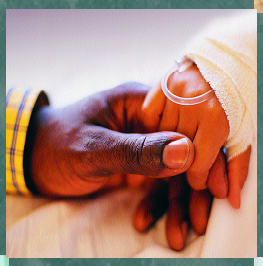
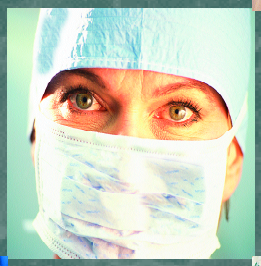
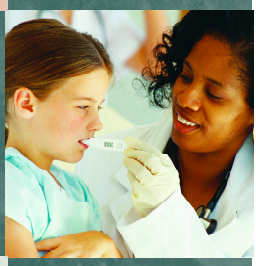
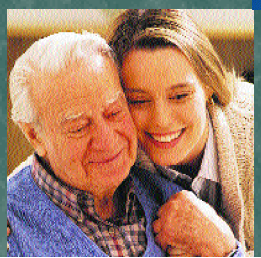
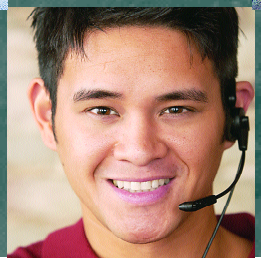
U.S. Department of Health and Human Services

CMS Financial Report

Fiscal Year 2004

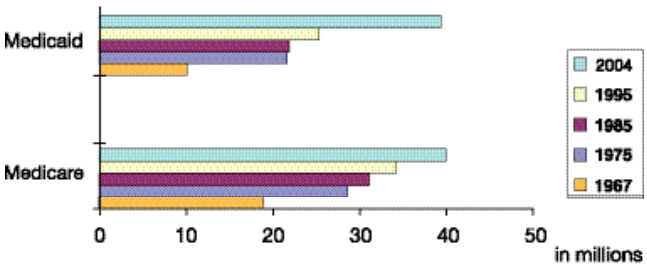





CMS
Centers for Medicare & Medicaid Services

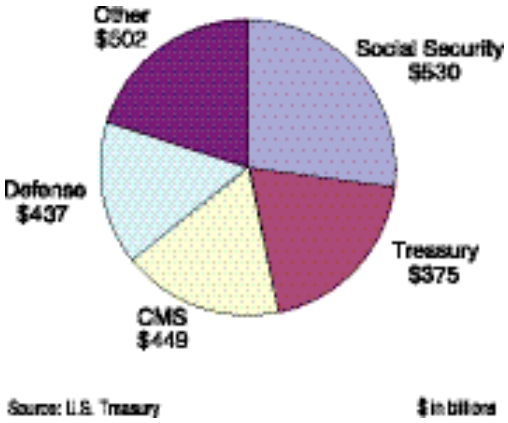
The Centers for Medicare & Medicaid Services At a Glance

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 42 million beneficiaries. Medicaid enrollment has increased from 10 million beneficiaries in 1967 to over 42.9 million beneficiaries.

2004 Program Enrollment



2004 Federal Outlays



The **CMS** outlayed approximately $449 billion (net of offsetting receipts and Payments to the Health Care Trust Funds) in fiscal year (FY) 2004, 20 percent of total Federal outlays. The only agency that outlayed more is the Social Security Administration.

The **CMS** has approximately 4,500 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 (estimated)
CMS	4,500
State Medicaid/SCHIP	102,000
Medicare Contractors	21,700
State Surveyors	6,700
Quality Improvement Orgs.	2,300

A Message from the Administrator

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) Annual Financial Report for fiscal year (FY) 2004. Next year will mark Medicare's 40th anniversary of giving America's seniors protection from rising health care costs and access to the best medical care in the world. Thanks to the leadership shown by the President, Congress and the Secretary of the Department of Health and Human Services with the enactment of the Medicare Prescription Drug, Improvement & Modernization Act of 2003 (MMA), we will honor this very important milestone anniversary by implementing the most sweeping changes and improvements to the Medicare program since 1965. The MMA brings Medicare into the 21st century by providing important new voluntary benefits, like coverage for prescription drugs, improved access to physician services, new preventive and health screening benefits, enhanced benefits, and more affordable health plan options in the Medicare Advantage program. Overall, MMA will allow beneficiaries to have more choices and services from Medicare.

Although major provisions of MMA are slated for implementation in FY 2006, CMS has made significant progress during FY 2004 to implement many of its provisions. In fact, we have taken aggressive steps to provide thousands of dollars of immediate help through the issuance of the Medicare-approved drug discount cards. The CMS is working with many community-based organizations across the country to reach seniors and people with disabilities who are struggling with the costs of their medicines. In addition, CMS has established the "Lower Cost Rx Comparison Tool" to help beneficiaries compare drug costs and make more informed decisions.

The CMS is also working to further expand health care for those who need it most. We continue to institute initiatives to allow greater access to medical care for children and lower-income Americans. The CMS continues to help States extend coverage to low-income Americans and children by granting state waivers and approving state plan amendments through the Medicaid and State Children's Health Insurance Program.

Medicare continues to have an enormous impact on the well-being of America's seniors and people with a disability. The CMS' mission is to assure health care security for beneficiaries. With better benefits than ever, we can do even more to accomplish our mission and improve the health care of our beneficiaries in the years ahead. This year marks a truly exciting and critical time for CMS and the customers we serve.

Mark B. McClellan, M.D., Ph.D.
November 2004

A Message from the Chief Financial Officer

As the Chief Financial Officer (CFO), I am proud to report that CMS has received an unqualified opinion on the Agency's financial statements for the sixth consecutive year. The CMS' unqualified opinions over the years provide continued assurance that our financial statements report reliable information regarding the administration of CMS' programs. While this is a significant accomplishment, it is not enough. We continue to work diligently to improve our financial management performance in many areas, including those areas identified as material weaknesses by our auditors. To this end, there were many initiatives undertaken in FY 2004 to further enhance and improve CMS' financial management performance:

- We continue to make progress toward the implementation of HIGLAS with "live" implementation pending at the pilot contractors. 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.

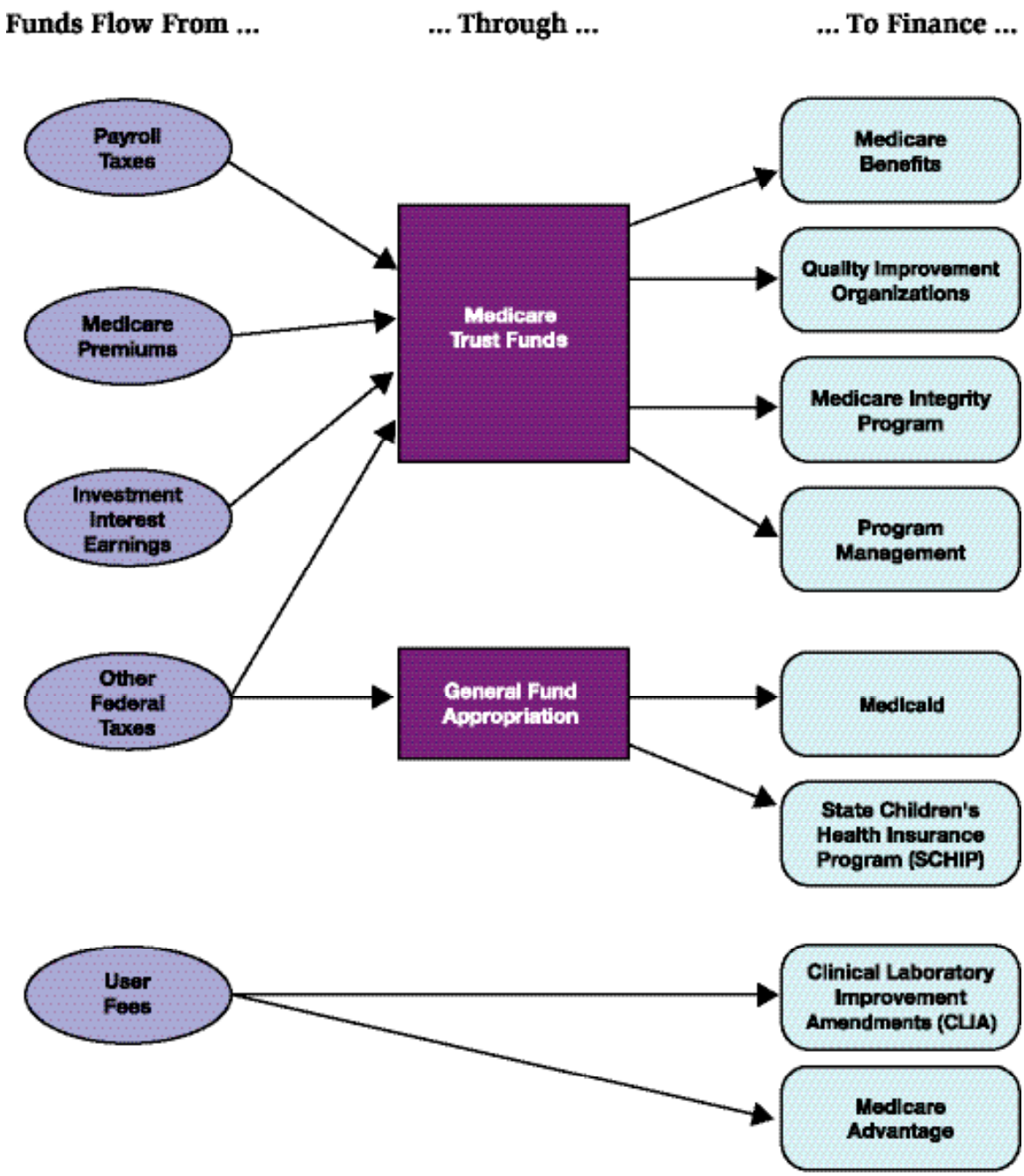
- We have strengthened our efforts to reduce fraud and abuse in the Medicare and Medicaid programs. CMS' program integrity efforts are being expanded beyond fee-for-service Medicare to encompass oversight of the discount drug card program, the prescription drug benefit and the new Medicare Advantage plans. We are also planning to focus more efforts relating to the oversight of Medicaid and SCHIP program integrity through the Payment Error Rate Measurement.

- As part of our financial management oversight, we conducted internal controls and accounts receivable reviews at 14 Medicare contractors to provide assurance that reported information is accurate, reliable, and uniform. We continue to implement initiatives to address the following four key financial oversight areas: Corrective Action Plans, Cash Reconciliation, Trend Analysis, and Internal Controls.

Our goals in the coming year will include continuing to strengthen our financial management. The magnitude and complexity of the programs that we administer demand nothing less. The unqualified opinion on our financial statements demonstrates CMS' discipline and accountability in the execution of our fiscal responsibilities. We must 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. As CFO, I have an obligation to build on the successes of the past and position the Agency for continued financial management excellence.

Timothy Hill
November 2004

Financing of CMS Programs and Operations



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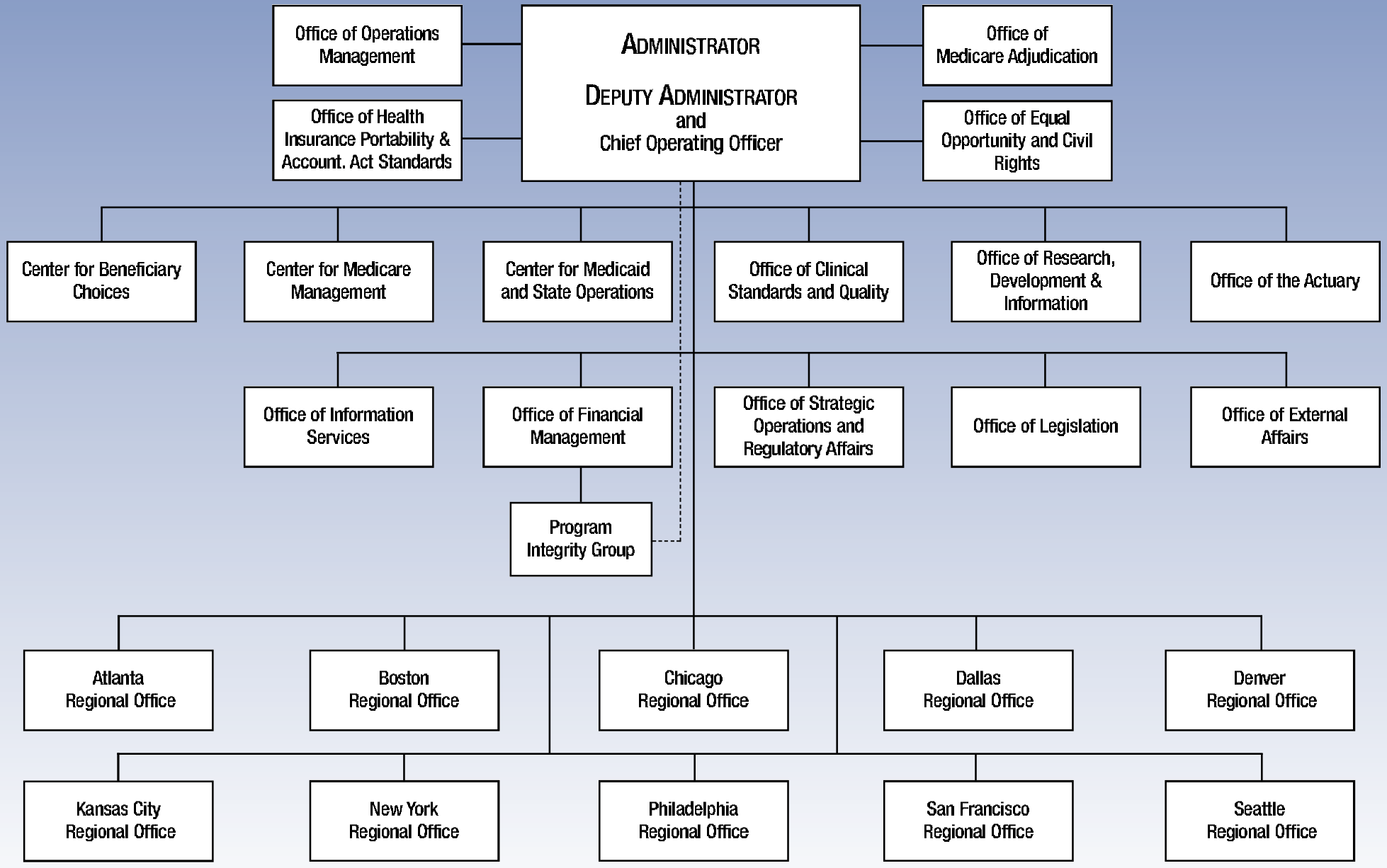
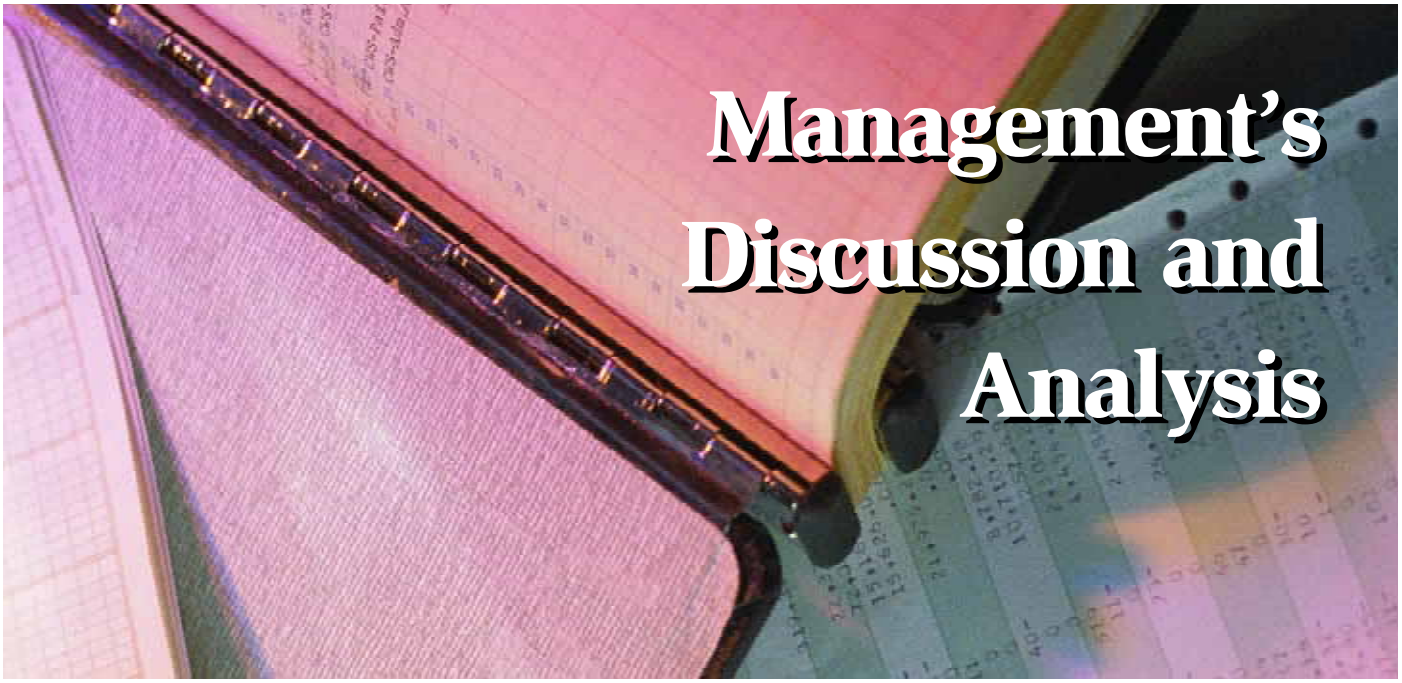
Approved Structure
As of September 2004

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES



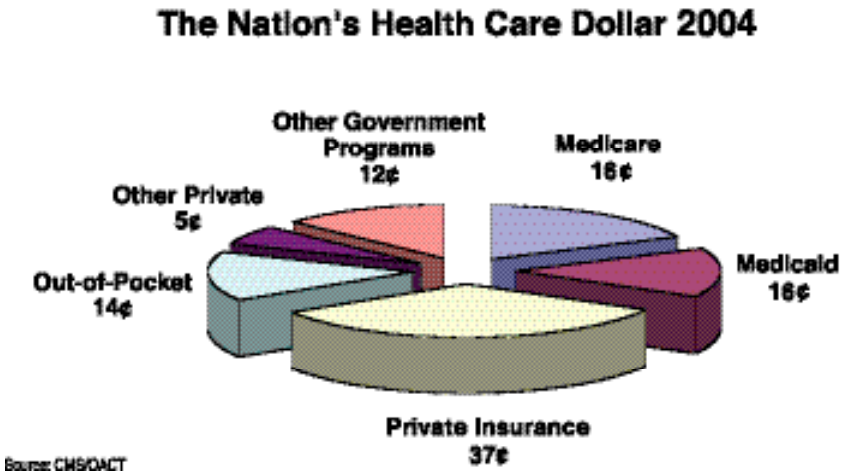


Management's Discussion and Analysis

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 of 1998 (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 32 cents of every dollar spent on health care in the United States (U.S.)—or looked at from three



different perspectives, 63 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 approximately $449 billion (net of offsetting receipts and Payments to the Health Care Trust Funds) in fiscal year (FY) 2004. Our **expenses** totaled $483.7 billion, of which $2.7 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 4,500 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. The remaining employees work in Baltimore, Maryland 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 the 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 102,000 state employees administer Medicaid and SCHIP; (2) 21,700 employees at 47 Medicare contractors—25 fiscal intermediaries, 18 carriers, and 4 Durable Medical Equipment Regional Carriers (DMERCs)—process Medicare claims, provide technical assistance to providers and service beneficiaries' needs, and respond to inquiries; (3) 6,700 state employees inspect hospitals, nursing homes, and other facilities to ensure that health and safety standards are met; and (4) 2,300 employees at 39 Quality Improvement Organizations (QIOs) conduct a wide variety of quality improvement programs to ensure quality of care provided to Medicare beneficiaries.

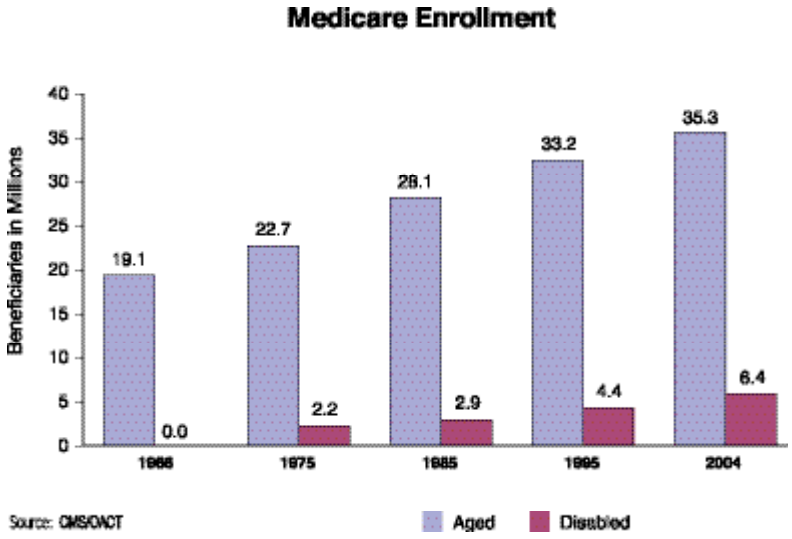
PROGRAMS

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 12 percent of the Federal Budget. Medicare is a combination of three programs: Hospital Insurance, Supplementary Medical Insurance, and Medicare Advantage. Since 1966, Medicare enrollment has increased from 19 million to approximately 42 million beneficiaries.

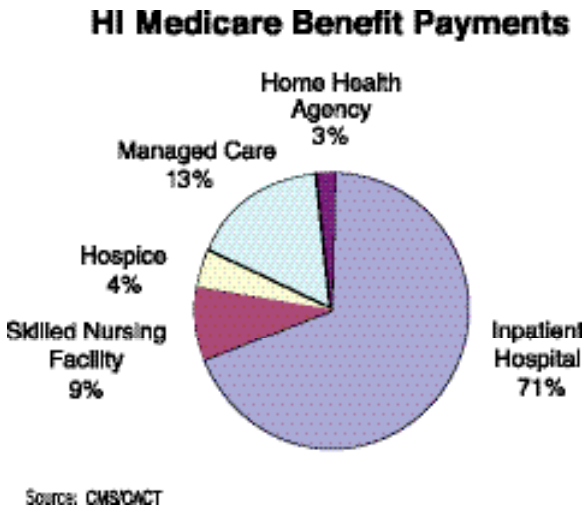


In December 2003, the President signed legislation to improve and modernize the Medicare program, including the addition of a drug benefit. This legislation—the Medicare Prescription Drug, Improvement & Modernization Act of 2003 (MMA)—represents the largest change to the Medicare program since its enactment in 1965. The diverse impacts of MMA are reflected in the various sections of this report.

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

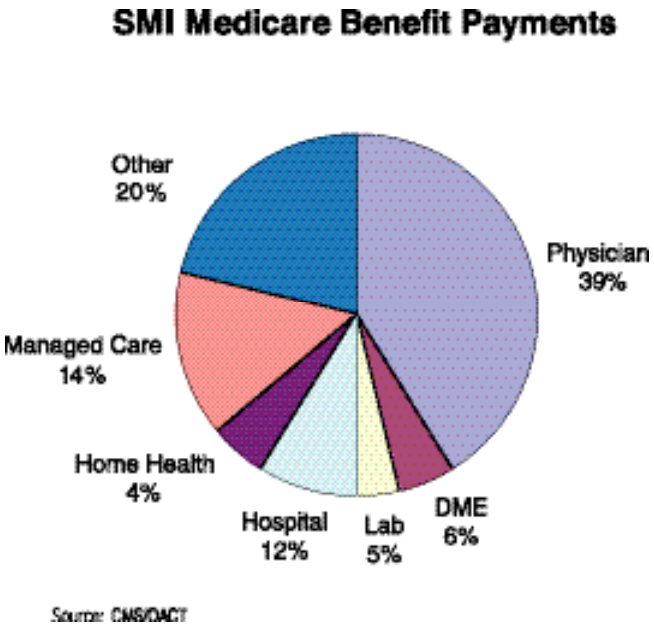
Railroad Retirement benefits. The HI program pays for hospital, skilled nursing facility, home health, and hospice care and is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed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



Based on estimates from the Mid-Session Review of the FY 2005 President's budget, inpatient hospital spending accounted for 71 percent of HI benefit outlays. Managed care spending comprised 13 percent of total HI outlays. During FY 2004, HI benefit outlays grew by 8.7 percent. The HI benefit outlays per enrollee are projected to increase by 6.8 percent to $4,040.

Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI or Medicare Part B and Medicare Part D, 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, Medicare prescription drug discount card enrollment fees and prescription drug expenses for Transitional Assistance beneficiaries, 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.



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 2004, SMI benefit outlays grew by 9.8 percent. Physician services, the largest component of SMI, accounted for 39 percent of SMI benefit outlays. The SMI benefit outlays per enrollee are projected to increase 8.3 percent to $3,370.

Medicare Advantage

The MMA created the Medicare Advantage (MA) program, which is 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 a MA 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 a MA 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. MA plans 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. MA plans currently serve Medicare beneficiaries through coordinated care plans, which include HMOs, point-of-service (POS) plans offered by HMOs, preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), and a private FFS plan. MA demonstration projects, as well as cost and Health Care Prepayment Plans (HCPPs) options, also exist.

All MA plans are currently paid a per capita premium, assume full financial risk for all care provided to Medicare beneficiaries, and must provide all Medicare covered services. Many MA 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 MA 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 current provisions.

Managed care expenses were $39.6 billion of the total $299.7 billion in Medicare benefit expenses in FY 2004.

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 42.9 million in FY 2004, about 14 percent of the U.S. population. Nearly 7 million people are dually eligible, that is, covered by both Medicare and Medicaid.

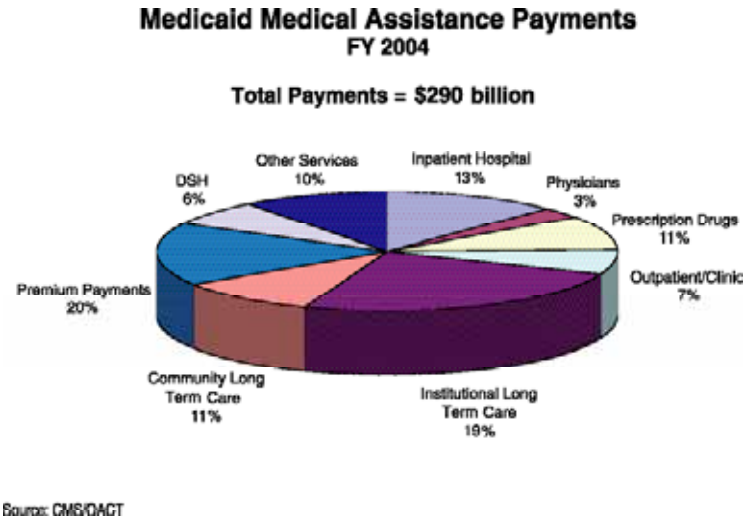
The CMS provides matching payments to States and Territories to cover the Medicaid program and related administrative costs. State medical assistance payments are matched according to a formula relating each State's per capita income to the national average. In FY 2004, the Federal matching rate for Medicaid program costs among the States according to the formula ranged from 50 to 77 percent. However, in 2003, Congress granted States a temporary increase in their matching rates on most services, which remained in effect through the first three quarters of FY 2004. As a result of this increase, the average matching rate for FY 2004 was about 59 percent. Federal matching rates for various State and local administrative costs are set by statute, and in FY 2004 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 its individual circumstances and priorities. Accordingly, there is a wide variation in the services offered by the States.

Medicaid is the largest single source of payment for health care services for persons with Acquired Immune Deficiency Syndrome (AIDS). Medicaid now serves over 50 percent of all AIDS patients and pays for the health care costs of most of the children and infants with AIDS. Medicaid spending for AIDS care and treatment in FY 2004 is estimated to be about $9.5 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 2004, State and Federal ADM gross outlays are estimated at $16 billion, about 5.3 percent of the gross Medicaid outlays. State and Federal MAP gross outlays are estimated at $290.5 billion or 95 percent of total Medicaid gross outlays, an increase of 11.3 percent over FY 2003. Thus, State and Federal MAP and ADM outlays for FY 2004 totaled $306.8 billion. The CMS share of Medicaid expenses totaled $180.3 billion in FY 2004.

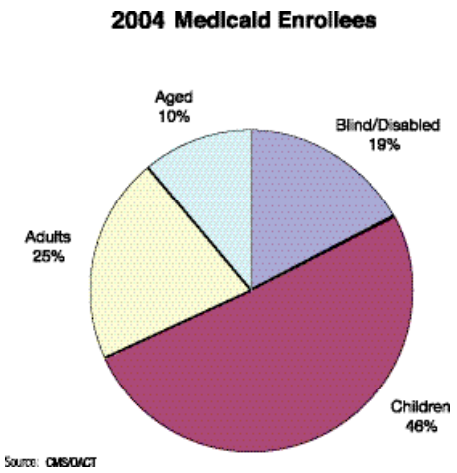


Enrollees

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 66 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 59 percent in 2003.



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

1) State health reform waivers—Section 1115 of the Social Security Act provides broad

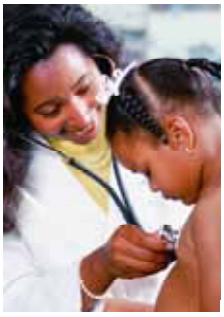
discretion to waive certain provisions of Medicaid law for experimental, pilot, or demonstration projects. In August 2001, the President announced a section 1115 initiative, known as Health Insurance Flexibility and Accountability, to increase health insurance coverage by coordinating available Medicaid 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 the States to develop innovative managed health care delivery systems.

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

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

State Children's Health Insurance (SCHIP)



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, use existing comprehensive State-based coverage; or provide coverage approved by the Secretary of HHS.

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.

The CMS works closely with the States, Congress, and other Federal agencies to meet the challenges of implementing this program. The CMS provides extensive guidance and technical assistance so the States can further develop their plans and use Federal funds to provide health care coverage to as many children as possible. Since September 30, 1999, all 50 States, the District of Columbia, and the Territories had approved SCHIP state plans, 17 Medicaid expansions, 18 separate SCHIPs, and 21 programs that are combination plans. In addition, as of September 2004, CMS has reviewed and approved over 200 SCHIP state plan amendments and 15 section 1115 waivers. Of the 15 section 1115 waivers approved, 12 were waivers of title XXI for Separate Child Health Programs, and 3 were waivers of title XIX for Medicaid Expansion Programs.

Other Activities

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

Survey and Certification Program

We are responsible for assuring the safety and quality of medical facilities, laboratories, providers, and suppliers by setting standards, training inspectors, conducting inspections, certifying providers as eligible for program payments, and ensuring that corrective actions are taken where deficiencies are found. The survey and certification program is designed to ensure that providers and suppliers comply with Federal health, safety, and program standards. We administer agreements with State survey agencies to conduct onsite facility inspections. Funding is provided through the Program Management and the Medicaid appropriations. Only certified providers, suppliers, and laboratories are eligible for Medicare or Medicaid payments. Currently, CMS Survey and Certification staff oversee compliance with Medicare health and safety standards in over 246,000 medical facilities of different types, including hospitals, laboratories, nursing homes, home health agencies, hospices, and end stage renal disease facilities.

Clinical Laboratory Improvement Program (CLIA)

The 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

Quality health care for people with Medicare is a high priority for the President, HHS, and CMS. In November 2001, the Secretary of HHS announced the Quality Initiative, his commitment to assure quality health care for all Americans through consumer information coupled with the support of Medicare's QIOs.

The Quality Initiative was launched nationally in 2002 as the Nursing Home Quality Initiative (NHQI) and expanded in 2003 with the Home Health Quality Initiative (HHQI) and the Hospital Quality Initiative (HQI). These initiatives provide consumers with *quality* of care information to make more informed decisions about their health care and providers/clinicians with information and technical support to provide *quality* health care. Over the next several years, CMS will work to develop and publish similar, meaningful consumer information for other types of providers.

Nursing Home

In January 2004, CMS launched an enhanced set of 14 publicly reported quality measures, 11 chronic care and 3 post-acute measures, on the Nursing Home Compare Web site. We anticipate adding a weight loss measure in late Fall 2004 and enhanced nurse staffing data in the Spring of 2005.

Home Health

Working with input from measurement experts, the Agency for Healthcare Research and Quality, and a diverse group of home health industry stakeholders, CMS adopted a set of 11 home health quality measures for Medicare-certified home health agencies. Beginning in November 2003, the quality measures are published at **www.medicare.gov** on Home Health Compare (HHC) for the approximately 7,100 Medicare-certified agencies in the country. The CMS has requested the National Quality Forum begin their consensus process to identify additional measures for future use.

Hospital

The CMS started reporting the starter set of 10 quality measures on **www.cms.hhs.gov** in October 2003. The measures are reported only for hospitals that volunteer to participate in the national voluntary reporting effort. There was an increase in the number of reporting hospitals during the May 2004 data update. Such data updates will occur quarterly. The CMS expects to launch Hospital Compare on **www.medicare.gov** in early 2005. The Medicare Reform Act (section 501b) requires eligible hospitals to submit performance data for the 10 quality measures in order to receive their full FY 2005 market basket update. Of the 3,906 hospitals participating, 98.3 percent have fulfilled the requirements to receive the full market basket update. In 2005, CMS expects to expand the number of clinical measures reported on Hospital Compare and include an additional condition. Results of the Hospital Patient Perspectives on Care Survey (HCAHPS) will be added to Hospital Compare once the survey data are available.

Physician Focused

This initiative includes the Doctors' Office Quality (DOQ) project, the Doctors' Office Quality Information Technology (DOQ-IT) project, several demonstration projects and valuation reports. The DOQ project measurement set has three components: clinical performance measures, an office-system assessment survey and a patient experience of care survey. Pilot states (California, Iowa and New York) will be used to evaluate different data collection processes and to study correlations between the three data collection components. The goal of this project is to identify a standard core set of physician office measures and thus, reduce collection burden on physicians and ensure data integrity. In support of the President's recent announcement supporting the need for information technology in healthcare, the DOQ-IT project encourages physicians to incorporate integrated information systems such as electronic medical records and e-Prescribing into their practices.

End-Stage Renal Disease

The CMS currently reports three quality measures on Dialysis Facility Compare and efforts are underway to expand the measure set. Additionally, CMS collects and reports clinical performance measures (CPMs) for provider feedback. Patient experience of care surveys are being developed for Hemodialysis Patients (ESRD CAHPS) to augment the clinical measures.

Coverage Policy

Coverage policy affects every insurer and health care purchaser in today's health care market. The CMS has 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 and others for assessing the effectiveness of a variety of medical treatments.

Insurance Oversight and Data Standards

The CMS has primary responsibility for implementing and enforcing Federal standards for the Medigap insurance offered to Medicare beneficiaries to help pay the coinsurance and deductibles that Medicare does not cover. We work with the 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 title II administrative simplification provisions, which are aimed at streamlining healthcare administration and at reducing administrative costs. Title II of 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. Title II of 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 title I, CMS has a role in relation to state regulation of health insurance coverage that is similar to its Medigap oversight responsibilities. We work with the State Insurance Commissioners' offices, the U.S. Department of Labor, and the Internal Revenue Service (IRS) to implement these provisions. The common goal is to improve access to health coverage for individuals who move from job to job, or who lose their group health coverage and must purchase individual coverage.

The CMS also has *advisory* jurisdiction with respect to the Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage as it pertains to state and local governmental employers and the group health plans that they sponsor. (Title XXII of the Public Health Service Act; 42 U.S.C. 300bb-1 through 300bb-8.) While there is no Federal administrative enforcement authority under the public sector COBRA statute, the law affords individuals a private cause of action for equitable relief with respect to a failure of a state, political subdivision, or agency or instrumentality of either, to comply with public sector COBRA requirements.

PERFORMANCE GOALS

The Government Performance and Results Act (GPRA) mandates 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 strategic and performance goals and its mission to "assure health care security for beneficiaries."

The CMS' 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 long-term strategic goals. It also complements and supports CMS' budget. The APP includes the steps to accomplish each performance goal, and establishes a method and data source for measuring and reporting. The CMS uses the performance information to identify opportunities for improvement and to shape its programs.

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 FFS 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 2004 APP includes 36 goals for CMS programs that highlight major program areas and budget categories. The APP does not reflect every activity and challenge encountered by the Agency. Instead, it reflects key Administration and CMS priorities that are representative of the vital activities CMS performs to fulfill its mission. 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.

Some of CMS key FY 2004 performance goals and outcomes are highlighted below. Our progress on the remaining 31 goals will be submitted with the Annual Performance Report along with the President's budget request for FY 2006.

Implement the New Medicare-Endorsed Drug Card

The CMS' FY 2004 target was to implement the new Medicare-Endorsed Prescription Drug Discount Card program through the development and publication of the requirements for the Medicare-Endorsed Prescription Drug Discount Card program, solicitation and approval of applications from prescription drug discount card program sponsors, and provision of information to people with Medicare about the program.

The MMA provides Medicare beneficiaries with access to prescription drug coverage and the buying power to reduce the prices they pay for drugs. The MMA provides enhanced coverage for the lowest income beneficiaries and an immediate prescription drug discount card for all people with Medicare until the full plan is available nationwide.

People with Medicare without drug coverage are now eligible for the Medicare-Endorsed Prescription Drug Discount Card, which began June 1, 2004, and continues until the full benefit is implemented. The card program is estimated to save beneficiaries between 10 to 25 percent on most drugs. Those with incomes below 135 percent of poverty will be given immediate assistance through a Medicare-Endorsed Prescription Drug Discount Card with $600 annually to apply toward purchasing their medications.

The CMS has entered into contracts establishing Medicare-Endorsed Prescription Drug Discount Cards administered through qualified private sector organizations such as pharmacy benefit managers, insurers, chain pharmacies, and managed care plans. In April 2004, CMS began displaying on the Internet the prices of all drug card products offered by approved organizations.

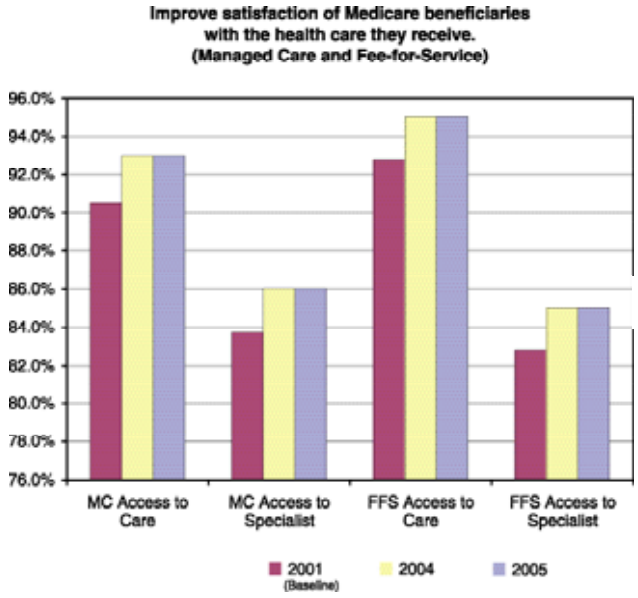
The CMS has also developed and posted a standard enrollment form that may be used by partners and other entities that assist beneficiaries. All Medicare approved drug card sponsors will accept applications for enrollment either via the standard form, or through their own form approved by CMS. Development and publication of the requirements for the

Medicare-Endorsed Prescription Drug Discount Card program and solicitation and approval of applications from drug card sponsors are complete.

The CMS developed and published the Notice of Proposed Rulemaking for the Prescription Drug Benefit, which is mandated to begin January 2006. The CMS will work closely with the IRS, Social Security Administration, and various governmental agencies in implementing this program.

Improve Medicare Beneficiary Satisfaction with the Health Care Services they Receive in Managed Care and FFS

The CMS' FY 2004 target was to collect and share data toward our FY 2005 targets, which are managed care access to care/specialists: 93 percent/86 percent and FFS access to care/specialists: 95 percent/85 percent.



A fundamental CMS goal 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 FFS plan. The CMS shares the results with health plans and Medicare beneficiaries through various means, including the National ***Medicare & You*** Education Program (NMEP), and with QIOs at the annual American Health Quality Association meetings.

Provision of CAHPS performance information assists beneficiaries in their health plan choices under Medicare. Annual development of specific performance measures also permits use of CAHPS as a tool for monitoring beneficiary experiences in and satisfaction with differing care delivery modes and in different regions of the country. Plan-specific measures provide direct incentives for managed care plans to improve performance and health services quality. FFS measures, reported by geographic area, assist in development of strategies to improve care quality through targeted interventions implemented either directly by CMS or through other partners. The performance indicators and satisfaction measures disseminated through the NMEP also are part of a long-term strategy to monitor and evaluate the use of specific services provided through Medicare, and improve consumer satisfaction regarding the services received.

The CMS conducts research on the use and understanding of these measures by beneficiaries, as well as in the effectiveness of specific initiatives monitored by these measures in improving service quality. Our baselines for both managed care and FFS satisfaction are already fairly high. Given this type of survey for a large group of people and considering the unrelated factors that could influence responses, we know that a target of 100 percent satisfaction is unrealistic. Nonetheless, our targets are challenging and are set for a five-year period in order for the percentage increases to be large enough to be statistically detected.

Increase Annual Influenza and Pneumococcal Vaccinations

The CMS' FY 2004 target was to increase influenza vaccinations to 72.5 percent and increase pneumococcal vaccinations to 69 percent.

In 2001 and 2002 the National Center for Health Statistics reported influenza and pneumonia to be the primary causes of death for a significant number of older adults. For all persons age 65 or older, the Advisory Committee on Immunization practices (ACIP) and other leading authorities recommend lifetime vaccination for pneumococcal pneumonia and annual vaccination for influenza. Consistent with HHS' strategic plan goals and through the collaborative efforts of CMS, the Centers for Disease Control and Prevention (CDC) and the National Coalition for Adult Immunization (NCAI), we are working to improve adult immunization rates in the Medicare population.

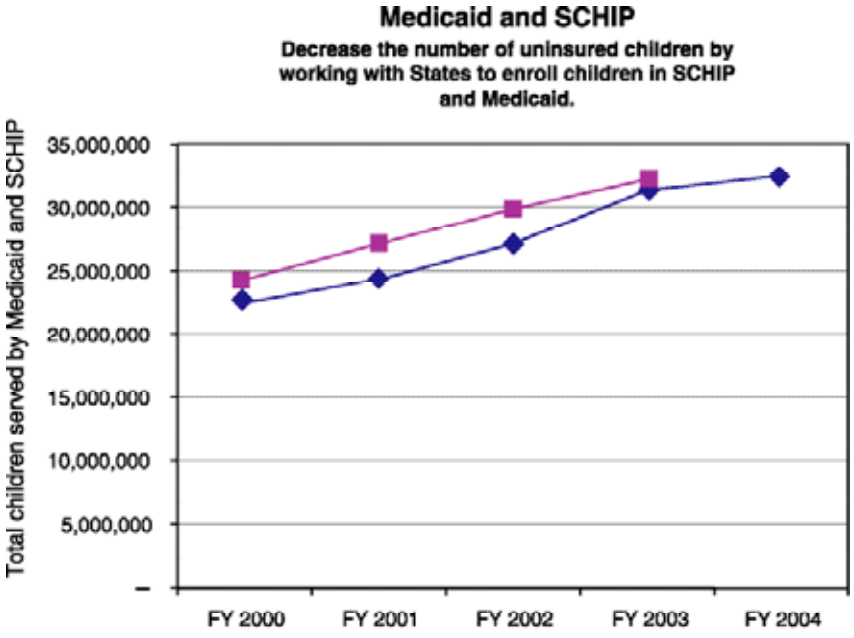
Manufacturing and distribution shortages of the vaccine for influenza have affected our ability to reach our influenza targets. Since the timing of the pneumococcal vaccination usually occurs at the same time as the influenza vaccination, performance in this area is affected as well. There remain external challenges to increasing the influenza and pneumococcal vaccination rates such as, reported public concerns about the side effects and general safety of immunizations, fueled by reports of potential side effects of the smallpox vaccine. Additionally, producing the specific strain needed in a given influenza season has also been a challenge which has affected supply. However, CMS is working to reduce known barriers to influenza and pneumococcal vaccinations in order to contribute to higher rates in the future.

The QIOs are also working in collaboration with beneficiaries, providers, managed care plans, community groups and other interested partners to design and implement immunization quality improvement projects. These projects are conducted in hospitals, long-term care facilities, dialysis facilities, physician offices, home health agencies and public health clinics. They combine education for healthcare workers, a plan for identifying high-risk patients, and efforts to remove administrative and financial barriers that prevent patients from receiving influenza and pneumococcal vaccines.

Decrease the Number of Uninsured Children by Working with the States to Enroll Children in SCHIP and Medicaid

The CMS' FY 2004 target was to maintain the enrollment of children in SCHIP and Medicaid at the FY 2003 levels.

Through title XXI of the Social Security Act, the States were given the option to expand their Medicaid program, establish a separate SCHIP, or use a combination of both. The SCHIP and Medicaid programs have enhanced the availability of health care coverage to improve the quality of life for millions of vulnerable, uninsured, low-income children. The energy invested by the States and Territories, communities, and the Federal Government has resulted in significant expansions in coverage, as well as new systems for enrolling children. While the main goal of SCHIP still remains to provide health assistance to uninsured, low-income children and to increase enrollment, the current economic conditions have made it difficult for CMS to achieve its enrollment targets for SCHIP. Therefore, CMS revised its GPRA enrollment targets for FY 2004 to maintain enrollment of children in SCHIP and Medicaid at the FY 2003 levels.



Many states have eliminated barriers that prevent families from enrolling in Medicaid and SCHIP. For example, some states simplified application forms and eliminated income verification requirements. Also, a number of states have expanded eligibility to provide coverage to other populations (i.e., parents, families with incomes at higher levels of the Federal poverty level, etc.) as a way to increase enrollment in Medicaid and SCHIP. In the face of the recent fiscal challenges, there are also a number of states limiting outreach in SCHIP and Medicaid to try to maintain their current eligibility levels. Since the inception of SCHIP, there has been a substantial increase in Medicaid enrollment, partly due to the mass media and outreach campaigns in the early years of SCHIP. In addition, the SCHIP requirement for states to screen all SCHIP applicants for Medicaid eligibility has enabled a number of children who may have been eligible for Medicaid to actually get enrolled in the program.

The CMS continues to work with states to assure that their programs are designed to best meet the needs of their children and provides extensive technical assistance to states that need to modify their programs. In addition, CMS published a regulation in 2002, which allows states to provide health care coverage under SCHIP to pregnant women for children who are not yet born.

Reduce the Medicare FFS Error Rate

The CMS FY 2004 target for the Medicare FFS error rate was 4.8 percent (net) and 5.6 percent (gross).

The CMS is committed to continuing to reduce the percentage of improper payments made under the Medicare FFS 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.

The FY 2004 ***CMS Financial Report*** includes estimates from CMS' two Medicare FFS measurement programs: the Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring Program (HPMP). This year, CMS sampled approximately 120,000 claims for CERT and approximately 40,000 discharges for HPMP. These programs provide CMS with a rigorous set of data that CMS can use to manage Medicare contractors, identify and prevent errors, and educate providers that bill CMS programs.

The CMS analysis for FY 2004 indicated that the paid claims net error rate was 9.3 percent or $19.8 billion in net improper payments.

The CMS did not meet its goal for FY 2004 but 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 to address state-specific admissions necessity and coding concerns, as well as to facilitate the surveillance and monitoring of inpatient payment error trends by error type. The CMS has directed Medicare contractors to develop local efforts to lower the error rate by developing plans that address the problems that result in errors. These plans must specify 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 FFS contractors accountable for the services they provide as CMS moves from contracts that simply pay contractors to process Medicare claims to performance-based contracts. There is additional discussion of the CERT program under the section of Improper Payments.

FINANCIAL ACCOMPLISHMENTS AND STATEMENT HIGHLIGHTS

For the sixth 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. 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. However, our auditors have identified a material weakness regarding CMS' financial systems, reporting, analysis and oversight in both the Medicare and Medicaid programs. The auditors found that CMS needs to improve its communication processes and procedures to prevent financial statements from being issued that are materially misstated. The Medicare contractors continue to

make improvements in maintaining supporting records for Medicare activities. However, because of the lack of a formal, integrated accounting system to accumulate and report financial information by Medicare contractors, States, CMS CO and ROs, CMS uses ad hoc, labor-intensive reports, which increases the risk of material misstatement or omission. As CMS progresses toward its long-term goal of developing an integrated general ledger system, we will continue to promote a uniform method of reporting and accounting for financial data.

Additionally, the auditors indicated the inadequate monitoring of managed care organizations. For example, the auditors disclosed instances of inadequate policies, documentation, and supervisory review related to the authorization and payment process for managed care organizations. Moreover, procedures regarding the Medicaid oversight function were not being performed to ensure that financial data provided by the States are reliable, accurate, and complete. In addition to implementing an integrated general ledger system, the financial oversight of the Medicaid program will be increased.

Accounts Receivable

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 2004, the CPAs conducted reviews at 14 Medicare contractors, which comprised about 88 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).

While we have made significant improvements in financial analyses and oversight of accounts receivables, our auditors continue to report a material weakness in the financial systems 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 TOP are matched to Federal payments for potential offset. Debts referred for cross-servicing, which is the other primary collection tool used by Treasury, can have a variety of collection activities, including sending additional demand letters, referring debts to TOP, referring debts to private collection agencies, negotiating repayment agreements, and 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 eligible CMS debts, and refers those debts to Treasury.

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 2004, we referred approximately $523 million of delinquent debt to Treasury for cross-servicing and TOP. This brought our total gross delinquent debt referred to approximately $6.7 billion, which is about 99 percent of the total net eligible to be referred.

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 2003, 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 CMS Central Office (CO) and RO 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 Office of the Inspector General (OIG), Government Accountability Office (GAO), independent CPA firms, and CMS CO and RO 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 improving financial management. Therefore, audit resolution remains a top priority at CMS. Medicare contractors are required to prepare an initial CAP, which describes activities to correct all identified findings and the timeframes for which they will be implemented. Additionally, quarterly updates to the CAPs are required. The CMS reviews all initial CAPs and quarterly CAP updates for adequacy.

The CAP report consolidates all findings identified during CFO initiated audits, SAS 70 internal control 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 our CAP manual policies and procedures was provided during our annual CFO training conferences.

The CMS contracted with independent CPA firms to conduct CAP follow-up reviews during the SAS 70 internal control reviews and accounts receivable agreed upon procedure reviews that were performed in FY 2004. The CPA firms were able to validate the successful implementation of 256 Medicare contractor CAPs.

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. During FY 2004, the CMS-1522 Cash Reconciliation Workgroup worked with the OIG 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 implemented during FY 2004 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 CMS selected and performed reviews at two Medicare contractor locations during FY 2004 to test compliance with the new procedures. During FY 2005, the workgroup will continue to perform reviews of the Form CMS-1522 report 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 continues to emphasize 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 2004, members of the CPIC workgroup conducted onsite CPIC protocol reviews at seven Medicare contractors for the FY 2003 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 2004, we also contracted with CPA firms to conduct SAS 70 internal control reviews of 14 Medicare contractors. The reviews indicated that each Medicare contractor 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 2005, we will continue to perform these SAS 70 internal control 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

For FY 2004, CMS' budget execution function continues to be a major strength. The CMS established a Chief Operating Officer who works closely with the Chief Financial Officer

to ensure that an operating plan is developed timely and supports the Agency's priorities. Strong fund control procedures ensure resources are only used for those activities in the operating plan that have been approved by the Administrator. The CMS closely monitors available resources throughout the year to ensure the Anti-Deficiency Act is not violated while at the same time meeting reasonable but aggressive lapse targets.

The CMS established two new accounts in FY 2004. The passage of the MMA and an Information Technology Revitalization Plan necessitated the development of an operating plan, an accounting structure, and operational processes to control these additional funds.

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 2004, we continued to revise, clarify and issue Medicare contractor financial reporting instructions. These instructions include revising policies regarding the calculation of the allowance for uncollectible accounts, recognizing and reporting credit balance receivables, and recognizing and reporting unsolicited/voluntary refunds.

We also 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. 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 provided clarification of our 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, financial reporting, enhances Medicare 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

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, 2003, March 31, 2004, and June 30, 2004, and, for the seventh consecutive year, submitted our financial statements through the automated financial statement system implemented by HHS.

We have also complied with Treasury's November 2004 reporting requirement for the Federal Agencies Centralized Trial Balance System (FACTS) II and the January 2004 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 and controls.

Medicare Secondary Payer

Our efforts in the MSP area saved the Medicare trust funds approximately $4.8 billion dollars in FY 2004. The CMS continues to actively pursue delinquent debts owed the Medicare program in compliance with DCIA. Despite the suspension of normal IRS/Social Security Administration/CMS data match (DM) operations in FY 2003 through late Spring of FY 2004, savings attributed to DM remained significant at $377 million for FY 2004. The DM activities resumed in FY 2004, i.e., the mailing of employer questionnaires for tax years 2001 and 2002; this activity should be completed in January FY 2005. The CMS expects savings attributable to this program to increase with normal DM activities resuming in FY 2005 for tax year 2003, combined with the completion of DM mailings for tax years 2001 and 2002.

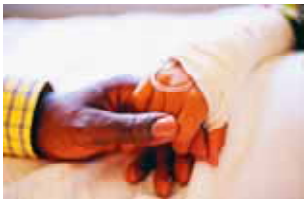
The CMS continues to pursue Voluntary Data Sharing Agreements (VDSAs) with insurers and large employers to secure health care coverage information on working enrollees and dependents. Current participation in the VDSA process includes 77 insurers and large employers. Of these, 18 were signed in FY 2004 with active negotiations and technical discussions continuing with other interested parties. The number of new agreements signed in FY 2004 reflects the rapidly accelerating interest in this program on the part of employers and insurers that recognize the VDSA process represents one of the most cost effective ways to coordinate benefits with Medicare. Overall annual savings attributed to this program grew from $184 million in FY 2003 to $282 million in FY 2004. The CMS expects savings from the VDSA program to grow significantly in FY 2005 with the execution of signed and pending agreements as these partners attain full production status.

We are also continuing with our workers' compensation (WC) DM initiative. This involves entering into data sharing agreements with state WC boards and commissions and large WC insurers. The CMS launched this effort in FY 2004 with the signing of the first WC DM agreement with the State of California. This agreement has resulted in the

creation of many new MSP auxiliary records and $779,396 in cost avoided savings to the Medicare program. The CMS has executed agreements with the States of Kansas, New York, Maryland and Oregon that will be effective in FY 2005. We are also in negotiations with the States of Texas, Florida and Pennsylvania, as well as two large insurance firms.

The CMS has also hired a contractor to review Workers' Compensation Set-aside Arrangements (WCMSA). Since the inception of the contract in October 2003, the contractor has approved WCMSA of $68 million (payments that Medicare would otherwise have been the primary payer). In FY 2004, CMS invested considerable effort in WC outreach and education for our MSP partners; as a result, an increasing number of WCMSA are being submitted to CMS for review and approval.

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 FY 2004 was 88. Disallowances resulting from FY 2004 settlement activity amounted to about $4 million. For FY 2004, we had a rate of return of 4 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). It is these reports that may eventually need many audit adjustments. Thus, many of the more recent cost reports sent to audit have fewer issues. Also, many of these audited plans have incorporated adjustments from prior audits and will require fewer adjustments. The most recent Return on Investment of 4% may well be an aberration because audits of plans with more serious issues are yet to be scheduled or completed.

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 96 percent of our vendor reimbursements and virtually 100 percent of our travel reimbursements are made electronically.

Improper Payments

In 2002, Congress passed the Improper Payment Information Act (IPIA) that aims to standardize the way Federal agencies report improper payments in programs they administer. The IPIA includes requirements for identifying and reporting improper payments and defines improper payments as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments). Incorrect payments also include payments to ineligible recipients or payments for ineligible services, as well as duplicate payments and payments for services not received. The identification and reporting of improper payments has been in place for Medicare FFS since FY 1996; however, CMS has initiatives in place to enhance its program integrity efforts to include Medicaid and SCHIP.

Medicare

The CMS has begun to implement the requirements of the Improper Payments Information Act of 2002 (IPIA). Although CMS has not fully complied with the IPIA, we have implemented a comprehensive program that measures the Medicare contractors' payment accuracy rates, and will update its risk assessment for managed care.

A change in methodology required by the IPIA is the use of gross improper payment figures. The gross improper payment figure is calculated by adding together the absolute value of underpayments and overpayments. In all prior years (FY 1996— FY 2003), CMS reported the Medicare FFS estimate of improper payments as a net number (where underpayments were subtracted from overpayments). The FY 2004 Medicare FFS estimate complies with the IPIA requirement to report gross numbers.

The FY 2004 paid claims error rate remained higher than our 2004 goal of 5.6 percent gross and 4.8 percent net. The CMS analysis for FY 2004 indicated that the paid claims gross error rate was 10.1 percent (9.3 percent net) or $21.7 billion in gross improper payments ($19.8 billion net). As discussed in the Performance Goals section of this Financial Report, CMS is taking steps to reduce the error rate for the future.

FY 2004 Gross and Net Improper Payments and Error Rates in the Medicare FFS Program

			Gross		Net	
FY	Overpayments	Underpayments	Improper Payment Amount (Overpayments + Underpayments)	Error Rate	Improper Payment Amount (Overpayments - Underpayments)	Error Rate
2004	$20.8 B	$0.9 B	$21.7 B	10.1%	$19.8 B	9.3%

Medicaid

Medicaid payments are susceptible to erroneous payments as well. Thus, the Federal Government and the States have a strong financial interest in ensuring that claims are paid accurately. In FY 2000, CMS adopted a GPRA goal to explore the feasibility of developing a methodology to estimate payment accuracy in the Medicaid program. In response to this GPRA goal, CMS initiated the Payment Accuracy Measurement (PAM) Project.

In July 2001, CMS solicited states to participate in the first year of the PAM demonstration project, which was implemented in FY 2002. The project essentially requested that states develop a methodology to estimate payment accuracy. The results of this pilot project indicated that it was feasible to estimate payment accuracy in the

Medicaid program. As a result, CMS conducted a second year of the pilot project in FY 2003. Shortly after the beginning of the second year of the PAM project, Congress passed the IPIA.

The CMS continued the pilot in FY 2004 and refined the methodology to include elements that allow for greater compliance with IPIA. The CMS has further refined its methodology for what it anticipates to be its final pilot project before national implementation. The CMS believes that the FY 2005 pilot will comply with all aspects of the IPIA that will be reported in FY 2006. The methodology has been designed to measure payment error in the title XIX Medicaid program and in the title XXI SCHIP in both the FFS and managed care components of these programs.

In FY 2004, CMS issued a draft regulation for the Payment Error Rate Measurement (PERM) project that will require all 50 States and the District of Columbia to annually estimate payment error in their Medicaid and SCHIP programs. We anticipate publishing a final regulation that will be nationally implemented in FY 2006. Once implemented CMS will be able to produce an annual national error rate for both the Medicaid and SCHIP programs.

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 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, and is providing application service provider services. Oracle Corporation is providing the financial accounting software. 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.

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 $324.6 billion in assets. The bulk of these assets are in the Trust Fund Investments totaling $285.8 billion, which are invested in U.S. Treasury Special Issues, special public obligations for exclusive purchase by the Medicare trust funds. Trust fund holdings not necessary to meet current expenditures are invested in interest-bearing obligations of the U.S. or in obligations guaranteed as to both principal and interest by the U.S. The next largest asset is the Fund Balance with Treasury of $26.6 billion, most of which is for Medicaid and SCHIP. Liabilities of $52.4 billion consist primarily of the Entitlement Benefits Due and Payable of $49.2 billion. The CMS net position totals $272.3 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 $481.2 billion for FY 2004. Administrative Expenses were $2.7 billion, less than 1 percent of total net Program/Activity Costs of $451.5 billion.

The net cost of the Medicare program including benefit payments, QIOs, Medicare Integrity Program spending, and administrative costs, was $269.7 billion. The HI total costs of $168.1 billion were offset by $1.8 billion in premiums. The SMI total costs of $133.8

billion were offset by premiums of $30.3 billion. Medicaid total costs of $177.1 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 $4.6 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 $176.7 billion, $104 billion in transfers from Payments to Health Care Trust Funds to HI and SMI, SCHIP appropriations of $4.6 billion, and Ticket to Work appropriations of $207 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 $153.4 billion. The Federal matching contribution is income to the SMI program from a general fund appropriation (Payments to Health Care Trust Funds) of $96.8 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 $608.6 billion. Obligations of $597.4 billion leave unobligated balances of $11,176 million (of which $820 million is not available). Total outlays were $585.1 billion. When offset by $136.6 billion relating to collection of premiums and general fund transfers from the Payments to Health Care Trust Funds, the net outlays were $448.5 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 ***2004 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, 2004 and 2003
(in millions)

	FY 2004 Consolidated Totals	FY 2003 Consolidated Totals
ASSETS		
Intragovernmental Assets:		
Fund Balance with Treasury ***(Note 2)***	$26,570	$18,536
Trust Fund Investments ***(Note 3)***	285,792	280,300
Accounts Receivable, Net ***(Note 4)***	421	700
Other Assets:		
Anticipated Congressional Appropriation ***(Note 5)***	9,248	11,830
Other	1	3
Total Intragovernmental Assets	**322,032**	**311,369**
Cash and Other Monetary Assets	460	843
Accounts Receivable, Net ***(Note 6)***	1,905	2,620
General Property, Plant and Equipment, Net	120	13
Other	101	72
TOTAL ASSETS	**$324,618**	**$314,917**
LIABILITIES ***(Note 9)***		
Intragovernmental Liabilities:		
Accounts Payable	$624	$246
Accrued Payroll and Benefits	3	3
Other Intragovernmental Liabilities ***(Note 7)***	344	233
Total Intragovernmental Liabilities	**971**	**482**
Federal Employee and Veterans' Benefits	10	11
Entitlement Benefits Due and Payable ***(Note 8)***	49,229	48,123
Accrued Payroll and Benefits	51	46
Other Liabilities ***(Note 7)***	2,104	256
TOTAL LIABILITIES	**52,365**	**48,918**
NET POSITION		
Unexpended Appropriations	16,422	13,441
Cumulative Results of Operations	255,831	252,558
TOTAL NET POSITION	**$272,253**	**$265,999**
TOTAL LIABILITIES AND NET POSITION	**$324,618**	**$314,917**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF NET COST
For the Years Ended September 30, 2004 and 2003

(in millions)

	FY 2004 Consolidated Totals	FY 2003 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS		
GPRA Programs		
Medicare	$269,748	$250,074
Medicaid	177,060	161,721
SCHIP	4,611	4,360
Net Cost - GPRA Programs	**451,419**	**416,155**
Other Activities		
CLIA	4	33
Ticket to Work Incentive	34	14
Other		(4)
Net Cost - Other Activities	**38**	**43**
NET COST OF OPERATIONS *(Note 10)*	**$451,457**	**$416,198**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION
For the Years Ended September 30, 2004 and 2003

(in millions)

	FY 2004		FY 2003	
	Cumulative Results of Operations	Unexpended Appropriations	Cumulative Results of Operations	Unexpended Appropriations
BEGINNING BALANCES	**$252,558**	**$13,441**	**$246,707**	**$14,096**
PRIOR PERIOD ADJUSTMENT				
Budgetary Financing Sources:				
Appropriations Received		292,330		261,307
Appropriations Transferred-in/out		(1,208)		(1,167)
Other Adjustments ***(Note 11)***		(2,637)		(5,143)
Appropriations Used	285,504	(285,504)	255,652	(255,652)
Nonexchange Revenue ***(Note 12)***	170,377		167,200	
Transfers-in/out Without Reimbursement ***(Note 13)***	(1,183)		(836)	
Other Financing Sources:				
Transfers-out Without Reimbursement	(1)			
Imputed Financing from Costs Absorbed by Others	33		33	
TOTAL FINANCING SOURCES	**454,730**	**2,981**	**422,049**	**(655)**
NET COST OF OPERATIONS	**451,457**		**416,198**	
ENDING BALANCES	**$255,831**	**$16,422**	**$252,558**	**$13,441**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENT OF BUDGETARY RESOURCES
For the Years Ended September 30, 2004 and 2003

(in millions)

	FY 2004 Combined Totals	RESTATED FY 2003 Combined Totals
Budgetary Resources:		
Budget authority:		
Appropriations received	$599,973	$547,308
Net transfers	(1,208)	(1,162)
Unobligated balance:		
Beginning of period	511	3,358
Net transfers, actual		(5)
Spending authority from offsetting collections:		
Earned:		
Collected	71	65
Change in unfilled customer orders:		
Advance received		(4)
Without advance from Federal sources	3	6
Transfers from trust funds	3,758	2,645
SUBTOTAL	**3,832**	**2,712**
Recoveries of prior year obligations	9,447	7,228
Temporarily not available pursuant to Public Law	(3,921)	(5,571)
Permanently not available	(55)	(6,589)
TOTAL BUDGETARY RESOURCES	**$608,579**	**$547,279**
Status of Budgetary Resources:		
Obligations incurred: ***(Note 15)***		
Direct	$597,329	$546,692
Reimbursable	74	76
SUBTOTAL	**597,403**	**546,768**
Unobligated balance:		
Apportioned	10,356	307
Unobligated balance not available	820	204
TOTAL STATUS OF BUDGETARY RESOURCES	**$608,579**	**$547,279**
Relationship of Obligations to Outlays:		
Obligated balance, net, beginning of period	$51,286	$46,137
Obligated balance, net, end of period:		
Accounts receivable	(1,691)	(1,185)
Unfilled customer orders from Federal sources	(8)	(6)
Undelivered orders	10,455	11,842
Accounts payable	41,568	40,635
Outlays:		
Disbursements	588,409	534,343
Collections	(3,323)	(2,664)
SUBTOTAL	**585,086**	**531,679**
LESS: OFFSETTING RECEIPTS	**136,625**	**118,299**
NET OUTLAYS	**$448,461**	**$413,380**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF FINANCING
For the Years Ended September 30, 2004 and 2003

(in millions)

	FY 2004 Consolidated Totals	RESTATED FY 2003 Consolidated Totals
RESOURCES USED TO FINANCE ACTIVITIES:		
Budgetary Resources Obligated:		
Obligations incurred	$597,403	$546,768
Less: Spending authority from offsetting collections and recoveries	13,279	9,940
Obligations net of offsetting collections and recoveries	584,124	536,828
Less: Offsetting receipts	136,625	118,299
NET OBLIGATIONS	**447,499**	**418,529**
Other Resources:		
Transfers in/out without reimbursement	(1)	
Imputed financing from costs absorbed by others	33	33
NET OTHER RESOURCES USED TO FINANCE ACTIVITIES	**32**	**33**
TOTAL RESOURCES USED TO FINANCE ACTIVITIES	**$447,531**	**$418,562**
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	$(1,364)	$(689)
Resources that fund expenses recognized in prior periods	12,368	11,290
Resources that finance the acquisition of assets	112	8
Other resources or adjustments to net obligated resources that do not affect net cost of operations	3,711	4,623
TOTAL RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS	**14,827**	**15,232**
TOTAL RESOURCES USED TO FINANCE THE NET COST OF OPERATIONS	**$432,704**	**$403,330**
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 entitlement benefit costs	$10,039	$8,987
Liability for unmatched SMI premiums ***(Note 5)***	5,645	3,381
Increase in annual leave liability	1	1
Decrease in receivables from the public	2,473	1,289
Other ***(Note 7)***	1,866	1
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL REQUIRE OR GENERATE RESOURCES IN FUTURE PERIODS	**20,024**	**13,659**
Components Not Requiring or Generating Resources:		
Depreciation and amortization	5	4
Other	(1,276)	(795)
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES	(1,271)	(791)
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD	**18,753**	**12,868**
NET COST OF OPERATIONS	**$451,457**	**$416,198**

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.

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 Prescription Drug Discount Card and Transitional Assistance

The Medicare Prescription Drug Discount Card and Transitional Assistance Program was enacted into law in December 2003 as part of the Medicare Modernization Act of 2003. The Drug Discount Card program enables Medicare beneficiaries to obtain discounts of 10 to 25 percent on prescription drugs. Medicare will also provide a $600 credit for the purchase of prescription drugs in 2004 and up to an additional $600 credit in 2005 to people with incomes that are not more than 135 percent of the poverty line ($12,569 for single individuals or $16,862 for married individuals in 2004—these income levels will vary slightly for subsequent years) if they do not have certain other drug coverage. This program is not intended to be a prescription drug benefit, but rather a measure to help people until the drug benefit is implemented on January 1, 2006.

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' admin-

istrative 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 2004 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 fund 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 helpworking people with disabilities purchase health coverage through Medicaid. The Act also provides funding for States to establish Demonstrations to Maintain Independence and Employment, which provide Medicaid benefits and services to working individuals who have a condition that, without medical assistance, will result in disability.

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

This account operates as a revolving fund without fiscal year restriction. The BBA established the Medicare+Choice program, now known as the Medicare Advantage program under the MMA, that requires 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 Health programs' 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 consist 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.

In FY 2001 the CMS began the Healthcare Integrated General Ledger Accounting System (HIGLAS) project to replace the Medicare contractors' and CMS' current accounting systems with a single, unified system. HIGLAS will eventually replace the different systems now in use by contractors that process and pay claims, in addition to CMS' current mainframe-based administrative accounting financial system. Costs incurred during the preliminary design phase from FYs 2001 through February 2003 were charged to expense. In March 2003, the project moved to the software development phase, and in accordance with the Federal Accounting Standards Advisory Board (FASAB) Statement of Federal Financial Accounting Standards (SFFAS) No. 10, costs incurred after that date are capitalized until the project moves into the operational phase.

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 2004 but paid in FY 2005, and (e) an estimate of retroactive settlements of cost reports submitted to the Medicare contractors by health care providers.

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 2004 estimate was developed based on historical relationships between prior Medicaid net payables and current Medicaid activity.

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 the Government Performance and Results Act (GPRA), CMS is required to identify the mission of the agency and develop a strategic plan and performance measures to show that desired outcomes are being met. The three major programs that CMS administers are: Medicare, Medicaid, and 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. Current system limitations prevent CMS from reporting the recoveries of prior year obligations. OMB has exempted CMS from the Circular No. A-11 requirement to report the recoveries of prior year obligations separately on the SF-133. 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.

Health Maintenance Organization (HMO) Loan and Loan Guarantee Fund

The HMO Loan and Loan Guarantee Fund has been closed out in FY 2004.

Reclassifications

Certain FY 2003 balances have been reclassified to conform to FY 2004 financial statement presentations, the effect of which is immaterial.

Restatements

Certain FY 2003 balances have been restated to comply with provisions in OMB circular A-11 (see Note 15).

Estimation of Obligations Related to Canceled Appropriations

As of September 30, 2004, CMS has canceled over $137 million in cumulative obligations to FY 1998 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 2000 through 2004 related to canceled appropriations, CMS anticipates an additional $1 million will be paid from current year funds for canceled obligations.

NOTE 2:

FUND BALANCES *(Dollars in Millions)*

FY 2004	Consolidated Totals
FUND BALANCES:	
Trust Funds	
HI Trust Fund Balance	$600
SMI Trust Fund Balance	1,943
Revolving Funds	
CLIA	122
Appropriated Funds	
Medicaid	15,245
SCHIP	8,323
TWI	328
Other Fund Types	
CMS Suspense Account	6
Program Management Reimbursables	3
TOTAL FUND BALANCES	**$26,570**
STATUS OF FUND BALANCES WITH TREASURY:	
Unobligated Balance	
Available	$10,356
Unavailable	(34,113)
Obligated Balance not yet Disbursed	50,327
TOTAL STATUS OF FUND BALANCES WITH TREASURY	**$26,570**

FY 2003	Original Consolidated Totals	Amount Restated	Restated Consolidated Totals
FUND BALANCES:			
Trust Funds			
HI Trust Fund Balance	$(206)		$(206)
SMI Trust Fund Balance	(178)		(178)
Revolving Funds			
HMO Loan	10		10
CLIA	116		116
Appropriated Funds			
Medicaid	8,788		8,788
SCHIP	9,754		9,754
TWI	234		234
Other Fund Types			
CMS Suspense Account	5		5
Program Management Reimbursables	13		13
TOTAL FUND BALANCES	**$18,536**		**$18,536**
STATUS OF FUND BALANCES WITH TREASURY:			
Unobligated Balance			
Available	$307		$307
Unavailable	(2,702)	$(30,339)	(33,041)
Obligated Balance not yet Disbursed	20,931	30,339	51,270
TOTAL STATUS OF FUND BALANCES WITH TREASURY	**$18,536**		**$18,536**

Fund Balances are funds with Treasury that are primarily available to pay current expenditures and liabilities.

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

Medicare Investments

FY 2004	Maturity Range	Interest Range	Value
HI			
Bonds	June 2005 to June 2019	3 1/2 - 8 3/4	264,375
Accrued Interest			3,705
TOTAL HI INVESTMENTS			**$268,080**
SMI			
Bonds	June 2006 to June 2016	4 5/8 - 7%	17,439
Accrued Interest			273
TOTAL SMI INVESTMENTS			**$17,712**
TOTAL MEDICARE INVESTMENTS			**$285,792**

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**

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 2004

	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
Expenditure Transfer-in	$497	$6,710	$125	$3	$1	$7,336	$(7,336)	
Nonexpenditure Transfer-in	15,269	18,085				33,354	(33,354)	
Railroad Retirement Principal	421					421		$421
TOTAL INTRAGOVERNMENTAL ACCOUNTS RECEIVABLE, NET	**$16,187**	**$24,795**	**$125**	**$3**	**$1**	**$41,111**	**$(40,690)**	**$421**

FY 2003 Restated

	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	16,142	15,638				31,780	(31,780)	
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	**$17,197**	**$19,740**	**$88**	**$3**	**$19**	**$37,047**	**$(36,347)**	**$700**

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.

FY 2003 nonexpenditure transfers-in from BPD to CMS' HI and SMI have been restated to include benefit expenses incurred but not reported liabilities (IBNR) as of September 30, 2003, which were not obligated or reported in FY 2003.

NOTE 5: ANTICIPATED CONGRESSIONAL APPROPRIATION

The CMS has recorded $9,248 million in anticipated Congressional appropriations ($11,830 in FY 2003) 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 2004, the IBNR expense exceeded the available unexpended Medicaid appropriations in the amount of $3,603 million ($8,449 in FY 2003). 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 $3,603 million anticipated appropriation in FY 2004 ($8,449 in FY 2003) 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 2004, the estimate was insufficient and the matching ceased prior to the close of the fiscal year. At September 30 approximately $5,573 million should have been matched to premiums paid by beneficiaries. OACT calculated an additional $72.1 million in interest on the unmatched amount, leaving a cumulative liability of $5,645 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 $5,645 million anticipated appropriation in FY 2004 for the amount of the unmatched SMI premiums. Although the actual transfer of funds will occur in FY 2005, CMS has reported the $5,645 million as revenues earned in FY 2004.

In addition, the $5,645 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 2004	Medicare HI	Medicare SMI	Medicaid	All Others	Consolidated Total
Provider & Beneficiary Overpayment					
Accounts Receivable Principal	$595	$721		$55	$1,371
Less: Allowance for Uncollectible Accounts	(224)	(394)		(36)	(654)
Accounts Receivable, Net	371	327		19	717
Medicare Secondary Payer (MSP)					
Accounts Receivable Principal	154	89		12	255
Less: Allowance for Uncollectible Accounts	(78)	(49)		(8)	(135)
Accounts Receivable, Net	76	40		4	120
CMPs & Other Restitutions					
Accounts Receivable Principal	125	287		1	413
Less: Allowance for Uncollectible Accounts	(119)	(278)		(1)	(398)
Accounts Receivable, Net	6	9			15
Fraud and Abuse					
Accounts Receivable Principal	116	211			327
Less: Allowance for Uncollectible Accounts	(115)	(207)			(322)
Accounts Receivable, Net	1	4			5
Managed Care					
Accounts Receivable Principal	2	7		3	12
Less: Allowance for Uncollectible Accounts	(2)	(4)		(3)	(9)
Accounts Receivable, Net		3			3
Medicare Premiums					
Accounts Receivable Principal	160	430			590
Less: Allowance for Uncollectible Accounts	(43)	(40)			(83)
Accounts Receivable, Net	117	390			507
Audit Disallowances					
Accounts Receivable Principal	4	8	$1,141		1,153
Less: Allowance for Uncollectible Accounts	(1)	(2)	(617)		(620)
Accounts Receivable, Net	3	6	524		533
Other Accounts Receivable					
Accounts Receivable Principal			90	21	111
Less: Allowance for Uncollectible Accounts			(88)	(18)	(106)
Accounts Receivable, Net			2	3	5
TOTAL ACCOUNTS RECEIVABLE PRINCIPAL	**$1,156**	**$1,753**	**$1,231**	**$92**	**$4,232**
Less: Allowance for Uncollectible Accounts Receivable	(582)	(974)	(705)	(66)	(2,327)
TOTAL ACCOUNTS RECEIVABLE, NET	**$574**	**$779**	**$526**	**$26**	**$1,905**

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**

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.

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 2004, 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 $22 million ($28 million in FY 2003). 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 2004	Medicare HI	Medicare SMI	Medicaid	All Others	Consolidated Total
Intragovernmental:					
Uncollected Revenue due Treasury	$64	$223		$22	$309
Other	13	20	$2		35
TOTAL OTHER INTRAGOVERNMENTAL LIABILITIES	**$77**	**$243**	**$2**	**$22**	**$344**
Deferred Revenue	$54	$167			$221
Suspense Account Deposit Funds				$10	10
Other	1,286	585		2	1,873
TOTAL OTHER LIABILITIES	**$1,340**	**$752**		**$12**	**$2,104**

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**

The 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.

Included in other liabilities are estimated amounts for a contingent liability payable to States (to reimburse them for payments they have paid on behalf of beneficiaries) at an amount of approximately $1,867 million, for probable unasserted claims that resulted from processing errors where incorrect Medicare eligibility determinations were made. No claims have been filed. Because appropriation law requires Congress to authorize the transfer of funds out of the Medicare Trust Funds into an appropriation account, the Medicare Trust Funds cannot reimburse the Health Program accounts in the general fund of the Treasury absent Congressional authorization. The CMS does not intend to seek such Congressional authorization and there will be no transactions recorded between the Trust Funds and the Health Programs' accounts in the general fund.

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.

Additionally, the SSA routinely collects Medicare Part B premiums from beneficiaries who receive Old Age and Survivors and Disability Insurance (OASDI) payments. Prior to December 2002, SSA did not have procedures in place to recover Medicare premiums as death notifications were received. The Department of Health and Human Services' (HHS) Office of General Counsel (OGC) advised CMS that it has no legal obligation to repay the SSA. The OGC based its decision on the fact that SSA has no legally enforceable claim against CMS because there is no statutory provision that expressly requires CMS to reimburse the OASDI Trust Funds for prior amounts transferred to the SMI Trust Fund.

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.

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, 2003, there were 7,634 (8,938 in FY 2002) PRRB cases under appeal. A total of 2,337 (1,622 in FY 2003) new cases were filed in FY 2003. The PRRB rendered decisions on 46 (66 in FY 2003) cases in FY 2004 and 4,345 (2,860 in FY 2003) 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 46 cases that were decided in FY 2004, a reasonable liability estimate cannot be projected for the value of the 5,580 (7,634 in FY 2003) cases remaining on appeal as of September 30, 2004. As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

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

FY 2004	Medicare				Consolidated
	HI	SMI	Total	Medicaid	Total
Medicare Benefits Payable *(1)*	$15,016	$14,778	$29,794		$29,794
Demonstration Projects and HMO Benefits	27	24	51		51
Transitional Assistance		30	30		30
Medicaid Benefits Payable *(2)*				$18,900	18,900
Medicaid Audit/Program Disallowances *(3)*				454	454
TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE	**$15,043**	**$14,832**	**$29,875**	**$19,354**	**$49,229**

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**

(1) Medicare benefits payable consists of a $29.8 billion estimate ($30.2 billion in FY 2003) by CMS' Office of the Actuary of Medicare services incurred but not paid, as of September 30, 2004. 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 2004 that were paid in 2005 and (e) an estimate of retroactive settlements of cost reports.

(2) Medicaid benefits payable of $18.9 billion ($17.5 billion in FY 2003) 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, 2004.

(3) Medicaid audit and program disallowances of $454 million ($284 million in FY 2003) 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. The 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.

Note that a portion of the Medicaid Entitlement Benefits Due and Payable is not covered by budgetary resources. Refer to Note 9 for the classification between the covered and not covered portions of this liability.

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

FY 2004	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		5,645			5,645	$(5,645)	
TOTAL INTRAGOVERNMENTAL	**$1**	**$5,647**			**$5,648**	**$(5,645)**	**$3**
Entitlement Benefits Due and Payable			$10,039		$10,039		$10,039
Federal Employee and Veterans' Benefits	3	6	1		10		10
Accrued Payroll and Benefits	10	20	1		31		31
Contingent Liabilities	1,283	604	1		1,888		1,888
TOTAL LIABILITIES NOT COVERED BY BUDGETARY RESOURCES	**$1,297**	**$6,277**	**$10,042**		**$17,616**	**$(5,645)**	**$11,971**
TOTAL LIABILITIES COVERED BY BUDGETARY RESOURCES	**$31,059**	**$35,027**	**$9,319**	**$34**	**$75,439**	**$(35,045)**	**$40,394**
TOTAL LIABILITIES	**$32,356**	**$41,304**	**$19,361**	**$34**	**$93,055**	**$(40,690)**	**$52,365**

FY 2003 Restated	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			$8,987		$8,987		$8,987
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	**$13**	**$3,410**	**$8,989**		**$12,412**	**$(3,381)**	**$9,031**
TOTAL LIABILITIES COVERED BY BUDGETARY RESOURCES	**$31,893**	**$32,222**	**$8,802**	**$37**	**$72,954**	**$(33,067)**	**$39,887**
TOTAL LIABILITIES	**$31,906**	**$35,632**	**$17,791**	**$37**	**$85,366**	**$(36,448)**	**$48,918**

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.

FY 2003 nonexpenditure transfers-in from BPD to CMS' HI and SMI have been restated to include benefit expenses incurred but not reported liabilities (IBNR) as of September 30, 2003, which were not obligated or reported in FY 2003.

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

FY 2004	Medicare			Health		All Others	Consolidated Totals
	HI	SMI	Total	Medicaid	SCHIP		
PROGRAM/ACTIVITY COSTS							
Medicare							
Fee for Service	$146,295	$113,778	$260,073				$260,073
Managed Care	20,920	18,683	39,603				39,603
Medicaid/SCHIP/TWI				$176,800	$4,607	$34	181,441
CLIA						64	64
TOTAL PROGRAM/ACTIVITY COSTS	**$167,215**	**$132,461**	**$299,676**	**$176,800**	**$4,607**	**$98**	**$481,181**
OPERATING COSTS							
Medicare Integrity Program	$1,057		$1,057				$1,057
Quality Improvement Organizations	314	$79	393				393
Bad Debt Expense and Writeoffs	(1,282)	(443)	(1,725)	$67			(1,658)
Reimbursable Expenses	2	3	5				5
Administrative Expenses	818	1,640	2,458	191	$4		2,653
Depreciation and Amortization	1	3	4				4
Imputed Cost Subsidies	10	21	31	2			33
TOTAL OPERATING COSTS	**$920**	**$1,303**	**$2,223**	**$260**	**$4**		**$2,487**
TOTAL COSTS	**$168,135**	**$133,764**	**$301,899**	**$177,060**	**$4,611**	**$98**	**$483,668**
LESS: EXCHANGE REVENUES:							
Medicare Premiums Collected	$1,799	$30,341	$32,140				$32,140
CLIA Revenues						$60	60
Other Earned Revenues	8	3	11				11
TOTAL EXCHANGE REVENUES	**$1,807**	**$30,344**	**$32,151**			**$60**	**$32,211**
TOTAL NET COST OF OPERATIONS	**$166,328**	**$103,420**	**$269,748**	**$177,060**	**$4,611**	**$38**	**$451,457**

FY 2003	Medicare			Health		All Others	Consolidated Totals
	HI	SMI	Total	Medicaid	SCHIP		
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	771	1,477	2,248	172	$5		2,425
Depreciation and Amortization	1	2	3				3
Imputed Cost Subsidies	10	21	31	2			33
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**

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. 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 $1.3 billion ($1.2 billion in FY 2003) 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 2004	Medicare					Consolidated
	HI	SMI	Medicaid	SCHIP	Other	Total
Unexpended Appropriations						
Withdrawal of Expired or Canceled Year Authority	$(45)				$(10)	$(55)
Net Change in Anticipated Congressional Appropriation		2,265	$(4,847)			(2,582)
TOTAL OTHER ADJUSTMENTS	**$(45)**	**$2,265**	**$(4,847)**		**$(10)**	**$(2,637)**

FY 2003	Medicare					Consolidated
	HI	SMI	Medicaid	SCHIP	Other	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)**

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 2004	Medicare		Consolidated
	HI	SMI	Total
FICA Tax Receipts	$142,659		$142,659
SECA Tax Receipts	10,789		10,789
Trust Fund Investment Interest	14,972	$1,602	16,574
Civil Monetary Penalties and Damages	355		355
TAXES AND OTHER NON-EXCHANGE REVENUE	**$168,775**	**$1,602**	**$170,377**

FY 2003	Medicare		Consolidated
	HI	SMI	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**

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.

Due to the reclassification of immaterial amounts by the BPD, certain lines were reported as *revenues* in FY 2003 are now reported in FY 2004 as *transfers-in* (see Note 13). FY 2003 Notes 12 and 13 have not been restated.

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

FY 2004

Transfers-in Without Reimbursement	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
Medicare Benefit Transfers	$178,835	$149,304				$328,139	$(328,139)	
Transfers to HCFAC	1,063					1,063	(1,063)	
Federal Matching Contributions		96,783				96,783	(96,783)	
Transitional Assistance Benefits		216				216	(216)	
Allocation to CMS Programs	1044	2,282	$266	$5	$(6)	3,591	(3,591)	
Fraud and Abuse Appropriation	114					114	(114)	
Transfer-Uninsured Coverage	365					365	(365)	
Prog. Mngmt. Admin. Expense *(1)*	201					201	(201)	
Military Service General Fund Transfer	173					173	(173)	
Military Service Adjustment	(147)					(147)		(147)
Income Tax OASDI Benefits *(2)*	8,577					8,577	(8,577)	
Railroad Retirement Board	434					434		434
Criminal Fines	315					315		315
Medicaid Part B Premiums			168			168	(168)	
Interest Adjustment	(25)					(25)		(25)
Gifts and Miscellaneous	2	2				4		4
TOTAL TRANSFERS-IN	**$190,951**	**$248,587**	**$434**	**$5**	**$(6)**	**$439,971**	**$(439,390)**	**$581**

FY 2004

Transfers-out Without Reimbursement	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
SSA Administrative Expenses	$(643)	$(1,098)				$(1,741)		$(1,741)
Medicare Benefit Transfers	(178,835)	(149,304)				(328,139)	$328,139	
Transfers to HCFAC	(1,063)					(1,063)	1,063	
Federal Matching Contributions		(96,783)				(96,783)	96,783	
Transitional Assistance Benefits		(216)				(216)	216	
Transfers to Program Management	(1,222)	(2,369)				(3,591)	3,591	
Fraud and Abuse Appropriation	(114)					(114)	114	
Transfer-Uninsured Coverage	(365)					(365)	365	
Prog. Mngmt. Admin. Expense *(1)*	(201)					(201)	201	
Income Tax OASDI Benefits *(2)*	(8,577)					(8,577)	8,577	
Military Service General Fund Transfer					$(173)	(173)	173	
Medicaid Part B Premiums		(168)				(168)	168	
Office of the Secretary	(5)	(3)				(8)		(8)
Payment Assessment Commission	(6)	(3)				(9)		(9)
Railroad Retirement Board		(6)				(6)		(6)
TOTAL TRANSFERS-OUT	**$(191,031)**	**$(249,950)**			**$(173)**	**$(441,154)**	**$439,390**	**$(1,764)**
TOTAL TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT	**$(80)**	**$(1,363)**	**$434**	**$5**	**$(179)**	**$(1,183)**		**$(1,183)**

FY 2003 Restated

Transfers-in Without Reimbursement	Medicare HI	Medicare SMI	Medicaid	SCHIP	All Others	Combined Total	Intra-CMS Eliminations	Consolidated Total
Medicare Benefit Transfers	$151,555	$121,786				$273,341	$(273,341)	
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	**$162,742**	**$207,653**	**$288**	**$5**	**$3**	**$370,691**	**$(370,268)**	**$423**

FY 2003 Restated

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	(151,555)	(121,786)				(273,341)	$273,341	
Transfers to HCFAC	(1,052)					(1,052)	1,052	
Federal Matching Contributions		(84,286)				(84,286)	84,286	
Transfers to Program Management	(854)	(1,678)				(2,532)	2,532	
Fraud and Abuse Appropriation	(114)					(114)	114	
Transfer-Uninsured Coverage	(393)					(393)	393	
Prog. Mngmt. Admin. Expense *(1)*	(120)					(120)	120	
Income Tax OASDI Benefits *(2)*	(8,318)					(8,318)	8,318	
Medicaid Part B Premiums		(112)				(112)	112	
Office of the Secretary	(6)	(3)				(9)		(9)
Payment Assessment Commission	(5)	(4)				(9)		(9)
Railroad Retirement Board		(5)				(5)		(5)
TOTAL TRANSFERS-OUT	**$(163,018)**	**$(208,509)**				**$(371,527)**	**$370,268**	**$(1,259)**
TOTAL TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT	**$(276)**	**$(856)**	**$288**	**$5**	**$3**	**$(836)**		**$(836)**

(1) During FY 2004, the Payments to the Health Care Trust Funds appropriation paid the HI Trust Fund $201 million ($120 million in FY 2003) 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.

FY 2003 Medicare Benefit Transfers-in-and-out have been restated. These transfers have been increased by the September 2003 IBNRs and decreased by the September 2002 IBNRs, which were reported as obligated and transferred in their respective following fiscal years.

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 $58.70 from October 2003 through December 2003 and $66.60 from January 2004 through September 2004. Premiums collected from beneficiaries totaled $30.3 billion ($26.8 billion in FY 2003) and were matched by a $96.8 billion ($84.3 billion in FY 2003) contribution from the Federal government.

NOTE 14:

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

FY 2004	Medicare	Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Intragovernmental Costs	$511	$43	$554		$554
With the Public	301,388	181,726	483,114		483,114
Gross Cost	301,899	181,769	483,668		483,668
Less: Exchange Revenue	(32,151)	(60)	(32,211)		(32,211)
NET COST	**$269,748**	**$181,709**	**$451,457**		**$451,457**

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**

The chart above displays gross costs and earned revenue with Federal agencies and the public by budget functional classification.

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 2004	Direct	Reimbursable	Combined Totals
Category A	$6,150	$72	$6,222
Category B	283,360	2	283,362
Exempt	307,819		307,819
TOTAL	**$597,329**	**$74**	**$597,403**

FY 2003 Restated	Direct	Reimbursable	Combined Totals
Category A	$16,679	$71	$16,750
Category B	526,051	5	526,056
Exempt	3,962		3,962
TOTAL	**$546,692**	**$76**	**$546,768**

The FY 2003 Category B direct obligations have been restated from $523,948 million to $526,051 million increasing obligations by $2,103 million for the restatement of the budgetary obligations for the liability for Medicare expenses.

In addition, amounts reported in Category B in FY 2003 representing the Medicare benefit payments are being reported as exempt in FY 2004 as a result of OMB's change in apportionment requirements. Medicare benefit payment obligations are exempt from apportionment in FY 2004.

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 $246,876 million ($242,955 million in FY 2003) as of September 30, 2004 are included in Investments on the Balance Sheet. The following table presents trust fund activities and balances for FY 2004 and FY 2003 (in millions):

FY 2004	Combined Balances
TRUST FUND BALANCES, BEGINNING	**$242,955**
Receipts	303,436
Less Obligations	299,515
Excess of Receipts Over Obligations	3,921
TRUST FUND BALANCES, ENDING	**$246,876**

FY 2003 Restated	Original Combined Balances	Amount Restated	Restated Combined Balances
TRUST FUND BALANCES, BEGINNING	**$265,620**	**$(28,236)**	**$237,384**
Receipts	285,984		285,984
Less Obligations	277,258	2,103	279,361
Less Transfers	1,052		1,052
Excess of Receipts Over Obligations	7,674	(2,103)	5,571
TRUST FUND BALANCES, ENDING	**$273,294**	**$(30,339)**	**$242,955**

Explanations of Differences Between the Statement of Budgetary Resources and the Budget of the United States Government for FY 2003

(in millions)

	Budgetary Resources	Net Outlays (Less Offsetting Receipts)
Statement of Budgetary Resources	$547,279	$413,380
Adjustments for Expired Accounts	(732)	
Other Adjustments	(851)	1,068
PRESIDENT'S BUDGET (actual)	**$545,696**	**$414,448**

The Other Adjustments Line includes a reduction to budgetary resources in the amount of $2,103 million for the restatement of the budgetary obligations for the liability for Medicare expenses, an increase in the amount of $1,185 million for the amounts reporting in the President's Budget but reported by the Centers for Disease Control (CDC) and the Department of Treasury (Treasury), an increase of $65 million for collections from offsetting collections and an increase of $2 million for rounding.

The Other Adjustments Line also includes an increase to net outlays in the amount of $1,067 million for the amounts reported in the President's Budget but reported by the CDC and Treasury, and $1 million for rounding.

Restatement

For fiscal years 2003 and prior, CMS did not record corresponding budgetary obligations for the September 30 accrual of the liability for Medicare expenses incurred but not reported (IBNR). The CMS recorded obligations when the Medicare contractors' banks actually drew on their letters-of-credit with the Federal Reserve as reimbursement for checks presented for payment. In FY 2003 OMB exempted CMS from the OMB Circular No. A-11 requirement to report obligations when the liability is incurred. For FY 2004 CMS has begun obligating funds when the Medicare IBNR is recorded. This treatment complies with Circular No. A-11 and results in the restatement of the FY 2003 SBR for the following lines:

COMBINED STATEMENT OF BUDGETARY RESOURCES
For the Year Ended September 30, 2003

(in millions)

	ORIGINAL FY 2003 Combined Totals	Amount Restated	RESTATED FY 2003 Combined Totals
BUDGETARY RESOURCES:			
Budgetary Authority:			
Appropriations received	$547,308		$547,308
Net transfers	(1,162)		(1,162)
Unobligated Balance:			
Beginning of period	3,358		3,358
Net transfers, actual	(5)		(5)
Spending Authority from Offsetting Collections:			
Earned:			
Collected	65		65
Receivable from Federal sources			
Change in unfilled customer orders:			
Advance received	(4)		(4)
Without advance from Federal sources	6		6
Transfers from trust funds	2,645		2,645
SUBTOTAL	**2,712**		**2,712**
Recoveries of prior year obligations	7,228		7,228
Temporarily not available pursuant to Public Law	(7,674)	$2,103	(5,571)
Permanently not available	(6,589)		(6,589)
TOTAL BUDGETARY RESOURCES	**$545,176**	**$2,103**	**$547,279**
STATUS OF BUDGETARY RESOURCES:			
Obligations Incurred:			
Direct	$544,589	$2,103	$546,692
Reimbursable	76		76
SUBTOTAL	**544,665**	**2,103**	**546,768**
Unobligated Balance:			
Apportioned	307		307
Unobligated Balance not Available	204		204
TOTAL STATUS OF BUDGETARY RESOURCES	**$545,176**	**$2,103**	**$547,279**
Relationship of Obligations to Outlays:			
Obligated balance, net, beginning of period	$17,901	$28,236	$46,137
Obligated balance, net, end of period:			
Accounts receivable	(1,185)		(1,185)
Unfilled customer orders from Federal sources	(6)		(6)
Undelivered orders	11,842		11,842
Accounts payable	10,296	30,339	40,635
Outlays:			
Disbursements	534,343		534,343
Collections	(2,664)		(2,664)
SUBTOTAL	**531,679**		**531,679**
LESS: OFFSETTING RECEIPTS	**28,432**	**89,867**	**118,299**
NET OUTLAYS	**$503,247**	**$(89,867)**	**$413,380**

Offsetting Receipts

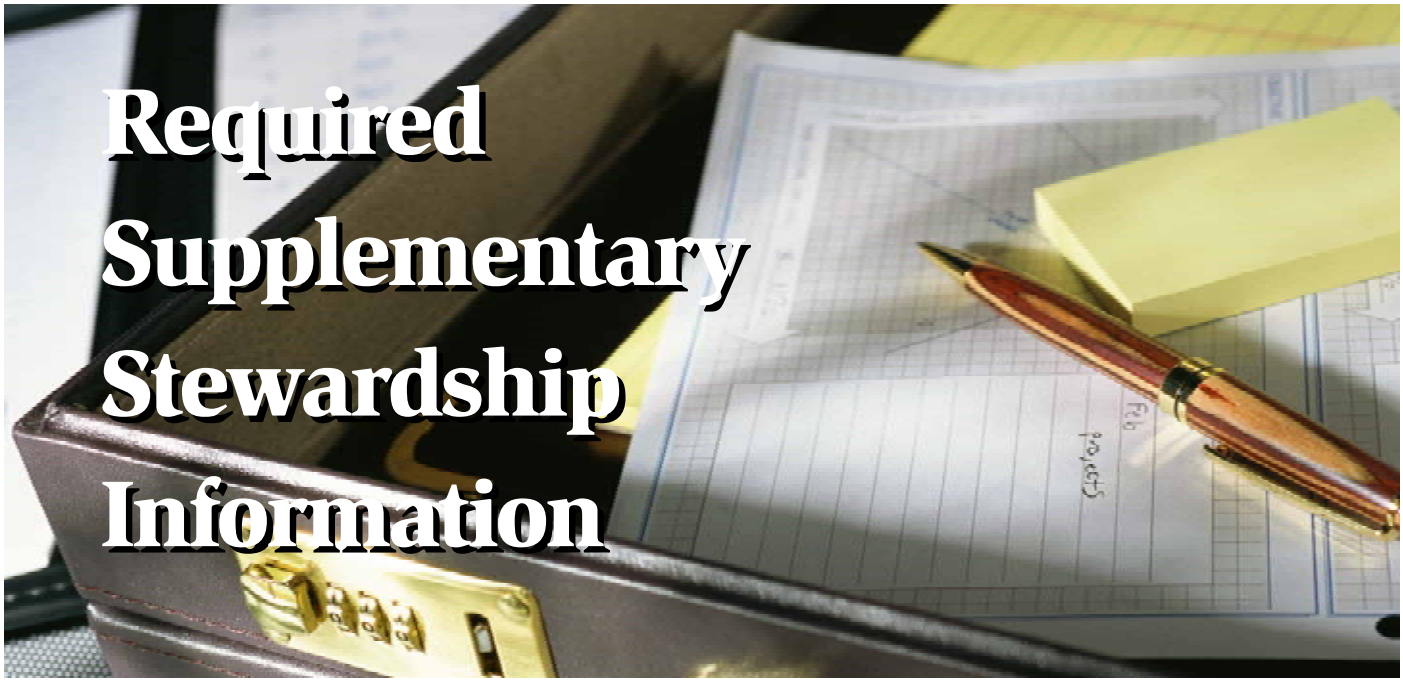
For fiscal years 2003 and prior, CMS reported only the HI and SMI premiums collected as Offsetting Receipts. The transfers from the Payments to the Health Care Trust Funds (PTF) to HI and SMI were not reported. This resulted in a duplication of CMS outlays: as both PTF outlays and as HI and SMI outlays. The U.S. Treasury Standard General Ledger crosswalk for the SBR included accounts for Medicare premiums but not for the PTF transfers. Also, OMB Circular No. A-11 did not provide definitive support as to whether PTF transfers should be reported on this line.

In FY 2004 the Treasury revised the crosswalk for Offsetting Receipts to include transfers between the general fund and trust funds. In addition, OMB revised Circular No. A-11, clarifying that "intrabudgetary receipts" (which includes PTF transfers) should be reported on the Offsetting Receipts line. Accordingly, CMS has restated the FY 2003 Offsetting Receipts to include PTF transfers to HI and SMI. (The Offsetting Receipts line of the Statement of Financing has been similarly restated).

The SOF has been further restated to reflect the funding of the Medicare IBNR: "Resources that fund expenses in prior periods" and "Accrued Unfunded Entitlement Benefit Costs" exclude the Medicare IBNR. The SOF Net Cost of Operations remains unchanged.

CONSOLIDATED STATEMENT OF FINANCING
For the Year Ended September 30, 2003
(in millions)

	ORIGINAL FY 2003 Consolidated Totals	Amount Restated	RESTATED FY 2003 Consolidated Totals
RESOURCES USED TO FINANCE ACTIVITIES:			
Budgetary Resources Obligated:			
Obligations incurred	$544,665	$2,103	$546,768
Less: Spending authority from offsetting collections and recoveries	9,940		9,940
Obligations net of offsetting collections and recoveries	534,725	2,103	536,828
Less: Offsetting receipts	28,432	89,867	118,299
NET OBLIGATIONS	**506,293**	**(87,764)**	**418,529**
Other Resources:			
Imputed financing from costs absorbed by others	33		33
NET OTHER RESOURCES USED TO FINANCE ACTIVITIES	**33**		**33**
TOTAL RESOURCES USED TO FINANCE ACTIVITIES	**$506,326**	**$(87,764)**	**$418,562**
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)		$(689)
Resources that fund expenses recognized in prior periods	39,526	$(28,236)	11,290
Resources that finance the acquisition of assets	8		8
Other resources or adjustments to net obligated resources that do not affect net cost of operations	94,490	(89,867)	4,623
TOTAL RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS	**133,335**	**(118,103)**	**15,232**
TOTAL RESOURCES USED TO FINANCE THE NET COST OF OPERATIONS	**$372,991**	**$30,339**	**$403,330**
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	$(30,339)	$8,987
Liability for unmatched SMI premiums ***(Note 5)***	3,381		3,381
Increase in annual leave liability	1		1
Decrease in receivables from the public	1,289		1,289
Other	1		1
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL REQUIRE OR GENERATE RESOURCES IN FUTURE PERIODS	**43,998**	**(30,339)**	**13,659**
Components Not Requiring or Generating Resources:			
Depreciation and amortization	4		4
Other	(795)		(795)
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES	(791)		(791)
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD	**43,207**	**(30,339)**	**12,868**
NET COST OF OPERATIONS	**$416,198**		**$416,198**



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. The recent Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (known informally as the Medicare Modernization Act, or MMA) introduced the most sweeping changes to the program since its enactment in 1965. The most significant change is that, beginning in 2004, the MMA established a new prescription drug benefit. A separate account within the SMI trust fund will handle the transactions for this new benefit. A brief description of the provisions of Medicare's Hospital Insurance (HI, or Part A) trust fund and Supplementary Medical Insurance (SMI, or Parts B and D) trust fund is included 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 ***2004 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**.

ACTUARIAL PROJECTIONS

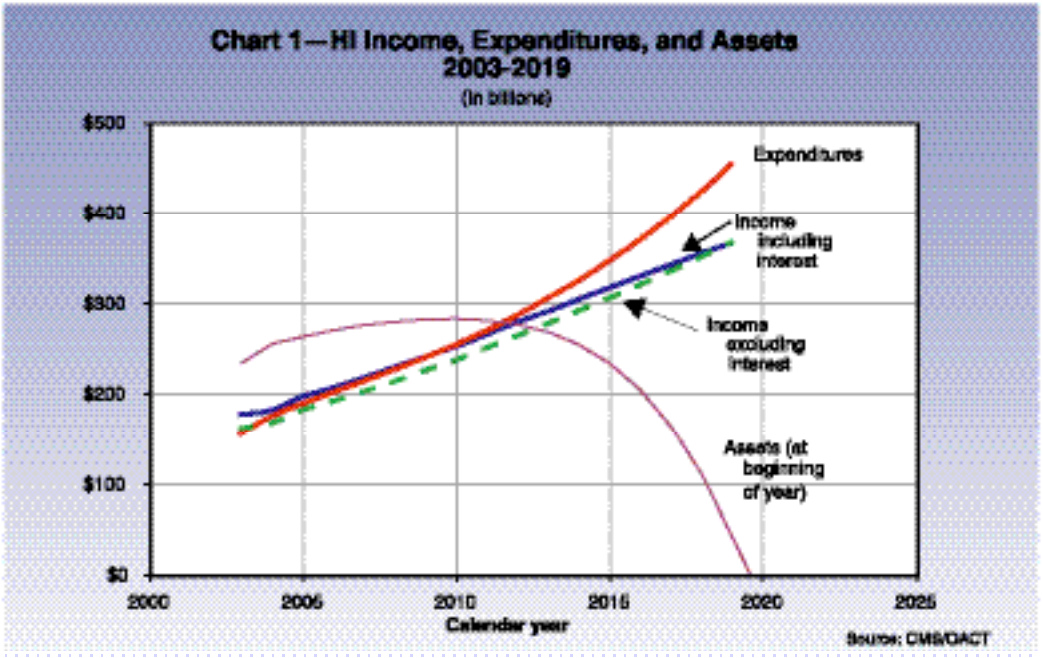
Cashflow in Nominal Dollars

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 2019. Estimates for SMI Parts B and D 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 16 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 16 years. The estimates also include expenditures attributable to these current and future workers, in addition to current beneficiaries.



[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 2010 and income excluding interest in 2004. This situation arises as a result of health cost increases that are expected to continue to grow faster than workers' earnings. Beginning in 2010, the trust fund would start redeeming trust fund assets; in 2019, the assets would be depleted—7 years earlier than estimated in the 2003 Trustees Report. For the first time since the 1999 Trustees Report, the HI trust fund does not meet an explicit test of short-range financial adequacy, as assets are predicted to fall below expenditures within the next 10 years.

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.

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

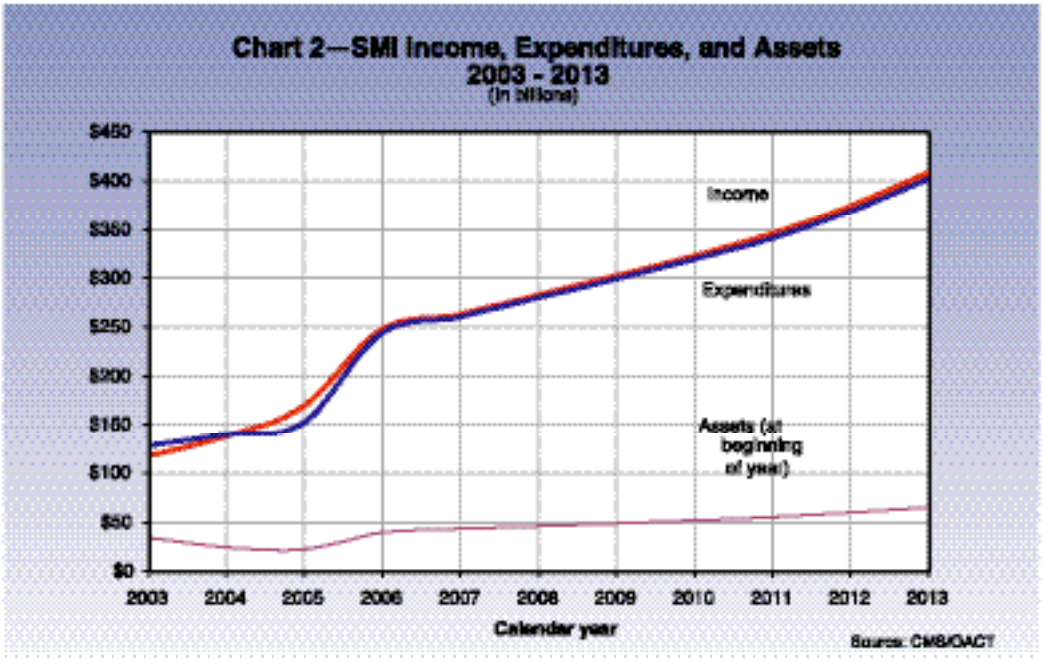
Chart 2 shows the actuarial estimates of SMI income, expenditures, and assets, for Parts B and D combined, for each of the next 10 years, in nominal dollars. Whereas HI estimates are displayed through the year 2019, SMI estimates cover only the next 10 years, as SMI differs fundamentally from HI in regard to the way it is financed. In particular, financing for SMI Parts B and D is not at all based on payroll taxes but instead on monthly beneficiary 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 depictions of income 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 the financing mechanism for Parts B and D. Under present law, both accounts are automatically in financial balance every year, regardless of future economic and other conditions.

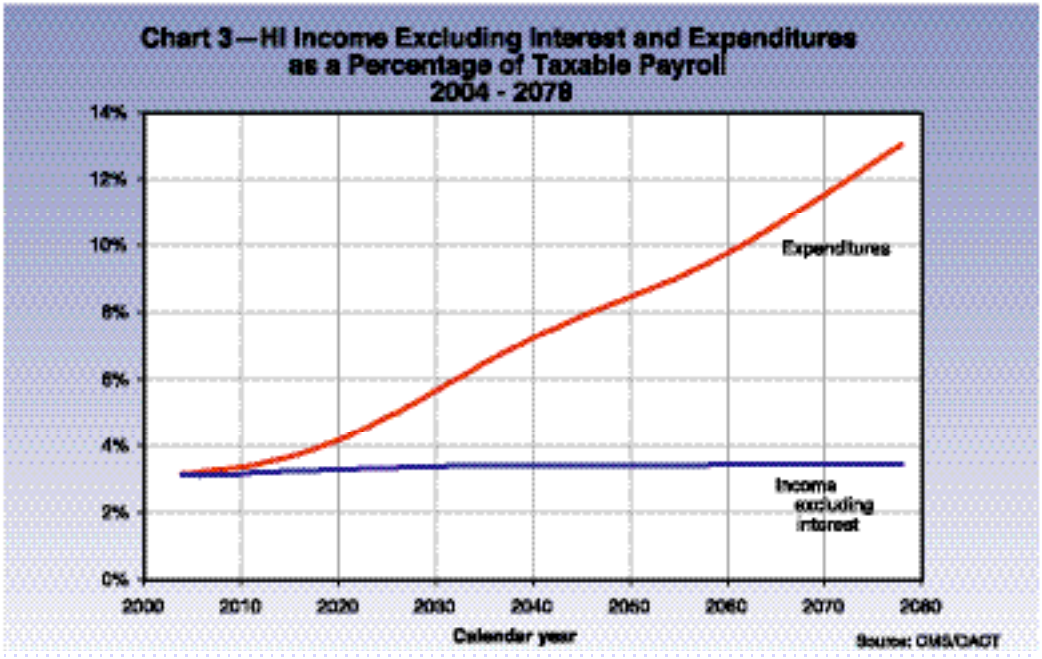


HI Cashflow as a Percent of Taxable Payroll

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. The long-range increase in average expenditures per beneficiary is assumed to equal growth in per capita gross domestic product (GDP) 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 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.

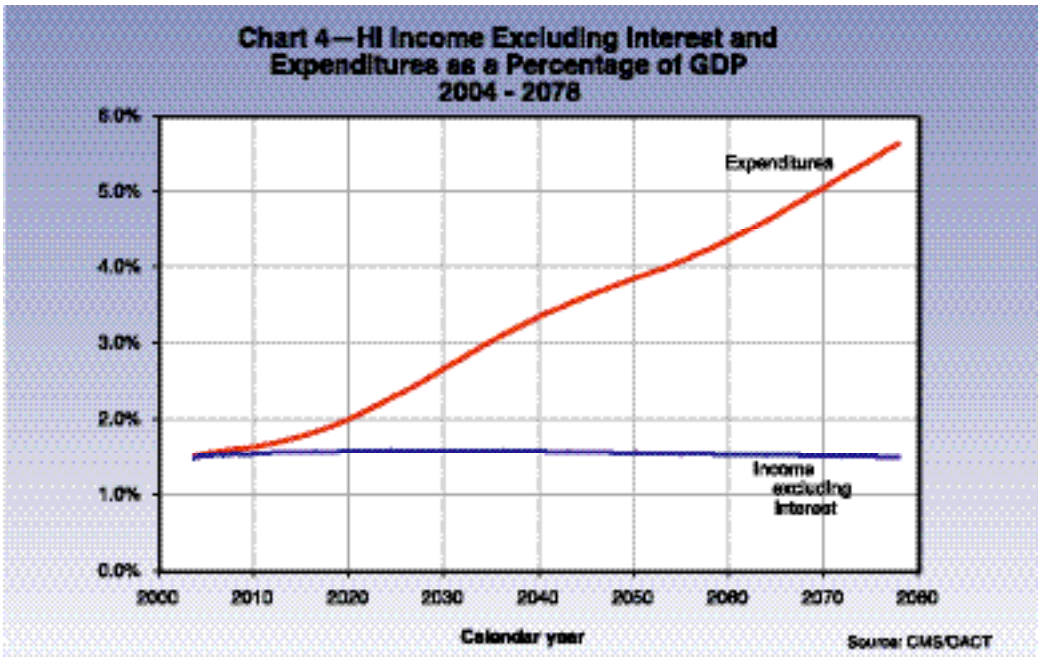
HI

Chart 4 shows HI income excluding interest and expenditures over the next 75 years expressed as a percentage of GDP. In 2003, the expenditures were $154.6 billion, which was 1.5 percent of GDP. This percentage is projected to increase steadily throughout the remainder of the 75-year period.

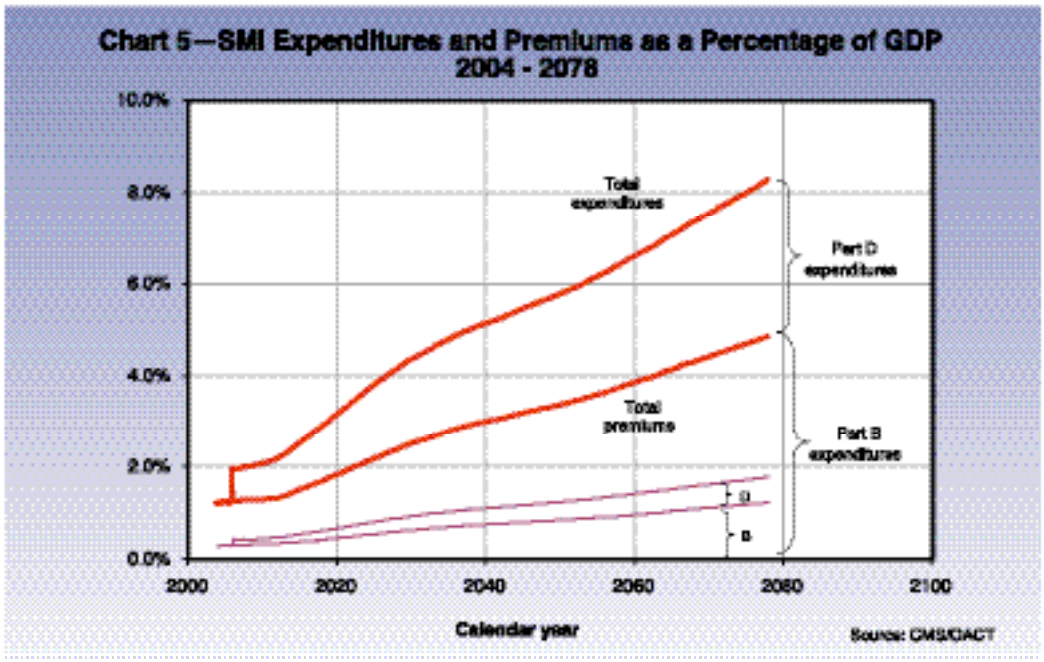
SMI

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

Chart 5 shows past and projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. As in the projections for HI, the long-range increase in average expenditures per beneficiary is assumed to equal growth in per capita GDP 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.



Under the intermediate assumptions, annual SMI expenditures would grow from about 1 percent of GDP in 2003 to 2 percent of GDP in 2006 with the commencement of the general prescription drug coverage. Then, within 20 years, they would grow to 4 percent of GDP and to more than 8 percent by the end of the projection period.

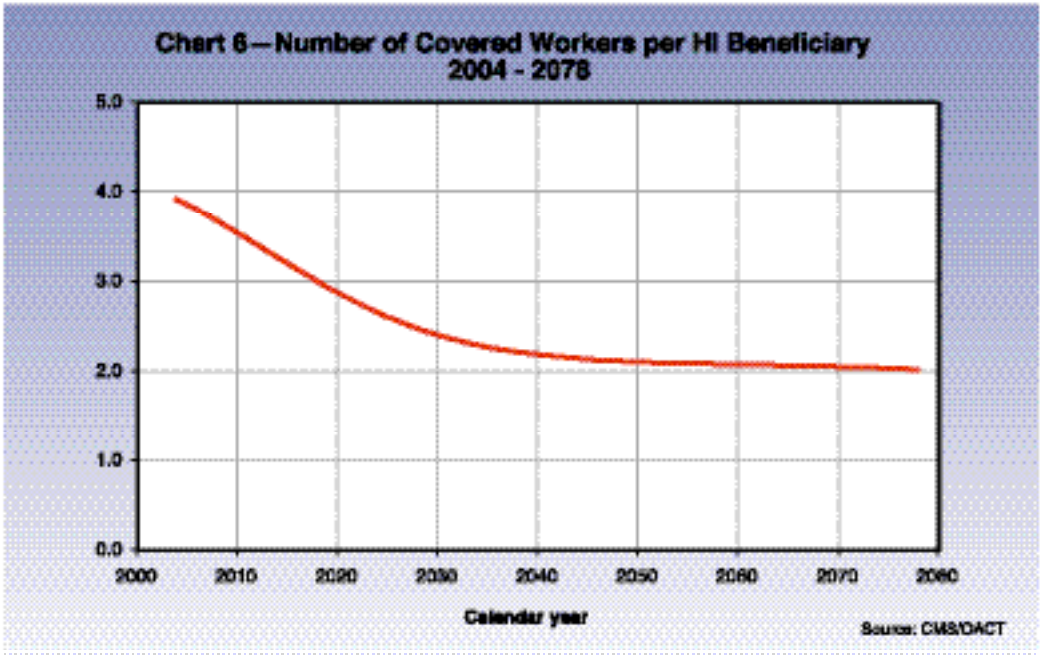


To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time. In fact, average per-beneficiary costs for Part B and Part D benefits are projected to increase in most years by at least 5 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate.

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 2003, 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 2078.



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 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 (Part A) and SMI (Part B and Part D) 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.

As shown in table 1, the HI trust fund has an actuarial deficit[4] of more than $8.2 trillion over the 75-year projection period, as compared to more than $5.9 trillion in the 2003 financial report. On the other hand, neither Part B nor Part D of SMI has similar problems because each account 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 $8.2 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 $272 trillion in the 2004 Trustees Report. Thus, the $8.2-trillion deficit represents approximately 3.0 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, 2004. 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 non-exchange 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.

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[4] Present value of estimated future income less expenditures, calculated over the 75-year projection period.

[5] As noted in footnote 2 on page 63, 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 and State governments. 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 2078 would exceed the present value of projected SMI premium and State transfer revenue alone by $19.5 trillion. When added to the corresponding differential for HI, the present value of expenditures for the Medicare program overall is projected to exceed non-general revenue receipts by $28.1 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 1—Actuarial Present Values of Hospital Insurance and Supplementary Medical Insurance Revenues and Expenditures: 75-year Projection as of January 1, 2004

(In billions)

	HI					SMI[2]									
						Part B					Part D				
	2004	2003	2002	2001	2000	2004	2003	2002	2001	2000	2004	2003	2002	2001	2000
Actuarial present value[1] of estimated future income (excluding interest) received from or on behalf of:															
Current participants[3] who, at start of projection period:															
Have not yet attained eligibility age (ages 15-64)	$4,820	$4,510	$4,408	$4,136	$3,757	$10,505	$8,796	$7,423	$7,378	$6,109	$7,545	—	—	—	—
Have attained eligibility age (age 65 and over)	148	128	125	113	97	1,310	1,160	1,008	1,032	934	713	—	—	—	—
Those expected to become participants (under age 15)	4,009	3,773	3,753	3,507	3,179	3,514	2,817	2,402	2,370	1,616	2,511	—	—	—	—
All current and future participants	8,976	8,411	8,286	7,757	7,033	15,329	12,773	10,833	10,780	8,659	10,770	—	—	—	—
Actuarial present value[1] of estimated future expenditures[4] paid to or on behalf of:															
Current participants[3] who, at start of projection period:															
Have not yet attained eligibility age (ages 15-64)	12,054	10,028	9,195	8,568	6,702	10,577	8,845	7,463	7,415	6,094	7,566	—	—	—	—
Have attained eligibility age (age 65 and over)	2,168	1,897	1,747	1,693	1,681	1,475	1,306	1,132	1,159	1,051	773	—	—	—	—
Those expected to become participants (under age 15)	3,246	2,653	2,470	2,225	1,349	3,277	2,622	2,238	2,206	1,514	2,431	—	—	—	—
All current and future participants	17,468	14,577	13,412	12,487	9,732	15,329	12,773	10,833	10,780	8,659	10,770	—	—	—	—
Actuarial present value[1] of estimated future income (excluding interest) less expenditures	-8,492	-6,166	-5,126	-4,730	-2,700	0	0	0	0	0	0	—	—	—	—
Trust fund assets at start of period	256	235	209	177	141	24	34	41	44	45	0	—	—	—	—
Assets at start of period plus actuarial present value[1] of estimated future income (excluding interest) less expenditures	-8,236	-5,931	-4,917	-4,553	-2,558	24	34	41	44	45	0	—	—	—	—

[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. Transfers from State governments are also included as income for Part D of SMI. See footnote 2 on page 63 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.

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 per beneficiary cost, 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.

Table 2 shows the most significant 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 2004. 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:									
							Per beneficiary cost[3]			
	Fertility rate[1]	Net immigration	Real-wage differential[2]	Wages	CPI	Real GDP	HI	SMI B	SMI D	Real-interest rate[4]
2004	2.02	1,175,000	2.4	3.6	1.2	4.4	6.5	7.0	—	3.2
2005	2.01	1,150,000	2.8	4.3	1.5	3.6	5.6	6.5	—	3.3
2010	2.00	1,025,000	1.3	4.1	2.8	2.6	3.9	3.8	6.5	3.1
2020	1.97	950,000	1.1	3.9	2.8	1.8	4.1	5.4	6.4	3.0
2030	1.95	900,000	1.1	3.9	2.8	1.8	5.6	5.2	4.9	3.0
2040	1.95	900,000	1.1	3.9	2.8	1.8	5.9	5.2	5.1	3.0
2050	1.95	900,000	1.1	3.9	2.8	1.8	5.1	5.0	5.1	3.0
2060	1.95	900,000	1.1	3.9	2.8	1.8	5.2	5.2	5.0	3.0
2070	1.95	900,000	1.1	3.9	2.8	1.8	5.4	5.1	5.1	3.0
2078	1.95	900,000	1.1	3.9	2.8	1.8	5.2	5.1	5.1	3.0

[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]

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, 2004 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 2019 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)*	-$8,639	-$8,492	-$8,350

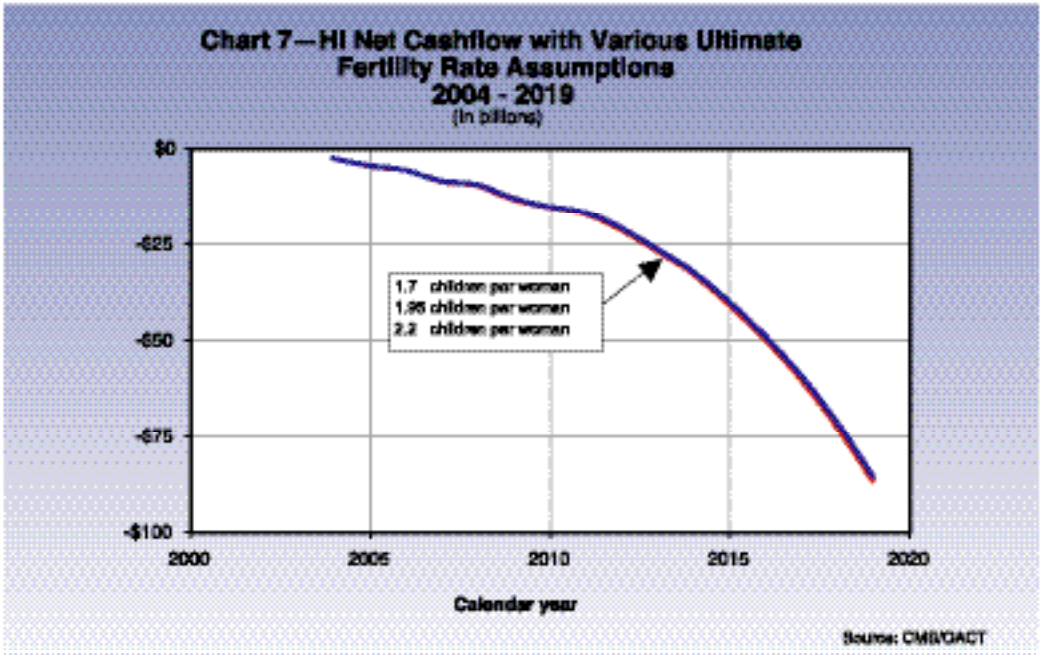
[1] The total fertility rate for any year is the average number of children who would be born to a woman in her lifetime if she were to experience the birth rates by age observed in, or assumed for, the selected year, and if she were to survive the entire childbearing period.

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

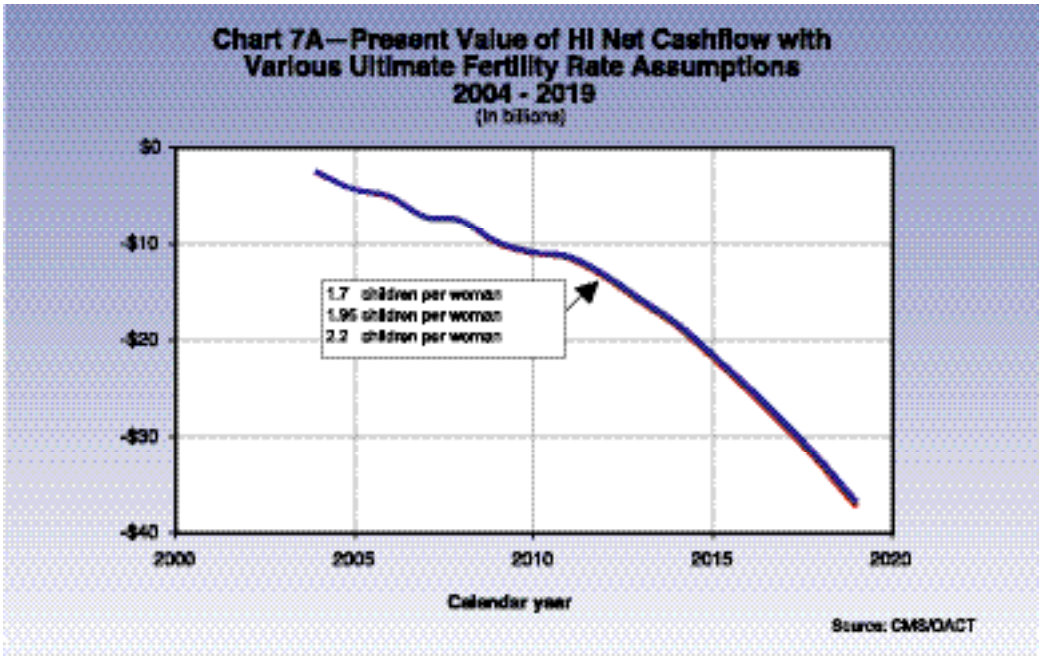
[6] Sensitivity analysis is not done for Parts B or D of the SMI trust fund due to its financing mechanism for each account. Any change in assumptions would have no impact on the net cashflow, since the change would affect income and expenditures equally.

[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.

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 16 years. In fact, 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

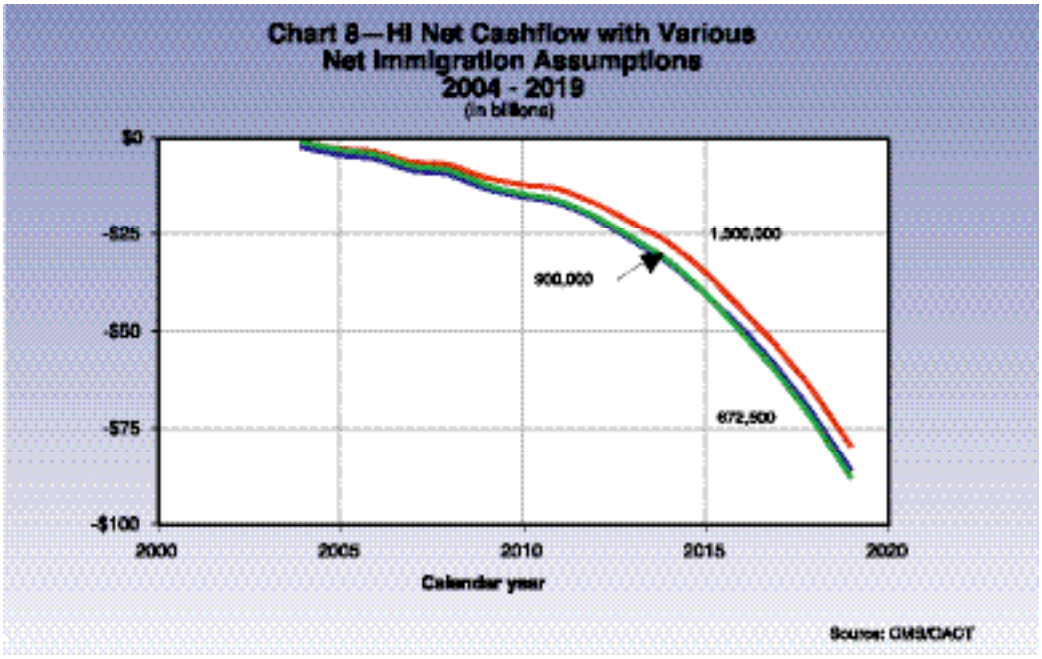
Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative net immigration assumptions: 672,500 persons, 900,000 persons, and 1,300,000 persons per year.

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

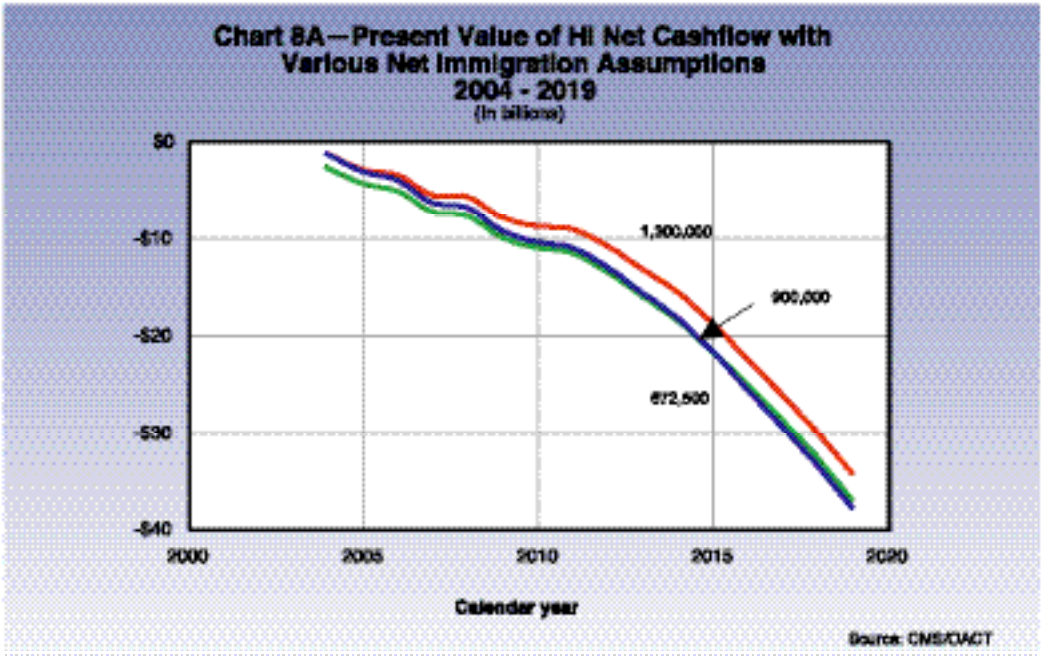
Ultimate net immigration	672,500	900,000	1,300,000
Income minus expenditures *(in billions)*	-$8,299	-$8,492	-$8,525

As shown in table 4, if the ultimate net immigration assumption is 672,500 persons, the deficit of income over expenditures decreases by $193 billion. On the other hand, if the ultimate net immigration assumption is 1,300,000 persons, the deficit increases less, by $33 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 those who work and pay taxes into the system, in the short term payroll taxes increase faster than benefits, while in the long term, the opposite occurs as those individuals age and become beneficiaries in a period with much greater health care costs per beneficiary.



Real-Wage Differential

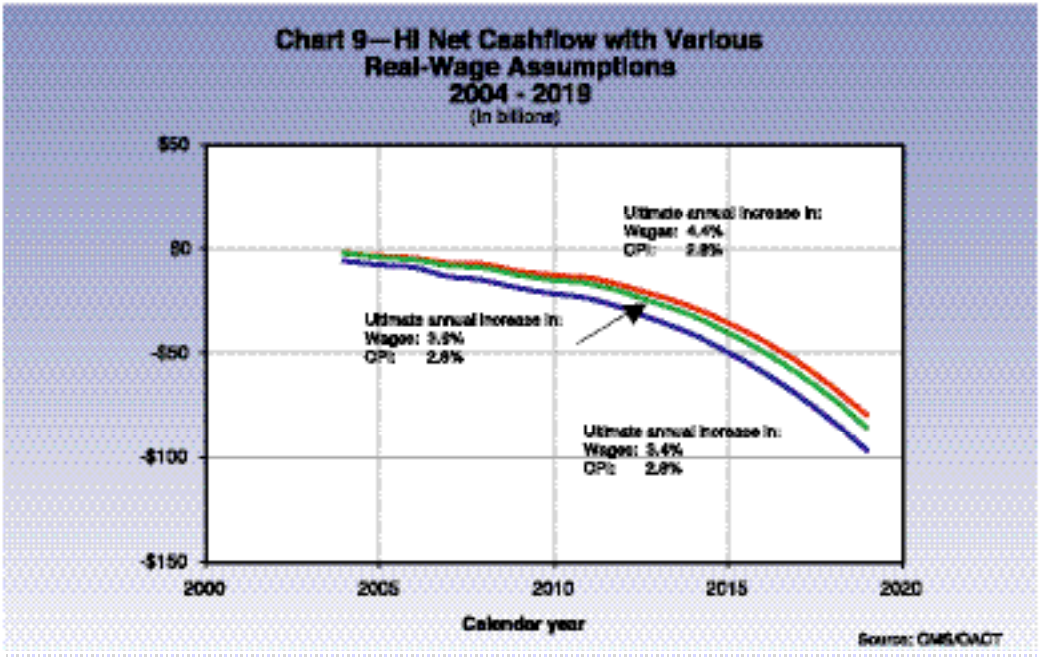
Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.6, 1.1, and 1.6 percentage points. In each case, the CPI is assumed to be 2.8 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.4, 3.9, and 4.4 percent, respectively.

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

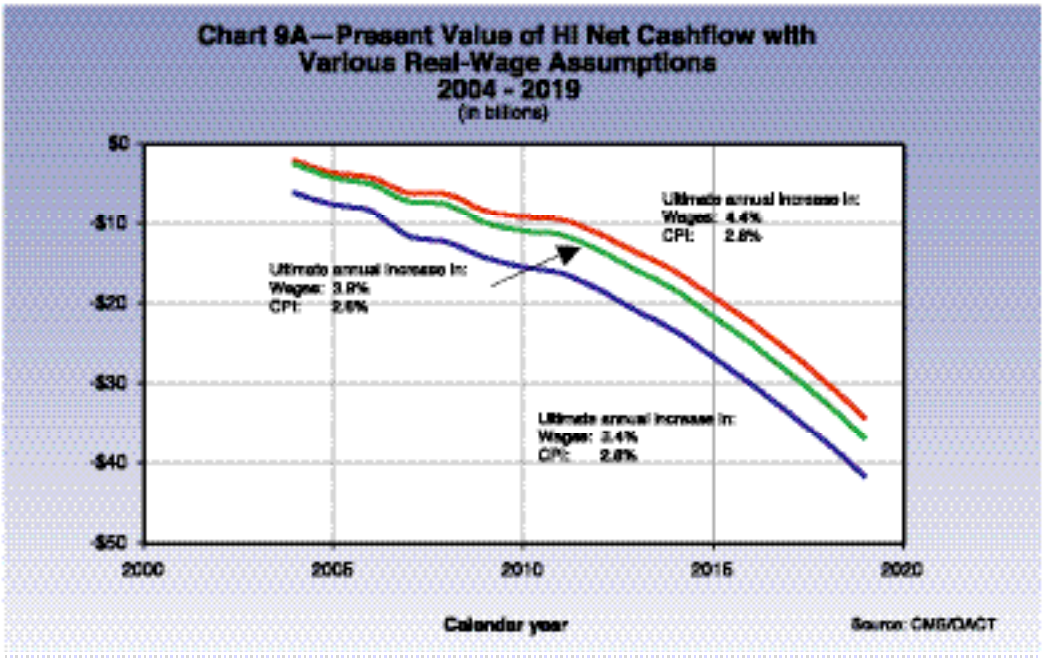
Ultimate percentage increase in wages - CPI	3.4 - 2.8	3.9 - 2.8	4.4 - 2.8
Ultimate percentage increase in real-wage differential	0.6	1.1	1.6
Income minus expenditures *(in billions)*	-$9,155	-$8,492	-$7,974

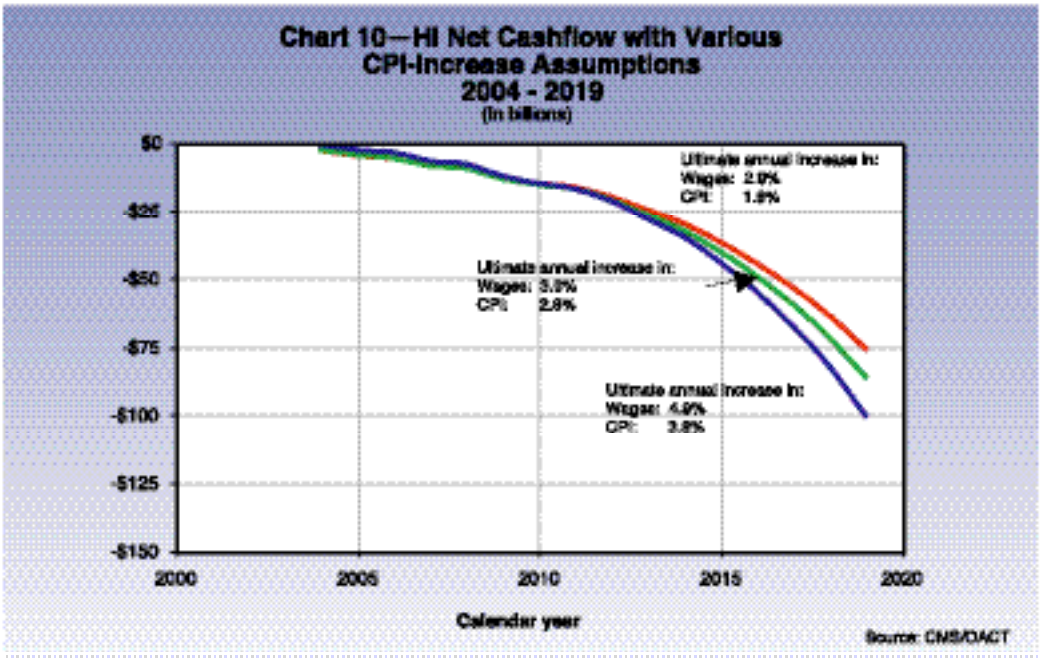
As indicated in table 5, for a half-point increase in the ultimate real-wage differential assumption, the deficit of income over expenditures decreases by approximately $500 billion.

Charts 9 and 9A show projections of the net cashflow under the three alternative real-wage differential assumptions presented in table 5.



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: 1.8, 2.8, and 3.8 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 2.9, 3.9, and 4.9 percent, respectively.

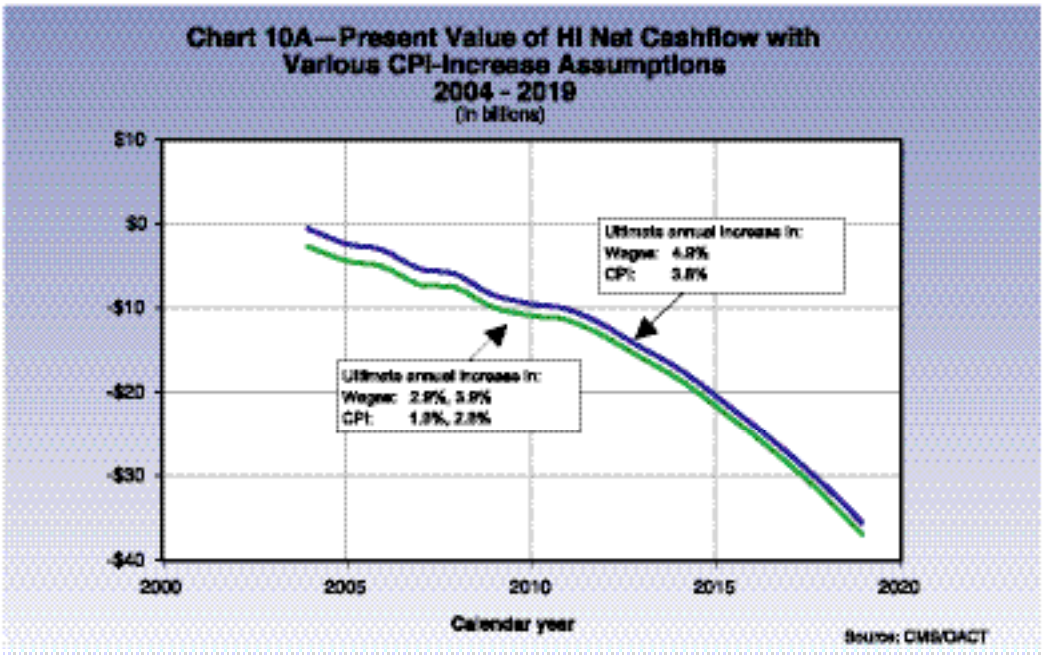
TABLE 6
Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

Ultimate percentage increase in wages - CPI	2.9 - 1.8	3.9 - 2.8	4.9 - 3.8
Income minus expenditures *(in billions)*	-$8,525	-$8,492	-$8,316

Table 6 shows that if the ultimate CPI-increase assumption is 1.8 percent, the deficit of income over expenditures increases by only $33 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit decreases more, by $176 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 cash-flow to different levels of general inflation occurs because inflation tends to affect both income and costs in a similar manner. 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

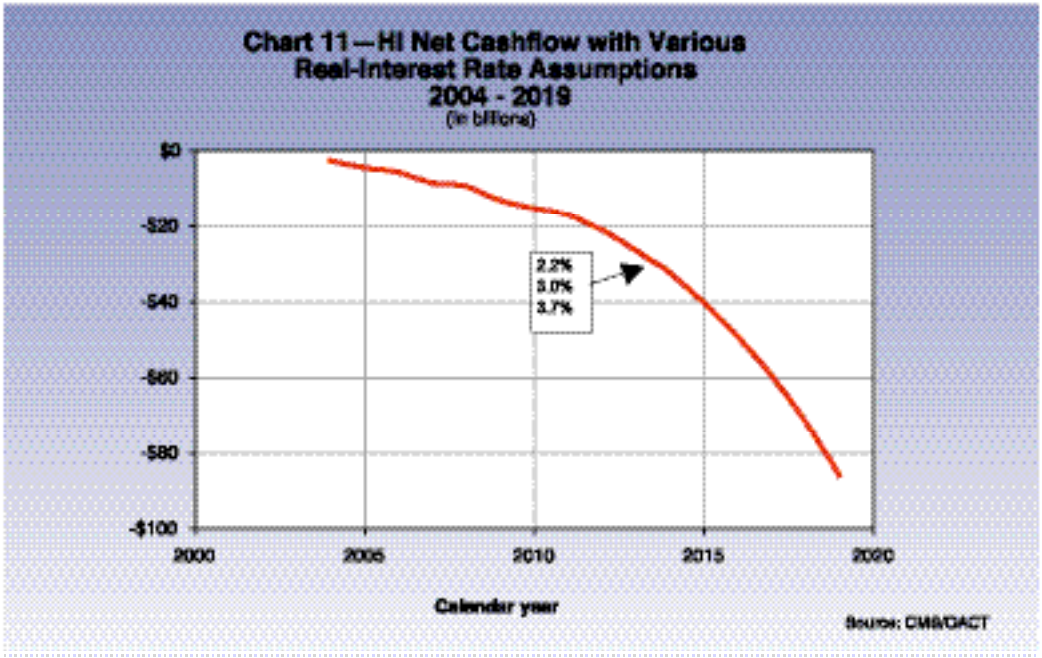
Table 7 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.2, 3.0, and 3.7 percent. In each case, the ultimate annual increase in the CPI is assumed to be 2.8 percent, resulting in ultimate annual yields of 5.0, 5.8, and 6.5 percent, respectively.

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

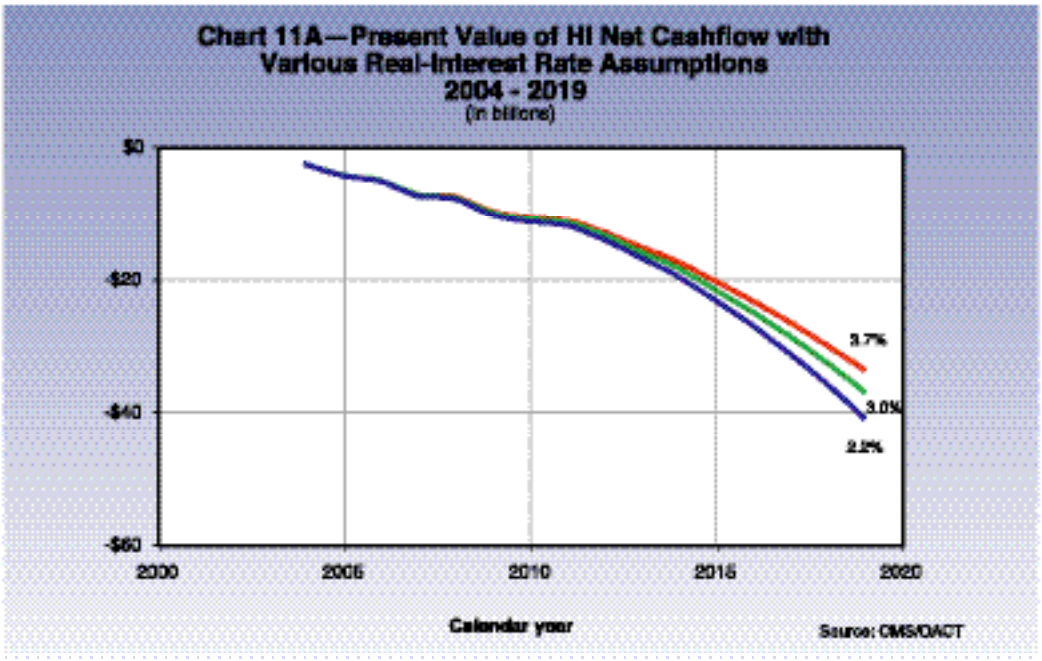
Ultimate real-interest rate	2.2 %	3.0 %	3.7 %
Income minus expenditures *(in billions)*	-$12,231	-$8,492	-$6.054

As illustrated in table 7, for an increase of 0.1 in the ultimate real-interest rate percentage, the deficit of income over expenditures decreases by approximately $400 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 2019. 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), with the result being that the overall net present value is smaller.



Health Care Cost Factors

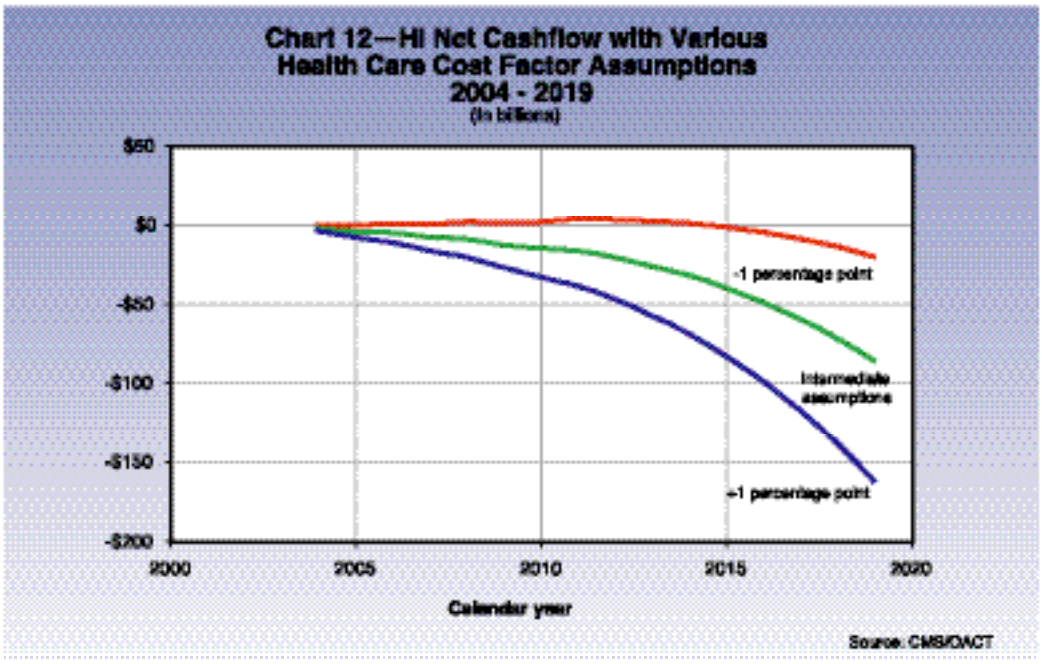
Table 8 shows the net present value of cashflow during the 75-year projection period under three alternative assumptions of the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, 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.

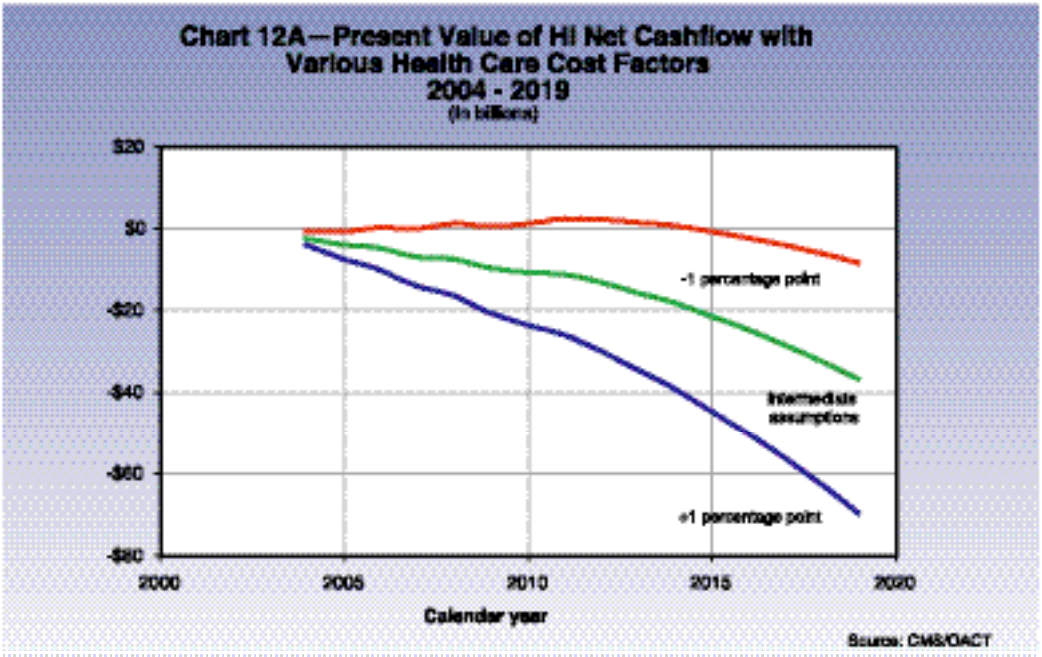
TABLE 8
Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions

Annual cost/payroll relative growth rate	-1 percentage point	Intermediate assumptions	+ 1 percentage point
Income minus expenditures *(in billions)*	-$2,990	-$8,492	-$17,531

Table 8 indicates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit of income over expenditures decreases by $5,502 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 $9,039 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 both HI income and costs. 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.

TRUST FUND FINANCES AND SUSTAINABILITY

HI

The financial status of the HI trust fund has deteriorated significantly, compared with last year's estimates; asset exhaustion is projected to occur in 2019 under current law compared to 2026. This change results primarily from the 2003 legislation and from higher HI expenditures and lower payroll tax revenues in 2003 than expected (and associated assumption adjustments). Under the Medicare Trustees' intermediate assumptions, income from all sources is projected to continue to exceed expenditures for the next 6 years but to fall short by steadily increasing amounts in 2010 and later. These shortfalls can be met with increasing reliance on interest payments on invested assets and the redemption of those assets, thereby adding to the draw on the Federal Budget. 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.

The HI trust fund is substantially out of financial balance in the long range. Bringing the fund into actuarial balance over the next 75 years under the intermediate assumptions would require 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

Under current law, the SMI trust fund will remain adequate, both in the near term and into the indefinite future, because of the automatic financing established for Parts B and D. Because there is no authority to transfer assets between the new Part D account and the existing Part B account, it is necessary to evaluate each account's financial adequacy separately.

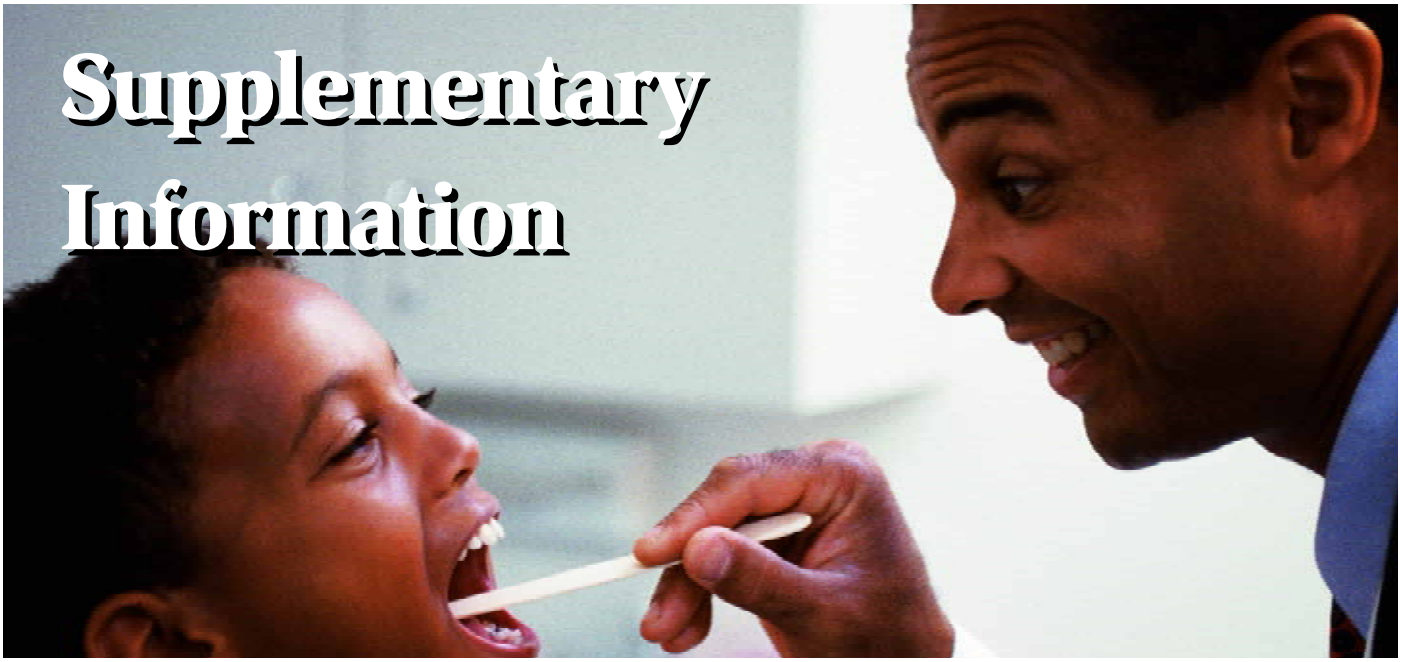
The financing established for the Part B account for calendar year 2004, along with a portion of account assets, is estimated to be sufficient to cover expenditures for that year and to maintain a minimally adequate contingency reserve. The Part B premium and corresponding general revenue transfers will need to be increased sharply for 2005 to match projected costs and to restore Part B assets to a more adequate reserve level.

The operations of the Part D account in 2004 and 2005 will relate only to the transitional assistance benefit for low-income beneficiaries. No financial imbalance is likely, since the general revenue subsidy for this benefit is expected to be drawn on a daily, as-needed basis. Potential variations in Part D costs in 2006 and later will necessitate an adequate asset balance.

For both the Part B and Part D accounts, beneficiary premiums and general revenue transfers will be set to meet expected costs each year. However, a critical issue for the 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.

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 heightened problem of rapid growth in expenditures. In their 2004 annual report to Congress, the Medicare Boards of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to take "prompt, effective and decisive action…to address these challenges." They also stated: "Consideration of such reforms should occur in the relatively near future."



Supplementary Information

CONSOLIDATING BALANCE SHEET
As of September 30, 2004

(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	$600	$1,943	$2,543	$15,245	$8,323	$459	$26,570		$26,570
Trust Fund Investments	268,080	17,712	285,792				285,792		285,792
Accounts Receivable, Net	16,187	24,795	40,982	125	3	1	41,111	$(40,690)	421
Other Assets:									
Anticipated Congressional Appropriation		5,645	5,645	3,603			9,248		9,248
Other		1	1				1		1
Total Intragovernmental Assets	**284,867**	**50,096**	**334,963**	**18,973**	**8,326**	**460**	**362,722**	**(40,690)**	**322,032**
Cash & Other Monetary Assets	110	350	460				460		460
Accounts Receivable, Net	574	779	1,353	526		26	1,905		1,905
General Property, Plant & Equipment, Net	36	75	111	9			120		120
Other	28	47	75	6		20	101		101
TOTAL ASSETS	**$285,615**	**$51,347**	**$336,962**	**$19,514**	**$8,326**	**$506**	**$365,308**	**$(40,690)**	**$324,618**
LIABILITIES									
Intragovernmental Liabilities:									
Accounts Payable	$15,876	$25,438	$41,314				$41,314	$(40,690)	$624
Accrued Payroll and Benefits	1	2	3				3		3
Other Intragovernmental Liabilities	77	243	320	$2		$22	344		344
Total Intragovernmental Liabilities	**15,954**	**25,683**	**41,637**	**2**		**22**	**41,661**	**(40,690)**	**971**
Federal Employee & Veterans' Benefits	3	6	9	1			10		10
Entitlement Benefits Due & Payable	15,043	14,832	29,875	19,354			49,229		49,229
Accrued Payroll & Benefits	16	31	47	4			51		51
Other Liabilities	1,340	752	2,092			12	2,104		2,104
TOTAL LIABILITIES	**32,356**	**41,304**	**73,660**	**19,361**		**34**	**93,055**	**(40,690)**	**52,365**
NET POSITION									
Unexpended Appropriations		7,750	7,750		$8,323	349	16,422		16,422
Cumulative Results of Operations	253,259	2,293	255,552	153	3	123	255,831		255,831
TOTAL NET POSITION	**$253,259**	**$10,043**	**$263,302**	**$153**	**$8,326**	**$472**	**$272,253**		**$272,253**
TOTAL LIABILITIES & NET POSITION	**$285,615**	**$51,347**	**$336,962**	**$19,514**	**$8,326**	**$506**	**$365,308**	**$(40,690)**	**$324,618**

CONSOLIDATING STATEMENT OF NET COST
For the Year Ended September 30, 2004

(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	$166,328	$103,420	$269,748				$269,748		$269,748
Medicaid				$177,060			177,060		177,060
SCHIP					$4,611		4,611		4,611
NET COST—GPRA PROGRAMS	**166,328**	**103,420**	**269,748**	**177,060**	**4,611**		**451,419**		**451,419**
Other Activities									
CLIA						$4	4		4
Ticket to Work Incentive						34	34		34
NET COST—OTHER ACTIVITIES						**38**	**38**		**38**
NET COST OF OPERATIONS	**$166,328**	**$103,420**	**$269,748**	**$177,060**	**$4,611**	**$38**	**$451,457**		**$451,457**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2004

(in millions)

	MEDICARE			HEALTH			Consolidated
	HI	SMI	Total	Medicaid	SCHIP	All Others	Totals
CUMULATIVE RESULTS OF OPERATIONS							
Beginning Balances	$241,625	$10,720	$252,345	$78	$2	$133	$252,558
Budgetary Financing Sources:							
Appropriations Used	9,257	94,734	103,991	176,699	4,607	207	285,504
Nonexchange Revenue	168,775	1,602	170,377				170,377
Transfers-in/out Without Reimbursement	(80)	(1,363)	(1,443)	434	5	(179)	(1,183)
Other Financing Sources:							
Transfers-out Without Reimbursement		(1)	(1)				(1)
Imputed Financing from Costs Absorbed by Others	10	21	31	2			33
TOTAL FINANCING SOURCES	**177,962**	**94,993**	**272,955**	**177,135**	**4,612**	**28**	**454,730**
NET COST OF OPERATIONS	**166,328**	**103,420**	**269,748**	**177,060**	**4,611**	**38**	**451,457**
ENDING BALANCES	**$253,259**	**$2,293**	**$255,552**	**$153**	**$3**	**$123**	**$255,831**
UNEXPENDED APPROPRIATIONS							
Beginning Balances	$45	$3,380	$3,425		$9,755	$261	$13,441
Budgetary Financing Sources:							
Appropriations Received	9,257	96,839	106,096	$182,754	3,175	305	292,330
Appropriations Transferred-in/out				(1,208)			(1,208)
Other Adjustments	(45)	2,265	2,220	(4,847)		(10)	(2,637)
Appropriations Used	(9,257)	(94,734)	(103,991)	(176,699)	(4,607)	(207)	(285,504)
TOTAL FINANCING SOURCES	**(45)**	**4,370**	**4,325**		**(1,432)**	**88**	**2,981**
NET COST OF OPERATIONS							
ENDING BALANCES		**$7,750**	**$7,750**		**$8,323**	**$349**	**$16,422**

COMBINING STATEMENT OF BUDGETARY RESOURCES
For the Year Ended September 30, 2004
(in millions)

	MEDICARE		Payments to				
	HI	SMI	Trust Funds	Medicaid	SCHIP	All Others	Combined Totals
Budgetary Resources:							
Budget Authority:							
Appropriations received	$179,760	$123,676	$106,096	$182,754	$3,175	$4,512	$599,973
Net transfers				(1,208)			(1,208)
Other							
Unobligated Balance:							
Beginning of period			45		7	459	511
Net transfers, actual							
Anticipated transfers balances							
Spending authority from offsetting collections:							
Earned:							
Collected						71	71
Receivable from Federal sources							
Change in unfilled customer orders:							
Advance received							
Without advance from Federal sources						3	3
Anticipated for rest of year, without advances							
Transfers from trust funds				168		3,590	3,758
SUBTOTAL				**168**		**3,664**	**3,832**
Recoveries of prior year obligations				7,257	1,826	94	9,447
Temporarily not available pursuant to Public Law	(13,941)	10,020					(3,921)
Permanently not available			(45)			(10)	(55)
TOTAL BUDGETARY RESOURCES	**$165,819**	**$133,696**	**$106,096**	**$189,241**	**$5,008**	**$8,719**	**$608,579**
Status of Budgetary Resources:							
Obligations Incurred:							
Direct	$165,819	$133,696	$103,991	$183,330	$5,008	$5,485	$597,329
Reimbursable						74	74
SUBTOTAL	**165,819**	**133,696**	**103,991**	**183,330**	**5,008**	**5,559**	**597,403**
Unobligated Balance:							
Apportioned			2,105	5,884		2,367	10,356
Exempt from apportionment							
Other available							
Unobligated Balance not available				27		793	820
TOTAL STATUS OF BUDGETARY RESOURCES	**$165,819**	**$133,696**	**$106,096**	**$189,241**	**$5,008**	**$8,719**	**$608,579**
Relationship of Obligations to Outlays:							
Obligated Balance, net, beginning of period	$16,235	$16,404		$8,797	$9,748	$102	$51,286
Obligated Balance transferred, net							
Obligated Balance, net, end of period:							
Accounts receivable						(1,691)	(1,691)
Unfulfilled customer orders from Federal sources						(8)	(8)
Undelivered orders	439	142			8,323	1,551	10,455
Accounts payable	15,651	15,837		9,315		765	41,568
Outlays:							
Disbursements	165,964	134,121	$103,991	$175,285	4,607	4,441	588,409
Collections				(168)		(3,155)	(3,323)
SUBTOTAL	**165,964**	**134,121**	**103,991**	**175,117**	**4,607**	**1,286**	**585,086**
LESS: OFFSETTING RECEIPTS	**11,547**	**125,078**					**136,625**
NET OUTLAYS	**$154,417**	**$9,043**	**$103,991**	**$175,117**	**$4,607**	**$1,286**	**$448,461**

GROSS COST AND EXCHANGE REVENUE
For the Year Ended September 30, 2004
(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	$364		$364	$2		$2	$167,771	$1,805	$166,328
SMI	147		147	3		3	133,617	30,341	103,420
Medicaid	20		20				177,040		177,060
SCHIP							4,611		4,611
SUBTOTAL	**531**		**531**	**5**		**5**	**483,039**	**32,146**	**451,419**
Other Activities									
CLIA	23		23				41	60	4
TWI							34		34
SUBTOTAL	**23**		**23**				**75**	**60**	**38**
PROGRAM/ACTIVITY TOTALS	**$554**		**$554**	**$5**		**$5**	**$483,114**	**$32,206**	**$451,457**

CONSOLIDATED INTRAGOVERNMENTAL BALANCES
For the Year Ended September 30, 2004
(in millions)

	*TFM Dept. Code	Fund Bal. with Treasury	Investments	Accounts Receivable	Other
INTRAGOVERNMENTAL ASSETS					
Agency					
Department of the Treasury	20, 99	$26,570	$285,792		$9,248
Department of Commerce	13				1
Railroad Retirement Board	60			$421	
		$26,570	**$285,792**	**$421**	**$9,249**

	*TFM Dept. Code	Accounts Payable	Environmental & Disposal Costs	Accrued Payroll & Benefits	Other
INTRAGOVERNMENTAL LIABILITIES					
Agency					
Department of the Treasury	20, 99				$309
Office of Personnel Management	24			$3	
Social Security Administration	28	$620			
General Services Administration	47				11
Department of Health and Human Services	75	4			
All Other Federal Agencies					24
		$624		**$3**	**$344**

	*TFM Dept. Code	Earned Revenue	Gross Cost	Non-exchange Revenue Transfers-in	Non-exchange Revenue Transfers-out
INTRAGOVERNMENTAL REVENUES & EXPENSES					
Agency					
Department of Agriculture	12		$1		
Department of Commerce	13		2		
Department of Justice	15	$2	114	$315	
Department of Labor	16		1		
Department of the Treasury	20, 99		2	(25)	
Department of Defense	17, 21, 57, 97		(51)	(147)	
Office of Personnel Management	24		87		
Social Security Administration	28		38	3	$(1,741)
General Services Administration	47		54		
Railroad Retirement Board	60			435	(6)
Department of Transportation	69				
Department of Health and Human Services	75	3	251		(8)
Department of Housing and Urban Development	86				
All Other Federal Agencies			55		(9)
		$5	**$554**	**$581**	**$(1,764)**

* Treasury Financial Manual

Department of Health and Human Services

CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

DEC 3 2004

TO: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

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

SUBJECT: Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2004 (A-17-04-02004)

This memorandum transmits the independent auditors' reports on the fiscal year (FY) 2004 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and regulations of the Centers for Medicare & Medicaid Services (CMS). The CMS audit supports the Department of Health and Human Services audit, as required by the Chief Financial Officers Act of 1990 (Public Law 101-576), as amended.

We contracted with the independent certified public accounting (CPA) firm of PriceWaterhouseCoopers, LLP (PwC), to audit the CMS financial statements, with the exception of the CMS health programs, as of September 30, 2004 and 2003, and for the fiscal years then ended. We contracted with the independent CPA firm of Ernst and Young, LLP (hereafter referred to as other auditors) to audit the financial statements of the CMS health programs as of September 30, 2004, and for the fiscal year then ended. PwC's opinion expressed on the CMS financial statements, insofar as it relates to the amounts included for the health programs, is based solely on the report of the other auditors. The contracts required that the audits be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in the "Government Auditing Standards," issued by the Comptroller General of the United States; and OMB Bulletin No. 01-02, Audit Requirements for Federal Financial Statements.

Results of Independent Audit

Based on its audit and the report of the other auditors, PWC found that the fiscal years 2004 and 2003 CMS consolidated/combined financial statements were fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. However, during testing of internal controls as of September 30, 2004, PwC noted certain matters involving internal controls over financial reporting that were reportable, of which three were deemed to be material weaknesses under standards issued by the American Institute of Certified Public Accountants. Specifically, PwC reported significant weaknesses regarding CMS's financial systems, analyses, and oversight for its Medicare and health programs, as well as weaknesses in the Medicare electronic data processing controls.

- *Financial Systems, Analyses, and Oversight—Medicare Programs.* Although CMS continued to make progress in providing reliable financial information, CMS remained impaired by the absence of a fully integrated financial management system to accumulate, analyze, and report financial information in a timely manner. Further, CMS lacked a coordinated process to monitor activities, identify situations in which accounting evaluation or decisionmaking may be necessary, and effectively and efficiently implement changes to its financial statements.

- *Financial Systems, Analyses, and Oversight—Health Programs.* The lack of an integrated financial management system continued to impair CMS's ability to adequately analyze and monitor its financial balances reported for the health programs. In addition, deficiencies were noted in the oversight of regional offices and the estimation procedures for entitlement benefits due and payable. The processes to estimate improper payments were also incomplete. Overall, communication needed to be improved to ensure that critical material issues were considered and addressed timely for financial reporting purposes.

- *Medicare Electronic Data Processing.* To administer the Medicare program and to process and account for Medicare expenditures, CMS relies on extensive information systems operations at its central office and Medicare contractor sites. Although improvement since the FY 2003 audit was noted, numerous general and application control weaknesses were identified in areas such as entity-wide security programs and access and change controls.

Exclusive of the Federal Financial Management Improvement Act of 1996 and the Improper Payment Information Act of 2002, PwC disclosed no instances of noncompliance that are required to be reported under "Government Auditing Standards" and OMB Bulletin No. 01-02.

Evaluation and Monitoring of Audit Performance

We reviewed the audit performed on the CMS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;

- reviewing the approach and planning of the audits;

- attending key meetings with auditors and CMS officials;

- monitoring the progress of the audits;

- examining audit documentation related to the review of internal controls over financial reporting;

- reviewing the auditors' reports; and

- reviewing the CMS Management Discussion and Analysis, Financial Statements and Footnotes, and Supplementary Information.

PwC is responsible for the attached auditors' report dated December 2, 2004, and the conclusions expressed in the report. Our review, as differentiated from an audit in accordance with U.S. generally accepted government auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on CMS's financial statements, the effectiveness of internal controls, whether CMS's financial management systems substantially complied with the Federal Financial Management Improvement Act, or compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which PwC did not comply, in all material respects, with generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may call Joseph E. Vengrin, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at Joseph.Vengrin@oig.hhs.gov. Please refer to report number A-17-04-02004 in all correspondence.

Attachment

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

George H. Strader
Deputy Assistant Secretary, Finance

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Report of Independent Auditors

To the Administrator of the Centers for Medicare and 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, 2004 and 2003, and the related consolidated statements of net cost, changes in net position and financing, and the combined statements of budgetary resources for the years then ended. These financial statements are the responsibility of CMS's management. Our responsibility is to express an opinion on these financial statements based on our audits.

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 $28,345 and $28,057 million and total combined net costs of $ 181,709 and $166,124 million, as of and for the years ended September 30, 2004 and 2003. Those statements and financial information were audited by other auditors whose reports thereon have 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 reports of the other auditors.

We conducted our audits 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 audits and the reports of other auditors provide a reasonable basis for our opinion.

In our opinion, based on our audits and the reports of other auditors, the consolidated and combined financial statements referred to above, present fairly, in all material respects, the financial position of CMS and its components as of September 30, 2004 and 2003, and their net cost, changes in net position, budgetary resources, and reconciliation of net cost to

budgetary resources for the years 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 CMS from certain requirements of OMB Circular No. A-11, *Preparation, Submission and Execution of the Budget*. Specifically, for the Medicare program, CMS is exempted 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 and its components taken as a whole. The supplementary information, which includes the required combining statement of budgetary resources and the consolidating financial statements, is presented for purposes of additional analysis and is not a required part of the consolidated or combined financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated and combined financial statements and, in our opinion, are fairly stated in all material respects in relation to the consolidated and combined financial statements taken as a whole.

The Management's Discussion and Analysis (MD&A), Required Supplementary Information (RSI) and Required Supplementary Stewardship Information (RSSI) are not a required part of the financial statements but are supplementary information required by the Federal Accounting Standards Advisory Board and OMB Bulletin No. 01-09, *Form and Content of Agency Financial Statements*. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the MD&A, RSI and RSSI. However, we did not audit the information and express no opinion on it.

The other accompanying information is presented for purposes of additional analysis and is 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.

In accordance with *Government Auditing Standards*, we have also issued a report dated December 2, 2004 on our consideration of CMS's internal control and a report dated December 2, 2004 on CMS's compliance with laws and regulations. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are 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 audits.

PricewaterhouseCoopers LLP

December 2, 2004

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Report of Independent Auditors on Compliance with Laws and Regulations

To the Administrator of the Centers for Medicare and 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, 2004 and 2003 and the related consolidated statements of net cost, changes in net position and financing, and the combined statements of budgetary resources for the years then ended and issued our report thereon dated December 2, 2004. We conducted our audits 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 $28,346 and $28,057 million and total combined net costs of $ 181,709 and $166,124 million, as of and for the years ended September 30, 2004 and 2003. Those statements were audited by other auditors whose reports thereon has been furnished to us, and our report on CMS's compliance with laws and regulations herein, insofar as it relates to Health Programs, is based solely on the reports of the other auditors.

The management of CMS is responsible for compliance with laws and regulations. As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we performed tests of the 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 (FFMIA) of 1996. We limited our tests of compliance to these provisions and we did not test compliance with all laws and regulations applicable to CMS. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion.

PRICEWATERHOUSECOOPERS

Report of Independent Auditors on Compliance and Other Matters

The results of our tests and other auditors' tests of CMS's compliance with laws and regulations, described in the preceding paragraph, exclusive of FFMIA or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 01-02, resulted in one instance of non-compliance as described below.

CMS has begun to implement the requirements of the Improper Payments Information Act of 2002 (IPIA). Although CMS has not complied with OMB's IPIA guidance, CMS has implemented a process that measures the payment accuracy rates for the Medicare fee-for-service program.

Under FFMIA, we are required to report whether CMS's financial management systems substantially comply with the Federal financial management systems requirements, applicable Federal accounting standards, and the United States Government 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 below where CMS's financial management systems did not substantially comply with Federal financial management systems requirements and the U.S. Government Standard General Ledger at the transaction level.

In our report on internal control dated December 2, 2004, we reported material weaknesses (of which one relates to the Health Programs and is based solely on the report of the other auditors referred to in the second paragraph of this report) related to internal controls surrounding financial systems, analyses and oversight as well as internal controls surrounding electronic data processing. We believe that these matters, taken together, represent substantial non-compliance with the Federal financial management system requirements under FFMIA. In addition, CMS has not yet implemented the HIGLAS general ledger system and as a result is not compliant with the U.S. Government Standard General Ledger at the transaction level. Further details surrounding these findings, together with our recommendations for corrective action have been reported separately to CMS in our report on internal control dated December 2, 2004.

This report is intended solely for the information and use of the management of 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

December 2, 2004

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Report of Independent Auditors on Internal Control

To the Administrator of the Centers for Medicare and 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, 2004 and 2003, and the related consolidated statements of net cost, changes in net position and financing, and the combined statements of budgetary resources for the years then ended and have issued a report thereon dated December 2, 2004. We conducted our audits 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 $28,346 and $28,057 million and total combined net costs of $ 181,709 and $166,124 million, as of and for the years ended September 30, 2004 and 2003. Those statements were audited by other auditors whose report thereon has been furnished to us, and our report on CMS's internal control herein, insofar as it relates to the Health Programs, is based solely on the reports of the other auditors.

In planning and performing our audit, we considered CMS's internal control over financial reporting by obtaining an understanding of CMS's internal control, determined whether internal controls had been placed in operation, assessed control risk, and performed tests of controls in order to determine our auditing procedures for the purpose of expressing our opinion on the consolidated and combined financial statements and not to provide an opinion on the internal controls. We limited our control testing to those controls necessary to achieve the following OMB control objectives that provide reasonable, but not absolute assurance, that: (1) transactions are properly recorded, processed, and summarized to permit the preparation of the consolidated and combined financial statements and Required Supplementary Stewardship Information (RSSI) in accordance with accounting principles generally accepted in the United States of America, and to safeguard assets against loss from unauthorized acquisition, use, or disposition; (2) transactions are executed in compliance with laws governing the use of budget authority, other laws and regulations that could have a direct

and material effect on the consolidated financial statements or RSSI and any other laws, regulations, and government-wide policies identified in Appendix C of OMB Bulletin No. 01-02; and (3) transactions and other data that support reported performance measures are properly recorded, processed, and summarized to permit the preparation of performance information in accordance with criteria stated by management. We did not test all internal controls relevant to the operating objectives broadly defined by the Federal Managers' Financial Integrity Act of 1982. Our purpose was not to provide an opinion on CMS's internal control. Accordingly, we do not express an opinion on internal control.

Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control over financial reporting that might be material weaknesses. Under standards issued by the American Institute of Certified Public Accountants (AICPA) and OMB, reportable conditions are matters coming to our attention, that in our judgment, should be communicated because they represent significant deficiencies in the design or operation of the internal control that, could adversely affect the agency's ability to meet the internal control objectives related to the reliability of financial reporting, compliance with laws and regulations, and the reliability of performance reporting previously noted. Material weaknesses are reportable conditions in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that errors, fraud or noncompliance in amounts that would be material in relation to the consolidated and combined financial statements or RSSI being audited, or material to a performance measure or aggregation of related performance measures, may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. We noted certain matters, discussed at the end of this report, involving the internal control and its operation that we consider to be material weaknesses (of which one relates to the Health Programs and is based solely on the report of the other auditors referred to in the second paragraph of this report).

In addition, we considered CMS's internal control over RSSI by obtaining an understanding of CMS's internal control, determining whether these internal controls had been placed in operation, assessing control risk, and performing tests of controls as required by OMB Bulletin No. 01-02, and not to provide assurance on these controls. Accordingly, we do not provide an opinion on such controls.

With respect to internal control relevant to data that support reported performance measures, we obtained an understanding of the design of significant internal control 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. Accordingly, we do not express an opinion on such control.

Material Weaknesses -- Medicare Program

Over the past year, CMS has made progress in addressing the financial systems, analyses and oversight weaknesses noted during fiscal year 2003:

- CMS referred an additional $523 million in delinquent debt to Treasury, which brings the total referrals to approximately 99% of all eligible debt.

- 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.

- CMS continued performing Statement on Auditing Standards No. 70 (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.

- Finalized the Certification Package on Internal Controls (CPIC) onsite and desk review protocol. Conducted onsite reviews at select Medicare contractors to continue to develop and communicate a heightened awareness of internal controls within the Medicare contractor community.

- Continued to revise, clarify, and issue Medicare contractor financial reporting instructions, for example, revising policies regarding the calculation of the allowance for uncollectible accounts, recognizing and reporting credit balance receivables, and recognizing and reporting unsolicited/voluntary refunds.

While progress has been made during the current year, we continued to note significant weaknesses regarding CMS's financial systems, analyses and oversight and Medicare electronic data processing.

Financial Systems, Analyses and Oversight (Repeat Condition)

Overview

OMB Circular A-127 requires that financial statements be the culmination of a systematic accounting process. The statements are to result from an accounting system that is an integral part of a total financial management system containing sufficient structure, effective internal control, and reliable data. CMS relies on decentralized processes and complex systems—many within the Medicare Contractor organizations and CMS regional offices—to accumulate data for financial reporting. An integrated financial system, sufficient number of properly trained personnel and a strong oversight function are needed to ensure periodic analyses and reconciliations are completed to detect and resolve errors and irregularities in a timely manner.

Lack of Integrated Financial Management System

CMS's 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 CMS's ability 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 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 CMS, and the CMS contractors, do not have a JFMIP compliant financial management system, the preparation of the 750 and 751 reports, and the review and monitoring of individual accounts receivable, are dependent on labor intensive manual processes that are subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to CMS. Likewise the reporting mechanism used by the CMS contractors to reconcile and report funds expended, the 1522 – Monthly Contractor Financial Report, is heavily dependent on inefficient, labor intensive, manual processes, that are also subject to an increased risk of inconsistent, incomplete, or inaccurate information being submitted to CMS.

The lack of integration in financial reporting is clearly demonstrated through the results of the SAS 70 reviews performed at Medicare Contractors during the current fiscal year. These reports noted a total of 23 auditor qualifications related to financial reporting control objectives at seven of the fourteen contractors where reviews were completed. This indicates a potential problem in relying upon the data as reported without completion of significant review by the regional and central office. This prevents the timely use and reliance of this information by both operations and financial reporting personnel. For example, the contractors are unable to report all information required for the completion of quarterly financial statements in accordance with OMB timelines and provides only minimal information at year-end which supports the completion of financial statements but does provide enough data for oversight and management of the contractors' activities.

Recommendation

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 claims activity.

Managed Care Organization Oversight

PwC noted improvement in the implementation of formal policies and procedures and documentation to support the processing, approval and acceptance of applications for managed care organizations applying to join the Managed Care program. CMS is in the process of issuing final rules implementing the Medicare Advantage program which replaces the Medicare+Choice managed care program. As such, CMS plans to provide extensive technical assistance and training to plans, providers and internal staff which should lead to improved monitoring of the managed care program. However, during our testing, PwC noted other matters that indicate inadequate monitoring of managed care organizations by both the central office and regional offices as a result of the following:

- The management system used by central office to monitor the execution and status of managed care organization reviews performed by the regional office is not being updated on a timely basis. PwC noted instances where the management system had not been updated to reflect changes in the monitoring review dates. We noted two terminated plans that where scheduled for review. We also found evidence of duplicate plan identification numbers in the system.

- As discussed last year, 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. As a result of this year's audit procedures we continued to identify inconsistencies regarding the documentation that was available for review. The documentation maintained by the regional offices to support the execution of monitoring reviews performed at managed care organizations is inconsistent and in some instances incomplete due to the lack of established documentation policies for regional office reviews.

- There are no tailored policies and procedures for monitoring reviews related to demonstration projects. These are specialized health care programs/services established to address the needs of specific beneficiary populations. The current process for monitoring reviews of demonstration projects performed by the regional offices mirror the standard procedures used for existing non-demonstration project managed care organizations. However, such an approach does not contemplate or address the unique requirements or complexities that each demonstration project may possess.

- PwC noted instances of inadequate policies, documentation and supervisory review related to the authorization and payment process for managed care organizations.

    - Division of Enrolment and Payment Operations (DEPO) has no established procedures to reconcile payments that are authorized to the actual payment made by Treasury.

    - DEPO does not maintain a log of anomalies or errors resulting from their review of payments.

    - The current methodology employed to analyze payment information is based on a simple fluctuation analysis on month to month payments. This simplistic model does consider additional variables which may indicate potential payment issues.

    - We found inconsistent execution of the documentation policy related to payment adjustment.

    - We noted instances in which documentation to support payment adjustments was not available.

Recommendation

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,

- Ensure that the management system is updated on a timely basis to provide information for adequate management oversight to be executed.
- Ensure that established policies address standard documentation and retention requirement that each regional office is required to follow in the execution of the monitoring reviews of the managed care organizations.
- Establish policies that require the regional office in the performance of monitoring of demonstration projects to create tailored procedures that contemplate and address the unique requirements or risks of each demonstration project.
- More extensive data and payment information analysis should be performed to identify potential errors, unusual variances or inappropriate payment trends. Using information such as; 1) Demographic makeup of the plans population as compared to the coverage areas population, 2) Enrollment fluctuations as compare to other pans and enrollment in the overall Medicare program.

Due to importance of the Division of Enrollment and Payment Operations function in ensuring the validity and accuracy of payments to the managed care organizations and to maximize the detection of payment errors, we would recommend that DEPO perform a timely reconciliation of authorized payments made by Treasury. The Division should also establish a log to document anomalies and errors that are identified and resolved as part of the authorization process in order to further support decisions made as part of the authorization process.

Financial Analysis and Reporting – CMS Central Office

Communication:

CMS lacks a coordinated process among cross-functional teams of finance, program management, and legal personnel to monitor business activities to identify situations where accounting evaluation or decision-making may be necessary. For example, no structured process exists to communicate potential loss contingencies to legal or accounting personnel.

Further, upon identification of potential loss contingencies, no rational, structured process exists to ensure timely resolution of accounting questions by the appropriate personnel. During the FY2004 audit, we noted an instance in which a material liability was not identified or disclosed by CMS on a timely basis. Furthermore, CMS did not consult with the HHS Office of General Counsel on this loss contingency; therefore, this matter was not included in the interim legal letter dated August 15, 2004. In addition, executive management personnel did not inform OFM of the ongoing analysis surrounding this loss contingency which prevented the issue from being properly assessed and accounted for on a timely basis.

CMS lacks a comprehensive process for identifying and evaluating written employee complaints which could contain information alleging improper acts or other matters causing legal, operational or financial risk to the agency. There are numerous ways in which complaints are received by the agency as whole. These methods include, but are not limited to, calls to the HHS OIG hotline, e-mails sent directly to members of the executive management team, letters sent directly to supervisory personnel and/or executive management, and correspondence sent directly to the HHS OIG. CMS has not developed formal policies and procedures regarding actions to be taken when such correspondence or verbal notification is received.

Recommendation

CMS should establish appropriate policies, procedures and protocol to address situations or transactions that require cross-functional involvement in determining accounting-related estimates. The financial management function should serve as the primary coordinator to facilitate the input and involvement of the other cross-functional units whose involvement and input are required to formulate accounting estimates and the related financial statement disclosures. Further, where review and approval is required by parties outside of CMS, for example, HHS Department-Level management, OMB or others, the CMS financial management function should coordinate the process of attaining such review and approval.

In addition, CMS should develop and implement policies and procedures to track all incoming correspondence related to employee grievances and concerns. In particular, CMS should establish a process by which CMS, HHS Department-Level management and the HHS OIG share information regarding correspondence that contains matters potentially causing legal, operational or financial risk to the agency.

Report Preparation:

CMS's current financial reporting process lacks the framework needed to effectively and efficiently implement changes to their financial statements. Procedures do not exist to ensure that changes/updates to CMS's accounting and financial reporting policies are properly evaluated by supervisory personnel and approved in writing. Furthermore, CMS does not have sufficient policies and procedures in place to ensure that changes/updates to the financial statements conform to generally accepted accounting principles. For example, CMS did not complete a formal process when undertaking the restatement of the FY 2003 Statement of Budgetary Resources. This was evidenced by the fact that a written approved "white paper" had not been completed prior to the completion of the accounting journal entries. Further, the accounting journal entries associated with the FY03 SBR restatement were incomplete.

The control processes currently in place to ensure the accuracy of CMS's financial statements are not working as intended by management as noted through our review of CMS's financial report which contained errors such as: the opening obligation balance on the SBR for FY 2004 did not tie to the FY 2003 restated ending obligation balance: the benefits due and payable for the Managed Care program was not obligated as required by A-11 and outlined in the agency white paper on the restatement of the SBR; contractor cash balances reflected on the financial statements did not agree to the balance per contractor 750 reports; discrepancies between the 1522 and 750 reports filed by the Medicare Contractor were not investigated; and adjusting entries related to the HI and SMI trust funds were not complete which totaled more than $100 million.

Recommendation

CMS should develop formal written processes to evaluate and approve changes in accounting and financial reporting policies. This would include a process for preparing a "white paper" to support any significant changes/updates to the financial statements. This paper should include references to the applicable guidance that supports the changes/updates and CMS's conclusion. The white papers should be approved by the Chief Financial Officer.

During FY 2004, we noted an increase in attrition within the OFM, which had a negative impact on the preparation of the annual financial report. To ensure that CMS's financial report is completed in an accurate and timely manner, personnel with financial statement and reporting backgrounds need to be added to the OFM staff in addition to completing a re-design of the process as noted below.

CMS should re-design the current procedures used to prepare their financial reports. This process should include the use of a cross-functional team representing all components that are

responsible for information which is included in the annual financial report. This cross-functional team should be led by OFM to ensure that all information is accurate and supported by areas appropriate supporting documentation. This team should be responsible for the reviews of the financial reports to ensure internal consistency and accuracy. The following should be considered in this re-design:

- Analytical procedures should be completed to ensure logical relationships between various financial statement amounts. Variances from expected results should be thoroughly researched and resolved.

- Establish standard methodologies and formats for completing supporting schedules and reports across all programs. To ensure the accuracy and completeness of work performed, supervisory reviews need to be critical as opposed to cursory.

- A "cold" review should be conducted by someone that has not worked on the financial statements to ensure that amounts within the MD&A, financial statements and performance measures are internally consistent.

Management should consider creating a financial reporting function as part of implementing these recommendations. This financial reporting function would serve as the "specialist" in areas of accounting and reporting policy, oversee the process of developing financial reporting information for financial statement purposes and be responsible for underlying procedures and controls.

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 output of data from CMS application systems.

Our audit included general controls reviews at 16 sites: the CMS central office and 15 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 four of the Medicare contractors which included the Fiscal Intermediary Standard System (FISS), the Viable Processing System (VIPS), the Viable Medicare System (VMS), 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 14 Medicare contractors audited.

Further, we conducted vulnerability reviews of network controls at all 16 sites audited. The vulnerability reviews included both external and internal penetration testing in 15 of the sites, and network vulnerability assessments in all 16 sites, including reviews of security configurations of network servers.

Numerous general and application control findings were identified which is consistent with that found in prior years. The actual numeric count of findings was decreased this year versus FY 2003; however, this was primarily the result of combining similar findings. 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. CMS security over Medicare electronic data processing reflected improvement over our FY 2003 audit, but strengthened controls are still needed. 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 did not have programs to:

- Consistently identify weaknesses in their systems;
- Assess the risks posed by these weaknesses;
- Undertake specific actions to reduce risks to acceptable levels; and,

- Perform periodic reviews of controls to ensure their continued effectiveness.

We noted again that many of the sites had continued to designate security administration duties to personnel who did not possess the proper background and education to perform their job requirements, and who did not receive specific security training required to perform their security responsibilities during the current year. Further, we noted instances where security administration duties were improperly segregated from the duties of application programming. Finally, we noted some contractor sites for which an overall EWSP was not 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, understanding and involvement by security personnel with the proper background and education to ensure the implementation of the program. Robust plans also require ongoing risk assessment, clear identification of controls to mitigate risks and ongoing testing to ensure the effectives of the controls used to mitigate risks.

Logical and Physical Access Controls – Access controls ensure that critical system 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 several sites, primarily due to poor security settings resulting from the lack of sufficient security configuration standards for the network computers tested. We attribute the lack of sufficient security controls to the lack of a robust entity-wide security program, as noted in the EWSP section above. A robust EWSP would consistently identify weaknesses, assess the risks posed by these weaknesses, undertake specific actions to reduce risks to acceptable levels and require the performance of periodic reviews of controls to ensure their continued effectiveness. Such controls would include annual internal and external penetration reviews, and periodic reviews of security control settings on platforms throughout the contractor sites' networks.

Our testing of access controls at contractor sites also noted that we were 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, programs and data without proper authorization. Our review did not disclose any exploitation of critical systems tested; however, clear potential existed.

The lack of specific guidance for computer security configuration settings and effective entity-wide security programs, including ongoing review and testing of security controls, and an

EWSP 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 Control – 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 again that contractor processing sites have the ability to turn on and off front end edits in the APASS, FISS, MCS and VMS systems without consistent procedures to ensure that edits are only turned off when required and that all such activity is properly controlled and reviewed. This represents an important area of concern because the ability to negate system edits may degrade 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 again 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. CMS has implemented changes in its testing procedures to address the issue at the Medicare contractors. Finally, we noted again sites at which application programmers had the ability to directly update production source code for applications thereby bypassing application change controls. This potential exists in the FISS system, but CMS has developed and implemented compensating controls to address this vulnerability.

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 and 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 and system software 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. The lack of security configuration standards at some sites contributed to the weaknesses noted and the

ability of our external penetration teams to penetrate several sites tested; however, the biggest contributor to this issue was the lack of ongoing testing to ensure the effectiveness of security settings within contractor networks. Ongoing testing includes internal and external penetration tests and tests to ensure the propriety of security configuration settings on platforms used by contractors, including mainframe, Windows, UNIX, firewall and router server security configuration settings.

Overall Conclusion - During FY 2004, improvements were noted at a number of sites we visited, a reflection of increased management attention and interest. CMS made progress by continuing their reviews of contractors, including penetration tests and reviews of configuration settings on servers. CMS has also continued its programs to review the contractors through SAS 70 audits, an extensive contractor self-assessment program (the CAST) and reporting process and greater central oversight by contractor management. Additionally, CMS has requested and received updated system security plans and risk assessments from its contractors and has a certification and accreditation program initiative featuring system vulnerability assessments. However, the number of findings documented during our audit indicates that improvements are still needed.

CMS also launched a program to evaluate the security levels of all contractors regarding their compliance with the Federal Information Security Management Act (FISMA) under the requirements of the Medical Modernization Act for Medicare. This evaluation program includes all eight key areas of FISMA: periodic risk assessments, policies and procedures to reduce risk, systems security plans, security awareness training, periodic testing and evaluation of the effectiveness of IT security policies and procedures, remedial activities, processes and reporting for deficiencies, incident detection, reporting and response, and continuity of operations for IT systems. We believe that these evaluations will serve CMS greatly in better understanding the current state of security operations at all contractors.

Efforts to address the findings noted in our review are challenged by budgetary constraints and the decentralized nature of Medicare operations and the complexity of fee-for-service processing. According to CMS officials, the CMS modernization program represents a long-term solution to simplify the application software code and change controls needed for more robust security. CMS is also in the process of its contractor reform initiative, including data center consolidation, which should reduce the number of contractors and data centers.

Recommendation

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

Provide additional guidance to the contractors regarding the requirements to formally assess and reduce risk on an ongoing basis by specifically identifying and matching controls to mitigate risks and by specifically requiring ongoing and consistent tests of mitigating controls to ensure their continued effectiveness. Compliance with CMS Acceptable Risk Safeguards will provide a foundation for improvement.

Develop formal and consistent policies and procedures to control the processes used to turn off edits in systems and to assess the impact of processing during periods when edits are negated. The control process should include identification of who in the organization is authorized to make edit changes and the potential impact on claims processing errors.

Develop and implement procedures to continuously monitor and track compliance with the security configuration models for all platforms maintained within the CMS central office, the CMS contractor sites and the maintainer sites.

Material Weakness – Health Programs

Financial Management Systems and Oversight (New Condition)

OMB Circular A-127 requires that financial statements be the culmination of a systematic accounting process. The statements are to result from an accounting system that is an integral part of a total financial management system containing sufficient structure, effective internal control, and reliable data. CMS relies on decentralized processes and complex systems—many within the states and regional offices—to accumulate data for financial reporting. An integrated financial system, sufficient number of properly trained personnel, and a strong oversight function are needed to ensure periodic analyses and reconciliations are completed to detect and resolve errors and irregularities in a timely manner. The growth of the Health Programs has not been accompanied by a corresponding growth and maturation of HHS and CMS financial management resources.

Identification and Resolution of Financial Reporting and Management Issues

As the Health Programs grow and consume additional resources, at the margin it can be anticipated that certain matters which might formerly be considered insignificant in relation to CMS and HHS as a whole may loom larger. An issue regarding whether the Health Program would be reimbursed by the Medicare Trust Funds was surfaced as part of the audit process after year-end. While certain HHS and CMS personnel were addressing the issue earlier in the year, it is clear that the financial reporting implications of the issue were not assessed early in the process, and at a minimum several quarters of reports were presented without appropriate

consideration of the issue. Up until shortly before finalization of the financial statements, consideration was being given to alternative approaches to addressing this issue, some of which could have resulted in significant changes in the Health Programs financial statements. Departmental, overall CMS, and Health Programs management communication processes need to be improved to ensure that critical issues are addressed timely and fully considered to prevent financial statements from being issued which are materially misstated.

Financial Management Systems Lack FFMIA Compliance

CMS's financial management systems, including its general ledger, grant award and expenditure systems are not fully 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 impairs CMS's abilities to adequately analyze and monitor its financial balances reported. For example:

- The Medicaid Budget and Expenditure System (MBES) lacks sufficient integration with the CMS general ledger system.

- There are no formal written policies and procedures in place to document CMS access control procedures. For example, CMS was unable to provide access authorization documentation to support for 8 of the 45 samples selected.

- Formal written policies and procedures are not in placed for terminated users and revalidation of access rights for the MBES.

- Periodic reviews of user access to the MBES are not performed. We reviewed the entire population of users and noted that certain terminated users were still active.

- During our review, test and discussion with application Medicaid systems management, we noted that the MBES does not have sufficient detailed policies and procedures on segregation of duties where incomparable duties are specifically identified. Policies were provided, but these procedures were not sufficiently detailed for personnel to identify 77 potential segregation of duties violations.

CMS is currently in the process of implementing a new integrated financial management system and updating its policies and procedures that may resolve CMS's issues related to compliance with the FFMIA.

Regional Office Oversight

In September 2000, CMS O issued financial review guides to assist the Regional Office (RO) analysts in examining budget and expenditure reports as well as to standardize the review procedures performed between analysts and regions. These review guides encompass all areas of the review process but allow each region and analyst the flexibility of determining what areas need to be addressed based on the activity of the Region as well as available resources. These guides also set forth guidance on work paper standards and supervisory review. During FY 2004, we visited two regional offices to assess the Regional Office oversight function and found that certain procedures were not being performed to ensure financial data provided by the states is reliable, accurate, and complete. CMS management identified the most significant cause as inadequate resources, multiple oversight activities assigned to financial analysts, and inadequate travel funds. We noted the following:

Documentation and Scope of Reviews – Within the CMS Regional Office, each analyst uses the CMS Financial Review guides as the procedures required to assess each states' budget requests, quarterly expenditure reports, and other state activities related to SCHIP and Medicaid funding. We noted in the two regions visited that the Regional office did not document fully what steps were performed and the reasons for steps not performed. Additionally, we noted limited supporting documentation in the files to support the prepared financial review guide. For example, for four states, there was either no supporting documentation maintained or insufficient documentation maintained in the workpapers to support the analysts' conclusions. Finally, the workpapers supporting the assessment did not bear evidence that they were properly reviewed by a supervisor to ensure consistency of reviews within the state and among regional offices

Monitoring of state submissions— Analysis of changes in quarterly budget submissions is a major consideration in the Regional Office's decision to award a grant. Although recommended, during our visit to the regional offices, we noted that analysts did not adequately perform trend analyses on Medical Assistance Payments (MAP), Administration (ADM), and SCHIP payments. For certain states, no evidence of trend analysis was available. For other states, where trending was available, balances selected for review were based on dollar amounts and judgments; however, the scope of the items selected for review were not documented in the work papers nor was there evidence of which amounts were investigated. In many cases, explanations for variances were not readily available, or were not sufficient to

assist a reviewer in verifying that CMS gathered appropriate evidence to support the execution of its oversight responsibilities over the Health Programs.

Oversight of Medicaid State Information Technology-Although CMS assesses the Information technology environment for Medicare intermediaries, it currently does not systematically assess or monitor the internal control supporting state-based information systems used in processing Medicaid and SCHIP benefits. However, significant funding of such systems has been provided by CMS. CMS relies on state auditors and nongovernmental auditors executing audits pursuant to the Single Audit Act to determine whether control environments related to Medicaid state-based systems are effective. The depth of these reviews is typically far less extensive then the specialized reviews that CMS undertakes of its Medicare intermediaries. The OIG has also performed several more extensive assessments at various states and has found significant matters related to access controls and other internal control issues. Processes are not in place to ensure that adequate inspections are performed on a periodic basis, or that the results of such inspection activities are made available to, analyzed and followed up on by CMS in executing its oversight function.

Beginning in FY 2005, CMS has taken steps to increase regional office personnel by hiring more than 100 analysts to work in the states to ensure compliance with Medicaid requirements. These analysts are currently undergoing extensive training to ensure adequate knowledge of CMS policies and procedures.

The GAO's *Standards for Internal Control in the Federal Government* indicates that internal control monitoring should assess the quality of performance over time and ensure that findings of audits and other reviews are promptly resolved. Without appropriate monitoring and oversight of state operations, deficiencies in internal control may allow material misstatements to occur without being identified in a timely manner.

Entitlement Benefits Due and Payable

Medicaid entitlement benefits due and payable (IBNR), totaling approximately $18 billion at September 30, 2004, represent the cost of services provided by states but not paid at the end of the fiscal year. CMS bases its estimate of IBNR receivables and payables on historical trends of expenditures and prior year payables identified on surveys obtained from the States. CMS validates their estimate by considering current year program changes, performing analytical procedures, and evaluating significant differences. For SCHIP, CMS has not implemented procedures to accrue an estimate for SCHIP IBNR payables and receivables at year-end. However, a large portion of SCHIP expenditures is reimbursed on a fee for service basis, indicating the need for an IBNR accrual. Currently, CMS has not been able to develop a

method of accessing claims level data submitted by the states and maintained internally to estimate IBNR amounts and relies upon summary information submitted by the States. Although we believe this methodology produced a reasonable IBNR estimate for Medicaid and is the best available estimate in the circumstances, we believe that the process is time consuming, error prone due to the various states' inconsistency and interpretations of how to calculate the amount due from CMS and heavily dependent upon information provided by the States.

Given the significance of the IBNR estimate, and the possibility that accessing claims level data as part of a process to estimate the liability will aid CMS in its management of the program and in developing trends, we suggest that the Office of the Actuary be engaged to refine the estimate in accordance with actuarial standards of practice, in a process analogous to that used to calculate the IBNR for Medicare. In the interim, if CMS continues to utilize historical trending as a basis for the IBNR, further training of state personnel preparing the survey may be necessary to ensure consistency in calculating the amount payable to the state, and more explicit recognition should be made by CMS in assessing trends in the programs and the propriety of utilizing the current trending and averaging approach, which may imperfectly capture fundamental changes in the programs or how the states are administering their programs.

Claims Estimated Improper Payments

The Improper Payment Information Act requires agencies to review annually all programs and activities they administer and identify those which may be susceptible to significant erroneous payments. For all programs and activities identified as susceptible to significant erroneous payments, agencies are required to determine an annual estimated amount of erroneous payments made in those programs and activities. Although both Medicaid and SCHIP have been identified as programs which are susceptible to improper payments, CMS has not completed its implementation of a process to estimate improper payments. For FY 2004, because only 12 states have volunteered to participate in the pilot project for Medicaid, a national estimate is not available. CMS is not expected to report a national estimate for Medicaid or SCHIP until FY 2006. Additionally, because the process is highly dependent on states, CMS Central Office and its Regional Offices will be required to train State personnel in the calculation of improper payments and closely monitor the process to ensure reliability of the results to be reported.

Recommendation

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

- Continue to enhance its financial systems to ensure compliance with the FFMIA.
- Enhance its policies and procedures related to access controls to:
  - Require all system administrators to maintain audit evidence of the access request forms for users created on MBES.
  - Require all system administrators to perform periodic reviews of access authorization to the MBES application.
  - Ensure that incompatible duties are identified and segregated so that segregation of duties issues does not occur.

In order to help strengthen the estimating process and promote consistency between CMS's programs, develop a methodology to collect the necessary data to estimate an IBNR amount similar to the methodology used for Medicare. For SCHIP, we recommend that CMS identify a methodology for estimating an IBNR for SCHIP related expenditures.

- Assess whether Regional Offices are adequately staffed with trained personnel to ensure financial management activities at the states are adequately performed, and financial information generated is complete, valid, and properly valued.
- Continue to refine its procedures to provide a mechanism for CMS Central and Regional Offices to monitor states' activities and enforce compliance with CMS financial management procedures. For example, we recommend that:
  - The Financial Review Guides issued by CMS Central Office be used to document procedures performed during the quarterly expenditure reviews and that any decision to expand or curtail the scope of the review or review procedures be documented.
  - The CMS Central Office implements procedures at the Regional Offices to ensure that all applicable areas of the Financial Review Guides are addressed at least annually.

- Work papers be prepared in accordance with procedures outlined in the Financial Review Guide.

- The Regional Office analysts develop a scope to be used to identify areas for review and that this scope, or any deviations from the scope, be documented within the trend analysis work paper(s) along with explanations.

- Consideration be given to developing and implementing a peer review process where analysts from within and between regions review the Regional Office's current procedures being performed to help identify areas that can be strengthened and best practices.

- Provide additional training for financial personnel at the CMS Central Office, the Regional Offices, and for the states to ensure that personnel update their knowledge of financial reporting requirements.

- Develop and implement a plan to monitor Medicaid-related systems at the states to ensure compliance with Federal system requirements.

- Continue in the implementation of the pilot project to estimate improper payments for both the Medicaid and SCHIP- related payments.

* * * * * * *

We also identified other less significant matters that will be reported to CMS's management in a separate letter.

This report is intended solely for the information and use of the management of CMS and the Department of Health and Human Services, the Office of the Inspector General of the Department of Health and Human Services, 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

December 2, 2004

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

December 2, 2004

PriceWaterhouse Coopers, LLP
1301 K. Street NW
Washington, D.C. 20005

Dear Sir:

This letter is in response to your audit report on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2004 financial statements. Your report identifies three material weaknesses: 1) Financial Systems, Analyses, and Oversight - Medicare, 2) Electronic Data Processing (EDP) Controls - Medicare, and 3) Financial Management Systems and Oversight - Health Programs. The first two weaknesses are repeated from the FY 2003 audit of CMS' financial statements.

The CMS generally concurs with the findings and descriptions of the weaknesses. As noted in your report, CMS continued to improve its financial management performance in FY 2004 in many areas, including those areas identified as material weaknesses by the auditors. For example, CMS referred an additional $523 million in delinquent debt to the Department of the Treasury, which brings the total referrals to approximately 99 percent of all eligible debt. We also continued to perform reviews documenting and assessing internal controls at Medicare contractors.

The CMS' lack of an integrated general ledger accounting system continues to be a major factor contributing to the weaknesses identified by the auditors. We are aggressively addressing this material weakness by continuing our efforts to implement the Healthcare Integrated General Ledger Accounting System that will strengthen CMS' financial management by standardizing the collection, recording, and reporting of financial information among all the Medicare contractors and CMS.

Although we are pleased with these results, we have already developed a plan to further strengthen our financial management processes and ensure that all the material weaknesses identified by the auditors will be corrected. The CMS remains 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. We will continue to track and report our progress on a regular basis.

I would also like to thank your office for its diligent work in completing the audit and look forward to working with our auditors in correcting these outstanding issues.

Sincerely,

Deborah A. Taylor for

Timothy B. Hill
Chief Financial Officer

Other Congressional Reports

SUMMARY OF FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT REPORT

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 and management self-assessments, (2) OIG audits, (3) GAO audits and high risk reports, (4) the CFO financial audit, (5) other review mechanisms, such as SAS 70 internal control reviews, and (6) certification and accreditation of systems. As of September 30, 2004, the management controls and financial management systems of CMS provided reasonable assurance that the objectives of FMFIA were achieved. However, two material weaknesses (similar to prior years) existed and a noncompliance was identified.

Material Weakness 1: Financial Systems, Analyses, and Oversight

This material weakness covers the financial reporting and oversight in both the Medicare and Medicaid programs. The auditors found that CMS needs to improve its communication processes and procedures to prevent financial statements from being issued that are materially misstated. Quarterly meetings that include the Administrator, Deputy Administrator, Chief Operating Officer, Chief Actuary, CFO, and Chief Counsel will be conducted to ensure that all financial statement issues (for example, potential liabilities) are identified.

The Medicare contractors continue to make improvements in maintaining supporting records for Medicare activities. However, because CMS lacks a formal, integrated accounting system to accumulate and report financial information by Medicare contractors, states

and CMS CO and ROs, they use ad hoc, labor-intensive reports, which increases the risk of material misstatement or omission. We continue to contract with Independent Public Accountants to test financial management internal controls and to analyze financial transactions at Medicare contractors. As CMS progresses toward its long-term goal of developing an integrated general ledger system, we will continue to promote a uniform method of reporting and accounting for financial data.

Additionally, the auditors indicated the inadequate monitoring of managed care organizations as the result of the following: 1) the management system used by CO to monitor the execution and status of managed care organization reviews performed by the RO is not being updated on a timely basis; 2) insufficient documentation to evidence the on-going monitoring of managed care organizations by the ROs in accordance with the CMS policies and procedures; 3) tailored policies and procedures for monitoring reviews related to demonstration projects are nonexistent; and 4) instances of inadequate policies, documentation, and supervisory review related to the authorization and payment process for managed care organizations. The CMS will ensure that managed care systems will be updated for any changes in a timely manner and Medicare managed care organization-related documents will be maintained.

Moreover, the auditors found that weaknesses in CMS' financial oversight of the Medicaid program. For example, inadequate resources, multiple oversight activities assigned to financial analysts, and inadequate travel funds contributed to the lack of internal controls to ensure that financial data provided by the states are reliable, accurate, and complete. The CMS believes implementing an integrated general ledger system will strengthen CMS' financial management oversight of the Medicaid program.

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

The CMS relies on extensive EDP operations at CMS Central Office 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 availability of critical data while reducing the risk of errors, fraud, and other illegal acts.

The material weakness for the Medicare EDP controls is very complex involving approximately 33 contracts with the fiscal intermediaries and carriers who process claims using 16 data centers. The majority of weaknesses were noted at the Medicare contractors versus the CMS Central Office. The audit procedures disclosed no exploitation or compromise of CMS systems. No individual weakness was considered material, but in the aggregate the weaknesses were considered material. Because of this complexity, resolution of the material weakness will take time and resources. Progress in addressing individual findings is being made in areas such as access control, system software, and segregation of duties. Corrective actions of individual weaknesses are tracked as part of the CMS Plan of Actions and Milestones (POA&M) Report. The long-term strategy in eliminating the material weakness is rooted in the CMS modernization initiative that will further improve our security posture.

The President's budget for FY 2005 includes funding for information technology (IT) modernization. A more secure system environment is a key component of the IT modernization plan. The CMS is implementing its modernization plan using a two-track policy for security. On the first track, we are aggressively taking reasonable and appropriate remedial

steps to close the highest risk vulnerabilities. These actions are reflected in our POA&M report. On the second complementary track, we are building security into the Agency's modernized infrastructure through capital investments targeted to reduce our security perimeter. The CMS will limit its exposure to risk through such preemptive measures as data center consolidation and simplifying application development in a way that leaves less opportunity for exploitation than is the case in the current highly complex systems environment. To reinforce this further, our Information Services Modernization Implementation Strategy includes security components for application modernization, data modernization, and infrastructure modernization. The CMS main effort is on building a secure infrastructure versus managing corrective actions. We intend to be proactive in managing IT modernization versus reactive in response to audit results.

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, and CMS Central offices. The HIGLAS will initially integrate our financial systems with the Medicare contractors' existing shared claims processing systems. In addition, the current mainframe-based financial system will also be replaced by HIGLAS, the foundation of which is a web-based, certified Joint Financial Management Improvement Program, commercial-off-the-shelf system.

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 2003, CMS randomly selected approximately 1 percent of all JCAHO-accredited hospitals to receive a validation survey. For FY 2003, the number of hospitals selected to receive a validation survey.

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. In FY 2003, the accreditation decisions included: accreditation, accreditation with requirements for improvement, 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 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 2002 and 2003.

TABLE 1
JCAHO Accreditation Decisions,
Medicare-Approved Hospitals Surveyed in FY 2002 and FY 2003

Accreditation Decisions	**No. Hospitals in 2002** *(Percent)*	**No. Hospitals in 2003** *(Percent)*
Accreditation	257 (16.7)	320 (21.0)
Accreditation with Requirements for Improvement	1306 (82.7)	1191 (78.15)
Conditional Accreditation	14 (0.9)	13 (0.85)
Preliminary Denial of Accreditation	1 (0.06)	1 (0)
Accreditation Denied (0.06)	1 (0)	0
Total Surveyed	1578 (100)	1524 (100)

Sample Validation Surveys

A total of 71 sample validation surveys were performed in JCAHO-accredited hospitals during FY 2003. The validation sample includes the following categories:

1. Traditional surveys
2. Mid-cycle 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 57 traditional validation surveys conducted during FY 2003.

[1] JCAHO accreditation decisions also include preliminary denial of accreditation and provisional accreditation. [During FY 2003, CMS did not recognize provisional accreditation for deeming.] Effective January 2004, JCAHO redefined their accreditation decision categories and CMS now recognizes 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.

As part of CMS efforts to improve oversight overall, CMS initiated a new "mid-cycle" survey in 2003. The mid-cycle validation survey is designed to validate the correction of deficiencies cited during the JCAHO accreditation survey and to evaluate a hospital's ability to maintain compliance with the Medicare requirements between JCAHO accreditation surveys. The mid-cycle survey is a full survey conducted at the mid-point in the accreditation cycle, approximately 18 months after the JCAHO triennial survey. Hospitals selected to receive a mid-cycle survey had all received "requirements for improvement" during their JCAHO accreditation survey. Mid-cycle surveys were performed on a pilot basis in 14 hospitals during FY 2003.

Validation Survey Findings

In FY 2003, a total of 71 JCAHO-accredited hospitals received a validation survey, 57 hospitals received a traditional survey and 14 received a mid-cycle 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 2003

Survey Type	No. Hospitals Out of Compliance *(Percent)*	No. Hospitals In Compliance *(Percent)*	Total
Sample Validations	23 (32.3)	48 (67.6)	71
Routine Non-Accredited	36 (13.0)	241 (87.0)	277

Table 3 presents compliance determinations for JCAHO-accredited hospitals by category of validation survey for FY 2003.

TABLE 3
JCAHO-Accredited Hospitals Out of Compliance by Validation Survey Category, FY 2003

Survey Type	No. Hospitals Out of Compliance	No. Hospitals In Compliance	Total
Traditional	18	39	57
Mid-cycle	5	9	14

The health and safety CoPs found out of compliance most frequently for the 71 validation surveys performed in FY 2003 are shown in Table 4. The three CoPs found out of compliance most frequently for the 277 non-accredited hospitals surveyed in FY 2003 are shown for comparison.

TABLE 4
Most Frequently Cited Conditions of Participation During Surveys, FY 2003

Accredited Hospitals	Frequency	Non-Accredited Hospitals	Frequency
1 Physical Environment *(Includes Life Safety Code)*	16	Infection Control	14
2 Patients' Rights	3	Governing Body	13
3 Quality Assessment and Performance Improvement (QAPI)	3	Medical Staff Physical Environment (QAPI)	8

For the mid-cycle validation surveys, we found that:

- 100 percent of the problems identified by the JCAHO that would result in non-compliance with a Medicare CoP had been corrected by the hospital.
- However, in 36 percent of the hospitals (5 of 14 hospital mid-cycle surveys) the State survey agency found non-compliance with at least one other Medicare CoP.

The purpose of the mid-cycle survey is to evaluate the JCAHO process for ensuring that hospitals adequately correct the deficiencies cited during the JCAHO accreditation survey. Therefore, we expect that the deficiencies identified during the JCAHO accreditation survey to be corrected before the time of the mid-cycle survey.

Allegation (Complaint) Surveys

In addition to sample validation surveys, CMS conducts substantial allegation (complaint) surveys in 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 2003, 3,645 allegation surveys of JCAHO-accredited hospitals were conducted with 118 found out of compliance with one or more CoPs. This means that 3 percent of the allegation surveys were substantiated by findings of noncompliance. Also, 294 allegation surveys of non-accredited hospitals were conducted with 24 found out of compliance with one or more CoPs. This means 8 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, FY 2003

JCAHO-ACCREDITED HOSPITALS		NON-ACCREDITED HOSPITALS	
Condition Not Met	**Frequency**	**Condition Not Met**	**Frequency**
1 Patients' Rights	46	Nursing Services	8
2 Nursing Services	44	Patients' Rights	6
3 Governing Body	23	Governing Body	5

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 57 traditional validation surveys performed in JCAHO-accredited hospitals in FY 2003, the State survey agencies found non-compliance with one or more conditions in 18 hospitals. Comparison of the JCAHO-accreditation survey reports with the validation survey reports for these hospitals revealed that in 15 of the 18 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 26 percent. While the disparity rate falls within the range found in previous years (22 percent in FY 2002, 24 percent in FY 2001, and 27 percent in FY 2000), the smaller sample size used by CMS (57 surveys in FY 2003 compared to 112 surveys in FY 2002) means that we cannot conclude that the disparity rate is necessarily increasing, but that it is within historical range. In 50 percent of the hospitals in which JCAHO missed a deficiency finding, the sole type of deficiency is related to the Physical Environment CoP. Compliance with the Life Safety Codes (LSC) is the most common issue in the Physical Environment CoP, typically involving fire-safety precautions.

The fact that the LSC disparity accounts for such a high proportion of the overall disparity rate is consistent with the pattern found in previous years. For the years FY 2000 through FY 2002, in all the hospitals in which JCAHO missed a deficiency finding, approximately 68 percent accounted for Physical Environment/LSC issues.

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. Based on FY 2000 findings, CMS performed a comprehensive review of the JCAHO requirements for LSC. The CMS has always considered LSC compliance, on the part of all provider types, to be of critical importance. In August of 2002, as a result of that review, CMS conveyed to

JCAHO a number of recommendations that we believe would improve the JCAHO evaluation of LSC compliance in hospitals. Those recommendations were:

Completion of the Statement of Conditions (SOC) by Qualified Personnel. The JCAHO should require that hospitals use certain types of personnel to complete the SOC. These requirements should specify both credentialing (e.g., architect, fire marshal, etc) and specific knowledge, skills, and abilities.

Minimum standards for the content of the SOC/Plan for Improvement (PFI). The JCAHO should set forth minimum standards for the SOC and PFI.

Submission of the SOC and PFI documents to JCAHO prior to survey. The JCAHO should require that hospitals submit the SOC and PFI documents to JCAHO central office within a specified time frame prior to their accreditation renewal date (date certain). This would enable JCAHO central office personnel and surveyors to review the documents prior to beginning the survey. Currently, the surveyors do not receive the SOC and PFI documents until on-site at the hospital.

Increase number of LSC experts. The JCAHO should increase the capacity of LSC experts in their central office to review the SOCs and PFIs that are submitted by the hospitals prior to the survey. These individuals could evaluate whether or not these materials meet the standards set forth above, and identify areas of concern to determine the best course of action for the surveyors to take.

Develop mechanisms for facilities that fail to comply with the time frames for correction. The JCAHO should develop mechanisms in the accreditation process for facilities that fail to follow their own time frames for completion of the tasks listed on their PFI.

The JCAHO reports that it has now implemented all of those recommendations. We therefore expect that future validation survey results will reflect the improvements that they have made in their evaluation of LSC. Improvement in the area of LSC compliance would, by itself, result in significant reduction in the overall disparity rate, as LSC deficiencies account for approximately 50 percent of the overall disparity rate.

CMS Oversight Improvement

In July 2004, the Government Accountability Office (GAO) issued a report on CMS oversight of the hospital accreditation program.[2] In that report, the GAO made several recommendations that might be used to improve CMS oversight of the hospital accreditation program, including modifying the method used to calculate the disparity rate, identifying additional indicators of JCAHO performance, and increasing the validation sample size to 5 percent as in previous years. The GAO recommendations are similar to those conclusions reached by our own internal review of the hospital accreditation program.

[2] GAO-04-850, *CMS Needs Additional Authority to Adequately Oversee Patient Safety in Hospitals*.

The CMS will seek to increase the validation sample size as we formulate future budget requests. We note that a return to the 5 percent validation sample would require additional survey and certification funding that ranges from about $2.6 million annually to almost $4.8 million per year, depending on the sampling methodology. Thus, rather than simply increasing the sample rate to 5 percent, there may be more cost-effective approaches to enhancing our survey activities, such as exploring ways that data from the complaint investigations might be used to further assess JCAHO accreditation practices.

We are developing a hospital accreditation oversight improvement plan that may include regulatory changes to provide CMS with additional and more substantial information on the JCAHO processes and findings and to revise the formula for calculating the disparity rate. Additionally, we are working to develop more sensitive indicators of JCAHO performance.

Consistent with CMS findings for FY 2000 through FY 2002, the GAO also determined that Physical Environment/LSC deficiencies represent the greatest discrepancy (68 percent) between JCAHO findings and the CMS-sponsored validation surveys. This is compared with a facility discrepancy rate of approximately 29 percent for health care deficiencies only, and approximately 3 percent where there was a finding of a deficiency for both health care and physical environment. We will continue to emphasize with JCAHO the need to improve both health and LSC compliance.

The CMS will continue to pilot test the mid-cycle survey as an additional tool for measuring JCAHO performance and seek to increase the mid-cycle sample size to enlarge the degree of confidence we have in the findings. We will also continue to explore improved methods of oversight. The CMS will continue to 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.

CLINICAL LABORATORY IMPROVEMENT VALIDATION PROGRAM

Introduction

This report on the Clinical Laboratory Improvement Validation Program covers the evaluations of fiscal year 2003 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)

The CMS appreciates the cooperation of all of the organizations in providing their inspection schedules and results. While an annual performance evaluation of each approved accreditation organization is required by law, CMS sees 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.

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 2003. Laboratories seek and relinquish accreditation on an ongoing basis, so the number of laboratories accredited by an organization during any given year

[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.

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. Seven 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. Five 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: 4 percent

Validation surveys were conducted at 163 COLA-accredited laboratories. Ten of the laboratories were cited with condition-level deficiencies. Comparable deficiencies were noted by COLA in three out of the ten 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
01D0667988	Alabama	Proficiency Testing—Unsuccessful Participation
11D0676348	Georgia	Hematology Quality Control
16D0387197	Iowa	Proficiency Testing—Unsuccessful Participation
26D0705365	Missouri	Laboratory Director—Moderate complexity
28D0664972	Nebraska	Laboratory Director—Moderate complexity
37D0469645	Oklahoma	Laboratory Director—Moderate complexity
49D0231165	Virginia	Proficiency Testing—Unsuccessful Participation

College of American Pathologists

Rate of disparity: 7 percent

A total of 94 validation surveys were conducted at laboratories accredited by the College. Eight surveys were cited with condition-level deficiencies. Comparable deficiencies were noted by the College 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 College's findings were disparate.

CLIA number	Location	CLIA Conditions
05D0545353	California	Quality Control—Bacteriology Quality Control—General Immunology Laboratory Director—Moderate complexity Laboratory Director—High complexity Quality Assurance
05D0867804	California	Laboratory Director Quality Assurance
25D0319160	Mississippi	Laboratory Director
30D0866896	New Hampshire	Laboratory Director

34D0673610	North Carolina	Quality Assurance
45D0493714	Texas	Quality Assurance
45D0660098	Texas	Proficiency Testing—Testing of Samples Laboratory Director Laboratory Technical Supervisor Quality Assurance

Joint Commission on Accreditation of Healthcare Organizations

Rate of disparity: 4 percent

During this validation period, a total of 74 validation surveys were conducted at laboratories accredited by the Joint Commission. Three laboratories were cited with condition-level deficiencies. Comparable deficiencies were noted by the Joint Commission in all three of those laboratories.

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
04D0466391	Arkansas	General Quality Control Quality Assurance
17D0046976	Kansas	Proficiency Testing—Unsuccessful Participation
52D0396957	Wisconsin	Proficiency Testing—Enrollment and Testing of Samples

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 FY 2003 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, there was no indication in the validation review that would raise questions about the overall equivalency of any organization's accreditation standards.

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 care 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 third 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.

This year, as required under MMA, hospitals will receive the full market basket update only if they submit the 10 hospital quality measures established by the Secretary. Because those hospitals who do not submit would receive an update of the market basket minus 0.4 percentage points, QIOs assisted hospitals with the process of abstracting and submitting data in order to receive the full annual payment update for 2005. The QIOs helped many hospitals install and utilize a computerized abstraction and reporting tool; provided data abstraction training to hospital staff; provided hospitals with communications and guidance on the reporting registration process and offered technical assistance to overcome problems. The QIOs continued to offer assistance right up until the final deadline to ensure that every eligible hospital submitted the data and earned the payment incentive.

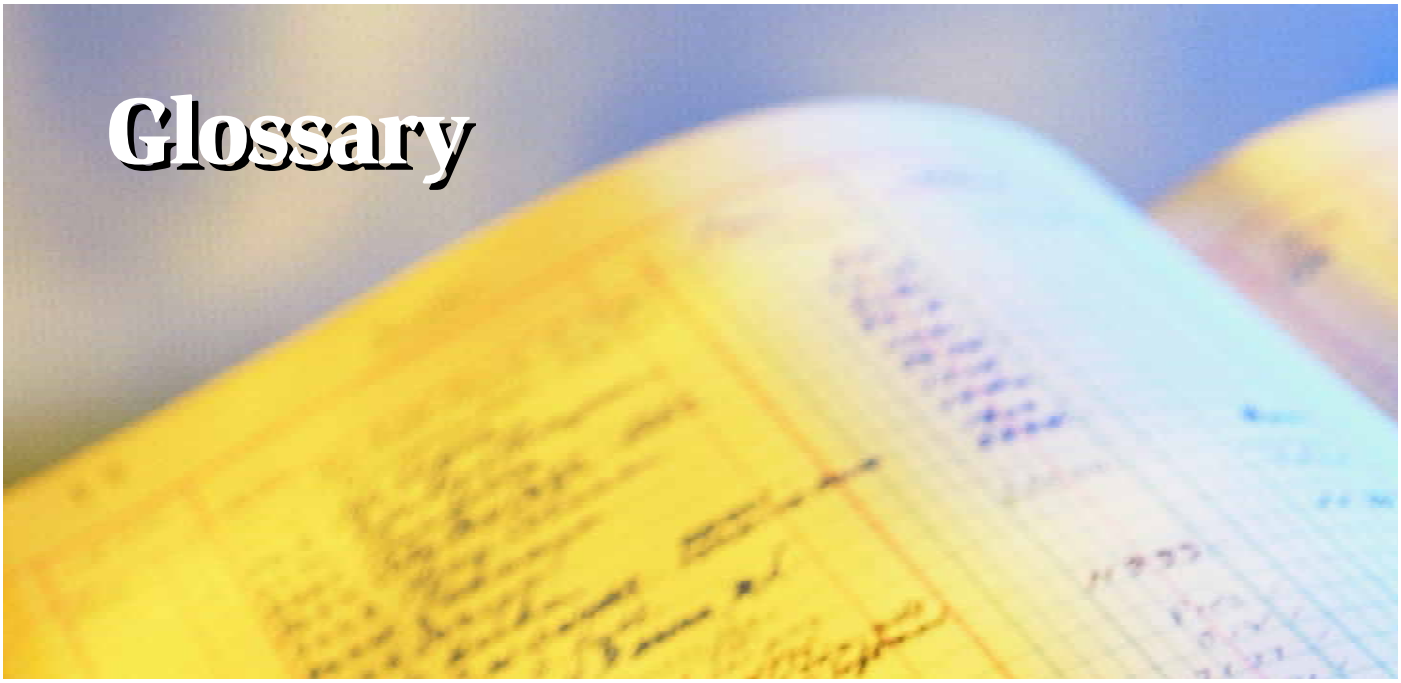
The HCQIP relies on provider-based quality improvement, a data driven external monitoring system based on quality indicators, and sharing of comparative data and best practices with providers to stimulate improvement. The QIOs conduct a wide variety of improvement projects on important clinical and non-clinical 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 2004 totaled $393 million, which compares with $350.4 million spent in FY 2003.

There were 39 QIOs doing business with CMS in FY 2004. 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 (HI) and Supplementary Medical Insurance (SMI) financing as determined by the difference between trust fund assets and liabilities for specified periods.

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

B

Balanced Budget Act of 1997 (BBA): Major provisions provided for the State Children's Health Insurance Program, Medicare +Choice (currently known as Medicare Advantage), 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).

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.

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

H

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Major provisions include portability provisions for group and individual health insurance, 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.

I

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

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 Advantage (MA) Program: A replacement for the Medicare+Choice program. It reforms and expands the availability of private health options to Medicare beneficiaries while retaining most of the key features of the Medicare+Choice program.

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

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA): Legislation passed that establishes a new program in Medicare to provide a prescription drug benefit, Medicare Part D, which will become available on January 1, 2006. It also provides Medicare beneficiaries the option to enroll in the Prescription Drug Discount Card program until the Part D benefit becomes available. Additionally, MMA sets forth numerous changes to existing programs, including a revised managed care program, certain payment reforms, rural health care improvements, and other changes involving administrative improvements, regulatory reduction, administrative appeals, and contracting reform.

Medicare 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 (QIOs): Formerly known as Peer Review Organizations (PROs), QIOs monitor the quality of care provided to Medicare beneficiaries to ensure that health care services are medically necessary, appropriate, provided in a proper setting, and 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.

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U.S. Department of Health and Human Services

Tommy G. Thompson, Secretary

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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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