance with the Medicare requirements between JCAHO accreditation surveys, examined only a select set of CoPs. Because these surveys were performed between 60 days and six months following the JCAHO accreditation survey, it is not reasonable to conclude that the deficiencies were present at the time of that accreditation survey. Of

the 89 focused surveys conducted, only six hospitals (6.7 percent) were found to have one or more condition-level deficiencies in the areas surveyed.

The conditional validation surveys were full surveys in which the State agency surveyors examined all the Medicare CoPs. However, because these surveys were conducted between six and eight months following the JCAHO accreditation survey it is not reasonable to expect the same findings to be identified during both the State agency and JCAHO surveys. Furthermore, a *conditional* accreditation decision by the JCAHO requires the hospital to take immediate corrective action to address the identified problems. Therefore, CMS would expect that the deficiencies identified during the JCAHO accreditation survey would be corrected before the time the validation survey is conducted.[2] In three of the four conditional validation surveys performed during FY 2002, the hospitals were found to be in compliance with all Medicare CoPs at the time of the State agency survey. While not enough information is available at this time to formulate definitive conclusions, CMS believes that the methodology behind a JCAHO accreditation decision of conditional is an effective means to bring the hospital into full compliance within a reasonable timeframe.

As set forth in regulation at 42 CFR 488.8(d), accreditation programs with a disparity rate of 20 percent or more are subject to review by CMS to determine if that organization has adopted and maintains requirements for accreditation that are comparable to CMS requirements. The CMS initiated and performed a comprehensive review of the JCAHO requirements for LSC. In August of 2002, as a result of that review, CMS shared with the JCAHO a number of recommendations that we believe will improve the JCAHO evaluation of LSC compliance in hospitals. A summary of these recommendations was included in last year's report on the hospital validation program.[3]

The JCAHO is currently making significant revisions to the process they use to evaluate hospitals that reflect a new beneficiary-centered approach to the survey. These revisions are also designed around the concept that accredited hospitals should be in continuous compliance with the JCAHO standards. As part of this approach, the JCAHO will require accredited hospitals to perform certain ongoing and periodic assessments. These assessments will be sent to the JCAHO for review and discussion of both the findings and the organization's plan for improvement. Included in this will also be the Statement of Conditions (SOC)/Plan for Improvement (PFI) process.

As the JCAHO continues to pilot test this new survey process, they have committed to also test changes to the evaluation of compliance with the Life Safety Code that are consistent with the recommendations made by CMS. Additionally, the JCAHO is currently in discussion with the American Society of Healthcare Engineering (ASHE) to pilot test collaborative review of the SOC and PFI documents. The JCAHO would

[2] For hospitals granted *conditional* accreditation, the JCAHO conducts a follow-up survey, generally three to six months following the hospital's accreditation survey to determine that the hospital has implemented the necessary corrective actions.

[3] For more information, please see the CMS Financial Report, Fiscal Year 2002.

provide ASHE with a copy of the SOC and PFI documents for an expert review, the results of which would be made available to surveyors prior to the start of the JCAHO accreditation survey.

The CMS anticipates that the validation survey results for FY 2003 will reflect some of the improvements that the JCAHO has made in their evaluation of LSC. Additionally, CMS believes the adoption of the 2000 edition of the Life Safety Code by both the JCAHO and CMS in September 2003 will help address some of the differences in validation findings. The CMS and JCAHO continue to work together to ensure that the JCAHO's standards for LSC and survey requirements are at least as strong as those of Medicare.

Changing the Evaluation Methodology

In response to concerns raised several years ago by the GAO and OIG regarding the quality of care in our nation's hospitals, CMS implemented a quality improvement initiative that included a review of the hospital validation program and tested additional validation survey types that might be used to improve JCAHO accountability for its performance when accrediting hospitals. These survey types, the Focused survey and Concurrent/Observational survey were piloted on a limited basis during FY 2001 and FY 2002.[4] In 2001, CMS contracted for an independent evaluation of the current hospital validation program, the changes proposed by CMS, and to suggest additional measures that could be used to evaluate the JCAHO performance. The CMS is currently considering suggestions for improvement made by the contractor, including an evaluation of the procedures JCAHO uses to monitor hospitals' correction of deficiencies. The current validation system does not assess this aspect of JCAHO performance—yet it is crucial to CMS' determination of whether JCAHO accreditation provides reasonable assurance of hospitals' continuing compliance with the Medicare CoPs. Another suggestion is to gather the descriptive information about JCAHO's accreditation-related activities (e.g., number of accreditation surveys conducted, number of complaints received regarding JCAHO-accredited hospitals) currently obtained on a regular basis and in a way that is more useful to CMS in the monitoring of JCAHO activities. Trends in this data and in JCAHO performance measures could then be tracked more effectively.

The CMS is expecting to see considerable changes in the JCAHO accreditation process beginning in 2004 as they begin the rollout of their new accreditation methodology and survey process. During future reporting periods, CMS will work towards evaluating JCAHO's ability to promote their hospitals' correction of deficiencies and of developing a measure of how well JCAHO follows this procedure. The CMS will also work with JCAHO to obtain more comprehensive and regular information about the organization's accreditation activities and to expedite the exchange of data and information between the two organizations.

[4] The Concurrent/Observational survey was tested during FY 2001; the Focused survey was tested during both FY 2001 and FY 2002. For additional information, please refer to the CMS Financial Report, Fiscal Year 2002.

CLINICAL LABORATORY IMPROVEMENT VALIDATION PROGRAM

Introduction

This report on the Clinical Laboratory Improvement Validation Program covers the evaluations of fiscal year 2002 performance by the six accreditation organizations approved under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The six organizations are as follows:

- American Association of Blood Banks (AABB)
- American Osteopathic Association (AOA)
- American Society of Histocompatibility and Immunogenetics (ASHI)
- COLA
- College of American Pathologists (the College)
- Joint Commission on Accreditation of Healthcare Organizations (Joint Commission)

We appreciate the cooperation of all of the organizations in providing their inspection schedules and results. While an annual performance evaluation of each approved accreditation organization is required by law, we see this as an opportunity to present information about, and dialogue with, each organization in our mutual interest in improving the quality of testing performed by clinical laboratories across the nation.

Legislative Authority and Mandate

Section 353 of the Public Health Service Act, as amended by CLIA, requires any laboratory that performs testing on human specimens to meet the requirements established by the Department of Health and Human Services (HHS) and have in effect an applicable certificate. Section 353 further provides that a laboratory meeting the standards of an approved accreditation organization may obtain a CLIA Certificate of Accreditation. Under the CLIA Certificate of Accreditation, the laboratory is not routinely subject to direct federal oversight by CMS. Instead, the laboratory receives an inspection by the accreditation organization in the course of maintaining its accreditation, and by virtue of this accreditation, is "deemed" to meet the CLIA requirements. The CLIA requirements pertain to quality assurance and quality control programs, records, equipment, personnel, proficiency testing and others to assure accurate and reliable laboratory examinations and procedures.

In section 353(e)(2)(D), the Secretary is required to evaluate each approved accreditation organization by inspecting a sample of the laboratories they accredit and

"such other means as the Secretary determines appropriate." In addition, section 353(e)(3) requires the Secretary to submit to Congress an annual report on the results of the evaluation. This report is submitted to satisfy that requirement.

Regulations implementing section 353 are contained in 42 CFR part 493 Laboratory Requirements. Subpart E of part 493 contains the requirements for validation inspections, which are conducted by CMS or its agent to ascertain whether the laboratory is in compliance with the applicable CLIA requirements. Validation inspections are conducted no more than 90 days after the accreditation organization's inspection, on a representative sample basis or in response to a complaint. The results of these validation inspections or "surveys" provide:

- on a laboratory-specific basis, insight into the effectiveness of the accreditation organization's standards and accreditation process; and
- in the aggregate, an indication of the organization's capability to assure laboratory performance equal to or more stringent than that required by CLIA.

The CLIA regulations, in section 493.575 of subpart E, provide that if the validation inspection results over a one-year period indicate a rate of disparity of 20 percent or more between the findings in the accreditation organization's results and the findings of the CLIA validation surveys, CMS can re-evaluate whether the accreditation organization continues to meet the criteria for an approved accreditation organization (also called "deeming authority"). Section 493.575 further provides that CMS has the discretion to conduct a review of an accreditation organization program if validation review findings, irrespective of the rate of disparity, indicate such widespread or systematic problems in the organization's accreditation process that the requirements are no longer equivalent to CLIA requirements.

Validation Reviews

The validation review methodology focuses on the actual implementation of an organization's accreditation program described in its request for approval. The accreditation organization's standards, as a whole, were approved by CMS as being equivalent to, or more stringent than, the CLIA condition-level requirements,[1] as a whole. This equivalency is the basis for granting deeming authority.

In evaluating an organization's performance, it is important to examine whether the organization's inspection findings are similar to the CLIA validation survey findings. It is also important to examine whether the organization's inspection process sufficiently identifies, brings about correction, and monitors for sustained correction, laboratory practices and outcomes that do not meet their accreditation standards, so that equivalency of the accreditation program is maintained.

[1] A condition-level requirement pertains to the significant, comprehensive requirements of CLIA, as opposed to a standard-level requirement, which is more detailed, more specific. A condition-level deficiency is an inadequacy in the laboratory's quality of services that adversely affects, or has the potential to adversely affect, the accuracy and reliability of patient test results.

The organization's inspection findings are compared, case-by-case for each laboratory in the sample, to the CLIA validation survey findings at the condition level. If it is reasonable to conclude that one or more of those condition-level deficiencies was present in the laboratory's operations at the time of the organization's inspection, yet the inspection results did not note them, the case is a disparity. When all of the cases in each sample have been reviewed, the "rate of disparity" for each organization is calculated by dividing the number of disparate cases by the total number of validation surveys, in the manner prescribed by section 493.2 of the CLIA regulations.

Number of Validation Surveys Performed

As directed by the CLIA statute, the number of validation surveys should be sufficient to "allow a reasonable estimate of the performance" of each accreditation organization. A representative sample of the more than 15,000 accredited laboratories received a validation survey in 2002. Laboratories seek and relinquish accreditation on an ongoing basis, so the number of laboratories accredited by an organization during any given year fluctuates. Moreover, many laboratories are accredited by more than one organization. Each laboratory holding a Certificate of Accreditation, however, is subject to only one validation survey—for the organization it selected to maintain its CLIA certification, irrespective of the number of accreditations it attains.

Nationwide, fewer than 500 of the accredited laboratories used AABB, AOA, or ASHI accreditation for CLIA purposes. Given these proportions, very few validation surveys were performed in laboratories accredited by those organizations. The overwhelming majority of accredited laboratories in the CLIA program used their accreditation by COLA, the College, or the Joint Commission, thus the sample sizes for these organizations were larger. The sample sizes are usually proportionate to each organization's representation in the universe of accredited laboratories, however true proportionality is not always possible due to the complexities of scheduling.

The number of validation surveys performed for each organization is specified below in the summary findings for the organization.

Results of the Validation Reviews of Each Accreditation Organization

American Association of Blood Banks

Rate of disparity: No disparity

Approximately 220 laboratories used their AABB accreditation for CLIA purposes. Five validation surveys were conducted. No condition-level deficiencies were cited on any of the surveys, thus disparity was precluded.

American Osteopathic Association

Rate of disparity: No disparity

For CLIA purposes, approximately 50 laboratories used their AOA accreditation. Three validation surveys were conducted. This year, as in the previous years of CLIA validation review, disparity was precluded because no condition-level deficiencies were cited on any of the surveys.

American Society of Histocompatibility and Immunogenetics

Rate of disparity: No disparity

Approximately 130 laboratories used their ASHI accreditation for CLIA purposes. Five validation surveys were conducted. Condition-level compliance was found in all the validation surveys, thus disparity was precluded this year, as in the previous years of CLIA validation review.

COLA

Rate of disparity: 1 percent

Validation surveys were conducted at 144 COLA-accredited laboratories. Eleven of the laboratories were cited with condition-level deficiencies. Comparable deficiencies were not noted by COLA in nine out of the eleven laboratories cited with condition-level deficiencies.

Following is a listing of the laboratory identification number, location and condition-level deficiencies of the laboratories where COLA findings were disparate.

CLIA number	Location	CLIA Conditions
17D0452210	Kansas	Proficiency Testing—Enrollment and Testing of Samples
28D0456083	Nebraska	Personnel—Laboratory Director Personnel—Technical Consultant

College of American Pathologists

Rate of disparity: 7 percent

A total of 75 validation surveys were conducted at laboratories accredited by the College; however, two were removed from the pool: one for administrative reasons, and one because it was performed more than 90 days after the accreditation inspection. Among the remaining 73 laboratories, six were cited with condition-level deficiencies. Comparable deficiencies were noted by the College in only one of the six laboratories cited with condition-level deficiencies.

Following is a listing of the CLIA identification number, location, and condition-level deficiencies of the laboratories where the College's findings were disparate.

CLIA number	Location	CLIA Conditions
04D0467983	Arkansas	Personnel—Technical Consultant, moderate complexity
04D0469292	Arkansas	Quality Assurance
16D0384964	Iowa	Proficiency Testing—Enrollment and Testing of Samples Proficiency Testing—Successful Participation
19D0464540	Louisiana	Quality Control—Bacteriology Quality Control—General Immunology Quality Control—Routine Chemistry Quality Control—Endocrinology Quality Control—Toxicology Quality Control—Hematology Personnel—Laboratory Director, moderate complexity Quality Assurance
45D0940696	Texas	Proficiency Testing—Successful Participation Personnel—Laboratory Director, moderate complexity Quality Assurance

Joint Commission on Accreditation of Healthcare Organizations

Rate of disparity: 8 percent

During this validation period, a total of 88 validation surveys were conducted at laboratories accredited by the Joint Commission. One survey was removed from the pool for administrative reasons. Among the remaining 87 laboratories, eight were cited with condition-level deficiencies. Comparable deficiencies were noted by the Joint Commission in only one of the eight laboratories cited with condition-level deficiencies.

Following is a listing of the CLIA identification number, location and condition-level deficiencies of the laboratories where the Joint Commission's findings were disparate.

CLIA number	Location	CLIA Conditions
05D0542002	California	Quality Assurance
05D0552389	California	Quality Assurance
19D0464915	Louisiana	Quality Control—Routine Chemistry Personnel—Laboratory Director Quality Assurance
19D0649118	Louisiana	Quality Control—Routine Chemistry Personnel—Laboratory Director Quality Assurance
19D0668410	Louisiana	Quality Control—Hematology Personnel—Laboratory Director Quality Assurance
45D0506417	Texas	Quality Assurance
52D0397129	Wisconsin	PT Enrollment and Testing of Samples Quality Control—Hematology Personnel—Laboratory Director

Conclusion

The CMS has performed this validation review in order to evaluate and report to Congress on the performance of the six laboratory accreditation organizations approved under CLIA. The findings of the validation review for fiscal year 2002 indicate that all of the accreditation organizations performed at a level well below the 20 percent disparity threshold that would trigger a deeming authority review. Moreover, the validation review did not reveal widespread or systematic problems in accreditation processes that cause the equivalency of any organization's accreditation program to be questioned.

QUALITY IMPROVEMENT ORGANIZATIONS (QIOs)

Over the last several years, CMS has re-engineered the QIO program to better meet our strategic goal of improving the health status of Medicare beneficiaries. The QIOs still perform quality assurance activities in accordance with their original mandate. However, the principal focus of the QIO program has evolved from a mix of utilization review, diagnosis related group (DRG) validation, and quality of care review to an expanded approach that features emphasis on quality improvement projects through the Health Care Quality Improvement Program (HCQIP). For the seventh round of QIO contracts, now in the second year of a 3-year cycle, focused strategic efforts are also being directed at Medicare program integrity via the Hospital Payment Monitoring Program (HPMP) in compliance with the Balanced Budget Act.

The HCQIP relies on provider-based quality improvement, a data driven external monitoring system based on quality indicators, and sharing of comparative data and best practices with providers to stimulate improvement. The QIOs conduct a wide variety of improvement projects on important clinical and non-clinical topics that have the potential to improve care provided to many Medicare beneficiaries. Such projects vary in size depending on the study purpose and design. For example, there are national projects featuring clinical topic areas that CMS has determined to have a high impact on Medicare beneficiaries; where the process measures are linked to outcomes; where room for improvement exists; and where QIOs have experience with the topic. Similarly, individual QIOs also design and structure local projects whereby they work collaboratively with specific providers and managed care plans in their areas, particularly with respect to disadvantaged and/or under-served beneficiary groups. The QIOs also conduct pilot projects in alternative provider settings.

Consistent with our strategic goal to promote the fiscal integrity of CMS programs, the HPMP activities are part of the Comprehensive Plan for Program Integrity to ensure Medicare hospital inpatient claims are billed and paid appropriately. Using CMS-

developed baseline data, each QIO is required to identify the extent of payment errors occurring in its area and implement appropriate educational interventions aimed at changing provider behavior and decreasing the observed payment error rate.

Under Federal budget rules, the QIO program is defined as mandatory rather than discretionary because QIO costs are financed directly from the Medicare trust funds and are not subject to the annual appropriations process. The QIO outlays in FY 2003 totaled $350.4 million, which compares with $354.0 million spent in FY 2002.

In FY 2003, CMS administered 53 QIO performance-based contracts, one per State, the District of Columbia, the Virgin Islands, and Puerto Rico. Program compliance is ensured via performance-based evaluation measures for both project results and program integrity efforts, as well as use of inter-rater reliability measures and International Organization for Standardization (ISO) 9000-type documentation of QIO processes.

Glossary

A

Accrual Accounting: A basis of accounting that recognizes costs when incurred and revenues when earned and includes the effect of accounts receivable and accounts payable when determining annual net income.

Actuarial Soundness: A measure of the adequacy of Hospital Insurance and Supplementary Medical Insurance financing as determined by the difference between trust fund assets and liabilities for specified periods.

Administrative Costs: General term that refers to Medicare and Medicaid administrative costs, as well as CMS administrative costs. Medicare administrative costs are comprised of the Medicare related outlays and non-CMS administrative outlays. Medicaid administrative costs refer to the Federal share of the States' expenditures for administration of the Medicaid program. The CMS administrative costs are the costs of operating CMS (e.g., salaries and expenses, facilities, equipment, rent and utilities). These costs are accounted for in the Program Management account.

B

Balanced Budget Act of 1997 (BBA): Major provisions provided for the State Children's Health Insurance Program, Medicare +Choice, and expansion of preventive benefits.

Beneficiary: A person entitled under the law to receive Medicare or Medicaid benefits (also referred to as an enrollee).

Benefit Payments: Funds outlayed or expenses accrued for services delivered to beneficiaries.

C

Carrier: A private business, typically an insurance company, that contracts with CMS to receive, review, and pay physician and supplier claims.

Cash Basis Accounting: A basis of accounting that tracks outlays or expenditures during the current period regardless of the fiscal year the service was provided or the expenditure was incurred.

Clinical Laboratory Improvement Amendments of 1988 (CLIA): Requires any laboratory that performs testing on specimens derived from humans to meet the requirements established by the Department of Health and Human Services and have in effect an applicable certificate.

Cost-Based Health Maintenance Organization (HMO)/Competitive Medical Plan (CMP): A type of managed care organization that will pay for all of the enrollees/members' medical care costs in return for a monthly premium, plus any applicable deductible or co-payment. The HMO will pay for all hospital costs (generally referred to as Part A) and physician costs (generally referred to as Part B) that it has arranged for and ordered. Like a health care prepayment plan (HCPP), except for out-of-area emergency services, if a Medicare member/enrollee chooses to obtain services that have not been arranged for by the HMO, he/she is liable for any applicable deductible and co-insurance amounts, with the balance to be paid by the regional Medicare intermediary and/or carrier.

D

Demonstrations: Projects and contracts that CMS has signed with various health care organizations. These contracts 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.

Discretionary Spending: Outlays of funds subject to the Federal appropriations process.

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

Durable Medical Equipment (DME): Purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used in a patient's home.

Durable Medical Equipment Regional Carrier (DMERC): A company that contracts to process Medicare claims for Durable Medical Equipment (DME).

GLOSSARY

E

Expenditure: Expenditure refers to budgeted funds actually spent. When used in the discussion of the Medicaid program, expenditures refer to funds actually spent as reported by the States. This term is used interchangeably with Outlays.

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

F

Federal General Revenues: Federal tax revenues (principally individual and business income taxes) not identified for a particular use.

Federal Insurance Contribution Act (FICA) Payroll Tax: Medicare's share of FICA is used to fund the HI trust fund. Employers and employees each contribute 1.45 percent of taxable wages, with no compensation limits, to the HI trust fund.

Federal Medical Assistance Percentage (FMAP): The portion of the Medicaid program that is paid by the Federal government.

Federal Managers' Financial Integrity Act (FMFIA): A program that identifies management inefficiencies and areas vulnerable to fraud and abuse so that such weaknesses can be corrected with improved internal controls.

H

Health Care Prepayment Plan (HCPP): A type of managed care organization. In return for a monthly premium, plus any applicable deductible or co-payment, all or most of an individual's physician services will be provided by the HCPP. The HCPP will pay for all services it has arranged for (and any emergency services) whether provided by its own physicians or its contracted network of physicians. If a member enrolled in an HCPP chooses to receive services that have not been arranged for by the HCPP, he/she is liable for any applicable Medicare deductible and/or coinsurance amounts, and any balance would be paid by the regional Medicare carrier.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Major provisions include portability provisions for group and individual health insurance, establishes the Medicare Integrity Program, and provides for standardization of health data and privacy of health records.

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

GLOSSARY

I

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

Intermediary: A private business—typically an insurance company—that contracts with CMS to process hospital and other institutional provider benefit claims.

Internal Controls: Management systems and policies for reasonably documenting, monitoring, and correcting operational processes to prevent and detect waste and to ensure proper payment. Also known as management controls.

M

Mandatory Spending: Outlays for entitlement programs such as Medicaid and Medicare benefits.

Material Weakness: A serious flaw in management or internal controls requiring high-priority corrective action.

Medicare Current Beneficiary Survey (MCBS): A comprehensive source of information on the health, health care, and socioeconomic and demographic characteristics of aged, disabled, and institutional Medicare beneficiaries.

Medicare Contractor: A collective term for the carriers and intermediaries who process Medicare claims.

Medicare+Choice: A provision in the BBA that restructures CMS authority to contract with a variety of managed care entities, including health maintenance organizations (HMO) and Competitive Medical Plans (CMP), both of which were previously allowed to participate in Medicare, as well as preferred provider organizations (PPO) and preferred supplier organizations (PSO), religious fraternal benefit society plans, private fee-for-service-plans, and medical saving accounts (MSAs), for which the BBA authorizes a special demonstration for up to 390,000 beneficiaries.

Medicare Integrity Program (MIP): A provision in HIPAA that sets up a revolving fund to support the CMS program integrity program.

Medicare Trust Funds: Treasury accounts established by the Social Security Act for the receipt of revenues, maintenance of reserves, and disbursement of payments for the HI and SMI programs.

Medical Review/Utilization Review (MR/UR): Contractor reviews of Medicare claims to ensure that the service was necessary and appropriate.

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.

O

Obligation: Budgeted funds committed to be spent.

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."

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

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

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

Q

Quality Improvement Organizations: 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 is of acceptable quality.

R

Recipient: An individual covered by the Medicaid program (also referred to as a beneficiary).

Risk-Based Health Maintenance Organization (HMO)/Competitive Medical Plan (CMP): A type of managed care organization. After any applicable deductible or co-payment, all of an enrollee/member's medical care costs are paid for in return for a monthly premium. However, due to the "lock-in" provision, all of the enrollee/member's services (except for out-of-area emergency services) must be arranged for by the risk HMO. Should the Medicare enrollee/member choose to obtain service not arranged for by the plan, he/she will be liable for the costs. Neither the HMO nor the Medicare program will pay for services from providers that are not part of the HMO's health care system/network.

Revenue: The recognition of income earned and the use of appropriated capital from the rendering of services in the current period.

S

Self Employment Contribution Act (SECA) Payroll Tax: Medicare's share of SECA is used to fund the HI trust fund. Self-employed individuals contribute 2.9 percent of taxable annual net income, with no limitation.

State Certification: Inspections of Medicare provider facilities to ensure compliance with Federal health, safety, and program standards.

State Children's Health Insurance Program (SCHIP) (also known as Title XXI): A provision of the BBA that provides federal funding through CMS to States so that they can expand child health assistance to uninsured, low-income children.

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

T

Ticket to Work and Work Incentives Improvement Act of 1999: This legislation amends the Social Security Act and increases beneficiary choice in obtaining rehabilitation and vocational services, removes barriers that require people with disabilities to choose between health care coverage and work, and assures that disabled Americans have the opportunity to participate in the workforce.

CMS Key Financial Management Officials

Timothy B. Hill
Chief Financial Officer and Director,
Office of Financial Management

Deborah A. Taylor, CPA
Deputy Director,
Office of Financial Management

Maria Montilla, CPA
Acting Deputy Director,
Accounting Management Group and
Director, Division of Financial Oversight

Dennis Czulewicz
Director,
Division of Accounting Operations

Jeff Chaney, CPA
Acting Deputy Chief Financial Officer
and Acting Director,
Accounting Management Group

Richard Foster
Chief Actuary

Marvin Washington, CPA
Director,
Division of Financial Reporting and
Debt Referral

Kurt Pleines
Director,
Division of Accounting Systems

Karen Fedi
Director,
Division of Premium Billing
and Collections

For additional information on the following, please call or email:

Financial Report
Julie Frank, CPA
(410) 786-0328
jfrank@cms.hhs.gov

Paul Konka
(410) 786-7842
pkonka@cms.hhs.gov

Financial Statement Preparation
Margaret Bone
(410) 786-5466
mbone@cms.hhs.gov

Robert Fox, CPA
(410) 786-5458
rfox@cms.hhs.gov

Healthcare Integrated General Ledger Accounting System Project
John Moeller
(410) 786-5841
jmoeller@cms.hhs.gov

Performance Measures
Harriet Rubinson
(410) 786-0366
hrubinson@cms.hhs.gov

More information relating to CMS is available at www.cms.hhs.gov.

The CMS welcomes comments and suggestions on both the content and presentation of this report. Please send them to Paul Konka by email or CMS, Mail Stop C3-13-08, 7500 Security Blvd., Baltimore, MD 21244-1850.

U.S. Department of Health and Human Services

Tommy G. Thompson, Secretary

Centers for Medicare & Medicaid Services

Thomas A. Scully, Administrator

The Chief Financial Officers (CFO) Act of 1990 (P.L. 101-576) marks a major effort to improve U.S. Government financial management and accountability. In pursuit of this goal, the Act instituted a new Federal financial management structure and process modeled on private sector practices. It also established in all major agencies the position of Chief Financial Officer with responsibilities including annual publication of financial statements and an accompanying report. The form and content of this ***Financial Report*** follows guidance provided by the Department of Health and Human Services, the Office of Management and Budget, and the General Accounting Office. It reflects the Centers for Medicare & Medicaid Services's support of the spirit and requirements of the CFO Act and our continuing commitment to improve agency financial reporting.

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7500 Security Boulevard
Baltimore, Maryland 21244-1850

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