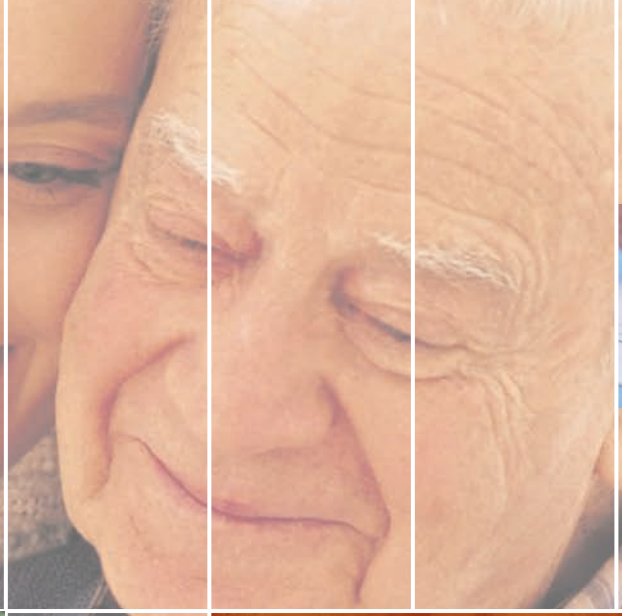
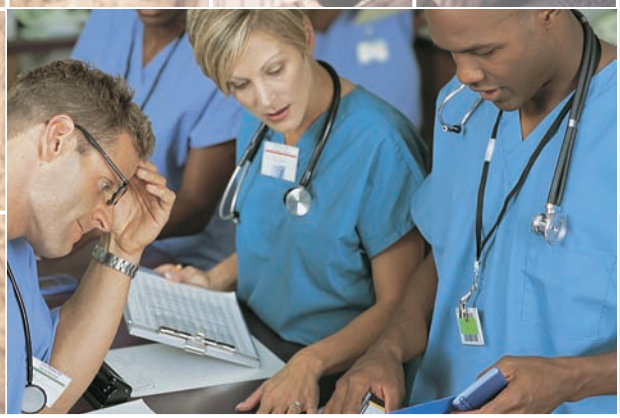






CMS Financial Report

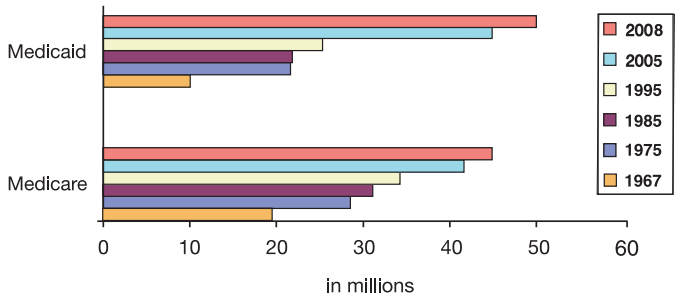
FISCAL YEAR 2008

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

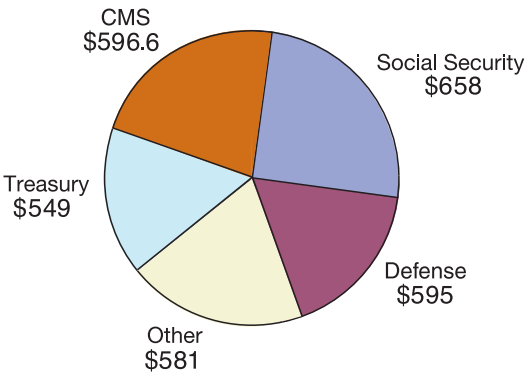
The Centers for Medicare & Medicaid Services At a Glance

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 approximately 45 million beneficiaries. Medicaid enrollment has increased from 10 million beneficiaries in 1967 to over 50 million beneficiaries.

2008 Program Enrollment



2008 Federal Outlays



Source: U.S. Treasury

$ in billions

The **CMS** had outlays of approximately $596.6 billion (net of offsetting receipts and Payments to the Health Care Trust Funds) in fiscal year (FY) 2008, approximately 20 percent of total Federal outlays. The only agency that outlayed more is the Social Security Administration.

The **CMS** has over 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 the States with matching funds for Medicaid benefits, and develop policies and procedures designed to give the best possible service to beneficiaries. The CMS also assures 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.

A Message from the Acting Administrator

On behalf of the Centers for Medicare & Medicaid Services (CMS), I invite you to review the fiscal year (FY) 2008 annual ***CMS Financial Report***. This financial report provides insight into CMS' programs and activities. It is the principal publication and report to the public on our stewardship and management of the resources entrusted to us. The financial and program data presented in this report is a representation of CMS' activities towards its mission and goals during the past year.

The CMS' first priority is the health and well being of our beneficiaries. This includes ensuring that our beneficiaries receive the most value from the services paid for by Medicare. A commitment to high quality and efficient health care is the primary reason that Medicare is pursuing value-based purchasing initiatives. Measuring performance, reporting results publicly, and providing payment incentives that encourage high quality and efficient care are paramount to the Agency as we are accountable to the beneficiaries we serve as well as the public.

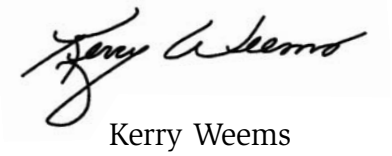
The Agency also continues its progress in reengineering the way in which the government contracts for claims administration for the largest part of the Medicare program, the Medicare fee-for-service program. We seek the best value, from a cost and technical perspective for this critical function from these contractors. In addition, CMS continues to develop meaningful performance measures for these contracts that align resources to deliver outcomes and help ensure taxpayer dollars are spent effectively. New legislation was passed this year to amend titles XVIII and XIX of the Social Security Act—the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). MIPPA extended expiring provisions and provided physicians with an update to their payment rates for 2008 and 2009. MIPPA also required improvements to beneficiary access to preventive and mental health services, enhancements to low-income benefit programs, and access to care in rural areas, including pharmacy access.

The Agency continues to excel with the Medicare prescription drug benefit. As this program enters its fourth year, beneficiary satisfaction rates remain persistently high, program costs remain lower than originally expected, and Medicare prescription drug plan bids reflect nationwide drug price trends. The Medicare prescription drug program has in a short time become a stable, familiar, and vital part of Medicare. Given their past record of making smart choices, I expect beneficiaries will continue to compare their plan options in the upcoming enrollment period based on cost, coverage, and convenience. In turn, CMS will continue to do its part by providing up-to-date information about plan benefits at

www.medicare.gov and 1-800-MEDICARE (1-800-633-4227) and issuing our annual ***Medicare & You 2009*** handbook.

Over the years, the Agency has worked to increase the effectiveness and efficiency of Medicare, Medicaid and SCHIP. The CMS has made great strides in modernizing and improving health care benefits, but there is more work to be done as we build on these past efforts by updating and strengthening our payment systems, beginning to incorporate value-based purchasing strategies, and improving quality and efficiency while restraining costs. As the largest health care purchaser in the world, we are continually seeking strategies that will help us ensure high quality health care at an appropriate price. But this takes an accumulation of efforts within CMS and with other Federal and State agencies, contractors, and a wide range of providers to solicit their expertise, listen to their concerns, and develop better ways of doing business.

As another successful year has been put behind us, CMS continues to renew its commitment to its mission: ensuring effective, up-to-date health care coverage, and promote quality care for beneficiaries. The Agency has made, and will continue to make, a positive difference in the lives of those we serve thanks to its highly experienced, hard-working, and dedicated staff. We look forward to moving ahead into the next year and together, we will strive to do what is best for our programs and the people we serve.



Kerry Weems
November 2008

A Message from the Chief Financial Officer

As the Agency's Chief Financial Officer (CFO), I am pleased to report that the Centers for Medicare & Medicaid Services (CMS) continued its journey of financial management excellence in fiscal year (FY) 2008. The CMS received its 10th consecutive unqualified ("clean") opinion on its consolidated financial statements. I want to acknowledge the hard work and dedication of the many CMS employees whose contributions made it possible for us to meet this milestone. The unqualified opinions over the years provide continued assurance that our financial statements report reliable information regarding the administration of our programs. We are extremely proud of this milestone and strive to continually increase our levels of accountability and remain fiscally responsible.

FY 2008 has been another productive year in our efforts to implement and enhance our sound financial management practices through the individual and collaborative dedication and efforts of managers, employees, business partners, and other stakeholders. Building on our accomplishments, we will continue to develop and implement the CFO initiatives so that we can better demonstrate the financial and program results the public expects and deserves. We have undertaken exciting new initiatives and continue to make progress on existing initiatives to improve in the area of financial management and in the operation of the Medicare program. Noteworthy initiatives and accomplishments include:

- The CMS successfully implemented the recovery audit contractors (RAC) demonstration program identifying approximately $1 billion in improper Medicare payments during the three years of the demonstration. Section 302 of the Tax Relief and Health Care Act of 2006 requires CMS to implement a permanent RAC Program nationwide no later than January 1, 2010.

- The work of the Agency's Program Safeguard Contractors (PSCs) resulted in a total of $1.65 billion dollars in savings for Medicare Parts A and B in FY 2008 by identifying overpayments, by referring more than 539 cases to law enforcement, recouping funds from court determined fines, settlements and/or restitutions, and by taking an aggressive approach with other administrative actions such as payment suspensions and revocations.

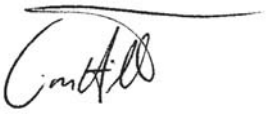
- The CMS continued our efforts to reduce improper payments in its programs. Medicare fee-for-service payment errors have been reduced to 3.6 percent, a remarkable achievement for such a large and complex program. To strengthen our confidence

in the CERT review findings and assure the accuracy of the reported error rate, CMS began an effort to independently perform blind, random reviews of its CERT review contractors' payment determinations starting with the FY 2008 measurement. At the time of this report publication, the results of those reviews were incomplete. In addition, CMS has finalized the Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid program and the State Children's Health Insurance Program (SCHIP).

- The Healthcare Integrated General Ledger Accounting System (HIGLAS) was implemented at CMS' Central Office (CO) for Medicaid and SCHIP payments. In addition, four additional Medicare contractors were effectively transitioned to HIGLAS in FY 2008, bringing the total to 14 contractors that have successfully transitioned to the system. HIGLAS, when fully implemented across all Medicare contractors and at CMS CO, will strengthen the financial management of CMS' operations by providing timely and reliable financial information to decision makers throughout the Agency. It will also allow the Agency to enhance its oversight of contractor financial operations.

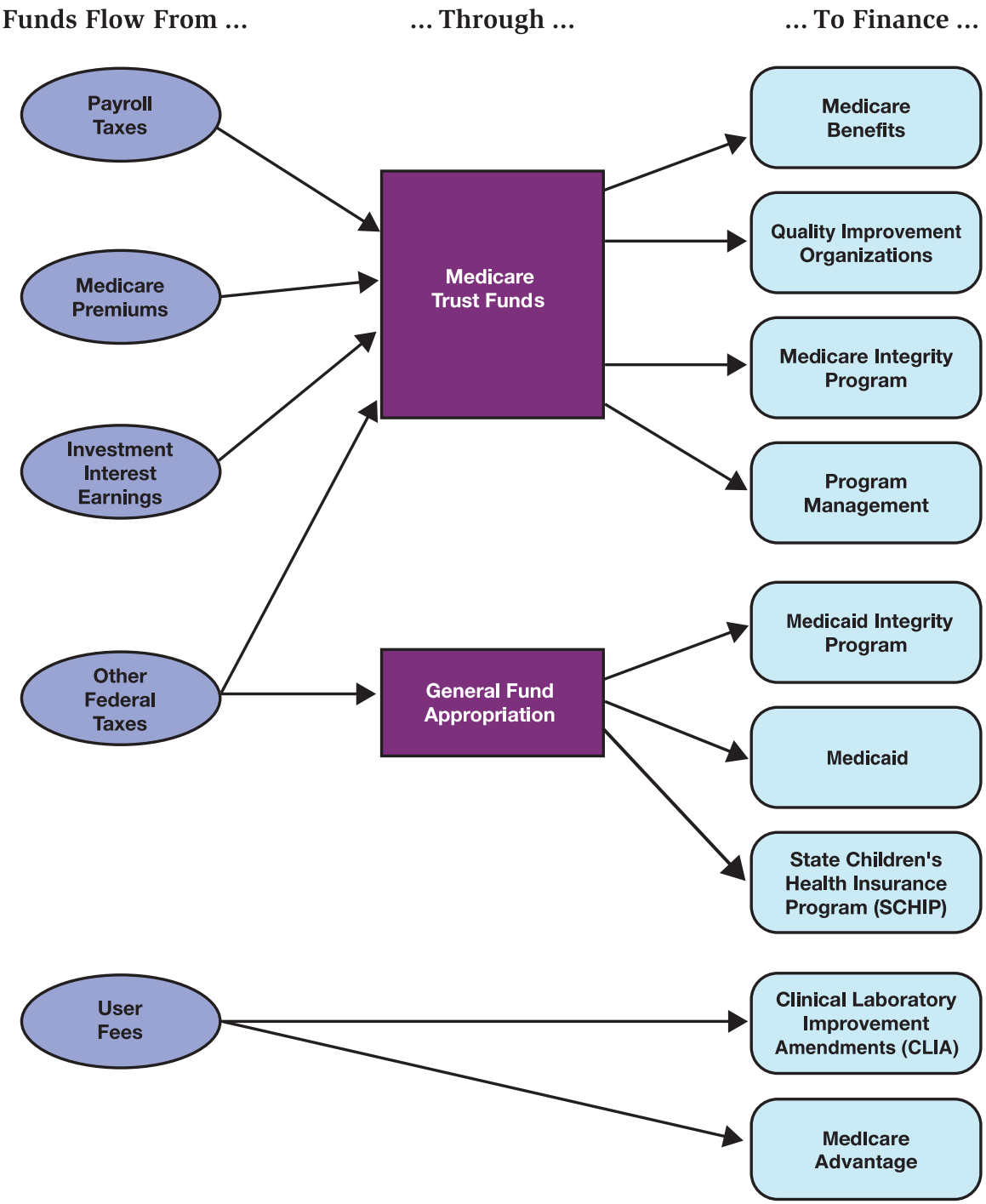
- The CMS continued to meet existing and new requirements under the Office of Management and Budget (OMB) Circular A-123, *Management's Responsibility for Internal Control*, which makes our internal control structure more transparent and has improved our internal controls by institutionalizing accountability, and decreasing the risk of financial fraud and errors. As of September 30, we were able to provide a statement of reasonable assurance regarding our internal controls and financial management systems, reporting no material weaknesses.

We are clearly aware of the importance of our fiduciary and operating responsibilities and the need for continuous monitoring and improvement of our programs. Each year, we develop, implement and track detailed corrective action plans to ensure we resolve any audit findings as we continue to improve our financial management business processes, internal controls, and financial systems. As an agency, we will continue in our efforts to maintain the highest level of accountability in the area of financial management and in the operation of the Agency's programs.



Timothy B. Hill
November 2008

Financing of CMS Programs and Operations



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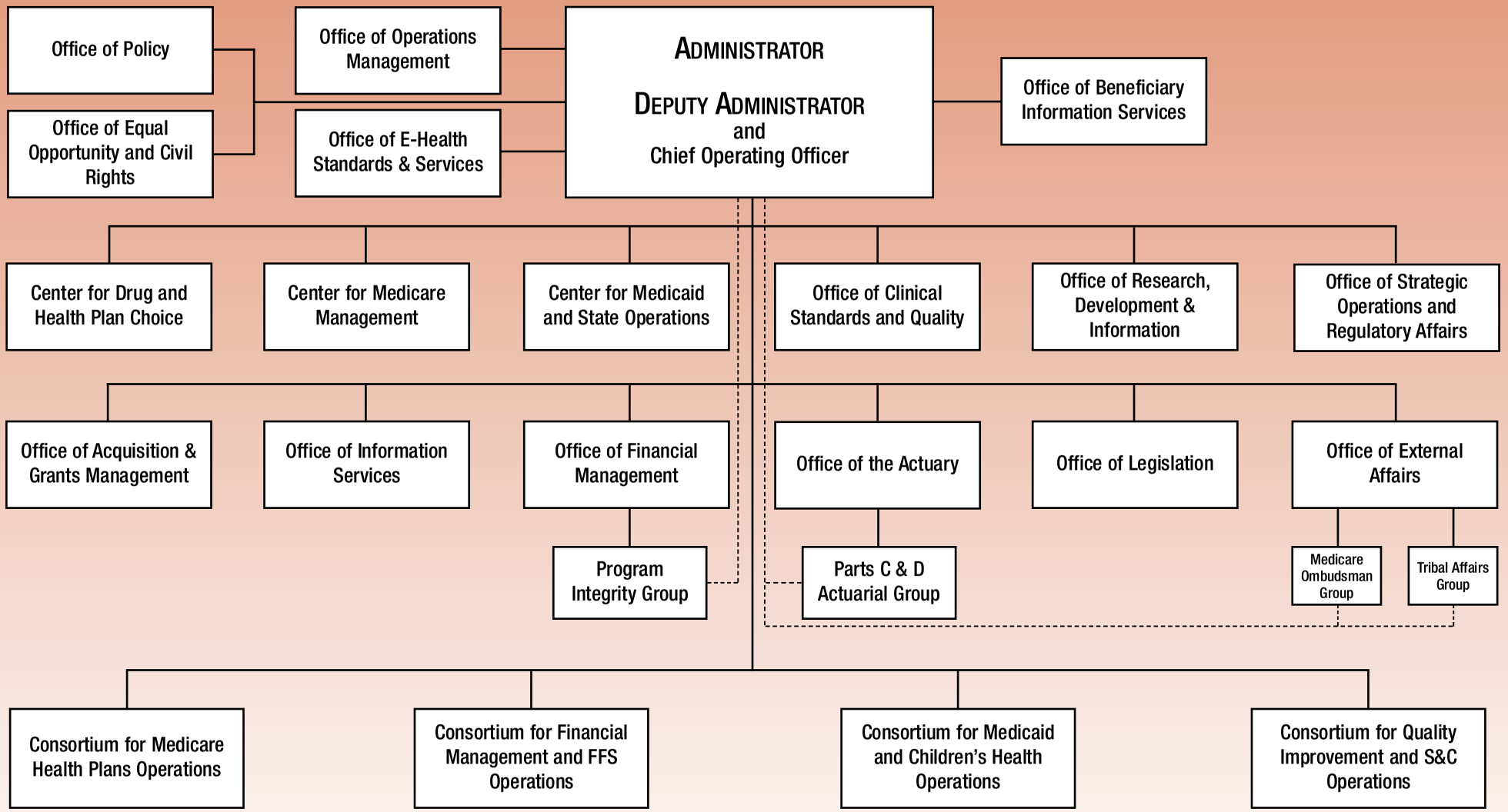
Approved Structure
As of September 19, 2008

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES



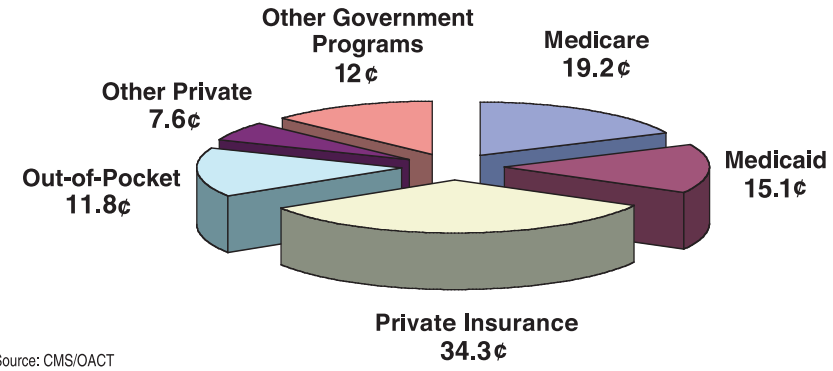
Management's Discussion and Analysis

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 1988 (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 34 cents of every dollar spent on health care in the United States (U.S.)—or looked at from three different perspectives, 61 cents of every dollar spent on nursing homes, 46 cents of every dollar

The Nation's Health Care Dollar 2008



Source: CMS/OACT

received by U.S. hospitals, and 28 cents of every dollar spent on physician services.

The CMS **outlays** totaled approximately $596.6 billion (net of offsetting receipts and Payments to the Health Care Trust Funds) in fiscal year (FY) 2008. Our **expenses** totaled approximately $657.9 billion, of which $3.3 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.

The CMS establishes policies for program eligibility and benefit coverage, processes over one billion Medicare claims annually, matches the States with funds for Medicaid and SCHIP, ensures quality of health care for beneficiaries, and safeguards funds from fraud, waste, and abuse. The CMS employs over 4,500 Federal employees in Baltimore, Maryland, Washington, DC, and 10 regional offices (ROs) throughout the country. The RO employees mainly provide direct services to Medicare contractors, State agencies, health care providers, beneficiaries, and the general public. The employees in Baltimore and Washington 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 Medicare providers, survey hospitals, nursing homes, labs, home health agencies and other health care facilities for compliance with Medicare health and safety standards; work with state insurance companies; and assist the States and Territories with Medicaid and SCHIP. The CMS also maintains the Nation's largest collection of health care data and provides technical assistance to the Congress, the executive branch, universities, and other private sector researchers.

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

PROGRAMS

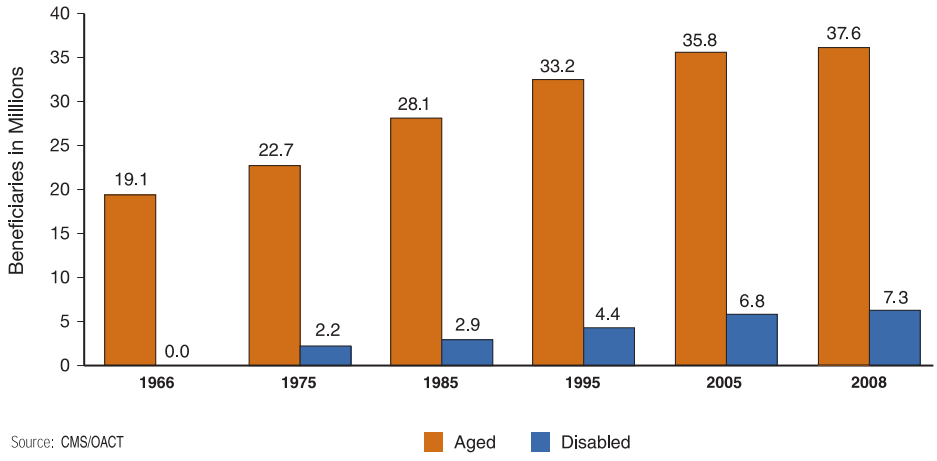
Medicare

Introduction

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 that elect Medicare coverage. 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.

Medicare processes over one billion fee-for-service (FFS) claims a year, is the Nation's largest purchaser of managed care, and accounts for approximately 14 percent of the Federal Budget. Medicare is a combination of four programs: Hospital Insurance, Supplementary Medical Insurance, Medicare Advantage, and Medicare Prescription Drug Benefit. Since 1966, Medicare enrollment has increased from 19 million to approximately 45 million beneficiaries.

Medicare Enrollment



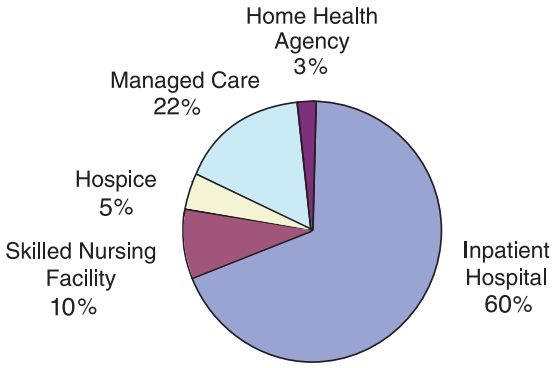
Source: CMS/OACT

Hospital Insurance

Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. The HI program pays for hospital, skilled nursing facility, home health, and hospice care and is financed primarily by payroll taxes paid by workers and

employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the HI trust fund, and invested in U.S. Treasury securities.

HI Medicare Benefit Payments



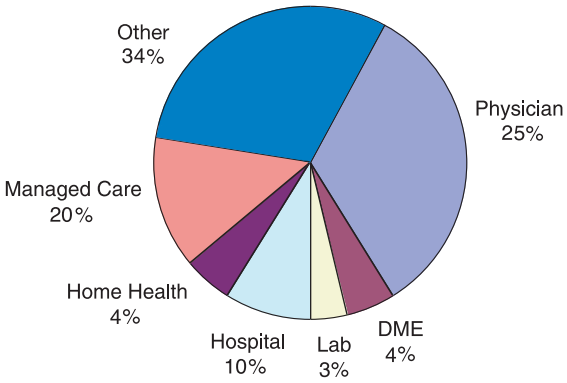
Source: CMS/OACT

Based on estimates from the Mid-Session Review of the FY 2009 President's budget, inpatient hospital spending accounted for 60 percent of HI benefit outlays. Managed care spending comprised 22 percent of total HI outlays. During FY 2008, HI benefit outlays grew by 6.3 percent and the HI benefit outlays per enrollee were projected to increase by 4.5 percent to $4,890.

Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI or Medicare Part B and Medicare Part D, is voluntary and available to nearly all people aged 65 and over, the disabled, and people with ESRD who are entitled to Part A benefits. The SMI program pays for physician, outpatient hospital, home health, laboratory tests, durable medical equipment, designated therapy, outpatient prescription drugs, and other services not covered by HI. The SMI coverage is optional and beneficiaries are subject to monthly premium payments. About 93 percent of HI enrollees elect to enroll in SMI to receive Part B benefits.

SMI Medicare Benefit Payments



Source: CMS/OACT

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

Also based on estimates from the Mid-Session Review of the FY 2009 President's budget, SMI benefit outlays grew by 3.7 percent during FY 2008. Physician services, the largest component of SMI, accounted for 25 percent of SMI benefit outlays. During FY 2008, the SMI benefit outlays per enrollee were projected to increase 2.2 percent to $5,600.

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 eligible because of age (65 or older) or disability may choose to join a MA plan rather than

participate in FFS Medicare. Those who are eligible for Medicare because of ESRD may join a MA plan only under special circumstances.

Medicare beneficiaries have long had the option to choose to enroll in prepaid health care plans that participate in Medicare instead of receiving services under traditional FFS arrangements. MA plans, other than private fee-for-service plans (PFFS), 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. In most cases, PFFS plans have not contracted with providers and plan members can receive services from any provider who is eligible to receive payment from Medicare and agrees to accept payment from the PFFS plan sponsor. MA plans currently serve Medicare beneficiaries through coordinated care plans, which include HMOs, point-of-service (POS) plans offered by HMOs, preferred provider organizations (PPOs), provider-sponsored organizations (PSOs) and PFFS plans. MA demonstration projects, as well as cost plans and Health Care Prepayment Plans (HCPPs), also exist.

All MA plans are currently paid a per capita premium, and must provide all Medicare covered services. Further, with the exception of regional PPOs (RPPOs), MA plans assume full financial risk for care provided to their Medicare enrollees. Many MA plans offer additional services such as prescription drugs, vision, and dental benefits to beneficiaries. 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 approximately $91.8 billion of the total $444.6 billion in Medicare benefit payment expenses in FY 2008.

Medicare Prescription Drug Benefit

The passage of the MMA amended Title XVIII of the Social Security Act by establishing a voluntary Prescription Drug Benefit Program. Effective January 1, 2006, the new program established an optional prescription drug benefit (Medicare Part D) for individuals who are entitled to or enrolled in Medicare benefits under Part A and Part B. The prescription drug benefit is funded through the SMI account. Beneficiaries who qualify for both Medicare and Medicaid (full-benefit dual eligibles) automatically receive the Medicare drug benefit. The statue also provides for assistance with premiums and cost sharing to full benefit dual-eligibles and other qualified low-income beneficiaries. In general, coverage for this benefit will be provided under private prescription drug plans (PDPs), which will offer only prescription drug coverage, or through Medicare Advantage prescription drug plans (MA PDs), which will offer prescription drug coverage that is integrated with the health care coverage they provide to Medicare beneficiaries under Medicare Advantage.

Participating Part D plans must offer a statutorily defined standard benefit or an alternative actuarial equivalent. The 2008 standard benefits generally have a $275 deductible and coinsurance of 25 percent after the deductible for coverage limit of $2,510. This is followed by a coverage gap for which beneficiaries pay 100 percent to

an out-of-pocket spending limit of $4,050. Once the out-of-pocket spending reaches this level, the plan pays 95 percent of drugs costs for catastrophic coverage.

PDPs and MA PDs submit annual bids to CMS reflecting expected benefit payments plus administrative costs after a deduction for expected reinsurance subsidies. Payment for basic Part D benefits is made using four funding streams. Throughout the benefit year, CMS pays plans monthly prospective payments through a direct subsidy, a prospective payment for the low-income cost-sharing subsidy (LICS), and a prospective payment for the reinsurance subsidy. A fourth funding mechanism—risk sharing—is calculated after the LICS and reinsurance payments have been reconciled after the end of each contract year.

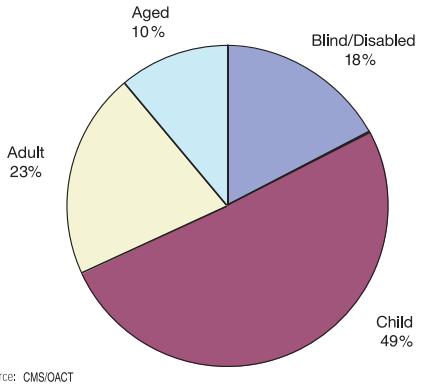
Employer, union, and other Plan Sponsors (PS) of group health plans that offer a prescription drug benefit that is actuarially equivalent to Part D are able to apply for the Retiree Drug Subsidy (RDS) program. A PS may only receive subsidy payments for qualifying covered retirees. All PS that provide a drug benefit plan to their retirees may apply annually for participation in the RDS program. To qualify for the subsidy, PS are required to demonstrate that their coverage is "actuarially equivalent" to defined standard prescription coverage under Medicare Part D.

Medicaid

Introduction

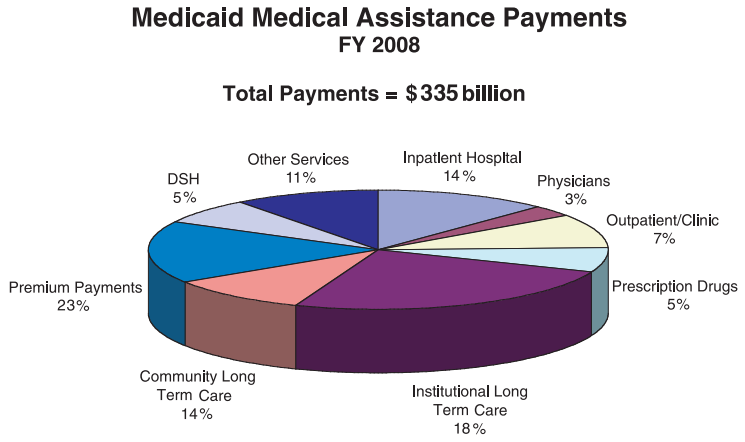
Medicaid is the means-tested health care program for low-income Americans, administered by CMS in partnership with the States. Enacted in 1965 as title XIX of the Social Security Act, Medicaid was originally legislated to provide medical assistance to recipients of cash assistance. Over the years, Congress incrementally expanded Medicaid well beyond the traditional population of the low-income elderly, 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 who require long-term care. The average enrollment for Medicaid was estimated at 50 million in FY 2008, about 16 percent of the U.S. population. About 8 million people are dually eligible, that is, covered by both Medicare and Medicaid.

FY 2008 Medicaid Enrollees



Source: CMS/OACT

The CMS provides matching payments to the 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 2008, the Federal matching rate for Medicaid program costs among the States according to the formula ranged from 50 to 76 percent. The average matching rate for FY 2008 was about 57 percent. Federal matching rates for various state and local administrative costs are set by statute, and currently average about 55 percent. Medicaid payments are funded by Federal general revenues



Source: President's FY 2008 Budget, Midsession Review

provided to CMS through an annual appropriation. There is no cap on Federal matching payments to the States, except with respect to the disproportionate share hospital 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. In FY 2008, Medicaid spending for persons with AIDS as well as others infected with the Human Immunodeficiency Virus (HIV) is estimated to be about $7.5 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 (FDA) for treatment of AIDS.

Payments

Under Medicaid, state payments for both medical assistance payments (MAP) and administrative (ADM) costs are matched with Federal funds. In FY 2008, state and Federal ADM gross outlays are estimated at $19.5 billion, about 5.4 percent of the gross Medicaid outlays. State and Federal MAP gross outlays are estimated at $341.0 billion or 95 percent of total Medicaid gross outlays, an increase of 7.9 percent over FY 2007. Thus, state and Federal MAP and ADM outlays for FY 2008 totaled $360.6 billion. The CMS share of Medicaid outlays totaled $198.9 billion in FY 2008.

Enrollees

Children comprise nearly half of Medicaid enrollees, but account for only 19 percent of Medicaid outlays. In contrast, the elderly and disabled comprise 28 percent of Medicaid enrollees, but accounted for 63 percent of program spending. The elderly and disabled use more expensive services in all categories, particularly nursing home services.

Service Delivery Options

Many states are pursuing managed care as an alternative to the FFS system for their Medicaid programs. Managed health care provides several advantages for Medicaid beneficiaries, such as enhanced continuity of care, improved preventive care, and prevention of duplicative and contradictory treatments and/or medications. Most States have taken advantage of waivers provided by CMS to introduce managed care plans tailored to their state and local needs, and 49 States now offer a form of managed care. The number of Medicaid beneficiaries enrolled in managed care has grown from 40 percent in 1996 to 64 percent in 2007.

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.

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

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

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

State Children's Health Insurance Program (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 original SCHIP budget authority expired September 30, 2007. Congress extended the program through March 31, 2009 in the Medicare, Medicaid, and SCHIP Extension Act of 2007. Congress is currently considering the reauthorization of SCHIP.

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 Deficit Reduction Act of 2005 (DRA) established a prohibition of using Federal SCHIP funds to provide health benefits coverage to nonpregnant childless adults. States that submit a section 1115 demonstration application on or after the October 1, 2005 effective date of this DRA provision can no longer obtain title XXI funds to provide coverage for nonpregnant childless adults.

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. All 50 States, the District of Columbia, and the territories had approved SCHIP State plans, 14 Medicaid expansions, (includes District of Columbia and all of the territories), 18 separate SCHIPs, and 24 programs that are combination plans.

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 approximately 274,000 currently active medical facilities of different types, including hospitals, laboratories, nursing homes, home health agencies, hospices, and end stage renal disease facilities.

Clinical Laboratory Improvement Amendments 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 for health purposes. We regulate all laboratory testing (whether provided to beneficiaries of CMS programs or to others) including those performed in physicians' offices for a total of 206,940 facilities. In partnership with the States, we certify and inspect approximately 19,400 laboratories on a biennial basis. Data from these inspections reflect significant improvements in quality of testing over time. The CLIA program is a 100 percent user-fee financed program. The CLIA program is jointly administered by three HHS components: (1) CMS manages the financial aspects of the program, contracts and trains State surveyors to inspect labs, and oversees program administration including enrollment, fee assessment, regulation development, approval of accrediting organizations and proficiency testing providers, certification, enforcement and data system design, (2) the Centers for Disease Control and Prevention (CDC) provides research and technical support, and (3) the FDA performs test categorization.

Transformation Grants

The Deficit Reduction Act of 2005 authorized the Medicaid Transformation Grants and appropriated $150 million in Federal fiscal year 2007 and 2008 funding. Thirty-five States, the District of Columbia and Puerto Rico were awarded grants—the focus of which includes: health information technology (electronic health records, health information exchange, clinical decision support tools, and e-prescribing); lien/estate recovery and fraud and abuse detection systems; medication risk management; predictive modeling for improved care coordination; streamlined eligibility and citizenship determination; and web-based preauthorization systems for pharmacy and/or home and community-based services.

Health Care Quality Improvement

The CMS continues its leadership as a public health agency with priorities centered on improving quality of American heath care. Unlike any time in the agency's history, all Americans—not just Medicare beneficiaries—can better compare quality and make informed health care decisions with confidence that providers can get access to the information and resources they need to improve.

The CMS' quality agenda, set by its Quality Council, has membership from across the agency and is chaired by the Administrator. The Council has emphasized that accelerated change is needed; to achieve it, CMS will use partnerships, public reporting, value-based purchasing, quality education and resources, and the promotion of effective health care technologies.

The CMS' vision for quality improvement is the right care for every person every time. To accomplish it, CMS will influence both the health care system and the care that is delivered

so it can be made safe, effective, timely, patient-centered, efficient, and equitable—the aims that correspond to the Institute of Medicine's (IOM's) ***Crossing the Quality Chasm*** report.

To achieve these aims, CMS utilizes regulation and enforcement activities, improved consumer information, community-based quality improvement programs, as well as collaboration and partnership. One of CMS' resources is its Quality Improvement Organizations (QIOs), Medicare contractors that work to improve quality of care, measure and reduce the incidence of improper FFS inpatient payments, and address beneficiary complaints and patterns of potentially substandard care. Congress created the QIO Program in 1982 to provide a nationwide network of health care organizations to help practitioners and providers improve. In 2007, CMS announced its own extensive internal review and improvements to the QIO Program based on recommendations provided by the IOM.

The 9th statement of work (SOW) gives CMS additional tools to better manage the QIOs by linking their work to measurable outcomes that CMS will review and measure throughout the 3-year contract. As part of this effort, QIOs will be required to provide direct quality improvement support to nursing homes, hospitals, and physicians' offices. The QIOs will be focusing their measurable improvement efforts on protecting beneficiaries, care transitions, patient safety, and prevention. They will continue to emphasize utilization review, quality of care review, alternative dispute resolution, review of beneficiary appeals of certain provider notices, and review of potential anti-dumping cases. The QIOs also work on CMS' national agenda for the Government Performance and Results Act (GPRA), with goals that include priorities for improving adult immunization rates and diabetes care, optimizing the timing of antibiotics prior to surgery and increasing vascular access for hemodialysis patients, and reducing the prevalence of pressure ulcers and the use of physical restraints in nursing homes.

Through innovative partnerships, public reporting and its QIOs, CMS has achieved greater momentum toward IOM's six aims. Through its public-private collaboration with the Hospital Quality Alliance (HQA), CMS provides a robust, prioritized, and standardized set of hospital quality measures for use in voluntary public reporting. Medicare beneficiaries, as well as all consumers, can access ***Hospital Compare***, a web tool that provides valid, credible, and user-friendly information about the quality of care delivered in the Nation's hospitals. To date, more than 95 percent of approximately 4,000 participating U.S. hospitals are reporting at least the 10 clinical "starter" measures. Additionally, 36 percent of participating hospitals reporting all 20 measures are posted on ***Hospital Compare***.

In our current 9th SOW, QIOs are working with hospitals and nursing homes to improve the quality of care through system and process changes in ten focused areas: surgical care, heart failure, Methicillin-Resistant Staphylococcus Aureus (MRSA), pressure ulcers, physical restraints, the Health Care Leadership and Quality Assessment Tool, the AHRQ Culture Survey, drug safety, and public reporting.

The CMS is one of 10 national organizations spearheading a public and private-sector partnership, the Surgical Care Improvement Project (SCIP), which has the goal of improving patient safety and reducing the incidence of postoperative complications by 25 percent in U.S. hospitals by the year 2010. Surgical infection prevention measures are the first of a larger set of patient safety measures that will be collected to improve surgical care. QIOs are working to continue quality improvement around these and other care measures for hospital patients, including rural settings, and are collecting and reporting quality performance data for more transparency for a better informed public.

Kidney dialysis patients stand to benefit from CMS efforts around the Fistula First, a consumer and provider awareness initiative to improve the use of fistulas as the

preferred form of vascular access for dialysis. Fistula First is a key component of Medicare's ESRD Quality Initiative. ESRD is Medicare's only disease-specific program that entitles people of all ages to Medicare coverage on the basis of their diagnosis. The objective of the ESRD Quality Initiative is to stimulate and support significant improvement in the quality of dialysis care.

In the nursing home setting, CMS participated in the formation of a coalition with groups representing healthcare providers, caregivers, medical and quality improvement experts, government agencies, consumers and others to launch a two-year *Advancing Excellence in America's Nursing Homes* campaign. The campaign will continue through the 9th SOW. The campaign seeks excellence in the quality of life and quality of care for the more than 1.5 million American nursing home residents by enhancing choice, strengthening workforce, and improving clinical outcomes. Nursing homes participating in the campaign will work on goals and can access technical assistance and guidance from quality experts, such as QIOs, in reaching their targeted goals. Consumers participating in the campaign will help to create greater awareness of quality care and the resources available now, and encourage providers to improve the care they deliver. The campaign will report on providers' continuing quality improvement progress overall, and those reports will inform consumer choices for future long term care needs.

Cultural competency education and technical assistance to physician offices are also part of CMS' quality improvement aim for identifying and addressing unique racial and/or ethnic factors that contribute to an underserved population's disparate burden of disease and disability. Reducing disparities is a cross-cutting theme throughout the 9th SOW. Additionally, some QIOs are working to reduce disparities in the clinical areas of diabetes and chronic kidney disease.

In the home health care setting, patients are recovering faster and with less chance of re-hospitalization, a priority focus for QIOs in working with home health agencies under the care transitions theme of the CMS 9th SOW contract.

Coverage Policy

Medicare is a leader in evidence-based decision making for 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 and health care experts, through the two public comment processes that occur for every National Coverage Determination. The CMS also involves the public through its Medicare Evidence Development Coverage Advisory Committee (MedCAC). The MedCAC reviews and evaluates medical literature, technology assessments, and examines data and information on the effectiveness and appropriateness of medical items and services that are covered under Medicare, or that may be eligible for coverage under Medicare. The MedCAC is comprised of experts in clinical and administrative medicine, biologic and physical sciences, public health administration, patient advocacy, health care data and information management and analysis, health care economics, and medical ethics to serve on the MedCAC. The CMS holds several meetings each year to include opportunities for the general public to participate. We also rely on state-of-the-art technology assessment and support from other Federal agencies.

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 increasing the use of electronic health transactions to increase efficiency and reduce administrative costs across all sectors of the health care industry. Title II of HIPAA required HHS to adopt uniform national standards for the electronic transmission of certain health information. As a result, "covered entities" such as health plans, health care clearinghouses, and health care providers who conduct certain transactions electronically, must use the adopted standards for certain transactions, code sets, and identifiers. HIPAA requires that adopted standards be used for the electronic transmission of specific transactions, including claims, remittance advices, eligibility requests and responses, and coordination of benefits. Title II of HIPAA also requires that an individual's electronic personal health information be maintained securely while being stored or transmitted.

In August of 2008, CMS published two proposed rules to update the HIPAA code set and transactions standards. The first rule proposes to replace the ICD-9-CM code set with ICD-10 for diagnosis and inpatient hospital procedure coding. The second rule proposes to adopt the updated X12 standard (Version 5010) and the National Council for Prescription Drug Programs standard (Version D.0) for electronic transactions, such as health care claims. It also proposes to adopt a new standard for Medicaid pharmacy subrogation.

With regard to HIPAA enforcement activities (non-privacy), we continue to operate based on a complaint-driven process, addressing complaints filed against covered entities by requesting and reviewing documentation of their compliance status and/or corrective actions. In addition, CMS has the authority to conduct compliance reviews of covered entities and began doing so in January 2008. The reviews to date have targeted covered entities for which CMS had already received and investigated a HIPAA security complaint.

The CMS is also responsible for identifying and adopting standards for electronic prescribing in the Medicare Part D program. In April 2008, CMS published a final rule adopting uniform standards for medication history, formulary and benefits, and fill status notification (RxFill) for e-prescribing under Medicare Part D. These standards, which take effect on April 1, 2009, are the second set in a continuing process of issuing e-prescribing final standards for the Medicare Part D program.

PERFORMANCE GOALS

The Government Performance and Results Act (GPRA) mandates that agencies have strategic plans, annual performance goals, and annual performance 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 annual goals and its mission to "To ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries."

The CMS' approach to performance measurement under GPRA is to develop goals that are representative of our vast responsibilities. The CMS performance budget describes its performance goals and their linkage to long-term strategic goals, while also complementing

and supporting the CMS budget submission. The performance budget includes the steps to accomplish each performance goal, and establishes a method and data source for measuring and reporting. The CMS uses performance information to identify opportunities for improvement and to shape its programs.

The CMS annual performance goals also reinforce the President's Management Agenda (PMA). For example, the PMA objective to improve financial performance is reflected by the 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 improving program performance.

The FY 2008 performance budget includes 34 goals for CMS programs, highlighting major program areas. The Agency does not reflect every activity and challenge it encounters but reflects key Administration and CMS priorities that represent vital mission-critical activities CMS performs. The 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 2008 performance goals and outcomes are highlighted below. Progress on all of the goals will be submitted with the FY 2010 President's budget request.

Reduce the Percentage of Improper Payments Made Under the Medicare FFS Program

The CMS is committed to reducing 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 CMS FY 2008 target for the Medicare FFS error rate is 3.8 percent (gross) with a baseline of 10.1 percent in 2004.

The error rate estimate consists of 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 130,000 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 2008 indicates that the gross paid claims error rate is 3.6% percent or $10.4 billion in gross improper payments. The CMS met its goal for FY 2008.

To strengthen our confidence in the CERT review findings and assure the accuracy of the reported error rate, CMS began an effort to independently perform blind, random reviews of its CERT review contractors' payment determinations starting with the FY 2008 measurement. At the time of this report publication, the results of those reviews were incomplete. The CMS is also continually working with the contractors that pay Medicare claims and the Quality Improvement Organizations (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, (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, and (4) developing new data analysis procedures to assist CMS in identifying payment aber-rancies and using that information to stop improper payments before they occur. 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 tool in monitoring contractor performance. It provides 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.

For documentation and copies of reports, see the Comprehensive Error Rate Testing (CERT) program website: **http://www.cms.hhs.gov/CERT/**. The FY 2008 Mid-Year Report can be viewed within this site until the final report is released; click on "CERT Reports" and locate the 2008 Mid-Year Improper Medicare FFS Payments Report.

Decrease the Prevalence of Restraints in Nursing Homes

In establishing quality of care performance goals, CMS focused on measures that have been recognized as clinically significant and/or closely tied to care given to beneficiaries. The reduction in the use of physical restraints has been one of CMS' major quality initiatives. Individuals in nursing homes are a particularly vulnerable population and, consequently, CMS places considerable importance on nursing home quality measures. A significant portion of both Medicare and Medicaid benefit dollars pay for care in nursing homes.

"Physical restraints" are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the nursing home resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. According to the law, restraints may only be imposed to treat the resident's medical symptoms, to ensure safety, and only upon the written order of a physician (except in emergency situations). The prevalence of physical restraints is an accepted indicator of quality of care and may be considered a quality of life measure of nursing home residents.

The CMS exceeded its FY 2007 target of 6.2 percent by reaching a rate of 5 percent. The FY 2008 target is 6.1 percent. Results will be available in February 2009. The CMS will promote the reduced use of physical restraints through the annual nursing home survey process and through the efforts of the QIOs, which are dedicated to working directly with individual providers to improve quality of care delivered.

Increase the Number of States that Have the Ability to Assess Improvements in Access and Quality of Health Care through Implementation of the Medicaid Quality Strategy

The CMS released a Quality Roadmap with the vision for the "right care for every person every time." The Roadmap outlined a plan of action to "implement, in close partnership with states, a strategy to improve the quality of care for Medicaid beneficiaries." The CMS also established

a Medicaid Quality Strategy to complement the CMS Quality Roadmap. This commitment allows CMS to provide technical assistance to states regarding quality improvement, quality measurement, and External Quality Review. The aim of the strategy includes supporting states in achieving safe, effective, efficient, timely, equitable, and patient-centered care. The CMS plans to use information gained from these state-level quality improvement initiatives as the building blocks for the development of a larger, national-level quality framework.

This long-term measure tracks the number of states participating in the Medicaid Quality Improvement Program (MQIP), which provides technical assistance to states to bolster their targeted health quality improvement projects. State participation is voluntary. By working with CMS, states can receive technical assistance to help them achieve improvements in health care quality for Medicaid beneficiaries. The CMS will track state participation in quality improvement efforts and disseminate tools to provide guidance in achieving objectives in areas of evidence-based care, health disparities and program evaluation. In FY 2007, our baseline year, CMS reviewed data sources and data collection tools to document state quality activity. Quality Assessment Reports were developed for dissemination to states for both informational purposes and validation of state quality activities. The CMS has established the goal that at least eight states will demonstrate improvement related to access and quality of health care by FY 2008.

FINANCIAL ACCOMPLISHMENTS

For the tenth consecutive year, CMS' financial statement auditors have issued an unqualified audit opinion on CMS' financial statements, indicating that the financial statements are fairly presented in all material respects. To accomplish the task of maintaining a strong financial management operation, CMS implemented many initiatives throughout the Agency—although all may not be discussed in detail here. All of the initiatives set out to improve CMS' financial management and reporting in order to provide timely, reliable, and accurate financial information to allow CMS management and other decision makers to make timely and accurate program and administrative decisions.

Financial Management and Reporting

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

Healthcare Integrated General Ledger Accounting System

Although the 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 Federal Financial Management Improvement Act of 1996 (FFMIA). Therefore, a key element of our strategic vision is to acquire a FFMIA-compliant financial management system that will include all Medicare contractors. This project is called the Healthcare Integrated General Ledger Accounting System (HIGLAS). As part of this effort, CMS will replace the Financial Accounting and Control System (FACS), which accumulates all of CMS' financial activities, both programmatic and administrative, in its general ledger.

Following the guidance of the Office of Management and Budget (OMB) Circular A-130, *Management of Federal Information Resources*, CMS acquired a commercial

off-the-shelf (COTS) product 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 as a pilot program with one of the largest Medicare FFS contractors (Palmetto Government Benefit Administrators) that processes primarily hospital and other institutional claims, and another large Medicare contractor (Empire Medicare Services) that processes primarily physician and supplier claims. The pilot phase resulted in the reengineering of the accounting business processes of the pilot Medicare contractors to support the accounting software. The pilot phase culminated with the successful production cut-overs at both Palmetto Government Benefit Administrators—Part A in May 2005, and Empire Medicare Services—Part B in July 2005. Since that time CMS has deployed HIGLAS at twelve additional Medicare contractors, with four transitions taking place during FY 2008—Wisconsin Physician Services (Carrier), Associated Hospitals of Maine & Anthems Health Plan of Vermont/New Hampshire (Fiscal Intermediary), Administar/Anthem of Kentucky (Fiscal Intermediary) and Cahaba-Alabama BC/BS (Fiscal Intermediary). HIGLAS is now the system of record for these contractor sites. Since going "live" at the first pilot contractor in May 2005, HIGLAS has processed more than 815.3 million claims and processed 34 million payments worth $352.4 billion as of September 30, 2008.

In Fiscal Year (FY) 2007, HIGLAS began accounting for federal Grants to States for Medicaid as well as State Children's Health Insurance Program (SCHIP) federal funding. The cumulative federal obligation for these programs as of September 30, 2008 was $209.05 billion for Medicaid and $6.36 billion for SCHIP. In addition, during FY 2007 CMS started the process of implementing the Administrative Program Accounting module of HIGLAS.

HIGLAS will not only enable CMS' compliance with FFMIA, 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.

Communication & Financial Reporting

During FY 2008, CMS continued with its Risk Management and Financial Oversight Committee. The Risk Management and Financial Oversight Committee, which holds monthly meetings with designated members of CMS' senior management, acts as the conduit for discussing financial management issues. This committee ensures effective communication and a coordinated process among cross-functional areas within CMS. The Office of Financial Management (OFM) also meets monthly with upper-level management from various program centers/offices to discuss financial and budget concerns that could impact the CMS audit and day-to-day operations.

The CMS continued to prepare "white papers" to ensure that any significant changes/updates to CMS' accounting and financial reporting policies are properly evaluated by the management in the OFM (and, for some cases, management in other CMS components) and approved in writing. This process ensures that changes are

implemented in an effective and efficient manner and that changes/updates to the financial statements conform to generally accepted accounting principles.

We continued preparing automated financial statements directly from FACS, which includes all financial data, including data provided by Treasury's Bureau of Public Debt and other Federal agencies. 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, 2007, March 31, 2008, and June 30, 2008, and submitted our financial statements through the automated financial statement system implemented by HHS.

As required by the Statement of Federal Financial Accounting Standards (SSFAS) Numbers 25, *Reclassification of Stewardship Responsibilities*, CMS is presenting social insurance as a basic financial statement. The information required to be disclosed for social insurance programs is intended to help citizens assess the current financial position of the program as well as the ability of future budgetary resources to meet obligations as they come due.

We have also complied with Treasury's FY 2008 reporting requirements for the Federal Agencies Centralized Trial Balance System (FACTS) I and II. 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.

Recovery Audit Contractor

The CMS completed a three year demonstration project to demonstrate the use of recovery audit contractors (RACs) in identifying and correcting underpayments and overpayments and recouping overpayments in the Medicare FFS program. The demonstration was initiated in the three states with the highest Medicare utilization rates (California, Florida, and New York) and expanded in the summer of 2007 to include Massachusetts, South Carolina, and Arizona. For the demonstration project, the CMS provided the RACs with all the claims paid between FY 2002 and FY 2007. The RACs reviewed the claims to see if they were correctly coded, medically necessary, and consistent with the Medicare billing rules, or for potential Medicare Secondary Payer occurrences where a beneficiary has access to another Group Health Plan insurer and Medicare should not have paid the claim as primary. As of March 27, 2008, RACs collected $992.7 million in overpayments and refunded $37.8 million in underpayments.

Section 302 of the Tax Relief and Health Care Act of 2006 makes the RAC Program permanent and requires CMS to implement the program in all 50 states no later than January 1, 2010. The CMS has initiated a full and open competition to hire four permanent RACs. Each RAC will be responsible for identifying and correcting improper payments in approximately one-quarter of the country. The CMS awarded the contracts in October 2008 and is initiating a gradual implementation nationwide. The CMS and the RACs will provide extensive outreach to the provider community during implementation.

Debt Management

Through our Medicare contractors, we collect the majority of our debt by offsetting claims against the debt. We also pursue recovery of debt through demand letters. Debts that are over 180 days delinquent are subject to the Debt Collection Improvement Act of

1996 (DCIA). Under the DCIA, CMS refers all eligible debts over 180 days delinquent to Treasury—via the HHS Program Support Center (PSC), which serves as the Debt Collection Center (DCC)—for collection. Treasury uses a variety of collection tools, including sending additional demand letters, referring debts to the Treasury Offset Program (TOP), referring debts to private collection agencies, negotiating repayment agreements, and referring some debts to the Department of Justice for litigation. During FY 2008, we referred to Treasury approximately $1.1 billion delinquent debt eligible for referral.

Administrative Payments

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

Budget Execution

For FY 2008, CMS' budget execution function continues to be a major strength. The CMS Chief Operating Officer works closely with the Chief Financial Officer to ensure that an Administrator approved operating plan is developed timely and supports CMS' priorities. Strong fund control procedures ensure resources are only used for those activities in the operating plan that 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.

Medicare Secondary Payer (MSP)

The CMS efforts in the MSP area saved the Medicare trust funds approximately $4.5 billion through the first ten months of FY 2008. The CMS continues to expand and improve its coordination of benefits activities to ensure that fewer mistaken payments are made while, at the same time, continuing to actively pursue delinquent debts owed the Medicare program in compliance with DCIA. The Initial Enrollment Questionnaire (IEQ), which is sent to Medicare eligible beneficiaries three months prior to their entitlement to Medicare, has netted the Medicare trust fund $681 million for the first ten months of FY 2008. The projected total for FY 2008 is approximately $817 million. Savings attributed to the Internal Revenue Service/Social Security Administration/CMS Data Match (DM) operations for the first ten months of FY 2008 were $327 million. The CMS expects savings attributable to the MSP Program to continue to grow as improved methods of collecting MSP information are expanded.

The CMS continues to pursue Voluntary Data Sharing Agreements (VDSAs) with public and private insurance programs to secure health care coverage information on working Medicare enrollees and dependents. Currently 213 insurers, employers, and pharmacy benefit managers have signed VDSAs with CMS and interest in the VDSA program continues to be high. The CMS continued expansion of the VDSA program during FY 2008 as more employers, insurers, and other programs began to use VDSAs to coordinate their coverage—and their drug coverage, in particular—with Medicare. Overall savings attributed to this program were $564 million in FY 2006, $737 million in FY 2007, and $814 million through July 2008. Savings are on track to reach $977 million by fiscal year end.

In addition, the CMS continues to contract for the legal, financial, and medical review of proposed Workers' Compensation Medicare Set-aside Arrangement (WCMSA) amounts that represent monies earmarked in a workers' compensation settlement for future medical services/items that would otherwise be payable by the Medicare Program. As a result, CMS has calculated and approved WCMSA amounts totaling approximately $534 million over the period November 2007 through July 2008 (payments that Medicare might otherwise erroneously make in terms of beneficiaries' future medical expenses related to their associated accident, illness, or injury).

The CMS consolidated all of the functions related to recovering MSP Group Health Plan (GHP) and "non-GHP" (liability insurance, no-fault insurance, and workers' compensation) debts into one MSP Recovery Contractor (MSPRC). Previously, the Medicare claims processing contractors performed these functions. The MSPRC is fully operational, is completing the transition backlog of work it received from the Medicare claims processing contractors, and is successfully handling a higher level of both telephone and written inquiries than were originally anticipated and budgeted. Operating on 40 percent of the fee-for-service contractors' aggregate postpay MSP budget, the MSPRC is recovering conditional and mistaken primary payments at the rate of more than one million per business day. During its start up year of FY 2007, the MSPRC collected $273 million and during the first ten months of FY 2008 it collected $407 million. The Agency expects additional efficiencies through enhanced automation to be attained in the out years of the contract. One example of this type of automation in FY 2008 is the availability of conditional payment information to beneficiaries (and their attorneys) through a special MSP page on the **mymedicare.gov** website. Consolidation of the MSP recovery functions with a single national contractor continues to enhance administrative and operational efficiencies, standardize the recovery process, and enhance overall customer service.

Finally, CMS is in the process of implementing Section 111 of the Medicare and Medicaid SCHIP Extension Act of 2007 which amended the MSP provisions to provide for mandatory reporting for both GHP and non-GHP. The effective date is January 1, 2009, for GHP and July 1, 2009, for non-GHP. This mandatory reporting will increase MSP savings by further reducing the need for CMS pay-and-chase efforts, particularly for GHP, and by permitting greater recoveries.

Medicare Integrity Program

Program Integrity is continuing its aggressive local efforts with the assistance of two regional Medicare Drug Integrity Contractors (MEDICs). The MEDICs help identify, prevent, and combat fraud in the Medicare prescription drug benefit. Through the use of MEDICs, CMS is able to use new and innovative techniques to monitor and analyze data to help identify fraud, work with key partners to enforce Medicare's rules, and protect consumers from potential scams. Anyone can report potential fraud, waste or abuse in the Medicare Prescription Drug program by calling 1-877-7-SAFERX.

Program Safeguard Contractors (PSCs) produced a total of $1.649 billion dollars in savings for Medicare Parts A and B through the first eleven months of fiscal year 2008 by identifying overpayments, referring more than 539 cases to law enforcement, recouping funds from court determined fines, settlements and/or restitutions, and by taking an aggressive approach with other administrative actions such as payment suspensions,

prepaid claims edit denials, auto denial edits, and revocations. In 2008, Program Integrity's Field Offices (FOs) in Miami and Los Angeles provided on-the-ground support by performing beneficiary interviews and on-site visits to supplier and physician locations for the Referring Physician UPIN/NPI Projects involving Durable Medical Equipment (DME) and Home Health Services, and for the Beneficiary Identity Theft Projects, conducted in coordination with the PSCs. They continue to provide support for the Department of Justice (DOJ) Strike Forces in Miami focusing on DME suppliers and infusion providers and in Los Angeles focusing on DME suppliers. The New York FO developed and led the Florida Infusion Fraud Demonstration project until turning oversight over to the Miami FO in July 2008.

The New York FO continues to be the national point of contact on infusion fraud. The New York FO developed and will lead the recently announced CMS' Program Integrity Stop Gap Plan to address Medicare durable medical equipment, prosthetics and orthotics (DMEPOS) fraud in seven states (Florida, California, Texas, Illinois, Michigan, North Carolina and New York). Likewise, the Miami FO developed the Medicare Miami-Dade HHA Outlier Project, which it will lead in coordination with the Zone 7 ZPIC and the regional home health intermediary. All three FOs closely interact with the Medicare Administrative Contractors in Los Angeles, Miami, and New York.

Medicaid Integrity Program

The Deficit Reduction Act of 2005 created the Medicaid Integrity Program (MIP) which represents a substantial milestone in CMS' first national strategy to detect and prevent Medicaid fraud and abuse in the program's history. This program offers a unique opportunity to identify, recover, and prevent inappropriate Medicaid payments. It will also support the efforts of State Medicaid agencies through a combination of oversight and technical assistance.

The CMS created the Medicaid Integrity Group which reports directly to the Center for Medicaid & State Operations (CMSO) Director to implement, among other things, the following four major functions to accomplish the requirements of the legislation: (1) Creation of the Comprehensive Medicaid Integrity Plan in consultation with internal and external partners to guide CMS' efforts; (2) Procurement and oversight of Medicaid Integrity Contractors who will conduct reviews, audits and education; (3) Field Operations to conduct state program integrity oversight reviews and provide training and technical assistance to states; and (4) Fraud Research & Detection to provide statistical data support, identify emerging fraud trends and conduct special studies.

Medicare Advantage and Prescription Drug Oversight

In 2008, CMS implemented the audit program for examinations of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs). The audit program was designed to examine the health plans' financial records, data relating to costs, Medicare utilization, and the computation of the bids. In order to satisfy the annual one-third audit requirement, CMS awarded contracts for 169 audits for the contract year 2006. In addition, CMS awarded contracts for 86 audits and will award contracts for another 102 audits in 2009 to meet the one third audit requirement for the contract year 2007. Furthermore, CMS performed the desk reviews of the Risk-Sharing Reconciliations for the Regional Preferred Provider Organizations (RPPOs). In addition, CMS (through our

ROs) also conducts audits of the MAOs—outside of the one-third audit requirement—to further improve oversight of both Part C and Part D MAOs.

The CMS has also reduced the number of unsettled managed care cost reports. In FY 2008, CMS reduced the backlog of unsettled managed care cost reports by 38. Disallowances resulting from FY 2008 settlement activity amounted to about $17 million. For FY 2008, CMS had a rate of return of 7.2 to 1. The remaining backlog still represents a challenge to CMS because these cost reports have critical issues that must be resolved with MAOs.

The CMS continues the development of an error rate reporting program during FY 2008 for the Medicare Advantage and Prescription Drug programs. The CMS prepared an error rate development project plan, a comprehensive mapping of the Part D payment process, and comprehensive risk assessments. The CMS prepared a methodology for a Part C Composite Error Rate for FY 2008, and is on track to report this rate in FY 2008. CMS prepared a methodology for calculating an element of the Part D payment error and is also prepared to report this rate in FY 2008.

The CMS continues to enhance the use of controls in the monthly payment process. Through the implementation of enhanced internal controls, CMS has significantly reduced the level of system-based payment error.

For the 2009 contract year, CMS implemented several steps designed to reduce the time required to complete the Part C solicitations. These steps included automating substantial portions of the Part C Plan solicitations within CMS' Health Plan Management System (HPMS) and streamlining key information previously requested by attachments. As a result of these steps, CMS ensured the appropriate systems' testing was completed, and applicants were educated and trained in completing the submission of the various types of applications within HPMS.

Medicare Electronic Data Processing (EDP)

The CMS continues to make incremental improvements in Medicare EDP internal controls. During FY 2008, CMS retained utilization of its strategy and project plan to address not just current audit findings but the root or environmental causes of those findings. To retain executive buy-in and awareness over the requirement for improvements in Medicare EDP controls, results from audits and evaluations were included as part of our reports of contractor performance. The CMS executives and staff also briefed our expectations and requirements to both Medicare contractor executives as well as the contractor system security officers. Further, CMS sponsored conferences—both in person and via teleconference—with the Medicare contractors to emphasize best practices to address individual audit findings and the root causes. The CMS has also released updated policies, procedures, and processes for the Medicare contractors, one of which set forth our expectations for Medicare data processing internal controls. A part of those expectations was that Medicare contractors were required to submit attestations certifying they have met the requirements outlined in the issued instructions. The CMS has received those attestations and is in the process of conducting on-site Medicare contractor reviews to validate them.

Oversight of Medicare Contractor Financial Operations & Reporting

Medicare contractors administer the day-to-day operations of the Medicare FFS program by paying claims, auditing provider cost reports, and establishing and collecting overpayments. As part of these activities, Medicare contractors are required to maintain a vast array of financial data. The CMS' implementation of new and/or revised policies over the past several years and other key initiatives to train staff and review contractor operations has resulted in significant improvements in the contractors' financial management activities and in the Agency oversight.

The CMS continues to enhance its analytical tools to provide the steps to identify potential errors, unusual variances, system weaknesses, or inappropriate patterns of financial data accumulation. One example of these analytical tools is the review of 1522 reconciliation procedures. On a monthly basis, non-HIGLAS Medicare contractors perform a reconciliation of their Form CMS-1522 Funds Expended Report to their paid claims or system reports. HIGLAS contractors are required to complete the HIGLAS Contractor's Monthly Bank Reconciliation Worksheet. The worksheet is designed to provide a monthly reconciliation of the Medicare Contractor's benefit and time account activity to the CMS Monthly Balance Sheet and Summary 2 Trial Balance. The CMS regional offices review their Medicare contractors' 1522 reconciliations and monthly cash reconciliations for one month each quarter. Furthermore, Medicare contractors are required to perform trend analysis on a quarterly basis and maintain supporting documentation to ensure that accounts receivable balances reported are reasonable.

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

The CMS also requires all Medicare contractors to submit an annual Certification Package for Internal Controls (CPIC). In the CPIC, contractors are required to report all material weaknesses identified during the FY, along with CAPs to remedy the weaknesses.

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

The CMS built upon the previous two successful years, FY 2006 and FY 2007, of implementing OMB's revisions to Circular A-123, *Management's Responsibility for Internal Control*. The Agency again procured an independent CPA firm in FY 2008 to assist in meeting reasonable assurance on internal controls over financial reporting as of June 30. The scope of the review included CMS central office and the ten regional offices. In addition, the CPA firm conducted Circular A-123 Appendix A Internal Control over Financial

Reporting (ICOFR) reviews at 17 Medicare contractors (including the Retiree Drug Subsidy and the Medicare Secondary Payer Recovery Contractor) and 12 data centers.

Also during FY 2008, five CMS Medicare Administrative Contractors (MACs) contracted with CPA firms to conduct Statement on Auditing Standards No. 70 (SAS 70) internal control audits. Those audit reports were leveraged for the FY 2008 Circular A-123 ICOFR review. The Circular A-123, Appendix A CPA firm also conducted CAP follow-up reviews related to SAS 70 internal control audits and other reviews conducted in previous years.

The CMS followed the five-step process of the Department for implementing Appendix A of OMB Circular A-123: (1) Plan and scope the evaluation, (2) Document controls and evaluate design of the controls, (3) Test operating effectiveness, (4) Identify and correct deficiencies, and (5) Report on Internal Controls. The CMS provided an assurance statement as of June 30 and updated it as of September 30. The results of our self-assessment are provided in the ***Summary of Federal Managers' Financial Integrity Act Report and OMB Circular A-123 Statement of Assurance*** section.

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

Financial Statement Introduction & Highlights

Consolidated Balance Sheets

The Consolidated Balance Sheets present as of September 30, 2008 and 2007, amounts of future economic benefits owned or managed by CMS (assets), amounts owed (liabilities), and amounts that comprise the difference (net position). A consolidating Balance Sheet by Major Program is provided as additional information. The CMS' Consolidated Balance Sheet shows $439.8 billion in assets. The bulk of these assets are in the Earmarked Investments totaling $382.5 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 $48.0 billion, most of which is for Medicaid and SCHIP. Liabilities of $71.2 billion consist primarily of the Entitlement Benefits Due and Payable of $65.9 billion. The CMS net position totals $368.7 billion and reflects primarily the cumulative results of operations for the Medicare Trust Funds and the unexpended balances for Medicaid and SCHIP.

Consolidated Statements of Net Cost

The Consolidated Statements of Net Cost present the net cost of operations for the years ended September 30, 2008 and 2007. 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. Both Medicare and Medicaid MIP are included under the HI trust fund. The

costs related to the Program Management Appropriation are cost-allocated to all three major components. The net cost of operations of the CLIA program and other programs are shown separately under "Other Activities." A consolidating Statement of Net Cost is provided to show the earmarked vs. non-earmarked components of net cost as additional information.

Total Benefit Payments were $652.8 billion for FY 2008. Administrative Expenses were $3.3 billion, less than 1 percent of total net Program/Activity Costs of $603.6 billion.

The net cost of the Medicare program including benefit payments, QIOs, Medicare Integrity Program spending, and administrative costs, was $395.1 billion. The HI total costs of $220.5 billion were offset by $2.8 billion in revenues. The SMI total costs of $228.8 billion were offset by premiums of $51.4 billion. Medicaid total costs of $201.1 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 $6.9 billion.

Consolidated Statements of Changes in Net Position

The Consolidated Statements of Changes in Net Position present the change in net position for the years ended September 30, 2008 and 2007. 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. Earmarked funds are shown in a separate column from other funds. A consolidating Statement of Changes in Net Position is provided to present the change in net position by major programs as additional information.

The line, Appropriations Used, represents the Medicaid appropriations used of $200.5 billion; $193.0 billion in transfers from Payments to Health Care Trust Funds to HI and SMI; SCHIP appropriations of $6.9 billion and State Grants and Demonstrations appropriations of $415 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 Contributions Act (FICA) and Self-Employment Contributions Act (SECA) for the HI trust fund and totaled $197.2 billion. The Federal matching contribution is income to the SMI program from a general fund appropriation (Payments to Health Care Trust Funds) of $144.9 billion, which matches monthly premiums paid by beneficiaries approximately three to one.

Combined Statements of Budgetary Resources

The Combined Statements of Budgetary Resources provide information about the availability of budgetary resources, as well as their status for the years ended September 30, 2008 and 2007. An additional Schedule of Budgetary Resources is provided as Required Supplementary Information to present each budgetary account. In this statement, the Program Management and the Program Management User Fee accounts are combined and are not allocated back to the other programs. Also, there are no intra-CMS eliminations in this statement.

The CMS total budgetary resources were $907.3 billion. Obligations of $884.2 billion leave unobligated balances of $23.1 billion (of which $411 million is not available). Total outlays, net of collections, were $859.7 billion. When offset by $263.1 billion relating to collection

of premiums and general fund transfers from the Payments to Health Care Trust Funds, as well as refunds of Medicare contractor overpayments, the net outlays were $596.6 billion.

Statement of Social Insurance (SOSI)

As required by the Statement of Federal Financial Accounting Standards (SSFAS) Numbers 25, *Reclassification of Stewardship Responsibilities*, CMS is presenting social insurance as a basic financial statement. SSFAS Number 28, *Deferral of the Effective Date of Reclassification of the Statement of Social Insurance: Amending SFFAS 25 and 26* deferred the effective date for classifying the SOSI as a basic financial statement to periods beginning after September 30, 2005.

The Statement of Social Insurance presents the 75-year actuarial present value of the income and expenditures of the HI and SMI trust funds. Future expenditures are expected to arise from the formulas specified in current law for current and future program participants. This projection is considered to be important information regarding the potential future cost of the program. These projected potential future obligations under current law are not included in the Balance Sheet, Statement of Net Cost, Statement of Changes in Net Position, Statement of Budgetary Resources, or Statement of Financing.

Required Supplementary Information (RSI)

As required by the SFFAS Number 17, CMS has included information about the Medicare trust funds—HI and SMI. The Required Supplementary Information (RSI) presents required long-range cashflow projections, the long-range projections of the ratio of contributors to beneficiaries (dependency ratio), and the sensitivity analysis illustrating the effect of the changes in the most significant assumptions on the actuarial projections and present values. The RSI assesses the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the ***2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds***, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds.

Limitations of the Financial Statements

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

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

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

Principal Statements and Notes

CONSOLIDATED BALANCE SHEETS
As of September 30, 2008 and 2007

(in millions)

	FY 2008 Consolidated Totals	FY 2007 Consolidated Totals
ASSETS		
Intragovernmental Assets:		
Fund Balance with Treasury ***(Note 2)***	$48,012	$39,005
Earmarked Investments ***(Note 3)***	382,465	363,195
Accounts Receivable, Net ***(Note 4)***	511	484
Other Assets	17	
Total Intragovernmental Assets	**431,005**	**402,684**
Cash and Other Monetary Assets	354	129
Accounts Receivable, Net ***(Note 4)***	7,191	12,808
General Property, Plant and Equipment, Net	428	424
Other Assets	840	161
TOTAL ASSETS	**$439,818**	**$416,206**
LIABILITIES		
Intragovernmental Liabilities:		
Accounts Payable	$438	$436
Accrued Payroll and Benefits	6	4
Other Intragovernmental Liabilities	627	530
Total Intragovernmental Liabilities	**1,071**	**970**
Federal Employee and Veterans' Benefits	12	11
Entitlement Benefits Due and Payable ***(Note 5)***	65,851	61,470
Accrued Payroll and Benefits	58	55
Contingencies ***(Note 6)***	3,513	4,111
Other Liabilities	647	389
TOTAL LIABILITIES *(Note 7)*	**71,152**	**67,006**
NET POSITION		
Unexpended Appropriations—earmarked funds	12,267	8,978
Unexpended Appropriations—other funds	13,258	9,889
Total Unexpended Appropriations	**25,525**	**18,867**
Cumulative Results of Operations—earmarked funds	342,640	329,931
Cumulative Results of Operations—other funds	501	402
Total Cumulative Results of Operations	**343,141**	**330,333**
TOTAL NET POSITION	**$368,666**	**$349,200**
TOTAL LIABILITIES AND NET POSITION	**$439,818**	**$416,206**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF NET COST
For the Years Ended September 30, 2008 and 2007
(in millions)

	FY 2008 Consolidated Totals	FY 2007 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS		
GPRA Programs		
Medicare (Earmarked)	$395,055	$367,551
Medicaid	201,094	187,940
SCHIP	6,978	6,010
Net Cost - GPRA Programs	**603,127**	**561,501**
Other Activities		
CLIA	(14)	(18)
State Grants and Demonstrations	444	455
Net Cost - Other Activities	**430**	**437**
NET COST OF OPERATIONS *(Notes 8, 12 and 17)*	**$603,557**	**$561,938**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2008
(in millions)

	Consolidated Earmarked Funds	Consolidated Other Funds	FY 2008 Consolidated Total
CUMULATIVE RESULTS OF OPERATIONS			
BEGINNING BALANCES	**$329,931**	**$402**	**$330,333**
Budgetary Financing Sources:			
Appropriations Used	193,008	207,818	400,826
Nonexchange Revenue:			
FICA and SECA Taxes	197,195		197,195
Interest on Earmarked Trust Fund Investments	19,134		19,134
Other Nonexchange Revenue	566		566
Transfers-in/out Without Reimbursement ***(Note 9)***	(2,163)	781	(1,382)
Other Financing Sources (Nonexchange):			
Transfers-out Without Reimbursement	(1)		(1)
Imputed Financing	25	2	27
TOTAL FINANCING SOURCES	**407,764**	**208,601**	**616,365**
NET COST OF OPERATIONS	**395,055**	**208,502**	**603,557**
NET CHANGE	**12,709**	**99**	**12,808**
CUMULATIVE RESULTS OF OPERATIONS	**$342,640**	**$501**	**$343,141**
UNEXPENDED APPROPRIATIONS			
BEGINNING BALANCES	**$8,978**	**$9,889**	**$18,867**
Budgetary Financing Sources:			
Appropriations Received	205,320	214,354	419,674
Appropriations Transferred-in/out		(2,515)	(2,515)
Other Adjustments ***(Note 10)***	(9,023)	(652)	(9,675)
Appropriations Used	(193,008)	(207,818)	(400,826)
TOTAL BUDGETARY FINANCING SOURCES	**3,289**	**3,369**	**6,658**
TOTAL UNEXPENDED APPROPRIATIONS	**12,267**	**13,258**	**25,525**
NET POSITION	**$354,907**	**$13,759**	**$368,666**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2007
(in millions)

	Consolidated Earmarked Funds	Consolidated Other Funds	FY 2007 Consolidated Total
CUMULATIVE RESULTS OF OPERATIONS			
BEGINNING BALANCES	**$301,853**	**$313**	**$302,166**
Budgetary Financing Sources:			
Appropriations Used	190,743	193,885	384,628
Nonexchange Revenue:			
FICA and SECA Taxes	187,992		187,992
Interest on Earmarked Trust Fund Investments	18,369		18,369
Other Nonexchange Revenue	237		237
Transfers-in/out Without Reimbursement ***(Note 9)***	(1,737)	589	(1,148)
Other Financing Sources (Nonexchange):			
Transfers-out Without Reimbursement	(1)		(1)
Imputed Financing	26	2	28
TOTAL FINANCING SOURCES	**395,629**	**194,476**	**590,105**
NET COST OF OPERATIONS	**367,551**	**194,387**	**561,938**
NET CHANGE	**28,078**	**89**	**28,167**
CUMULATIVE RESULTS OF OPERATIONS	**$329,931**	**$402**	**$330,333**
UNEXPENDED APPROPRIATIONS			
BEGINNING BALANCES	**$27,658**	**$32,521**	**$60,179**
Budgetary Financing Sources:			
Appropriations Received	199,309	174,643	373,952
Appropriations Transferred-in/out		(2,805)	(2,805)
Other Adjustments ***(Note 10)***	(27,246)	(585)	(27,831)
Appropriations Used	(190,743)	(193,885)	(384,628)
TOTAL BUDGETARY FINANCING SOURCES	**(18,680)**	**(22,632)**	**(41,312)**
TOTAL UNEXPENDED APPROPRIATIONS	**8,978**	**9,889**	**18,867**
NET POSITION	**$338,909**	**$10,291**	**$349,200**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENTS OF BUDGETARY RESOURCES
For the Years Ended September 30, 2008 and 2007

(in millions)

	FY 2008 Combined Totals Budgetary	FY 2007 Combined Totals Budgetary
Budgetary Resources:		
Unobligated balance, brought forward, October 1:	$14,735	$56,270
Recoveries of prior year unpaid obligations	12,552	15,972
Budget authority:		
Appropriation	900,247	837,011
Spending authority from offsetting collections:		
Earned		
Collected	4,255	221
Change in unfilled customer orders:		
Advance received	(3)	(58)
Without advance from Federal sources	232	63
Expenditure transfers from trust funds	3,626	3,546
SUBTOTAL	**908,357**	**840,783**
Nonexpenditure transfers, net, anticipated & actual	(2,432)	(2,958)
Temporarily not available pursuant to Public Law	(16,135)	(20,793)
Permanently not available	(9,762)	(27,908)
TOTAL BUDGETARY RESOURCES	**$907,315**	**$861,366**
Status of Budgetary Resources:		
Obligations incurred ***(Note 13)***:		
Direct	$883,992	$846,012
Reimbursable	188	194
SUBTOTAL	**884,180**	**846,206**
Unobligated balance:		
Apportioned	22,683	13,617
Exempt from apportionment	41	—
SUBTOTAL	**22,724**	**13,617**
Unobligated balance not available	411	1,543
TOTAL STATUS OF BUDGETARY RESOURCES	**$907,315**	**$861,366**
Change in Obligated Balance:		
Obligated balance, net:		
Unpaid obligations, brought forward, October 1	$70,983	$70,834
Uncollected customer payments from		
Federal sources, brought forward, October 1	(1,786)	(1,432)
TOTAL UNPAID OBLIGATED BALANCE, NET	**$69,197**	**$69,402**
Obligations incurred, net	884,180	846,206
Gross Outlays	(867,427)	(830,086)
Obligated balance transferred, net:		
Recoveries of prior year unpaid obligations, actual	(12,552)	(15,972)
Change in uncollected customer payments from Federal sources	(410)	(353)
Obligated balance, net, end of period:		
Unpaid obligations	75,184	70,983
Uncollected customer payments from Federal sources	(2,196)	(1,786)
TOTAL, UNPAID OBLIGATED BALANCE, NET, END OF PERIOD	**72,988**	**69,197**
Net Outlays:		
Net Outlays		
Gross outlays	867,427	830,086
Offsetting collections	(7,700)	(3,419)
Distributed offsetting receipts	(263,149)	(256,204)
NET OUTLAYS	**$596,578**	**$570,463**

The accompanying notes are an integral part of these statements.

STATEMENT OF SOCIAL INSURANCE
75-Year Projection as of January 1, 2008 and Prior Base Years
(in billions)

		Estimates from Prior Years			
	2008	2007	2006	2005 unaudited	2004 unaudited
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: ***(Notes 14 through 16)***					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$6,320	$5,975	$5,685	$5,064	$4,820
SMI Part B	14,932	12,112	12,446	11,477	10,505
SMI Part D	6,527	7,285	7,366	7,895	7,545
Have attained eligibility age (age 65 and over)					
HI	202	178	192	162	148
SMI Part B	1,785	1,648	1,606	1,436	1,310
SMI Part D	581	746	750	817	713
Those expected to become participants					
HI	5,361	4,870	4,767	4,209	4,009
SMI Part B	4,480	4,460	3,562	3,658	3,514
SMI Part D	2,856	2,735	2,134	2,522	2,511
All current and future participants					
HI	11,883	11,023	10,644	9,435	8,976
SMI Part B	21,197	18,221	17,613	16,571	15,329
SMI Part D	9,964	10,766	10,250	11,233	10,770
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: ***(Notes 14 through 16)***					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	17,365	15,639	15,633	12,668	12,054
SMI Part B	14,949	12,130	12,433	11,541	10,577
SMI Part D	6,527	7,273	7,338	7,913	7,566
Have attained eligibility age (age 65 and over)					
HI	2,747	2,558	2,397	2,179	2,168
SMI Part B	1,986	1,834	1,773	1,622	1,475
SMI Part D	581	794	792	880	773
Those expected to become participants					
HI	4,506	5,118	3,904	3,417	3,246
SMI Part B	4,262	4,257	3,407	3,408	3,277
SMI Part D	2,856	2,699	2,121	2,440	2,431
All current and future participants					
HI	24,619	23,315	21,934	18,264	17,468
SMI Part B	21,197	18,221	17,613	16,571	15,329
SMI Part D	9,964	10,766	10,250	11,233	10,770
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures ***(Notes 14 through 16)***					
HI	$(12,737)	$(12,292)	$(11,290)	$(8,829)	$(8,492)
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0

Additional Information

Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures ***(Notes 14 through 16)***					
HI	$(12,737)	$(12,292)	$(11,290)	$(8,829)	$(8,492)
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0
Trust Fund assets at start of period					
HI	312	300	285	268	256
SMI Part B	53	38	23	19	24
SMI Part D	3	1	0	0	0
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over expenditures ***(Notes 14 through 16)***					
HI	$(12,425)	$(11,993)	$(11,006)	$(8,561)	$(8,236)
SMI Part B	53	38	23	19	24
SMI Part D	3	1	0	0	0

Totals do not necessarily equal the sum of the rounded components. The accompanying notes are an integral part of these statements. With the exception of the 2007 projections presented, current participants are assumed to be the "closed group" of individuals who are at least age 15 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or both. For the 2007 projections, the "closed group" are assumed to be individuals who are at least 18 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or both.

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity

The Centers for Medicare & Medicaid Services (CMS), a component of the Department of Health and Human Services (HHS), administers Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). The CMS is a separate financial reporting entity of HHS.

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

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

Use of Estimates

The preparation of financial statements, in conformity with GAAP, requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the dates of the financial statements and the reported amounts of revenues and expenses during the reporting periods. Actual results could differ from those estimates.

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

Earmarked Funds

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

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

The Medicare **Earmarked** funds include:

Medicare Hospital Insurance Trust Fund—Part A

Section 1817 of the Social Security Act established the Medicare Hospital Insurance 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 Medicare Advantage plans (previously known as 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). The HI trust fund has permanent indefinite authority. Employment tax revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under FICA and SECA. Employees and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI trust fund. Self-employed individuals contribute the full 2.9 percent of their net income. The Social Security Act requires the transfer of these contributions from the General Fund of Treasury to the HI trust fund based on the amount of wages certified by the Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 as the basis for conducting quarterly certification of regular wages. (See "Payments to the Health Care Trust Funds Appropriation" and "Permanent Appropriations" below for additional descriptions of revenues and financing sources for the HI trust fund).

Medicare Supplementary Medical Insurance Trust Fund—Part B

Section 1841 of the Social Security Act established the Supplementary Medical Insurance 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 Medicare Advantage plans are also charged to this fund. The financial statements include SMI trust fund activities administered by Treasury. The SMI trust fund has permanent indefinite authority. SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. (See Note 9 for descriptions of revenues and financing sources for the SMI trust fund).

Medicare Supplementary Medical Insurance Trust Fund—Part D

The Medicare Prescription Drug Benefit—Part D, established by the Medicare Modernization Act of 2003 (MMA), became effective January 1, 2006. The program makes a prescription drug benefit available to everyone who is in Medicare, though beneficiaries must join a drug plan to obtain coverage. The drug plans are offered by insurance companies and other private companies approved by Medicare and are of two types: Medicare Prescription Drug Plans (which add the coverage to basic Medicare) and Medicare Advantage Prescription Drug Plans and other Medicare Health Plans in which drug coverage is offered as part of a benefit package that includes Part A and Part B services. In addition, Medicare helps employers or unions continue to provide retiree drug coverage that meets Medicare's standards through the Retiree Drug Subsidy (RDS). In addition, the Low Income Subsidy (LIS) helps those with limited income and resources. (See "Payments to the Health Care Trust Funds Appropriation" below as well as Note 9 for descriptions of revenues and financing sources for the SMI trust fund).

The Part D is considered part of the SMI trust fund and is reported in the SMI TF column of the financial statements.

Medicare and Medicaid Integrity Programs

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, *Public Law No. 104-191*. § *202*) established the Medicare Integrity Program at section 1893 of the Social Security Act, and codified Medicare program integrity activities previously known as "payment safeguards." HIPAA section 201 also established the Health Care "Fraud and Abuse Control Account, which provides a dedicated appropriation for carrying out the Medicare Integrity Program". Through the Medicare Integrity Program, 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 Medicare Integrity Program is funded by the HI trust fund.

Separately, the Medicaid Integrity Program was established by the Deficit Reduction Act of 2005 (DRA, *Public Law No. 109-171*. § *6034*), and codified at section 1936 of the Social Security Act. The Medicaid Integrity Program represents the Federal government's first effort to directly review and audit Medicaid providers, tasks that were formerly performed solely by States. Under the Medicaid Integrity Program, CMS contracts with eligible entities to perform, with respect to Medicaid providers, activities generally similar to those currently performed by Medicare Integrity Program contractors with respect to Medicare providers.

Payments to the Health Care Trust Funds Appropriation

The Social Security Act provides for payments to the HI and SMI trust funds for SMI (appropriated funds to provide for Federal matching of SMI premium collections) and HI (for the Uninsured and Federal Uninsured Payments). The MMA of 2003 prescribes that funds covering the Medicare Prescription Drug Benefit, retiree drug coverage, reimbursements to the States and Transitional Assistance benefits be transferred from Payments to the Health Care Trust Funds to the SMI trust fund. The Health Insurance Portability and Accountability Act of 1996 prescribes that criminal fines and civil monetary penalties arising from health care cases be transferred to the HCFAC account of the HI trust fund through permanent appropriations of the Payments to the Health Care Trust Funds. In addition, funds are provided by this appropriation to cover the Health programs' share of CMS' administrative costs. To prevent duplicative reporting, the Fund Balance, Unexpended Appropriation, Financing Sources and Expenditure Transfers of this appropriation are reported only in the Medicare HI TF and SMI TF columns of the financial statements.

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

The Health Insurance Portability and Accountability Act of 1996 prescribes that criminal fines and civil monetary penalties arising from health care cases be appropriated to the HCFAC account of the HI trust fund. There is permanent indefinite authority for the transfer of general funds containing criminal fines and civil monetary penalties to the HCFAC account of the HI trust fund.

The **Health (Other Funds)** programs 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) and the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), was designed to provide health insurance for children, many of whom come from working families with incomes too high to qualify for Medicaid, but too low to afford private health insurance. The BBA set aside funds for ten years to provide this insurance coverage. The MMSEA extended the funding through March 2009. The 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.

State Grants and Demonstrations

Several grant programs have been established through the 75-0516 State Grants and Demonstrations appropriation fund group.

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

The MMA of 2003 appropriates funds annually, from FY 2005 through FY 2008, for the Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens. The Deficit Reduction Act Section 6201 provides Federal payments for several projects, including Hurricane Katrina Relief, the establishment of alternative non-emergency providers, and the expansion of State Long-Term Care Partnerships.

Health Care Infrastructure Improvement Program

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

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

This account operates as a revolving fund without fiscal year restriction. The BBA established the Medicare + Choice program, now known as the Medicare Advantage program under the MMA, that requires Medicare Advantage plans to make payments for their share of the estimated costs related to enrollment, dissemination of information, and certain counseling and assistance programs. These user fees are devoted to educational efforts for beneficiaries and outreach partners. The Clinical Laboratory Improvement

Amendments of 1988 (CLIA) marked the first comprehensive effort by the Federal government to regulate medical laboratory testing. 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 9). User fees collected from Medicare Advantage plans seeking Federal qualification and funds received from other Federal agencies to reimburse CMS for services performed for them are credited to the Program Management Appropriation.

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

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

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

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

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

Benefit Payments are payments made by Medicare contractors, CMS, and Medicaid State agencies to health care providers for their services. CMS recognizes the cost associated with payments in the period incurred and based on entitlement. In accordance with Public Law and existing Federal accounting standards, no expense or liability is recorded for any future payment to be made on behalf of current workers contributing to the Medicare HI trust fund. By law, if the monthly disbursement date falls on a weekend or a federal recognized holiday, CMS is required to accelerate the disbursement date to the preceding business day.

State Phased-Down Contributions are reimbursements to the SMI trust fund for the Federal assumption of Medicaid prescription

drug costs for dually eligible beneficiaries pursuant to the MMA. This subsection prescribes a formula for computing the states' contributions and allows States to make monthly payments. Amounts billed and collected under the State Phased-Down provision are recognized as a reduction to expense.

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

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

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

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

Unobligated Balances—beginning of period represent funds brought forward from the previous year. (See Note 13 for an explanation of the adjustment made to the beginning balance.)

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

Reclassifications

Certain FY 2007 balances have been reclassified to conform to FY 2008 financial statement presentations, the effect of which is immaterial.

Estimation of Obligations Related to Canceled Appropriations

As of September 30, 2008, CMS has canceled over $172 million in cumulative obligations to FY 2003 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 2004 through 2008 related to canceled appropriations, CMS anticipates an additional $4 million will be paid from current year funds for canceled obligations.

NOTE 2:

FUND BALANCE WITH TREASURY *(Dollars in Millions)*

FY 2008	Consolidated Totals
FUND BALANCES:	
Trust Funds	
HI Trust Fund (Earmarked)	$182
SMI Trust Fund (Earmarked)	12,261
Revolving Funds	
CLIA	208
General Funds	
Medicaid	29,119
SCHIP	4,337
State Grants and Demonstrations	1,835
Program Management	60
Other Fund Types	
CMS Deposit/Suspense Accounts	10
TOTAL FUND BALANCES	**$48,012**
STATUS OF FUND BALANCES WITH TREASURY:	
Unobligated Balance	
Available	$22,724
Unavailable	411
Obligated Balance not yet Disbursed	72,988
Non-Budgetary FBWT	(48,111)
TOTAL STATUS OF FUND BALANCES WITH TREASURY	**$48,012**

FY 2007	Consolidated Totals
FUND BALANCES:	
Trust Funds	
HI Trust Fund (Earmarked)	$38
SMI Trust Fund (Earmarked)	8,755
Revolving Funds	
CLIA	189
General Funds	
Medicaid	23,223
SCHIP	5,250
State Grants and Demonstrations	1,499
Program Management	
Other Fund Types	
CMS Deposit/Suspense Accounts	51
TOTAL FUND BALANCES	**$39,005**
STATUS OF FUND BALANCES WITH TREASURY:	
Unobligated Balance	
Available	$13,617
Unavailable	1,543
Obligated Balance not yet Disbursed	69,197
Non-Budgetary FBWT	(45,352)
TOTAL STATUS OF FUND BALANCES WITH TREASURY	**$39,005**

Fund Balances are funds with Treasury that are primarily available to pay current expenditures and liabilities. The Unobligated Balance includes $307 million, which is restricted for future use and is not apportioned for current use for Program Management and State Grants and Demonstrations.

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

Medicare Investments *(Earmarked)*

FY 2008	Maturity Range	Interest Range	Value
HI TF			
Certificate	June 2009	3 3/4%	$4,611
Bonds	June 2009 to June 2023	3 1/2 - 7 1/4%	314,130
Accrued Interest			3,963
TOTAL HI TF INVESTMENTS			**$322,704**
SMI TF			
Certificate	June 2009	3 3/4 - 4%	$6,085
Bonds	June 2010 to June 2023	4 - 6 7/8%	53,005
Accrued Interest			671
TOTAL SMI TF INVESTMENTS			**$59,761**
TOTAL MEDICARE INVESTMENTS			**$382,465**

FY 2007	Maturity Range	Interest Range	Value
HI TF			
Certificate	June 2008	4 1/2%	$7,111
Bonds	June 2008 to June 2022	3 1/2 - 7 1/4%	312,266
Accrued Interest			4,090
TOTAL HI TF INVESTMENTS			**$323,467**
SMI TF			
Certificate	June 2008	4 1/2 - 4 3/4%	$5,105
Bonds	June 2008 to June 2019	4 1/8 - 6 7/8%	34,143
Accrued Interest			480
TOTAL SMI TF INVESTMENTS			**$39,728**
TOTAL MEDICARE INVESTMENTS			**$363,195**

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

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

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

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

FY 2008	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	Other Health	Consolidated Total
INTRAGOVERNMENTAL					
Railroad Retirement Board Principal	$511				$511
WITH THE PUBLIC					
Provider & Beneficiary Overpayments					
Accounts Receivable Principal	$467	$822		$42	$1,331
Less: Allowance for Uncollectible Accounts	(114)	(415)		(25)	(554)
Accounts Receivable, Net	353	407		17	777
Medicare Secondary Payer (MSP)					
Accounts Receivable Principal	347	299		20	666
Less: Allowance for Uncollectible Accounts	(164)	(194)		(14)	(372)
Accounts Receivable, Net	183	105		6	294
Medicare Prescription Drug					
Accounts Receivable Principal		1,811			1,811
Less: Allowance for Uncollectible Accounts					
Accounts Receivable, Net		1,811			1,811
CMPs and Other Restitutions					
Accounts Receivable Principal	609	450		1	1,060
Less: Allowance for Uncollectible Accounts	(558)	(441)		(1)	(1,000)
Accounts Receivable, Net	51	9			60
Fraud and Abuse					
Accounts Receivable Principal	127	357	$157		641
Less: Allowance for Uncollectible Accounts	(127)	(343)	(123)		(593)
Accounts Receivable, Net		14	34		48
Medicare Advantage					
Accounts Receivable Principal	6	14		3	23
Less: Allowance for Uncollectible Accounts		(2)		(3)	(5)
Accounts Receivable, Net	6	12			18
Medicare Premiums					
Accounts Receivable Principal	269	761			1,030
Less: Allowance for Uncollectible Accounts	(56)	(75)			(131)
Accounts Receivable, Net	213	686			899
State Phased-Down					
Accounts Receivable Principal		1,041			1,041
Less: Allowance for Uncollectible Accounts					
Accounts Receivable, Net		1,041			1,041
Audit Disallowances					
Accounts Receivable Principal			$2,460		$2,460
Less: Allowance for Uncollectible Accounts			(222)		(222)
Accounts Receivable, Net			2,238		2,238
Other Accounts Receivable					
Accounts Receivable Principal				23	23
Less: Allowance for Uncollectible Accounts				(18)	(18)
Accounts Receivable, Net				5	5
TOTAL ACCOUNTS RECEIVABLE PRINCIPAL	**$1,825**	**$5,555**	**$2,617**	**$89**	**$10,086**
Less: Allowance for Uncollectible Accounts Receivable	(1,019)	(1,470)	(345)	(61)	(2,895)
TOTAL ACCOUNTS RECEIVABLE, NET	**$806**	**$4,085**	**$2,272**	**$28**	**$7,191**

FY 2007	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	Other Health	Consolidated Total
INTRAGOVERNMENTAL					
Railroad Retirement Board Principal	$484				$484
WITH THE PUBLIC					
Provider & Beneficiary Overpayments					
Accounts Receivable Principal	$552	$927		$38	$1,517
Less: Allowance for Uncollectible Accounts	(151)	(529)		(26)	(706)
Accounts Receivable, Net	401	398		12	811
Medicare Secondary Payer (MSP)					
Accounts Receivable Principal	195	125		7	327
Less: Allowance for Uncollectible Accounts	(98)	(85)		(5)	(188)
Accounts Receivable, Net	97	40		2	139
Medicare Prescription Drug					
Accounts Receivable Principal		8,409			8,409
Less: Allowance for Uncollectible Accounts					
Accounts Receivable, Net		8,409			8,409
CMPs and Other Restitutions					
Accounts Receivable Principal	793	417		1	1,211
Less: Allowance for Uncollectible Accounts	(661)	(401)		(1)	(1,063)
Accounts Receivable, Net	132	16			148
Fraud and Abuse					
Accounts Receivable Principal	124	327	$166		617
Less: Allowance for Uncollectible Accounts	(124)	(313)	(118)		(555)
Accounts Receivable, Net		14	48		62
Medicare Advantage					
Accounts Receivable Principal		5		3	8
Less: Allowance for Uncollectible Accounts		(3)		(3)	(6)
Accounts Receivable, Net		2			2
Medicare Premiums					
Accounts Receivable Principal	250	679			929
Less: Allowance for Uncollectible Accounts	(54)	(64)			(118)
Accounts Receivable, Net	196	615			811
State Phased-Down					
Accounts Receivable Principal		1,024			1,024
Less: Allowance for Uncollectible Accounts					
Accounts Receivable, Net		1,024			1,024
Audit Disallowances					
Accounts Receivable Principal			$1,480		$1,480
Less: Allowance for Uncollectible Accounts			(81)		(81)
Accounts Receivable, Net			1,399		1,399
Other Accounts Receivable					
Accounts Receivable Principal				22	22
Less: Allowance for Uncollectible Accounts				(19)	(19)
Accounts Receivable, Net				3	3
TOTAL ACCOUNTS RECEIVABLE PRINCIPAL	**$1,914**	**$11,913**	**$1,646**	**$71**	**$15,544**
Less: Allowance for Uncollectible Accounts Receivable	(1,088)	(1,395)	(199)	(54)	(2,736)
TOTAL ACCOUNTS RECEIVABLE, NET	**$826**	**$10,518**	**$1,447**	**$17**	**$12,808**

Intragovernmental Accounts Receivable

Intragovernmental accounts receivable represent CMS claims for payment from other Federal agencies. CMS accounts receivable for transfers from the HI and SMI trust funds maintained by the Treasury Bureau of Public Debt (BPD) are eliminated against BPD's corresponding liabilities to CMS in the Consolidated Balance Sheets. Included in the intra-CMS eliminations in FY 2007, the SMI trust fund reported a receivable from the HI trust fund in the amount of $8,484 million for hospice benefits that were incorrectly paid out of the Part B account of the SMI trust fund that should have been paid out of the HI trust fund. This receivable in the SMI trust fund and the corresponding payable in the HI trust fund were liquidated in FY 2008.

Accounts Receivable with the Public

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

Provider and Beneficiary Overpayments

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

Medicare Secondary Payer (MSP)

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

Medicare Prescription Drug

The Medicare Prescription Drug receivable of $1,811 million consists of amounts due CMS after completion of the Part D payment reconciliation for calendar year 2007. For FY 2007, the gross receivable was $8,409 million which consisted of the Part D reconciliation for calendar year 2006 of $5,189 million, and the estimate for first nine months of calendar year 2007 of $3,220 million. The estimate for the first nine months of calendar year 2008 is reported as an advance of $645 million in "Other Assets" on the Balance Sheets. The estimated advance is caused by the fact that CMS payments to the plans are made evenly throughout the year while payments made by the plans are more heavily weighted towards the fourth calendar quarter. This amount will be liquidated as claims are incurred and submitted to the plans during the first quarter of FY 2009. As a result, CMS management believes the Part D accrual estimate will become a liability by the end of CY 2008.

Civil Monetary Penalties (CMPs) and Other Restitutions

CMP accounts receivable result from penalties assessed against individuals or entities that commit fraud against the Medicare program. CMPs are imposed on a skilled nursing facility and/or a nursing facility under section 1819 (h) and/or 1919 (h) of the Social Security Act when the facility is determined to be non-compliant with established Medicare policies and procedures. The CMS' 10 ROs are responsible for ensuring that annual site surveys are performed and the survey summary is reviewed. ROs utilize the Civil Monetary Penalty Tracking System (CMPTS), ASPEN and Online System and Certification Access Remote (OSCAR) database to maintain all Health Care provider information.

Medicare Premiums

The accounts receivable for the standard Part A and Part B Premiums as well as Medicare Advantage Premiums are billed to beneficiaries, states, and other third party groups, which establish the Medicare premium accounts receivable. The CMS utilizes two computer systems: Direct Billing Integration System (DBIS), and SMI Premium Accounting, Collection, and Enrollment (SPACE) System to bill Medicare premiums.

State Phased-Down Contributions

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

Audit Disallowances

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

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

Write Offs and Adjustments

The implementation of the revised policies and other initiatives undertaken in recent fiscal years resulted in significant adjustments and write offs made to CMS' accounts receivable balance. CMS' financial reporting reflected additional adjustments, resulting from the validation and reconciliation efforts performed, revised policies and supplemental guidance provided by CMS to the Medicare contractors. The accounts receivable

ending balance continues to reflect adjustments for accounts receivable which have been reclassified as Currently Not Reportable debt.

The allowance for uncollectible accounts receivable derived this year has been calculated from data based on the agency's collection activity and the age of the debt for the most current fiscal year, while taking into consideration the average uncollectible percentage for the past five years. The Medicaid accounts receivable has been recorded at a net realizable value based on 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.

Currently Not Reportable/ Currently Not Collectible Debt

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

NOTE 5: ENTITLEMENT BENEFITS DUE AND PAYABLE *(Dollars in Millions)*

FY 2008	Medicare (Earmarked)					Other	Consolidated
	HI TF	SMI TF	Total	Medicaid	SCHIP	Health	Total
Medicare Benefits Payable *(1)*	$20,242	$18,373	$38,615				$38,615
Medicare Advantage *(2)*	737	2,783	3,520				3,520
Retiree Drug Subsidy *(3)*		2,807	2,807				2,807
Undocumented Aliens						$165	165
Medicaid/SCHIP *(6)*				$20,410	$334		20,744
TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE	**$20,979**	**$23,963**	**$44,942**	**$20,410**	**$334**	**$165**	**$65,851**

FY 2007	Medicare (Earmarked)					Other	Consolidated
	HI TF	SMI TF	Total	Medicaid	SCHIP	Health	Total
Medicare Benefits Payable *(1)*	$18,235	$16,828	$35,063				$35,063
Medicare Advantage *(2)*	1,175	2,460	3,635				3,635
Retiree Drug Subsidy *(3)*		2,906	2,906				2,906
Undocumented Aliens						$163	163
Medicaid/SCHIP *(6)*				$19,414	$289		19,703
TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE	**$19,410**	**$22,194**	**$41,604**	**$19,414**	**$289**	**$163**	**$61,470**

(1) Medicare benefits payable consists of a $38,615 million estimate ($35,063 million in FY 2007) by CMS' Office of the Actuary for Medicare services incurred but not paid, as of September 30, 2008. 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 2008 that were paid in 2009 and (e) an estimate of retroactive settlements of cost reports.

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

(2) Medicare Advantage and Prescription Drug Program benefits payable consist of a $1,729 million estimate ($2,653 million in FY 2007) for amounts owed to plans relating to risk and other payment related adjustments and $1,791 million ($982 million in FY 2007) owed to plans after the completion of the Prescription Drug Payment reconciliation.

(3) The Retiree Drug Subsidy (RDS) consists of a $2,807 million estimate ($2906 in FY 2007) of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2008. As part of MMA (incorporated in Section 1860D-22 of the Social Security Act), the RDS program makes subsidy payments available to sponsors of retiree prescription drug coverage. The program is designed to strengthen health care coverage for Medicare-eligible retirees by encouraging the retention of private, employer- and union-based retiree prescription drug plans.

(4) Medicaid benefits payable of $20,410 million ($19,414 million in FY 2007) 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, 2008. An estimated SCHIP benefits payable of $334 million has been recorded ($289 million in FY 2007) for the net Federal share of expenses that have been incurred by the States but not yet reported to CMS as of September 30, 2008.

NOTE 6: CONTINGENCIES

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

The Medicaid amount for $3,513 million ($1,702 million in FY 2007) consists of Medicaid audit and program disallowances of $753 million ($463 million in FY 2007) and $2,760 million ($1,239 million in FY 2007) for reimbursement of state plan amendments. Contingent liabilities have been established as a result of Medicaid audit and program disallowances that are currently being appealed by the States. 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. There are also outstanding reviews of the State expenditures in which a final determination has not been made. Examples of these reviews are the Office of Inspector General Audits, Focused Financial Management Reviews, and Quarterly Medicaid Statement of Expenditures Report (Form CMS-64) reviews. The appropriate Center for Medicaid & State Operations (CMSO) Regional Office is responsible for reviewing the findings and recommendations. The monetary effect of these reviews is not known until a final decision is determined and rendered by the Director of CMSO. The outcome of these reviews is that CMS could be owed funds.

As of September 30, 2008, CMS did not accrue an amount for a contingent liability for asserted and unasserted claims that could be owed to States arising from the payment of claims by State Medicaid Programs for beneficiaries who allegedly were eligible for Medicare because CMS management has determined the probability of loss is remote. However, in FY 2007, CMS accrued $1,742 million for this case because one state asserted a claim in a civil action brought in federal district court. The agency intends to vigorously defend against this claim.

The CMS accrued $667 million as of September 30, 2007, for a contingent liability to providers for previous years' disputed cost report adjustments for disproportionate share hospitals. During FY 2008, this case was settled in exchange for payment by CMS for the $667 million.

Appeals at the Provider Reimbursement Review Board

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. However, historical cases that have been appealed and settled by the PRRB are considered in the development of the actuarial Medicare IBNR liability, resulting in a projected liability for the 7,712 cases (6,644 in FY 2007) remaining on appeal as of September 30, 2008. A total of 2,971 new cases (2,901 in FY 2007) were filed in FY 2008. The PRRB rendered decisions on 77 cases (119 in FY 2007) in FY 2008 and 1,826 additional cases (2,024 in FY 2007) were dismissed, withdrawn, or settled prior to an appeal hearing. The PRRB receives no information on the value of these cases that are settled prior to a hearing.

NOTE 7: LIABILITIES NOT COVERED BY BUDGETARY RESOURCES *(Dollars in Millions)*

FY 2008	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	SCHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Intragovernmental:								
Accrued Payroll and Benefits	$2	$4				$6		$6
TOTAL INTRAGOVERNMENTAL	**$2**	**$4**				**$6**		**$6**
Federal Employee and Veterans' Benefits	3	8	$1			12		12
Accrued Payroll and Benefits	10	22	3	$1	$1	37		37
Contingencies			3,513			3,513		3,513
TOTAL LIABILITIES NOT COVERED BY BUDGETARY RESOURCES	**$15**	**$34**	**$3,517**	**$1**	**$1**	**$3,568**		**$3,568**
TOTAL LIABILITIES COVERED BY BUDGETARY RESOURCES	**$43,797**	**$51,101**	**$20,415**	**$334**	**$212**	**$115,859**	**$(48,275)**	**$67,584**
TOTAL LIABILITIES	**$43,812**	**$51,135**	**$23,932**	**$335**	**$213**	**$119,427**	**$(48,275)**	**$71,152**

FY 2007	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	SCHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Intragovernmental:								
Accrued Payroll and Benefits	$1	$3				$4		$4
TOTAL INTRAGOVERNMENTAL	**$1**	**$3**				**$4**		**$4**
Federal Employee and Veterans' Benefits	3	7	$1			11		11
Accrued Payroll and Benefits	9	22	2			33		33
Contingent Liabilities	1,813	596	1,702			4,111		4,111
TOTAL LIABILITIES NOT COVERED BY BUDGETARY RESOURCES	**$1,826**	**$628**	**$1,705**			**$4,159**		**$4,159**
TOTAL LIABILITIES COVERED BY BUDGETARY RESOURCES	**$49,009**	**$47,230**	**$19,419**	**$289**	**$243**	**$116,190**	**$(53,343)**	**$62,847**
TOTAL LIABILITIES	**$50,835**	**$47,858**	**$21,124**	**$289**	**$243**	**$120,349**	**$(53,343)**	**$67,006**

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

NOTE 8:
NET COST OF OPERATIONS *(Dollars in Millions)*

FY 2008	Medicare (Earmarked)			Health			Consolidated Totals
	HI TF	SMI TF	Total	Medicaid	SCHIP	Other Health	
PROGRAM/ACTIVITY COSTS							
Medicare							
Fee for Service	$171,361	$138,180	$309,541				$309,541
Medicare Advantage	46,672	45,113	91,785				91,785
Prescription Drug (Part D)		43,285	43,285				43,285
Medicaid/SCHIP/State Grants & Demos				$200,704	$6,945	$414	208,063
CLIA						144	144
TOTAL PROGRAM/ACTIVITY COSTS	**$218,033**	**$226,578**	**$444,611**	**$200,704**	**$6,945**	**$558**	**$652,818**
OPERATING COSTS							
Medicare Integrity Program	$1,121		$1,121				$1,121
Quality Improvement Organizations	326	$61	387				387
Bad Debt Expense and Writeoffs	(71)	64	(7)	$146		$17	156
Reimbursable Expenses	1	5	6	1			7
Administrative Expenses	1,015	1,999	3,014	253	$35	34	3,336
Depreciation and Amortization	22	34	56	4			60
Imputed Cost Subsidies	8	17	25	2			27
TOTAL OPERATING COSTS	**$2,422**	**$2,180**	**$4,602**	**$406**	**$35**	**$51**	**$5,094**
TOTAL COSTS	**$220,455**	**$228,758**	**$449,213**	**$201,110**	**$6,980**	**$609**	**$657,912**
LESS: EXCHANGE REVENUES:							
Medicare Premiums	$2,707	$51,270	$53,977				$53,977
CLIA Revenues						$158	158
Other Exchange Revenues	56	125	181	$16	$2	21	220
TOTAL EXCHANGE REVENUES	**$2,763**	**$51,395**	**$54,158**	**$16**	**$2**	**$179**	**$54,355**
TOTAL NET COST OF OPERATIONS	**$217,692**	**$177,363**	**$395,055**	**$201,094**	**$6,978**	**$430**	**$603,557**

FY 2007	Medicare (Earmarked)			Health			Consolidated Totals
	HI TF	SMI TF	Total	Medicaid	SCHIP	Other Health	
PROGRAM/ACTIVITY COSTS							
Medicare							
Fee for Service	$171,267	$132,229	$303,496				$303,496
Medicare Advantage	37,949	36,282	74,231				74,231
Prescription Drug (Part D)		35,207	35,207				35,207
Medicaid/SCHIP/State Grants & Demos				$187,759	$6,005	$512	194,276
CLIA						120	120
TOTAL PROGRAM/ACTIVITY COSTS	**$209,216**	**$203,718**	**$412,934**	**$187,759**	**$6,005**	**$632**	**$607,330**
OPERATING COSTS							
Medicare Integrity Program	$998		$998				$998
Quality Improvement Organizations	329	$63	392				392
Bad Debt Expense and Writeoffs	51	501	552	$(28)		$17	541
Reimbursable Expenses	1	3	4				4
Administrative Expenses	901	1,944	2,845	203	$5	1	3,054
Depreciation and Amortization	26	40	66	5			71
Imputed Cost Subsidies	7	19	26	2			28
TOTAL OPERATING COSTS	**$2,313**	**$2,570**	**$4,883**	**$182**	**$5**	**$18**	**$5,088**
TOTAL COSTS	**$211,529**	**$206,288**	**$417,817**	**$187,941**	**$6,010**	**$650**	**$612,418**
LESS: EXCHANGE REVENUES:							
Medicare Premiums	$2,835	$47,407	$50,242				$50,242
CLIA Revenues						$138	138
Other Exchange Revenues	8	16	24	$1		75	100
TOTAL EXCHANGE REVENUES	**$2,843**	**$47,423**	**$50,266**	**$1**		**$213**	**$50,480**
TOTAL NET COST OF OPERATIONS	**$208,686**	**$158,865**	**$367,551**	**$187,940**	**$6,010**	**$437**	**$561,938**

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 State Grants and Demonstrations programs based on the CMS cost allocation system. Administrative costs allocated to the Medicare program include $1,830 million ($1,748 million in FY 2007) paid to Medicare contractors to carry out their responsibilities as CMS' agents in the administration of the Medicare program.

For reporting purposes, Medicare Part D expense has been reduced by actual and accrued reimbursements made by the States pursuant to the State Phased-Down provision. The FY 2008 Part D expense of $43,285 million ($35,207 million in FY 2007) is net of State reimbursements of $7,054 million ($6,854 million in FY 2007). The gross FY 2008 expense would have been $50,339 million in FY 2008 ($42,061 million in FY 2007).

NOTE 9: TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT *(Dollars in Millions)*

FY 2008

Transfers-in Without Reimbursement	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	SCHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Medicare Benefit Transfers	$225,199	$233,188				$458,387	$(458,387)	
Transfers to HCFAC	1,107					1,107	(1,107)	
Federal Matching Contributions		144,888				144,888	(144,888)	
Medicare Part D Benefits		35,157				35,157	(35,157)	
Medicare Part D Administrative		389				389	(389)	
Allocation to CMS Programs	846	1,936	$265	$49	$71	3,167	(3,167)	
Fraud and Abuse Appropriation	121					121	(121)	
Transfer-Uninsured Coverage	506					506	(506)	
Prog. Mngmt. Admin. Expense *(1)*	192					192	(192)	
Income Tax OASDI Benefits *(2)*	11,733					11,733	(11,733)	
Railroad Retirement Board	551					551		$551
Criminal Fines	22					22	(22)	
Medicaid Part B Premiums			396			396	(396)	
Medicare Advantage Stabilization	20	19				39	(39)	
Interest Adjustments	(855)	812				(43)		(43)
Miscellaneous	1	2				3		3
TOTAL TRANSFERS-IN	**$239,443**	**$416,391**	**$661**	**$49**	**$71**	**$656,615**	**$(656,104)**	**$511**

FY 2008

Transfers-out Without Reimbursement	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	SCHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
SSA Administrative Expenses	$(830)	$(973)				$(1,803)		$(1,803)
Medicare Benefit Transfers	(225,199)	(233,188)				(458,387)	$458,387	
Transfers to HCFAC	(1,107)					(1,107)	1,107	
Federal Matching Contributions		(144,888)				(144,888)	144,888	
Medicare Part D Benefits		(35,157)				(35,157)	35,157	
Medicare Part D Administrative		(389)				(389)	389	
Transfers to Program Management	(998)	(2,169)				(3,167)	3,167	
Fraud and Abuse Appropriation	(121)					(121)	121	
Transfer-Uninsured Coverage	(506)					(506)	506	
Prog. Mngmt. Admin. Expense *(1)*	(192)					(192)	192	
Income Tax OASDI Benefits *(2)*	(11,733)					(11,733)	11,733	
Criminal Fines	(22)					(22)	22	
Medicaid Part B Premiums		(396)				(396)	396	
Medicare Advantage Stabilization	(20)	(19)				(39)	39	
Office of the Secretary	(38)	(35)				(73)		(73)
Payment Assessment Commission	(6)	(4)				(10)		(10)
Railroad Retirement Board		(7)				(7)		(7)
TOTAL TRANSFERS-OUT	**$(240,772)**	**$(417 225)**				**$(657,997)**	**$656,104**	**$(1,893)**
TOTAL TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT	**$(1,329)**	**$(834)**	**$661**	**$49**	**$71**	**$(1,382)**		**$(1,382)**

FY 2007

Transfers-in Without Reimbursement	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	SCHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Medicare Benefit Transfers	$204,338	$231,849				$436,187	$(436,187)	
Transfers to HCFAC	1,094					1,094	(1,094)	
Federal Matching Contributions		137,822				137,822	(137,822)	
Medicare Part D Benefits		40,342				40,342	(40,342)	
Medicare Part D Administrative		1,017				1,017	(1,017)	
Allocation to CMS Programs	836	2,121	$223	$6	$1	3,187	(3,187)	
Fraud and Abuse Appropriation	118					118	(118)	
Transfer-Uninsured Coverage	468					468	(468)	
Prog. Mngmt. Admin. Expense *(1)*	175					175	(175)	
Income Tax OASDI Benefits *(2)*	10,593					10,593	(10,593)	
Railroad Retirement Board	494					494		$494
Criminal Fines	208					208	(208)	
Medicaid Part B Premiums			359			359	(359)	
Interest Adjustment	3	(6)				(3)		(3)
Miscellaneous	1	1				2		2
TOTAL TRANSFERS-IN	**$218,328**	**$413,146**	**$582**	**$6**	**$1**	**$632,063**	**$(631,570)**	**$493**

FY 2007

Transfers-out Without Reimbursement	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	SCHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
SSA Administrative Expenses	$(679)	$(877)				$(1,556)		$(1,556)
Medicare Benefit Transfers	(204,338)	(231,849)				(436,187)	$436,187	
Transfers to HCFAC	(1,094)					(1,094)	1,094	
Federal Matching Contributions		(137,822)				(137,822)	137,822	
Medicare Part D Benefits		(40,342)				(40,342)	40,342	
Medicare Part D Administrative		(1,017)				(1,017)	1,017	
Transfers to Program Management	(824)	(2,363)				(3,187)	3,187	
Fraud and Abuse Appropriation	(118)					(118)	118	
Transfer-Uninsured Coverage	(468)					(468)	468	
Prog. Mngmt. Admin. Expense *(1)*	(175)					(175)	175	
Income Tax OASDI Benefits *(2)*	(10,593)					(10,593)	10,593	
Criminal Fines	(208)					(208)	208	
Medicaid Part B Premiums		(359)				(359)	359	
Office of the Secretary	(36)	(33)				(69)		(69)
Payment Assessment Commission	(6)	(4)				(10)		(10)
Railroad Retirement Board		(6)				(6)		(6)
TOTAL TRANSFERS-OUT	**$(218 539)**	**$(414,672)**				**$(633,211)**	**$631,570**	**$(1,641)**
TOTAL TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT	**$(211)**	**$(1,526)**	**$582**	**$6**	**$1**	**$(1,148)**		**$(1,148)**

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

(1) During FY 2008, the Payments to the Health Care Trust Funds appropriation paid the HI trust fund $192 million ($175 million in FY 2007) to cover the Medicaid, SCHIP, and State Grants and Demonstrations 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.

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 $93.50 from October 2007 through December 2007 and $96.40 from January 2008 through September 2008. Premiums collected from beneficiaries totaled $49,366 million ($45,743 million in FY 2007) and were matched by a $144,888 million ($137,822 million in FY 2007) contribution from the Federal government.

Part D Transfers-In

Part D benefits and administrative expenses are financed by the general fund appropriation, Payments to the Health Care Trust Funds. As of September 30, 2008, approximately $35,546 million has been transferred-in ($41,359 million in FY 2007) to Part D from the general fund.

NOTE 10: BUDGETARY FINANCING SOURCES: OTHER ADJUSTMENTS *(Dollars in Millions)*

FY 2008	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	SCHIP	Other Health	Consolidated Total
Unexpended Appropriations						
Withdrawal of Expired or Canceled Year Authority		$(9,023)		$(652)		$(9,675)
TOTAL OTHER ADJUSTMENTS		**$(9,023)**		**$(652)**		**$(9,675)**

FY 2007	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	SCHIP	Other Health	Consolidated Total
Unexpended Appropriations						
Withdrawal of Expired or Canceled Year Authority	$(33)	$(27,213)		$(585)		$(27,831)
TOTAL OTHER ADJUSTMENTS	**$(33)**	**$(27,213)**		**$(585)**		**$(27,831)**

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 11: EARMARKED FUNDS *(Dollars in Millions)*

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

Balance Sheet as of September 30, 2008

	HI TF	SMI TF	Total Earmarked Funds
ASSETS			
Fund Balance with Treasury	$182	$12,261	$12,443
Investments	322,704	59,761	382,465
Other Assets	23,833	31,113	54,946
TOTAL ASSETS	**$346,719**	**$103,135**	**$449,854**
Entitlement Benefits Due & Payable	$20,979	$23,963	$44,942
Other Liabilities	22,833	27,172	50,005
TOTAL LIABILITIES	**$43,812**	**$51,135**	**$94,947**
Unexpended Appropriations		$12,267	$12,267
Cumulative Results of Operations	$302,907	39,733	342,640
TOTAL LIABILITIES AND NET POSITION	**$346,719**	**$103,135**	**$449,854**

Statement of Net Cost for the Year Ended September 30, 2008

Benefit Expense	$218,033	$226,578	$444,611
Operating Costs	2,422	2,180	4,602
LESS EARNED REVENUES	**$2,763**	**$51,395**	**$54,158**
NET COST OF OPERATIONS	**$217,692**	**$177,363**	**$395,055**

Statement of Changes in Net Position for the Year Ended September 30, 2008

Net Position, Beginning of Period	$294,989	$43,920	$338,909
Taxes and Other Nonexchange Revenue	214,357	2,538	216,895
Other Financing Sources	11,253	182,905	194,158
NET COST OF OPERATIONS	**$217,692**	**$177,363**	**$395,055**
CHANGE IN NET POSITION	**$7,918**	**$8,080**	**$15,998**
NET POSITION, END OF PERIOD	**$302,907**	**$52,000**	**$354,907**

Balance Sheet as of September 30, 2007

	HI TF	SMI TF	Total Earmarked Funds
ASSETS			
Fund Balance with Treasury	$38	$8,755	$8,793
Investments	323,467	39,728	363,195
Other Assets	22,319	43,295	65,614
TOTAL ASSETS	**$345,824**	**$91,778**	**$437,602**
Entitlement Benefits Due & Payable	$19,410	$22,194	$41,604
Other Liabilities	31,425	25,664	57,089
TOTAL LIABILITIES	**$50,835**	**$47,858**	**$98,693**
Unexpended Appropriations		$8,978	$8,978
Cumulative Results of Operations	294,989	34,942	329,931
TOTAL LIABILITIES AND NET POSITION	**$345,824**	**$91,778**	**$437,602**

Statement of Net Cost for the Year Ended September 30, 2007

Benefit Expense	$209,216	$203,718	$412,934
Operating Costs	2,313	2,570	4,883
LESS EARNED REVENUES	**$2,843**	**$47,423**	**$50,266**
NET COST OF OPERATIONS	**$208,686**	**$158,865**	**$367,551**

Statement of Changes in Net Position for the Year Ended September 30, 2007

Net Position, Beginning of Period	$287,852	$41,659	$329,511
Taxes and Other Nonexchange Revenue	204,498	2,100	206,598
Other Financing Sources	11,325	159,026	170,351
NET COST OF OPERATIONS	**$208,686**	**$158,865**	**$367,551**
CHANGE IN NET POSITION	**$7,137**	**$2,261**	**$9,398**
NET POSITION, END OF PERIOD	**$294,989**	**$43,920**	**$338,909**

NOTE 12: INTRAGOVERNMENTAL COSTS AND EXCHANGE REVENUE *(Dollars in Millions)*

FY 2008	Gross Cost			Less: Exchange Revenue			
	Intra-governmental	Public	Total	Intra-governmental	Public	Total	Consolidated Net Cost of Operations
PROGRAM/ACTIVITY COSTS							
GPRA Programs							
Medicare (Earmarked)							
HI TF	$588	$219,867	$220,455	$2	$2,761	$2,763	$217,692
SMI TF	176	228,582	228,758	3	51,392	51,395	177,363
Medicaid	23	201,087	201,110		16	16	201,094
SCHIP	3	6,977	6,980		2	2	6,978
SUBTOTAL	**$790**	**$656,513**	**$657,303**	**$5**	**$54,171**	**$54,176**	**$603,127**
OTHER ACTIVITIES							
CLIA	$30	$114	$144		$158	$158	$(14)
State Grants & Demonstrations	9	456	465	$3	18	21	444
SUBTOTAL	**$39**	**$570**	**$609**	**$3**	**$176**	**$179**	**$430**
PROGRAM/ACTIVITY TOTALS	**$829**	**$657,083**	**$657,912**	**$8**	**$54,347**	**$54,355**	**$603,557**

FY 2007	Gross Cost			Less: Exchange Revenue			
	Intra-governmental	Public	Total	Intra-governmental	Public	Total	Consolidated Net Cost of Operations
PROGRAM/ACTIVITY COSTS							
GPRA Programs							
Medicare (Earmarked)							
HI TF	$445	$211,084	$211,529	$2	$2,841	$2,843	$208,686
SMI TF	167	206,121	206,288	5	47,418	47,423	158,865
Medicaid	18	187,923	187,941		1	1	187,940
SCHIP		6,010	6,010				6,010
SUBTOTAL	**$630**	**$611,138**	**$611,768**	**$7**	**$50,260**	**$50,267**	**$561,501**
OTHER ACTIVITIES							
CLIA	$38	$82	$120		$138	$138	$(18)
State Grants & Demonstrations		530	530	$58	17	75	455
SUBTOTAL	**$38**	**$612**	**$650**	**$58**	**$155**	**$213**	**$437**
PROGRAM/ACTIVITY TOTALS	**$668**	**$611,750**	**$612,418**	**$65**	**$50,415**	**$50,480**	**$561,938**

The chart above displays gross costs and earned revenue with Federal agencies and the public by budget functional classification. The intragovernmental expenses relate to the source of services purchased by CMS, and not to the classification of related revenue. The classification of revenue or cost being identified as “intragovernmental” or with the “public” is defined on a transaction by transaction basis.

NOTE 13: STATEMENT OF BUDGETARY RESOURCES DISCLOSURES *(Dollars in Millions)*

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

FY 2008	Direct	Reimbursable	Combined Totals
Category A	$58,485	$160	$58,645
Category B	395,061	28	395,089
Exempt	430,446		430,446
TOTAL	**$883,992**	**$188**	**$884,180**

FY 2007	Direct	Reimbursable	Combined Totals
Category A	$59,887	$148	$60,035
Category B	385,088	46	385,134
Exempt	401,037		401,037
TOTAL	**$846,012**	**$194**	**$846,206**

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 $329,970 million as of September 30, 2008 ($313,882 million in FY 2007) are included in Investments on the Balance Sheets. The following table presents trust fund activities and balances for FY 2008 and FY 2007 (in millions):

	FY 2008 Combined Balance	FY 2007 Combined Balance
TRUST FUND BALANCE, BEGINNING	**$313,882**	**$292,426**
Receipts	434,263	410,518
Less Obligations	418,175	389,062
Less Transfers		
Excess of Receipts Over Obligations	16,088	21,456
TRUST FUND BALANCE, ENDING	**$329,970**	**$313,882**

Beginning Balances of Budgetary Resources

The FY 2008 beginning balance of the Unobligated Balance Brought Forward on the SBR was adjusted by $425 million. This was a result of an adjustment to prior year allocation of administrative funds for the Medicare Part D program. The decreased amount of the unobligated balance was not available for FY 2008. The Treasury Accounting Scenario, "Adjustments for Changes to Prior-Year Allocation of Budgetary Resources," covers multi-year funds, but does not appropriately treat annual trust funds such as the Part D Program. A new scenario for the annual trust fund allocation adjustment transactions in FY 2008 was established as a result. Therefore, this beginning balance adjustment is a one-time occurrence, and OMB and Treasury concur with CMS' presentation.

Explanations of Differences Between the Statement of Budgetary Resources and the Budget of the United States Government for FY 2007

(in millions)

	Budgetary Resources	Obligations Incurred	Offsetting Receipts	Net Outlays
Statement of Budgetary Resources	$861,366	$846,206	$256,204	$826,667
Unobligated Balances Not Available	(1,317)			
Other Adjustments	2,057	1,813		2,736
PRESIDENT'S BUDGET (actual)	**$862,106**	**$848,019**	**$256,204**	**$829,403**

The Other Adjustments Line for Budgetary Resources includes an increase in the amount of $2,928 million for the amounts reported in the President's Budget but reported on the Centers for Disease Control (CDC) SBR; a reclassification during the preparation of the President's Budget of the Stabilization Fund in the amount of $24 million from a special fund requiring non-expenditure transfers to an expenditure fund requiring expenditure transfers; amounts that are appropriately reported on the SBR but not included as new budgetary resources in the President's Budget (obligations incurred line for expired accounts in the amount of ($947) million, cancellations of expired years in the HI and SMI trust funds in the amount of $59 million; and an adjustment made during the President's Budget in the amount of ($7) million to Transitional Assistance.

The Other Adjustments Line for Obligations Incurred includes an increase of $2,736 for the amounts reported in the President's Budget but reported on the CDC SBR; a reclassification during the preparation of the President's Budget of the Stabilization Fund in the amount of $24 million from a special fund requiring non-expenditure transfers to an expenditure fund requiring expenditure transfers; and the obligations incurred line for expired accounts in the amount of ($947) million that are appropriately reported on the SBR but not included as new obligations incurred in the President's Budget.

The Other Adjustments Line for Net Outlays includes an increase to net outlays in the amount of $2,736 million for the amounts reported in the President's Budget but reported on the CDC SBR.

The President's Budget with actual numbers for FY 2008 has not yet been published. It is expected that the OMB will publish the FY 2008 numbers in January 2009 and will be available from OMB.

Undelivered Orders at the End of the Period

The amount of budgetary resources obligated for undelivered orders totaled $6,928 million at September 30, 2008 ($7,295 million in FY 2007).

NOTE 14: STATEMENT OF SOCIAL INSURANCE

The Statement of Social Insurance (SOSI) presents the projected 75-year actuarial present value of the income and expenditures of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds. Future expenditures are expected to arise from the health care payment provisions specified in current law for current and future program participants and from associated administrative expenses. Actuarial present values are computed on the basis of the intermediate set of assumptions specified in the Annual Report of the Board of Trustees. These assumptions represent the Trustees' best estimate of likely future economic, demographic, and healthcare-specific conditions.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. The Trustees' projections are based on the Medicare laws, regulations, and policies in effect on March 25, 2008, and do not reflect any actual or anticipated changes subsequent to that date. (See Note 15 concerning the impact of the Medicare Improvements for Patients and Providers Act of 2008, enacted on July 15, 2008.) The present values are calculated by discounting the future annual amounts of non-interest income and expenditures (including benefit payments as well as administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of FICA and SECA payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of,

beneficiaries and general revenue contributions made on behalf of beneficiaries. Transfers from State governments are also included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

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

Actuarial present values of estimated future income (excluding interest) and estimated future expenditures are presented for three different groups of participants: (1) current participants who have not yet attained eligibility age; (2) current participants who have attained eligibility age; and (3) new entrants, those who are expected to become participants in the future. With the exception of the 2007 projections presented, current participants are the "closed group" of individuals who are at least age 15 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or both. For the 2007 projections, the "closed group" of individuals includes individuals who are at least 18 at the start of the projection period. The age cohort assumptions for the 2008 projections and related balances have been refined as compared to the projections shown in the 2008 Medicare Trustees Report. Since the projection period consists of 75 years, the period covers virtually all of the current participants' working and retirement years.

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

In addition to the actuarial present value of estimated future excess of income (excluding interest) over expenditures for the open group of participants, it is possible to make an analogous calculation for the "closed group" of participants. The "closed group" of participants consists of those who, in the starting year of the projection period, have attained retirement eligibility age or have attained ages 15 through 64 (18 through 64 in the case of the 2007 projections). In order to calculate the actuarial net present value of the excess of future income over future expenditures for the closed group, the actuarial present value of estimated future expenditures for or on behalf of current participants is subtracted from the actuarial present value of future income (excluding interest) for current participants.

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

In order to make projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the trust funds will continue to operate under the law in effect on March 25, 2008. In addition, the estimates depend on many economic, demographic, and healthcare-specific assumptions, including changes in per beneficiary health care cost, wages and the consumer price index (CPI), fertility rates, mortality rates, immigration rates, and interest rates. In most cases, these assumptions vary from year to year during the first 5 to 30 years before reaching their ultimate values for the remainder of the 75-year projection period. The assumed growth rates for per beneficiary health care costs vary throughout the projection period. The most significant underlying assumptions used in the projections of Medicare spending displayed in this section are included in table 1 below. The assumptions underlying the 2008 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2008. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions. Detailed information, similar to that denoted within table 1, for the prior years is publicly available on the CMS website at: **www.cms.hhs.gov/CFOReport/**.

Table 1: Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2008

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
2008	2.06	1,250,000	822.2	1.3	4.1	2.8	2.3	7.1	1.4	2.9	1.9
2010	2.06	1,195,000	812.2	1.3	4.0	2.8	2.7	4.3	3.8	6.4	2.3
2020	2.03	1,130,000	750.5	1.1	3.9	2.8	2.2	4.3	6.1	7.8	2.9
2030	2.01	1,085,000	689.8	1.1	3.9	2.8	2.1	5.6	5.8	5.7	2.9
2040	2.00	1,050,000	635.9	1.1	3.9	2.8	2.2	5.9	5.5	5.3	2.9
2050	2.00	1,035,000	588.6	1.1	3.9	2.8	2.1	4.9	4.9	5.0	2.9
2060	2.00	1,030,000	546.8	1.1	3.9	2.8	2.1	4.8	4.8	4.7	2.9
2070	2.00	1,025,000	509.8	1.1	3.9	2.8	2.1	4.7	4.6	4.5	2.9
2080	2.00	1,025,000	476.8	1.1	3.9	2.8	2.1	4.4	4.3	4.4	2.9

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

The ultimate values of the above-specified assumptions used in determining the estimates for each of the five years presented in the Statement of Social Insurance are listed within table 2 below. They are based on the intermediate assumptions of the respective Medicare Trustees Reports.

Table 2: Significant Ultimate Assumptions Used for the Statement of Social Insurance, FY 2008–2004

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
FY 2008	2.0	1,025,000	476.8	1.1	3.9	2.8	2.1	4.4	4.3	4.4	2.9
FY 2007	2.0	900,000	496.8	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9
FY 2006	2.0	900,000	497.6	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9
FY 2005	1.95	900,000	495.5	1.1	3.9	2.8	1.8	5.2	5.1	5.1	3.0
FY 2004	1.95	900,000	497.2	1.1	3.9	2.8	1.8	5.2	5.1	5.1	3.0

[1] Average number of children per woman. The ultimate fertility rate is assumed to be reached in the 25th year of the projection period.
[2] Includes legal immigration, net of emigration, as well as other, non-legal, immigration. For 2008, the ultimate level of net legal immigration was increased from 600,000 to 750,000 persons per year. In addition, the method for projecting annual net other immigration was changed and it now varies throughout the projection period. So for 2008, the assumption presented is the value assumed in the year 2080. For 2004-2007, the ultimate assumption is displayed and is reached by the 20th year of each projection period.
[3] The age-sex adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.
[4] Difference between percentage increases in wages and the CPI. Except for minor fluctuations, the ultimate assumption is reached within the first 10 years of the projection period.
[5] Average annual wage in covered employment. The ultimate assumption is reached within the first 10 years of the projection period.
[6] Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services. The ultimate assumption is reached within the first 10 years of the projection period.
[7] The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.
[8] These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The annual rate of growth declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.
[9] Average rate of interest earned on new trust fund securities, above and beyond rate of inflation. The ultimate assumption is reached within the first 10 years of each projection period.

Part D Projections

In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the Part D program is still relatively new (having begun operations in January 2006), with very little actual program data currently available. The actual 2006 through 2008 bid submissions by the private plans offering this coverage, together with data on beneficiary enrollment and preliminary data on program spending, have been used in the current projections. Nevertheless, there remains a high level of uncertainty surrounding these cost projections, pending the availability of sufficient data on actual Part D expenditures to establish a trend baseline.

NOTE 15: MEDICARE IMPROVEMENTS FOR PATIENTS AND PROVIDERS ACT OF 2008

On July 15, 2008, the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 was enacted. There were many provisions in MIPPA that affected the Medicare program. These include beneficiary improvements, such as expanded access to care, enrollment assistance and increased coverage. There were also provisions affecting payments to providers, such as physicians and managed care plans. The net overall impact of all MIPPA provisions over the 10-year period from FY 2009-2018 is roughly $25 billion (unaudited) in increased Medicare spending. This represents less than 0.5 percent of total Medicare spending during the same time period.

As described in Note 14, the long-range financial projections underlying the Statement of Social Insurance are drawn from the annual report of the Medicare Board of Trustees to Congress, which was issued on March 25, 2008. These projections are based on an assumption that the Medicare laws, regulations, and policies in effect on that date will continue indefinitely without modification. In practice, the subsequent enactment of MIPPA will have an effect on Medicare expenditures and revenues. Due to the timing, complexity, and scope of the legislation, it is not possible to incorporate the impact of MIPPA into the long-range SOSI projections. The short-range estimates of the Medicare costs and savings under MIPPA, summarized above, provide an indication of the relative financial effect of the legislation. As stated above, the impact these provisions would have on the projections presented in the SOSI are relatively minor.

NOTE 16: SMI PART B PHYSICIAN UPDATE FACTOR

The projected Part B expenditure growth reflected in the accompanying SOSI is significantly reduced as a result of the structure of physician payment updates under current law. In the absence of legislation, this structure would result in multiple years of significant reductions in physician payments, totaling an estimated 41 percent over the next 9 years. Although the Medicare Improvements for Patients and Providers Act of 2008 overrode the payment reductions that would have occurred in July 2008 and again in January 2009, its effects are temporary and do not significantly change the longer-term reduction in physician payments that would result under the current-law physician update formula. Reductions of this magnitude are very unlikely to occur fully. For example, Congress has overridden scheduled negative updates for 2003 through 2009. However, since these reductions are required in the future under the current-law payment system, they are reflected in the accompanying SOSI as required under generally accepted accounting principles. Consequently, the projected actuarial present values of Part B expenditures shown in the accompanying SOSI are likely to be understated.

The potential magnitude of the understatement of Part B expenditures, due to the physician payment mechanism, can be illustrated using two hypothetical examples of changes to current law. These examples were developed by management for illustrative purposes only; the calculations have not been audited; and the examples do not attempt to portray likely or recommended future outcomes. Thus, the illustrations are useful only as general indicators of the substantial impacts that could result from future legislation on physician payments under Medicare and of the broad range of uncertainty associated with such impacts.

Under the Medicare Board of Trustees' projections, the projected 75-year present value of future Part B expenditures is $21.2 trillion. An alternative scenario indicates that if Congress were to set future physician payment updates at zero percent per year, then, absent other provisions to offset these costs, the projected present value would increase to $23.4 trillion. Similarly, if Congress were to set future physician payment updates equal to the Medicare Economic Index (projected to be 2 to 2.5 percent per year), the present value would be $25.4 trillion.

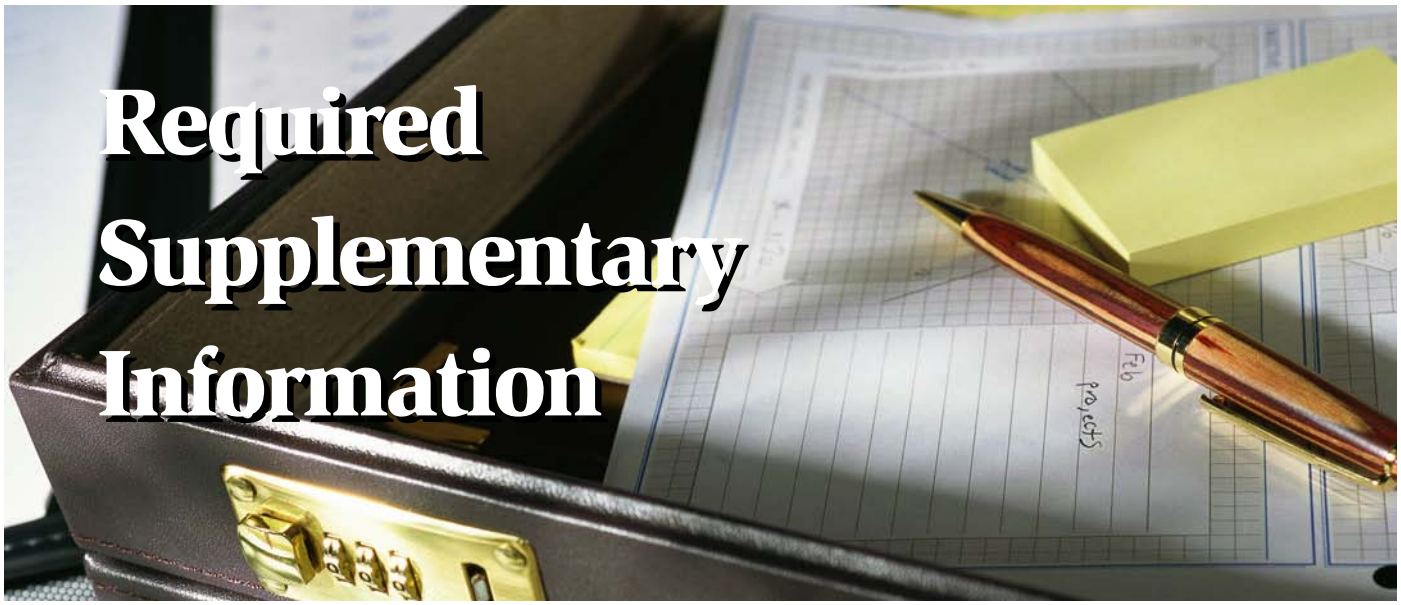
The extent to which actual future Part B costs exceed the projected current-law amounts due to physician payments depends on both the level of physician payment updates that might be legislated and on whether Congress would pass further provisions to help offset such costs (as it did, for example, in the Deficit Reduction Act in 2005 and the Medicare Improvements for Patients and Providers Act in 2008). As noted, these examples only reflect hypothetical changes to physician payments.

It is likely that in the coming years Congress will consider, and pass, numerous other legislative proposals affecting Medicare. Many of these will likely be designed to reduce costs in an effort to make the program more affordable. In practice, it is not possible to anticipate what actions Congress might take, either in the near term or over longer periods.

NOTE 17: RECONCILIATION OF NET COST OF OPERATIONS TO BUDGET *(Dollars in Millions)*

	FY 2008 Consolidated Totals	FY 2007 Consolidated Totals
RESOURCES USED TO FINANCE ACTIVITIES:		
Budgetary Resources Obligated:		
Obligations incurred	$884,180	$846,206
Less: Spending authority from offsetting collections and recoveries	20,662	19,744
Obligations net of offsetting collections and recoveries	863,518	826,462
Less: Distributed offsetting receipts	263,149	256,204
NET OBLIGATIONS	**600,369**	**570,258**
Other Resources:		
Transfers in/out without reimbursement	(1)	(1)
Imputed financing from costs absorbed by others	27	28
NET OTHER RESOURCES USED TO FINANCE ACTIVITIES	**26**	**27**
TOTAL RESOURCES USED TO FINANCE ACTIVITIES	**$600,395**	**$570,285**
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	$98	$(321)
Resources that fund expenses recognized in prior periods		
Budgetary offsetting collections and receipts that do not affect net cost of operations	(4)	(95)
Resources that finance the acquisition of assets	64	57
Other resources or adjustments to net obligated resources that do not affect net cost of operations	1,653	1,460
TOTAL RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS	**1,811**	**1,101**
TOTAL RESOURCES USED TO FINANCE THE NET COST OF OPERATIONS	**$598,584**	**$569,184**
COMPONENTS OF THE NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD:		
Components Requiring or Generating Resources in Future Periods:		
Increase in annual leave liability	$2	
Decrease/(Increase) in receivables from the public	$5,594	$(10,369)
Other	(595)	2,510
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL REQUIRE OR GENERATE RESOURCES IN FUTURE PERIODS	**5,001**	**(7,859)**
Components Not Requiring or Generating Resources:		
Depreciation and amortization	60	72
Other	(88)	541
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES	(28)	613
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD	**$4,973**	**$(7,246)**
NET COST OF OPERATIONS	**$603,557**	**$561,938**

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



Required Supplementary Information

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for over four decades. The 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 prescription drug benefit. A separate Part D account within the SMI trust fund handles the transactions for this coverage. 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 3-6 of this Financial Report.

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

RSI material is generally drawn from the ***2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds***, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

The 2008 Trustees Report, which was issued on March 25, 2008, presents projections that are based on the assumption that the Medicare laws, regulations, and policies in effect on that date will continue indefinitely without modification. However, the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 was enacted on July 15, 2008, and will have an effect on Medicare expenditures and revenues. Due to the timing, complexity, and scope of the legislation, it is not possible to incorporate the impact of MIPPA into the long-range projections. Additional information on this issue is shown in Note 15 on page 58 of this financial report.

The Medicare Trustees emphasize that the SMI Part B expenditures projected under current law are significantly understated. Although MIPPA overrode payment reductions that were scheduled for the second half of 2008 and all of 2009, its effects are temporary and do not significantly change the longer-term reduction in physician payments that would result under the current-law physician update formula. Additional information on this issue is shown in Note 16 on page 58 of this financial report.

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

ACTUARIAL PROJECTIONS

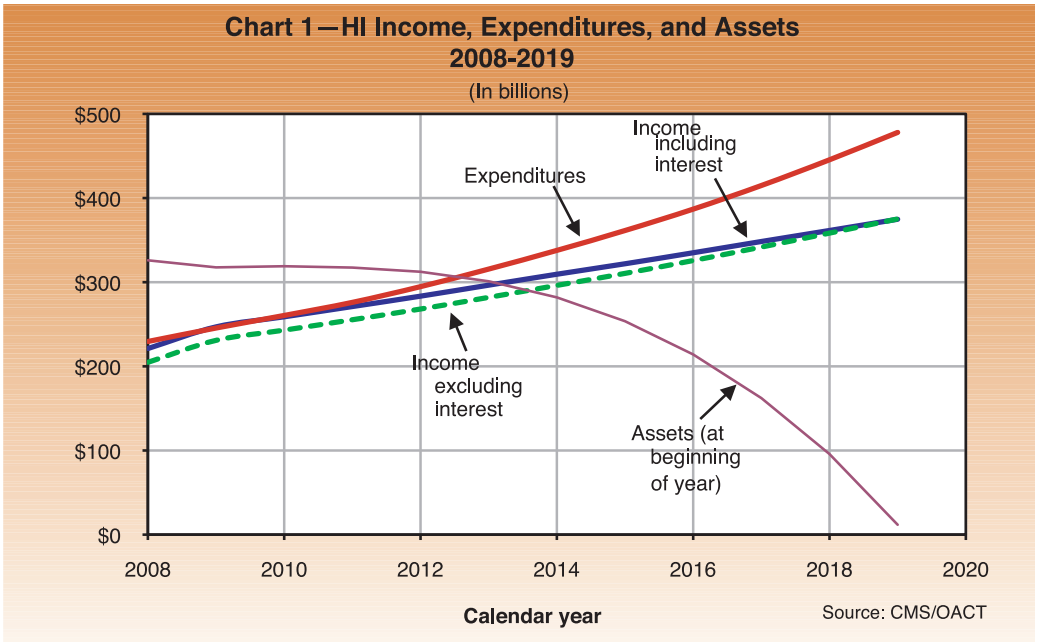
Cashflow in Nominal Dollars

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 can be reasonably comprehended in today's experience.

For this reason, long-range (75-year) Medicare projections in nominal dollars are seldom used and are not presented in this section. Instead, nominal-dollar estimates for the HI trust fund are displayed only through the projected date of depletion, currently the year 2019. Corresponding 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 years 2008 through 2019, 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 HI 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 HI taxpayers or beneficiaries, or both—and consist of payments from, and on behalf of, employees now in the workforce, as well as those who are expected to enter the workforce through 2019. The estimates also include income and expenditures attributable to these current and future workers, in addition to current beneficiaries.



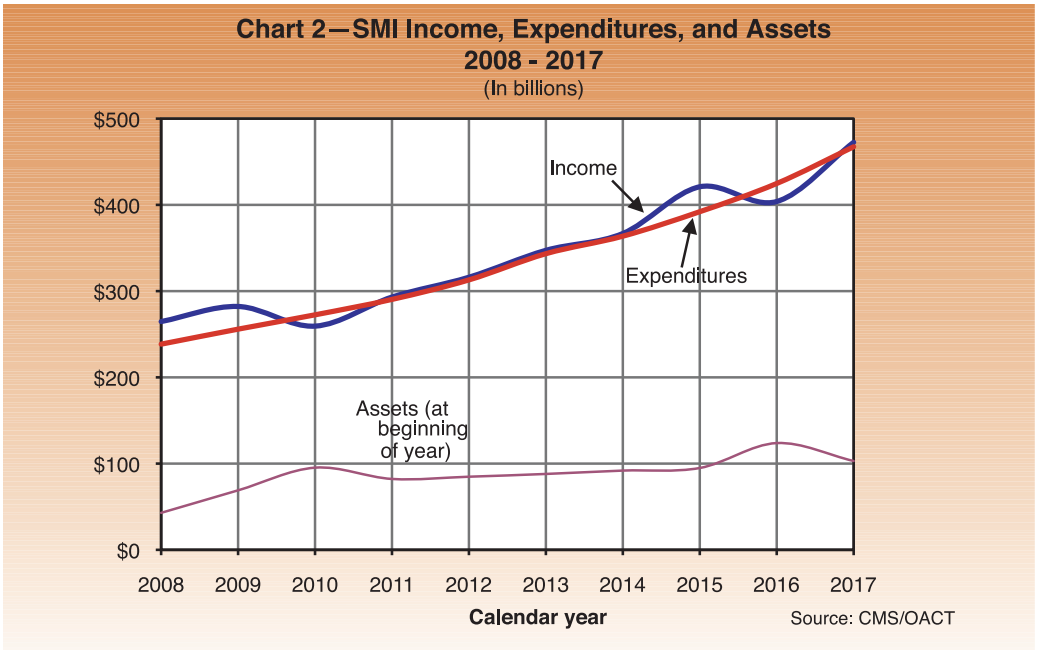
[1] Dollar amounts that are not adjusted for inflation or other factors are referred to as "nominal."

As chart 1 shows, HI expenditures are expected to exceed income excluding interest in 2008 and, under the intermediate assumptions, would begin to exceed income including interest in 2010. 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 HI trust fund would start redeeming its assets; by the end of 2019, the assets would be depleted. For the fifth year in a row, 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 HI trust fund is very sensitive to assumed future economic and other trends. Under less favorable conditions the cash flow could turn negative earlier and thereby accelerate asset exhaustion.

SMI

Chart 2 shows the actuarial estimates of SMI income, expenditures, and assets, for Parts B and D combined, for each of the years 2008 through 2017, in nominal dollars. Whereas HI estimates are displayed through 2019, SMI estimates cover only the years through 2017, 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 based on payroll taxes but rather on a combination of 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.[2] 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 2017.[3]



[2] The Part D account also receives special payments from the States, representing a portion of their forgone Medicaid expenditures attributable to the Medicare drug benefit.

[3] Delivery of Social Security benefit checks normally due January 3, 2010 is expected to occur on December 31, 2009. Consequently, the Part B premiums withheld from the checks and the associated general revenue contributions are expected to be added to the Part B account on December 31, 2009. Likewise, January 3, 2016 will fall on a Sunday, and therefore delivery of the majority of Social Security checks is expected to occur on December 31, 2015. These amounts are excluded from the premium income and general revenue income for 2010 and 2016, resulting in the income pattern shown in chart 2.

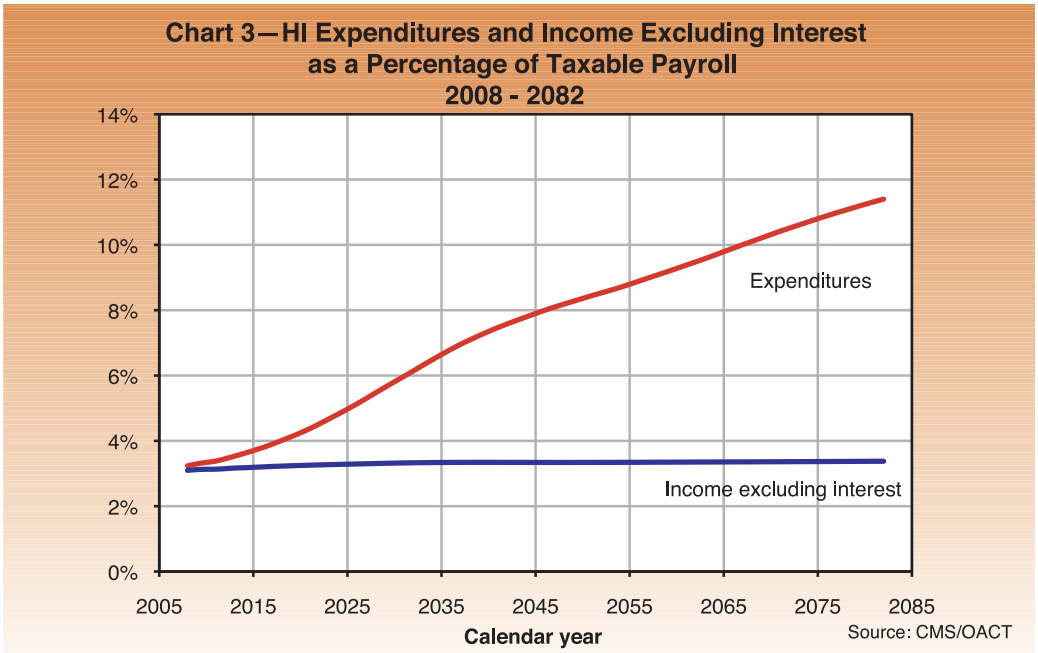
Income includes monthly premiums paid by, or on behalf of, beneficiaries, transfers from the general fund of the U.S. Treasury, certain payments by the States to the Part D account, and interest earned on the U.S. Treasury securities held by the SMI trust fund. Chart 2 displays only total income; it does not separately show income excluding interest. The difference between the two depictions of income is not visible graphically since interest is not a significant source of income.[4] Expenditures include benefit payments as well as administrative expenses.

As chart 2 indicates, SMI income is very close to expenditures. As mentioned earlier, this is because of 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 Percentage of Taxable Payroll

Each year, estimates of the financial and actuarial status of the HI trust fund are prepared for the next 75 years. Because it is difficult to meaningfully compare 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. Prior to the 2006 Trustees Report, the long-range increase in average expenditures per beneficiary was assumed to equal growth in per capita gross domestic product (GDP) plus 1 percentage point. Beginning with the 2006 report, the Board of Trustees adopted a refinement of these long-range growth assumptions. The refinement provides a smoother and more realistic transition from current Medicare cost



[4] Interest income is generally about 1 to 2 percent of total SMI income.

growth rates, which have been significantly above the level of GDP growth, to the ultimate assumed level of GDP plus zero percent for the indefinite future.

Based on these projections, the Medicare Trustees apply a formal test of "long-range close actuarial balance." The HI trust fund fails this test by a wide margin, as it has in almost all previous years.

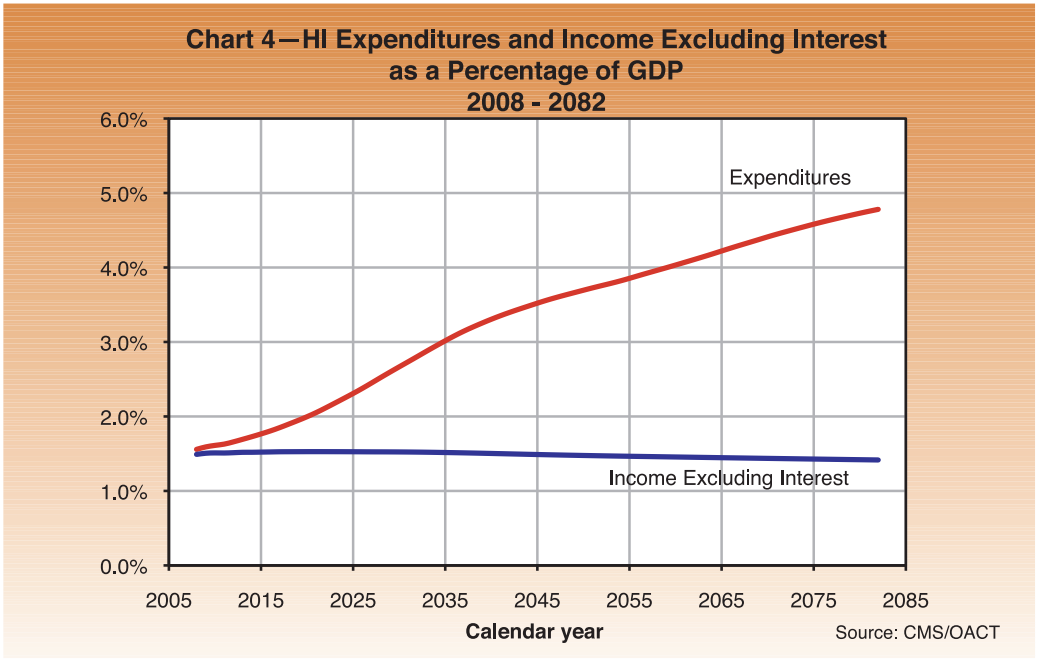
Since HI payroll tax rates are not scheduled to change in the future under present law, payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. Income from taxation of benefits will increase only gradually as a greater proportion of Social Security beneficiaries 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 Percentage of GDP

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

HI

Chart 4 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2007, the expenditures were $203.1 billion, which was 1.5 percent of GDP. This percentage is projected to increase steadily throughout the remainder of the 75-year period.



SMI

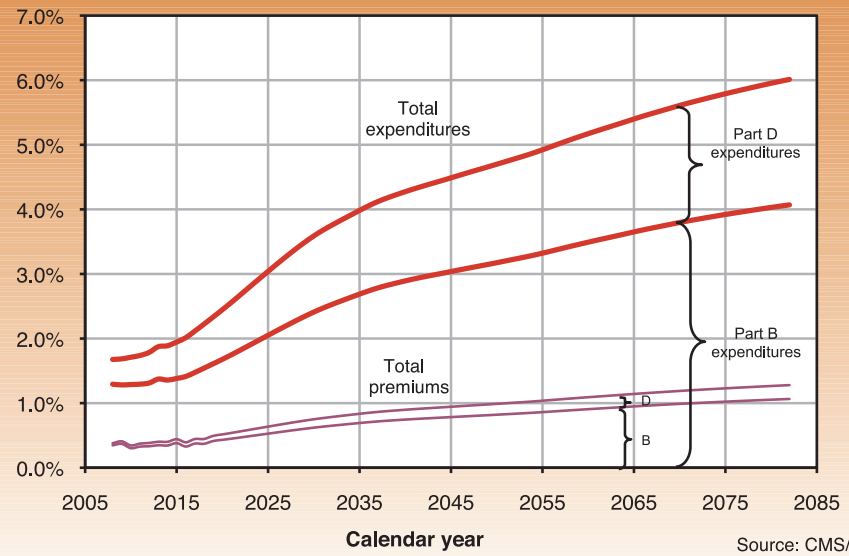
Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long-range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and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

Chart 5 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. As in the projections for HI, the assumed long-range increase in average expenditures per beneficiary was refined in the 2006 Trustees Report. This refinement provides a more gradual transition from current health cost growth rates to the ultimate assumed level of GDP plus zero percent just after the 75th year and for the indefinite future. 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 assumption.

Under the intermediate assumptions, annual SMI expenditures were $228.5 billion, or about 1.7 percent of GDP, in 2007. Then, in about 25 years, they would grow to about 4 percent of GDP and to approximately 6 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. The special State payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the State payments are also expected to increase faster than GDP.

Chart 5—SMI Expenditures and Premiums as a Percentage of GDP 2008 - 2082

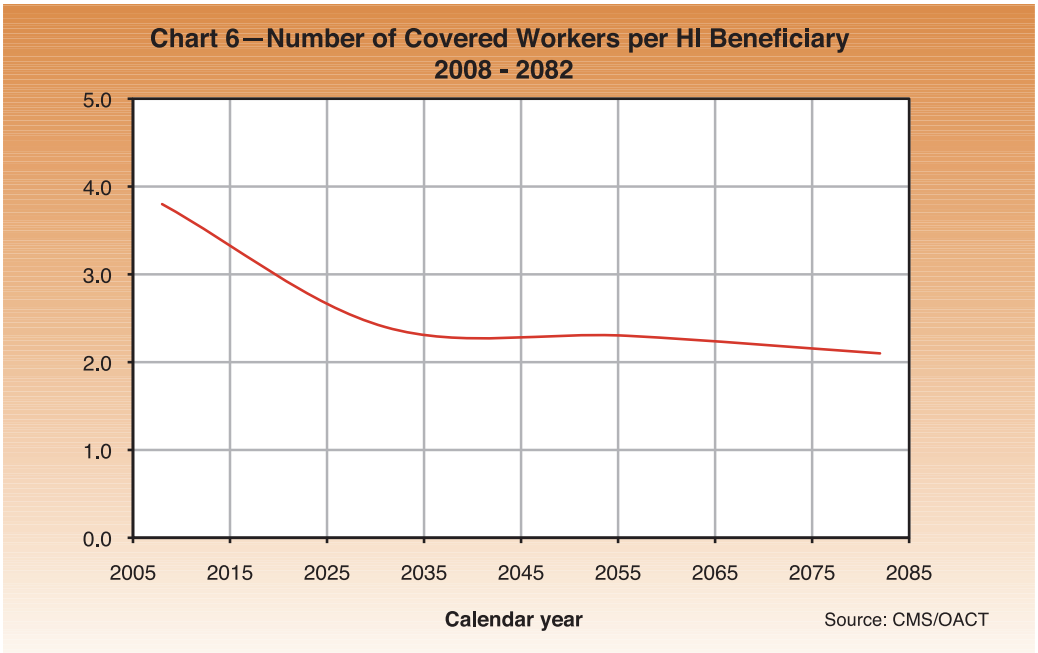


Source: CMS/OACT

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 2007, every beneficiary had 3.8 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 2.1 workers per beneficiary by 2082.



SENSITIVITY ANALYSIS

In order to make projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that both trust funds will continue under present law. In addition, the estimates depend on many economic and demographic assumptions (which are summarized on page 57 of this financial report). Because of revisions to these assumptions, due to either changed conditions or updated information, estimates sometimes change substantially compared to those made in prior years. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty.

In order to illustrate 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.[5] The assumptions varied are the health care cost factors, fertility rate, net immigration, real-wage differential, consumer price index (CPI), and real-interest rate.[6]

For this analysis, the intermediate economic and demographic assumptions in the ***2008 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, 2008 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.[7] The charts depicting the estimated net cashflow indicate that net cashflow decreases steadily through 2082 under all three scenarios displayed. On the present value charts, the same pattern is evident, in most cases, until around 2070, when the present values begin to increase (or become less negative). This occurs as a result of the discounting process used for computing present values, which is used to help interpret the net cashflow deficit in terms of today's dollar. In other words, the amount required today to cover this deficit begins to decrease at the end of the 75-year period.

Health Care Cost Factors

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

TABLE 1
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)*	-$5,083	-$12,737	-$25,196

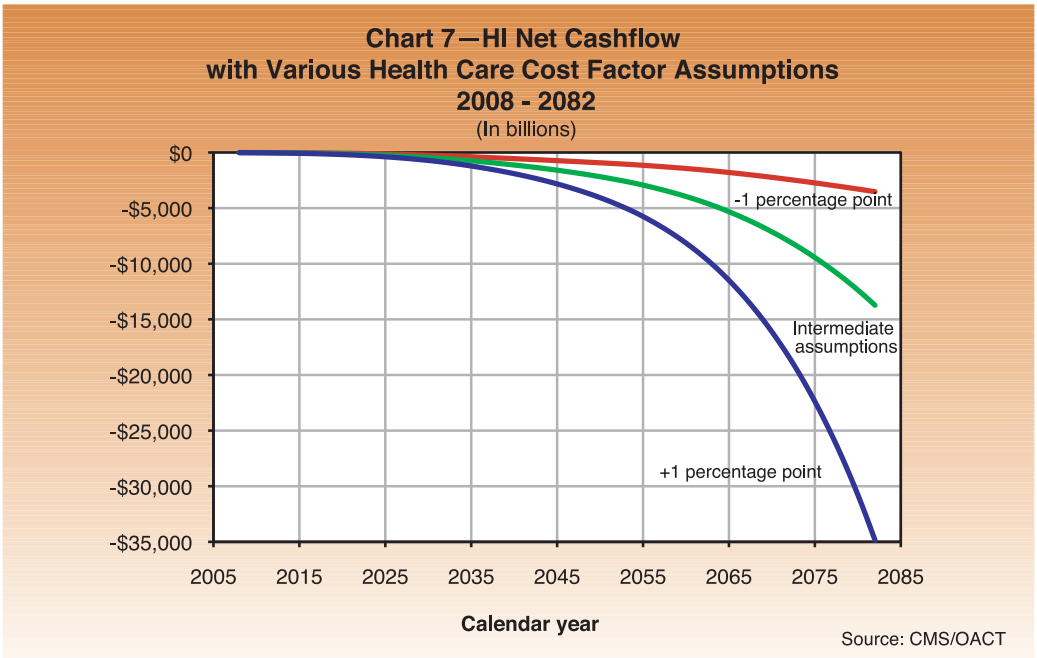
Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $7,654 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases more substantially, by $12,459 billion.

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

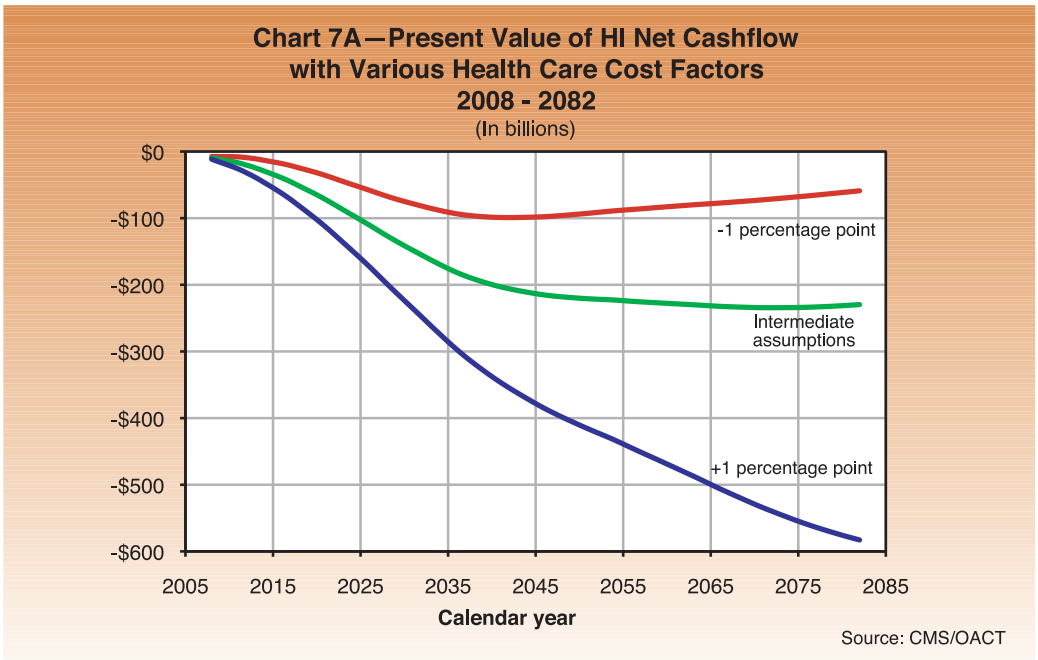
[6] The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures.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

[7] As noted previously, long-range projections expressed in nominal dollar amounts can be very difficult to interpret, due to the changing value of the dollar over time. Amounts expressed in present values are less subject to this difficulty.

Charts 7 and 7A show projections of the net cashflow under the three alternative annual growth rate assumptions presented in table 1.



This assumption has a dramatic impact on projected HI cashflow. 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 7 and 7A indicate, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs.



Fertility Rate

Table 2 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.7, 2.0, and 2.3 children per woman.

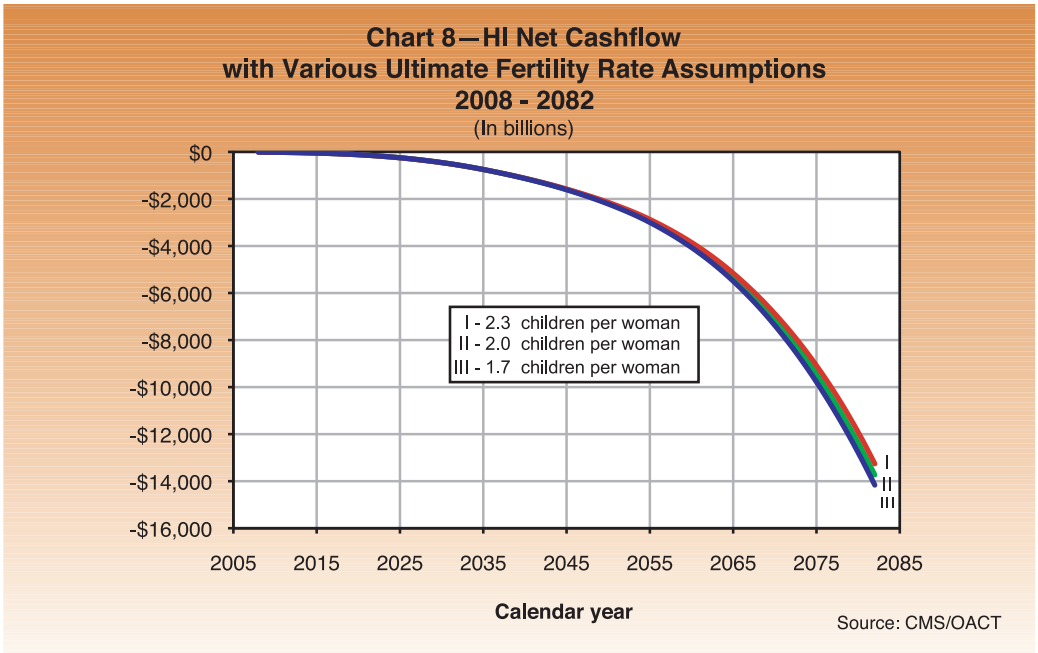
TABLE 2
Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate fertility rate[1]	1.7	2.0	2.3
Income minus expenditures *(in billions)*	-$12,980	-$12,737	-$12,499

[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.

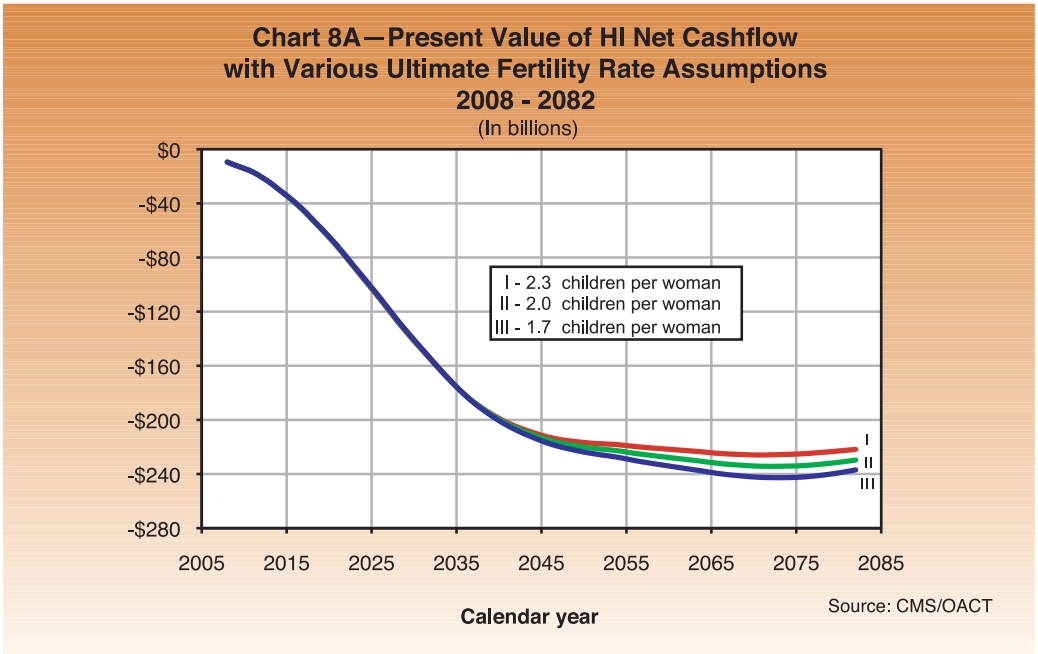
As table 2 demonstrates, for an increase of 0.3 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $240 billion.

Charts 8 and 8A show projections of the net cashflow under the three alternative fertility rate assumptions presented in table 2.



As charts 8 and 8A indicate, the fertility rate assumption has only a negligible impact on projected HI cashflows. 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 impacts are expected to be somewhat greater, as illustrated by the present values in table 2.



Net Immigration

Table 3 shows the net present value of cashflow during the 75-year projection period under three alternative average annual net immigration assumptions: 790,000 persons, 1,070,000 persons, and 1,375,000 persons per year.

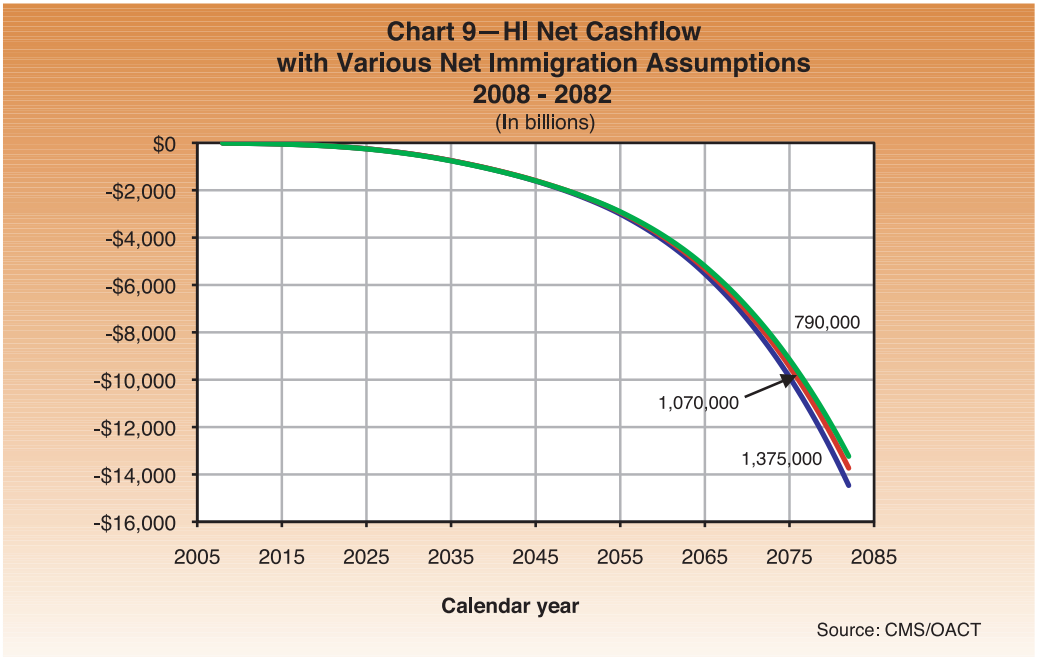
TABLE 3
Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

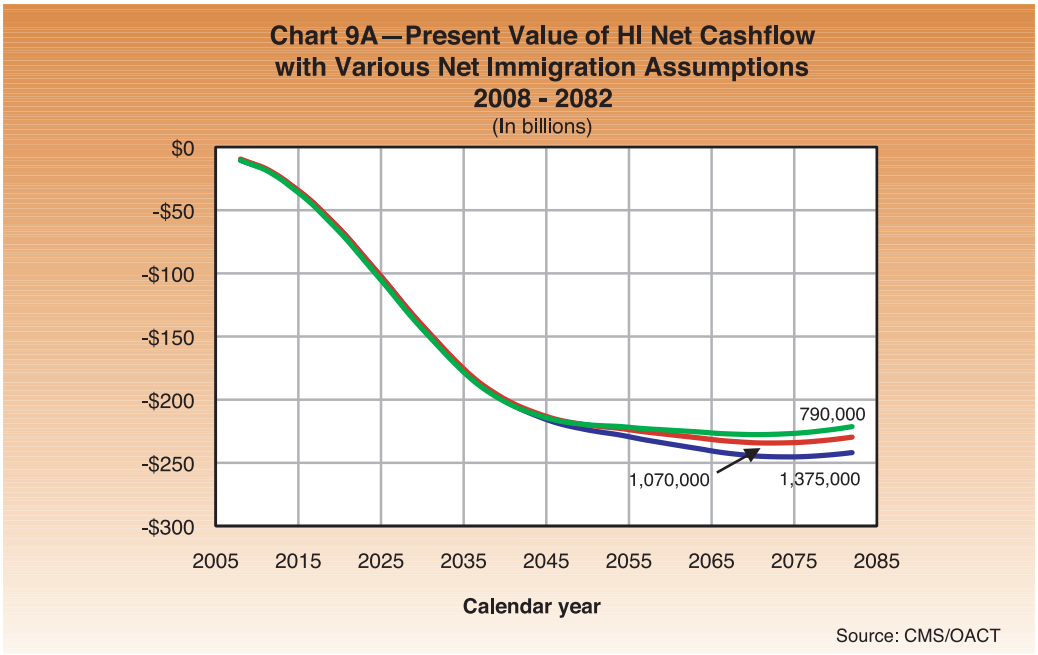
Average annual net immigration	790,000	1,070,000	1,375,000
Income minus expenditures *(in billions)*	-$12,658	-$12,737	-$13,062

As shown in table 3, if the average annual net immigration assumption is 790,000 persons, the deficit decreases by $79 billion. Conversely, if the assumption is 1,375,000 persons, the deficit increases by $325 billion.

Charts 9 and 9A show projections of the net cashflow under the three alternative average annual net immigration assumptions presented in table 3.

As charts 9 and 9A 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; in the long term, however, 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 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential[8] assumptions: 0.6, 1.1, and 1.6

[8] The difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.

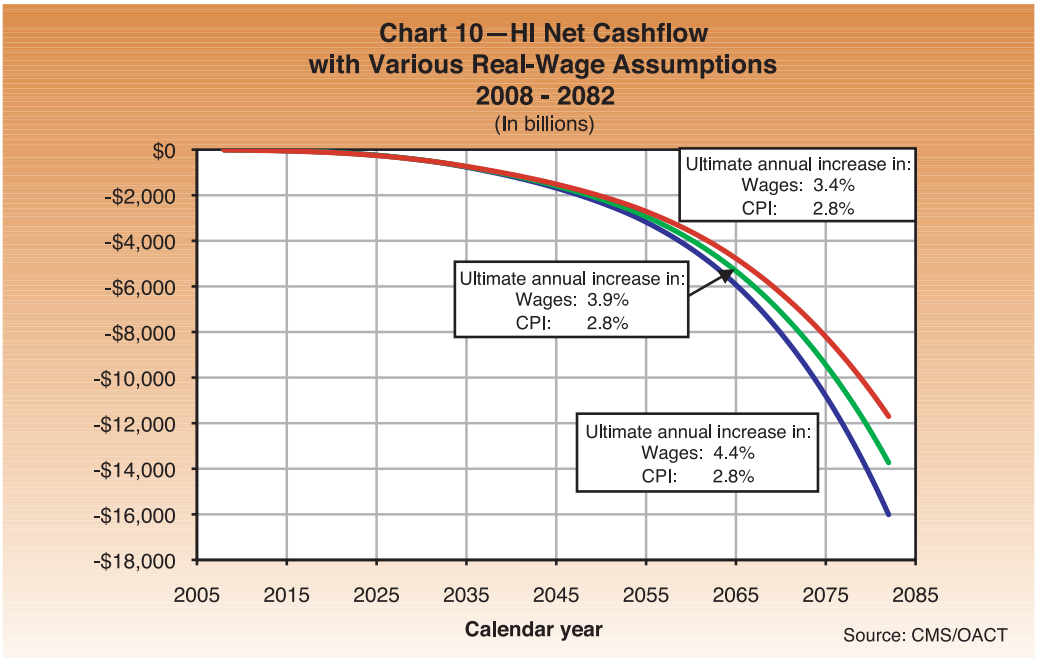
percentage points. In each case, the ultimate CPI-increase is assumed to be 2.8 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.4, 3.9, and 4.4 percent, respectively.

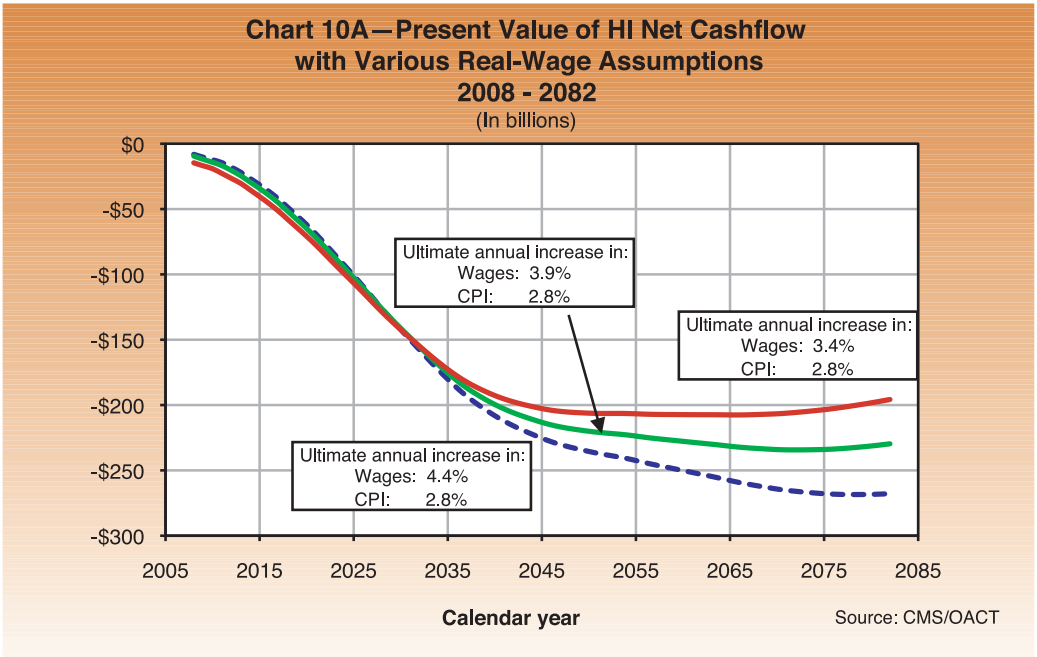
TABLE 4
Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions

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)*	-$11,918	-$12,737	-$13,742
Income minus expenditures *(as a percentage of taxable payroll)*	-3.91%	-3.54%	-3.26%

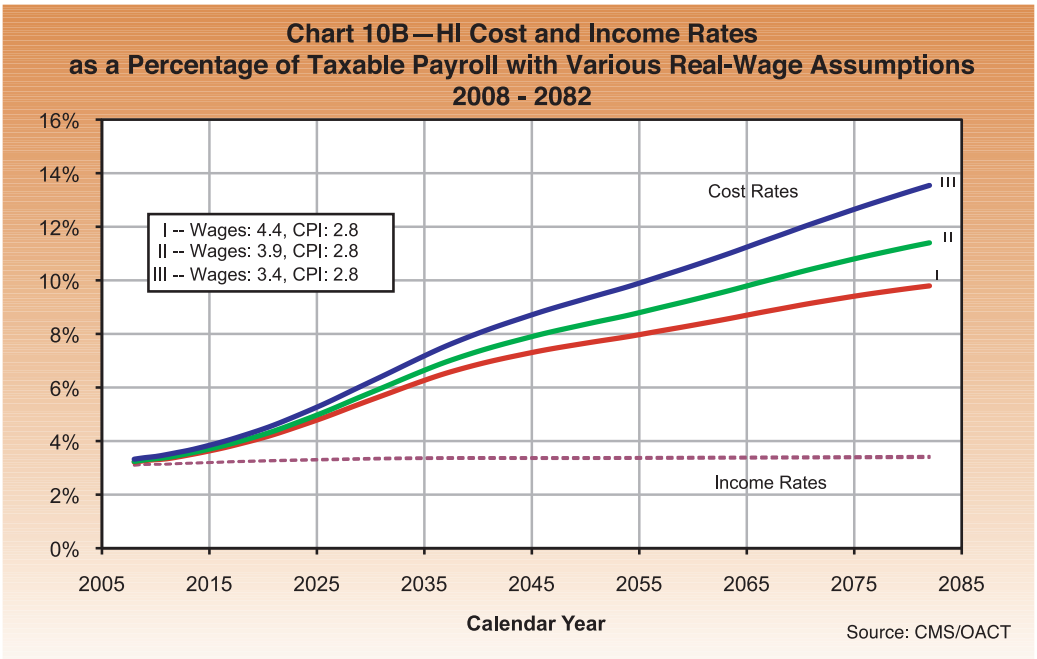
As indicated in table 4, for a half-point increase in the ultimate real-wage differential assumption, the deficit—expressed in present-value dollars—increases by approximately $910 billion. In this instance, the results expressed in present-value dollars do not reveal the full implications of faster or slower growth in real wages. While the dollar amount of the trust fund deficit is lower, for a smaller real-wage differential, table 4 also indicates that the deficit represents a higher percentage of taxable payroll. In other words, with slower growth in real wages, a higher tax increase would be necessary to cover the corresponding HI trust fund deficit. In practice, slow growth in real wages worsens the financial status of the HI trust fund, and, conversely, rapid growth in real wages improves the fund's condition. The reasons for the apparent inconsistency between the present-value and taxable-payroll measures are described below.

Charts 10 and 10A show projections of the net cashflow under the three alternative real-wage differential assumptions presented in table 4.





As noted previously and illustrated in charts 10 and 10A, slower real-wage growth results in smaller HI cashflow deficits, when expressed in either nominal or present-value dollars. While this result appears to suggest that the financial status of the HI trust fund improves with slower real-wage growth, in practice the opposite is true. To better illustrate this result, chart 10B shows projected HI expenditures and tax revenues under the three scenarios, expressed as a percent of taxable payroll.



As indicated in chart 10B, HI expenditures represent a significantly higher proportion of taxable payroll under conditions of slow real-wage growth (and vice versa). HI tax revenues, however, as a percentage of taxable payroll, are largely unaffected. As a result, the HI deficit as a percentage of taxable payroll increases substantially with slow wage growth, and faster real-wage growth leads to lower HI cost rates and deficits.

A higher real-wage differential immediately increases both HI expenditures for health care and wages for all workers. There is a full effect on wages and payroll taxes, but the effect on benefits is only partial, since not all health care costs are wage-related. In dollar terms (either nominal or present-value), expenditures, revenues, deficits, and taxable payroll all increase with faster real-wage growth. In relative terms, however, faster wage growth increases taxable payroll, and thus tax revenues, more than it increases expenditures. This scenario leads to an improved financial status, where a smaller increase in the HI payroll tax rate would be required to attain financial balance. Similarly, slower real-wage growth worsens the financial outlook for the HI trust fund. For these reasons, the dollar cashflow measures required by Federal accounting standards do not adequately describe the sensitivity of the HI financial status to changes in the real-wage assumptions and must be supplemented by other measures.

Consumer Price Index

Table 5 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.

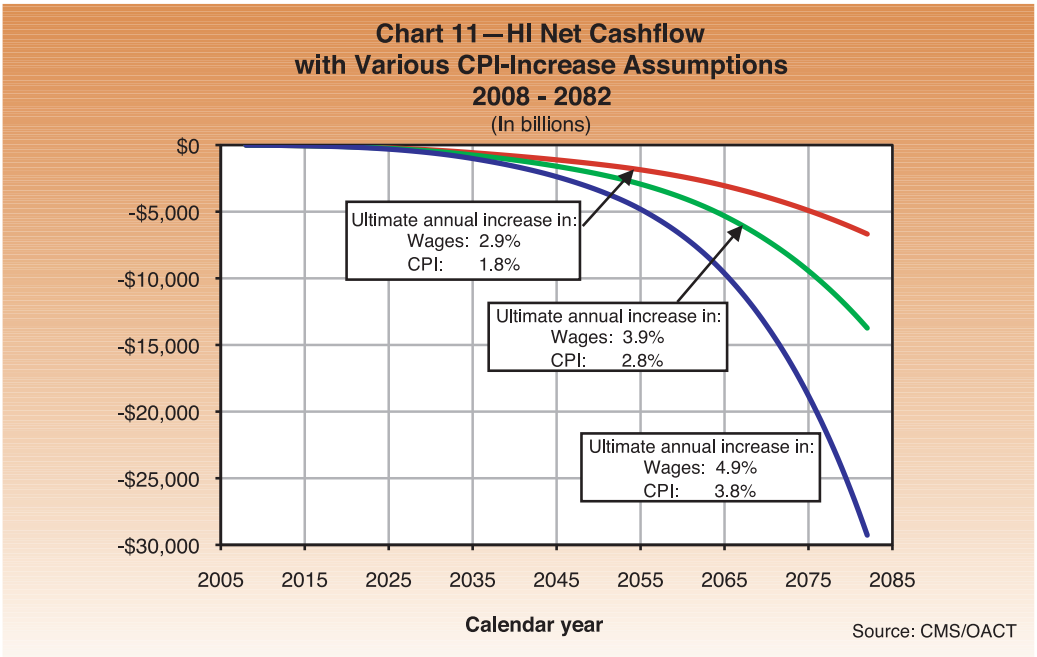
TABLE 5
Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

Ultimate percentage increase in wages - CPI	2.9 - 1.8	3.9 - 2.8	4.9 - 3.8
Income minus expenditures *(in billions)*	-$12,669	-$12,737	-$12,744

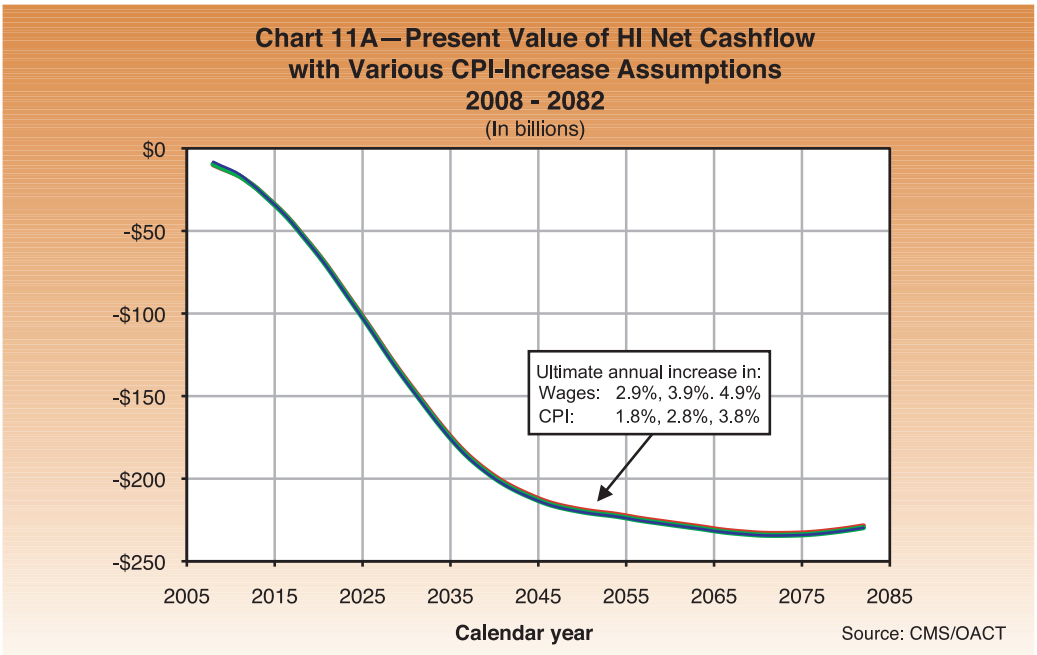
Table 5 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit decreases by $68 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit increases by only $7 billion.

Charts 11 and 11A show projections of the net cashflow under the three alternative CPI rate-of-increase assumptions presented in table 5.

As charts 11 and 11A indicate, this assumption has a large impact on projected HI cashflow in nominal dollars but only a negligible impact when the cashflow is expressed as present values. The relative insensitivity of the projected present values of HI cashflow to different levels of general inflation occurs because inflation tends to affect both income and costs 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

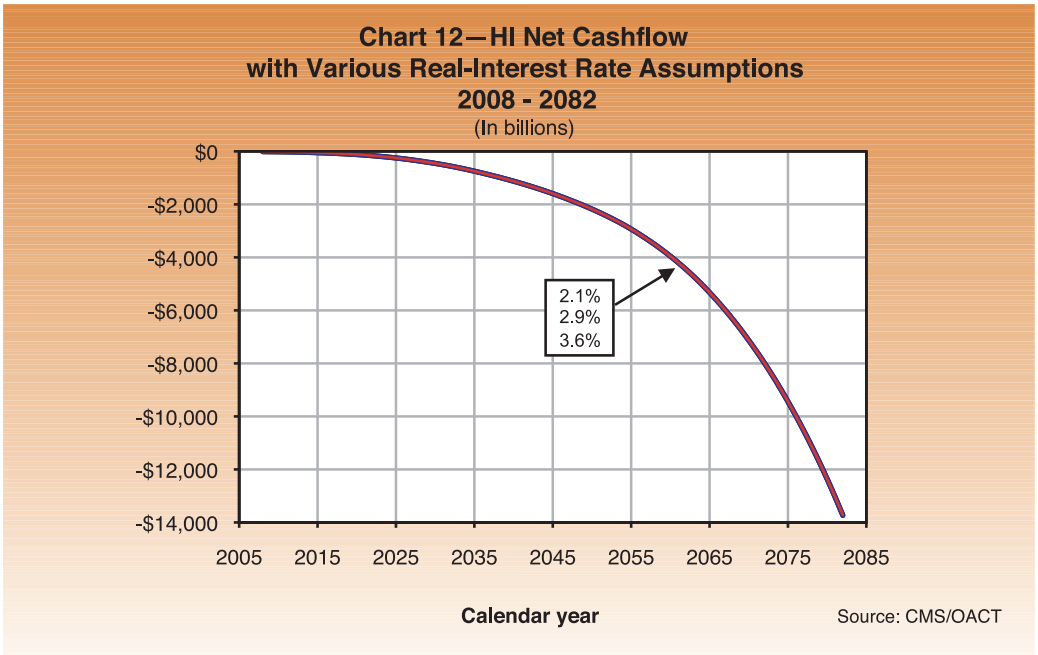
Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.1, 2.9, and 3.6 percent. In each case, the ultimate annual increase in the CPI is assumed to be 2.8 percent, resulting in ultimate nominal annual yields of 4.9, 5.7, and 6.4 percent, respectively.

TABLE 6
Present Value of Estimated HI Income Less Expenditures under Various Real-Interest Assumptions

Ultimate real-interest rate	2.1 percent	2.9 percent	3.6 percent
Income minus expenditures *(in billions)*	-$17,936	-$12,737	-$9,599

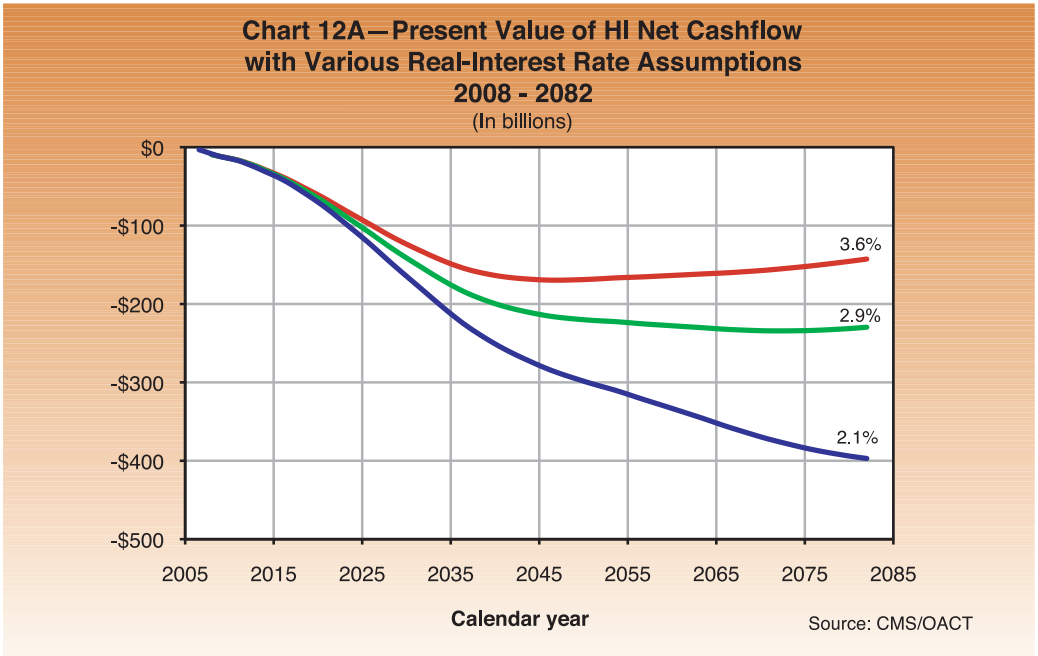
As illustrated in table 6, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $550 billion.

Charts 12 and 12A show projections of the net cashflow under the three alternative real-interest assumptions presented in table 6.



As shown in charts 12 and 12A, the projected HI cashflow when expressed in present values is more sensitive to the interest assumption than when it is expressed in nominal dollars. 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), resulting in a smaller overall net present value.



TRUST FUND FINANCES AND SUSTAINABILITY

HI

Under the Medicare Trustees' intermediate assumptions, the HI trust fund is projected to be exhausted in 2019. Expenditures are projected to exceed total income 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 HI trust fund would initially produce payment delays, but very quickly lead to a curtailment of health care services to beneficiaries. In practice, Congress has never allowed a Medicare or Social Security trust fund to become fully depleted.

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 Part D and Part B accounts, it is necessary to evaluate each account's financial adequacy separately.

The financing established for the Part B account for calendar year 2008 is adequate to cover 2008 expected expenditures and to maintain the financial status of the Part B account in 2008 at a satisfactory level. No financial imbalance is anticipated for the Part D account, since the general revenue subsidy for this benefit is expected to be drawn on a daily, as-needed basis. The projected Part D costs shown in this section are significantly lower than previously estimated, reflecting the latest data on prescription drug costs, higher manufacturer rebates, and lower projected growth in prescription drug spending.

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 SMI trust fund is the impact of the past and expected rapid growth of SMI costs, which place steadily increasing demands on beneficiaries, the Federal Budget, and society at large.

Medicare Overall

The Medicare Modernization Act requires the Board of Trustees to determine whether the difference between Medicare outlays and "dedicated financing sources" is projected to exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2008– 2014).[9] This difference is projected to first exceed 45 percent of total expenditures in 2014, which is within the 7-year test period. Consequently, the Trustees issued a determination of projected "excess general revenue Medicare funding," as required by law. A similar determination was made in their 2006 and 2007 annual reports to Congress. Under the MMA, two consecutive determinations trigger a "Medicare funding warning," indicating that the general revenues provided to Medicare under current law are becoming a substantial proportion of total program costs. This finding requires the President to submit to Congress, within 15 days after the release of the next budget, proposed legislation to respond to the warning.[10] Congress is then required to consider this legislation on an expedited basis. This new requirement will help call attention to Medicare's impact on the Federal Budget.

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 2008 annual report to Congress, the Medicare Boards of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to take "prompt action…to address these challenges." They also stated: "Consideration of such reforms should occur in the relatively near future."

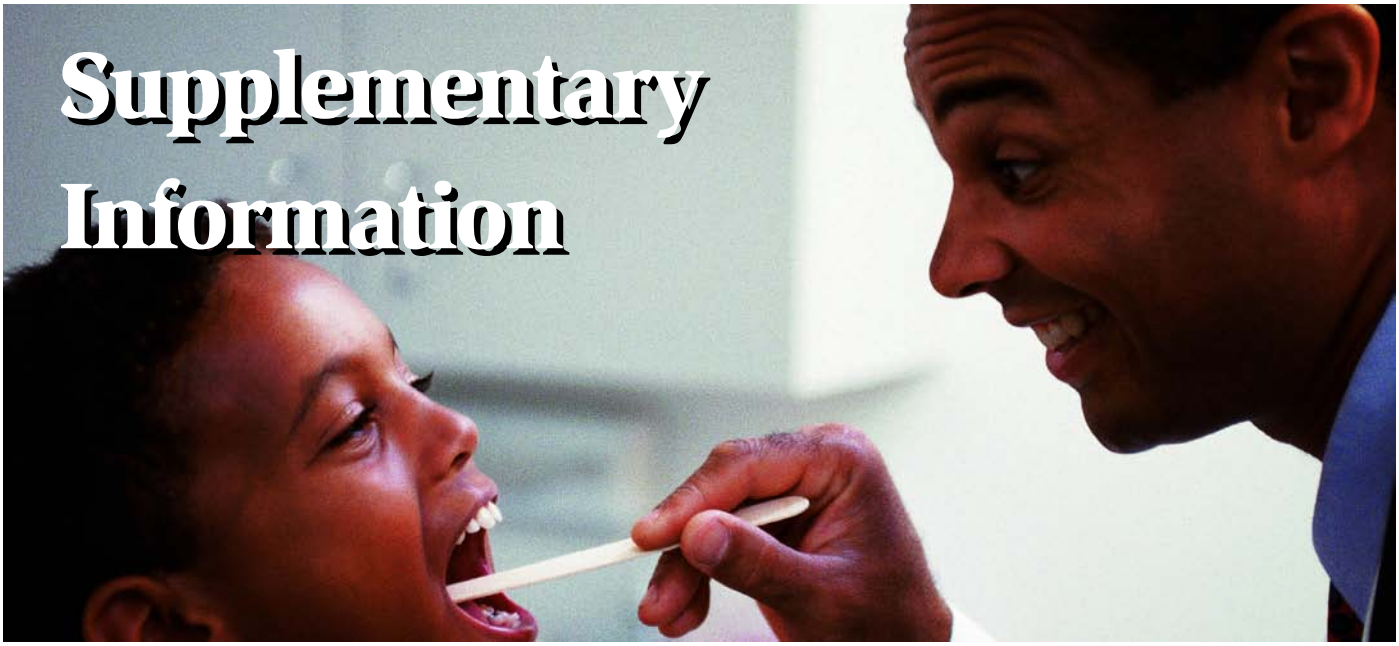
[9] Dedicated Medicare financing sources include HI payroll taxes; income from taxation of Social Security benefits; State transfers for the prescription drug benefit; premiums paid under Parts A, B, and D; and any gifts received by the Medicare trust funds.

[10] The President submitted legislation to Congress to address the "Medicare funding warning" triggered in the 2007 Trustees Report. In order to address the warning triggered in the 2008 report, the President will again be required to submit legislation to Congress, following the February 2009 release of the President's Fiscal Year 2010 Budget.

COMBINING STATEMENT OF BUDGETARY RESOURCES
For the Year Ended September 30, 2008

(in millions)

	MEDICARE		Payments to			Medicare	All	Combined
	HI TF	SMI TF	Trust Funds	Medicaid	SCHIP	Part D	Others	Totals Budgetary
Budgetary Resources:								
Unobligated balance, brought forward, October 1:	$13	$12	$8,977	$3,816	$814	$1	$1,102	$14,735
Recoveries of prior year unpaid obligations	86	135		11,431	195	405	300	12,552
Budget authority:								
Appropriation	233,742	200,521	205,321	206,886	6,640	45,176	1,961	900,247
Spending authority from offsetting collections:								
Earned								
Collected	1					3,894	360	4,255
Change in receivables from Federal sources								
Change in unfilled customer orders:								
Advance received							(3)	(3)
Without advance from Federal sources							232	232
Anticipated for rest of year, without advance								
Previously unavailable								
Expenditure transfers from trust funds	33	30		396			3,167	3,626
SUBTOTAL	**233,776**	**200,551**	**205,321**	**207,282**	**6,640**	**49,070**	**5,717**	**908,357**
Nonexpenditure transfers, net, anticipated & actual	95	(12)		(2,515)				(2,432)
Temporarily not available pursuant to Public Law	(6,555)	(9,580)						(16,135)
Permanently not available	(24)	(37)	(9,023)		(652)		(26)	(9,762)
TOTAL BUDGETARY RESOURCES	**$227,391**	**$191,069**	**$205,275**	**$220,014**	**$6,997**	**$49,476**	**$7,093**	**$907,315**
Status of Budgetary Resources:								
Obligations incurred:								
Direct	$227,357	$191,039	$193,008	$211,296	$6,360	$49,433	$5,499	$883,992
Reimbursable	1						187	188
SUBTOTAL	**227,358**	**191,039**	**193,008**	**211,296**	**6,360**	**49,433**	**5,686**	**884,180**
Unobligated balance:								
Apportioned			12,267	8,718	421		1,277	22,683
Exempt from apportionment						41		41
SUBTOTAL			**12,267**	**8,718**	**421**	**41**	**1,277**	**22,724**
Unobligated balance not available	33	30			216	2	130	411
TOTAL STATUS OF BUDGETARY RESOURCES	**$227,391**	**$191,069**	**$205,275**	**$220,014**	**$6,997**	**$49,476**	**$7,093**	**$907,315**
Change in Obligated Balance:								
Obligated balance, net:								
Unpaid obligations, brought forward, October 1	$20,473	$19,514		$19,415	$4,436	$4,405	$2,740	$70,983
Uncollected customer payments from Federal sources, brought forward, October 1	(1)						(1,785)	(1,786)
Total unpaid obligated balance, net	20,472	19,514		19,415	4,436	4,405	955	69,197
Obligations incurred, net	227,358	191,039	$193,008	211,296	6,360	49,433	5,686	884,180
Gross Outlays	(225,725)	(189,947)	(193,008)	(198,870)	(6,900)	(48,031)	(4,946)	(867,427)
Obligated balance transferred, net:								
Recoveries of prior year unpaid obligations, actual	(86)	(135)		(11,431)	(195)	(405)	(300)	(12,552)
Change in uncollected customer payments from Federal sources	(33)	(30)					(347)	(410)
Obligated balance, net, end of period:								
Unpaid obligations	22,020	20,471		20,410	3,701	5,402	3,180	75,184
Uncollected customer payments from Federal sources	(34)	(30)					(2,132)	(2,196)
Total, unpaid obligated balance, net, end of period	21,986	20,441		20,410	3,701	5,402	1,048	72,988
Net Outlays:								
Net Outlays								
Gross outlays	225,725	189,947	193,008	198,870	6,900	48,031	4,946	867,427
Offsetting collections	(1)			(396)		(3,894)	(3,409)	(7,700)
Distributed offsetting receipts	(19,822)	(243,323)					(4)	(263,149)
NET OUTLAYS	**$205,902**	**$(53,376)**	**$193,008**	**$198,474**	**$6,900**	**$44,137**	**$1,533**	**$596,578**



Supplementary Information

CONSOLIDATING BALANCE SHEET
As of September 30, 2008
(in millions)

	MEDICARE (Earmarked)			HEALTH (Other Funds)			Combined	Intra-CMS	Consolidated
	HI TF	SMI TF	Total	Medicaid	SCHIP	Other Health	Totals	Eliminations	Totals
ASSETS									
Intragovernmental Assets:									
Fund Balance with Treasury	$182	$12,261	$12,443	$29,119	$4,337	$2,113	$48,012		$48,012
Earmarked Investments	322,704	59,761	382,465				382,465		382,465
Accounts Receivable, Net	22,795	25,776	48,571	145	19	51	48,786	$(48,275)	511
Other Assets	17		17				17		17
Total Intragovernmental Assets	**345,698**	**97,798**	**443,496**	**29,264**	**4,356**	**2,164**	**479,280**	**(48,275)**	**431,005**
Cash & Other Monetary Assets	44	310	354				354		354
Accounts Receivable, Net	806	4,085	4,891	2,272		28	7,191		7,191
General Property, Plant & Equipment, Net	145	248	393	33	1	1	428		428
Other Assets	26	694	720	6	1	113	840		840
TOTAL ASSETS	**$346,719**	**$103,135**	**$449,854**	**$31,575**	**$4,358**	**$2,306**	**$488,093**	**$(48,275)**	**$439,818**
LIABILITIES									
Intragovernmental Liabilities:									
Accounts Payable	$22,286	$26,425	$48,711			$2	$48,713	$(48,275)	$438
Accrued Payroll and Benefits	2	4	6				6		6
Other Intragovernmental Liabilities	169	424	593	$4		30	627		627
Total Intragovernmental Liabilities	**22,457**	**26,853**	**49,310**	**4**		**32**	**49,346**	**(48,275)**	**1,071**
Federal Employee & Veterans' Benefits	3	8	11	1			12		12
Entitlement Benefits Due & Payable	20,979	23,963	44,942	20,410	$334	165	65,851		65,851
Accrued Payroll & Benefits	17	35	52	4	1	1	58		58
Contingencies				3,513			3,513		3,513
Other Liabilities	356	276	632			15	647		647
TOTAL LIABILITIES	**43,812**	**51,135**	**94,947**	**23,932**	**335**	**213**	**119,427**	**(48,275)**	**71,152**
NET POSITION									
Unexpended Appropriations—earmarked funds		12,267	12,267				12,267		12,267
Unexpended Appropriations—other funds				7,477	4,004	1,777	13,258		13,258
Cumulative Results of Operations—earmarked funds	302,907	39,733	342,640				342,640		342,640
Cumulative Results of Operations—other funds				166	19	316	501		501
TOTAL NET POSITION	**$302,907**	**$52,000**	**$354,907**	**$7,643**	**$4,023**	**$2,093**	**$368,666**		**$368,666**
TOTAL LIABILITIES & NET POSITION	**$346,719**	**$103,135**	**$449,854**	**$31,575**	**$4,358**	**$2,306**	**$488,093**	**$(48,275)**	**$439,818**

SUPPLEMENTARY INFORMATION

CONSOLIDATING STATEMENT OF NET COST
For the Year Ended September 30, 2008
(in millions)

	MEDICARE (Earmarked)			HEALTH (Other Funds)			Consolidated
	HI TF	SMI TF	Total	Medicaid	SCHIP	Other Health	Totals
NET PROGRAM/ACTIVITY COSTS							
GPRA Programs							
Medicare (Earmarked)	$217,692	$177,363	$395,055				$395,055
Medicaid				$201,094			201,094
SCHIP					$6,978		6,978
NET COST—GPRA PROGRAMS	**217,692**	**177,363**	**395,055**	**201,094**	**6,978**		**603,127**
Other Activities							
CLIA						$(14)	(14)
State Grants & Demonstrations						444	444
NET COST—OTHER ACTIVITIES						**430**	**430**
NET COST OF OPERATIONS	**$217,692**	**$177,363**	**$395,055**	**$201,094**	**$6,978**	**$430**	**$603,557**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2008
(in millions)

	MEDICARE (Earmarked)			HEALTH (Other Funds)			Consolidated
	HI TF	SMI TF	Total	Medicaid	SCHIP	Other Health	Total
CUMULATIVE RESULTS OF OPERATIONS							
Beginning Balances	$294,989	$34,942	$329,931	$138	$4	$260	$330,333
Budgetary Financing Sources:							
Appropriations Used	12,574	180,434	193,008	200,459	6,944	415	400,826
Nonexchange Revenue:							
FICA and SECA Taxes	197,195		197,195				197,195
Interest on Earmarked Trust Fund Investments	16,605	2,529	19,134				19,134
Other Nonexchange Revenue	557	9	566				566
Transfers-in/out Without Reimbursement	(1,329)	(834)	(2,163)	661	49	71	(1,382)
Other Financing Sources (Nonexchange):							
Transfers-out Without Reimbursement		(1)	(1)				(1)
Imputed Financing	8	17	25	2			27
TOTAL FINANCING SOURCES	**225,610**	**182,154**	**407,764**	**201,122**	**6,993**	**486**	**616,365**
NET COST OF OPERATIONS	**217,692**	**177,363**	**395,055**	**201,094**	**6,978**	**430**	**603,557**
NET CHANGE	**7,918**	**4,791**	**12,709**	**28**	**15**	**56**	**12,808**
CUMULATIVE RESULTS OF OPERATIONS	**$302,907**	**$39,733**	**$342,640**	**$166**	**$19**	**$316**	**$343,141**
UNEXPENDED APPROPRIATIONS							
Beginning Balances	$0	$8,978	$8,978	$3,565	$4,960	$1,364	$18,867
Budgetary Financing Sources:							
Appropriations Received	$12,574	192,746	205,320	$206,886	6,640	828	419,674
Appropriations Transferred-in/out				(2,515)			(2,515)
Other Adjustments		(9,023)	(9,023)		(652)		(9,675)
Appropriations Used	(12,574)	(180,434)	(193,008)	(200,459)	(6,944)	(415)	(400,826)
TOTAL BUDGETARY FINANCING SOURCES	**0**	**3,289**	**3,289**	**3,912**	**(956)**	**413**	**6,658**
TOTAL UNEXPENDED APPROPRIATIONS	**0**	**12,267**	**12,267**	**7,477**	**4,004**	**1,777**	**25,525**
NET POSITION	**$302,907**	**$52,000**	**$354,907**	**$7,643**	**$4,023**	**$2,093**	**$368,666**

Department of Health and Human Services

CENTERS FOR MEDICARE & MEDICAID SERVICES

NOV 10 2008

TO: Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson
Inspector General

SUBJECT: Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2008 (A-17-08-02008)

This memorandum transmits the independent auditors' reports on the fiscal year (FY) 2008 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and regulations applicable to 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 firm of Ernst & Young, LLP (E&Y), to audit the CMS consolidated balance sheet as of September 30, 2008, and the related consolidated statements of net cost and changes in net position, the combined statement of budgetary resources for the year then ended, and the statement of social insurance as of January 1, 2008. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in the "Government Auditing Standards," issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 07-04, Audit Requirements for Federal Financial Statements.

Results of Independent Audit

Based on its audit, E&Y found that the FY 2008 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, 2008, E&Y noted certain matters involving internal control and its operation that we consider to be significant deficiencies, of which one is considered to be a material weakness under standards issued by the American Institute of

Certified Public Accountants. Specifically, E&Y reported a material weakness regarding CMS's information systems controls. The weakness related primarily to CMS oversight of information security, access to programs, and control over application configuration management for shared systems.

Exclusive of the Federal Financial Management Improvement Act of 1996 and the Improper Payments Information Act of 2002, E&Y disclosed no instances of noncompliance that are required to be reported under "Government Auditing Standards" and OMB Bulletin 07-04.

Evaluation and Monitoring of Audit Performance

We reviewed the audit of the CMS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the audits;
- attending key meetings with auditors and CMS officials;
- monitoring the progress of the audit;
- examining audit documentation 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.

E&Y is responsible for the attached auditors' reports dated November 10, 2008, and the conclusions expressed in the reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on CMS's financial statements, the effectiveness of internal controls, whether 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 E&Y did not comply, in all material respects, with U.S. generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact 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-17-08-02008.

Attachment

cc:
Charles E. Johnson
Assistant Secretary for Resources and Technology

Sheila Conley
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 U.S. Department of Health and Human Services

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

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

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

As discussed in Note 14 to the financial statements, the statement of social insurance presents the actuarial present value of the CMS' Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds' estimated future income to be received from or on behalf of the participants and estimated future expenditures to be paid to or on behalf of participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. In preparing the statement of social insurance, management considers and selects assumptions

and data that it believes provide a reasonable basis for the assertions in the statement. However, because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the SMI Part D projections have an added uncertainty in that they were prepared using very little program data upon which to base the estimates.

Our audit was conducted for the purpose of forming an opinion on the 2008 basic financial statements taken as a whole. The information presented in Management's Discussion and Analysis, required supplementary information, and other accompanying information is not a required part of the basic financial statements but is supplementary information required by OMB Circular No. A-136. The other accompanying information has not been subjected to the auditing procedures applied in our audit of the basic financial statements and, accordingly, we express no opinion on it. For the remaining information, we have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit the information and express no opinion on it.

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 10, 2008 on our consideration of CMS' internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations and other matters. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

Ernst & Young LLP

November 10, 2008

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Report on Compliance with Laws and Regulations

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

We have audited the financial statements of the Centers for Medicare and Medicaid Services (CMS) as of and for the year ended September 30, 2008 and the statement of social insurance as of January 1, 2008, and have issued our report thereon dated November 10, 2008. We conducted our audit in accordance with auditing standards generally accepted in the United States, the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 07-04, *Audit Requirements for Federal Financial Statements,* as amended.

The management of CMS is responsible for complying with laws and regulations applicable to CMS. As part of obtaining reasonable assurance about whether CMS' financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in Office of Management and Budget (OMB) Bulletin No. 07-04, as amended, including the requirements referred to in the Federal Financial Management Improvement Act of 1996 (FFMIA). We limited our tests of compliance to these provisions, and we did not test compliance with all laws and regulations applicable to CMS.

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

The Improper Payments Information Act (IPIA) of 2002 requires federal agencies to identify the program and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. CMS has begun to implement the requirements of IPIA, but has not yet completed its implementation of a process to fully estimate improper payments. Although CMS has not complied with IPIA, it 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' financial management systems substantially comply with federal financial management systems requirements, applicable federal accounting standards, and the United States Standard General Ledger (USSGL) 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 in which CMS' financial management systems did not substantially comply with certain requirements discussed in the preceding paragraph. We have identified the following instance of noncompliance.

The results of our tests of CMS' compliance with FFMIA requirements disclosed that CMS is not in substantial compliance with the requirements of FFMIA section 803(a). In our report on internal control dated November 10, 2008, we reported a material weakness related to Information Systems Controls and significant deficiencies related to Financial Reporting Systems and Processes and the Statement of Social Insurance. We believe these matters, taken together, represent substantial noncompliance with FFMIA requirements. In addition, though operational at some of the Medicare Contractors, CMS has not yet completed the implementation of the HIGLAS general ledger system and as a result is not compliant with the US 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 November 10, 2008.

* * * * *

Our Report on Internal Control dated November 10, 2008, includes additional information related to the financial management systems that were found not to comply with the requirements, relevant facts pertaining to the noncompliance to FFMIA, and our recommendations related to the specific issues presented. It is our understanding that management agrees with the facts as presented and that relevant comments from the CMS' management responsible for addressing the noncompliance are provided as an attachment to its report. We did not audit management's comments and accordingly, we express no opinion on them. Additionally, CMS is updating its agency-wide corrective action plan to address FFMIA and other financial management issues.

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

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

Ernst & Young LLP

November 10, 2008

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Report on Internal Control

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

We have audited the financial statements of the Centers for Medicare and Medicaid Services (CMS) as of and for the year ended September 30, 2008 and the statement of social insurance as of January 1, 2008, and have issued our report thereon dated November 10, 2008. We conducted our audit in accordance with auditing standards generally accepted in the United States, the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 07-04*, Audit Requirements for Federal Financial Statements*, as amended.

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

Our consideration of internal control over financial reporting was for the limited purposes described in the preceding paragraph and would not necessarily identify all deficiencies in internal control over financial reporting that might be significant deficiencies or material weaknesses. However, as discussed below, we identified certain deficiencies in internal control over financial reporting that we consider to be significant deficiencies.

A control deficiency exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects CMS' ability to initiate, authorize, record, process, or report financial data reliably in accordance with generally accepted accounting principles such that there is more than a remote likelihood that a misstatement of CMS' financial statements that is more than inconsequential will not be prevented or detected by CMS' internal control. We

consider the deficiencies described below to be significant deficiencies in internal control over financial reporting.

A material weakness is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the financial statements will not be prevented or detected by CMS' internal control. Our consideration of internal control was for the limited purpose described in the second paragraph of this report and would not necessarily identify all deficiencies in internal control that might be significant deficiencies and would not necessarily disclose all significant deficiencies that are also considered to be material weaknesses. However, of the significant deficiencies described below, we considered the first significant deficiency – Information Systems Controls – to be a material weakness.

Material Weakness

Information Systems Controls

Business Environment Overview
A substantial portion of CMS transactions and administration of CMS programs is performed by geographically diverse contractors. CMS relies on extensive information systems operations to counteract the risks of its enormous size and the decentralized nature of the organization. These systems, resident at its Central Office and Medicare contractor sites, are designed to assure consistency in administration of the Medicare program in addition to processing, accounting for, and reporting on 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.

Controls over information systems should be augmented by controls designed to detect errors that have occurred on a timely basis and mitigate the potential impact of imperfections in the prevent controls. Generally, detect controls are accomplished by means of robust manual, financial reporting and periodic monitoring activities. As noted below under the caption, Financial Reporting Systems and Processes, improvements are needed in the detect controls at CMS. This weakness increases the importance of a thorough and closely followed system of IT security.

The contracts between CMS and its contractors that have IT responsibilities include provisions requiring the contractors to follow security standards described in a series of documents, the cornerstone of which is the Business Partners Systems Security Manual (BPSSM), Version 9. The specific security standards followed at each location are to be documented by the contractors in their System Security Plan (SSP). Contractors are also required to periodically (at least annually) test and certify their systems for operation. In addition, in some cases CMS has contractually required contractors to obtain Statement on Auditing Standards (SAS) No. 70 reports to document compliance with the BPSSM and the contractor's SSP.

While this approach to IT security supports continuous monitoring of the contractor's information security controls, CMS controls would be enhanced by additional interactions in approving the specific security approaches and settings used to process its data and defining with sufficient granularity the details intended for contractor compliance to be tested (either by the contractors themselves in the self assessment process or through other monitoring activities).

The CMS IT controls should be improved in the following areas:

I. Enhancement of CMS Oversight of Information Security

CMS has developed processes and policies for supporting their Information Security Program in accordance with NIST Special Publication 800-53, *Recommended Security Controls for Federal Information Systems* and NIST Special Publication 800-37, *Guide for the Security Certification and Accreditation of Federal Information Systems*. These policies are documented in the CMS BPSSM, CMS Information Security (IS) Certification and Accreditation (C&A) Program Procedures, and SSP Methodology that present the CMS plan for information security.

CMS requires certain key contractors to obtain a third-party report (SAS 70) and penetration tests as part of the information security monitoring procedures. However, due to the timing of contractor transition, the SAS 70 reports were not required for most of the Medicare contractors during fiscal year 2008. As part of our audit we read the summary documentation of the CMS self assessment of internal controls under OMB Circular No. A-123, *Management's Responsibility for Internal Control*, that touched on IT controls. We noted in that review that they did not assess compliance against configuration baselines at the level of detail necessary to help ensure that CMS systems are functioning consistent with NIST compliant baselines, or that such baselines exist.

During our audit activities as part of the CFO audit, we noted instances of potential weaknesses in information security, including:

- CMS Central Office did not have a security software or operating systems software baseline for the IBM mainframe computer that processes a significant portion of CMS' financial applications, including the general ledger system.

- Four of the eight data centers and software maintainers tested did not have baseline security standards for the computer systems used to process Medicare data. Baseline security standards are a requirement of the CMS BPSSM and CMS SSP Methodology.

- One data center had a deficiency in controls over security of the Medicare data being transmitted through the Medicare Data Communication Network (used to transmit data amongst all Medicare contractors) nor was this condition identified during the CMS-mandated certification and accreditation process and recertification process.

In addition, we noted that the system security plans that were reviewed as part of the audit did not have consistent content as to the baseline security settings. As a result, it was not possible to determine if the information security requirements accepted by CMS were the information

security controls implemented or that such settings were contemplated to appropriately consider risks pursuant to NIST guidance.

CMS conducted follow-up oversight activities at its Medicare contractors to reinforce the importance of CMS requirements and they noted improvements in contractor compliance. Some of these controls were not fully implemented until the fourth quarter of fiscal year 2008.

II. Access to Programs

Access controls ensure that critical system assets are physically protected from unauthorized access and logical controls provide assurance that only authorized personnel are granted access data and programs maintained on systems; such controls include monitoring of security events for proper assessment and remediation.

Segregation of duties is not maintained between the business function and the information security administration function for the Office of Financial Management's (OFM) Financial Accounting and Control System (FACS) general ledger-related application. The CMS OFM has certain assigned personnel who are able to grant access to the FACS general ledger application as a system administrator to potentially unauthorized employees and process transactions. The accounting employees also have user accounts for the FACS application and they are granted access to the accounting functions within FACS.

These security weaknesses could allow internal users to access and update sensitive systems, program parameters and data without proper authorization. The audit did not disclose any exploitation of critical systems tested.

III. Control over Application Configuration Management for Shared Systems

Configuration Management depends on the consistent application of change management processes and policies to automated computer systems in order to ensure the integrity and security of financial and claims data. CMS has contracted with software maintainers to support the software development and support of the shared systems used to process Medicare claims. The software maintainers have agreed in their contract with CMS to provide services that include system development production environment simulation, documentation, training and unit testing of software the contractor develops. During the audit the following observations were made at software maintainers:

- The Medicare system processes claims using standardized shared application systems. Application edits were tested at four software maintainer sites; the software maintainer was not able to demonstrate the successful execution of eight of the 100 edits tested.

- Automated Adjudication System programs such as SuperOps and System Control Facility are developed and processed independently of the shared system applications to process CMS claims rejected by the standard systems. It was determined that changes made by the software maintainer for SuperOps were not made using standard CMS change control processes.

- The role of the software maintainer in the application development and deployment process as described during the audit was not consistent with the CMS Statement of Work. One software maintainer lacked current documentation on the shared application system and another software maintainer lacked complete systems documentation. In addition, the software maintainers were unable to support the development of user documentation for training of employees on security administration.

CMS depends on the software maintainers' consistent adherence to the requirements as set forth in the contract to develop and deploy shared systems that will support claims processing that provides for the integrity of claims data. The contractors' ability to meet these objectives is an important component of the internal controls at CMS.

Recommendation

CMS systems have undergone significant change, with efforts taken to remediate specific security weaknesses leading to improvements. CMS management should continue its efforts to appropriately organize and direct the information security program administered by Office of Information Services (OIS) for all of the affected information system processing activities. Such activities should include continuous monitoring of the information security program at the Central Office and contractor sites. Specifically, as part of the program improvements, CMS Central Office should analyze the following for all contractors:

- Validation of the implementation of BPSSM requirements and embedded NIST standards by the contractor. Deviations from the defined requirements and standards should be evaluated and, if acceptable, approved.

- Documentation of the actual security settings implemented on the computer systems that support CMS financial and claims processing.

- Documentation to support certifications reports provided by the contractors.

- Documentation to support that the specific control objectives and processes being tested in self assessments and SAS 70 reviews are sufficiently granular to demonstrate compliance on a detail basis with CMS information security requirements. Consultation between the contractors and CMS on whether specific security settings for particularly vulnerable systems and data should be agreed upon and specified for periodic monitoring should be considered.

To address the FACS deficiency, we recommend that CMS move the application security administration process and configuration management process from personnel within OFM to OIS. This would remediate the segregation of duties issues for the FACS. OIS has an established user security administration process as well as an established configuration management process. CMS would strengthen the internal controls by capitalizing on these OIS processes.

CMS management should also enhance their efforts to increase contractor compliance with the implementation of controls conforming to the published CMS and other related federal

standards. Through oversight activities, proactively monitoring contractor compliance with security baselines and related directives for data access control and application program management can enhance the integrity of Medicare data and programs. Specifically, they should focus on the requirements set forth in the software maintainer contracts to ensure all changes follow the change control process and that contractors provide the services and activities required by their contracts in support of the overall protection of computer system processing integrity and security for CMS.

Significant Deficiencies

Financial Reporting Systems and Processes

Financial management in the federal government requires accountability of financial and program managers for financial results of actions taken, control over the federal government's financial resources and protection of federal assets. To enable these requirements to be met, financial management systems must be in place to process and record financial events effectively and efficiently, and to provide complete, timely, reliable and consistent information for decision-makers and the public.

OMB Circular No. A-127, *Financial Management Systems*, prescribes the policies and standards that each agency should follow in developing, operating, evaluating, and reporting on financial management systems. The agency's financial statements are the culmination and an integral part of the total financial management system that encompasses sufficient structure, effective internal controls and reliable data necessary for the agency to carry out its financial management functions, manage financial operations and report on the agency's financial status. CMS management is responsible for establishing and maintaining effective internal controls and financial management systems that meet the objectives of FMFIA and OMB Circular No. A-123.

CMS relies on a decentralized organization/structure and complex financial management systems – not only within its central office and regional offices' processes but within many of the Medicare Contractor organizations – to accumulate data for financial reporting. A common set of accounting and reporting standards, an integrated financial system, a sufficient number of properly trained personnel and a strong oversight function are all necessary to ultimately prevent, and/or detect, and resolve errors and irregularities in a timely manner. A robust financial management system also captures and produces key financial data and analyses, including critical performance measures and anomalies that chief decision-makers within the organization would monitor on a periodic basis to fulfill their fiduciary responsibility; deter fraud, waste and abuse of federal government resources; and facilitate efficient and effective delivery of designated programs.

The Agency created the Risk Management and Financial Oversight Committee (the Committee) that is chaired by its Chief Operating Officer and comprises the Directors of various Centers and Offices. The Committee has played a critical role in focusing senior management's attention on those activities identified in the prior year audit as weaknesses or vulnerabilities and ensuring that corrective action plans were developed and implemented to address the agency's

deficiencies in an effective manner. We encourage the Committee to continue its work and further strengthen its value to CMS by sponsoring studies of other potential business, accounting and reporting risks; encouraging design of improved accounting and financial controls; and enforcing timely investigation, response and remediation of all findings from external audits, OIG investigations and A-123 testing.

We noted the following items in the current year audit that indicate additional improvements in the financial reporting systems and processes are required.

I. Required Coordination and Communication to Facilitate an Effective Financial Management System

CMS should improve its process for managing cross-functional teams of financial management, information technology, actuarial, general counsel, operations and other personnel to better monitor business activities, and identify situations where accounting evaluation or decision-making may be required to arrive at and document an accurate conclusion in a timely manner. The coordination and communication of critical financial information is inconsistent and does not ensure the appropriate level of involvement and participation among the cross-functional team. For example, critical accounting matters such as accruals and contingencies require a robust process on a quarterly basis including the documentation of these critical accounting matters through a series of white papers. These white papers supporting the conclusions on several critical accounting matters had not been timely approved and available for the auditor's review. Critical financial management responsibilities such as, reconciliations of Medicare Advantage (Part C) and Prescription Drug (Part D) payments and monitoring of Medicaid expenditures are performed in various program Centers/Offices of CMS. The dispersed nature of the financial management environment leaves CMS vulnerable to program responsibilities taking precedence over financial management. Additional examples of these include:

- The lack of a legal contingency process at interim and annual periods to record legal accruals in accordance with generally accepted accounting principles in the United States.

- Significant last minute adjustments to the financial statements ($1.3 billion).

The decentralized nature of the organization results in a significant number of controls being performed at the contractors, regional offices and other Centers/Offices outside of OFM. Robust analytical procedures or measures against benchmarks can monitor and mitigate risks associated with the decentralized nature of CMS operations. The limited analytical procedures performed centrally and circulated within CMS management increase the likelihood that adjustments, which are other than inconsequential to the financial statements, may not be identified and corrected in a timely manner. In addition, we noted that CMS does not perform a claims-level detailed look-back analysis for the Medicaid Entitlement Benefits Due and Payable (EBDP) to determine the reasonableness of the various state calculations of unpaid claims. In another example, CMS performs an analysis of changes in prior year to current year balances; however, this analysis should be enhanced and further supplemented by additional performance measures and analyses (e.g., actual expenditures on a monthly, quarterly or annual basis by program and by contractor compared to prior year periods and expectations, etc.). To the extent that such analyses are

performed by the various program Centers/Offices, OFM should ensure that these analyses reconcile to the financial statements. CMS has incorporated the use of some analytical procedures into its monitoring controls as demonstrated by the Benefit Payment Validation process, which analyzes Part C and D program benefit payment expectations compared to the actual benefit payments. This is an excellent example of an overall detect control that allows program management to monitor and understand payment trends and investigate anomalies before the funds are disbursed.

II. Lack of a Single Integrated Financial Management System

The Federal Financial Management Improvement Act of 1996 (FFMIA) requires agencies to implement and maintain financial management systems that comply with federal financial management systems requirements. FFMIA requires federal agencies to have a single integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, processes (manual and automated), procedures, controls, and data necessary to carry out the financial management functions, manage the agency's financial operations and report the agency's financial status. CMS continues their efforts to implement the Healthcare Integrated General Ledger Accounting System (HIGLAS), which will integrate the CMS contractors' standard claims processing system and replace the CMS current mainframe-based financial system with a web-based accounting system. Currently, CMS remains out of compliance and the lack of a single integrated financial management system continues to impair CMS' ability to efficiently and effectively support and analyze financial reports.

The Medicare contractors that have not implemented HIGLAS continue to rely on a combination of claims processing systems, personal computer-based software applications and other ad hoc systems to tabulate, summarize and prepare information that is reported to CMS on the *750—Statement of Financial Position Reports*, the *751—Status of Accounts Receivable Reports* and the reporting of funds expended, the *1522—Monthly Contractor Financial Report*. The accuracy of these reports remains heavily dependent on inefficient, labor-intensive, manual processes that are also subject to an increased risk of inconsistent, incomplete, or inaccurate information being submitted to CMS.

III. Business Partner Risk Management

CMS, as stewards of the Medicare and Medicaid programs' administrative and financial operations, has a fiduciary responsibility to ensure that the programs' funds are spent in the best interest of the beneficiaries and the American taxpayers. CMS administers an extensive internal control program to protect the Agency's resources from fraud, waste and mismanagement. CMS also relies heavily on third-party contractors as it outsources substantially all the day-to-day operations for its information technology systems, the payment of Medicare and Medicaid fee-for-service claims and the Medicare Advantage (Part C) and Part D Drug programs.

CMS has developed internal controls that help prevent fraud and waste from occurring such as edits in the claims processing systems that attempt to identify and filter inappropriate claims. CMS also has developed internal controls that will help detect fraud and waste that may have

occurred. Any strong control environment will have a combination of both prevent and detect controls with a greater emphasis on prevent controls.

While we noted during the current year audit that CMS had a significant amount of both prevent and detect controls in operation, we noted several examples of areas where improvements could be made in the overall control environment. This is especially true of CMS' relationships with its third-party contractors. The following are examples of control deficiencies we noted:

- Reductions have been made to the amount of funds advanced to the Part D plans as compared to prior years. However, the Part D program has a funding mechanism that results in a substantial amount of cash being advanced to various plans in anticipation of future beneficiary prescription drug claims throughout the first three quarters of the year. This is especially important given the condition of the financial and credit markets and the increased risk that a Part D plan could have financial difficulties.

- During 2007, CMS transferred a majority of the Medicare Secondary Payor recovery process to a single third-party contractor. This contractor is responsible for collecting several hundred million dollars of cash on an annual basis. We noted several instances where internal controls related to this third-party contractor, including CMS' oversight of the contractor, segregation of incompatible duties and the untimely application of cash receipts, were not designed or operating effectively.

The processes designed to prevent errors should also be supplemented by controls analyses that highlight any material errors that may occur. In this regard, errors or abuses within the Medicare claim data, if material, should be detected in the annual Comprehensive Error Rate Testing (CERT) process, while for Medicaid the Payment Error Rate Measurement (PERM) process can be useful in this regard. Processes to assess accuracy rates as applicable and monitor Part C and D plans, particularly prescription drug event data, are evolving, but such monitoring activities can also be useful. To be fully effective in compensating for inherent risks in the programs, the monitoring activities must be well understood, susceptible to replication and highly credible. Framing the issue, the error rate on CERT was 3.9% with projected gross improper payments of $10.8 billion in the prior reporting period.

The OIG, through recent audit activities, has indicated that for certain select services comprising a small portion of the CMS programs, the error rate calculation appears to have produced estimates that are at variance from experience in the programs, and were not readily replicated. Recent CMS activities to selectively retest CERT results over the entire spectrum of claims activity will be useful in assessing the reasons for differing results and ensuring the overall credibility of the process. Similarly, ensuring that a fully reconciled population of claims is susceptible to testing is an important starting point in the development of PERM error rates. The work performed by the OIG in reconciling such populations indicates that further focus on this area is needed.

Recommendation

We recommend that CMS continue to develop, enhance, refine and provide robust analyses over its financial reporting systems and processes. Specifically, CMS should:

- Establish specific policies, procedures and a protocol to address situations or transactions that require cross-functional involvement in order to ensure interim and year end financial statements are accurate and complete. This includes policies and procedures to ensure changes to critical systems outputs are appropriately discussed and reviewed with all users. 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 important factors to consider in formulating accounting treatment and financial reporting implications.

- Continue to enhance its process related to the development, documentation, and validation of critical accounting matters and the timeliness of its white papers.

- CMS should perform and circulate for review more analytical analysis as part of the monthly, quarterly and annual close process. To the extent that such analyses are performed by various program Centers/Offices, we would expect the information would be reviewed and analyzed by OFM and reconciled to CMS financial reports.

- Establish a process to perform a claims-level detailed look-back analysis on the Medicaid EBDP to determine the reasonableness of the methodology utilized to record the $20.4 billion accrual. One potential method to verify the reasonableness of the Medicaid EBDP balance would be to use the detail claims data from the PERM process to calculate the average days outstanding.

- Continue the process of enhancing the integrity and improving the process of the CERT and PERM tools.

- Continue to implement an integrated financial management system for use by Medicare contractors and CMS to promote consistency and reliability in accounting and financial reporting.

- With respect to the Part D program, CMS should evaluate the timing of the "Reinsurance" payments and consider a payment process that matches the timing of the "Reinsurance" payments with the incurrence of the related claims. This will result in substantially less advances to Part D plans throughout the year.

- Implement controls at and enhance CMS monitoring controls over the Medicare Secondary Payor recovery contractor. In addition, CMS should evaluate its overall directives to third-party contractors to ensure that adequate controls are in place and that appropriate documentation is maintained to support the conduct of those controls.

Finally, in light of the extraordinary financial crisis that exists in 2008, we believe that CMS should evaluate its risks with respect to all its third-party contractors to ensure that the Agency is doing everything possible to ensure that its resources are protected.

Statement of Social Insurance (SOSI)

The SOSI for CMS presents a long-term projection of the present value, of over a 75-year time horizon, of the benefits to be paid for the closed and open groups of existing and future participants of the Medicare social insurance programs, less the income to be received from or on behalf of those same individuals. The presentation assumes the programs will continue in their current form under current law, albeit with certain economic assumptions that serve to constrain growth of the programs and imply refinements in response to the burden of the programs on economic activity and observations in the related report of the Board of the Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (the Trustees Report) that growth as projected will substantially strain the nation.

The presentation in the CMS annual report includes estimates not only of the payroll taxes, premiums and other contributions to be made directly by the participants but also estimates of general fund contributions on their behalf to help finance the programs for which this funding mechanism exists. In contrast, the presentation included in the consolidated annual financial statements of the U. S. government excludes such intragovernmental transfers. Starting in FY 2006, the SOSI was required to be presented as part of the basic financial statements rather than as Required Supplementary Information as previously presented. As such, the process for preparing the SOSI must comply with appropriate financial reporting internal control requirements established by OMB.

The additional visibility provided to the projections highlights the need to periodically assess the level of investment made in further refining the models, transitioning them to a robust model platform with effective programmed controls, developing alternatives for critical economic modeling and involving outside experts and public members of the Board of Trustees in critically assessing the models and associated projections. We note that the two Public Trustee positions were vacant at issuance of the 2008 Trustee Report.

The models used as inputs to the Trustees Report and the SOSI consist largely of spreadsheets with myriad data inputs from internal and external sources, and extensive movement of data between such spreadsheets. No current plans exist to replace these spreadsheets, which have been used for a number of years for their intended purpose. CMS has implemented policies, processes, controls and related documentation that will enable them to support the related financial statement assertions, but the use of spreadsheets will continue to pose risks that errors that are other than inconsequential will not be detected. We noted improvements in the areas of change control and internal control documentation but certain modifications needed in preparing the 2008 SOSI presentation highlights the need to improve the controls. The lack of robust automated controls over spreadsheet changes and inputs, and complexity of the models that greatly impact the ability to rely on output analysis as a principal control with sufficient granularity, may result in output that varies from management’s intentions.

Recommendation
We recommend that CMS continue to develop and refine its SOSI financial reporting spreadsheet applications and processes. Specifically, CMS should:

- Implement automated controls to ensure that data moved between and within spreadsheets are moved correctly.
- Implement automated controls to prevent the possibility of overwriting critical spreadsheet data or formula cells.
- Implement automated controls to test, review and verify all formulae changes within and between spreadsheets (e.g., spreadsheet change logging capabilities).
- Continue to emphasize compliance with compensating controls developed to ensure spreadsheets are critically assessed as they are used each year through use of input/output controls such as reviews of output against expected results and systematic signoffs on changes as data is input and the spreadsheets changed.
- Continue to work with appropriate parties to engage Public Trustees, expert panels and other internal and external resources to continue to refine the models and explore alternatives to the existing spreadsheet applications and somewhat simplified economic models.

We have reviewed our findings and recommendations with CMS management. Management generally concurs with our findings and recommendations and will provide a corrective action plan to the OIG in accordance with applicable Agency directives.

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, OMB and Congress. This report is not intended to be and should not be used by anyone other than these specified parties.

Ernst & Young LLP

November 10, 2008

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

November 10, 2008

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

Dear Sir:

This letter is in response to your audit report on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2008 financial statements. Your report identifies one material weakness, Information Systems Controls, and two significant deficiencies, Financial Reporting Systems and Processes and Statement of Social Insurance (SOSI). While we generally agree with your findings and descriptions of the matters noted, we believe the findings related to Information Systems Controls do not rise to the level of a material weakness, and have observations regarding the recommendations to improve the SOSI process.

During FY 2008, we implemented a robust corrective action plan to address the FY 2007 Medicare claims processing material weakness, and we strongly believe these actions remediated last year's issues down to a significant deficiency. Furthermore, the results of CMS' annual Office of Management and Budget Circular A-123, Appendix A review process for FY 2008, where we reviewed the Agency's internal controls over financial reporting, supported this conclusion as well.

The significant deficiency for SOSI is based on an assertion that the current system of policies, processes, controls, and related documentation for SOSI internal controls should be further refined by the addition of certain automated controls and other processes. However, we continue to believe our SOSI estimating process does include a comprehensive and effective set of internal controls that have been carefully practiced. You recommend modest refinements including the addition of automated controls that could potentially help further reduce the likelihood of an error. While these recommendations may be worth pursuing, we believe that their implementation would offer very little additional assurance of accuracy compared to the existing comprehensive process.

As noted in your report, CMS continued to improve its financial management performance in FY 2008 in many areas. For example, CMS continued to show improvement around the controls over trust fund draws and the oversight of Managed Care organizations which were reported as significant deficiencies in our FY 2007 audit and are not separately reported as audit issues this year.

While receiving an unqualified opinion on our financial statements is an outstanding achievement, we are already developing a strong corrective action plan to address the audit issues identifiedin your report. We are committed to correcting these issues as quickly as possible and are strengthening our

efforts to improve the financial management of CMS' operations so we can fulfill our stewardship responsibilities and exceed our high financial management standards. We will continue to track and report our progress on a regular basis.

I would also like to thank the Ernst & Young, LLP audit team for the professional manner in which they conducted their audit and look forward to working with you to resolve these outstanding issues.

Sincerely,

Timothy B. Hill
Chief Financial Officer

Other Accompanying Information

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

The Federal Managers' Financial Integrity Act (FMFIA) requires executive agencies to report annually if: (1) they have reasonable assurance that their internal 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 internal controls through: (1) management self-assessments including annual tests of security controls, (2) OMB Circular No. A-123, Appendix A self-assessment, (3) OIG audits and GAO audits and High-Risk reports, (4) SAS 70 internal control audits, (5) evaluations and tests of Medicare contractor controls conducted pursuant to Section 912 of the Medicare Modernization Act, (6) the annual Chief Financial Officer (CFO) financial statements audit, and 7) certification and accreditation of systems. As of September 30, 2008, the internal controls and financial management systems of CMS provided reasonable assurance that the objectives of FMFIA were achieved. However, two instances of noncompliance were identified, one of which is also a nonconformance under Section 4 of FMFIA.

Noncompliance/Nonconformance

The CMS financial management systems—because they are not integrated—do not conform to government-wide requirements and therefore are not compliant with the Federal Financial Management Improvement Act (FFMIA). We are bringing our financial systems into compliance by implementing HIGLAS, which will integrate the Medicare contractors' standard claims processing systems and replace the CMS mainframe-based financial system with a web-based accounting system.

While we are not fully in compliance with the Improper Payments Information Act (IPIA), we are continuing to implement the requirements of IPIA and to enhance our program integrity efforts. Since 2002, we have been measuring the payment error rates for the Medicare fee-for-service (FFS) program, and have lowered rates from as high as 10.1 percent to 3.9 percent nationally. We will report an annual FY 2006 Medicaid FFS "component" paid claims error rate, as well as the annual FY 2007 "composite" paid claims error rate in the HHS FY 2008 Agency Financial Report (AFR). The "composite" error rate will be calculated for both the Medicaid and SCHIP programs, including FFS, managed care, and eligibility benefits. We continue to make significant progress toward the development of an error rate measurement program for the Medicare Advantage and Prescription Drug programs. We reported one element of the Medicare Advantage and Prescription Drug payments in the HHS FY 2007 AFR. Additionally, we will report a calendar year 2006 composite Part C payment error rate and two components of the Part D payment error rate in the HHS FY 2008 AFR.

OMB Circular No. A-123 Statement of Assurance

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

As required by OMB Circular No. A-123, CMS evaluated its internal controls and financial management systems to determine whether these objectives are being met. Accordingly, CMS provided a qualified statement of assurance that its internal controls and financial management systems met the objectives of FMFIA due to noncompliance with the Improper Payments Information Act (IPIA) and the Federal Financial Management Improvement Act (FFMIA), as well as a nonconformance under Section 4 of FMFIA regarding financial management systems because they are not integrated and do not conform to government-wide requirements of FFMIA.

Assurance for Internal Control over Operations and Compliance

The CMS conducted its assessment of internal control over the effectiveness and efficiency of operations and compliance with applicable laws and regulations in accordance with OMB Circular No. A-123. Based on the results of this evaluation, as of September 30, 2008, the CMS provided reasonable assurance that internal controls over operations were operating effectively and no material weaknesses were found in the design or operation of these internal controls. As of September 30, 2008, we also complied with applicable laws and regulations, except for the noncompliance and nonconformance noted above. While the Government Accountability Office's (GAO) High-Risk Areas listed the Medicare and Medicaid programs as high risk, we do not believe that they constitute a material weakness. As the GAO notes, legislation is likely to be necessary to effectively address these high-risk areas.

Assurance for Internal Control over Financial Reporting

The CMS conducted its assessment of the effectiveness of internal control over financial reporting, which includes safeguarding of assets and compliance with applicable laws and regulations, in accordance with the requirements of Appendix A of OMB Circular No. A-123.

Based on the results of this assessment, CMS provided reasonable assurance that internal controls over financial reporting as of June 30, 2008 were operating effectively and no material weaknesses were found in the design or operation of the internal control over financial reporting.

Downgrading of the FY 2007 Medicare Claims Processing Material Weakness

The material weakness reported in FY 2007, for Medicare Claims Processing Controls was reduced to a significant deficiency in FY 2008. Based on the results of the FY 2008 A-123, Appendix A self-assessment, SAS 70 internal control audits, CPIC, FMFIA Self-Assessment Tracking and Reporting System (F-STARS), and Federal Information Security Management Act (FISMA) reports, the CMS has concluded that no material weakness exists because it was not found that there was a more than remote likelihood that a material misstatement of the CMS financial statements would not be prevented or detected.

The CMS is continuing to work diligently to address the systemic control deficiencies in claims processing noted in the ***FY 2007 CMS Financial Report***. The A-123, Appendix A assessment determined that the Medicare contractors and corresponding data centers have complied with the requirements of Joint Signatory Memorandum (JSM) 08019 *Medicare Data Processing Internal Controls* as well as the Control Objectives delineated in the CMS Internet Only Manual (IOM), Publication 100-6, Chapter 7, *Medicare Financial Management Manual*, Control Objective Area A, Information Systems. The Medicare contractors have demonstrated reasonable assurance in the areas of data access, configuration management, and in the general IT control environment as required by A-123, Appendix A.

Furthermore, no instances of exploitation of the EDP security findings have been found by any of the auditors/reviewers, which further corroborates that the likelihood of a material misstatement having occurred or occurring without detection is less than remote. In addition, while a number of EDP security findings were identified, they do not meet the materiality threshold either individually or in the aggregate.

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 oversee or 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 CMS has begun to implement the requirements of IPIA. Although CMS has not fully complied with the OMB's IPIA guidance, CMS has implemented a comprehensive process that measures the payment error rates for the Medicare FFS program, Medicaid, and SCHIP pro-

grams. The CMS has initiatives in place to enhance its program integrity efforts and IPIA compliance to include the Medicare Advantage and Medicare Prescription Drug programs.

Medicare

The identification and reporting of improper payments has been in place for Medicare FFS since FY 1996. 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. From FY 1996–FY 2003, CMS reported the Medicare FFS estimate of improper payments as a net number (where underpayments were subtracted from overpayments). Beginning in FY 2004, Medicare FFS estimates comply with the IPIA requirement to report gross numbers.

The CMS analysis for FY 2008, indicated that the paid claims gross error rate was 3.6 percent or $10.4 billion in gross improper payments. To strengthen our confidence in the CERT review findings and assure the accuracy of the reported error rate, CMS began an effort to independently perform blind, random reviews of its CERT review contractors' payment determinations starting with the FY 2008 measurement. At the time of this report publication, the results of those reviews were incomplete. As discussed in the Performance Goals section of this Financial Report, CMS is taking steps to continue to reduce the error rate for the future.

FY 2008 Gross Improper Payments and Error Rates in the Medicare FFS Program

		Gross	
Overpayments	**Underpayments**	**Improper Payment Amount (Overpayments + Underpayments)**	**Error Rate**
$9.5 B	$0.9 B	$10.4 B	3.6%

Medicare Advantage and Prescription Drugs

A key challenge facing CMS in the coming years will be achieving IPIA compliance with the Medicare Advantage and Medicare Prescription Drug Benefit. In FY 2008, CMS made significant strides towards this goal by completing the following tasks:

- Prepared a measurement methodology for a Medicare Advantage (Part C) composite error rate.
- Prepared a measurement methodology for calculating two elements of a Prescription Drug (Part D) program payment error.

For FY 2008 IPIA reporting, the CMS will report a Part C composite error rate. The Part C composite error rate scheduled for FY 2008 reporting combines two component error rates into a single composite measure on total Part C payments: the Medicare Advantage and Prescription Drug System (MARx) payment error (MPE) rate and the Part C risk adjustment error (RAE) rate. The Calendar Year (CY) 2006 Part C composite payment error estimate for FY 2008 is 10.6 percent.

For FY 2008 IPIA reporting for the Medicare Prescription Drug Benefit, CMS calculated two components of payment error, based on (1) the MPE for CY 2007 (MPE); and (2) a Low Income Subsidy (LIS) payment error estimate for CY 2007. The CMS calculated a Part D

MPE rate of .59 percent for prospective payments made from January 1, 2007 through December 31, 2007. The CMS calculated a Part D LIS error rate for prospective payments made from January 1, 2007 through December 31, 2007 of 0.25 percent.

Medicaid and SCHIP

Medicaid and SCHIP 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.

The CMS has developed a multi-faceted strategy to measure the national payment error rate for Medicaid and SCHIP annually. The FFS and managed care components of these programs are measured by national contractors. States will lead the effort to measure errors in the eligibility components of Medicaid and SCHIP. A sample of states have been selected to be measured once, every three years in each program to produce and report national program error rates to OMB for inclusion in the HHS AFR. This strategy was developed in response to recommendations made by states and other interested parties in commenting on the proposed rule that CMS published August 27, 2004, (that proposed to require all 50 States and the District of Columbia to annually estimate payment errors in their Medicaid and SCHIP programs). The subsequent interim final rule with comment period, published on October 5, 2005, informed the public of CMS' national contracting strategy and of the Agency's plan to measure improper payments in a sub-set of states each year. The CMS published a second interim final rule on August 28, 2006, which announced its plan to measure SCHIP and Medicaid together in a state and set forth an eligibility measurement methodology and invited further comments on that methodology. The CMS published a final rule on August 31, 2007 that finalized the eligibility measurement methodology.

The CMS is using the national contracting strategy to measure Medicaid FFS improper payments in FY 2006. In FY 2008, CMS completed the FY 2006 Medicaid fee-for-service component measurement and is reporting the annual FY 2006 Medicaid fee-for-service component error rate of 4.7 percent. The CMS is also measuring improper payments in Medicaid and SCHIP FFS, managed care and eligibility in FY 2007 for reporting, along with the FY 2006 annual Medicaid FFS component rate in the FY 2008 HHS AFR. The FY 2007 national Medicaid program payment error rate is 10.5 percent, or $18.6 billion in gross improper payments. The FY 2007 national SCHIP program payment error rate is 14.7 percent or $0.8 billion in gross improper payments. Finally, CMS is currently measuring FY 2008 Medicaid and SCHIP FFS, managed care, and eligibility for reporting in the FY 2009 HHS AFR and is beginning measurement of these programs for FY 2009, for reporting in the FY 2012 HHS AFR.

MEDICARE'S VALIDATION PROGRAM FOR JOINT COMMISSION-ACCREDITED HOSPITALS

Introduction

Section 1865 of the Social Security Act (the Act) provides that hospitals accredited by the Joint Commission (JC) are deemed to meet the Medicare Conditions of Participation

(CoPs) for Hospitals.[1] Section 1875(b) of the Act requires that the Secretary shall conduct a validation of the accreditation process of the JC and transmit an annual report to Congress on the findings of that validation.[2]

Currently, there are approximately 4,072 JC-accredited hospitals, accounting for 82 percent of all hospitals (4,976) participating in the Medicare program. (This does not include critical access hospitals (CAHs), small rural hospitals that are subject to different Medicare requirements than hospitals, because the JC's current statutory accreditation authority does not extend to CAHs.) The JC's accreditation survey assesses a hospital's compliance with the JC standards, and following completion of the on-site survey, the JC makes an accreditation decision. Each hospital is surveyed on a triennial basis to verify ongoing compliance. The JC also conducts random unannounced surveys of a sample of accredited hospitals on a more frequent basis as an additional means to ensure ongoing compliance.

Hospitals accredited by Centers for Medicare & Medicaid Services (CMS)-recognized accrediting organizations (AOs) (including the JC per section 1865 of the Act) are not subject to routine Medicare surveys by State survey agencies (SAs). However, these hospitals are subject to validation surveys conducted by SAs on behalf of CMS. Subsection 1864(c) of the Act authorizes the Secretary to enter into an agreement with any SA to survey 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. Validation surveys by SAs are one component of CMS' overall validation of the accreditation process of AOs, except in the case of the JC. Due to the statutory status of the JC's hospital program, CMS' validation of its process is focused on the conduct of validation surveys to determine if the JC accreditation process provides reasonable assurance that accredited hospitals are in compliance with the statutory requirements set forth at subsection 1861(e) of the Act and the Hospital CoPs.

The CMS used two types of SA validation surveys to evaluate the JC's performance in FY 2007: comprehensive "look-back" surveys of hospitals selected on a representative sample basis and conducted within sixty days of a JC survey; and focused "allegation," or complaint investigation surveys. The results of these validation surveys permit CMS to evaluate the JC's ability to identify deficiencies in hospitals' compliance with the Medicare CoPs.

The look-back validation surveys performed in FY 2007 found that there is an ongoing disparity between the JC and the SAs in their ability to identify hospital deficiencies, with significant deficiencies identified by SAs and not identified by the JC in 40 percent of the 55 hospitals subject to a look-back survey. The FY 2007 disparity rate is markedly higher than the FY 2006 rate of 25.4 percent, as well as previous disparity rates. From FY 2000 through FY 2007, the average disparity rate was 25.7 percent. As in previous years, the single largest source of the disparity remains the JC's ability to detect deficient compliance with requirements related to hospitals' physical environment, particularly *Life Safety Code®*

[1] The Joint Commission was formerly known as the "Joint Commission on Accreditation of Health Care Organizations (JCAHO)."

[2] The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), enacted on July 15, 2008, removes the JC's statutory accreditation authority for hospitals, effective July 15, 2010. At that time, JC's hospital accreditation program will be subject to the Centers for Medicare & Medicaid Services' (CMS) requirements for accreditation organizations (AO) seeking deeming authority. AOs seeking deeming authority from CMS must apply and undergo a thorough review of their accreditation policies and procedures for each provider type for which they seek deeming authority. The review includes determining the equivalency of the AO's requirements to CMS requirements; a review of the AO's survey process; monitoring procedures for providers and suppliers; the ability of the AO to report deficiencies to the facility; the ability of the AO to respond to the facility's plan of correction; and the ability to provide CMS with electronic data. MIPPA also expanded the Section 1875(b) which requires an annual report to Congress on the validation of the accreditation process of the JC to all national accreditation organizations under section 1865(a).

compliance. During FY 2007, in 16 of the 23 (70 percent) validation surveys with condition-level deficiencies, the Physical Environment CoP (which includes *Life Safety Code*® requirements) was the only non-compliant CoP cited. This is a disparity rate of 29 percent for *Life Safety Code*® alone. Condition-level deficiencies are those deficiencies that are serious enough that as a result, CMS takes enforcement action, including placing the accredited hospital under the jurisdiction of the SA until it either comes back into compliance or is terminated from participation in Medicare.

While 90 percent of complaints that warranted an on-site investigation by an SA of a hospital in FY 2007 involved a JC-accredited hospital, only 3 percent of the 4,109 allegation surveys conducted in JC-accredited hospitals by SAs found condition-level deficiencies.

JC Accreditation Activity

In FY 2007, the JC surveyed 1,451 hospitals and rendered six different types of accreditation decisions.

- Accreditation with full standards compliance—the hospital meets all JC standards and requirements.
- Accreditation with requirements for improvement—the hospital is granted accreditation after providing assurance that the recommendations for improvement identified in the JC survey process will be implemented.
- Conditional accreditation—the JC survey found the hospital was not in substantial compliance with JC standards, but is believed to be capable of achieving acceptable compliance relatively quickly. The JC conducts a follow-up survey, during which the hospital must demonstrate substantial correction of the identified deficiencies before it can be considered for full accreditation.
- Provisional accreditation—the hospital fails to successfully address all requirements for improvement within 45 days of the posting of the hospital's accreditation survey findings.
- Preliminary denial of accreditation—the hospital is denied accreditation but may appeal the denial with the possibility that the decision will be reversed.
- Accreditation denied—this final accreditation decision does permit further opportunity for review or appeal.

For Medicare initial certification, CMS accepts only JC accreditation decisions indicating full standards compliance. For accredited JC hospitals already participating in Medicare, CMS does not take action to terminate the provider agreement of a hospital that the JC puts into a status of accredited with requirements for improvement, conditional accreditation or provisional accreditation since CMS expects that the JC's oversight process will work to correct the deficiencies identified in these hospitals. If the JC terminates a Medicare-participating hospital's accreditation, the hospital reverts to the jurisdiction of the SA which will conduct a comprehensive survey to determine the hospital's compliance with the CoPs and take enforcement action as necessary.

Table 1 summarizes the JC hospital accreditation decisions reported to CMS for hospitals receiving an initial or renewal survey in fiscal years 2004 through 2007.

TABLE 1
JC Accreditation Decisions
Hospitals Surveyed in FY 2004, 2005, 2006, and 2007

Accreditation Decisions	# Hospitals, 2004 *(Percent)*	# Hospitals, 2005 *(Percent)*	# Hospitals, 2006 *(Percent)*	# Hospitals, 2007 *(Percent)*
Accreditation w/Full Standards Compliance	244 (14.96)	61 (4.18)	27 (1.81)	25 (1.72)
Accreditation with Requirements for Improvement	1,364 (83.63)	1,330 (91.03)	1,400 (94.02)	1,284 (88.49)
Conditional Accreditation	23 (1.41)	63 (4.31)	51 (3.43)	72 (4.96)
Provisional Accreditation	——±	——±	6 (0.40)	65 (4.48)
Preliminary Denial of Accreditation (PDA)*	2	13	3	4
Accreditation Denied	0 (0)	7 (0.48)	5 (0.34)	5 (0.35)
Total Surveyed	1,631 (100)	1,461 (100)	1,489 (100)	1,451 (100)

*The PDA count is a duplicate count to reflect the changing accreditation status during the JC appeals process. *(Source: JC)* Therefore this number is not included in the total surveyed.

±CMS does not currently have this information.

The JC revised its approach to assessing standards compliance with the introduction of its Shared Visions/New Pathways initiative in January 2004. This initiative was designed to support the JC's continuous improvement efforts. Key components of the initiative include a hospital self assessment, priority focus areas, and an outcomes-focused survey methodology that evaluates what happens to individual patients from their admission to discharge. Prior to January 2005, all JC surveys occurred on an announced triennial schedule with the hospital aware of the survey date well in advance. The JC incorporated unannounced periodic surveys into its approach in January 2005. Since implementation of the JC's outcomes-focused survey approach, the JC reports it has been identifying more instances of hospital noncompliance, and the table above supports this, as the percentage of hospitals determined to be in full standards compliance declined significantly after 2005, while those with requirements for improvement or warranting conditional accreditation only increased. In FY 2007, 88.49 percent of the hospitals the JC surveyed were identified as having requirements for improvement. In FY 2007, 72 hospitals, or approximately 5 percent, were conditionally accredited, and 5 hospitals (0.35 percent) were denied accreditation.

The CMS Validation Program Activity in FY 2007

A total of 55 comprehensive look-back validation surveys were completed by SAs in FY 2007. Through these unannounced surveys, SAs independently evaluate hospitals' compliance with all Medicare CoPs. SAs are not given knowledge in advance of any findings from the JC survey. In order to assure that the "look-back" survey is a reasonable assessment of the JC's survey process, rather than reflecting changed circumstances within a hospital, the look-back survey is conducted within 60 days following the hospital's JC accreditation survey.

The CMS selected a representative sample across all States of all hospitals surveyed in FY 2007 by the JC for look-back surveys. The 55 hospitals surveyed represent a 1.4 percent sample of all JC-accredited hospitals, but a 3.79 percent sample of all hospitals surveyed by the JC in FY 2007. In addition to these comprehensive surveys, SAs conducted focused

investigations of 4,109 complaints alleging substantial violations of Medicare CoPs in JC-accredited hospitals.

Table 2 summarizes CMS' validation program activity for FY 2005, 2006, and 2007.

TABLE 2
CMS Surveys Completed in JC-Accredited Hospitals

	2005		2006		2007	
Survey Type	**Number**	**Surveys with Condition-Level Deficiencies** *(Percent)*	**Number**	**Surveys with Condition-Level Deficiencies** *(Percent)*	**Number**	**Surveys with Condition-Level Deficiencies** *(Percent)*
Look-Back Surveys	47	20 (42.6)	67	30 (44.8)	55	23 (41.8)
Allegation Surveys	4,275	120 (2.8)	4,101	95 (2.3)	4,109	125 (3.0)

Look-Back Surveys—Validation and Disparity Rate

The rate of disparity is the percentage of look-back surveys for which an SA finds a hospital out of compliance with one or more Medicare CoPs, but no comparable condition-level deficiency was cited by the JC. Look-back validation surveys are conducted within 60 days of the JC survey. The assumption is that it is reasonable to conclude that significant, condition-level deficiencies found by the SA on a validation survey completed within 60 days of the JC survey were present at the time of the JC survey and should have been identified.

SAs found non-compliance with one or more CoPs in 23 of the 55 hospitals that had a look-back survey. Comparison of the JC-accreditation survey reports with the SA survey reports for these 23 hospitals showed that in 22 (96 percent) of these hospitals the JC surveyors did not identify deficiencies comparable to all of the condition-level deficiencies cited by the State agency surveyors. This equals a disparity rate of 40 percent between the JC and SA ability to detect deficiencies. This FY 2007 disparity rate of 40 percent compares with an average disparity rate of 25.7 percent between FY 2000-2006. Table 3 illustrates the FY 2007 results. Considering only those surveys where Physical Environment (PE), includes *Life Safety Code*®, was the sole condition-level deficiency, the disparity rate would be 29.1 percent. Table 3 illustrates the FY 2007 results.

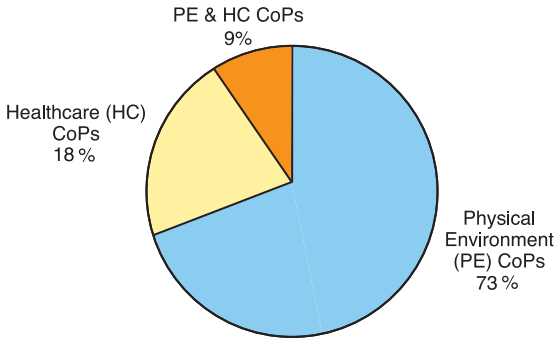
TABLE 3
Look-Back Survey FY 2007 Results

State Agency Deficiency Citations (CoPs Only)	Hospitals where SA cited CoP-Level Non-Compliance	Hospitals with Comparable JC Requirements for Improvement	Hospitals where JC missed 1 or More CoP-Level Area(s) of Non-Compliance	Total Hospitals Sampled	Disparity Rate (percent)
Physical Environment (PE)	16	0	16	55	29.1
Healthcare (HC)	5	0	4	55	7.3
Both PE & HC	2	0	2	55	3.6
Total	**23**	**0**	**22**	**55**	**40.0**

Other Accompanying Information

For the hospital validation analysis CMS compares the SA condition-level findings with the JC's requirements for improvement. Graph A illustrates the fact that compliance with the PE CoP (primarily the *Life Safety Code*® requirements involving fire safety precautions) was the most common area of discrepancy during FY 2007.

Graph A: Hospitals with Condition-level Findings Missed by JC during FY 2007



Several factors may have contributed to the JC's disparity rate: smaller CMS validation survey sample size; JC policy of citing PE as a supplemental finding; and, a different approach between CMS and JC to evaluating PE compliance.

- **Small sample size.** Due to delay in adopting the FY 2007 budget, which resulted in a shorter timeframe for selection and completion of validation surveys, the sample size for validation surveys is smaller than in FY 2006, and consisted of only 55 surveys, 18 percent smaller than the FY 2006 sample. Smaller sample size can increase the apparent impact of year-to-year changes.
- **Citing a deficiency as a supplemental finding as opposed to a requirement for improvement.** For a number of hospitals, the JC surveyors actually found deficiencies in the same areas as SA surveyors. However, the findings were cited as supplemental findings rather than as requirements for improvement. JC policy requires hospitals to correct their deficiencies when requirements for improvement are cited. JC policy on supplemental findings, on the other hand, does not require the facility to correct the deficiencies. CMS considers only JC requirements for improvement as comparable to SA condition-level findings in the hospital validation analysis because there is no follow-up oversight by the JC for supplemental findings. If those supplemental findings were instead cited as requirements for improvement and were comparable to SA findings, then the disparity rate for FY 2007 would have changed from 40 percent to 25.4 percent. This would represent a 37 percent decrease in disparity rate and would have yielded the same disparity rate as FY 2006.
- **Different approach to citing PE.** The JC has a Building Maintenance Program that requires hospitals to complete a self assessment of their physical environment (including *Life Safety Code*®) on a regularly scheduled basis. If a JC surveyor finds a deficiency on survey that it expects would have been detected by the hospital in its next Building Maintenance Program self-assessment, the JC surveyor does not cite the deficiency. This approach is not permitted under the CMS survey methodology, which requires surveyors to cite all documented deficiencies. This difference in survey methodology may also have resulted in PE deficiencies that were observed by the JC surveyors, but not cited in the JC's survey report.

Other Accompanying Information

The JC's performance in identifying *Life Safety Code®* problems in hospitals has been the subject of frequent communication between CMS and the JC in recent years. In response, the JC has implemented various measures to improve its performance in this area. A number of these measures are highlighted later in this report.

Table 4 shows the specific types and frequency of health and safety CoPs that were identified by the SA and where the JC did or did not make similar findings during the JC accreditation survey. Since the disparity rate calculated by CMS is based on the percentage of hospitals with disparate findings, rather than the number of times specific CoPs were missed, the results of this table do not correspond directly with the disparity rate. The table is useful, however, to identify the specific areas where the JC did not identify the types of deficiencies SAs found. Since FY 2005, in addition to PE, the following CoPs have represented repeat areas of disparate findings between the JC and SAs: Infection Control, Patient Rights, Nursing Services, Governing Body, and Food and Dietetic Services.

TABLE 4
Conditions of Participation Cited During FY 2007 Look-Back Surveys

Conditions of Participation	Cited by the State Agency	Similar Findings Identified by the JC	Findings Not Identified by the JC *(Percent)*
Physical Environment Condition of Participation			
Physical Environment *(Includes Life Safety Code®)*	20	6	14 (70%)
Other Conditions of Participation			
Governing Body	2	1	1 (50%)
Patient Rights	3	0	3 (100%)
Quality Assessment Performance Improvement	2	0	2 (100%)
Medical Records	1	1	0 (0%)
Infection Control	1	1	0 (0%)
Nursing Services	2	1	1 (50%)
Pharmaceutical Services	2	2	0 (0%)
Food and Dietetic Services	2	0	2 (100%)
Medical Staff	1	1	0 (0%)
Emergency Services	1	1	0 (0%)
Total	**37**	**14**	**23 (62%)**

Table 5 shows the look-back disparity rate from FY 2000 through FY 2007. The FY 2007 rate of 40.0 percent is a substantial increase from the 2006 disparity rate of 25.4 percent. However, the look-back survey disparity rate has been consistently above 20 percent since FY 2000. While it may be argued that the relatively small number of look-back surveys (55 in FY 2007) creates some statistical uncertainty when calculating the disparity rate, JC's disparity rate has consistently exceeded 20 percent for the past eight years and it is unlikely that larger sample sizes would alter this finding.

TABLE 5
Look-Back Survey Disparity Rates
FY 2000–2007

FY	Disparity Rate
2000	26.6%
2001	24.0%
2002	22.3%
2003	26.3%
2004	27.2%
2005	27.6%
2006	25.4%
2007	**40.0%**

Following the end of a validation review period, the regulation at 42 CFR 488.8(d) requires that CMS identify any AO with a disparity rate exceeding 20 percent. The regulation at 42 CFR 488.8(f) also requires that CMS conduct a deeming authority review of the AO's program if the validation review produces a disparity rate of 20 percent or more, or; irrespective of the disparity rate, indicates widespread problems in the accreditation process providing evidence that there is no longer reasonable assurance that the AO meets Medicare's requirements. While current law does not provide for application of this standard to the JC hospital accreditation program, in order for the JC to retain CMS recognition of its Hospital accreditation program after July 15, 2010, it will be required to submit an application for such recognition and demonstrate that its program satisfies CMS requirements. In the meantime, CMS nonetheless reviews the look-behind survey results with the JC each year, makes recommendations, and solicits response from the JC with regard to future actions the JC may take. CMS will continue to work closely with the JC to minimize differences in the two organizations' standards and survey procedures as a means to reduce the JC's disparity rate.

Allegation (Complaint) Survey Findings

In addition to the comprehensive validation surveys, CMS conducts focused surveys through SAs to investigate allegations of serious deficiencies in JC-accredited hospitals. CMS evaluates each such allegation received. If CMS believes that the complaint, if substantiated, would mean the hospital is out of compliance with one or more CoPs, CMS will then authorize the SA to conduct a substantial allegation survey focused on those specific CoPs.

JC-accredited facilities accounted in FY 2007 for approximately 83 percent of all Medicare-participating hospitals. As was indicated in Table 2, SAs conducted 4,109 allegation surveys in JC-accredited hospitals, and 3 percent of these surveys involved condition-level deficiencies, (i.e., they were serious enough to warrant CMS taking enforcement action against these hospitals). Table 6 indicates the CoPs most frequently cited for non-compliance by the SAs.

Patients' Rights, Nursing Services, and Governing Body continue to be among the top 3 CoPs for 2006 and 2007. At present, CMS does not include allegation surveys in the disparity rate calculation. However, CMS may develop specific accreditation agency performance measures to apply to complaint data and findings in the future.

TABLE 6
Most Frequently Cited Conditions of Participation During Allegation Surveys for JC-Accredited Hospitals, FY 2006-2007

2006 Conditions Not Met	Frequency (Percent of allegation surveys)
Patients' Rights	52 (44)
Nursing Services	37 (31)
Governing Body	24 (20)

2007 Conditions Not Met	Frequency (Percent of allegation surveys)
Patients' Rights	62 (50)
Governing Body	46 (37)
Nursing Services	41 (33)

JC Improvement Efforts

The CMS continues to make recommendations to the JC that would improve the JC's evaluation of *Life Safety Code*® compliance by hospitals. The JC reports it has implemented the following recommendations.

- **Completion of the Statement of Conditions by Qualified Personnel.** We recommended that the JC require hospitals to use personnel with specific *Life Safety Code*® credentials and skills to contribute to the statement of conditions self-assessment that hospitals prepare as part of the JC accreditation process. The JC reports it now requires hospitals to assign responsibility for completing the PE portion of the statement of conditions to someone whose experience is commensurate with the scope of the *Life Safety Code*® activities required for the assessment.
- **Set Minimum Standards for the Statement of Conditions/Plans for Improvement.** The JC reports that all hospital statement of conditions and plans for improvement are now reviewed for adequacy by the JC corporate office staff.
- **Submission of the Statement of Conditions and Plans for Improvement to the JC prior to survey.** The JC has required prior submission of these documents since implementation of its comprehensive revision of its survey process, Shared Visions/Shared Pathways in 2004.
- **Increase number of *Life Safety Code*® experts.** The CMS' initial recommendation focused on the JC increasing the capacity of *Life Safety Code*® experts in the corporate office to evaluate statement of conditions and plans for improvement. However, the JC has made many improvements since 2004 in the area of *Life Safety Code*®.
  - — In the fall of 2004, the JC hired and trained 50 *Life Safety Code*® specialty surveyors to review *Life Safety Code*® in hospitals with greater than 200 beds.
  - — In 2006, the JC increased the number of corporate office professional engineers by 30 percent to evaluate the statement of conditions and plans for improvement.
  - — During 2007 the length of time spent on-site for the *Life Safety Code*® portion of the JC hospital survey was expanded to two days for hospitals with greater than 750,000 square feet.

— Beginning January 2008, all hospitals and critical access hospitals (CAH) are now surveyed for *Life Safety Code*® by a *Life Safety Code*® specialist.

— In 2009, as part of the Standards Improvement Initiative, the JC will have a chapter in each of its accreditation manuals devoted entirely to the *Life Safety Code*®.

— With the addition of the *Life Safety Code*® surveyors, there has been a notable increase in conditional accreditation decisions related to life safety issues and a significant increase in environment of care findings.

JC's Conditional Findings Related to the Life Safety Code®
Statement of Conditions and Interim Life Safety Measures

Year	# of Conditional Findings
2005	2
2006	17
2007	20

- **Suspension of the Building Maintenance Program.** The JC's Building Maintenance Program (BMP) was initiated in 1998. Its premise is that hospital facility staff has scheduled activities that manage common deficiencies such as door latch failures, broken door closures, penetrations in smoke barriers, etc. If an organization provides evidence of an effective BMP to JC surveyors, the related identified deficiencies are not cited during survey. Instead, the JC expects that the organization will identify and document the deficiency during its next scheduled rounds. This is not consistent with CMS' approach. Although CMS supports the concept of a BMP, CMS expects SA surveyors to cite all identified deficiencies. In 2009, the JC plans to remove the BMP as an option for *Life Safety Code*® compliance. The Life Safety chapter overview will, however, identify a BMP as a best practice that organizations may want to consider to help manage their buildings.
- **Develop Mechanisms for Facilities that Fail to Comply with the Timeframes for Correction Identified in their Plans for Improvement.** The JC reports that it has expanded its use of requirements for improvement, conditional accreditation, and preliminary denial of accreditation as a mechanism to bring hospitals into compliance with accreditation standards. As discussed below, recent data support these assertions, and we believe these are positive developments.

In addition to implementing the previous CMS recommendations, the JC has undertaken other improvement efforts:

- **Elimination of Supplemental Findings.** Beginning January 1, 2009, the JC will eliminate supplemental findings. One of the factors that contributed to the JC's disparity rate for FY 2007 was the citation of deficiencies as a supplemental finding as opposed to a requirement for improvement. Perhaps with the elimination of the supplemental findings, many of the deficiencies that were once cited as supplemental will be cited as a requirement for improvement and positively impact the disparity rate.
- **Electronic Statement of Conditions™.** The JC is also working with its accredited organizations to have a more efficient and effective methodology for managing deficiencies though the use of an electronic Statement of Conditions™. Starting on

September 9, 2007, all JC-accredited organizations have been required to use this electronic process, which includes basic building information and an electronic plan for improvement.

- **Expanded Use of "Requirements for Improvement" and "Conditional Accreditation."** The JC continues its expanded use of requirements for improvement and conditional accreditation. The number of surveys with full standards compliance remains at about 2 percent compared to 15 percent in FY 2004. Hospitals with conditional accreditation increased from 1 percent to an average of 4 percent between 2005 and 2007. Hospitals that were denied accreditation increased from 0 percent in 2004 to an average of 0.34 percent between 2005 and 2007. Because the JC also raised the number of identified deficiencies that may be evident before a hospital's unconditional accreditation is seriously threatened, it is unclear if there has been a net change in enforcement itself. Nonetheless, we regard the recent changes in JC survey methods and interpretation as clear improvements that result in better ability to identify deficiencies and provide important feedback to hospitals. The provision of such expanded feedback can be instrumental in setting the stage for improvement in hospital practices.
- **Conducting its own Version of "Look-back" Surveys.** In August 2005, the JC began a one-time series of "look back" random announced validation surveys, using a survey team with specialized training. Results were used to identify further areas of improvement in the JC survey process.

According to the JC data, the above actions have already resulted in a substantial increase in the number of deficiencies identified in the *Life Safety Code®* area in hospitals. In 2007, there were 2,212 citations for life safety deficiencies; 1,328 (60 percent) were on surveys with a *Life Safety Code®* surveyor. This is a 55.7 percent increase in citations over FY 2006. Table 7 provides information regarding the *Life Safety Code®* scoring trends and the increase in citations between 2004 and 2007.

TABLE 7
Joint Commission Life Safety Code® Scoring Trends
CY 2004–2007

	2004	2005	2006	2007
Number of Surveys	1,425	1,436	1,427	1,451
Number of Citations for Life Safety	521	1,345	1,363	2,122
Percentage of Surveys including a Life Safety Code® specialist	N/A	38%	38%	37%

Source: JC

Table 8 provides information regarding the number of immediate threat to life findings that related to *Life Safety Code®* between 2004 and 2007. An immediate threat to life is a designation given by the JC to situations identified on survey that have or may potentially have a serious adverse effect on patient health and safety. The CMS is also very pleased that the JC has continued to communicate in a timely manner with SAs and CMS about such cases, in order to mobilize collaborative action in response to situations that pose a very serious and immediate threat to the safety of patients.

TABLE 8
Joint Commission Immediate Threat to Life Comparison

Year	Number of Threat to Life Findings	Environment of Care/ *Life Safety Code*® (percent)
1993–2004	13	4 (30.8)
2005–2006	16	10 (62.5)
2007	11	5 (45.5)

While CMS commends the significant efforts that the JC has invested overall in improving its ability to identify *Life Safety Code*® deficiencies and enforce compliance with *Life Safety Code*®, it remains to be seen whether these changes will translate into future reductions in the disparity rate. CMS recognizes that the JC's efforts have yielded better feedback to hospitals. Despite this year's high disparity rate, indicating that the JC did not identify all of the serious deficiencies that SAs did, our review of JC surveys shows an increase in the JC's identification of deficiencies related in *Life Safety Code*®. We expect the FY 2008 data to offer better opportunity to determine whether the JC's investments in enhanced *Life Safety Code*® enforcement will succeed in future years in bringing its disparity rate down significantly.

CMS Oversight Improvement

In July 2004, the Government Accountability Office (GAO) made several recommendations that might be used to improve CMS' oversight of the hospital accreditation program[2]. The recommendations included modifying the method used to calculate the disparity rate, identifying additional indicators of JC performance, and increasing the validation sample size. The CMS initiated action to enhance our oversight of JC hospital accreditation (described below) although resource limitations have made for slow progress. We expect that Congressional support for the President's 2009 budget request for survey and certification will enable more rapid progress.

- **Ongoing Communication with the JC.** The CMS instituted a series of periodic meetings with all of the accreditation organizations with deeming authority, including the JC. These meetings serve to foster communication between the AOs and CMS and serve as a forum to discuss any issues as they arise in order to better assure ongoing provider compliance with Medicare CoPs.
- **Emergency Preparedness.** The CMS has continued to collaborate and communicate with the JC and other AOs on strategies for improved health care provider emergency preparedness in response to all hazards regardless of the magnitude.
- **Methodological Changes to Improve Oversight.** The CMS is assessing differing approaches to refining and improving upon the current method of measuring the JC's performance in assuring compliance with the CoPs. CMS continues to work with the contractor secured in FY 2006 to assist in this endeavor. A revised approach to performance assessment may also require regulatory revisions.

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

- **Hospital Validation Sample Size.** In recent years, CMS has attempted to increase the hospital validation sample size to increase the significance of the validation survey analyses despite growth in both SA costs and the number of facilities participating in Medicare. Each year, CMS instructs SAs to plan for a base level of hospital validation surveys, but must await the adoption of the Federal budget to determine how much funding will be available to increase the validation sample size taking into consideration the number of JC surveys to be conducted during the remainder of the fiscal year, and the operational feasibility within SAs of conducting an increased number of look-back surveys during a compressed time period. In FY 2008, these factors combined to reduce the comprehensive validation survey sample size by 18 percent when compared with FY 2007 levels. The President's proposed budget for FY 2009 would permit a larger sample size than the level permitted in FY 2008.
- **Analysis of Complaint Data.** The CMS is investigating cost-effective approaches to enhancing hospital survey activities, including integration into our overall assessment of the JC's performance, the results of complaint investigations conducted in JC-accredited hospitals.
- **Database Accuracy and Regular Exchange of Data.** Timely, complete, and readily usable data on the JC's accreditation activities is a prerequisite to effective evaluation by CMS of the JC's performance. A number of operational barriers have made optimal data exchange challenging for both the JC and CMS. We will continue to work with the JC to obtain more comprehensive and regular information about its accreditation activities and accredited facilities, and to expedite the exchange of data and information between the two organizations. In 2008, CMS initiated a national database ("Assure") to improve the accuracy of data-matching between CMS and AO information systems. The new database will improve the accuracy of CMS accreditation information and strengthen oversight.
- **Disparity Rate Methodology.** Action to revise the regulations amending methodologies used to calculate disparity rates will await further learning from analysis of recent data, as well as addition of resources sufficient to enlarge the sample size for validation surveys.

CLINICAL LABORATORY IMPROVEMENT VALIDATION PROGRAM

Introduction

This report on the Clinical Laboratory Improvement Validation Program covers the evaluations of fiscal year (FY) 2007 performance by the six accreditation organizations approved under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The six organizations are as follows:

- AABB
- American Osteopathic Association (AOA)

- American Society for Histocompatibility and Immunogenetics (ASHI)
- COLA
- College of American Pathologists (the College)
- The Joint Commission[1]

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, we see this as an opportunity to present information about, and dialogue with, each organization as part of our mutual interest in improving the quality of testing performed by clinical laboratories across the Nation.

Legislative Authority and Mandate

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

In Section 353(e)(2)(D), the Secretary is required to evaluate each approved accreditation organization by inspecting a sample of the laboratories they accredit and "such other means as the Secretary determines appropriate." In addition, Section 353(e)(3) requires the Secretary to submit to Congress an annual report on the results of the evaluation. This report is submitted to satisfy that requirement.

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

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

The CLIA regulations, in Section 493.575 of Subpart E, provide that if the validation inspection results over a one-year period indicate a rate of disparity of 20 percent or more

[1] Formerly known as the Joint Commission on Accreditation of Healthcare Organizations.

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,[2] 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 2007. Laboratories seek and relinquish accreditation on an ongoing basis, so the number of laboratories accredited by an organization during any given year fluctuates. Moreover, many laboratories are accredited by more than one organization. Each laboratory holding a Certificate of Accreditation, however, is subject to only one validation survey, 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

[2] 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.

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 roughly proportionate to each organization's representation in the universe of accredited laboratories, however true proportionality is not always possible due to the complexities of scheduling.

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

Results of the Validation Reviews of Each Accreditation Organization

AABB

Rate of disparity: 10 percent

Approximately 220 laboratories used their AABB accreditation for CLIA purposes.

Ten validation surveys were conducted. Of those ten surveys, nine resulted in no condition-level deficiencies and one resulted in a condition-level deficiency. A comparable deficiency was not noted by the AABB inspection, thus it was a disparity.

Following is a listing of the laboratory identification number, location, and condition-level deficiency of the laboratory where the AABB finding was disparate.

CLIA number	Location	CLIA Conditions
26D0696099	Missouri	Inspection Requirements

We note that AABB has had no disparities in ten years of the twelve-year history of CLIA validation reviews.

American Osteopathic Association

Rate of disparity: 25 percent*

For CLIA purposes, approximately 40 laboratories used their AOA accreditation. Four validation surveys were conducted this year. No condition-level deficiencies were cited in three of the surveys. In one survey the CLIA validation survey cited the laboratory for improper enrollment for gynecologic proficiency testing and the AOA inspection report did not have a comparable finding.

*When the pool of validation surveys is four, one disparate case causes a mathematical outcome that can be disproportionate and must viewed in that context as well as the historical context.

Following is a listing of the laboratory identification number, location, and condition-level deficiency of the laboratory where the AABB finding was disparate.

CLIA number	Location	CLIA Conditions
O5D0612926	California	Enrollment and Testing of Samples—Gynecologic Proficiency Testing

This organization has had a history of 0 percent disparity in the eleven annual validation reviews prior to this year, and has taken measures to ensure proper enrollment by all

AOA-accredited laboratories. Moreover, CMS has required the AOA to report on its corrective actions and whether those measures have been effective and sustained. CMS views this to be the most appropriate action in light of the small pool of validation surveys and the AOA's history of no disparities (0 percent) in all the previous CLIA validation reviews.

American Society for Histocompatibility and Immunogenetics

Rate of disparity: No disparity

Approximately 130 laboratories used their ASHI accreditation for CLIA purposes. Three validation surveys were conducted. One of the three surveys resulted in a condition-level deficiency. Comparable deficiency findings were indicated in the ASHI inspection report, thus there was no disparity.

COLA

Rate of disparity: 7 percent

A total of 158 validation surveys were conducted at laboratories accredited by COLA. One survey was removed from the review pool for administrative reasons. Of the remaining 157 surveys, fourteen laboratories were cited with condition-level deficiencies. Comparable deficiencies were noted by COLA in three out of the fourteen laboratories cited with CLIA condition-level deficiencies.

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

CLIA number	Location	CLIA Conditions
04D0906955	Arkansas	Analytic System; Laboratory Testing Personnel
05D0990631	California	Successful Participation—Proficiency Testing
17D0449611	Kansas	Laboratory Director
19D0463281	Louisiana	Pre-analytic Systems Analytic Systems Laboratory Director
23D1044410	Michigan	Enrollment and Testing of Samples— Proficiency Testing; Hematology
33D0163892	New York	Laboratory Director; Technical Consultant
34D0998524	N. Carolina	Laboratory Director
36D0333631	Ohio	Successful Participation—Proficiency Testing
36D0875059	Ohio	Laboratory Director
44D0694745	Tennessee	Pre-analytic Systems; Analytic Systems Post-analytic Systems
52D1024720	Wisconsin	Successful Participation—Proficiency Testing

College of American Pathologists

Rate of disparity: 7 percent

A total of 97 validation surveys were conducted at laboratories accredited by the College. Seven of the laboratories surveyed were cited with condition-level deficiencies.

In each of the seven laboratories, the College either noted some comparable deficiencies or no comparable deficiencies, but did not note comparable deficiencies for all of the CLIA condition-level deficiencies cited. Thus each was determined to be disparate.

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
12D0064446	Hawaii	Successful Participation—Proficiency Testing
17D045262	Kansas	Inspection Requirements
26D0917611	Missouri	Inspection Requirements
32D0538733	New Mexico	Syphilis Serology
34D0247682	N. Carolina	Analytic Systems
34D0663140	N. Carolina	Analytic Systems
46D0524409	Utah	Laboratory Testing Personnel

The Joint Commission

Rate of disparity: 3 percent

During this validation period, a total of 77 validation surveys were conducted at laboratories accredited by the Joint Commission. Three surveys were removed from the review pool for administrative reasons. Of the remaining 74 validation surveys, six laboratories were cited with CLIA condition-level deficiencies. Comparable deficiencies were noted by the Joint Commission in four of the six laboratories cited with condition-level deficiencies.

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

CLIA number	Location	CLIA Conditions
34D0018409	N. Carolina	Analytic Systems
40D0680682	Puerto Rico	Facility Administration; Analytic Systems Laboratory Director

Conclusion

The CMS has performed this validation review in order to evaluate and report to Congress on the performance of the six laboratory accreditation organizations approved under CLIA. For fiscal year 2007 there was no indication in the validation review of all of the accreditation organizations that would raise questions about the overall equivalency of each of their accreditation programs.

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 the Medicare Advantage program), and expansion of preventive benefits.

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

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

C

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

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

Deficit Reduction Act of 2005: The Deficit Reduction Act restrains Federal spending for entitlement programs (i.e. Medicare and Medicaid) while ensuring that Americans who rely on these programs continue to get needed care. Provisions of the act include a requirement for wealthier seniors to pay higher premiums for their Medicare coverage; restrain Medicaid spending by reducing Federal overpayment for prescription drugs so that taxpayers do not have to pay inflated markups; and include increased benefits to students and to those with the greatest need.

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.

GLOSSARY

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.

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

Medicare Advantage (MA) Program: This program reforms and expands the availability of private health options that were previously offered to Medicare beneficiaries by allowing for the establishment of new regional preferred provider organizations plans as well as a new process for determining beneficiary premiums and benefits. Title II of MMA modified and renamed the existing Medicare+Choice program established under title XVIII of the Social Security Act to the MA program.

Medicare 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 established a new program in Medicare to provide a prescription drug benefit, Medicare Part D, which became available on January 1, 2006. Additionally, MMA sets forth numerous changes to existing programs, including a revised managed care program, certain payment reforms, rural health care improvements, and other changes involving administrative improvements, regulatory reduction, administrative appeals, and contracting reform.

Medicare Prescription Drug Program: The implementation of the MMA amended Title XVIII of the Social Security Act by establishing a new Part D—the Voluntary Prescription Drug Benefit Program. This program became effective January 1, 2006, and established an optional prescription drug benefit for individuals who are entitled to or enrolled in Medicare benefits under Part A and Part B. Beneficiaries who qualify for both Medicare and Medicaid (full-benefit dual eligibles) automatically receive the Medicare drug benefit.

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

Medicare Secondary Payer (MSP): A statutory requirement that private insurers who provide general health insurance coverage to Medicare beneficiaries must pay beneficiary claims as primary payers.

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 are of acceptable quality.

R

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

Reportable Condition: A matter coming to the auditor's attention that should be communicated because it represents either an opportunity for improvement or a significant deficiency in the design or operation of the internal control structure.

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

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

S

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

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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The CMS welcomes comments and suggestions on both the content and presentation of this report. Please send them to Lataysheia Lance by email or CMS, Mail Stop N3-11-17, 7500 Security Blvd., Baltimore, MD 21244-1850. Copies of this report are also available on the Internet at http://www.cms.hhs.gov/CFOReport/

U.S. Department of Health and Human Services

Michael Leavitt, Secretary

Centers for Medicare & Medicaid Services

Kerry Weems, Acting Administrator

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