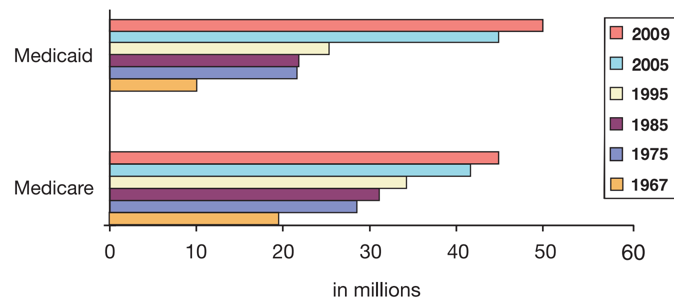
CMS Financial Report

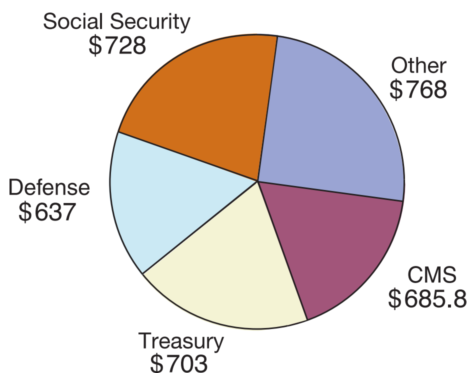
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

FISCAL YEAR 2009

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





The **CMS** had outlays of approximately $685.8 billion (net of offsetting receipts and Payments to the Health Care Trust Funds) in fiscal year (FY) 2009, approximately 19 percent of total Federal outlays.

The **CMS** has over 4,550 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, provides health insurance protection to workers changing jobs, and maintains the largest collection of health care data in the United States.

Acting Administrator
Washington, DC 20201

A Message from the Acting Administrator

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) Financial Report for fiscal year (FY) 2009. This report describes our financial results for the last year and our accomplishments in pursuing our mission and vision of ensuring effective, up-to-date health care coverage, promoting quality of care for beneficiaries, and achieving a transformed health care system that is fully in step with medical care in the 21st century. I am certain you will find the financial and program data presented in this report a reliable representation of how CMS managed its finances and administered its programs during the past year.

On February 17, 2009, President Obama signed into law the American Recovery and Reinvestment Act of 2009 (the Recovery Act), which sought to revitalize the overall economic condition of the country, as well as foster unprecedented levels of accountability and transparency in government spending. One of the key provisions of the law required CMS, under tight time constraints, to make Recovery Act funds immediately available to the states and territories to ensure they could meet the health care needs of their most vulnerable citizens —certain low-income Americans, including children, their parents, pregnant women, the elderly and people with disabilities. Over the course of FY 2009, CMS disbursed approximately $31 billion to the states and territories, making the Department of Health and Human Services the Federal Agency that has disbursed the most Recovery Act funds in the Nation.

Additionally, the Medicare and Medicaid Health Information Technology (HIT) provisions in the Recovery Act provides major opportunities for modernizing our health care systems by providing incentives and support for the adoption of certified electronic health records. Patient privacy and security is also an important part of HIT. The CMS has led the effort of developing the proposed rules for administering this new incentive program, and is working closely with the Office of the National Coordinator for Health Information Technology to implement these Recovery Act provisions.

The President also signed into law the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) in February 2009, which reauthorized the Children's Health Insurance Program (CHIP) through 2013, and preserves health care coverage for millions of children who rely on CHIP today. CHIPRA also provides the resources for states to cover millions of additional uninsured children. This was welcomed legislation, as it will help CMS ensure the health and well-being of our Nation's children.

As the largest health care purchaser in the world, we are continually seeking strategies that will help us ensure access to high quality health care at a reasonable price. The CMS is well underway

in implementing the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, which will be a vital tool in helping Medicare pay appropriately for health care. We strongly believe that the DMEPOS Competitive Bidding Program will result in reduced beneficiary out-of-pocket expenses and savings to taxpayers and the Medicare program.

In addition, reducing Medicare waste, fraud and abuse is a high priority for the Agency. At the direction of the Secretary, CMS is partnering with the United States Department of Justice in the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) joint task force to respond to health care waste, fraud, and abuse by using advanced data analysis techniques to identify criminals operating as health care providers and detecting emerging or migrating fraud schemes.

The CMS has made great strides this year, thanks to its outstanding and dedicated employees. It is CMS' employees, in conjunction with our myriad of partners that makes all of the work we do possible. Looking to the future, I am certain that together we will continue to improve and do what is best for our health care programs, and for the beneficiaries that we serve. As always, I am confident that CMS will rise to that challenge.

Charlene Frizzera
November 2009

A Message from the Acting Chief Financial Officer

Fiscal year (FY) 2009 marks the 11th consecutive year the Centers for Medicare & Medicaid Services (CMS) has achieved an unqualified financial statement audit opinion. This is an accomplishment that I am very proud of, and I believe, shows that CMS has clearly established a culture of integrity and fiscal accountability. As the Acting Chief Financial Officer (CFO), I have an obligation to build on our past successes in order to position the Agency for continued success in the future. To that end, we have undertaken exciting new initiatives and continue to make progress on existing ones to improve financial management and the operation of our programs. This fiscal year's noteworthy initiatives and accomplishments include:

- Continuing the implementation of the Healthcare Integrated General Ledger Accounting System (HIGLAS). HIGLAS was implemented at another Medicare contractor this year, bringing the total to 15 contractors that have successfully transitioned to the system. HIGLAS, when fully implemented at CMS and across all Medicare contractors, will strengthen the financial management of CMS' operations by providing timely and reliable financial information to decision makers throughout the Agency.

- Implementing the Department of the Treasury's Federal Payment Levy Program (FPLP), which was effective starting in FY 2009 under the *Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)*. The Agency has supported the FPLP by focusing on its implementation through HIGLAS, and completed FPLP withholding functionality for all the current HIGLAS Medicare contractors on November 7, 2008. During FY 2009, CMS realized approximately $40.8 million in tax levy offsets through HIGLAS, on behalf of FPLP.

- Continuing 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 provided a statement of reasonable assurance regarding our internal controls and financial management systems, reporting no material weaknesses.

During FY 2009, CMS significantly revised and restructured the way that it calculates the Medicare fee-for-service (FFS) error rate based on both the recommendations contained in recent OIG audit reports and those of CMS' advisory medical staff. As a result of refining our procedures, this year's error rate calculation was 7.8 percent. While this is an increase over the FY 2008 level of 3.6 percent, the use of new methodology and stricter review criteria makes it difficult to compare error rates between the two years. In the coming fiscal year, the CMS will work closely with its contractors to reduce the error rate by ensuring that Medicare FFS claims

receive more vigilant review before being processed and paid. The more vigilant review should result in more accurate and better documented claims.

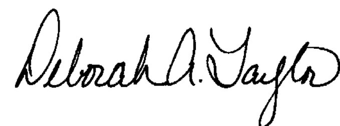
The CMS also continued to measure improper payments in the Medicaid program. However, in accordance with the *Children's Health Insurance Program Reauthorization Act of 2009*, the Children's Health Insurance Program (CHIP) error rate measurement is undergoing regulatory changes and has been temporarily suspended while CMS develops a new final rule for the Payment Error Rate Measurement (PERM) program.

Reducing Medicare waste, fraud and abuse is one of CMS' highest priorities to ensure that the program remains strong for current Medicare beneficiaries and future generations. During FY 2009, CMS took aggressive actions to ensure the solvency of the Medicare Trust Funds by:

- Combating Medicare fraud in high risk areas of the country by identifying and preventing over $2.1 billion in improper payments. The CMS worked with law enforcement to address a Medicare infusion scam that involved sham clinics recruiting HIV/AIDS patients, paying them kickbacks and then billing Medicare for astronomical amounts of infusion services. To date these efforts have resulted in more than $1.8 billion dollars in Medicare savings, with 20 criminal cases prosecuted against 42 defendants.

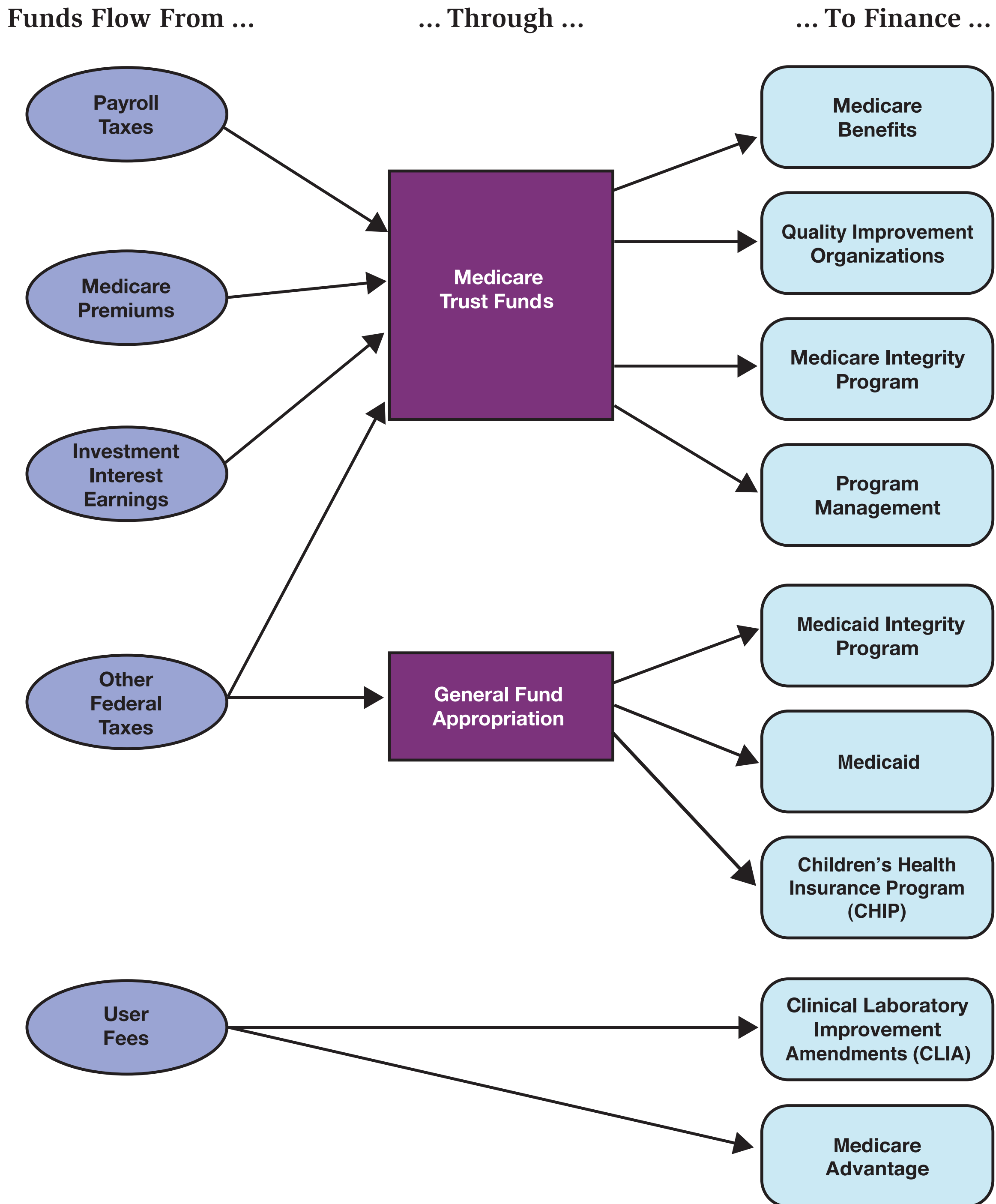
- Focusing on high vulnerabilities of fraud and abuse activities in the Medicare provider enrollment area, where there are a large number of beneficiaries and providers/suppliers. The CMS has implemented new accreditation standards for suppliers of durable medical equipment, orthotics, prosthetics, and supplies; tightened the provider enrollment process; provided more rigorous oversight and monitoring once a provider/supplier enrolls in the program; and strengthened the provider revocation process.

The CMS' commitment to financial management excellence is demonstrated in the work that we do and the accomplishments that we have made but there are still challenges that remain ahead of us. We are committed to reducing payment errors, identifying and eliminating health care fraud and improving program oversight. Ensuring the financial integrity and efficiency of our programs is essential to meeting our responsibilities to the Nation's taxpayers and to our beneficiaries. As we begin a new FY, we will continue to focus our efforts on the many initiatives we have in place to improve our financial management processes, systems, and programs as well as set new goals to improve our performance.



Deborah A. Taylor, CPA
November 2009

Financing of CMS Programs and Operations



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DEPARTMENT OF HEALTH & HUMAN SERVICES • USA

Approved Structure
As of November 2, 2009

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Office of Policy

Office of Equal Opportunity and Civil Rights

Office of Operations Management

Office of E-Health Standards & Services

Administrator

Deputy Administrator
and
Chief Operating Officer

Office of Beneficiary Information Services

Center for Drug and Health Plan Choice

Center for Medicare Management

Center for Medicaid and State Operations

Office of Clinical Standards and Quality

Office of Research, Development & Information

Office of Strategic Operations and Regulatory Affairs

Office of Acquisition & Grants Management

Office of Information Services

Office of Financial Management

Program Integrity Group

Office of the Actuary

Parts C & D Actuarial Group

Office of Legislation

Office of External Affairs

Medicare Ombudsman Group

Tribal Affairs Group

Consortium for Medicare Healthplans Operations

Consortium for Financial Management and FFS Operations

Consortium for Medicaid and Children's Health Operations

Consortium for Quality Improvement and S&C Operations

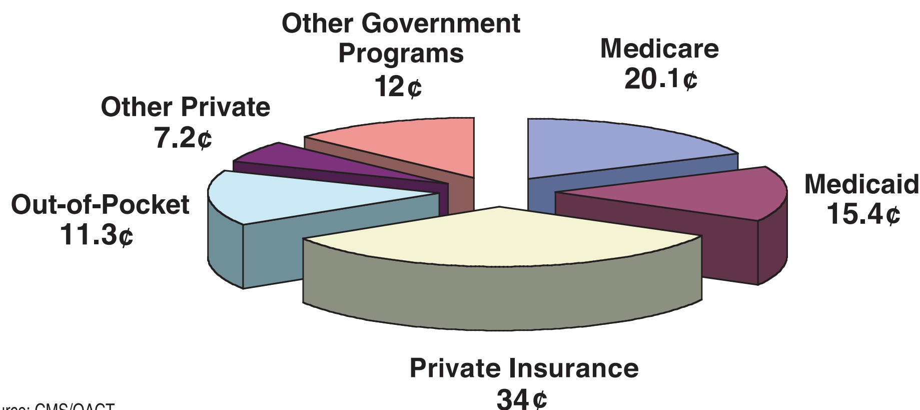
Management's Discussion and Analysis

OVERVIEW

The Centers for Medicare & Medicaid Services (CMS), a component of the Department of Health and Human Services (HHS), administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), 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 35 cents of every dollar spent on health care in the United States (U.S.)—or looked at from three different perspectives, 60 cents of every dollar spent on nursing homes, 46 cents of every dollar received by U.S. hospitals, and 28 cents of every dollar spent on physician services.

The Nation's Health Care Dollar 2009



Source: CMS/OACT

The CMS **outlays** totaled approximately $685.8 billion (net of offsetting receipts and Payments to the Health Care Trust Funds) in fiscal year (FY) 2009. Our **expenses** totaled approximately $749 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 CHIP, ensures quality of health care for beneficiaries, and safeguards funds from fraud, waste, and abuse. The CMS employs over 4,550 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, sponsors of group health plans, 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 CHIP. 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 CHIP, 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.

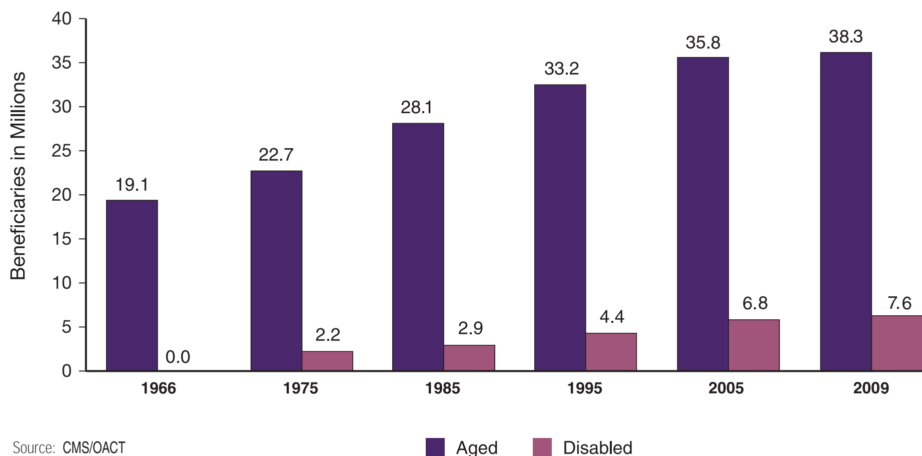
PROGRAMS

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 one of the largest changes to the Medicare program since its enactment in 1965.

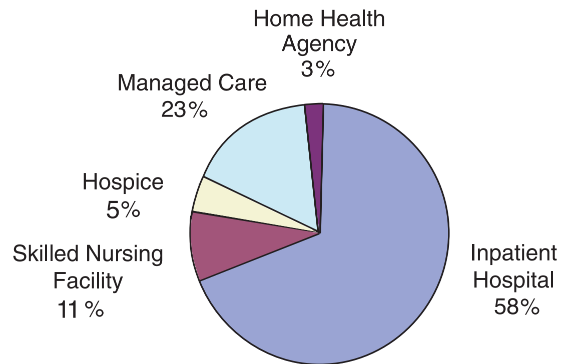
Medicare processes over one billion fee-for-service (FFS) claims a year, is the Nation's largest purchaser of managed care, and accounts for approximately 12 percent of the Federal Budget. Medicare is a combination of four programs: Hospital Insurance, Supplementary Medical Insurance, Medicare Advantage, and Medicare Prescription Drug Benefit. Since 1966, Medicare enrollment has increased from 19 million to approximately 46 million beneficiaries.



Hospital Insurance

Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. The HI program pays for hospital, skilled nursing facility, home health, and hospice care and is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the HI trust fund, and invested in U.S. Treasury securities.

Based on estimates from the FY 2010 President's budget, inpatient hospital spending accounted for 58 percent of HI benefit outlays. Managed care spending comprised 23 percent of total HI outlays. During FY 2009, HI benefit outlays grew by 8.7 percent and the HI benefit outlays per enrollee were projected to increase by 6.9 percent to $5,220.

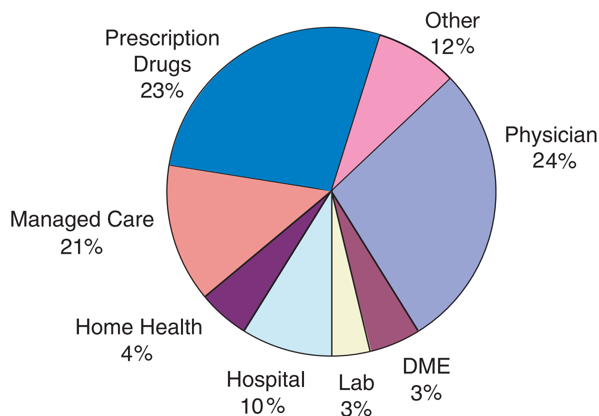


Supplementary Medical Insurance

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.

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 FY 2010 President's budget, SMI benefit outlays grew by 10.6 percent during FY 2009. Physician services, the largest component of SMI, accounted for 24 percent of SMI benefit outlays. During FY 2009, the SMI benefit outlays per enrollee were projected to increase 8.8 percent to $6,000.



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 if they are entitled to Part A and enrolled in Part B, if there is a plan available in their area. 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 (HMOs) 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 $109.7 billion of the total $483.6 billion in Medicare benefit payment expenses in FY 2009.

Medicare Prescription Drug Benefit

The passage of the MMA amended Title XVIII of the Social Security Act by establishing a new voluntary Prescription Drug Benefit Program. This new benefit constitutes one of the most significant changes to the Medicare program since its inception in 1965. The addition of this program recognizes the vital role of prescription drugs in our health care delivery system, and the need to modernize Medicare to assure their availability to Medicare beneficiaries. The prescription drug benefit is funded through the SMI account.

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. Beneficiaries who qualify for both Medicare and Medicaid (full-benefit dual-eligibles) automatically receive the Medicare drug benefit. The statute also provides for assistance with premiums and cost sharing to full benefit dual-eligibles and other qualified low-income beneficiaries. In general, coverage for this benefit 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 actuarially equivalent to standard coverage benefit. The 2009 standard benefits generally have a $295 deductible and coinsurance of 25 percent after the deductible up to the initial coverage limit of $2,700 in total drug spending. This is followed by a coverage gap for which beneficiaries pay 100 percent to an out-of-pocket spending limit of $4,350. Once the out-of-pocket spending reaches this level, Medicare pays 80 percent, the plan pays 15 percent, and the beneficiary generally pays 5 percent of drug costs for catastrophic coverage.

PDPs and MA PDs submit annual bids to CMS reflecting expected benefit payments plus administrative costs after a deduction for expected reinsurance subsidies. Payment for basic Part D benefits is made using five funding streams. Throughout the benefit year, CMS pays plans monthly prospective payments through a direct subsidy, a prospective payment for the low income cost-sharing subsidy (LICS), pays for the low income premium subsidy (LIPS), and a prospective payment for the reinsurance subsidy. After each plan year, the prospective payments are reconciled

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

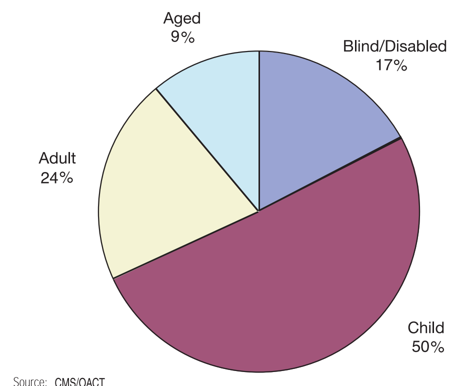
Employer, union, and other Plan Sponsors (PS) of group health plans that offer a prescription drug benefit that is actuarially equivalent to Part D are able to apply for the Retiree Drug Subsidy (RDS) program. A PS may only receive subsidy payments for qualifying covered retirees. All PS' that provide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

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. At the time cash assistance was provided to low-income families and children through the Aid to Families with Dependent Children (AFDC) program, while the Supplemental Security Income (SSI) program provided cash assistance to low-income aged, blind and disabled individuals. Over the years, Congress incrementally expanded Medicaid well beyond these original traditional populations. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including low-income families, pregnant women, and people of all ages with disabilities, who require long-term care. The average enrollment for Medicaid was estimated at 51 million in FY 2009 about 17 percent of the U.S. population. About 8 million people are dually eligible, that is, covered by both Medicare and Medicaid.

FY 2009 Medicaid Enrollees



American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law on February 17, 2009. Portions of ARRA directly affected the Medicaid Program under title XIX of the Social Security Act.

Federal Medical Assistance Percentage (FMAP) Increase for States

Congress acted to temporarily increase FMAP payments for the 50 states, the District of Columbia, and options for increased funding for the Territories during the current recession. Section 5001(a) and (b) of ARRA provide for maintenance of FMAPs for FY 2009 through the first quarter of FY 2011, and a general across-the-board increase of 6.2 percent for each of such fiscal years. Section 5001(c) provides for a further increase to the FMAPs for those states that have especially high unemployment rates.

FMAP Increase for Territories

Each Territory received a 30 percent increase in its cap on Federal funds provided under section 1108(f) and (g) of the Social Security Act. In accordance with the requirements of that provision, the Territories can receive an increase in the section 1108 cap specifically for the purpose of matching certain drugs provided to Part D eligible individuals. The amount of the 1108 cap, as adjusted in accordance with section 1935(e) of the Act, would then be increased under the ARRA by 30 percent. The increase in the 1108 cap does not at all change the existing requirement that in order for the jurisdictions to access these funds they must have actual expenditures for which the funds are available.

Medicaid Disproportionate Share Hospital (DSH) Program

Section 5002 of the ARRA amended section 1923(f)(3) of the Act to add a new subparagraph (E) under which the DSH payment allotments for the 50 states and the District of Columbia for FY 2009 and FY 2010 are increased by 2.5 percent above the amount such allotments would otherwise be determined under title XIX. This provision does not apply to the States of Hawaii and Tennessee; however, section 616 of the Children's Health Insurance Program Reauthorization Act of 2009 extended DSH allotments for such States to the first quarter of FY 2012.

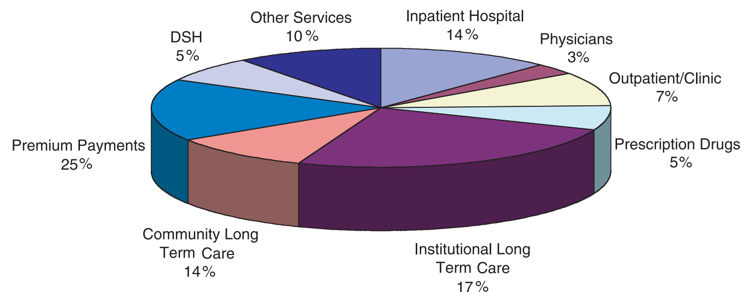
The CMS provides matching payments to the States and Territories to cover the Medicaid program and related administrative costs. State medical assistance payments are matched according to a formula relating each state's per capita income to the national average. In FY 2009, the basic Federal matching rate for Medicaid program costs among the States according to the formula ranged from 50 to 76 percent. However, the ARRA provides States with additional Federal matching funds. As a result, the average matching rate for FY 2009 was about 66 percent. Federal matching rates for various state and local administrative costs are set by statute, and currently average about 54 percent. Medicaid payments are funded by Federal general revenues 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 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 2009, Medicaid spending for persons with AIDS as well as others infected with the Human Immunodeficiency Virus (HIV) is estimated to be about $8 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 2009, state and Federal ADM gross outlays are estimated at $19.5 billion, about 5 percent of the gross Medicaid outlays. State and Federal MAP gross outlays are estimated at $371.9 billion or 95 percent of total Medicaid gross outlays, an



increase of 11.2 percent over FY 2008. Thus, state and Federal MAP and ADM outlays for FY 2009 totaled $391.4 billion. The CMS share of Medicaid outlays totaled $248.2 billion in FY 2009.

Enrollees

Children comprise nearly half of Medicaid enrollees, but account for only 20 percent of Medicaid outlays. In contrast, the elderly and disabled comprise 26 percent of Medicaid enrollees, but accounted for 62 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 50 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 71 percent in 2008[1].

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

1) State health reform waivers—section 1115 of the Social Security Act provides broad discretion to waive certain provisions of Medicaid law for experimental, pilot, or demonstration projects. In August 2001, the President announced a section 1115 initiative, known as Health Insurance Flexibility and Accountability, to increase health insurance coverage by coordinating available Medicaid and CHIP funding with private insurance options.

[1] 50 states offer managed care, the number includes DC and PR. VI, WY, and AK do not offer managed care. For MS, we counted them as having managed care because they have a capitated transportation program. The June 30, 2008 data is collected from the States and represents that point-in-time.

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, who are eligible for care in nursing homes according to state standards.

Children's Health Insurance Program (CHIP)

CHIP was created through the BBA of 1997 to address the fact that at the time nearly 11 million American children—one in seven—were uninsured and therefore at increased risk for preventable health problems. Many of these children were in working families that earned too little to afford private insurance on their own, but too much to be eligible for Medicaid. Congress and the Administration agreed to set aside nearly $40 billion over ten years, beginning in FY 1998, to create CHIP—the largest health care investment in children since the creation of Medicaid in 1965. The original CHIP budget authority expired September 30, 2007, but was extended by Congress through March 31, 2009 in the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007. On February 4, 2009, the Children's Health Insurance Reauthorization Act of 2009 (CHIPRA) was enacted and further extended CHIP through September 30, 2013. Section 101 and 108 of CHIPRA appropriated funds for the purposes of providing allotments to the States for their CHIP programs. Section 105 of CHIPRA changed the availability of the States' annual CHIP allotments from three to two years beginning with the FY 2009 CHIP allotments.

CHIP funds cover the cost of insurance, reasonable costs for administration, and outreach services to get children enrolled. To make sure that funds are used to cover as many children as possible, funds must be used to cover previously uninsured children, and not to replace existing public or private coverage. Important cost-sharing protections were also established so families would not be burdened with out-of-pocket expenses they could not afford.

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

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

The Deficit Reduction Act of 2005 (DRA) established a prohibition of using Federal CHIP 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. Section 112 of CHIPRA expands on this provision by stating that no new renewals of a waiver, experimental, pilot, or demonstration project for nonpregnant childless adults may be approved on or after February 4, 2009 (date of the enactment of CHIPRA). In addition, no new renewals of a waiver, experimental, pilot, or demonstration project for parents may be approved on or after February 4, 2009.

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 CHIP State plans and use Federal funds to provide health care coverage to as many children as possible. All 50 States, the District of Columbia, and the territories had approved CHIP State plans. As of April 1, 2009, State programs for CHIP included 12 Medicaid expansions (includes District of Columbia and all of the territories), 18 separate children health programs and 26 combination CHIP programs.

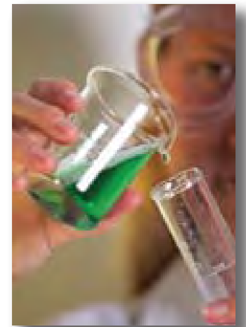
Other Activities

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

Survey and Certification Program

We are responsible for assuring the safety and quality of medical facilities, laboratories, providers, and suppliers by setting standards, training inspectors, conducting inspections, certifying providers as eligible for program payments, and ensuring that corrective actions are taken where deficiencies are found. The survey and certification program is designed to ensure that providers and suppliers comply with Federal health, safety, and program standards. We administer agreements with State survey agencies to conduct onsite facility inspections. Funding is provided through the Program Management and the Medicaid appropriations. Only certified providers, suppliers, and laboratories are eligible for Medicare or Medicaid payments. Currently, CMS Survey and Certification staff oversee compliance with Medicare health and safety standards in approximately 278,000 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 213,000 facilities. In partnership with the States, we certify and inspect approximately 20,200 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. The majority of the grants have been awarded no-cost extensions through 2010. Final project evaluations, those focused on health information technology, will be disseminated broadly to States and other stakeholders via the electronic health record incentive payment program authorized under ARRA.

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 emphasizes 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 the Quality Improvement Organization (QIO) Program, which Congress created in 1982 to provide a nationwide network of health organizations aimed at helping practitioners and providers improve. QIOs are Medicare contractors that work to improve quality of care, assess medical necessity and appropriateness of care, and review beneficiary and hospital appeals of discharge decisions. One QIO is stationed in each of the 50 states as well as the District of Columbia, the U.S. Virgin Islands, and Puerto Rico.

In 2008, CMS launched the QIO Program's 9th Statement of Work (SOW), which represented a significant shift in the way CMS approaches its quality responsibilities. In designing the SOW, CMS implemented recommendations from the IOM, the Government Accountability Office (GAO), and other internal and external stakeholders about how the QIO Program could better implement CMS' vision for improving the quality of American health care. In response to these recommendations, CMS has developed a robust framework of quality measures within the 9th SOW that provides accountability to the QIOs for making changes at all levels of the health care system. The 9th SOW also allows QIOs to focus their intervention projects across the spectrum of care, rather than in "silos" based on settings of care, as CMS has done in previous statements of work. This allows the QIOs to have a sector-wide impact on the provision of care to beneficiaries. Furthermore, for the 9th SOW, QIOs are focusing their interventions on those providers and practitioners who are most in need of assistance. QIOs are providing intensive,

one-on-one support with low-performing providers, rather than casting their nets of limited resources in less strategic ways, as many have done in the past.

The 9th SOW, which extends from August 2008 through July 2011, 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. Now in the second year of the SOW, QIOs are focusing their measurable improvement efforts on protecting beneficiaries, care transitions, patient safety, and prevention of chronic diseases. As QIOs have done in the past, they 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.

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 Agency for Healthcare Research and Quality (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.

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 the *Advancing Excellence in America's Nursing Homes* campaign. The campaign continues today. The campaign seeks excellence in the quality of life and quality of care for the more than 1.8 million American nursing home residents by enhancing choice, strengthening workforce, and improving clinical outcomes. Nursing homes participating in the campaign are working 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 help to create greater awareness of quality care and the resources available, and encourage providers to improve the care they deliver. The campaign reports 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 QIOs 9th SOW.

Through innovative partnerships, public reporting and its QIOs, CMS has achieved greater momentum toward Internet Only Manual's six aims. Through its public-private collaboration with the Hospital Quality Alliance (HQA), CMS provides a robust, prioritized, and standard 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. As of July 2009, information on over 4,400 hospitals is available on ***Hospital Compare***.

The data have been expanded to include:

- Process of care measures in the areas of heart attack, heart failure, pneumonia, pediatric asthma and surgical care,
- Outcomes of care measures (mortality and re-admission) related to hospitalizations for heart attack, heart failure and pneumonia,
- Hospital Consumer Assessment of Health Plans Survey (HCAHPS) that measures patients' perspectives on hospital care, and
- Medicare Payment and Volume data.

Kidney dialysis patients stand to benefit from CMS efforts around Medicare's End-Stage Renal Disease (ESRD) Quality Initiative. This initiative works to stimulate and support significant improvement in the quality of dialysis care. The CMS' primary strategy for implementing the Quality Initiative is the ESRD Network Organization Program. ESRD Network Organizations are CMS contractors who work throughout 18 geographic regions of the U.S. to oversee the quality of care ESRD patients receive, collect data that Networks and CMS use to administer the national Medicare ESRD program, and provide technical assistance to ESRD providers and patients about issues relating to quality and access of ESRD care. One example of this is the ESRD Networks' leadership of the Kidney Community Emergency Response (KCER) Coalition. Administered by ESRD Networks, KCER is the leading authority on emergency preparedness and response for the kidney community. KCER brings private and public stakeholders together to provide organization and guidance that seamlessly bridges emergency management stakeholders and the ESRD community nationwide. Other critical elements of the ESRD Quality Initiative include the availability of quality information on the Dialysis Facility Compare website and the collection of Clinical Performance Measures that help the entire kidney community identify the state of dialysis care in the nation.

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. Public comments are available on the Coverage website. 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 Health Insurance Portability and Accountability Act (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 January of 2009, CMS published two final rules to update the HIPAA code set and transactions standards. The first rule adopts the ICD-10 code set for diagnosis and inpatient hospital procedure coding as of October 1, 2013. The second rule adopts 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 adopts a new standard for Medicaid pharmacy subrogation. The compliance date for these changes is January 1, 2012.

With regard to HIPAA enforcement activities (non-privacy), in July 2009 the Secretary delegated authority for enforcement of HIPAA security complaints from CMS to the Office of Civil Rights (OCR). The CMS continues to operate based on a complaint-driven process, addressing transaction and code set complaints filed against covered entities by requesting and reviewing documentation of their compliance status and/or corrective actions. In addition, CMS has the authority to conduct compliance reviews of covered entities. Reviews target covered entities for which CMS had already received and investigated a HIPAA transaction and code set complaint.

The CMS is also responsible for identifying and adopting standards for electronic prescribing in the Medicare Part D program. In April 2009, CMS adopted uniform standards for medication history, formulary and benefits, and fill status notification (RxFill). It also required the National Provider Identifier (NPI), for use in e-prescribing transactions under Medicare Part D. These standards 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) of 1993 mandates that agencies have strategic plans, annual performance goals, and annual performance reports that make them accountable stewards of public programs. The CMS' performance measures are included in the

Annual Performance Budget and its Online Performance Appendix. The CMS performance measures emphasize the themes of accountability, stewardship, and a renewed focus on the customer with its strategic and annual goals and its mission "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 measures that are representative of our vast responsibilities. The Agency GPRA plan does not reflect every activity and challenge it encounters, but reflects key Administration and CMS priorities that represent vital mission-critical activities. The performance budget includes targets for the performance measures depicted, and establishes a method and data source for measuring and reporting progress. The CMS uses performance results to inform budget and operating decisions.

The FY 2009 performance budget includes 34 measures for CMS programs, highlighting major program areas. Some of CMS' key FY 2009 performance measures and outcomes are highlighted below. Progress on all of the measures will be submitted through FY 2011 President's budget request process.

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 2009 target for the Medicare FFS error rate was 3.5 percent (gross) with a baseline of 10.1 percent in 2004.

The CMS analysis for FY 2009 indicates that the gross paid claims error rate is 7.8 percent or $24.1 billion in gross improper payments. The CMS did not meet its goal for FY 2009.

This year CMS implemented a number of changes in the improper payment measurement methodology that impacted the error rate. In the past, the Medicare FFS improper payment estimate was derived from two programs: the Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring Program (HPMP). The CERT program calculated the error rate for Medicare Administrative Contractors (MACs), carriers, and non-Prospective Payment System (PPS) inpatient hospital claims submitted to fiscal intermediaries (FIs). The HPMP calculated the error rate for PPS inpatient hospital claims submitted to the FIs. Beginning with claims sampled for the FY 2009 report, the CERT program will sample and review the inpatient hospital claims previously reviewed by the HPMP.

Additionally, based on both the recommendations contained in recent Office of Inspector General (OIG) audit reports and those of CMS' advisory medical staff, CMS modified the medical review process for the November 2009 improper payments report. The CMS implemented three separate revisions to the CERT review criteria based on these recommendations. Due to these modifications, the CERT contractor was not able to meet the original goal of 120,000 reviewed claims. Approximately 99,500 claims completed the review process. Of that number, approximately 19,000 claims were reviewed using the most stringent criteria. The national paid claims error rate for those claims reviewed under the strictest criteria, when applied to the entire year, is 12.4 percent or $35.4 billion. However, CMS consulted with the OIG concerning the limited time period covered by these claims and determined that reporting the error rate for this subset of claims only would not be in compliance with IPIA requirements.

The CERT program provides 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 is continually working with the contractors that pay Medicare claims on aggressive efforts to lower the paid claims error rate, including: (1) developing comparative billing reports to help Medicare contractors and providers analyze administrative claims data, (2) increasing and refining one-on-one educational contacts with providers found to be billing in error, (3) revising Medicare FFS manuals to clarify requirements for reviewing documentation to promote uniform interpretation of our policies across all medical reviews performed by Medicare contractors, and (4) developing new data analysis procedures to assist CMS in identifying payment aberrancies and using that information to prevent improper payments. The CMS has directed contractors that pay Medicare claims to develop local efforts to lower the error rate through plans that address problems that result in payment errors. These plans must specify the steps being taken to fix identified problems, as well as other recommendations that will ultimately lower the error rate.

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. In addition, 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 2008 target of 6.1 percent by reaching a rate of 4 percent. The FY 2009 target is 5.1 percent. Results will be available in February 2010. The CMS will promote the reduced use of physical restraints through the annual nursing home survey process and through the efforts of the Quality Improvement Organizations, 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 met its 2008 target to complete eight Quality Assessment Reports and its 2009 target to complete nine Quality Assessment Reports.

FINANCIAL ACCOMPLISHMENTS

For the 11th 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. 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 thirteen additional Medicare contractors, and in 2009 CMS transitioned the first Medicare Administrative Contractor (MAC) onto HIGLAS—Jurisdiction J4-Part A. 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 one billion claims and processed over 51 million payments worth $556.3 billion as of September 30, 2009.

In Fiscal Year (FY) 2007, HIGLAS began accounting for Federal grants made to states for the Medicaid program as well as Children's Health Insurance Program (CHIP). In addition, during FY 2007, CMS started the process of implementing the Administrative Program Accounting module of HIGLAS that has resulted in major milestone accomplishments which include Medicaid/CHIP Grants accounting in HIGLAS, as well as the ability to produce financial statements in HIGLAS for the first three quarters of FY 2009.

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 financial management and reporting improvements 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.

Federal Payment Levy Program (FPLP)

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

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted by Congress in July 2008, allows CMS to take all necessary steps to participate in the FPLP effective the start of FY 2009. Specifically, the MIPPA legislation requires that Medicare Fee-For-Service (FFS) payments to providers will be offset by a maximum of 15 percent to satisfy payment of delinquent Federal tax debt and 100 percent to satisfy payment of Administrative Offsets for Federal non-tax debt. All (100 percent) of Medicare FFS payments will be subject to FPLP by 2012. The CMS is supporting the FPLP by focusing on implementation of the requirements through HIGLAS. Contractors on the legacy CMS shared systems will participate in FPLP when they transition to HIGLAS. The CMS began participating in the FPLP, effective October 6, 2008, for Medicare FFS payments made through HIGLAS. The CMS completed FPLP withholding functionality for all the current HIGLAS Medicare contractors on November 7, 2008. As of September 25, 2009, CMS has realized a cumulative total of $40.8 million in tax levy offsets through HIGLAS, on behalf of FPLP.

Additional Medicare contractors will be rolled out in conjunction with future MAC transitions to HIGLAS. The CMS will expand FPLP functionality during FY 2010 for recoupment of administrative offsets for Federal non-tax debts as mandated by section 189 of the MIPPA legislation.

Communication & Financial Reporting

During FY 2009, CMS continued to improve its communication through the 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 impacting the Agency and its financial statements. 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 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 and Federal Financial Accounting Standards.

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, 2008, March 31, 2009, and June 30, 2009, and submitted our financial statements through the automated financial statement system maintained by HHS.

As required by the Statement of Federal Financial Accounting Standards (SSFAS) Number 25, *Reclassification of Stewardship Responsibilities*, CMS continues to present the Statement of 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 2009 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 which ensured that we met new program and Treasury requirements, as well as improved our administrative and accounting operations and controls.

Recovery Audit Contractor (RAC)

Section 302 of the Tax Relief and Health Care Act of 2006 made the RAC Program permanent and requires CMS to implement the program in all 50 states no later than January 1, 2010. The CMS completed the procurement effort in October 2008, and awarded contracts to four RACs. A protest delayed the implementation until February 2009. Each RAC is responsible for identifying and correcting improper payments in approximately one-quarter of the country. The CMS has initiated a gradual implementation and will be nationwide by January 2010. The CMS and the RACs will continue to provide extensive outreach to the provider community after implementation.

The CMS has been proceeding with implementation since February 2009. Extensive provider outreach in all fifty states has occurred as well as coordination and implementation activities with the Medicare claim processing contractors. The CMS developed a new issue review process to ensure that every topic proposed for review by the RAC is approved by CMS. In the summer

of 2009, CMS began to approve new issues for RAC review and all of the RACs have begun to review and adjust claims. Near the end of FY 2009 a small amount of claims were adjusted and collected. The first adjustment and collection files for the RAC program totaled $63,825. In addition to the small collections from the permanent program, a larger amount of residual collections from the demonstration program occurred (those overpayments that were identified before the demonstration end date but were collected after the demonstration end date). As of September 30, 2009, these residual collections totaled approximately $14.8 million. The CMS is on target to complete implementation by January 1, 2010, and CMS expects collections to increase as the implementation process is complete.

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 2009, we referred to Treasury approximately $1.3 billion delinquent debt eligible for referral.

Administrative Payments

To date in FY 2009, we have continued to make all of our payments on-time in accordance with the prompt payment act. We also continue to have more than 99% of our vendor payments made via ACH and nearly 100% of our travel payments via ACH.

Budget Execution

For FY 2009, 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 has 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.

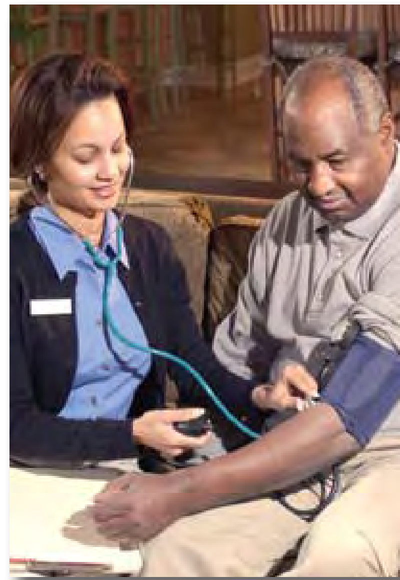
Medicare Secondary Payer (MSP)

The CMS efforts in the MSP area saved the Medicare trust funds approximately $6.24 billion through the first eleven months of FY 2009. 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 $706 million for the first eleven months of FY 2009. The projected total for FY 2010 is approximately $750 million. Savings attributed to the Internal Revenue Service/Social Security Administration/CMS Data Match (DM) operations for the first ten months of FY 2009 were $449 million. The CMS is confident that savings attributable to the MSP Program will continue to grow as new and improved methods of collecting MSP information are implemented.

The CMS continues its Voluntary Data Sharing Agreement (VDSA) program to secure health insurance coverage information provided to working Medicare enrollees, and covered

dependents who are Medicare beneficiaries. In 2009, 120 employers, State Pharmaceutical Assistance Programs (SPAPs), state AIDS Drug Assistance Programs (ADAPS), and Pharmacy Benefit Management firms (PBMs) have signed VDSAs with CMS and participation in the VDSA program continues to draw a significant amount of interest. The CMS has continued expansion of the VDSA program in FY 2009 as more employers 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 $881 million through August 2009.

During calendar year 2008, CMS began implementing Section 111 of the Medicare and Medicaid CHIP Extension Act of 2007. Section 111 amended existing MSP provisions, adding a new ***mandatory*** MSP reporting requirement for all Group Health Plan (GHP) and non-GHP insurers. Having become effective January 1, 2009, for GHP, and July 1, 2009, for non-GHP insurers, this mandatory reporting of MSP coverage data will lead to significantly increased MSP savings. From January 2009 through August 2009, savings attributed to this program are $223.3 million. The incoming MSP data from insurers will make our initial primary or secondary payment decisions more precise. In turn, this will reduce the need for CMS post-pay "pay-and-chase" efforts, and will assist in more efficient recovery actions when they are needed.



In addition, the CMS continues to contract for the 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 $723 million over the period November 2008 through July 2009 (payments that Medicare might otherwise erroneously make in terms of beneficiaries' future medical expenses related to their associated accident, illness, or injury). The CMS' recovery functions for all new MSP GHP and NGHP debt were consolidated into one MSP Recovery Contractor (the MSPRC) effective FY 2007. Total savings from recoveries were $883 million in FY 2007, $985 million in FY 2008, and $1 billion for the first ten months in FY 2009.

Medicare Integrity Program

Program Integrity is continuing its aggressive efforts with the assistance of the 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 $1.0 billion in savings for Medicare Parts A and B through the first eleven months of FY 2009, by identifying overpayments, referring more than 514 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.

All three Program Integrity's Field Offices (FOs) closely interact with the Medicare Administrative Contractors (MAC) in Los Angeles (LA), Miami, and New York (NY). They continue to provide support for the Department of Justice (DOJ) Strike Forces in Miami focusing on DME suppliers and infusion providers and in LA focusing on DME suppliers. In 2008 and 2009, the FOs in Miami and LA 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. The LA FO also developed the Texas home health agency (HHA) project that it will lead and coordinate with Health Integrity (HI) the Zone 4 Zone Program Integrity Contractor (ZPIC). The LA FO is currently working with SGS, the PSC for California, on a new Independent Diagnostic Testing Facility Project. The LA FO works in concert with the Palmetto MAC and the state on CLIA and fraudulent laboratories. 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. In addition, the Miami FO conducts a variety of initiatives to combat home health fraud in South Florida, including the following:

- Home Health Fraud Project—From January–August 2009, 469 HHA beneficiaries have been interviewed, resulting in the implementation of 201 edits. Onsite reviews have been performed at 19 HHAs, and 19 HHAs have been placed on payment suspension. The amount paid to these 19 HHAs in 2008 was $117.7 million. There have been 175 home health ordering physician interviews conducted with 30 disavowments and the implementation of 17 physician NPI edits.
- High Volume Claims Beneficiary Project—total project savings from January–September 2009 is approximately $9.9 million.

The NY FO led the Florida infusion initiative (developed with the Miami FO, First Coast Service Options and SGS) in 2005 and 2006 which resulted in denial of Medicare payments in excess of $2 billion (for a return on investment of $195 to $1), suspension of 169 Medicare providers (involving more than 300 doctors and clinics), initiation of 160 new investigations and 31 law enforcement referrals. The success of this initiative led to the two-year Infusion Demonstration Project (2007-2009) which was led by the NY FO until the Miami FO assumed oversight in July 2008. The NY FO continues to be the national point of contact on infusion fraud. The NY FO developed and will lead the recently announced CMS' Program Integrity 7 State DME Stop Gap Plan to address Medicare durable medical equipment, prosthetics and orthotics (DMEPOS) fraud in the "high risk" states of Florida, California, Texas, Illinois, Michigan, North Carolina and New York. To date, the National Supplier Clearinghouse (NSC) has conducted 621 site visits to high and medium risk suppliers in the seven states, resulting in approximately 100 revocations. The NSC issued revocation notices on October 9, 2009, to an additional 614 suppliers in the seven states (2,051 nationally) for failure to apply for accreditation and/or surety bonds by the statutory deadlines.

The NY FO also designed and is leading the Compromised Number Contract (CNC) initiative, which was funded in September, 2009. The CNC is designed to provide a repository for and searchable database of all compromised Medicare beneficiary identification numbers (Health Insurance Claim Numbers) and provider identification numbers (National Provider Identifiers) used to bill or order Medicare services. The CNC contractor and CMS Identity Theft Workgroup will collaborate to develop a consistent process to designate when an identifier is "compromised." Not only will this consolidation of problem numbers facilitate data analysis for fraud detection and prevention but the development of autodenial or other prepay edits to prevent the continued geographic spread of misused numbers and inappropriate payments.

The CMS is a major participant in a new government effort to combat health care waste, fraud, and abuse. In May 2009, the Health Care Fraud Prevention and Enforcement Action Team (HEAT) was formed. HEAT is a partnership between the Department of Health and Human Services and the Department of Justice, combining our respective resources to identify fraud, prosecute criminals, and recover taxpayer dollars through inter-agency strike forces. These strike forces are being established in areas of the country where organized criminals have caused spikes in the submission of fraudulent Medicare claims.

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 (MIG) 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.

In FY 2009, CMS issued task orders for the Review and Audit Medicaid Integrity Contractors (MICs) to work in all 10 CMS regions. The CMS also issued two separate task orders for the Education MICs in September 2009, and has now completed the procurement of all MICs.

The CMS also conducted 18 comprehensive program integrity reviews. In June 2009, CMS released its third Report to Congress for FY 2008. In July 2009, CMS released the fourth CMIP for FYs 2009-2013. The CMS has also developed numerous algorithms to detect emerging fraud trends.

Medicare Advantage and Prescription Drug Financial Oversight

In 2009, CMS continued its implementation of the financial audit program for examinations of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs). The financial audit program is 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 and for 200 audits for contract year 2007. The CMS completed 100 audits for 2006 and 19 audits for 2007 in 2009. Furthermore, CMS performed the desk reviews of the Risk-Sharing Reconciliations for the Regional Preferred Provider Organizations (RPPOs) for contract years 2006 and 2007. In addition, CMS (through our ROs) conducts audits of the MAOs and PDPs—outside of the one-third audit requirement—to further improve oversight of both Part C and Part D sponsors.

The CMS has also reduced the number of unsettled managed care cost reports. In FY 2009, CMS reduced the backlog of unsettled managed care cost reports by 34. Disallowances resulting from FY 2009 settlement activity amounted to about $24.7 million. For FY 2009, CMS had a rate of return of $15.2 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 continued the development of an error rate reporting program during FY 2009 for the Medicare Advantage and Prescription Drug programs. The CMS implemented the methodology developed in FY 2008 to estimate a Medicare Advantage (Part C) Composite Payment Error Rate, and is on track to report this rate for FY 2009. The CMS continues to develop the methodology for a Medicare Prescription Drug (Part D) Composite Payment Error rate. In FY 2008, CMS developed and implemented two methodologies to measure component error rates for Part D. In FY 2009, CMS implemented these two measures, developed a third measure, and is on track to report these three error rates for FY 2009.

The CMS continues to enhance the use of controls in the monthly payment process.

Medicare Information Technology (IT)

During FY 2009, the CMS continued its program to strengthen Medicare IT internal controls, particularly our oversight of the implementation of those controls. Our management approach featured a strategy and project plan to address not just current audit findings but the root or environmental causes of those findings regardless of the source of those findings. To retain executive buy-in and awareness within CMS, we briefed the status of our progress throughout the year in monthly meetings chaired by the Chief Financial Officer. The contractor executive management was sensitized to the importance for improvements in the Medicare IT controls by our including this as a factor in their annual report 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. The CMS sponsored two security conferences and several teleconferences with the Medicare contractors to emphasize best practices to address individual audit findings and the root causes. The CMS also released updated policies, procedures, and processes for the Medicare contractors, one of which set forth our expectations for Medicare data processing internal controls with an emphasis on a requirement to better document baseline security configurations. Contractors were required to submit an aggressive on-site validation of internal controls for more intensive scrutiny of contractor compliance with requirements. Under this program, Medicare fiscal intermediaries, carriers, Medicare Administrative Contractors, shared systems, and data centers were subject to an on-site review by a CMS technical support team, or formal security test and evaluation by our independent testing contractor.

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 oversight of the Agency.

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 IT security 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 monitoring 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 continued to build upon the previous three successful years 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 2009 to assist in performing management's self-assessment in support of the assurance statement regarding internal controls over financial reporting as of June 30. The scope of the review included CMS central office, four regional offices, and 20 major IT applications. In addition, the CPA firm conducted Circular A-123, Appendix A Internal Control over Financial Reporting (ICOFR) reviews at 14 Medicare contractors (including the Retiree Drug Subsidy and the Medicare Secondary Payer Recovery Contractor), 15 data centers, and four Shared System Maintainers. The CMS was also able to leverage the work performed under the OMB Circular A-123 ICOFR review to address additional requests from the HHS regarding the American Recovery and Reinvestment Act (ARRA) risk assessment and mitigation.

Also during FY 2009, CMS Medicare Administrative Contractors (MACs) continued to contract with CPA firms to conduct Statement on Auditing Standards No. 70 (SAS 70) internal control audits. As a result, seven SAS 70 audit reports were leveraged for the FY 2009 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 HHS 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 and comprised of Directors from various centers and offices —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 Statements Introduction & Highlights

Consolidated Balance Sheets

The Consolidated Balance Sheets present as of September 30, 2009 and 2008, 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 $435.5 billion in assets. The bulk of these assets are in the Earmarked Investments totaling $377.9 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 $49.3 billion, most of which is for Medicaid and CHIP. Liabilities of $77.7 billion consist primarily of the Entitlement Benefits Due and Payable of $72.2 billion. The CMS net position totals $357.8 billion and reflects primarily the cumulative results of operations for the Medicare Trust Funds and the unexpended balances for Medicaid and CHIP.

Consolidated Statements of Net Cost

The Consolidated Statements of Net Cost present the net cost of operations for the years ended September 30, 2009 and 2008. 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 CHIP. 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 $744.6 billion for FY 2009. Administrative Expenses were $3.3 billion, less than 1 percent of total net Program/Activity Costs of $691.5 billion.

The net cost of the Medicare program including benefit payments, QIOs, Medicare Integrity Program spending, and administrative costs, was $430 billion. The HI total costs of $238.3 billion were offset by $3.1 billion in revenues. The SMI total costs of $249 billion were offset by premiums of $54.2 billion. Medicaid total costs of $253.4 billion, of which $34.8 billion were tracked under ARRA, represent expenses incurred by the States and Territories that were reimbursed by CMS during the fiscal year, plus accrued payables. The CHIP total costs were $7.6 billion.

Consolidated Statements of Changes in Net Position

The Consolidated Statements of Changes in Net Position present the change in net position for the years ended September 30, 2009 and 2008. 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 $252.7 billion; $209.3 billion in transfers from Payments to Health Care Trust Funds to HI and SMI; CHIP appropriations of $7.6 billion and State Grants and Demonstrations appropriations of $394 million. Medicaid and CHIP are financed by a general fund appropriation provided by Congress. Employment tax revenue is Medicare's portion of payroll and self employment taxes collected under the Federal Insurance Contributions Act (FICA) and Self Employment Contributions Act (SECA) for the HI trust fund and totaled $194.1 billion. The Federal matching contribution is income to the SMI program from a general fund appropriation (Payments to Health Care Trust Funds) of $150.7 billion, which matches monthly premiums paid by beneficiaries.

Combined Statements of Budgetary Resources

The Combined Statements of Budgetary Resources provide information about the availability of budgetary resources, as well as their status for the years ended September 30, 2009 and 2008. 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 $1,016.2 billion. Obligations of $995.1 billion leave unobligated balances of $21.1 billion (of which $1.2 billion is not available). Total outlays, net of collections, were $969 billion. When offset by $283.2 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 $685.8 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)

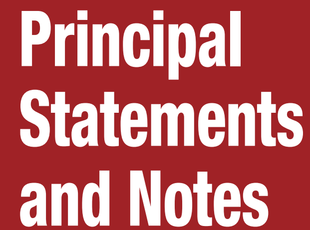
As required by the SFFAS Number 17, CMS has included information about the Medicare trust funds—HI and SMI. The Required Supplementary Information (RSI) presents required long-range cashflow projections, the long-range projections of the ratio of contributors to beneficiaries (dependency ratio), and 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 ***2009 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.



CONSOLIDATED BALANCE SHEETS
As of September 30, 2009 and 2008

(in millions)

	FY 2009 Consolidated Totals	FY 2008 Consolidated Totals
ASSETS		
Intragovernmental Assets:		
Fund Balance with Treasury ***(Note 2)***	$49,340	$48,012
Investments ***(Note 3)***	377,948	382,465
Accounts Receivable, Net ***(Note 4)***	492	511
Other Assets	17	17
Total Intragovernmental Assets	**427,797**	**431,005**
Cash and Other Monetary Assets	357	354
Accounts Receivable, Net ***(Note 4)***	5,165	7,191
General Property, Plant and Equipment, Net	384	428
Other Assets	1,821	840
TOTAL ASSETS	**$435,524**	**$439,818**
LIABILITIES		
Intragovernmental Liabilities:		
Accounts Payable	$602	$438
Accrued Payroll and Benefits	7	6
Other Intragovernmental Liabilities	513	627
Total Intragovernmental Liabilities	**1,122**	**1,071**
Federal Employee and Veterans' Benefits	15	12
Entitlement Benefits Due and Payable ***(Note 5)***	72,218	65,851
Accrued Payroll and Benefits	62	58
Contingencies ***(Note 6)***	3,793	3,513
Other Liabilities	529	647
TOTAL LIABILITIES *(Note 7)*	**77,739**	**71,152**
NET POSITION		
Unexpended Appropriations—earmarked funds	3,590	12,267
Unexpended Appropriations—other funds	20,936	13,258
Total Unexpended Appropriations	**24,526**	**25,525**
Cumulative Results of Operations—earmarked funds	332,752	342,640
Cumulative Results of Operations—other funds	507	501
Total Cumulative Results of Operations	**333,259**	**343,141**
TOTAL NET POSITION	**$357,785**	**$368,666**
TOTAL LIABILITIES AND NET POSITION	**$435,524**	**$439,818**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF NET COST
For the Years Ended September 30, 2009 and 2008
(in millions)

	FY 2009 Consolidated Totals	FY 2008 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS		
GPRA Programs		
Medicare (Earmarked)	$430,025	$395,055
Medicaid	253,352	201,094
CHIP	7,610	6,978
Net Cost - GPRA Programs	**690,987**	**603,127**
Other Activities		
CLIA	(56)	(14)
State Grants and Demonstrations	498	444
Other	23	
Net Cost - Other Activities	**465**	**430**
NET COST OF OPERATIONS ***(Notes 8, 12 and 16)***	**$691,452**	**$603,557**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF CHANGES IN NET POSITION
For the Year Ended September 30, 2009
(in millions)

	Consolidated Earmarked Funds	Consolidated Other Funds	FY 2009 Consolidated Total
CUMULATIVE RESULTS OF OPERATIONS			
BEGINNING BALANCES	**$342,640**	**$501**	**$343,141**
Budgetary Financing Sources:			
Appropriations Used	209,270	260,700	469,970
Nonexchange Revenue:			
FICA and SECA Taxes	194,091		194,091
Interest on Investments	18,587	1	18,588
Other Nonexchange Revenue	499		499
Transfers-in/out Without Reimbursement ***(Note 9)***	(2,342)	730	(1,612)
Other Financing Sources (Nonexchange):			
Imputed Financing	32	2	34
TOTAL FINANCING SOURCES	**420,137**	**261,433**	**681,570**
NET COST OF OPERATIONS	**430,025**	**261,427**	**691,452**
NET CHANGE	**(9,888)**	**6**	**(9,882)**
CUMULATIVE RESULTS OF OPERATIONS	**$332,752**	**$507**	**$333,259**
UNEXPENDED APPROPRIATIONS			
BEGINNING BALANCES	**$12,267**	**$13,258**	**$25,525**
Budgetary Financing Sources:			
Appropriations Received	213,023	287,460	500,483
Appropriations Transferred-in/out		(3,125)	(3,125)
Other Adjustments ***(Note 10)***	(12,430)	(15,957)	(28,387)
Appropriations Used	(209,270)	(260,700)	(469,970)
TOTAL BUDGETARY FINANCING SOURCES	**(8,677)**	**7,678**	**(999)**
TOTAL UNEXPENDED APPROPRIATIONS	**3,590**	**20,936**	**24,526**
NET POSITION	**$336,342**	**$21,443**	**$357,785**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS 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.

COMBINED STATEMENTS OF BUDGETARY RESOURCES
For the Years Ended September 30, 2009 and 2008

(in millions)

	FY 2009 Combined Totals Budgetary	FY 2008 Combined Totals Budgetary
Budgetary Resources:		
Unobligated balance, brought forward, October 1:	$23,135	$14,735
Recoveries of prior year unpaid obligations	10,410	12,552
Budget authority:		
Appropriation	1,008,695	900,247
Spending authority from offsetting collections:		
Earned		
Collected	2,700	4,255
Change in unfilled customer orders:		
Advance received	(2)	(3)
Without advance from Federal sources	(137)	232
Expenditure transfers from trust funds	3,936	3,626
SUBTOTAL	**1,015,192**	**908,357**
Nonexpenditure transfers, net, anticipated & actual	(2,867)	(2,432)
Temporarily not available pursuant to Public Law	(1,215)	(16,135)
Permanently not available	(28,483)	(9,762)
TOTAL BUDGETARY RESOURCES	**$1,016,172**	**$907,315**
Status of Budgetary Resources:		
Obligations incurred ***(Note 13)***:		
Direct	$994,876	$883,992
Reimbursable	217	188
SUBTOTAL	**995,093**	**884,180**
Unobligated balance:		
Apportioned	19,677	22,683
Exempt from apportionment	234	41
SUBTOTAL	**19,911**	**22,724**
Unobligated balance not available	1,168	411
TOTAL STATUS OF BUDGETARY RESOURCES	**$1,016,172**	**$907,315**
Change in Obligated Balance:		
Obligated balance, net:		
Unpaid obligations, brought forward, October 1	$75,184	$70,983
Uncollected customer payments from Federal sources, brought forward, October 1	(2,196)	(1,786)
TOTAL UNPAID OBLIGATED BALANCE, NET	**$72,988**	**$69,197**
Obligations incurred, net	995,093	884,180
Gross Outlays	(975,137)	(867,427)
Obligated balance transferred, net:		
Recoveries of prior year unpaid obligations, actual	(10,410)	(12,552)
Change in uncollected customer payments from Federal sources	(362)	(410)
Obligated balance, net, end of period:		
Unpaid obligations	84,730	75,184
Uncollected customer payments from Federal sources	(2,558)	(2,196)
TOTAL, UNPAID OBLIGATED BALANCE, NET, END OF PERIOD	**82,172**	**72,988**
Net Outlays:		
Net Outlays		
Gross outlays	975,137	867,427
Offsetting collections	(6,135)	(7,700)
Distributed offsetting receipts	(283,209)	(263,149)
NET OUTLAYS	**$685,793**	**$596,578**

The accompanying notes are an integral part of these statements.

STATEMENT OF SOCIAL INSURANCE
75-Year Projection as of January 1, 2009 and Prior Base Years
(in billions)

		Estimates from Prior Years			
	2009	**2008**	**2007**	**2006**	**2005** unaudited
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: *(Notes 14 and 15)*					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$6,348	$6,320	$5,975	$5,685	$5,064
SMI Part B	16,323	14,932	12,112	12,446	11,477
SMI Part D	6,144	6,527	7,285	7,366	7,895
Have attained eligibility age (age 65 or over)					
HI	209	202	178	192	162
SMI Part B	1,924	1,785	1,648	1,606	1,436
SMI Part D	595	581	746	750	817
Those expected to become participants					
HI	5,451	5,361	4,870	4,767	4,209
SMI Part B	4,909	4,480	4,460	3,562	3,658
SMI Part D	2,632	2,856	2,735	2,134	2,522
All current and future participants					
HI	12,008	11,883	11,023	10,644	9,435
SMI Part B	23,156	21,197	18,221	17,613	16,571
SMI Part D	9,371	9,964	10,766	10,250	11,233
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: *(Notes 14 and 15)*					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	18,147	17,365	15,639	15,633	12,668
SMI Part B	16,342	14,949	12,130	12,433	11,541
SMI Part D	6,144	6,527	7,273	7,338	7,913
Have attained eligibility age (age 65 or over)					
HI	2,958	2,747	2,558	2,397	2,179
SMI Part B	2,142	1,986	1,834	1,773	1,622
SMI Part D	595	581	794	792	880
Those expected to become participants					
HI	4,673	4,506	5,118	3,904	3,417
SMI Part B	4,672	4,262	4,257	3,407	3,408
SMI Part D	2,632	2,856	2,699	2,121	2,440
All current and future participants					
HI	25,778	24,619	23,315	21,934	18,264
SMI Part B	23,156	21,197	18,221	17,613	16,571
SMI Part D	9,371	9,964	10,766	10,250	11,233
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures *(Notes 14 and 15)*					
HI	$-13,770	$-12,737	$-12,292	$-11,290	$-8,829
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0

Additional Information

	2009	2008	2007	2006	2005
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures *(Notes 14 and 15)*					
HI	$-13,770	$-12,737	$-12,292	$-11,290	$-8,829
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0
Trust Fund assets at start of period					
HI	321	312	300	285	268
SMI Part B	59	53	38	23	19
SMI Part D	1	3	1	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 and 15)*					
HI	$-13,449	$-12,425	$-11,993	$-11,006	$-8,561
SMI Part B	59	53	38	23	19
SMI Part D	1	3	1	0	0

Totals do not necessarily equal the sum of the rounded components. The accompanying notes are an integral part of these financial 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 Children's Health Insurance Program (CHIP). 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 (HI) Trust Fund. Medicare contractors are paid by CMS to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI trust fund. The CMS payments to Medicare Advantage plans are also charged to this fund. The financial statements include HI trust fund activities administered by the Department of the Treasury (Treasury). The HI trust fund has permanent indefinite authority. Employment tax revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under 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 (SMI) Trust Fund. Medicare contractors are paid by CMS to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end stage renal disease (ESRD), rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI trust fund. The CMS payments to 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, 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. HIPAA prescribes that criminal fines and civil monetary penalties arising from health care cases be transferred to the Health Care Fraud and Abuse Control (HCFAC) account of the HI trust fund through permanent appropriations of the Payments to the Health Care Trust Funds. 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.

In FY 2009, there was a transfer of general funds to the HI trust fund for costs attributable to noncontributory wage credits for military service performed before January 1, 1957 (see Note 9 for Quinquennial adjustment). The Social Security Amendments of 1983 (Section 217 (g) of the Social Security Act) require that these costs be recomputed every five years.

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 American Recovery and Reinvestment Act of 2009 (ARRA) provides additional federal funding for the States through a temporary increase in the Federal Medical Assistance Percentages (FMAP) from the first quarter of FY 2009 through the first quarter of FY 2011.

Children's Health Insurance Program (CHIP)

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

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

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

State Grants and Demonstrations

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

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 2009, 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. The 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.

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

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).

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

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, as well as on the Child Enrollment Contingency Fund investments, is also reported as nonexchange revenue.

Unobligated Balances—beginning of period represent funds brought forward from the previous year. (See Note 13 for an explanation of the adjustment made to the beginning balance of FY 2008.)

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 2008 balances have been reclassified to conform to FY 2009 financial statement presentations, the effect of which is immaterial.

Estimation of Obligations Related to Canceled Appropriations

As of September 30, 2009, CMS has canceled over $189 million in cumulative obligations related to FY 2004 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 2005 through 2009 related to canceled appropriations, CMS anticipates an additional $3 million will be paid from current year funds for canceled obligations.

NOTE 2:
FUND BALANCE WITH TREASURY *(Dollars in Millions)*

FY 2009	Consolidated Totals
FUND BALANCES:	
Trust Funds	
HI Trust Fund (Earmarked)	$375
SMI Trust Fund (Earmarked)	2,890
Revolving Funds	
CLIA	279
General Funds	
Medicaid	33,132
CHIP	10,550
State Grants and Demonstrations	1,930
Program Management	178
Other Fund Types	
CMS Deposit/Suspense Accounts	6
TOTAL FUND BALANCES	**$49,340**
STATUS OF FUND BALANCES WITH TREASURY:	
Unobligated Balance	
Available	$19,911
Unavailable	1,168
Obligated Balance not yet Disbursed	82,172
Non-Budgetary FBWT	(53,911)
TOTAL STATUS OF FUND BALANCES WITH TREASURY	**$49,340**

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
CHIP	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**

Fund Balances are funds with Treasury that are primarily available to pay current expenditures and liabilities. The Medicaid balance of $33,132 million in FY 2009 includes $11,339 million of funds for ARRA. The Unobligated Balance Available includes $3,566 million, which is restricted for future use and is not apportioned for current use for CHIP, Program Management, State Grants and Demonstrations, and ARRA Heath Information Technology.

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

Medicare Investments *(Earmarked)*

FY 2009	Maturity Range	Interest Range	Value
HI TF			
Certificate	June 2010	3 1/8%	$4,521
Bonds	June 2010 to June 2024	3 1/4 - 7%	305,181
Accrued Interest			3,702
TOTAL HI TF INVESTMENTS			**$313,404**
SMI TF			
Certificate	June 2010	3 1/8 - 3 1/4%	$6,126
Bonds	June 2011 to June 2024	3 1/4 - 6 7/8%	55,638
Accrued Interest			667
TOTAL SMI TF INVESTMENTS			**$62,431**
TOTAL MEDICARE INVESTMENTS			**$375,835**

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**

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 HI trust fund or the 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.

Medicare Investments *(Non-Earmarked)*

	Maturity Date	Cost	Amortized Discount	Investments, Net
Treasury Bill	10/22/09	$500		$500
Treasury Bill	10/29/09	1,613		1,613
TOTAL NON-EARMARKED INVESTMENTS		**$2,113**		**$2,113**

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

CMS Investment Summary

FY 2009	Medicare (Earmarked)			(Non-Earmarked)	Consolidated
	HI TF	SMI TF	Total	CHIP	Total
Certificates	$4,521	$6,126	$10,647		$10,647
Bonds	305,181	55,638	360,819		360,819
Treasury Bills				$2,113	2,113
Accrued Interest	3,702	667	4,369		4,369
TOTAL INVESTMENTS	**$313,404**	**$62,431**	**$375,835**	**$2,113**	**$377,948**

FY 2008	Medicare (Earmarked)			(Non-Earmarked)	Consolidated
	HI TF	SMI TF	Total	CHIP	Total
Certificates	$4,611	$6,085	$10,696		$10,696
Bonds	314,130	53,005	367,135		367,135
Treasury Bills					
Accrued Interest	3,963	671	4,634		4,634
TOTAL INVESTMENTS	**$322,704**	**$59,761**	**$382,465**		**$382,465**

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

FY 2009	Medicare (Earmarked)				
	HI TF	SMI TF	Medicaid	Other Health	Consolidated Total
INTRAGOVERNMENTAL					
Railroad Retirement Board Principal	$492				$492
WITH THE PUBLIC					
Provider & Beneficiary Overpayments					
Accounts Receivable Principal	$450	$426		$25	$901
Less: Allowance for Uncollectible Accounts	(97)	(173)		(13)	(283)
Accounts Receivable, Net	353	253		12	618
Medicare Secondary Payer (MSP)					
Accounts Receivable Principal	83	49		13	145
Less: Allowance for Uncollectible Accounts	(27)	(25)		(7)	(59)
Accounts Receivable, Net	56	24		6	86
Medicare Prescription Drug					
Accounts Receivable Principal		265			265
Less: Allowance for Uncollectible Accounts					
Accounts Receivable, Net		265			265
CMPs and Other Restitutions					
Accounts Receivable Principal	438	466			904
Less: Allowance for Uncollectible Accounts	(389)	(461)			(850)
Accounts Receivable, Net	49	5			54
Fraud and Abuse					
Accounts Receivable Principal	89	331	$229		649
Less: Allowance for Uncollectible Accounts	(89)	(316)	(60)		(465)
Accounts Receivable, Net		15	169		184
Medicare Advantage					
Accounts Receivable Principal	2	46		3	51
Less: Allowance for Uncollectible Accounts	(1)	(2)		(3)	(6)
Accounts Receivable, Net	1	44			45
Medicare Premiums					
Accounts Receivable Principal	268	848			1,116
Less: Allowance for Uncollectible Accounts	(174)	(98)			(272)
Accounts Receivable, Net	94	750			844
State Phased-Down Contributions					
Accounts Receivable Principal		1,096			1,096
Less: Allowance for Uncollectible Accounts					
Accounts Receivable, Net		1,096			1,096
Audit Disallowances					
Accounts Receivable Principal			$2,532		$2,532
Less: Allowance for Uncollectible Accounts			(564)		(564)
Accounts Receivable, Net			1,968		1,968
Others Accounts Receivable					
Accounts Receivable Principal	2			12	14
Less: Allowance for Uncollectible Accounts				(9)	(9)
Accounts Receivable, Net	2			3	5
TOTAL ACCOUNTS RECEIVABLE PRINCIPAL	**$1,332**	**$3,527**	**$2,761**	**$53**	**$7,673**
Less: Allowance for Uncollectible Accounts Receivable	(777)	(1,075)	(624)	(32)	(2,508)
TOTAL ACCOUNTS RECEIVABLE, NET	**$555**	**$2,452**	**$2,137**	**$21**	**$5,165**

FY 2008	Medicare (Earmarked) HI TF	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 Contributions					
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
Others 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**

Intragovernmental Accounts Receivable

Intragovernmental accounts receivable represent CMS claims for payment from other Federal agencies. The 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.

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 accounts receivable of $265 million consists of amounts due CMS after completion of the Part D payment reconciliation for calendar year (CY) 2008. The estimate for the first nine months of CY 2009 will be reported as an advance of $1,638 ($645 million in 2008) in "Other Assets" on the Balance Sheet. 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 advance will be liquidated as claims are incurred and submitted to the plans during the first quarter of FY 2010. As a result, CMS management believes the Part D accrual estimate will become a liability by the end of CY 2009.

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 Regional Offices (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 the Office of Inspector General (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. The 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 2009	Medicare (Earmarked)						
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Consolidated Total
Medicare Benefits Payable *(1)*	$21,299	$18,348	$39,647				$39,647
Medicare Advantage/ Prescription Drug Program *(2)*	1,052	4,011	5,063				5,063
Retiree Drug Subsidy *(3)*		2,062	2,062				2,062
Undocumented Aliens						$111	111
Medicaid/CHIP *(4)*				$24,977	$358		25,335
TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE	**$22,351**	**$24,421**	**$46,772**	**$24,977**	**$358**	**$111**	**$72,218**

FY 2008	Medicare (Earmarked)						
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Consolidated Total
Medicare Benefits Payable *(1)*	$20,242	$18,373	$38,615				$38,615
Medicare Advantage/ Prescription Drug Program *(2)*	737	2,783	3,520				3,520
Retiree Drug Subsidy *(3)*		2,807	2,807				2,807
Undocumented Aliens						$165	165
Medicaid/CHIP *(4)*				$20,410	$334		20,744
TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE	**$20,979**	**$23,963**	**$44,942**	**$20,410**	**$334**	**$165**	**$65,851**

(1) Medicare benefits payable consists of a $39,647 million estimate ($38,615 million in FY 2008) for Medicare services incurred but not paid, as of September 30, 2009. This actuarial 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 2009 that were paid in 2010 and (e) an estimate of retroactive settlements of cost reports. The September 30, 2009, estimate also includes amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals.

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 of $5,063 million ($3,520 million in FY 2008) consists of a $2,480 million estimate ($1,729 million in FY 2008) for amounts owed to plans relating to risk and other payment related adjustments and $2,583 ($1,791 million in FY 2008) owed to plans after the completion of the Prescription Drug Payment reconciliation.

(3) The Retiree Drug Subsidy (RDS) consists of a $2,062 million estimate ($2,807 in FY 2008) of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2009. 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 $24,977 million ($20,410 million in FY 2008) 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, 2009. This estimate incorporates claim activity tracked under ARRA ($3,176 million). An estimated CHIP benefits payable of $358 million has been recorded ($334 million in FY 2008) for the net Federal share of expenses that have been incurred by the States but not yet reported to CMS as of September 30, 2009.

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 if it is not estimable or probable but does disclose those contingencies in the financial statements.

The Medicaid amount for $3,793 million ($3,513 million in FY 2008) consists of Medicaid audit and program disallowances of $1,005 million ($753 million in FY 2008) and $2,788 million ($2,760 million in FY 2008) 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.

Appeals at the Provider Reimbursement Review Board

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. However, historical cases that have been appealed and settled by the PRRB are considered in the development of the actuarial Medicare IBNR liability. As of September 30, 2009, 7,984 cases (7,712 in FY 2008) remain on appeal. A total of 2,312 new cases (2,971 in FY 2008) were filed in FY 2009. The PRRB rendered decisions on 93 cases (77 in FY 2008) in FY 2009 and 1,947 additional cases (1,826 in FY 2008) 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 2009	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	CHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Intragovernmental:								
Accrued Payroll and Benefits	$1	$2				$3		$3
TOTAL INTRAGOVERNMENTAL	**$1**	**$2**				**$3**		**$3**
Federal Employee and Veterans' Benefits	5	9	$1			15		15
Accrued Payroll and Benefits	11	23	2		$1	37		37
Contingencies			3,793			3,793		3,793
TOTAL LIABILITIES NOT COVERED BY BUDGETARY RESOURCES	**$17**	**$34**	**$3,796**		**$1**	**$3,848**		**$3,848**
TOTAL LIABILITIES COVERED BY BUDGETARY RESOURCES	**$46,957**	**$53,224**	**$24,979**	**$360**	**$156**	**$125,676**	**$(51,785)**	**$73,891**
TOTAL LIABILITIES	**$46,974**	**$53,258**	**$28,775**	**$360**	**$157**	**$129,524**	**$(51,785)**	**$77,739**

FY 2008	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	CHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Intragovernmental:								
Accrued Payroll and Benefits	$1	$2				$3		$3
TOTAL INTRAGOVERNMENTAL	**$1**	**$2**				**$3**		**$3**
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	**$14**	**$32**	**$3,517**	**$1**	**$1**	**$3,565**		**$3,565**
TOTAL LIABILITIES COVERED BY BUDGETARY RESOURCES	**$43,798**	**$51,103**	**$20,415**	**$334**	**$212**	**$115,862**	**$(48,275)**	**$67,587**
TOTAL LIABILITIES	**$43,812**	**$51,135**	**$23,932**	**$335**	**$213**	**$119,427**	**$(48,275)**	**$71,152**

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 2009	Medicare (Earmarked)			Health			
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Consolidated Totals
PROGRAM/ACTIVITY COSTS							
Medicare							
Fee for Service	$179,067	$148,716	$327,783				$327,783
Medicare Advantage/ Managed Care	57,182	52,473	109,655				109,655
Prescription Drug (Part D)		46,145	46,145				46,145
Medicaid/CHIP/State Grants & Demos				$252,906	$7,571	$437	260,914
CLIA						132	132
TOTAL PROGRAM/ACTIVITY COSTS	**$236,249**	**$247,334**	**$483,583**	**$252,906**	**$7,571**	**$569**	**$744,629**
OPERATING COSTS							
Medicare Integrity Program	$1,071		$1,071				$1,071
Quality Improvement Organizations	246	$58	304				304
Bad Debt Expense and Writeoffs	(357)	(417)	(774)	$278		$17	(479)
Reimbursable Expenses	8	18	26	2			28
Administrative Expenses	1,090	1,947	3,037	172	$41	85	3,335
Depreciation and Amortization	28	50	78	6			84
Imputed Cost Subsidies	11	21	32	1		1	34
TOTAL OPERATING COSTS	**$2,097**	**$1,677**	**$3,774**	**$459**	**$41**	**$103**	**$4,377**
TOTAL COSTS	**$238,346**	**$249,011**	**$487,357**	**$253,365**	**$7,612**	**$672**	**$749,006**
LESS: EXCHANGE REVENUES:							
Medicare Premiums	$3,065	$54,127	$57,192				$57,192
CLIA Revenues						$188	188
Other Exchange Revenues	43	97	140	$13	$2	19	174
TOTAL EXCHANGE REVENUES	**$3,108**	**$54,224**	**$57,332**	**$13**	**$2**	**$207**	**$57,554**
TOTAL NET COST OF OPERATIONS	**$235,238**	**$194,787**	**$430,025**	**$253,352**	**$7,610**	**$465**	**$691,452**

FY 2008	Medicare (Earmarked)			Health			
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Consolidated Totals
PROGRAM/ACTIVITY COSTS							
Medicare							
Fee for Service	$171,361	$138,180	$309,541				$309,541
Medicare Advantage/ Managed Care	46,672	45,113	91,785				91,785
Prescription Drug (Part D)		43,285	43,285				43,285
Medicaid/CHIP/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**

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, CHIP, and State Grants and Demonstrations programs based on the CMS cost allocation system. Administrative costs allocated to the Medicare program include $1,772 million ($1,830 million in FY 2008) 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 2009 Part D expense of $46,145 million ($43,285 million in FY 2008) is net of State reimbursements of $7,565 million ($7,054 million in FY 2008). The gross expense would have been $53,710 million in FY 2009 ($50,339 million in FY 2008).

Of the Medicaid benefit expense of $252,906 million in FY 2009, $34,803 million were identified under ARRA.

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

FY 2009

Transfers-in Without Reimbursement	Medicare (Earmarked) HI TF	SMI TF	Medicaid	CHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Medicare Benefit Transfers	$241,526	$258,228				$499,754	$(499,754)	
Transfers to HCFAC	1,334					1,334	(1,334)	
Federal Matching Contributions		150,748				150,748	(150,748)	
Medicare Part D Benefits		43,286				43,286	(43,286)	
Medicare Part D Administrative		232				232	(232)	
Allocation to CMS Programs	1,032	2,129	$126	$44	$111	3,442	(3,442)	
Fraud and Abuse Appropriation	126					126	(126)	
Transfer-Uninsured Coverage	614					614	(614)	
Prog. Mngmt. Admin. Expense *(1)*	281					281	(281)	
Income Tax OASDI Benefits *(2)*	12,376					12,376	(12,376)	
Quinquennial Adjustment *(3)*	968					968	(968)	
Railroad Retirement Board	506					506		$506
Criminal Fines	638					638	(638)	
Medicaid Part B Premiums			449			449	(449)	
Medicare Advantage Stabilization	21	23				44	(44)	
Interest Adjustments	1	1				2		2
Miscellaneous	1	1				2		2
TOTAL TRANSFERS-IN	**$259,424**	**$454,648**	**$575**	**$44**	**$111**	**$714,802**	**$(714,292)**	**$510**

FY 2009

Transfers-out Without Reimbursement	Medicare (Earmarked) HI TF	SMI TF	Medicaid	CHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
SSA Administrative Expenses	$(950)	$(1,058)				$(2,008)		$(2,008)
Medicare Benefit Transfers	(241,526)	(258,228)				(499,754)	$499,754	
Transfers to HCFAC	(1,334)					(1,334)	1,334	
Federal Matching Contributions		(150,748)				(150,748)	150,748	
Medicare Part D Benefits		(43,286)				(43,286)	43,286	
Medicare Part D Administrative		(232)				(232)	232	
Transfers to Program Management	(1,291)	(2,151)				(3,442)	3,442	
Fraud and Abuse Appropriation	(126)					(126)	126	
Transfer-Uninsured Coverage	(614)					(614)	614	
Prog. Mngmt. Admin. Expense *(1)*	(281)					(281)	281	
Income Tax OASDI Benefits *(2)*	(12,376)					(12,376)	12,376	
Quinquennial Adjustment *(3)*	(968)					(968)	968	
Criminal Fines	(638)					(638)	638	
Medicaid Part B Premiums		(449)				(449)	449	
Medicare Advantage Stabilization	(21)	(23)				(44)	44	
Office of the Secretary	(39)	(35)				(74)		(74)
Payment Assessment Commission	(7)	(5)				(12)		(12)
AOA MIPPA Expense *(4)*	(9)	(8)				(17)		(17)
Railroad Retirement Board		(11)				(11)		(11)
TOTAL TRANSFERS-OUT	**$(260,180)**	**$(456,234)**				**$(716,414)**	**$714,292**	**$(2,122)**
TOTAL TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT	**$(756)**	**$(1,586)**	**$575**	**$44**	**$111**	**$(1,612)**		**$(1,612)**

FY 2008

Transfers-in Without Reimbursement	Medicare (Earmarked) HI TF	SMI TF	Medicaid	CHIP	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	SMI TF	Medicaid	CHIP	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)**

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 2009, the Payments to the Health Care Trust Funds appropriation paid the HI trust fund $281 million ($192 million in FY 2008) to cover the Medicaid, CHIP, and State Grants and Demonstrations programs' share of CMS' administrative costs.

(2) The Omnibus Budget Reconciliation Act of 1993 increased the maximum percentage of 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.

(3) In FY 2009, there was a transfer of $968 million from the Payments to the Health Care Trust Funds to the HI trust fund for costs attributable to noncontributory wage credits for military service performed before January 1, 1957. This amount represents the estimated present value of all past and future HI trust fund costs attributable to pre-1957 military service wage credits, less the accumulated value of past reimbursements. The Social Security Amendments of 1983 (Section 217 (g) of the Social Security Act) require that these costs be recomputed every five years. Previous transfers were made in fiscal years 1985, 1990, 1996 and 2001.

(4) In FY 2009, the HI and SMI trust funds recorded expenditure transfers of $9 million and $8 million, respectively, to the Administration on Aging for the Medicare Enrollment Assistance Program pursuant to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, Public Law 110-275. §119).

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 $96.40 from October 2008 through September 30, 2009.

Premiums collected from beneficiaries totaled $51,860 million ($49,366 million in FY 2008) and were matched by a $150,748 million ($144,888 million in FY 2008) 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, 2009, approximately $43,518 million has been transferred-in ($35,546 million in FY 2008) to Part D from the general fund.

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

FY 2009	Medicare (Earmarked)					
	HI TF	SMI TF	Medicaid	CHIP	Other Health	Consolidated Total
Unexpended Appropriations						
Withdrawal of Expired or Canceled Year Authority		$(12,430)		$(72)	$(16)	$(12,518)
Return of Indefinite Authority			$(15,869)			$(15,869)
TOTAL OTHER ADJUSTMENTS		**$(12,430)**	**$(15,869)**	**$(72)**	**$(16)**	**$(28,387)**

FY 2008	Medicare (Earmarked)					
	HI TF	SMI TF	Medicaid	CHIP	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)**

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.

Even though ARRA provided additional federal funding for the States through a temporary increase in the Federal Medical Assistance Program (FMAP), no additional appropriated funding sources were made to the original FY 2009 appropriation for Medicaid. As a result, the indefinite authority was invoked to provide the additional appropriation to fund the remaining Medicaid grant awards. The unobligated portion of the Medicaid indefinite appropriation is being returned.

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 HCFAC account. In addition, portions of the Program Management appropriation have been allocated to the HI and SMI trust funds. Condensed information showing assets, liabilities, gross cost, exchange and non-exchange revenues and changes in net position appears below.

Balance Sheet as of September 30, 2009

	HI TF	SMI TF	Total Earmarked Funds
ASSETS			
Fund Balance with Treasury	$375	$2,890	$3,265
Investments	313,404	62,431	375,835
Other Assets	25,569	31,905	57,474
TOTAL ASSETS	**$339,348**	**$97,226**	**$436,574**
Entitlement Benefits Due & Payable	$22,351	$24,421	$46,772
Other Liabilities	24,623	28,837	53,460
TOTAL LIABILITIES	**$46,974**	**$53,258**	**$100,232**
Unexpended Appropriations	$258	$3,332	$3,590
Cumulative Results of Operations	292,116	40,636	332,752
TOTAL NET POSITION	**$292,374**	**$43,968**	**$336,342**
TOTAL LIABILITIES AND NET POSITION	**$339,348**	**$97,226**	**$436,574**

Statement of Net Cost for the Period Ended September 30, 2009

	HI TF	SMI TF	Total Earmarked Funds
Benefit Expense	$236,249	$247,334	$483,583
Operating Costs	2,097	1,677	3,774
TOTAL COSTS	**$238,346**	**$249,011**	**$487,357**
LESS EARNED REVENUES	**$3,108**	**$54,224**	**$57,332**
NET COST OF OPERATIONS	**$235,238**	**$194,787**	**$430,025**

Statement of Changes in Net Position for the Period Ended September 30, 2009

	HI TF	SMI TF	Total Earmarked Funds
Net Position, Beginning of Period	$302,907	$52,000	$354,907
Taxes and Other Nonexchange Revenue	210,189	2,988	213,177
Other Financing Sources	14,516	183,767	198,283
LESS NET COST OF OPERATIONS	**$235,238**	**$194,787**	**$430,025**
CHANGE IN NET POSITION	**$(10,533)**	**$(8,032)**	**$(18,565)**
NET POSITION, END OF PERIOD	**$292,374**	**$43,968**	**$336,342**

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 NET POSITION	**$302,907**	**$52,000**	**$354,907**
TOTAL LIABILITIES AND NET POSITION	**$346,719**	**$103,135**	**$449,854**

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

	HI TF	SMI TF	Total Earmarked Funds
Benefit Expense	$218,033	$226,578	$444,611
Operating Costs	2,422	2,180	4,602
TOTAL COSTS	**$220,455**	**$228,758**	**$449,213**
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

	HI TF	SMI TF	Total Earmarked Funds
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
LESS 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**

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

FY 2009	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	$594	$237,752	$238,346	$3	$3,105	$3,108	$235,238
SMI TF	183	248,828	249,011	7	54,217	54,224	194,787
Medicaid	14	253,351	253,365	1	12	13	253,352
CHIP	6	7,606	7,612		2	2	7,610
SUBTOTAL	**$797**	**$747,537**	**$748,334**	**$11**	**$57,336**	**$57,347**	**$690,987**
OTHER ACTIVITIES							
CLIA	$28	$104	$132		$188	$188	$(56)
State Grants & Demonstrations	20	497	517		19	19	498
Other	2	21	23				23
SUBTOTAL	**$50**	**$622**	**$672**		**$207**	**$207**	**$465**
PROGRAM/ACTIVITY TOTALS	**$847**	**$748,159**	**$749,006**	**$11**	**$57,543**	**$57,554**	**$691,452**

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
CHIP	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**

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 2009

	Direct	Reimbursable	Combined Totals
Category A	$68,939	$212	$69,151
Category B	463,920	5	463,925
Exempt	462,017		462,017
TOTAL	**$994,876**	**$217**	**$995,093**

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**

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 $320,064 million as of September 30, 2009, ($329,970 million in FY 2008) are included in Investments on the Balance Sheets. The following table presents trust fund activities and balances for FY 2009 and FY 2008 (in millions):

	FY 2009 Combined Balance	FY 2008 Combined Balance
TRUST FUND BALANCE, BEGINNING	**$329,970**	**$313,882**
Receipts	442,286	434,263
Less Obligations	452,192	418,175
Excess (Shortage) of Receipts Over Obligations	(9,906)	16,088
TRUST FUND BALANCE, ENDING	**$320,064**	**$329,970**

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 2008

(in millions)

	Budgetary Resources	Obligations Incurred	Offsetting Receipts	Net Outlays
Statement of Budgetary Resources	$907,315	$884,180	$263,149	$859,727
Unobligated Balances Not Available	(249)			
Other Adjustments	2,711	2,378	41	2,953
PRESIDENT'S BUDGET (actual)	**$909,777**	**$886,558**	**$263,190**	**$862,680**

The Other Adjustments Line for Budgetary Resources includes an increase in the amount of $2,990 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 ($316) million, cancellations of expired years in HI and SMI in the amounts of $61 million.

The Other Adjustments Line for Obligations Incurred includes an increase of $2,720 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 ($318) 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 $2,953 million for the amounts reported in the President's Budget but reported on the CDC SBR.

The Other Adjustments Line for Offsetting Receipts includes $41 million Hospice interest that CMS picked up as an offsetting receipt that the Treasury Annual Report did not.

The President's Budget with actual numbers for FY 2009 has not yet been published. It is expected that the OMB will publish the FY 2009 numbers in January 2010 and will be available from OMB.

Undelivered Orders at the End of the Period

The amount of budgetary resources obligated for undelivered orders totaled $9,452 million at September 30, 2009 ($6,928 million in FY 2008).

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 May 12, 2009, and do not reflect any actual or anticipated changes subsequent to that date. 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. 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 statutory financing mechanism.

In addition to the actuarial present value of the estimated future excess of income (excluding interest) over expenditures for the open group of participants, 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 May 12, 2009. 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 2009 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2009. 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 2009

	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Annual percentage change in: Wages[5]	CPI[6]	Real GDP[7]	Per beneficiary cost[8] HI	SMI B	SMI D	Real-interest rate[9]
2009	2.08	1,210,000	811.4	1.8	0.7	-1.0	-2.2	5.8	10.0	6.1	4.7
2010	2.08	1,190,000	806.4	1.8	3.4	1.7	2.4	1.4	-2.9	5.4	1.3
2020	2.04	1,130,000	743.2	1.1	3.9	2.8	2.1	4.3	6.4	7.2	2.9
2030	2.01	1,085,000	679.5	1.1	3.9	2.8	2.2	5.7	6.0	5.8	2.9
2040	2.00	1,050,000	622.9	1.1	3.9	2.8	2.2	5.9	5.5	5.3	2.9
2050	2.00	1,035,000	573.5	1.1	3.9	2.8	2.1	5.0	4.9	5.0	2.9
2060	2.00	1,030,000	530.2	1.1	3.9	2.8	2.1	4.7	4.8	4.7	2.9
2070	2.00	1,025,000	492.0	1.1	3.9	2.8	2.1	4.6	4.5	4.5	2.9
2080	2.00	1,025,000	458.2	1.1	3.9	2.8	2.1	4.4	4.3	4.3	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 2009–2005

	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Annual percentage change in: Wages[5]	CPI[6]	Real GDP[7]	Per beneficiary cost[8] HI	SMI B	SMI D	Real-interest rate[9]
FY 2009	2.0	1,025,000	458.2	1.1	3.9	2.8	2.1	4.4	4.3	4.3	2.9
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

[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 and 2009, 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 and 2009, the assumption presented is the value assumed in the year 2080. For 2005-2007, 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 relatively little actual program data currently available. The actual 2006 through 2009 bid submissions by the private plans offering this coverage, together with actual data on beneficiary enrollment and program spending through 2008, 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: 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 38 percent over the next 6 years. 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 $23.2 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 $23.7 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 $25.7 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 16: RECONCILIATION OF NET COST OF OPERATIONS TO BUDGET *(Dollars in Millions)*

	FY 2009 Consolidated Totals	FY 2008 Consolidated Totals
RESOURCES USED TO FINANCE ACTIVITIES:		
Budgetary Resources Obligated:		
Obligations incurred	$995,093	$884,180
Less: Spending authority from offsetting collections and recoveries	16,907	20,662
Obligations net of offsetting collections and recoveries	978,186	863,518
Less: Distributed offsetting receipts	283,209	263,149
NET OBLIGATIONS	**694,977**	**600,369**
Other Resources:		
Transfers in/out without reimbursement		(1)
Imputed financing from costs absorbed by others	34	27
NET OTHER RESOURCES USED TO FINANCE ACTIVITIES	**34**	**26**
TOTAL RESOURCES USED TO FINANCE ACTIVITIES	**$695,011**	**$600,395**
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	$3,645	$98
Resources that fund expenses recognized in prior periods		
Budgetary offsetting collections and receipts that do not affect net cost of operations	(62)	(4)
Resources that finance the acquisition of assets	40	64
Other resources or adjustments to net obligated resources that do not affect net cost of operations	2,322	1,653
TOTAL RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS	**5,945**	**1,811**
TOTAL RESOURCES USED TO FINANCE THE NET COST OF OPERATIONS	**$689,066**	**$598,584**
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	$3	$2
Decrease/(Increase) in receivables from the public	2,519	5,594
Other	282	(595)
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL REQUIRE OR GENERATE RESOURCES IN FUTURE PERIODS	**2,804**	**5,001**
Components Not Requiring or Generating Resources:		
Depreciation and amortization	84	60
Other	(502)	(88)
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES	(418)	(28)
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD	**$2,386**	**$4,973**
NET COST OF OPERATIONS	**$691,452**	**$603,557**

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 was 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 ***2009 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 Medicare Trustees emphasize that the SMI Part B expenditures projected under current law are significantly understated. Congress is very likely to continue overriding certain statutory provisions that would otherwise require reductions in physician payment rates of about 21.5 percent for 2010 and about 5.5 percent for 2011 through 2014, as well as a small negative update for 2015. Additional information on this issue is shown in note 15 on page 61 of this financial statement.

Although financial balance for the Part B account can be maintained through annual premium adjustments, unusual steps may be required for the next few years. Specifically, about three-quarters of enrollees will not be subject to Part B premium increases for the next 1 to 3 years under a "hold-harmless" provision of current law.[1] Without action to respond to this situation, the loss of premium revenues from these beneficiaries, and the correspondingly lower level of matching general revenue transfers, could result in the depletion of Part B assets. The only actions possible under current law raise important equity concerns; the Part B projections shown in this section are based on the assumption that these actions will be taken.

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/**.

[1]The hold-harmless provision prevents a beneficiary's net Social Security benefit from decreasing when the Part B premium increase would be larger than his or her cash benefit increase.

ACTUARIAL PROJECTIONS

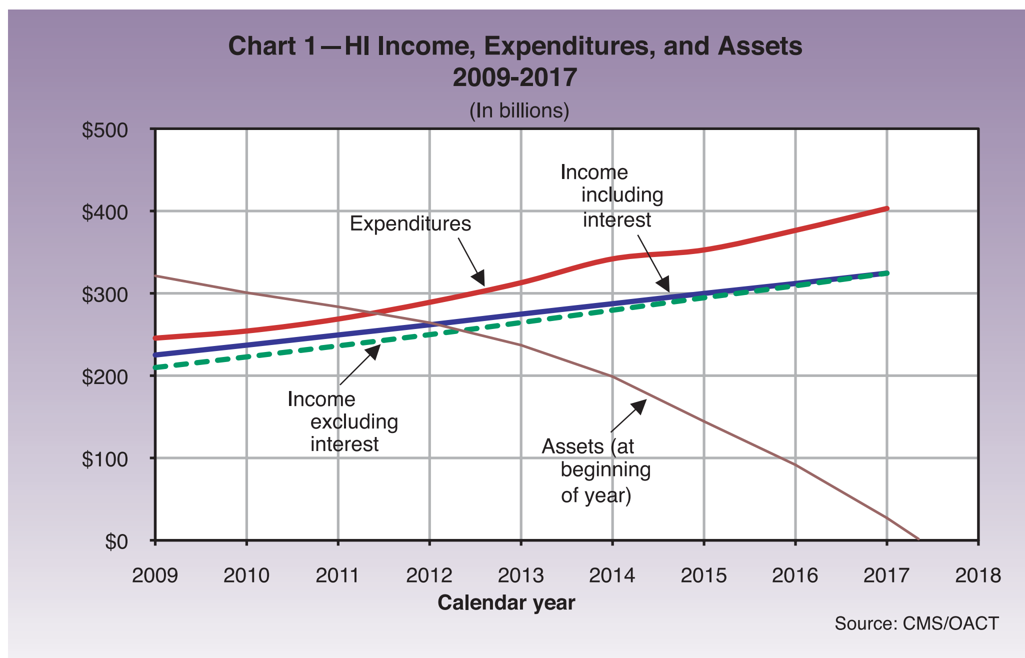
Cashflow in Nominal Dollars

Using nominal dollars for short-term projections paints a reasonably clear picture of expected performance with particular attention on cashflow and trust fund balances.[2] 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 2017. 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 2009 through 2017, 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 2017. The estimates also include income and expenditures attributable to these current and future workers, in addition to current beneficiaries.



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

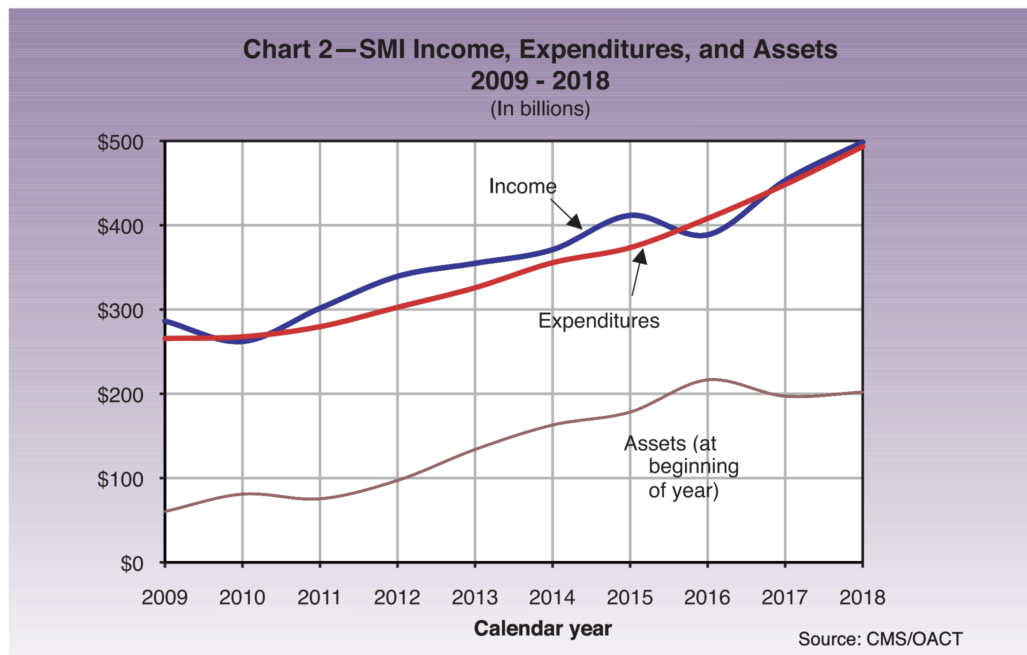
HI expenditures exceeded income in 2008 and, as chart 1 shows, are expected to continue to do so throughout the projection period under the intermediate assumptions. This situation arises due to much lower projected payroll tax income resulting from the serious economic recession that began in December 2007. The HI trust fund started redeeming its assets in 2008; by the end of 2017, the assets would be depleted. For the sixth 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 magnitude of the deficits could be greater 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 2009 through 2018, in nominal dollars. 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.[3,4]

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.[5] Expenditures include benefit payments as well as administrative expenses.



[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.

[4] Special payments from the states to the Part D account represent a portion of the states' forgone Medicaid expenditures attributable to the Medicare drug benefit.

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

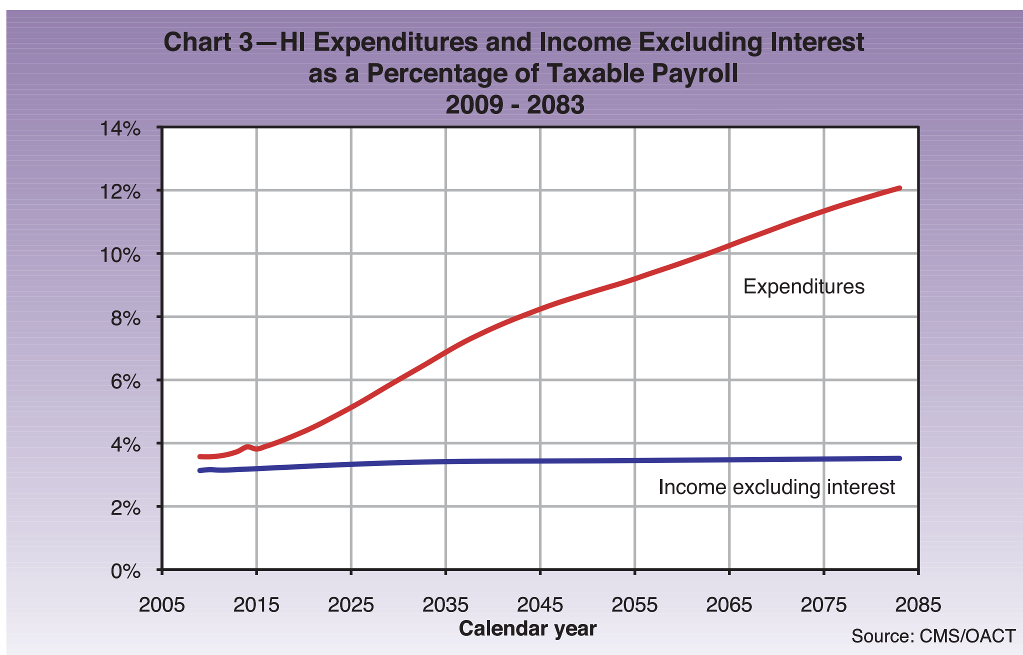
As chart 2 indicates, SMI income is close to expenditures because of the financing mechanism for Parts B and D. In particular, income for SMI Part B and Part D includes a combination of monthly beneficiary premiums and transfers from the general fund of the U.S. Treasury—both of which are established annually to cover the following year's expenditures. Under present law, both SMI accounts are automatically in financial balance every year, regardless of future economic and other conditions.

Maintaining adequate Part B premium and general revenue income, despite the impact of the premium "hold-harmless" provision, would require substantial premium increases for the roughly 25 percent of beneficiaries who are not subject to this provision. Such increases are assumed to occur, since no other mechanism is available under current law to ensure adequate income. The 2009 Medicare Trustees Report provides additional information on this issue.

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 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.

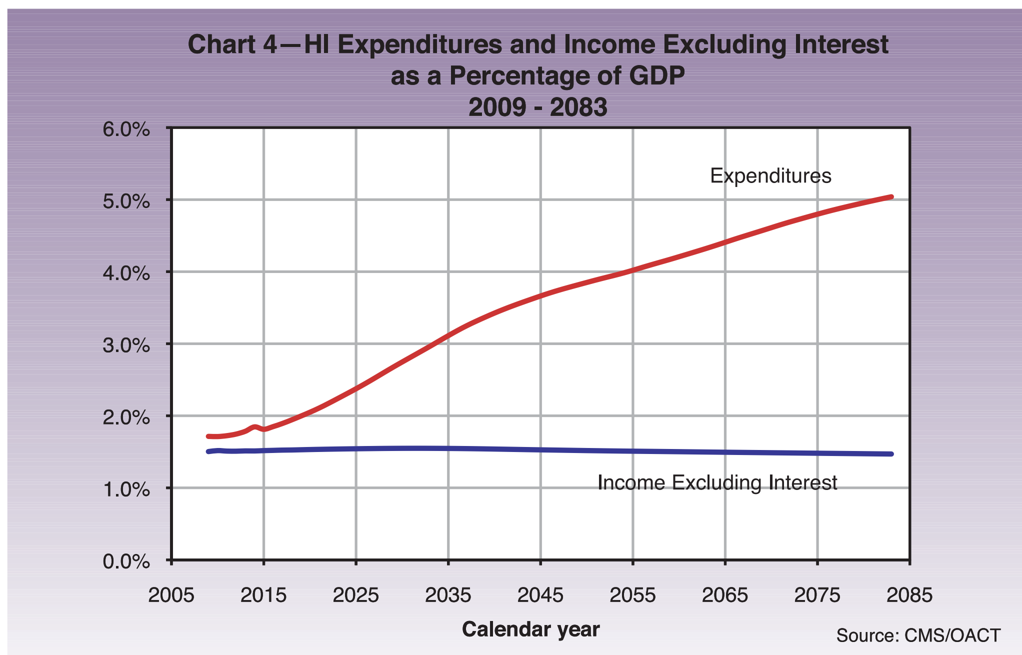
Since HI payroll tax rates are not scheduled to change in the future under present law, payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. Income from taxation of benefits will increase only gradually as a greater proportion of Social Security beneficiaries 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 2008, the expenditures were $235.6 billion, which was 1.6 percent of GDP. This percentage is projected to increase steadily throughout the remainder of the 75-year period.



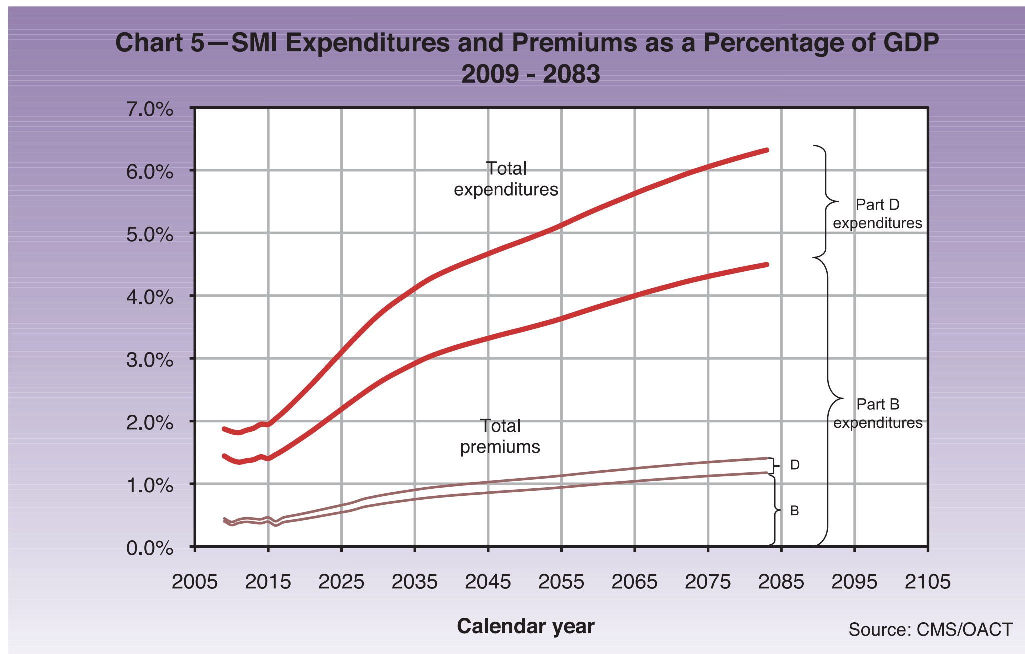
SMI

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 10 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 11 to 25 is assumed to grade smoothly into the long-range assumption.

Under the intermediate assumptions, annual SMI expenditures were $232.6 billion, or about 1.6 percent of GDP, in 2008. 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.

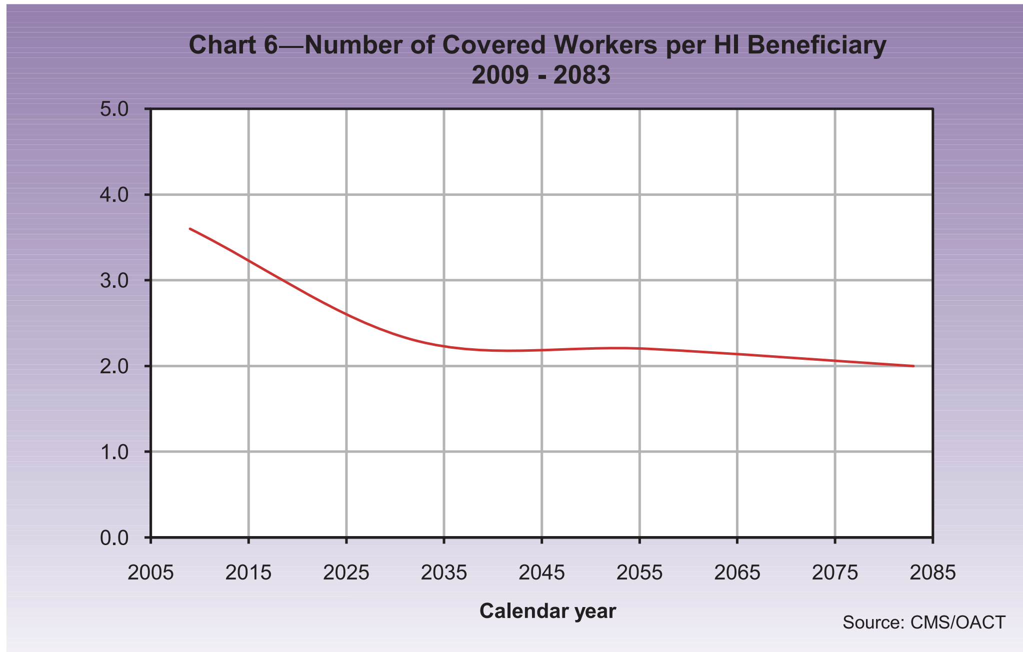


Worker-to-Beneficiary Ratio

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 2008, every beneficiary had 3.7 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.4 workers per beneficiary. The projected ratio continues to decline until there are just 2.0 workers per beneficiary by 2083.



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 60 of this financial statement). 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.[6] The assumptions varied are the health care cost factors, real-wage differential, consumer price index (CPI), real-interest rate, fertility rate, and net immigration.[7]

[6] 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.

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

For this analysis, the intermediate economic and demographic assumptions in the ***2009 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, 2009, 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.[8] The charts depicting the estimated net cashflow indicate that net cashflow decreases steadily through 2083 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 to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur.

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

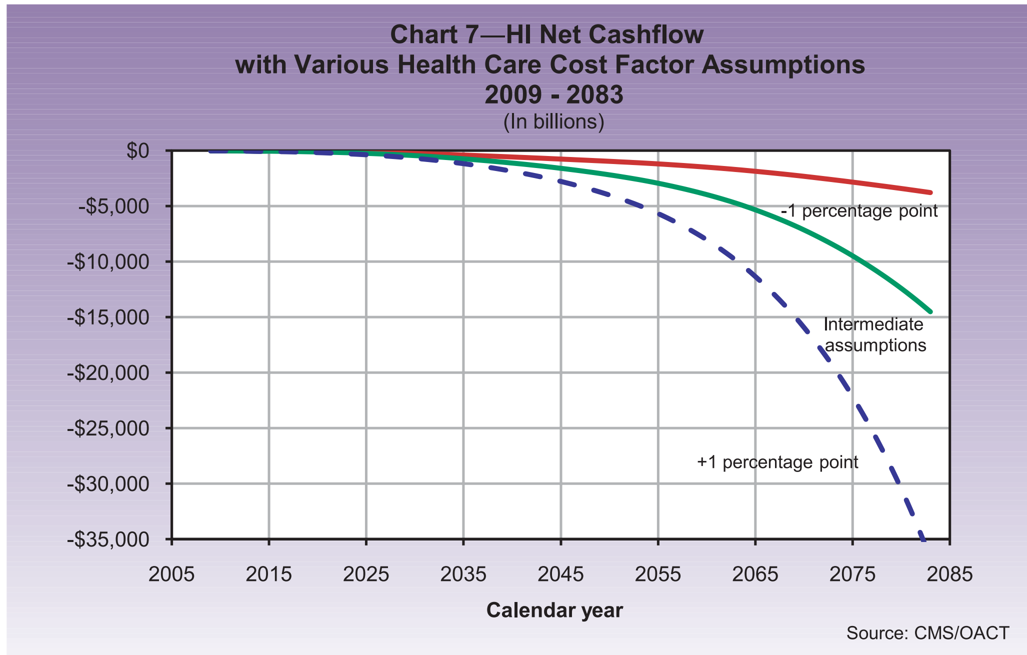
Annual cost/payroll relative growth rate	-1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures *(in billions)*	-$5,767	-$13,770	-$26,798

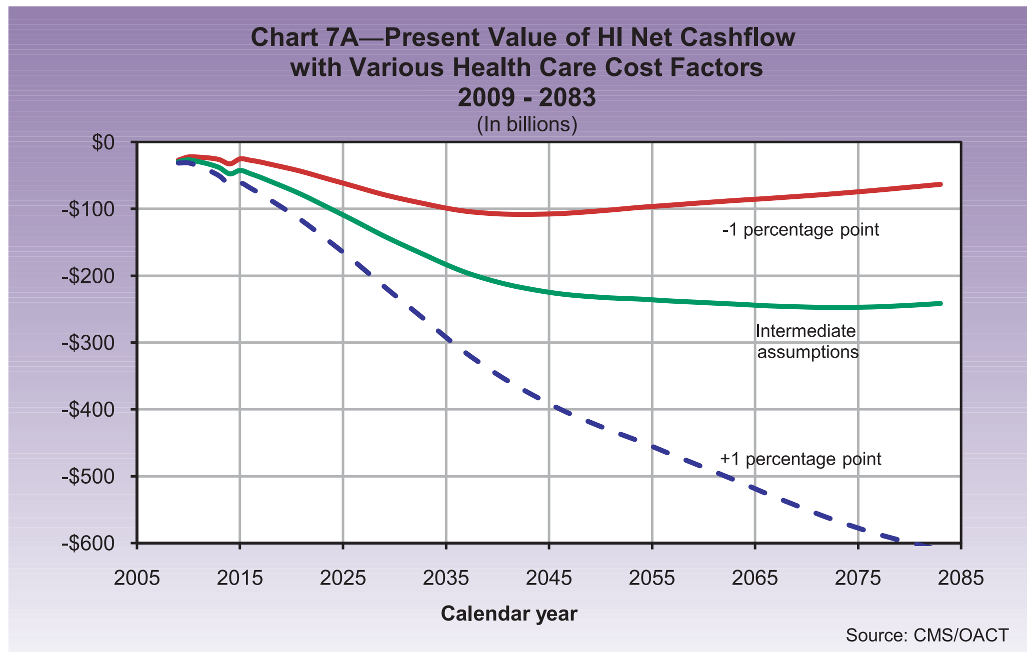
Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $8,003 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases more substantially, by $13,028 billion.

Charts 7 and 7A show projections of the net cashflow in nominal and present value dollars, respectively, under the three alternative annual growth rate assumptions presented in table 1.

[8] 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.

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.





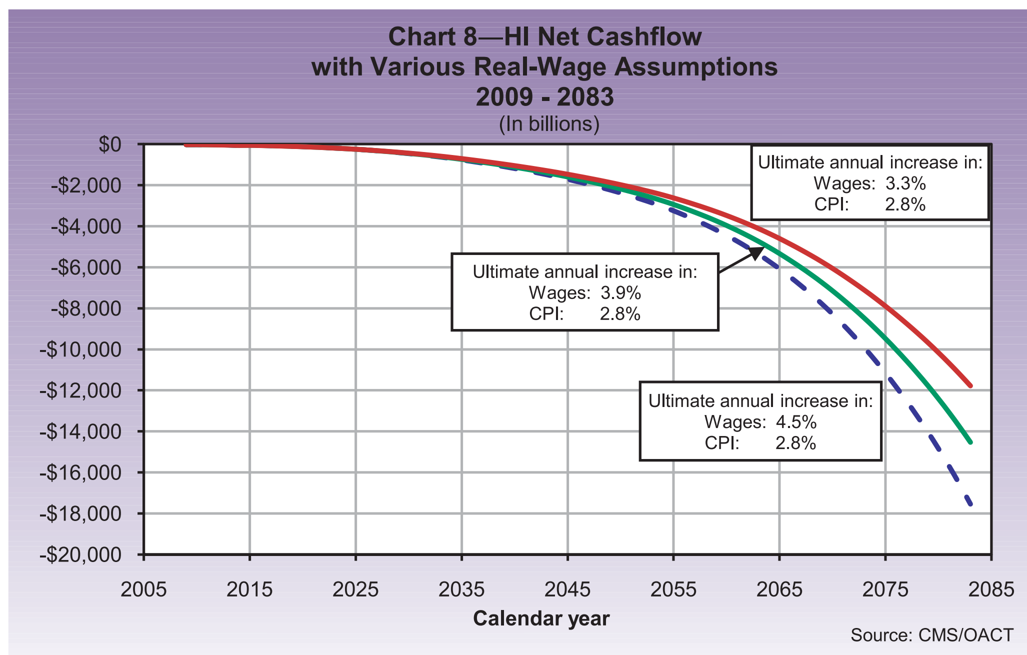
Real-Wage Differential

Table 2 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.5, 1.1, and 1.7 percentage points.[9] 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 3.3, 3.9, and 4.5 percent, respectively.

TABLE 2
Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions

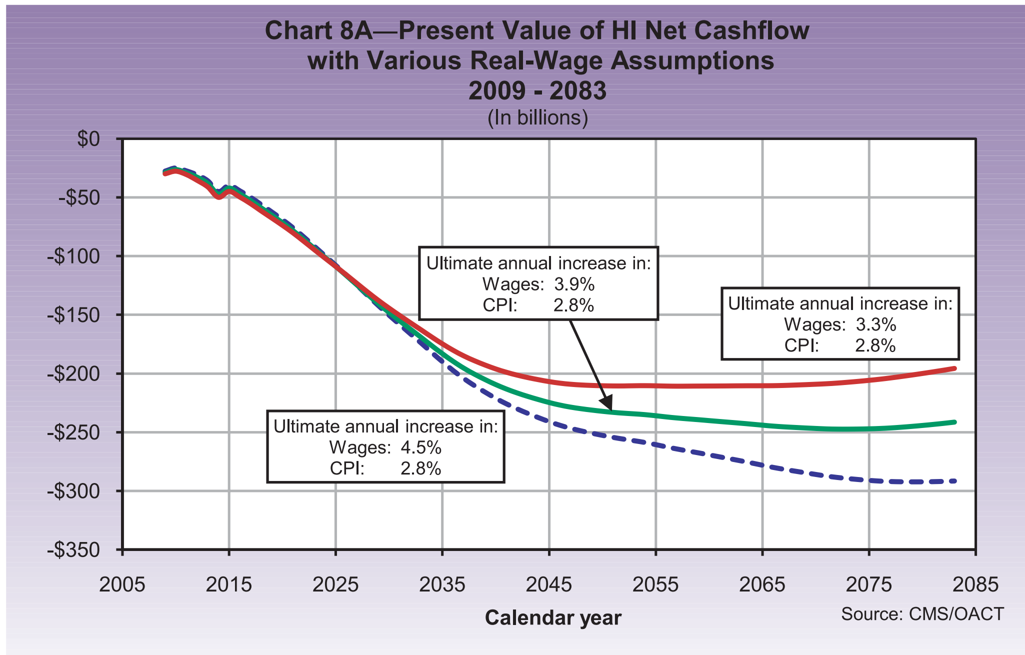
Ultimate percentage increase in wages - CPI	3.3 - 2.8	3.9 - 2.8	4.5 - 2.8
Ultimate percentage increase in real-wage differential	0.5	1.1	1.7
Income minus expenditures *(in billions)*	-$12,367	-$13,770	-$15,161
Income minus expenditures *(as a percentage of taxable payroll)*	-4.18%	-3.88%	-3.53%

As indicated in table 2, for a half point increase in the ultimate real-wage differential assumption, the deficit—expressed in present-value dollars—increases by approximately $1,400 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 2 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.

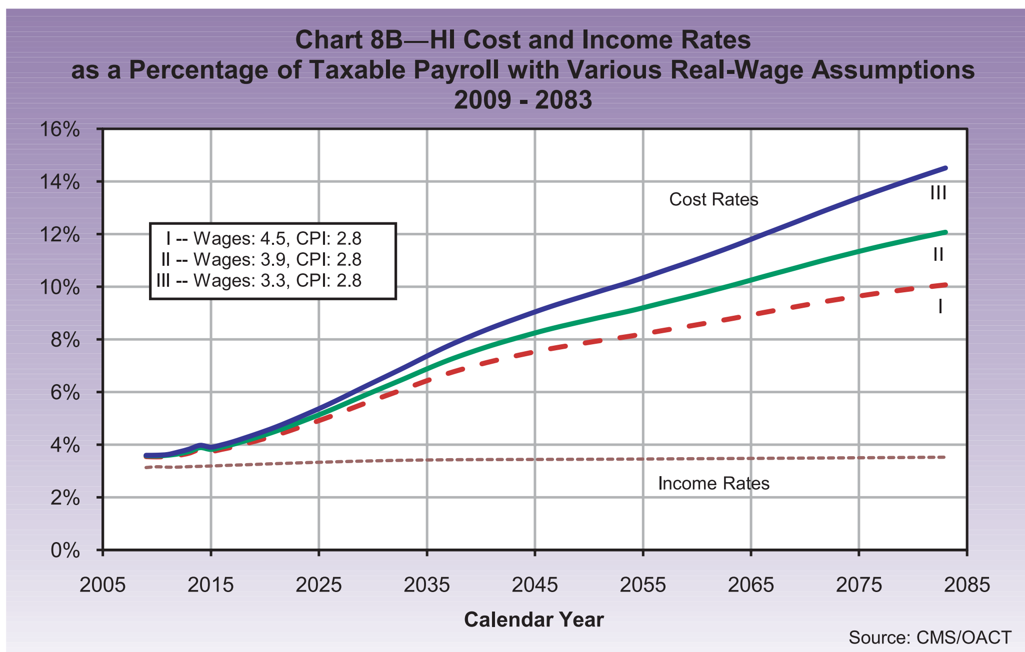


[9] The real-wage differential is the difference between the percentage increases in the average annual wage in covered employment and the average annual CPI.

Charts 8 and 8A show projections of the net cashflow under the three alternative real wage differential assumptions presented in table 2.



As noted previously and illustrated in charts 8 and 8A, 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 8B shows projected HI expenditures and tax revenues under the three scenarios, expressed as a percent of taxable payroll.



As indicated in chart 8B, 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 3 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.

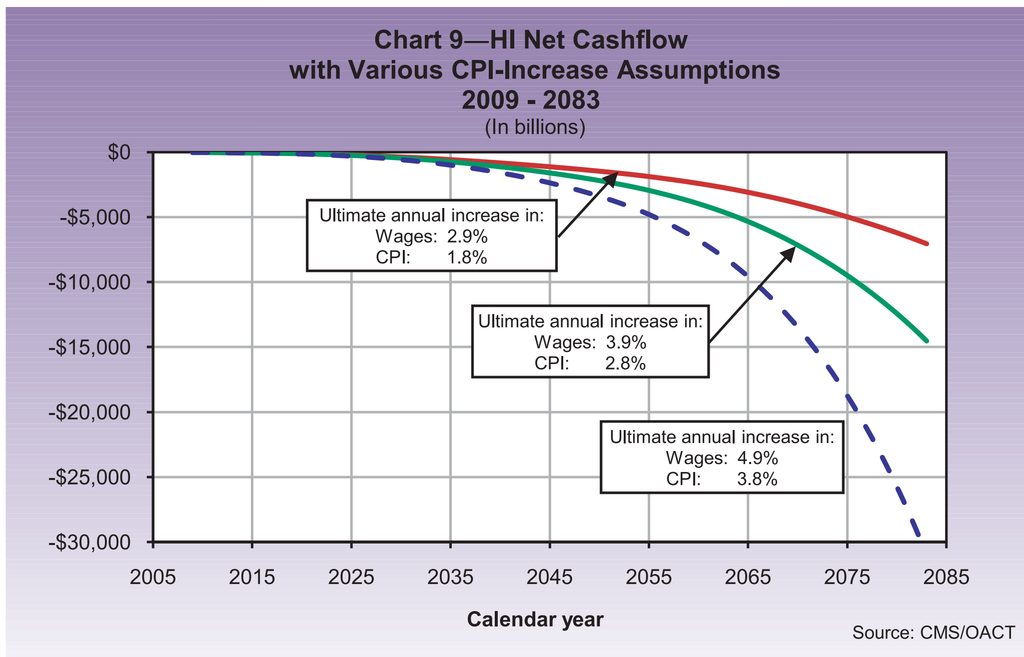
TABLE 3
Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

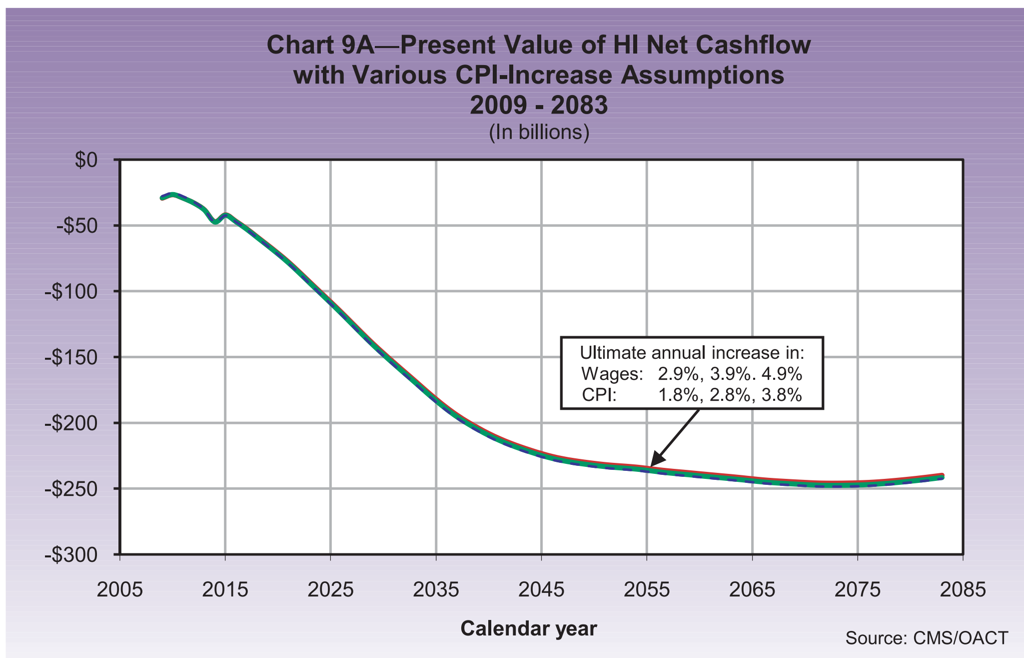
Ultimate percentage increase in wages - CPI	2.9 - 1.8	3.9 - 2.8	4.9 - 3.8
Income minus expenditures *(in billions)*	-$13,677	-$13,770	-$13,822

Table 3 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit decreases by $93 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit increases by $52 billion.

Charts 9 and 9A show projections of the net cashflow under the three alternative CPI rate-of-increase assumptions presented in table 3.

As charts 9 and 9A 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

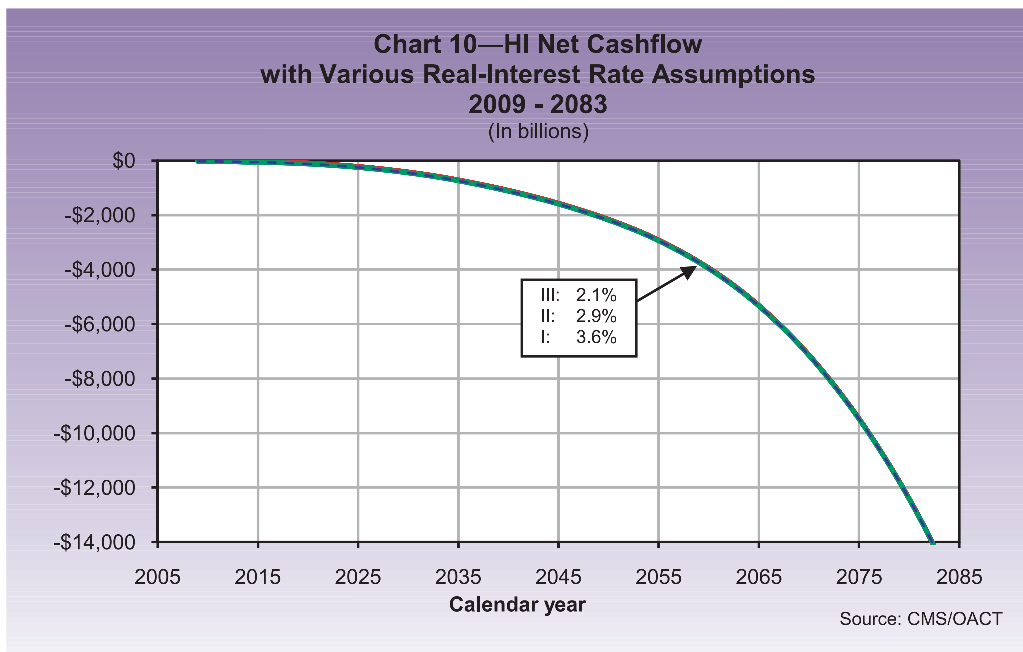
Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.1, 2.9, and 3.6 percent. In each case, the ultimate annual increase in the CPI is assumed to be 2.8 percent, resulting in ultimate nominal annual yields of 4.9, 5.7, and 6.4 percent, respectively.

TABLE 4
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)*	-$19,238	-$13,770	-$10,425

As illustrated in table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $580 billion.

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



As shown in charts 10 and 10A, 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 2017. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

Fertility Rate

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

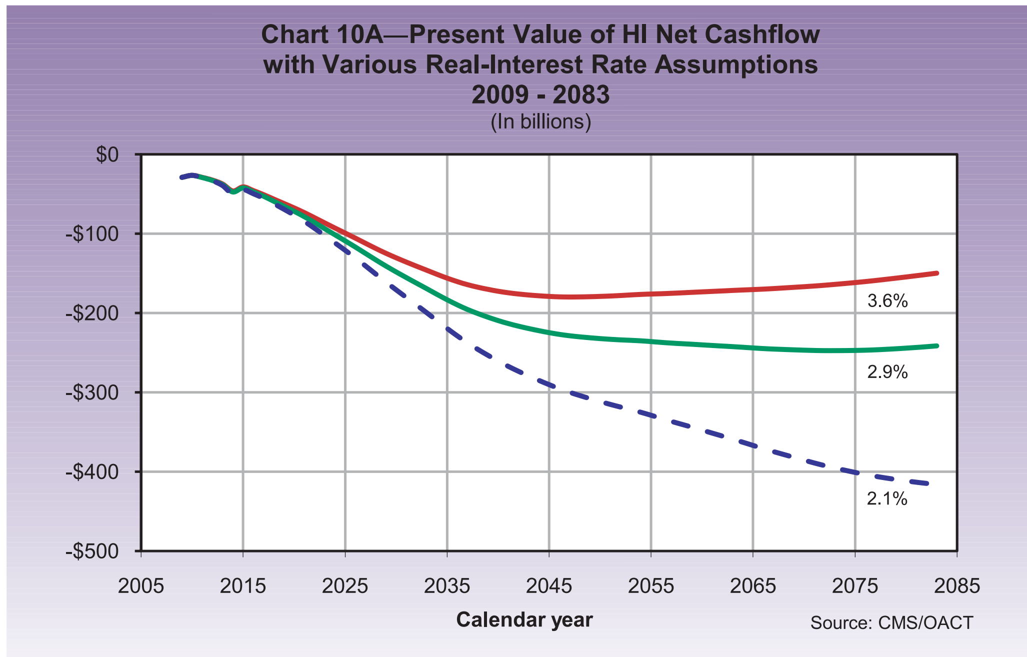
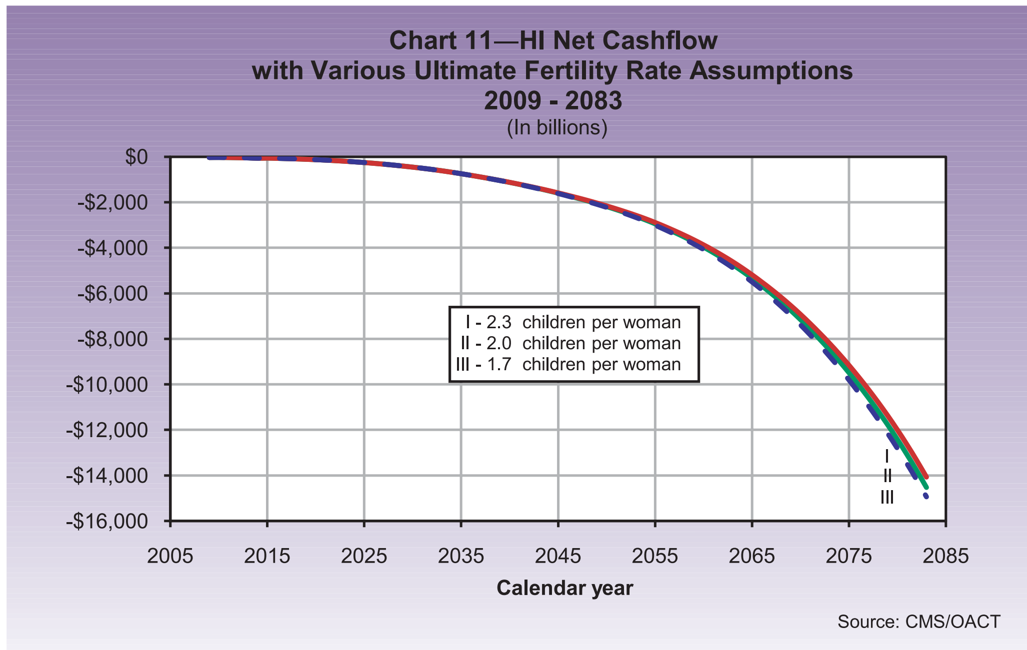


TABLE 5
Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

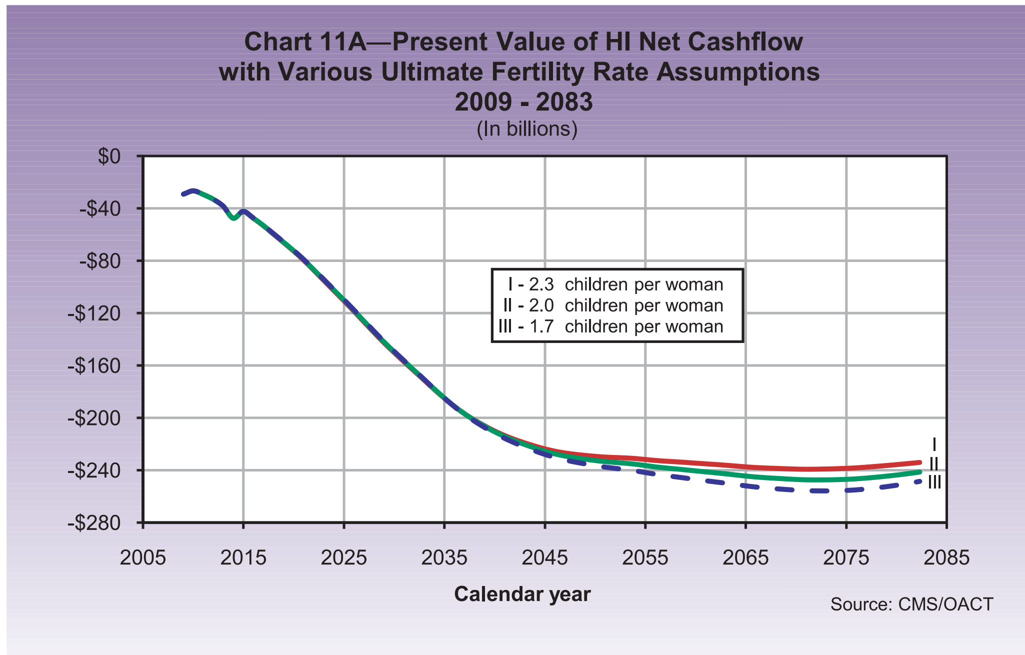
Ultimate fertility rate[1]	1.7	2.0	2.3
Income minus expenditures *(in billions)*	-$14,017	-$13,770	-$13,535

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



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



As charts 11 and 11A 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 5.

Net Immigration

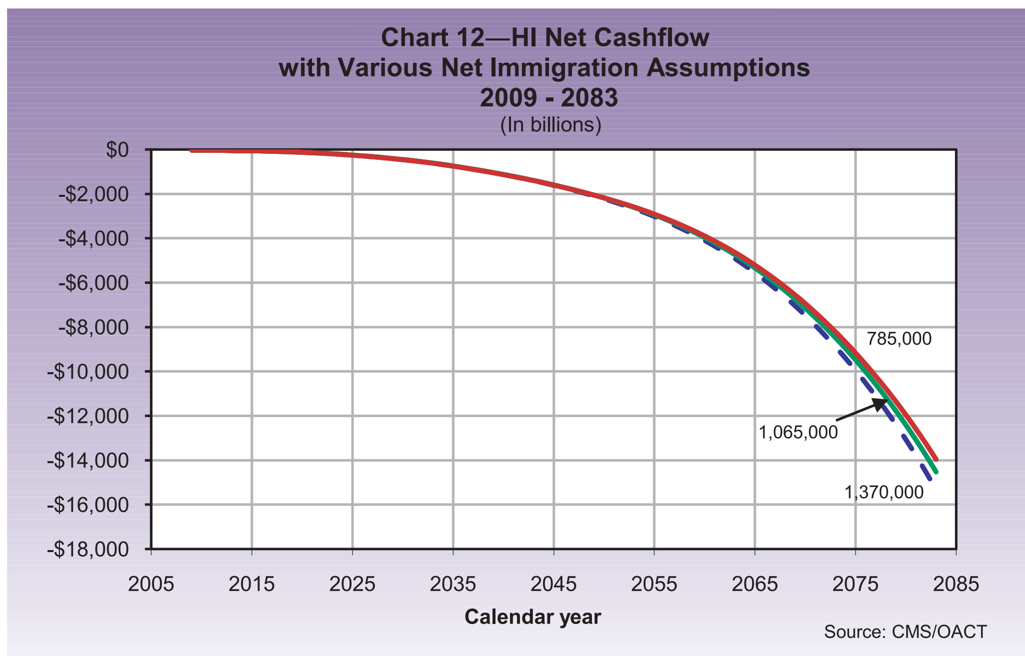
Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate annual net immigration assumptions: 785,000 persons, 1,065,000 persons, and 1,370,000 persons per year.

TABLE 6
Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Average annual net immigration	785,000	1,065,000	1,370,000
Income minus expenditures *(in billions)*	-$13,652	-$13,770	-$14,149
Income minus expenditures *(as a percentage of taxable payroll)*	-3.95%	-3.88%	-3.87%

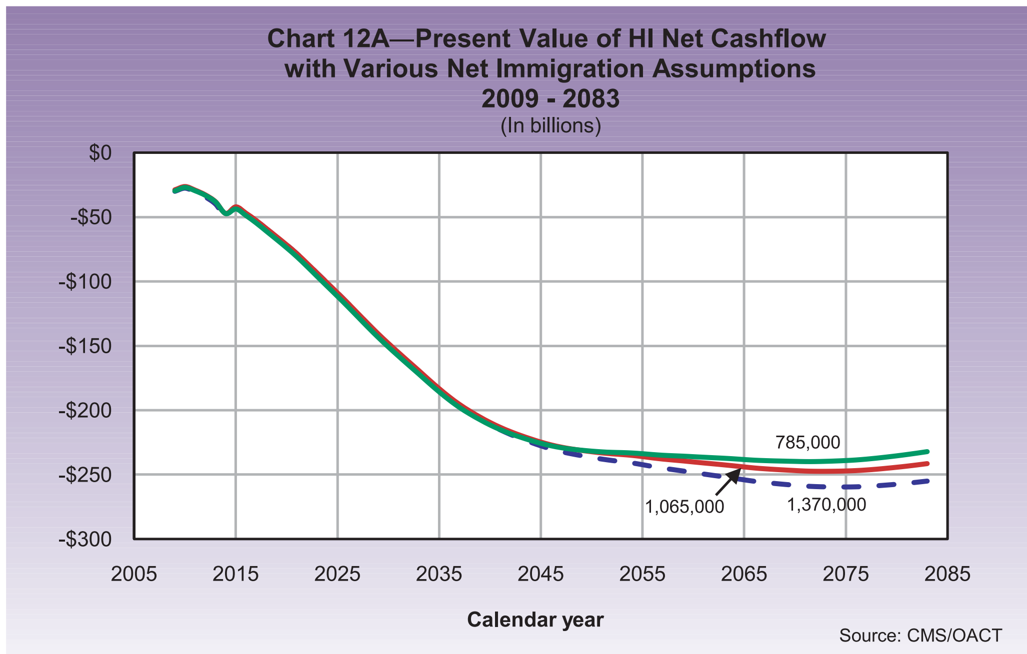
As indicated in table 6, if the average annual net immigration assumption is 785,000 persons, the deficit—expressed in present-value dollars—decreases by $118 billion. Conversely, if the assumption is 1,370,000 persons, the deficit increases by $379 billion. These results expressed in present-value dollars do not reveal the full implications of higher or lower net immigration assumptions. While the dollar amount of the trust fund deficit is smaller, for a lower net immigration assumption, table 6 also indicates that the deficit represents a higher percentage of taxable payroll. In other words, with a lower net immigration assumption, a higher tax increase would be necessary to cover the corresponding HI trust fund deficit. The reasons for the apparent inconsistency between the present-value and taxable-payroll measures are described below.

Charts 12 and 12A show projections of the net cashflow under the three alternative average annual net immigration assumptions presented in table 6.

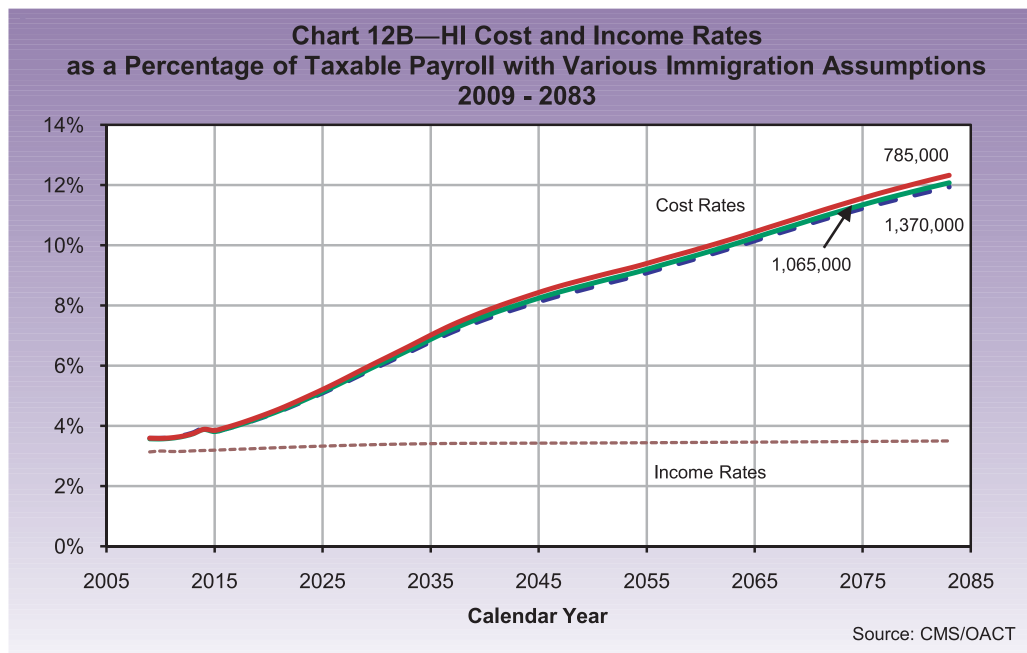


As noted previously and illustrated in charts 12 and 12A, a lower net immigration results in smaller HI cashflow deficits, when expressed in either nominal or present-value dollars. While this result appears to suggest that the financial status of the HI trust fund improves slightly with a lower net immigration assumption, in practice the opposite is true. To better illustrate this result, chart 12B shows projected HI expenditures and tax revenues under the three scenarios, expressed as a percent of taxable payroll.

As indicated in chart 12B, HI expenditures represent a slightly higher proportion of taxable payroll under lower net immigration assumptions (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 with a lower net immigration assumption and decreases with a higher net immigration assumption.



Since immigration tends to occur most often among people at working ages, who work and pay taxes into the HI system, a change in the net immigration assumption affects revenues from payroll taxes almost immediately. However, the impact on expenditures occurs later as those individuals age and become beneficiaries. Therefore, under a higher net immigration assumption, payroll taxes increase faster than expenditures, requiring a smaller increase in the HI payroll tax rate to attain financial balance. On the other hand, a larger increase in the HI payroll tax rate would be required under a lower net immigration assumption since payroll taxes are reduced more than expenditures. As noted previously in the section on real-wage sensitivity, the dollar cashflow measures do not always adequately describe the sensitivity of the HI financial status to changes in the immigration assumptions and must be supplemented by other measures.



TRUST FUND FINANCES AND SUSTAINABILITY

HI

Under the Medicare Trustees' intermediate assumptions, the HI trust fund is projected to be exhausted in 2017. Expenditures exceeded income in 2008 and are expected to continue to do so in 2009 and later. These shortfalls can be met with increasing reliance on the redemption of invested 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 2009 is adequate to cover 2009 expected expenditures and to maintain the financial status of the Part B account in 2009 at a satisfactory level. No financial imbalance is anticipated for the Part D account, since the general revenue subsidy for this benefit is drawn on a daily, as-needed basis. The projected Part D costs shown in this section are somewhat lower than previously estimated, principally because overall prescription drug costs are expected to grow at a slightly slower rate over the next 10 years.

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 (2009– 2015).[10] 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, 2007, and 2008 annual reports to Congress. With this fourth consecutive finding, another "Medicare funding warning" is triggered this year, 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.[11] Congress is then required to consider this legislation on an expedited basis. This requirement helps to 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 2009 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."

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

[11] President Bush submitted legislation in February 2008 in response to the 2007 warning, and President Obama's Fiscal Year 2010 Budget addressed this requirement stemming from the 2008 warning.

COMBINING STATEMENT OF BUDGETARY RESOURCES
For the Year Ended September 30, 2009

(in millions)

	MEDICARE HI TF	MEDICARE SMI TF	Payments to Trust Funds	Medicaid	CHIP	Medicare Part D	All Others	Combined Totals Budgetary
Budgetary Resources:								
Unobligated balance, brought forward, October 1:	$33	$30	$12,267	$8,718	$637	$43	$1,407	$23,135
Recoveries of prior year unpaid obligations	28	31		8,907	320	882	242	10,410
Budget authority:								
Appropriation	243,922	209,277	213,023	270,759	15,945	53,633	2,136	1,008,695
Spending authority from offsetting collections:								
Earned								
Collected			177			2,177	346	2,700
Change in unfilled customer orders:								
Advance received							(2)	(2)
Without advance from Federal sources							(137)	(137)
Expenditure transfers from trust funds	21	24		449			3,442	3,936
SUBTOTAL	**243,943**	**209,301**	**213,200**	**271,208**	**15,945**	**55,810**	**5,785**	**1,015,192**
Nonexpenditure transfers, net, anticipated & actual	134	124		(3,125)				(2,867)
Temporarily not available pursuant to Public Law		(1,215)						(1,215)
Permanently not available	(20)	(30)	(12,430)	(15,869)	(72)		(62)	(28,483)
TOTAL BUDGETARY RESOURCES	**$244,118**	**$208,241**	**$213,037**	**$269,839**	**$16,830**	**$56,735**	**$7,372**	**$1,016,172**
Status of Budgetary Resources:								
Obligations incurred:								
Direct	$244,064	$208,187	$209,447	$261,676	$9,609	$56,393	$5,500	$994,876
Reimbursable							217	217
SUBTOTAL	**244,064**	**208,187**	**209,447**	**261,676**	**9,609**	**56,393**	**5,717**	**995,093**
Unobligated balance:								
Apportioned			3,590	8,163	6,449		1,475	19,677
Exempt from apportionment						234		234
SUBTOTAL			**3,590**	**8,163**	**6,449**	**234**	**1,475**	**19,911**
Unobligated balance not available	54	54			772	108	180	1,168
TOTAL STATUS OF BUDGETARY RESOURCES	**$244,118**	**$208,241**	**$213,037**	**$269,839**	**$16,830**	**$56,735**	**$7,372**	**$1,016,172**
Change in Obligated Balance:								
Obligated balance, net:								
Unpaid obligations, brought forward, October 1	$22,020	$20,471		$20,410	$3,701	$5,402	$3,180	$75,184
Uncollected customer payments from Federal sources, brought forward, October 1	(34)	(30)					(2,132)	(2,196)
Total unpaid obligated balance, net	21,986	20,441		20,410	3,701	5,402	1,048	72,988
Obligations incurred, net	244,064	208,187	$209,447	261,676	9,609	56,393	5,717	995,093
Gross Outlays	(242,294)	(207,371)	(209,447)	(248,202)	(7,546)	(55,374)	(4,903)	(975,137)
Obligated balance transferred, net:								
Recoveries of prior year unpaid obligations, actual	(28)	(31)		(8,907)	(320)	(882)	(242)	(10,410)
Change in uncollected customer payments from Federal sources	(21)	(24)					(317)	(362)
Obligated balance, net, end of period:								
Unpaid obligations	23,762	21,256		24,977	5,444	5,539	3,752	84,730
Uncollected customer payments from Federal sources	(55)	(54)					(2,449)	(2,558)
Total, unpaid obligated balance, net, end of period	23,707	21,202		24,977	5,444	5,539	1,303	82,172
Net Outlays:								
Net Outlays								
Gross outlays	242,294	207,371	209,447	248,202	7,546	55,374	4,903	975,137
Offsetting collections			(177)	(449)		(2,177)	(3,332)	(6,135)
Distributed offsetting receipts	(23,301)	(259,846)					(62)	(283,209)
NET OUTLAYS	**$218,993**	**$(52,475)**	**$209,270**	**$247,753**	**$7,546**	**$53,197**	**$1,509**	**$685,793**

Supplementary Information

CONSOLIDATING BALANCE SHEET
As of September 30, 2009

(in millions)

	MEDICARE (Earmarked)			HEALTH (Other Funds)			Combined	Intra-CMS	Consolidated
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Totals	Eliminations	Totals
ASSETS									
Intragovernmental Assets:									
Fund Balance with Treasury	$375	$2,890	$3,265	$33,132	$10,550	$2,393	$49,340		$49,340
Investments	313,404	62,431	375,835		2,113		377,948		377,948
Accounts Receivable, Net	24,778	27,269	52,047	108	25	97	52,277	$(51,785)	492
Other Assets	17		17				17		17
Total Intragovernmental Assets	338,574	92,590	431,164	33,240	12,688	2,490	479,582	(51,785)	427,797
Cash & Other Monetary Assets	71	286	357				357		357
Accounts Receivable, Net	555	2,452	3,007	2,137		21	5,165		5,165
General Property, Plant & Equipment, Net	130	223	353	27	2	2	384		384
Other Assets	18	1,675	1,693	3	1	124	1,821		1,821
TOTAL ASSETS	$339,348	$97,226	$436,574	$35,407	$12,691	$2,637	$487,309	$(51,785)	$435,524
LIABILITIES									
Intragovernmental Liabilities:									
Accounts Payable	$24,330	$28,049	$52,379	$1		$7	$52,387	$(51,785)	$602
Accrued Payroll and Benefits	2	5	7				7		7
Other Intragovernmental Liabilities	42	442	484	2		27	513		513
Total Intragovernmental Liabilities	24,374	28,496	52,870	3		34	52,907	(51,785)	1,122
Federal Employee & Veterans' Benefits	5	9	14		$1		15		15
Entitlement Benefits Due & Payable	22,351	24,421	46,772	24,977	358	111	72,218		72,218
Accrued Payroll & Benefits	19	38	57	2	1	2	62		62
Contingencies				3,793			3,793		3,793
Other Liabilities	225	294	519			10	529		529
TOTAL LIABILITIES	46,974	53,258	100,232	28,775	360	157	129,524	(51,785)	77,739
NET POSITION									
Unexpended Appropriations—earmarked funds	258	3,332	3,590				3,590		3,590
Unexpended Appropriations—other funds				6,507	12,306	2,123	20,936		20,936
Cumulative Results of Operations—earmarked funds	292,116	40,636	332,752				332,752		332,752
Cumulative Results of Operations—other funds				125	25	357	507		507
TOTAL NET POSITION	$292,374	$43,968	$336,342	$6,632	$12,331	$2,480	$357,785		$357,785
TOTAL LIABILITIES & NET POSITION	$339,348	$97,226	$436,574	$35,407	$12,691	$2,637	$487,309	$(51,785)	$435,524

CONSOLIDATING STATEMENT OF NET COST
For the Year Ended September 30, 2009

(in millions)

	MEDICARE (Earmarked)			HEALTH (Other Funds)			Consolidated
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Totals
NET PROGRAM/ACTIVITY COSTS							
GPRA Programs							
Medicare (Earmarked)	$235,238	$194,787	$430,025				$430,025
Medicaid				$253,352			253,352
CHIP					$7,610		7,610
NET COST—GPRA PROGRAMS	**235,238**	**194,787**	**430,025**	**253,352**	**7,610**		**690,987**
Other Activities							
CLIA						$(56)	(56)
State Grants & Demonstrations						498	498
Other						23	23
NET COST—OTHER ACTIVITIES						**465**	**465**
NET COST OF OPERATIONS	**$235,238**	**$194,787**	**$430,025**	**$253,352**	**$7,610**	**$465**	**$691,452**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2009

(in millions)

	MEDICARE (Earmarked)			HEALTH (Other Funds)			Consolidated
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Total
CUMULATIVE RESULTS OF OPERATIONS							
Beginning Balances	$302,907	$39,733	$342,640	$166	$19	$316	$343,141
Budgetary Financing Sources:							
Appropriations Used	15,003	194,267	209,270	252,735	7,571	394	469,970
Nonexchange Revenue:							
FICA and SECA Taxes	194,091		194,091				194,091
Interest on Investments	15,612	2,975	18,587		1		18,588
Other Nonexchange Revenue	486	13	499				499
Transfers-in/out Without Reimbursement	(756)	(1,586)	(2,342)	575	44	111	(1,612)
Other Financing Sources (Nonexchange):							
Imputed Financing	11	21	32	1		1	34
TOTAL FINANCING SOURCES	**224,447**	**195,690**	**420,137**	**253,311**	**7,616**	**506**	**681,570**
NET COST OF OPERATIONS	**235,238**	**194,787**	**430,025**	**253,352**	**7,610**	**465**	**691,452**
NET CHANGE	**(10,791)**	**903**	**(9,888)**	**(41)**	**6**	**41**	**(9,882)**
CUMULATIVE RESULTS OF OPERATIONS	**$292,116**	**$40,636**	**$332,752**	**$125**	**$25**	**$357**	**$333,259**
UNEXPENDED APPROPRIATIONS							
Beginning Balances		$12,267	$12,267	$7,477	$4,004	$1,777	$25,525
Budgetary Financing Sources:							
Appropriations Received	$15,261	197,762	213,023	270,759	15,945	756	500,483
Appropriations Transferred-in/out				(3,125)			(3,125)
Other Adjustments		(12,430)	(12,430)	(15,869)	(72)	(16)	(28,387)
Appropriations Used	(15,003)	(194,267)	(209,270)	(252,735)	(7,571)	(394)	(469,970)
TOTAL BUDGETARY FINANCING SOURCES	**258**	**(8,935)**	**(8,677)**	**(970)**	**8,302**	**346**	**(999)**
TOTAL UNEXPENDED APPROPRIATIONS	**258**	**3,332**	**3,590**	**6,507**	**12,306**	**2,123**	**24,526**
NET POSITION	**$292,374**	**$43,968**	**$336,342**	**$6,632**	**$12,331**	**$2,480**	**$357,785**

Audit Opinion

Department of Health and Human Services

CENTERS FOR MEDICARE & MEDICAID SERVICES

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

NOV - 9 2009

TO: Charlene Frizzera
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 2009 (A-17-09-02009)

This memorandum transmits the independent auditors' reports on the fiscal year (FY) 2009 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 (P.L. No. 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, 2009, 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, 2009. 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 2009 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, 2009, 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 financial systems, and control over application configuration management.

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 9, 2009, 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 memorandum, 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 email at Joseph.Vengrin@oig.hhs.gov. Please refer to report number A-17-09-02009.

Attachments

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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 sheets of the Centers for Medicare and Medicaid Services (CMS) as of September 30, 2009 and 2008, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal years then ended, and the statement of social insurance as of January 1, 2009 and 2008. These financial statements are the responsibility of CMS' management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits 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 audits 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 audits provide a reasonable basis for our opinions.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of CMS as of September 30, 2009 and 2008, and its net cost, changes in net position, and budgetary resources for the years then ended, and the financial condition of its social insurance program as of January 1, 2009 and 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.

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 9, 2009 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 audits.

Our audits were conducted for the purpose of forming opinions on the 2009 and 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 audits 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, accordingly, we express no opinion on it.

Ernst + Young LLP

November 9, 2009

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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, 2009 and the statement of social insurance as of January 1, 2009, and have issued our report thereon dated November 9, 2009. 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 as discussed above. We have identified the following instances 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 9, 2009, we reported a material weakness related to Information Systems Controls and a significant deficiency related to Financial Reporting Systems and Processes. 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 9, 2009.

* * * * *

Our Report on Internal Control dated November 9, 2009, 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 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 U.S. 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 9, 2009

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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, 2009 and the statement of social insurance as of January 1, 2009, and have issued our report thereon dated November 9, 2009. 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 as a basis for designing our auditing procedures for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of CMS' internal control 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 purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be significant deficiencies or material weaknesses and therefore, there can be no assurance that all deficiencies, significant deficiencies, or material weaknesses have been identified. However, as discussed below, we identified certain deficiencies in internal control that we consider to be material weaknesses and other deficiencies that we consider to be significant deficiencies.

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

A significant deficiency is a deficiency or a combination of deficiencies in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider the deficiencies related to Financial Reporting Systems and Processes to be a significant deficiency.

Material Weakness

Information Systems Controls

Business Environment Overview

A substantial portion of CMS' data and claims processing is performed by geographically dispersed contractors. Because of CMS' enormous size and decentralized nature, it relies on extensive information systems operations. These systems, resident at CMS' 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, on a timely basis, errors that have occurred, and therefore, 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 controls. As noted below under the caption, Financial Reporting Systems and Processes, improvements are needed in the detect controls at CMS. This weakness in detect controls increases the importance of a thorough and closely followed system of IT security.

The contracts between CMS and its contractors that process or support the processing of Medicare fee-for-service claims include provisions requiring the adherence to security standards described in a series of documents, the cornerstone of which is the Business Partners Systems Security Manual (BPSSM). The specific security standards followed at each contractor are to be documented in their System Security Plan (SSP). Contractors are also required to periodically (at least annually) test and certify their systems for operation. Recent restructuring has centralized data processing services in Enterprise Data Centers (EDCs). CMS is transitioning the business function of claims processing to Medicare Administrative Contractors (MACs) who are responsible for processing Hospital Insurance (HI) and Supplemental Medical Insurance (SMI) claims activity for their assigned jurisdictions. Prior to the restructuring, claims processing contractors were responsible for both the data processing and the claims processing function. CMS has contractually required contractors who are designated as MACs to obtain Statement on Auditing Standards (SAS) No. 70 reports to document compliance with the BPSSM and the contractor's SSP. The EDCs, fiscal intermediaries, carriers, and software maintainers are monitored by CMS through annual reviews using Office of Management and Budget (OMB) Circular No. A-123, *Management's Responsibility for Internal Control*, which provides updated

internal control standards and specific requirements for conducting management's assessment of the effectiveness of internal control over financial reporting.

We performed our information systems general and application control procedures at six MACs, and general control procedures at the Baltimore Data Center at CMS Central Office and two contractor Enterprise Data Centers (collectively EDCs). These three EDCs now provide the majority of the electronic data processing and hosting operations to accommodate fee-for-service claims submitted by hospitals, physicians and other providers. The applications reviewed included the Fiscal Intermediary Shared System (FISS), the ViPS Medicare System (VMS), the Multi-Carrier System (MCS) and the Common Working File (CWF) (collectively "shared systems"). At CMS Central Office, we performed procedures over financial applications, including Financial Accounting Control System (FACS), Healthcare Integrated General Ledger Accounting System (HIGLAS) and Medicare Advantage Prescription Drug System (MARx).

While efforts have been made to remediate the prior year findings, we have identified the following similar areas where information technology controls need to be improved.

I. CMS Oversight of Information Security

CMS has developed processes and policies for supporting their Information Security Program in accordance with National Institute of Standards and Technology (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 requirements for information security. CMS embeds compliance with these overarching criteria in its formal policies and in contracts with the entities executing claims processing and other federal information system responsibilities on its behalf, while providing flexibility to the participants in meeting the objectives. A combination of such contractual requirements, contractor self assessments, selected third-party reviews, and follow up processes for remediation of prior findings provide principal monitoring and oversight information for CMS. However, these processes have not been fully effective in identifying information security issues or ensuring that they are timely remediated by contractors.

During our audit activities as part of the CFO audit, we identified weaknesses in information security oversight, including:

- CMS did not ensure that user roles and responsibilities were clearly defined. We noted this weakness at one EDC and two MACs where the MACs and the EDC have not formally documented the coordination of their user access roles. The BPSSM requires that business owners periodically review system access authorization listings and determine whether they remain appropriate. The lack of clearly defined user roles and responsibilities and coordination within the organization (for example, between the EDC and MACs as noted above) has resulted in insufficient reviews by the EDC and MACs of

access and situations where users were granted excessive or conflicting access to the shared systems, as illustrated by the examples in section II below.

- We noted a lack of periodic review of user access over the mainframe and shared systems at one EDC and four MACs. Periodic review of access is essential to ensure that access is appropriate and still required.

- CMS did not ensure the default passwords for several system accounts on a mission critical database were changed since its implementation in 2006. This resulted in vulnerabilities that could have allowed unauthorized users access to unencrypted personally identifiable information (PII) and sensitive user data.

- During our security assessment, we noted that certain MACs did not implement all of the system settings as required by CMS to secure their information systems. As a result, we were able to exploit vulnerabilities at two MACs to gain access to sensitive user data.

- Backup magnetic tapes managed by EDCs contained unencrypted PII (Medicare claims data). CMS is not following the Department of Health and Human Services (HHS) Standard for Encryption (HHS Standard 2008-0007.001S, dated December 23, 2008) that "all portable media that contains sensitive information shall be encrypted" and OMB Memorandum No. M-06-16, *Protection of Sensitive Agency Information*. CMS did not receive a waiver from OMB related to this issue.

- The EDCs did not implement all mainframe security settings as required by CMS to secure their information systems. In addition, we noted an excessive number of users (150 users at one EDC and 300 users at another EDC) who also had excessive system access to the mainframe. For example, the 150 users at one EDC were granted elevated security administrative privileges even though they only required limited access for resetting passwords. This access could allow users unauthorized access to Medicare data.

- Noncompliance with CMS security standards were not reported to CMS. At one MAC, we noted that eight out of 39 critical security settings tested were not in compliance with the established standard. Examples of these exceptions include dormant accounts not removed, privileged accounts not restricted based on job function and hard drive not encrypted.

The aggregation of these information technology vulnerabilities increases the risk of misappropriation of funds or unauthorized disclosure of PII. The risk of the vulnerabilities is magnified by the insufficient oversight and monitoring of the information technology controls by CMS management.

II. Access to Financial Systems

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 to data and programs maintained on systems; such controls include monitoring of security events for proper assessment and remediation.

- The application security design for Multi-Carrier System (MCS) did not support appropriate segregation of duties between security administrators and computer support activities or business functions. This access allows security administrative privileges to Medicare (Part B) claims processing at all contractors using MCS. Specifically, we noted that 24 business users at two MACs and 28 help desk users at another MAC were granted excessive security administrative privileges even though they only required limited access (resetting passwords).

- We noted that inappropriate and excessive access was granted to 72 users at two MACs. Specifically, access control privileges were granted that provide users with update and delete access to production data files although the users only needed update access. At one MAC, we noted that users were application developers and at another MAC the users were business function users. This access would allow users to create and also delete production files (Medicare data files).

- We noted that access was granted to four FISS users resulting in inappropriate segregation of duties at two MACs. The lack of segregation of duties may result in erroneous Medicare (Part A) claims processing.

- Segregation of duties conflicts also exist at Central Office between the business function and the information security administration function of the Office of Financial Management's (OFM) Financial Accounting and Control System (FACS) general ledger-related application. CMS OFM has assigned personnel to function as system and security administrators, who are able to grant access to the FACS general ledger application, and process transactions. A similar condition was noted last year.

These security weaknesses could allow internal users to access and update financial systems, program parameters, and data without proper authorization.

III. Control over Application Configuration Management

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 provide software development and support of the shared systems used to process Medicare claims.

The review of change management for Central Office financial applications identified inconsistencies in the processes and methods used for mainframe applications. The infrastructure change management process is centralized and uses a change configuration board to manage changes across the enterprise. However, Central Office mainframe application program changes are not part of the enterprise change process and rely on individual change processes within each business function. During the audit, the following weaknesses were noted:

- NIST requires a change management control and tracking process to ensure that all phases of the change control process (e.g., justification for change, approval, implementation and test of the change) are satisfied. We noted nine Central Office Medicare or financial applications that do not have an adequate change control process to manage configuration changes. For example, we tested 47 changes to the MARx and MBD systems and noted that there was no evidence of approval and no evidence of testing for 40 and 18, respectively, of the changes. In addition, we noted that monitoring of configuration changes for HIGLAS is not being performed. Specifically, the HIGLAS production environment is not reviewed and compared with approved changes to validate that only authorized and appropriate changes are made to the system. As a result of these weaknesses, unauthorized or unapproved changes may be implemented which could lead to inaccurate Medicare payments.

- We noted that segregation of duties conflicts existed with the change management software used to track changes in Central Office Medicare applications. We identified one individual each in five different Medicare applications where they were able to develop and also approve system changes. As a result of these weaknesses, unauthorized or unapproved changes may be implemented which could lead to inaccurate Medicare payments.

Software maintainers provide services for the shared systems that include system development, system documentation, training, and unit testing. The MACs' responsibilities over the shared systems include configuration of edits, customization of Automated Adjudication Software (AAS or script) and administration of security. During the audit, the following weaknesses were identified:

- In 2008, CMS management established formal control processes for the use of the AAS, including methods to establish, test, peer review, and approve AAS programs prior to their use. Our testing noted issues at five MACs regarding compliance with these processes for AAS. More than 25% of the tested AAS was not documented by four MACs as to the business purpose and planned date to activate and/or deactivate the script. In addition, we noted that scripts created several years ago and scripts inherited from previous claims processors have not been tested or documented as to the business purpose. Also, at one MAC, we noted five users were able to develop and write the scripts and also were able to activate the scripts, which results in a lack of segregation of

duties. Finally, we noted that there is no CMS requirement for the MACs to recertify the AAS on a periodic basis.

AAS programs provide a powerful tool to process large volumes of Medicare claims rapidly, without human intervention. The use of such programs, without the enforcement of strong controls, could result in inconsistent, uncertain, or improper Medicare payments. While new AAS are subject to an improved process, this condition has not been resolved for AAS programs from prior fiscal years.

Recommendations

CMS has made efforts to remediate specific information security and control weaknesses. CMS management should continue its efforts to appropriately coordinate 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 should:

- Improve its process for monitoring and managing its contractors through additional communication, coordination and assignment of clear responsibilities for processing Medicare data and adhering to CMS' policies.

- Provide specific direction to the MACs and EDCs as to their roles and responsibilities for performing information security functions and validate appropriate segregation of duties.

- Enforce the requirement that user access reviews are performed periodically and in a timely manner.

- Ensure the encryption of personally identifiable information on its information systems, including portable devices, as required by OMB and HHS to protect sensitive data against unauthorized disclosure.

- Strengthen its information technology systems by ensuring that the system and security settings have been implemented, monitored for compliance, and identified errors are corrected on a timely basis.

- Ensure that appropriate segregation of duties is established in all systems that support Medicare and financial processing to prevent excessive or inappropriate access. In addition, access to all systems should be periodically reviewed to ensure that access remains appropriate and no incompatible duties exist.

- Move the FACS application security administration process and configuration management process from personnel within OFM to OIS. CMS has continued to use its

existing process for supporting FACS, augmented by what it believes to be compensating manual controls to review activity. Pending replacement of FACS, we suggest CMS continue to periodically reassess and confirm this decision at senior levels and remain vigilant as to the risks posed by the segregation of duties issues noted. OIS has an established user security administration process as well as an established configuration management process. CMS would strengthen the internal controls by utilizing these OIS processes for FACS. In addition, CMS should ensure that segregation of duties are appropriately addressed in the implementation of the new accounting system.

- Require all changes to Medicare and financial applications to follow NIST guidance including reviewing and approving all changes. All phases of the change management process should be documented and retained.

- Ensure that all AAS programs are documented as to their business purpose and tested prior to being installed at a MAC. The scripts should be periodically tested and recertified as to business need and any prior year script should be properly validated.

CMS should continue its efforts to increase contractor compliance by enhancing controls through oversight activities and proactively monitoring contractor compliance with security settings and related directives for data access control and application programs. In addition, CMS management should validate the implementation of the requirements and standards by the contractors, review and evaluate the deviations noted, document the conclusions and, if acceptable, approve the documentation.

The combination of the need to improve CMS oversight of its contractors, prevent inappropriate or excessive access and incompatible duties to Medicare and financial systems, and validate that scripts are functioning as intended has resulted in more than a remote likelihood that a material misstatement of the financial statements will not be prevented or detected by CMS' internal controls. Accordingly, if the internal controls associated with the noted weaknesses are not functioning as intended, this may result in inconsistent and uncertain claims processing that could lead to inaccurate Medicare payments.

Significant Deficiency

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, *Management's Responsibility for Internal Control*.

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. An organization structure comprised of 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.

CMS 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, and continues to play, 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; challenging the design of accounting and financial controls to support the financial and operational needs of the organization; 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. Enhancement of Financial Management Analysis Function

Critical financial management responsibilities, for example, 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 requires a high degree of coordination between the financial and program management personnel to ensure the effective operation of the controls.

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. Critical accounting matters identified within the organization require a robust review process, including the documentation of these critical accounting matters through CMS' white paper process. While the white paper process has improved, we noted areas for further improvement in gathering and assessing information from across CMS to aid in enhancing financial management.

CMS can improve its analysis processes to develop further robust analytical procedures or measures against benchmarks to monitor and mitigate risks associated with the decentralized nature of CMS operations. CMS performs an analysis of changes in prior year to current year balances; however, this analysis is not extensive nor is it supplemented by additional 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.). Although we noted that CMS performs limited financial statement analytical review procedures on a quarterly basis (i.e., changes in current quarter to prior quarter balances), these procedures were not performed and reviewed timely (e.g., the June 30, 2009 quarterly financial statement analytical review was not completed and reviewed until September 25, 2009). 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, errors in the financial statements may not be detected if robust analytical analyses are not performed by the various program Centers/Offices and are not provided timely to OFM.

Consistent with the prior year, 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 incurred but not reported (i.e., unpaid claims) liability. The Medicaid EBDP is approximately $25.0 billion as of September 30, 2009 and is a significant liability on the financial statements. Currently, CMS does not obtain the Medicaid claims data from the states' systems. Accordingly, CMS is not able to validate its methodology in a manner similar to the Medicare methodology by using a claims-based approach. CMS continues to rely on its historical three-year average to record the Medicaid EBDP without the ability to confirm the reasonableness of its methodology.

All individuals within the organization are responsible for establishing, managing and maintaining an effective control environment. A good control environment not only ensures accountability, but also provides oversight and reasonable assurance that the organization's goals are met. The goals may pertain to promoting orderly, economical, efficient and effective operations, adhering to laws, regulations and management policies or developing, maintaining and reporting reliable financial and management information timely. The purpose of the monitoring or review function is to determine whether the controls are adequately designed, properly executed and effective. During the internal control tests, errors were noted that were not detected by the organization's monitoring and review function, and accordingly, the control was not functioning as designed or intended. The errors identified by our audit procedures at the

central office and regional offices and Medicare contractor locations may be summarized as follows: (i) no review or monitoring function was established (identified as a design deficiency); (ii) review or monitoring function was established but was not performed or effective; and (iii) the review or monitoring function was not performed timely. An example of a deficiency for each category includes: (i) no documentation of the execution of the centralized oversight to assess compliance with laws and regulations in connection with periodic financial reporting; (ii) formula or mathematical errors were noted in a specific reconciliation and related supporting documentation that were not identified by the review function; and (iii) the final cost reports for certain cost-based plans were not reviewed timely and the related calendar year 2008 cost plan settlements were not evaluated or recorded in the FY 2009 financial statements.

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 the steward of the Medicare and Medicaid programs' administrative and financial operations, has a fiduciary responsibility to ensure that the program 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 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.

During 2007, CMS transferred a majority of the Medicare Secondary Payor recovery process to a single third-party contractor. This contractor is responsible for initiating collection of several hundred million dollars on an annual basis. Although some additional procedures were implemented, we continued to note several instances where internal controls related to this third-party contractor were not designed or operating effectively, including lack of, or an ineffective level of, review and the untimely application of cash receipts.

In addition, the processes designed to prevent errors should also be supplemented by controls and analyses that highlight any material errors that may occur. In this regard, errors or abuses within the Medicare fee-for-service 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, continue to evolve, but these monitoring activities also can be useful, and the initial error rate development processes developed by CMS are important steps forward in this regard. 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. We reviewed these error analyses and these analyses quantify the challenges that CMS has regarding improper payments. Our audit procedures also consider the audit activities performed by the OIG and others for the Part C and D programs. Findings, such as timeliness of the plan audits and the accumulation of True-Out-of-Pocket costs (TROOP) and Prescription Drug Event (PDE) data, are inherent risks of the programs.

In the prior year, the OIG recommended revisions to the error rate review methodology, which were implemented by CMS during fiscal year 2009. Preliminary indications are that the refined process has resulted in higher projected error rates. 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.

IV. Statement of Social Insurance

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 SOSI models are complex, 75-year projections that contain a high degree of estimation. The lack of robust controls over spreadsheet changes and inputs, and complexity of the models may result in output that varies from management's intentions. We noted the following deficiencies that, if improved, would enhance the reliability and credibility of the SOSI model and process.

- CMS has developed and implemented a change management process over the SOSI model, which applies to significant changes or changes in the methodology of the model. During our testing, we noted that certain changes made to the models were not tracked through the change management process. For example, certain formula changes were made within, and other spreadsheets were removed from, the models and the reasons were not documented.

- The SOSI model is password protected to ensure that only authorized access and changes are made to the analyses within the model. During our testing, we noted that one CGE spreadsheet was not password protected, which could allow unauthorized access and changes to the CGE analysis.

- CMS' policies and procedures require that any input or output data within the SOSI models should be documented to properly understand the flow of the data. During our testing, we noted that OACT did not document their methodology and related calculations/estimates for certain assumptions and hard-coded adjustments within the model. In addition, the documentation for the Part C analysis was not completed. The

purpose of the documentation is to describe the steps within the process and the source of the input and output data.

Recommendations

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

- The various program Centers/Offices should provide robust analytical analyses to OFM on a periodic basis (e.g., quarterly) that would be analyzed and reconciled by OFM in connection with the preparation of the quarterly 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 $25.0 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 or sample the largest states and determine if information is available for subsequent analysis.

- Evaluate the monitoring and review function to determine the reason the reviews are not performed effectively. Reinforce the importance of the detect control within the internal control structure, the accountability of the control and the oversight required to maintain an effective control environment.

- 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.

- 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.

- Continue the process of enhancing the integrity, improving the process and capturing the benefits of the CERT, PERM, Part C and Part D error rate development and analysis tools. Error rate results should be developed at a sufficient level of detail to analyze, scrutinize and classify errors and identify anomalies to begin separate investigations or studies of the root causes of the errors and appropriate prevention, mitigation and recovery plans.

- Critically assess findings from OIG and other reviews of the Part C and D programs to ensure that the evolving nature of these programs are accompanied by robust internal control processes utilized by CMS to address the inherent risks of these programs. Continue to consider and implement the recommended audit results and modify the processes to hold plan sponsors more accountable for the findings identified. The

financial management group should ensure it monitors and maintains oversight over the programs and its activities to identify the appropriate financial statement impact and disclosure.

- Strengthen change management controls to test, review and document all formulae and spreadsheet changes to the SOSI model. In addition, CMS should verify that all spreadsheets are password protected to avoid unauthorized access or changes.

- Adhere to established policies and procedures to ensure that the SOSI model methodology and related calculations and estimates are consistently documented. Adherence to these policies will ensure that the model is evaluated to verify that the input/output data is appropriate based on the expected results of the data and spreadsheet changes.

Finally, in light of the extraordinary financial crisis that existed in 2008 and continues in 2009, and the pattern of advances to Part D drug plans, we believe that CMS should continue to evaluate its risks with respect to all its third-party contractors and providers to ensure that the Agency is appropriately protecting its resources.

We have reviewed our findings and recommendations with CMS management. CMS' response to our findings and recommendations is included in their letter dated November 9, 2009. Management will provide a corrective action plan to the Office of Inspector General in accordance with applicable Agency directives. We did not audit CMS' response and accordingly, we express no opinion on it.

This report is intended solely for the information and use of 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 9, 2009

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

November 9, 2009

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

Dear Sir:

The Centers for Medicare & Medicaid Services (CMS) has reviewed the report prepared by Ernst & Young, LLP (E&Y). We are pleased that the result of the audit is an unqualified opinion on our fiscal year (FY) 2009 financial statements. The CMS notes that your report identifies one material weakness, Information Systems Controls and one significant deficiency, Financial Reporting Systems and Processes. While we generally agree with your findings and descriptions of the matters noted, we strongly believe the findings related to Information Systems Controls do not rise to the level of a material weakness.

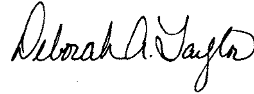
Considering the significant progress made on corrective actions taken, including the implementation of additional procedures and internal controls, we continue to believe that substantial efforts have been made to remediate the findings related to information systems down to a significant deficiency. This position is supported by the results of our annual Office of Management and Budget Circular A-123, Appendix A review, which confirmed that controls are in place and operating effectively. The CMS believes we have appropriate compensating controls which would reduce the risk of a material misstatement of our financial statements.

The CMS continued to show improvement through FY 2009, as evidenced by the removal of one of the prior year significant deficiencies. We will continue our efforts in FY 2010 to address the remaining significant deficiency cited by E&Y. However, CMS will work closely with the auditors in order to gain a better understanding of their proposed recommendations so that we can properly develop a remediation plan that will accomplish this task. For example, E&Y recommends that CMS develop more robust analytics surrounding its financial statement preparation process. The CMS is unclear on what additional analytics are being referenced that require development. We already perform an extensive monthly analysis and validation of Part C and D payments. This is conducted at both the plan and beneficiary level. In addition, CMS performs review steps as part of the states' expenditure submission that includes reconciling the expenditures reported by the state to the total cash draws reported in the Payment Management System. Furthermore, we perform many other analytics around the data that is incorporated into our financial statements which we believe are sufficiently robust and should satisfy the auditor's recommendation.

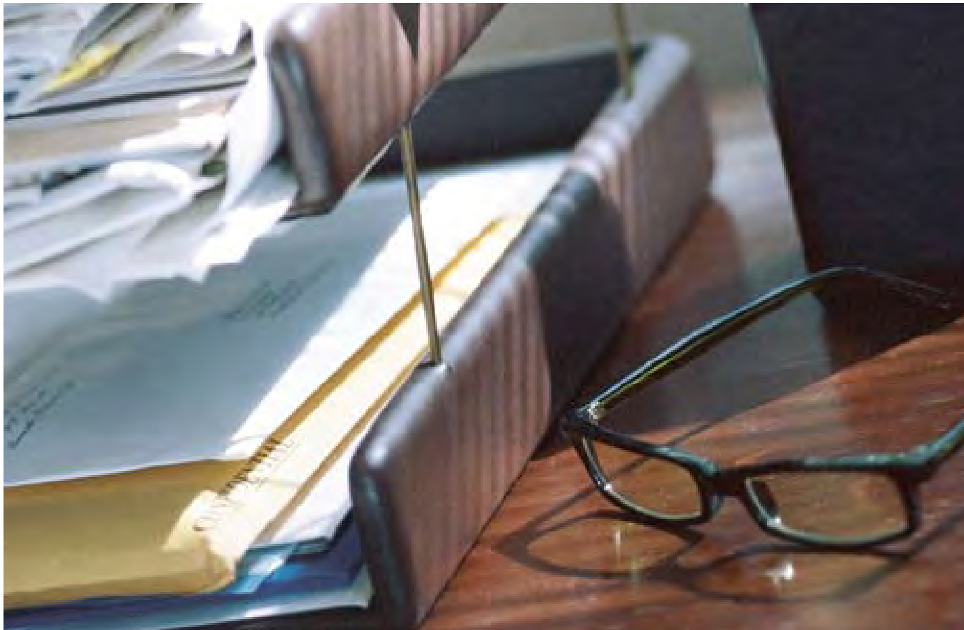
The CMS is committed to developing corrective action plans to address the audit issues identified in your report. It is the Agency's intent to correct the root causes of these issues as quickly as possible.

We continue to be committed to improving financial management and producing accurate and reliable financial information. The CMS would like to thank the Office of Inspector General and Ernst & Young, LLP audit team for the professional manner in which they conducted their audit and hope to work with you to resolve these outstanding issues.

Sincerely,



Deborah A. Taylor, CPA
Acting 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: 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 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 A-123, Appendix A self-assessment, (3) OIG audits and Government Accountability Office (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) audit, and (7) certification and accreditation of systems. As of September 30, 2009, 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 CMS contractors' shared claims processing system 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 measured the payment error rates for the Medicare fee-for-service (FFS) program. We will report an annual FY 2008 Medicaid "composite" paid claims error rate in the Department of Health and Human Services (HHS) FY 2009 Agency Financial Report (AFR). The "composite" error rate will be calculated for the Medicaid program, including FFS, managed care, and eligibility benefits. The CHIP error rate measurement has been temporarily suspended while CMS develops a new final rule for the Payment Error Rate Measurement (PERM) program as required by the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. We are in compliance with IPIA for the Part C Medicare Advantage program; we reported a calendar year (CY) 2006 Part C composite payment error rate in HHS's FY 2008 AFR, and will report a CY 2007 Part C composite payment error rate in the Department's FY 2009 AFR. We continue to make significant progress toward the development of an error rate measurement program for the Part D Prescription Drug program. We reported two Part D component payment error rates in the HHS FY 2008 AFR, and we will report at least two Part D component payment error rates in the HHS FY 2009 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, 2009, CMS provided reasonable assurance that internal controls over operations were effective and no material weaknesses were found in the design or operation of these internal controls. As of September 30, 2009, we also complied with applicable laws and regulations, except for the noncompliance and nonconformance noted above. While the GAO High-Risk Report includes

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, as a supplement to actions by the executive branch, in order to effectively address these high-risk areas.

Assurance for Internal Control over Financial Reporting

The CMS conducted its assessment of the effectiveness of internal controls over financial reporting, which includes the safeguarding of assets and compliance with applicable laws and regulations, in accordance with the requirements of Appendix A of OMB Circular No. A-123. Based on the results of this assessment, CMS provided reasonable assurance that internal controls over financial reporting as of June 30, 2009, were operating effectively and no material weakness were found in the design or operation of the internal controls over financial reporting.

Information System Control Deficiencies Noted in the FY 2009 OMB Circular A-123, Appendix A Review

During the FY 2008 CFO audit of CMS' financial statements, auditors reported a material weakness relating to information systems controls. However, based on the results of the FY 2009 OMB Circular A-123, Appendix A self-assessment, SAS 70 internal control audits of the CMS contactors, Certification Package for Internal Controls (CPIC) submitted by contractors, FMFIA Self-Assessment Tracking and Reporting System (F-STARS) management self-assessments, and Federal Information Security Management Act (FISMA) reviews, 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 CMS financial statements would not be prevented or detected.

The CMS is continuing to work diligently to address the systemic control deficiencies in information systems controls noted in the ***FY 2008 CMS Financial Report***. The CMS has enhanced and strengthened existing controls, as well as introduced a number of new controls.

One of the areas noted in the material weakness indicated that segregation of duties is not maintained between the business function and the information security administration function for the Office of Financial Management Financial Accounting Control System (FACS) general ledger-related application. Based on the results of the FY 2009 A-123 review, the current application architecture, as well as the business and security risks associated with implementing the CFO auditor's recommendations, preclude the ability to establish the segregation of duties structure recommended as a result of the FY 2008 CFO audit; however, CMS has implemented compensating controls to further apply 'least privilege access' and improve application monitoring.

The CMS has introduced controls to enhance oversight of the Information Security by providing guidance and direction to the Medicare Contractors in development and implementation of Configuration Baselines standards. Additionally, CMS has established controls over application configuration management for Shared Systems by establishing enhanced process for review, validation, and approval of Shared System Edits, as well as ensuring Change Control processes

are in place for the Auto Adjudication Software. Documentation for each Shared System has been developed and reviewed.

The OMB Circular A-123, Appendix A assessment determined that the CMS claims administration contractors (MACs, carriers, and fiscal intermediaries), Enterprise Data Centers, and Shared System Maintainers have complied with the requirements of Joint Signature Memorandum (JSM) 09107 *Baseline Secure Configuration* 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. These CMS contractors have demonstrated reasonable assurance in the areas of data access, configuration management, and in the general IT control environment as required by OMB Circular A-123.

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. Although CMS has not fully complied with the OMB's IPIA guidance, CMS has implemented comprehensive processes that measure the payment error rates for the Medicare FFS, Medicaid, CHIP, and Medicare Advantage programs. The CMS is continuing its initiatives to measure the payment error rate for the Medicare Prescription Drug program.

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 2009 indicated that the paid claims gross error rate was 7.8 percent or $24.1 billion in gross improper payments. Based on both the recommendations contained in recent OIG audit reports and those of CMS' advisory medical staff, CMS modified the medical review process for the November 2009, improper payments report. The CMS implemented three separate revisions to the Contractor Error Rate Testing (CERT) review criteria based on these

recommendations. Due to these modifications, the CERT contractor was not able to meet the original goal of 120,000 reviewed claims. Approximately 99,500 claims completed the review process. Of that number, approximately 19,000 claims were reviewed using the most stringent criteria. The national paid claims error rate for those claims reviewed under the strictest criteria, when applied to the entire year, is 12.4 percent or $35.4 billion. However, CMS consulted with the OIG concerning the limited time period covered by these claims and determined that only reporting the error rate for this subset of claims would not be in compliance with IPIA requirements. 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 2009 Gross Improper Payments and Error Rates in the Medicare FFS Program

		Gross	
Overpayments	Underpayments	Improper Payment Amount (Overpayments + Underpayments)	Error Rate
$23.0 B	$1.1 B	$24.1 B	7.8%

Medicare Advantage and Prescription Drugs

The CMS has developed a Part C composite payment error rate, thus achieving IPIA compliance. The Part C composite payment error rate combines two component error rates into a single composite measure for total Part C payments: (1) the Medicare Advantage and Prescription Drug System (MARx) payment error (MPE) rate for Part C; and (2) the Part C risk adjustment error (RAE) rate. We reported an IPIA Part C composite payment error rate of 15.4 percent in the FY 2009 HHS Annual Financial Report (AFR).

A key challenge facing CMS in the coming years will be achieving IPIA compliance for the Medicare Prescription Drug Benefit, a new Medicare benefit effective CY 2006. In FY 2009, CMS made significant strides towards this goal by preparing measurement methodologies for three elements of a Prescription Drug (Part D) program payment error estimates, and reporting these estimates. For IPIA reporting in the FY 2009 HHS AFR, CMS calculated three components of payment error: (1) the MARx payment error (MPE) rate for Part D; (2) a Payment Error related to the Low Income Subsidy (PELS) payments; and (3) a Payment Error related to Medicaid Status (PEMS). In the FY 2009 HHS AFR, we reported a Part D MPE rate of 0.59 percent, a PELS rate of 0.25 percent, and a PEMS rate of 1.06 percent. We continue to make significant progress toward the development of a composite payment error rate for the Part D program.

Medicaid and CHIP

Medicaid and CHIP 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 CHIP annually, through the Payment Error Rate Measurement (PERM) program. The PERM program measures improper payments in Medicaid and CHIP. The FFS and managed care components of these programs are measured by national contractors, while states lead the effort in measuring errors in the eligibility components of Medicaid and CHIP. A sample of 17 states has been selected to be measured once every three years in each program in order to produce and report national program error rates to OMB for inclusion in the HHS AFR.

The CMS measured improper payments in Medicaid FFS, managed care and eligibility in 2008. The FY 2008 national Medicaid program payment error rate is 8.7 percent, or $28.7 billion in gross improper payments.

Section 601 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) prohibits HHS from calculating or publishing any national or State-specific error rates for CHIP until six months after a new PERM final rule is in effect. The CMS is currently developing a final regulation as required by CHIPRA. Therefore, for the FY 2008 cycle, CMS is not reporting a national CHIP error rate.

REVIEW OF MEDICARE'S PROGRAM FOR OVERSIGHT OF ACCREDITATION ORGANIZATIONS

SECTION 1: Overview

Section 1865 of the Social Security Act (the Act) allows health care facilities to demonstrate compliance with Medicare Conditions of Participation (CoPs) or Conditions for Coverage (CfCs) through accreditation by an approved, private national Accreditation Organization (AO)[1]. If an AO is recognized by the Secretary as having standards for accreditation that meet or exceed Medicare requirements, any provider or supplier accredited by the AO's approved program would be deemed to meet the Medicare conditions. The CMS has the responsibility for the oversight and approval of the AOs' programs, and for ensuring that providers or suppliers that are accredited by the AO meet the quality and patient safety standards required by the Medicare CoPs or CfCs.[2]

[1] Accreditation is voluntary and not required for Medicare participation. Accreditation by an approved, national AO is an alternative to being subject to certification and ongoing surveys by the State Agency.

[2] Conditions of Participation apply to providers and Conditions for Coverage apply to suppliers. The term "facility" is used to cover both types of institutional health care providers which require certification in order to participate in Medicare.

Other Accompanying Information

The CMS has a comprehensive approach to the review and approval of an AO's accreditation program, as outlined at 42 Code of Federal Regulations (CFR) 488, subpart A. Currently CMS has approved accreditation programs for the following facility types: hospitals, critical access hospitals (CAHs), home health agencies (HHAs), hospices, and ambulatory surgery centers (ASCs)[3]. The primary goal of this review is to ensure that the AO's standards meet or exceed the Medicare CoPs or CfCs for each program type and that the organization has the capacity to adequately administer the program. The CMS has implemented several tools to strengthen and enhance ongoing oversight of AOs. These include: rigorous deeming application reviews, AO reporting on deemed facilities, AO performance measures, and the validation survey program.

Section 125 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted on July 15, 2008, revised sections 1865 and 1875 of the Act and contains the following provisions:

- The Joint Commission's (JC) longstanding, unique statutory deeming authority for hospitals is revoked, effective July 15, 2010, and JC may be recognized as a national accreditation body for hospitals based on terms and conditions required by the Secretary. Thus, JC must apply to CMS for approval of its hospital accreditation program. JC's program must meet the same requirements at 42 CFR Part 482 and Part 488, section 488.4 as any other AO program seeking deeming authority for hospitals.
- JC is allowed a 24-month transition period. Therefore, individual hospitals awarded accreditation by JC prior to July 15, 2010 will continue to be recognized by CMS as having Medicare deemed status until their accreditation expiration date.
- The CMS' required annual report to Congress on the oversight of accreditation programs is expanded to include all CMS-approved AO programs. Previous reports to Congress required review only of the JC hospital program. This is the first expanded annual report to Congress.

During the past several years, CMS has strengthened and expanded existing administrative systems and processes to improve its oversight of AOs. Substantial improvements have been made to CMS'systems for monitoring AO survey activities and decisions. Enhancements include the following:

- Building electronic systems for timely submission by AOs of accurate and complete information on their deemed facilities;
- Communicating detailed standards for AO data submissions;
- Providing electronic mailboxes and explicit requirements for AO communications to CMS;
- Providing information to AOs regarding compliance requirements via a resource manual, an annual conference, regular conference calls, face-to-face meetings, and written correspondence;
- Implementing formal performance measures to facilitate evaluation of AO compliance with these requirements and providing feedback to each AO on their performance on these measures; and
- Refining the standardized, robust AO deeming authority application review process.

This report reviews AO activities and CMS oversight of recognized accreditation programs, including:

- Scope of AO activities;
- The CMS' approval of accreditation programs;

[3] Note that other types of facilities may also participate in Medicare via an approved accreditation program, but to date no AO has sought and received approval for any of these additional facility types.

- AO survey activities and compliance with administrative requirements;
- Survey validation performance for each AO;
- Planned improvements as reported by the AOs; and
- The CMS' management and oversight of AOs.

SECTION 2: Scope of Accreditation Organization Medicare Deeming Programs

The CMS reviews and approves separately each program type (hospital, CAH, HHA, hospice, and ASC) for which an AO seeks CMS recognition. Currently, there are seven recognized AOs with approval for fourteen programs, as described in Table 1. Some AOs focus on one provider or supplier type while others have accreditation programs for a range of providers.

Table 1 summarizes the JC hospital accreditation decisions reported to CMS for hospitals receiving an initial or renewal survey in FYs 2004, 2005, and 2006.

TABLE 1
Approved Accreditation Organization Programs

	Hospital	Critical Access Hospital	Home Health Agency	Hospice	Ambulatory Surgery Center	Total
AAAHC					X	1
ACHC			X			1
AAAASF					X	1
AOA	X	X			X	3
CHAP			X	X		2
DNVHC	X					1
JC	X	X	X	X	X	5
Total	3	2	3	2	4	14

AAAHC	Accreditation Association for Ambulatory Health Care
ACHC	Accreditation Commission for Health Care
AAAASF	American Association for Accreditation of Ambulatory Surgery Facilities
AOA	American Osteopathic Association/Healthcare Facilities Accreditation Program
CHAP	Community Health Accreditation Program
DNVHC	Det Norske Veritas Health Care
JC	The Joint Commission

These accreditation programs are responsible for assuring compliance with Medicare CoPs and CfCs for 29 percent of all Medicare institutional providers and suppliers nationally, as described in Table 2. The AOs are responsible for monitoring compliance with health and safety standards for varying percentages of each facility type, ranging from a high of 89 percent for hospitals to a low of 8 percent for hospice providers. The AOs charge fees to facilities that seek their accreditation, and generally offer facilities two accreditation options, accreditation alone or

accreditation with Medicare deemed status. The CMS reviews and approves or denies recognition only for an AO's Medicare deemed status programs. Accordingly, this report addresses AO activity as it relates to accreditation with Medicare deemed status only.

TABLE 2
Medicare Certified Institutional Providers/Suppliers (FY 2008)

	Deemed* (percent)	Non-Deemed** (percent)	Total (percent)
Hospital	4,381 (89)	563 (11)	4,944 (100)
CAH	415 (32)	895 (68)	1,310 (100)
HHA	1,161 (12)	8,732 (88)	9,893 (100)
Hospice	278 (8)	3,110 (92)	3,388 (100)
ASC	893(17)	4,324 (83)	5,217 (100)
Total	7,128 (29)	17,624 (71)	24,752 (100)

*As reported by Accreditation Organizations
**Certified by a State Agency as complying with Medicare health and safety standards

A facility with deemed status based on accreditation by an AO is not subject to routine full certification surveys by a State Agency (SA) to determine compliance with all applicable CoPs or CfCs. However, these deemed facilities may be subject to validation surveys by a SA. Validation surveys are either a full survey by an SA as part of the CMS AO representative sample validation program, or a focused survey in response to a complaint which, if true, could indicate serious noncompliance with one or more CoPs or CfCs. Subsection 1864(c) of the Act authorizes the Secretary to enter into an agreement with any SA to perform such validation surveys. When the SA cites a condition-level deficiency in a deemed facility, CMS removes the provider's or supplier's deemed status and places the facility under the jurisdiction of the SA until all deficiencies are corrected. Once all deficiencies are corrected, CMS restores the facility's deemed status and returns the facility to the AO's jurisdiction.

SECTION 3: CMS Approval of Accreditation Organization Deeming Programs

The process for CMS approval of accreditation deeming programs is applicant-driven. In order to be approved as a recognized national AO, an organization must demonstrate the ability to effectively evaluate a facility using accreditation standards which meet or exceed Medicare CoPs or CfCs and survey processes comparable to those outlined in the State Operations Manual. The State Operations Manual is CMS' instructions to SAs on how to conduct survey and certification activities on behalf of CMS. Section 1865 of the Act requires that CMS shall base approval of an AO's accreditation deeming program application on the following:

- Requirements for accreditation;
- Survey procedures;
- Ability to provide adequate resources for conducting surveys;
- Capacity to furnish information for use in enforcement activities;
- Monitoring procedures for providers found out of compliance with conditions or requirements; and

- Ability to provide the necessary data for validation to CMS.

In order to be granted deeming program approval by CMS, an AO must demonstrate its ability to meet or exceed the Medicare CoPs or CfCs as cited in the CFR:

- ASCs in accordance with 42 CFR Part 416;
- CAHs in accordance with 42 CFR Part 485 Subpart F;
- HHAs in accordance with 42 CFR Part 484;
- Hospice in accordance with 42 CFR Part 418; and
- Hospitals in accordance with 42 CFR Part 482.

Section 1865(a)(3)(A) of the Act further requires that CMS publish in the *Federal Register*, within 60 days of receipt of an organization's complete application, a notice identifying the national accrediting body making the request, describing the nature of the request, and providing at least a 30-day public comment period. The CMS has 210 days from receipt of a complete application to publish a *Federal Register* notice of approval or denial of the application.

The regulations at 42 CFR 488.4 and 488.8 set forth the requirements an AO must satisfy in order to receive and maintain CMS recognition of a Medicare deeming program, as well as the procedures CMS follows in reviewing AO applications. Approval of an AO's Medicare deeming program is not open-ended; CMS may approve a program for a maximum of six years. Renewal applications are subject to the same criteria and scrutiny as an initial application for approval of an AO's Medicare deeming program.

The application and renewal process provides the opportunity for a comprehensive evaluation of an AO's performance, its ability to ensure accredited deemed facilities' compliance with Medicare CoPs or CfCs, and its ability to comply with CMS' administrative requirements that facilitate ongoing oversight of the AO's deeming program. The CMS evaluation process includes the following components:

- On-site observations—
  - Corporate onsite review
  - Survey observation
- Comparability review between AO standards and Medicare CoPs or CfCs
- Comprehensive review of the AO's—
  - Policies and procedures
  - Adequacy of resources to perform required surveys
  - Survey processes
  - Surveyor evaluation and training
  - Electronic data management

Once approved, subsequent changes in the AO's program standards and survey process must also be reviewed and approved by CMS to ensure that the accreditation deeming program requirements continue to meet or exceed Medicare requirements. The AO must notify CMS in writing of any proposed changes in its approved accreditation program at least 30 days in advance of the effective date of the changes. Additionally, when CMS adopts changes to the applicable CoPs or CfCs, or to its survey processes, the AO must submit documentation that it has revised its standards and/or survey process to comply with the new requirement(s) within 30 days of CMS' notification to the AO of the change(s).

During FY 2008 and 2009, CMS reviewed and approved six applications for renewal of deeming authority and one initial application for Medicare deeming programs. A summary of the major conditions of approval are outlined in a later section of this report which reviews individual AOs.

SECTION 4: Review of Accreditation Organization Survey Activities and Performance

Section 4 reviews AO activities with primary emphasis on survey activities and measures of AO performance. The initial section summarizes the results across all AOs, followed by a section presenting the performance of individual AOs and covers:

- **AO Deeming Activities:** a review of each AO deemed program's survey activities and decisions during FY 2008.
- **Performance Measures:** performance of each AO in key focus areas during FY 2009 (January 2009-June 2009).
- **Review of Accreditation Programs:** a summary of CMS' review of the AOs' initial and renewal applications for deeming authority during FYs 2007 and 2008. For each AO, a listing derived from the final approval notice concerning actions the AO took or agreed to take is provided. These actions reflect areas of program weakness identified by CMS through its review process which the AO was required to correct.

Overview: Deemed Survey Activity

The AO is responsible for evaluating a facility through an on-site survey to determine whether the facility complies with the health care quality and patient safety standards required by the Medicare CoPs or CfCs. Accreditation in a Medicare deeming program may be awarded to a facility by the AO for up to three years. The survey includes, but is not limited to: a review of the care provided in the facility, the physical environment, administrative and patient medical records, and staff qualifications. Table 3 presents a summary of the number of deemed facilities by AO as of the first quarter of 2008 as well as the number of initial and renewal surveys completed during FY 2008 as reported by the AOs.

TABLE 3
Total Deemed Facilities, Initial, and Renewal Surveys for Each Accreditation Organization by Program Type in FY 2008

Programs	Accreditation Organization	Total Deemed Facilities*	Initial Surveys	Renewal Surveys
Hospital**	AOA	171	20	64
	JC	4,256	93	1,315
Critical Access Hospital	AOA	14	4	2
	JC	401	22	85
Home Health Agency	ACHC	25	139	18
	CHAP	647	209	44
	JC	489	290	104
Hospice	CHAP	123	28	60
	JC	155	55	15
Ambulatory Surgery Center	AAAHC	670	202	243
	AAAASF	27	21	10
	AOA	6	6	4
	JC	190	35	64

*Note that some facilities choose to be accredited by an approved deeming program by more than one Accreditation Organization.

**DNVHC received initial approval of its hospital deeming program in FY 2009, and thus is not included in this table.

Most AO programs experienced significant growth during FY 2008 and continue to grow into FY 2009. This may in part be attributable to CMS' prioritizing of the SAs' workload such that initial surveys for facilities that have a deeming program option are assigned to the lowest of four workload priority tiers. Because a number of SAs have been unable to complete work in all four tiers each year for a variety of reasons (including constrained resources), seeking initial Medicare participation through an approved AO deeming program has become a timelier option to demonstrate their compliance with Medicare requirements for many new hospitals, CAHs, HHAs, hospices, and ASCs.

Overview: Performance Measures

A major focus of CMS' work with each deemed accreditation program has and continues to be the AO's ability to provide CMS with complete, timely, and accurate information regarding deemed facilities, as required at 42 CFR 488.4. It is important for CMS to know when a facility's deemed status has changed in order to accurately identify on an ongoing basis which facilities are subject to SA or AO oversight. Additionally, when an AO makes an adverse decision on a facility's accreditation status based on the facility's failure to satisfy the AO's health and safety standards, it is imperative that CMS be notified promptly in order to take appropriate follow-up enforcement action. It is also essential for CMS to have information concerning upcoming AO survey schedules, in order for CMS to implement its validation program based on a representative sample of AO surveys.

Several strategies have been implemented to facilitate obtaining timely, accurate, and complete information from AOs, including:

- Dedicated electronic mailboxes for submission to CMS of copies of AO notification letters to facilities concerning their deemed status;
- Monthly submission of AO survey schedules;
- Quarterly submission of cumulative reports on facility deemed status;
- Development of template AO notification letters to facilitate AO communication of all essential elements;
- Analysis and feedback to AO's on the accuracy and completeness of their notification letters and deemed facility lists, including whether the listed facilities could be matched to facilities in CMS' certification data base, and whether the facility lists were consistent with information in the notification letters; and
- Development and beta testing of the ASSURE electronic database to facilitate timely and more accurate AO reporting.

Building on this foundation, formal AO performance measures were implemented October 2008. These basic measures related to information and data submission requirements which have been a major area of focus in CMS' oversight activities with the AOs. The performance measures are presented in Table 4. These measures focus on the ability of AOs to provide consistent, accurate, complete and timely information related to their deemed status facilities. Such information is essential to support CMS monitoring of both the health care facilities participating in Medicare via their deemed status and the AO's ability to oversee these facilities. The CMS monitors the AOs' performance on the measures and provides written, individual feedback to each AO on a quarterly basis.

TABLE 4
Performance Measures

ASSURE Data Base

AOs are required as part of the beta testing to use the ASSURE Electronic Data Base to submit a record of AO accreditation and enforcement activity.

- **Timeliness** of ASSURE export file submission
- **Accuracy and Completeness** of ASSURE export file

Deemed Facility List

AOs are required to electronically submit a quarterly Excel spreadsheet list of all deemed facilities (in FY 2010 will be superseded by ASSURE submissions).

- **Timeliness** of Facility List submission
- **Accuracy and Completeness** of facility list including: proper format, inclusion of all deemed programs, required data elements, inclusion of only deemed facilities, no duplicates, and correction of discrepancies previously identified by CMS

Facility Notification Letters

AOs are required to electronically submit facility notification letters for all deemed accreditation actions.

- **Electronic** mailbox use for submission of letters
- **Updating** facility list consistent with new facility notification letters
- **Accuracy and Completeness** of letters submitted including: contain all information requested by CMS, effective dates of actions taken and follow-up actions, and no CMS follow-up required to clarify information

Survey Schedule

AOs are required to submit a monthly schedule which covers surveys completed in the past month as well as planned surveys for the next two months.

- **Timeliness** of monthly survey schedule report submission
- **Format** used for the survey schedule report
- **Accuracy and Completeness** of survey schedule report including: two prospective months and one past month, reporting changes in the survey schedule, marking changes in bold type, inclusion of all programs for which the AO has deeming authority and exclusion of information for non-deemed providers/suppliers, and no instances of arrival of the SA to conduct a validation survey and being informed that the accreditation survey had not been conducted as reported on the survey schedule.

Although the performance measures were implemented October 2008, the first quarter FY 2009 scores are not included in this report. This quarter was used to clarify and refine the measures. Therefore, only second and third quarter scores are included in this analysis. Fourth quarter results were not yet available for inclusion in this report.

Each measure is scored on a monthly or quarterly basis, as appropriate, depending on the required frequency of the particular data submission requirement. Measures are scored as **Yes** (100 percent) or **No** (0 percent) for a specific month/quarter. Measures related to the CMS discrepancy report and subsequent corrections are calculated as a percentage. Monthly scores are then averaged for the quarter. The average performance scores for each AO for the second and third quarters of FY 2009 (January 2009-June 2009), and the national averages are presented in Table 5. Scores are calculated by averaging the scores for each quarter.

AO performance on these basic measures has improved over the course of FY 2009. However, substantial opportunities for further improvement remain. The goal is for all AOs to consistently score at or near 100 percent on all measures.

TABLE 5
Performance Measures (Percentage) for Each Accreditation Organization (January–June 2009)

Performance Measures	AAAHC	ACHC	AAAASF	AOA/ HFAP	CHAP	DNVHC	JC	ALL AOs
ASSURE Data Base								
Timeliness	100	100	100	50	67	100	100	88
Accuracy	100	100	50	100	50	100	100	86
Deemed Facility List								
Timeliness	100	50	50	100	50	NA	100	75
Accuracy	73	68	79	78	76	NA	56	72
Facility Notification Letters								
Electronic Submission	100	100	100	100	100	100	94	99
Updating	0	17	37	25	18	100	4	29
Accuracy	50	22	0	33	33	100	39	40
Survey Schedule								
Timeliness	100	100	100	83	100	100	83	95
Format	100	67	0	0	100	100	100	67
Accuracy	100	100	85	76	87	100	90	91

NA: Not Applicable, as a more recently approved AO, DNVHC uses the ASSURE database only.

Individual Accreditation Organization Summaries

1. Accreditation Association for Ambulatory Health Care (AAAHC)

Organization Background: AAAHC is a private, non-profit organization formed in 1979 to assist ambulatory health care organizations to improve the quality of care provided to patients. The organization supports accreditation programs for a wide range of ambulatory care organizations, including ambulatory health clinics, ASCs, endoscopy centers, diagnostic health centers and women's health centers.

Accreditation Activity (Table 3): AAAHC has a CMS-approved accreditation program for ASCs and was responsible for 670 deemed ASCs as of first quarter FY 2008. During FY 2008, AAAHC reported completing a total of 445 deemed status surveys. Of these, 202 (45 percent) were initial surveys and 243 (55 percent) were re-accreditation surveys of ASCs already participating in Medicare and seeking initial or continued deemed status. AAAHC uses the following types of accreditation decisions:

- ***Full Accreditation (three years):*** The organization is in substantial compliance with standards with no reservation about the accuracy of the survey findings or the organization's commitment to providing care consistent with standards.
- ***One Year Accreditation:*** Some of the organization's operations are acceptable and other areas need to be addressed; the organization must have a re-survey within 10 months from the previous survey date.
- ***Six Month Accreditation:*** The organization is in substantial compliance but does not meet certain standards or demonstration of continued compliance is not well established; must have a re-survey within six months.
- ***Deferred Decision:*** The organization does not meet standards, but demonstrates the capability to correct identified deficiencies within six months; the organization must request a re-survey within three months. Facilities subjected to this type of decision are not recommended to CMS for approval.

- ***Denial:*** The organization is not in substantial compliance with standards. Facilities subjected to this type of decision are not recommended to CMS for approval.

AAAHC recommended accreditation for 99 percent of the 445 ASCs it surveyed in FY 2008.

Accreditation Decisions	Ambulatory Surgery Centers (percent)
Total Surveys	445
Full Accreditation	290 (65)
1 Year Accreditation	89 (20)
6 Month Accreditation	61 (14)
Deferred Decision	5 (1)
Denial	0

Performance Measures (Table 5): AAAHC performs well on measures related to the ASSURE data base submission and the survey schedule, with 100 percent scores on these measures. Opportunities for improvement exist with the performance measures related to facility notification letters and deemed facility list.

Approval of Accreditation Programs: AAAHC initially received CMS recognition as a national AO for ASCs December 19, 1996. Most recently, AAAHC received approval of a four-year renewal term, effective December 20, 2008, through December 20, 2012. The final notice announcing this decision was published in the *Federal Register* on November 14, 2008, and can be accessed at **http://edocket.access.gpo.gov/2008/pdf/E8-27122.pdf**. The major provisions of the final notice are as follows:

- AAAHC added language to its standards to ensure that the governing body will provide contracted services in a safe and effective manner.
- AAAHC modified its standards to require surgical procedures be performed only by qualified physicians.
- AAAHC modified its standards in the area of anesthesia.
- AAAHC amended its standards to ensure that ASCs establish programs for identifying and preventing infections, maintain sanitary environments, and report the results to appropriate authorities.
- AAAHC updated the requirements on its Physical Environment Checklist and modified its policies to clearly reflect that life safety code waivers may only be granted by a CMS regional office.
- AAAHC revised its standards to require that ASCs train personnel in the use of all types of emergency equipment, not just cardiopulmonary and cardiac emergency equipment.
- AAAHC revised its standards to require that the scope of procedures performed in the ASC be periodically reviewed and amended as appropriate.
- AAAHC revised its standards to require a registered nurse be available for emergency treatment whenever there is a patient in the ASC.
- AAAHC revised its survey procedures to ensure that surveyors use a random selection of medical records for review during a survey.

- AAAHC modified its surveyor training program to strengthen the Physical Environment and Life Safety Code portions of the survey and assist surveyors to operationalize knowledge and skills gained in training during the survey process.
- AAAHC revised its policies related to surveyor credentialing and privileging to ensure that surveyors were appropriately privileged, credentialed, and trained.
- AAAHC amended its policies and procedures to address any real or perceived conflict of interest issues between AAAHC's accreditation activities and AAAHC's consultative services.
- AAAHC modified its policies regarding condition-level noncompliance identified during an initial certification survey for participation in Medicare.
- AAAHC developed a policy regarding CMS requirements for submission of a plan of correction by the ASC and the completion of an onsite follow-up survey to determine compliance with the Medicare conditions for coverage (CfCs) after citing condition-level noncompliance during a recertification survey.
- AAAHC amended it policies for complaints to comply with Medicare requirements of SOM chapter five.
- AAAHC amended its accreditation decision letters to ensure they are accurate and contain all of the required elements necessary for the Regional Office to render a decision regarding deemed status of a provider.
- The CMS will conduct a follow-up survey observation during FY 2010 to validate the implementation of AAAHC's revised surveyor training program for Physical Environment and Life Safety Code and to assess surveyors' ability to conduct surveys in accordance with Medicare requirements.

2. Accreditation Commission for Health Care (ACHC)

Organization Background: The ACHC was incorporated in 1986 and provides support and accreditation for HHAs, Hospices, Pharmacy services, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) suppliers and other types of services.

Accreditation Activity (Table 3): ACHC has a CMS-approved accreditation program for HHAs and reported 25 deemed HHAs as of first quarter FY 2008. However, subsequently ACHC's program underwent rapid growth; as evidenced by the large number of initial surveys. ACHC reported completing a total of 157 deemed status surveys; 139 (89 percent) initial surveys and 18 (11 percent) re-accreditation surveys. The following are the types of accreditation decisions ACHC uses:

- ***Full Accreditation (three years):*** The organization receives an overall score and section scores which are 85 percent or above.
- ***Denial:*** The organization's total overall survey score is below 70 percent. Facilities subjected to this type of decision are not recommended to CMS for approval.

ACHC awarded a decision of full accreditation for 96 percent of the 157 HHAs surveyed in FY 2008.

Accreditation Decisions	Home Health Agencies (percentage)
Total Surveys	157
Full Accreditation	151 (96)
Denial	6 (4)

Performance Measures (Table 5): ACHC performs well on measures related to the ASSURE data base, with 100 percent scores on both timeliness and accuracy. Opportunities for improvement exist with the performance measures related to facility notification letters and deemed facility list.

Approval of Accreditation Programs: ACHC initially received recognition as a national AO for HHAs February 24, 2006. Most recently, ACHC received a six-year renewal term, effective February 24, 2009, through February 24, 2015. The final notice announcing this decision was published in the *Federal Register* on November 14, 2008, and can be accessed at **http://edocket.access.gpo.gov/2009/pdf/E9-684.pdf**. The major provisions of the final notice are as follows:

- ACHC revised its record retention policy to require all survey documentation be kept for a minimum of 3 years.
- ACHC revised its surveyor training and evaluation policy to include a process for addressing unsatisfactory performance.
- ACHC developed an action plan to resolve issues related to timely data submissions.
- ACHC modified its policies regarding timeframe for sending and receiving a plan of correction.
- ACHC amended its policies to ensure approved Plans of Correction contain all the required elements.

ACHC revised its accreditation decision letters to ensure they are accurate and contain all the required elements necessary for the CMS Regional Office to render a decision regarding participation of an HHA in Medicare.

3. American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

Organization Background: AAAASF was established in 1980 and supports quality in ambulatory surgery settings through accreditation.

Accreditation Activity (Table 3): AAAASF has an approved Medicare deeming program for ASCs and was responsible for 27 deemed ASCs as of the first quarter of FY 2008. During FY 2008, AAAASF's program also experienced growth, as it performed a total of 31 deemed status surveys. Of these, 21 (68 percent) were initial surveys and 10 (32 percent) were re-accreditation surveys. The types of accreditation decisions AAAASF uses are as follows:

- ***Full Accreditation (three years):*** The organization is in 100 percent compliance with all standards.
- ***Denial:*** The organization does not meet full accreditation standards. Facilities subjected to this type of decision are not recommended to CMS for approval.

AAAASF awarded full accreditation to 100 percent of the 31 ASCs surveyed in FY 2008.

Accreditation Decisions	Ambulatory Surgery Centers (percentage)
Total Surveys	31
Full Accreditation	31 (100)
Denial	0

Performance Measures (Table 5): Generally, AAAASF has performed well on measures related to timeliness of submission for ASSURE Data Base, notification letters, and survey schedules. Opportunities for improvement remain in measures related to accuracy of data submissions for all components and the format of the survey schedules.

Approval of Accreditation Programs: AAAASF initially received recognition as a national AO for ASCs December 2, 1998. Its current recognition is effective through December 26, 2009. AAAASF submitted a renewal application March 2009. A final notice announcing CMS' decision is scheduled for publication in the *Federal Register* in November 2009.

4. American Osteopathic Association/Healthcare Facilities Accreditation Program (AOA)

Organization Background: AOA was established in 1945 to review quality in osteopathic hospitals and has expanded its scope to support quality in all types of hospitals, CAHs, ambulatory care/surgical facilities, clinical laboratories, behavioral health, and primary stroke centers.

Accreditation Activities (Table 3): AOA has CMS-approved accreditation programs for hospitals, CAHs and ASCs. AOA was responsible for the following number of deemed facilities at the start of FY 2008: 171 deemed hospitals, 14 deemed CAHs, and 6 deemed ASCs. During FY 2008, AOA performed:

- 84 deemed status hospital surveys including 20 (24 percent) initial surveys and 64 (76 percent) re-accreditation surveys;
- 6 deemed status surveys for CAHs including 4 (67 percent) initial surveys and 2 (33 percent) re-accreditation surveys; and
- 10 deemed status surveys for ASCs including 6 (60 percent) initial surveys and 4 (40 percent) re-accreditation surveys.

The types of accreditation decisions used were as follows:

- ***Full Accreditation:*** The organization meets all accreditation requirements. Accreditation may require an Interim Progress Report.
- ***Denial:*** The organization does not meet accreditation requirements. The facility has 30 days to appeal. Facilities subjected to this type of decision are not recommended to CMS for approval.

AOA awarded full accreditation for 99 percent of the 84 hospitals surveyed, 100 percent of the 6 CAHs reviewed and 100 percent of the 10 ASCs reviewed.

Accreditation Decisions	Hospitals (percentage)	Critical Access Hospitals (percentage)	Ambulatory Surgery Centers (percentage)
Total Surveys	84	6	10
Full Accreditation	83 (99)	6 (100)	10 (100)
Denial	1 (1)	0	0

Performance Measures (Table 5): AOA performs well on measures related to accuracy of data submitted via the ASSURE database, timeliness of deemed facility list submission, and electronic submission of notification letters. Opportunities for improvement exist for the balance of the performance measures.

Approval of Accreditation Programs:
Hospitals
AOA has had deeming authority for hospitals since 1965. Although its hospital program is mentioned by name in the Act, it is also explicitly subject to the Secretary's review and approval. AOA's first application for renewal of this deeming authority was approved February 22, 2000. Most recently, AOA received a four-year renewal term, effective September 25, 2009, through September 25, 2013. The final notice announcing this decision was published in the *Federal Register* on August 28, 2009, and can be accessed at **http://edocket.access.gpo.gov/2009/pdf/E9-20203.pdf**. The major provisions of the final notice are as follows:

- AOA revised its standards to ensure that a medical history and physical is completed and documented.
- AOA amended its surveyor team handbook to ensure all hospital survey teams include a Registered Nurse.
- AOA modified its policies related to the accreditation effective date.
- AOA developed and implemented internal monitoring procedures to ensure its surveyors are trained and qualified.
- AOA modified its policies regarding timeframes for sending and receiving a plan of correction.
- AOA revised its policies to include timeframes for investigation of complaints.
- AOA developed and conducted surveyor training on the documentation of deficiencies to ensure that all cited deficiencies contain a regulatory reference, a clear detailed description of the deficient practice, and relevant finding.
- AOA revised its policies on blackout dates.
- AOA revised its accreditation decision letters to ensure that they are accurate and contain all the required elements for the Regional Office to render a decision regarding deemed status of an accredited hospital.
- AOA developed an action plan to ensure that deemed status survey files are complete, accurate, and consistent.
- AOA developed and incorporated measures to improve the accuracy and consistency of data submissions to CMS.
- AOA developed a policy outlining the minimum number of inpatient records required for review during a certification survey.
- AOA removed all references to mandatory consultative services from its policies to avoid potential conflict of interest issues.
- AOA developed a policy to ensure that facilities with condition level noncompliance on a recertification survey submit an acceptable PoC, and receive a follow- up onsite focused survey.
- AOA revised its policies and developed an internal tracking tool to ensure that facilities with condition level noncompliance on an initial survey receive an onsite follow-up full survey.
- The CMS will conduct a follow up corporate onsite in one year to validate continued compliance with the provisions set forth in the September 2009 final notice.

Critical Access Hospitals
AOA first received CMS recognition of its CAH deeming program on December 27, 2001. More recently, AOA received approval for a six-year renewal term, effective December 28, 2007, through December 28, 2013. The final notice announcing this approval was published in the *Federal Register* November 23, 2007, and can be accessed at **http://edocket.access.gpo.gov/2007/pdf/E7-22628.pdf**.

- AOA provided a list of trained surveyors that are able to provide consultative services to requesting facilities. In order to eliminate any real or perceived conflict of interest between the AOA's accreditation activities and AOA's list of surveyors able to provide consultation, AOA has formalized policies and procedures that adequately cover the conflict of interest process for surveyors that provide consultations.
- AOA has revised its complaint policies to address timeframes for addressing complaints that involve immediate jeopardy.

- AOA modified its application process for facilities undergoing a certification or recertification survey to allow fewer "black-out" dates to address CMS' concern of ensuring that surveys conducted by AOA comply with CMS' policy of unannounced surveys.
- AOA formalized a process to ensure that all surveyors are receiving an annual performance evaluation.
- AOA added standards to their CAH Manual to meet the requirements for a rural health network; personnel qualifications; CAH eligibility criteria; and the requirement to comply with hospital requirements at the time of application. AOA also added language to its standards to address agreements for credentialing and quality assurance for CAHs that are members of a rural health network.
- AOA revised its standards to address the requirement for adequate space for the provision of direct services.
- AOA revised its standards to address usage and location of alcohol-based hand rubs.
- AOA revised its standards to address the supervision requirements for patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, and physician assistants.
- AOA added clarifying language to specify that health care services provided in the CAH are consistent with applicable State laws.
- AOA added language to its standard to address the requirement that patient care policies are developed with at least one member of a group of professional personnel that is not a member of the CAH staff.
- AOA inserted language to address the requirements with respect to inpatients receiving post-hospital skilled nursing facility (SNF) care.
- AOA revised its standards concerning the representative sample of active and closed records in the periodic evaluation of the CAH's total program.
- AOA added language to its standards to address the requirements for utilization review.
- AOA made changes to meet the additional criteria for a distinct part psychiatric or rehabilitation unit of the CAH.
- AOA agreed to provide CMS with timely electronic data for effective validation and assessment of the organization's survey process.
- To comply with the Medicare requirements of conducting unannounced surveys, AOA revised its survey procedures to prohibit any advance mailings of surveyor materials to the facility prior to the survey and will not permit the hospital to mail back the surveyor findings to AOA after completion of the survey.

Ambulatory Surgery Centers
AOA received initial recognition by CMS as a national AO for ASCs on January 30, 2003. AOA submitted a renewal application for renewal of its ASC deeming program on March 6, 2009. A final notice announcing CMS' decision is scheduled for publication in the *Federal Register* in November 2009.

5. Community Health Accreditation Program (CHAP)

Organization Background: CHAP was created in 1965 to support community-based health care organizations, including DMEPOS suppliers.

Accreditation Activity (Table 3): CHAP has CMS-approved accreditation programs for HHAs and hospices. CHAP was responsible as of the first quarter of FY 2008 for 647 deemed HHAs and

123 deemed hospice providers. In FY 2008, CHAP's HHA program grew very rapidly, conducting a total of 253 HHA surveys. Of these, 209 (83 percent) were initial surveys and 44 (17 percent) were re-accreditation surveys. In FY 2008, CHAP conducted a total of 88 hospice surveys. Of these, 28 (32 percent) were initial surveys and 60 (68 percent) were re-accreditation surveys. The types of accreditation decisions are as follows:

- ***Accreditation:*** The organization meets meets standards; may include required facility actions.
- ***Denial:*** The organization does not meet standards. Facilities subjected to this type of decision are not recommended to CMS for approval.

CHAP awarded full accreditation for 100 percent of the 253 HHAs and 100 percent of the 88 hospice providers surveyed.

Accreditation Decisions	Home Health Agencies (percentage)	Hospices (percentage)
Total Surveys	253	88
Full Accreditation	253 (100)	88 (100)
Denials	0	0

Performance Measures (Table 5): CHAP performs well on the survey schedule and notification letters submission measures. Opportunities for improvement exist for the balance of the measures.

Approval of Accreditation Programs:
Home Health Agencies
CHAP initially received CMS recognition as a national AO for HHAs on August 27, 1992. Most recently, CHAP received a four year renewal term, effective March 31, 2008, through March 31, 2012. The final notice announcing this decision was published in the *Federal Register* on March 28, 2008, and can be accessed at **http://edocket.access.gpo.gov/2008/pdf/E8-5073.pdf**. The major provisions of the final notice are as follows:

- CHAP added language to its standards to address that home health aide services must be ordered by the physician in the plan of care.
- CHAP revised its policies related to its surveyors to ensure they are appropriately privileged, credentialed and trained.
- CHAP developed policies and procedures to address potential conflict of interest issues that may result for CHAP surveyors who act as consultants.
- CHAP revised its process for notifying facilities of accreditation-related decisions and developed a tracking system to ensure that deficiencies cited are appropriately addressed.
- CHAP added language to their complaint policies and procedures for increased clarity for the prioritization of complaints, timeframes for investigative site visits, and other required activities.
- CHAP revised its complaint policies to be consistent with CMS policies listed in the State Operations Manual regarding the management of complaints and incidents.
- CHAP updated its list of conditions surveyed during a standard survey to include the requirements at § 482.11 and § 482.55.
- The CMS conducted a follow-up corporate onsite one year following the publication of the final notice to assess CHAP's compliance with its own policies and procedures.

In the spring of 2009, CMS opened a formal review of CHAP's HHA deeming authority for several reasons. When CMS conducted its follow-up corporate onsite, it found that numerous problems previously identified remained uncorrected. In addition, perhaps as a result of its focus on conducting initial surveys during FY 2008, CHAP failed to conduct renewal surveys of its already-deemed HHAs as the expiration of their deemed accreditation approached or passed. That review is still ongoing.

Hospices
CHAP received initial recognition from CMS as a national AO for hospices on April 20, 1999. CHAP's current recognition for its hospice program is effective through November 20, 2009. CHAP submitted a renewal application for the hospice deeming program in April 2009. A final notice announcing CMS' decision is scheduled for publication in the *Federal Register* October 2009.

6. Det Norske Veritas Health Care (DNVHC)

Organization Background: DNVHC is an independent foundation designed to manage risk and safeguard life, property, and the environment. The organization was originally established in Norway but is now an international firm. The major focus of the organization has been on the maritime, oil, gas and energy, food and beverage industries, with a recent expansion to health care through DNVHC.

Accreditation Activities (Table 3): DNVHC received initial recognition as a national AO for their hospital program on September 29, 2008. Therefore, DNVHC did not perform any deemed status surveys in FY 2008.

Performance Measures (Table 5): As a more recently CMS-approved AO, DNVHC is using the ASSURE data base exclusively to submit deemed facility data. Therefore, DNVHC is not scored on the deemed facility list measures. DNVHC has consistently performed at 100 percent on all relevant measures.

Approval of Accreditation Programs: DNVHC received initial recognition by CMS as a national AO for hospitals on September 29, 2008. A four year term of approval was awarded, effective September 26, 2008, through September 26, 2012. The final notice announcing this decision was published in the *Federal Register* September 29, 2008, and can be accessed at **http://edocket.access.gpo.gov/2008/pdf/E8-22585.pdf**. The major provisions of the final notice are as follows:

- DNVHC modified its policies related to effective date of participation in Medicare for new providers.
- DNVHC modified its policies regarding time frames for sending and receiving a required plan of correction, and the required elements of an approved plan of correction.
- DNVHC amended its interpretive guidance and surveyor tool to meet the requirements at § 482.13(c)(2), § 482.22(c)(3), § 482.23(c)(3), § 482.24(c)(1)(iii), § 482.25(b)(2)(i), § 482.25(b)(6), § 482.(b)(7), § 482.30(b)(3)(i), § 482.43(e), § 482.45(a)(1), § 482.51(a), § 482.52, § 482.53(b), § 482.54, § 482.54(a), and § 482.56.
- DNVHC added language to its standards, and interpretive guidance to address the requirement at § 482.13(e)(9), § 482.30, and § 482.30(b)(1)(ii)(A)-(B).
- DNVHC amended its policies by eliminating recommendations referred to "opportunities for improvement" from the written survey finding.
- DNVHC developed and conducted training for surveyors to ensure that all deficiencies cited contain a regulatory reference, a clear detailed description of the deficient practice and relevant findings.
- DNVHC modified its policies regarding complaint investigation activities with appropriate licensing bodies and ombudsmen programs.

- DNVHC modified its policies to ensure that all off-campus provider based locations, satellite locations and services provided at remote locations are under a hospital's CMS certification.
- DNVHC developed a policy to ensure that facilities with condition level non-compliance on recertification survey submit an acceptable PoC, and receive a follow-up onsite focused survey.
- DNVHC developed a policy regarding condition level noncompliance identified during an initial certification survey for participation in Medicare.

7. The Joint Commission (JC)

Organization Background: The JC's goal is the improvement of patient safety and quality through accreditation and other means. While originally focused on hospitals, the JC now provides accreditation and other supportive services in a broad range of health care settings: ambulatory care, behavioral health care, CAHs, home care, laboratory services, long term care, office-based surgery, and DMEPOS suppliers.

Accreditation Activities (Table 3): In addition to JC's statutorily deemed hospital program, the JC has CMS-approved deeming programs for CAHs, HHAs, hospices and ASCs. As of the first quarter of FY 2008, JC was responsible for 4,256 deemed hospitals, 401 deemed CAHs, 489 deemed HHAs, 155 deemed hospice providers, and 190 deemed ASCs. During FY 2008, JC performed:

- 1,408 deemed status hospital surveys with 93 (7 percent) initial surveys and 1,315 (93 percent) re-accreditation surveys;
- 107 deemed status CAH surveys with 22 (21 percent) initial surveys and 85 (79 percent) re-accreditation surveys;
- 394 deemed status HHA surveys with 290 (74 percent) initial surveys and 104 (26 percent) re-accreditation surveys;
- 70 deemed status surveys for hospice providers with 55 (79 percent) initial surveys and 15 (21 percent) re-accreditation surveys; and
- 99 deemed status surveys for ASCs with 35 (35 percent) initial surveys and 64 (65 percent) re-accreditation surveys.

JC used the following types of accreditation decisions:

- ***Accreditation:*** The facility is in compliance with all standards at time of the onsite survey or has successfully addressed all requirements for improvement.
- ***Accreditation with Requirements for Improvement:*** The facility is granted accreditation after providing assurance that the recommendations for improvement identified in the JC survey process will be implemented.
- ***Conditional Accreditation:*** The organization was not in substantial compliance but is believed to be capable of achieving acceptable compliance with JC standards. The JC will conduct a follow-up survey, during which the hospital must demonstrate substantial correction of the identified deficiencies before being considered for full accreditation. Facilities subjected to this type of decision are not recommended to CMS for approval.
- ***Provisional Accreditation:*** The organization fails to address all requirements within time lines. Facilities subjected to this type of decision are not recommended to CMS for approval.
- ***Preliminary Denial:*** The facility appears to have an immediate threat to health or safety or failure to resolve requirements of a Conditional Accreditation or significant noncompliance. This decision is subject to review and appeal. Facilities subjected to this type of decision are not recommended to CMS for approval.

- ***Denials:*** This final accreditation decision does not permit further appeals. Facilities subjected to this type of decision are recommended to CMS for denial of Medicare participation.
- ***Ineligible:*** Facilities subjected to this type of decision are recommended to CMS for denial of Medicare participation.

Table 6 lists the outcomes of the JC accreditation decisions by provider type: 1,408 hospital surveys with 94 percent resulting in either full accreditation or accreditation with requirements for improvements; 107 CAH surveys with 90 percent approved for full accreditation; 394 HHA surveys with 87 percent approved for full accreditation or accreditation with improvement requirements; 70 hospice surveys with 90 percent awarded full accreditation or accreditation with improvement requirements; and 99 ASC surveys with 99 percent awarded full accreditation.

TABLE 6
The Joint Commission's Facilities and Accreditation Decisions

Accreditation Decisions	Hospital (percentage)	Critical Access Hospitals (percentage)	Home Health Agencies (percentage)	Hospices (percentage)	Ambulatory Surgery Centers (percentage)
Total Surveys	1,408	107	394	70	99
Full Accreditation	15 (1)	96 (90)	338 (86)	53 (76)	98 (99)
Accreditation w/ Improvement Requirements	1,317 (93)	0	3 (1)	10 (14)	0
Conditional Accreditation	69 (5)	9 (8)	0	0	1 (1)
Provisional Accreditation	NA	2 (2)	1 (0)	0	0
Preliminary Denial*	7	0	0	0	0
Denial	7 (1)	0	13 (3)	1 (1)	0
Ineligible	NA	NA	39 (10)	6 (9)	NA

*The Preliminary Denial 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.

Performance Measures (Table 5): The JC performed well on the ASSURE Data Base measures, timeliness of deemed facility list submission, and the format of the survey schedule. Opportunities for improvement exist for the remaining measures.

Approval of Accreditation Programs:
Ambulatory Surgery Centers
JC initially received CMS recognition as a national AO for ASCs December 19, 1996. More recently, JC received a six-year renewal effective December 20, 2008, through December 20, 2014. The final notice announcing this decision was published in the *Federal Register* on November 14, 2008, and can be accessed at **http://edocket.access.gpo.gov/2008/pdf/E8-27120.pdf**. The major provisions of the final notice are as follows:

- JC amended its policies to eliminate the use of supplemental findings. All survey findings will be identified as a requirement for improvement, and will, therefore, require resolution through the evidence of standards compliance process.
- JC modified its evidence of standards compliance process (ESC) to ensure that accepted ESCs contain the critical information necessary to provide assurance that an identified deficiency had been adequately corrected.
- JC modified its survey report to clearly identify whether an identified deficient practice represented condition level- or standard-level noncompliance. JC developed and conducted surveyor training on CMS documentation requirements to ensure that issues cited provide a clear and detailed description of the deficient practice and relevant finding.
- JC modified its policies regarding complaint investigation activities to comply with CMS requirements.
- To meet the Medicare requirements related to unannounced surveys JC modified its electronic application process to no longer allow an ASC to indicate "avoid dates" or "a ready month" in which organizations could receive an accreditation survey for deemed status.
- JC revised its accreditation decision letters to ensure they are accurate and contain all the required elements necessary for CMS to render a decision regarding deemed status of a provider.
- JC modified its policies regarding condition-level noncompliance identified during an initial certification survey for participation in Medicare to meet Medicare requirements.
- JC revised its standards to require that patients in Medicare-certified ASC that require emergency treatment beyond the capability of the ASC be transferred to local hospitals that meet Medicare requirements.
- JC revised its standards to require Medicare certified ASCs to provide a separate waiting area and post-anesthesia care unit.
- JC amended the crosswalk from its standards to the applicable Medicare standards to reflect current regulatory language.
- JC added a standard requiring Medicare-certified ASCs to ensure that licensed independent practitioners are accountable to the governing body.
- JC added a standard requiring Medicare-certified ASCs to periodically review and amend the scope of procedures performed by each physician.
- JC added a new standard requiring Medicare-certified ASCs to designate one individual responsible for pharmaceutical services.
- JC added a standard requiring ASCs to comply with requirements concerning which requires organizations will perform laboratory testing.

<u>Critical Access Hospitals</u>

JC first received CMS recognition as a national AO for CAHs November 21, 2002. More recently, JC received a three-year conditional approval with probationary period effective November 21, 2008, through November 21, 2011, with a 180-day probationary period through May 20, 2009. The final notice announcing this decision was published in the *Federal Register* on October 24, 2008, and can be accessed at **http://edocket.access.gpo.gov/2008/pdf/E8-25193.pdf**. The major provisions of this final notice are as follows:

- JC amended their policies to eliminate the use of supplemental findings. All survey findings will be identified as a requirement for improvement, and will, therefore, require resolution through the evidence of standards compliance process.

Other Accompanying Information

- JC modified its evidence of standards compliance process (ESC) to ensure that accepted ESCs contain the critical information necessary to provide assurance that an identified deficiency had been adequately corrected.
- JC modified its survey report to clearly identify whether an identified deficient practice represented condition-level noncompliance or standard-level noncompliance.
- JC developed and conducted training on the CMS documentation requirements for its surveyors to ensure that issues cited would provide a clear and detailed description of the deficient practice and relevant finding.
- JC modified its policies regarding complaint investigation activities.
- To ensure all surveys are unannounced, JC modified its electronic application process to no longer allow the CAH to indicate "avoid dates" or "a ready month" in which organizations could receive an accreditation survey for deemed status.
- JC revised its accreditation decision letters to ensure they are accurate and contain all the required elements necessary for the CMS Regional Office to render a decision regarding deemed status of a CAH.
- JC modified its policies regarding condition-level noncompliance identified during an initial certification survey for participation in Medicare.
- JC added language to its standards, and interpretive guidance to address the requirements at § 485.610(e) (off-campus and co-location requirements) and § 485.635(e) (rehabilitation therapy services).
- JC amended its standards to include a requirement for CAHs that are part of a rural health network to have an agreement with at least one hospital.
- JC amended its standards to clarify that the governing body must approve all services provided at the CAH through contractual agreements.
- JC revised several of its elements of performance (EP) to address the ventilation, lighting, and temperature control in pharmaceutical, patient care, and food preparation areas.
- JC modified its standards and EPs to address training of staff on handling emergencies.
- JC added language to the appendix of the CAH manual to clarify the provision of waivers related to life safety code (LSC).
- JC added an EP to address the requirement that the CAH must maintain written evidence of regular inspection and approval by state and local fire control agencies.
- JC amended its crosswalk to include language related to requirements of alcohol-based hand rubs.
- JC added language to its standards to address the requirements at § 485.627(b) (disclosure of ownership and control).
- JC added language to its standards to address the requirements related to the physician assistants (specifically, supervision and evaluation of nursing care).
- JC added language to its standards to address who may administer anesthesia.
- JC added language to the CAH manual that states that CAHs are not permitted to have satellite facilities.
- JC added language to its standards to include provisions related to admission of psychiatric patients.
- JC added language to its standards to address the requirements related to progress notes.

- JC added language to its standards to address the responsibilities of the social work staff.
- JC added language to its standards for a distinct part unit(s)(DPU) to address the requirement that a doctor manage or coordinate a patient's general medical condition.
- JC added language to its standards for DPUs to address the requirements related to budget and capital expenditures.
- JC added language to its standards for DPUs to address the requirements related to the governing body's responsibility to review and resolve grievances.
- JC added language to the standards for DPUs to address the requirements of the patient's right to access records.
- JC added language to its standards for DPUs to address the requirements related to duties and privileges of the medical staff.
- JC added language to its standards for DPUs to address the requirements related to autopsies.
- JC added language to its standards for DPUs to address the requirements related to the availability of a registered nurse.

In accordance with the requirements at § 488.8(f)(3)(i), when CMS determines that an AO failed to adopt requirements comparable to CMS requirements during the review of an application for deeming authority, CMS may grant a conditional approval of an AO's deeming program for a period of up to 180 days, during which the AO is expected to adopt comparable requirements. JC received a conditional approval with 180-day probationary period because review of JC's application's for renewal of CAH deeming authority revealed significant gaps between JC accreditation standards for distinct part psychiatric and rehabilitation units and the Medicare hospital CoPs, which apply to these specialized CAH units.

During the 180-day probationary period, JC made the necessary revisions to their distinct part unit standards and successfully implemented these revised standards to ensure that JC's accreditation program for CAH distinct part units meet or exceed the Medicare requirements. On June 26, 2009, CMS published the decision to approve JC's CAH program without condition. This final notice of approval is effective November 21, 2008, through November 21, 2012 and can be accessed at **http://edocket.access.gpo.gov/2009/pdf/E9-14778.pdf**. The major provisions of this final notice are as follows:

- JC added an element of performance (EP) to affirm that only one individual or designee may be the chief executive officer.
- JC added a new EP to require hospitals to maintain a list of all contracted services.
- JC added a new EP to require that the medical staff have written policies and procedures for on-campus and off-campus locations for appraising emergencies, providing initial treatment, and for referring and transferring patients.
- JC revised its EPs to include a definition of restraints.
- JC revised its EP to include a definition of seclusion.
- JC revised its EPs to include the reference "as specified under § 482.12(c)," which addresses the care of the patient.
- JC revised its EP to address the staff training requirements of individuals that monitor patients in restraints and seclusion.
- JC revised it EPs to require physicians and other licensed independent practitioners authorized to order restraints and seclusion have a working knowledge of hospital policy regarding the use of restraint and seclusion.

Other Accompanying Information

- JC revised its EPs to address the components of training, education, and demonstrated knowledge on restraint and seclusion.
- JC revised its EP to include "as defined in section 1861(r) of the Social Security Act," which contains the definition of a physician.
- JC revised its EP to address the nurse staffing requirements, supervisory personnel, and immediate availability of a registered nurse for bedside care.
- JC revised its EP to address the requirements related to orders for drugs and biologicals.
- JC revised its EPs to address the requirement that hospitals have policies and procedures on who is authorized to accept verbal orders.
- JC added a new EP to require special training for staff members administering blood transfusions.
- JC revised its EPs to include medical records as an essential service.
- JC added a new EP that states the hospital must be able to ensure prompt completion, filing, and retrieval of records.
- JC added a new EP that requires all patient medical records entries be timed.
- JC revised its EP to address "all orders."
- JC added a new EP to address the timeframe requirement for verbal order authentication.
- JC revised its EP to include a requirement that the pharmacy must be directed by a registered pharmacist.
- JC revised its EP to require a pharmacist supervise all compounding, packing, and dispensing of drugs and biologicals.
- JC revised its EP to require all controlled substances included in Schedules II, III, IV, and V of the Comprehensive Drug Abuse and Prevention and Control Act be locked and secure.
- JC revised its EP to address the requirement, if necessary, to report drug administration errors, adverse drug reactions and incompatibilities' to the hospital-wide quality assurance program.
- JC revised its EPs to state a radiologist is a doctor of medicine or osteopathy.
- JC revised its EP to include a statement that hospitals must provide laboratory services with a certified laboratory that meet the requirements of part 493 of title 42 of the Code of Federal Regulations.
- JC added a new EP requiring laboratory services be available 24 hours a day.
- JC added a new EP to require the medical staff and pathologist establish which tissue specimens require macroscopic and microscopic examinations.
- JC added new requirements associated with potentially infectious blood and blood components.
- JC revised its EP to include the requirement that the plan to transfer medical records must be "fully funded."
- JC revised its EPs to include the statement that if the hospital administered potentially HIV or HCV infectious blood or blood components and the physician is unavailable or declines to make the notification, the hospital must make reasonable attempts to give this notification to the patient, legal guardian, or relative.
- JC revised its EP to include that the full time director of food and dietetic services be qualified by experience or training.

- JC added a new EP to require hospitals have a discharge planning process that applies to all patients.
- JC added a new EP to require RNs, social workers, or other appropriately qualified personnel develop, or supervise the development of the evaluation.
- JC added EP to require the inclusion of a discharge planning evaluation in the medical record for use in establishing an appropriate discharge plan. JC also requires the hospital to discuss the results of the discharge plan with the patient or individual acting on behalf of the patient.
- JC added new EPs to address the discharge planning requirements.
- JC revised its EPs to include a requirement for an update when the medical history and physical examination is completed within 30 days before admission or registration.
- JC revised its EPs to include "as defined in § 410.69(c)," which provides the definition of an anesthesiologist assistant.
- JC added EP to address the requirements of the post anesthesia evaluation.
- JC added a new EP to identify the nuclear medicine services that must be supervised and administered by a qualified doctor of medicine or osteopathy.
- JC added a new EP to state that the "in-house preparation" of radiopharmaceuticals must be under the supervision of an "appropriately trained registered pharmacist or a doctor of medicine or osteopathy."
- JC added a new EP that requires a qualified member of the medical staff direct emergency services.
- JC added an EP to clarify that the policies and procedures governing medical care provided in the emergency department are established by and are a continuing responsibility of the medical staff.
- JC added a new EP to require a qualified member of the medical staff supervise emergency services.
- JC added a new EP to address the requirement that there must be a director of respiratory services who is a doctor of medicine or osteopathy.
- JC added new EPs to state respiratory services are provided only on and in accordance with, the orders of a doctor of medicine or osteopathy.

<u>Home Health Agencies</u>
JC initially received CMS recognition as a national AO for HHAs September 28, 1993. More recently, JC received a six-year renewal effective March 31, 2008, through March 31, 2014. The final notice announcing this decision was published in the *Federal Register* on March 28, 2008, and can be accessed at **http://edocket.access.gpo.gov/2008/pdf/E8-5074.pdf**. The major provisions of this final notice are as follows:

- JC revised its standards to require HHAs provide care to a minimum of ten patients and at least seven of the ten are receiving care at the time of the initial survey. It also required HHAs to provide nursing and at least one other therapeutic service.
- JC revised its standards to require HHAs provide care to a minimum of ten patients and at least seven of the ten are receiving care at the time of the initial survey. It also required HHAs to provide nursing and at least one other therapeutic service.
- JC updated its home care surveyor guide to reflect all patients (private pay and Medicare beneficiaries) are included in the clinical record review or selection of home visits for a Medicare certification survey.

- JC will no longer issue supplemental findings for HHAs seeking deemed status. All deficiencies identified during a certification survey will be cited as requirements for improvements which the HHA will be required to submit a written plan of correction.
- JC has agreed to provide CMS with a copy of its most current accreditation survey along with any other related information that CMS requires, including corrected action plans, when requested.

Hospices
JC initially received CMS recognition as a national AO for hospices June 18, 1999. More recently, JC received a six-year renewal effective June 18, 2009, through June 18, 2015. The final notice announcing this decision was published in the *Federal Register* on March 27, 2009, and can be accessed at **http://edocket.access.gpo.gov/2009/pdf/E9-6775.pdf**. The major provisions of the final notice are as follows:

- On June 5, 2008, CMS published a final rule (73 FR 32088) that revised the existing conditions of participation that hospices must meet to participate in the Medicare and Medicaid Program. JC updated and revised its standards and survey procedures to meet the revised Medicare requirements.
- JC modified its policies for posting the deemed status survey results within 10 days onto its extranet site.
- JC will conduct all for-cause surveys on an unannounced basis.
- JC modified its executive summary statement to clearly indicate that facilities must meet all accreditation standards in order to be recommended for deemed status.

Hospitals
As previously noted, the JC's unique statutory deeming authority for hospitals was revoked in Section 125 of MIPPA. JC submitted an application to CMS for recognition of its hospital deeming program February 2009. A final notice announcing our decision will be published in the *Federal Register* in November 2009.

SECTION 5: Accreditation Representative Sample Validation Program

Section 1864 of the Act authorizes the Secretary of Health and Human Services to conduct validation surveys of accredited facilities participating in Medicare, as a means of validating the AO's accreditation process. The Accreditation Validation Program is a significant component of CMS' oversight of AOs and consists of two types of validation surveys: full surveys of a representative sample of deemed facilities; and allegation surveys, i.e., focused surveys based on complaints which, if found to be true, would suggest serious noncompliance with Medicare CoPs or CfCs. Representative sample validation surveys generally are "look-back" surveys, conducted no more than 60 days after an AO survey of the same facility. In some cases representative sample surveys may also be "mid-cycle" validations, conducted independent of a preceding AO survey. Section 1865(d) of the Act permits validation surveys of all provider and supplier types that may be deemed for Medicare participation under Section 1865(a) of the Act.

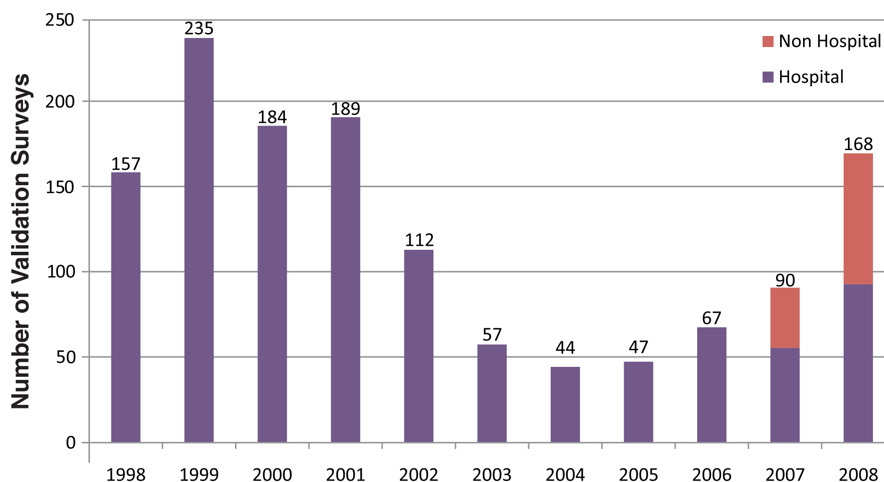
This section discusses CMS' validation of the AOs' deemed programs through the 60-day look-back validation surveys. The purpose of these validation surveys is to assess the AO's ability ensure compliance with Medicare's CoPs/CfCs. These validation surveys are onsite full surveys by SA surveyors of accredited providers/suppliers conducted no more than 60 days of the end date of an AO's full accreditation survey. The SA performs the survey without any knowledge of the findings of the AO's accreditation survey.

The CMS' validation analysis compares the condition-level, i.e., serious deficiencies identified by the SA with the deficiencies identified by the AO on its full accreditation survey to determine whether the findings of the two surveys are comparable. The premise of the analysis is that condition-level deficiencies identified by the SA during the 60-day look-back validation survey would also have been present 60 days prior during the AO's accreditation survey and should also have been identified by the AO. Following a validation survey, if a provider or supplier is found to have condition-level non-compliance with Medicare requirements, CMS will provide timely notification to the facility and AO, and maintain SA monitoring until either the deficiencies have been corrected or the facility has been terminated from participating in the Medicare program.

Prior to the enactment of MIPPA, the validation survey component of CMS' annual reporting to Congress was limited to those surveys conducted for the JC hospital program. As a result of section 125 of MIPPA, expansion of the CMS annual report to Congress to include all AOs and their approved accreditation programs, the validation survey program analysis will now be reported for all seven AOs and fourteen CMS-approved accreditation programs. This is the first expanded annual report to Congress.

Federal budget constraints have historically placed limits on the CMS representative sample validation program. Graph 1 presents the number of representative sample validation surveys performed by SAs over the past eleven years. The largest number of validation surveys was conducted in 1999 when 235 hospital validation surveys were conducted. However, since then, the number of validation surveys has declined. Since FY 2005, the overall number of validation surveys conducted has increased, but is now spread over multiple provider/supplier types and has not reached the 1999 level. In FY 2007, CMS began conducting representative sample validation surveys for non-hospital facilities (i.e., CAHs, HHAs, and ASCs) in addition to the hospital validation surveys. Prior to FY 2007, no validation surveys had been conducted in non-hospital deemed facilities. The validation program expanded significantly from FY 2007 to FY 2008, with an 87 percent increase in the overall number of validation surveys conducted from 90 to 168. Between FY 2007 and FY 2008, the number of non-hospital validation surveys conducted increased by 117 percent, from 35 surveys in FY 2007 to 76 surveys in FY 2008. The number of hospital validation surveys conducted also increased by 67 percent from 55 surveys in FY 2007 to 92 surveys in FY 2008. However, the hospital component of the validation program remains well below half the 1999 level.

GRAPH 1
Number of Representative Sample Validation Surveys for Both Hospital and Non Hospital Facilities (FY 1998-2008)

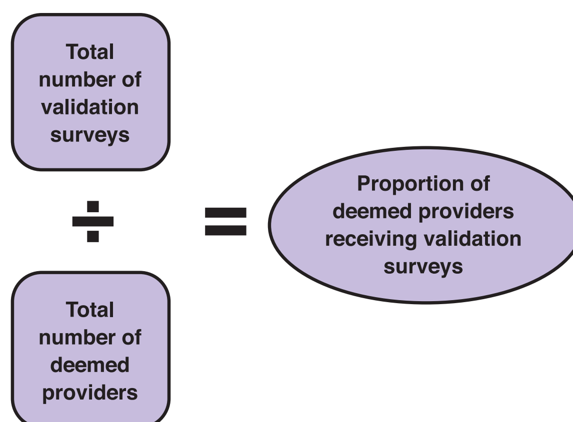


Methodology: Validation Sample Design

In FY 2008, CMS selected a representative sample of facilities within each of the following facility types: hospital, CAHS, HHAs, and ASCs. The CMS bases decisions on how many validation surveys to perform for each AO on the number of facilities the AO surveys each month, working within overall budgeted targets, by state and provider type, for validation surveys. The CMS then attempts to build a representative national sample for individual accreditation programs. Due to both budget constraints limiting the number of validation surveys which could be performed as well as the small size of some AO deeming programs, small sample sizes result for most of the AO deeming accreditation programs. This in turn limits the reliability of generalizations from the results.

Figure 1 provides the calculation for the proportion of validation surveys completed in deemed providers during FY 2008. Approximately 2 percent of deemed hospitals received a validation survey. Four percent of deemed CAHS received a validation survey. Almost 2 percent of deemed home health agencies received a validation survey during FY 2008. Four percent of deemed ambulatory surgery centers received a validation survey during FY 2008.

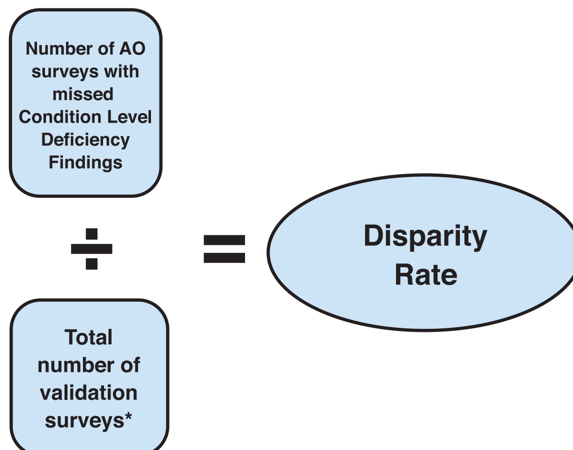
FIGURE 1
Proportion of Deemed Providers Receiving Validation Surveys



Each AO received feedback on the results of analysis of validation surveys for its deemed facilities conducted during FY 2007 and FY 2008. The JC has received feedback on the results of the analysis of validation surveys conducted for its accredited hospitals since the beginning of the validation program in FY 1998. Tables 7 through 12 use the following measures to review the survey results:

Disparity Rate: The methodology for the disparity rate is set by regulation at 42 CFR 488.1. Figure 2 outlines the calculation of the disparity rate. The numerator is the number of surveys where the AO missed a serious deficiency found by the SA. The denominator is the number of surveys in the validation sample. The result is the percentage of validation surveys where the SA identified non-compliance with one or more CoPs or CfCs in a facility, but the AO did not find similar non-compliance. A lower disparity rate indicates better AO performance.

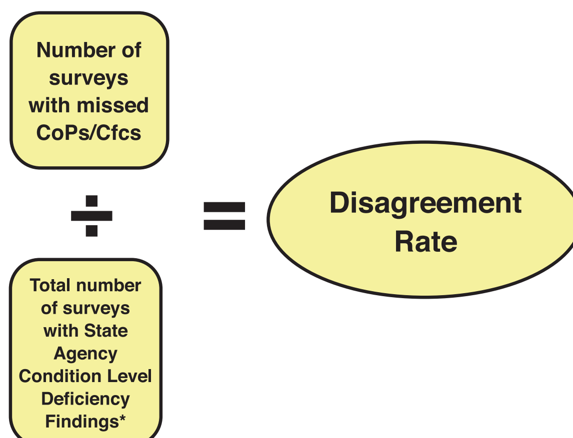
FIGURE 2
Disparity Rate Calculation



* Total validation surveys include those with or without condition level deficiency findings by the SA

Disagreement Rate: A different and more sensitive approach, the disagreement rate is provided by the percentage of CoP or CfC level deficiencies found by the SA that were missed by the AO; outlined in Figure 3. GAO recommended a similar calculation in their July 2004 report[4]. The numerator is the number of surveys where the AO missed a serious deficiency found by the SA. The denominator is the number of surveys in which the SA found deficiencies during a validation survey. If the AO found condition level deficiencies in half of the facilities where the SA identified condition level deficiencies, the disagreement rate would be 50 percent. A lower disagreement rate indicates better AO performance. Because the denominator restricts consideration only to those surveys where the SA found deficiencies, this measure is more sensitive to the extent of disagreement between the AO and the SA.

FIGURE 3
Disagreement Rate Calculation

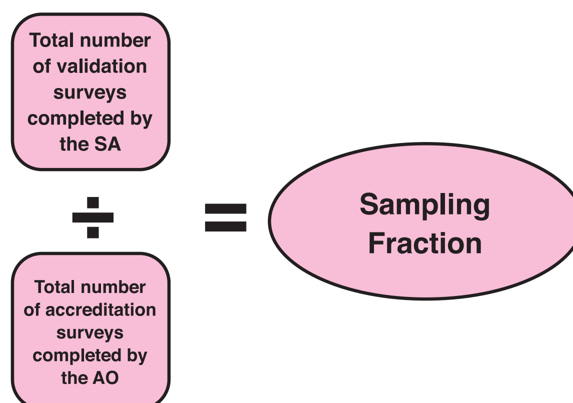


* Does not include those surveys for which the State Agency found no condition level deficiencies.

[4] *Medicare: CMS Needs Additional Authority to Adequately Oversee Patient Safety in Hospitals.* GAO-04-850. Washington, D.C.: July 2004.

Sampling Fraction: The sampling fraction, outlined in Figure 4, is the proportion of AO surveys for which a validation survey was completed. For example, the sampling fraction for AAAHC's accreditation program for ASCs is .05: the number of FY 2008 validation surveys (24 validation surveys) divided by the number of FY 2008 AAAHC ASC surveys (445 accreditation surveys as indicated in Table 3). The CMS is working to increase this fraction for each AO and to include a minimum of 5 validation surveys for each AO program no matter how small the AO. Budget limitations as well as the administrative process for selecting surveys to include in the validation process have limited the ability to achieve this goal.

FIGURE 4
Sampling Fraction Calculation



The disparity rate focuses on the number of disparate validation surveys with condition level deficiencies found by SAs in relation to the total number of validation surveys completed that fiscal year by the SA. In contrast, the disagreement rate examines the disparate validation surveys with condition level deficiencies found by the SAs and whether AOs found similar deficiencies on the AO survey. The sampling fraction is the proportion of validation surveys completed by the SA in relation to the number of accreditation surveys completed by the AO. When the number of validation surveys completed by the SA was less than five surveys, the disparity rate and disagreement rate are not presented. In the future, CMS may also perform an aggregate analysis by combining the validation surveys completed over several years as a means to identify trends and AO performance over time. For this review, the disparity and disagreement rates are calculated separately for 2007 and 2008.

Validation Performance Results: Overall

The regulations at 42 CFR 488.8(d) require that CMS identify any AO with a disparity rate exceeding 20 percent. In cases where the disparity rate for the AO's accreditation program exceeded the 20 percent threshold, CMS notified the AO of the finding. Results of the validation surveys have raised significant concerns about the effectiveness of the AO reviews. Table 7 presents the results of the validation reviews for each program for both FY 2007 and 2008.

With the exception of HHAs, the disparity rate scores for each facility type exceed the 20 percent threshold established in the regulation. For example, a disparity rate of 33 percent for hospitals means that the AO did not identify similar serious deficiencies as did the SA for more than three out of ten hospitals. Based on disagreement rates for FY 2008, the AOs missed 78 percent of the condition-level deficiencies identified by SAs for CAHs and 94 percent of the condition-level deficiencies for ASCs.

TABLE 7
Overall Validation Results for Each Facility Type (FY 2008 and 2007)

	Hospital	CAH	HHA	ASC	Total
FY 2008					
Validation Sample	92	17	21	38	168
SA: Condition level Deficiencies	43	9	5	17	74
Missed by AO	30	7	3	16	56
Disparity Rate	33%	41%	14%	42%	33%
Disagreement Rate	70%	78%	60%	94%	73%
FY 2007					
Validation Sample	55	12	6	17	90
SA: Condition level Deficiencies	23	4	1	5	33
Missed by AO	22	3	0	4	29
Disparity Rate	40%	25%	0	24%	32%
Disagreement Rate	96%	75%	0	80%	88%

Tables 8 through 11 present the results of the validation surveys in 2008 for individual AOs as well as the overall results for each facility type. Due to the small sample sizes, it is not possible to draw reliable conclusions for several accreditation programs. The disparity rates for sample sizes less than five are not presented. The disparity rates which are presented are generally above the 20 percent threshold established in the regulation. The disagreement rates also indicated that AOs did not find serious comparable deficiencies identified by the SAs. The validation sample is driven by a number of factors including the total number of re-accreditation surveys conducted by the AO and reported on the survey schedules, individual State validation targets, and the ability of the AO to provide accurate and timely survey schedules.

TABLE 8
Hospital Validation Results (FY 2008)

	JC	AOA	Total
Validation Sample	91	1	92
SA: Condition level Deficiencies	42	1	43
Missed by AO	29	1	30
Disparity Rate	32%	NA	33%
Disagreement Rate	69%	NA	70%
Sampling Fraction	.06	.01	.06

NA: Not applicable due to sample size less than five.

TABLE 9
Critical Access Hospital Validation Results (FY 2008)

	JC	AOA	Total
Validation Sample	16	1	17
SA: Condition level Deficiencies	8	1	9
Missed by AO	6	1	7
Disparity Rate	35%	NA	41%
Disagreement Rate	75%	NA	78%
Sampling Fraction	.15	.17	.15

NA: Not applicable due to sample size less than five.

TABLE 10
Home Health Agency Validation Results (FY 2008)

	JC	ACHC	CHAP	Total
Validation Sample	16	1	4	21
SA: Condition level Deficiencies	5	0	0	5
Missed by AO	3	0	0	3
Disparity Rate	19%	NA	NA	14%
Disagreement Rate	60%	NA	NA	60%
Sampling Fraction	.04	.01	.02	.03

NA: Not applicable due to sample size less than five.

TABLE 11
Ambulatory Surgery Center Validation Results (FY 2008)

	JC	AAAHC	AAAASF	Total
Validation Sample	12	24	2	38
SA: Condition level Deficiencies	4	11	2	17
Missed by AO	4	10	2	16
Disparity Rate	33%	42%	NA	42%
Disagreement Rate	100%	91%	NA	94%
Sampling Fraction	.12	.05	.06	.07

NA: Not applicable due to sample size less than five.

The number of surveys in which the AOs did not cite deficiencies comparable to condition-level deficiencies identified by the SAs suggests significant limitations in the AOs' ability to identify serious non-compliance with the Medicare CoPs/CfCs. Below is a more detailed discussion by type of facility and AO.

- **Hospital:** Of the 92 validation surveys conducted, SAs identified condition level deficiencies in 43 of the hospitals. The AOs did not cite deficiencies comparable to the condition-level deficiencies identified by the SAs in 30 hospitals, for a disparity rate of 33 percent and a disagreement rate of 70 percent.

  JC: The disparity rate is 32 percent based on 91 total validation surveys. The JC did not cite comparable findings in 29 of the 42 surveys cited for condition-level deficiencies by the SAs. The FY 2008 validation surveys conducted comprise a 6 percent sample of the 1,408 surveys completed by the JC during that period. The JC disparity rate has been above 20 percent for the past nine years, as shown in Table 12. The disparity rate reached a high of 40 percent in FY 2007, but has decreased to 32 percent in FY 2008.

  AOA: The validation sample included only one hospital. Due to the small validation sample, disparity rate and disagreement rate are not presnted.

- **CAH:** Of the 17 validation surveys conducted, the SAs identified nine facilities with condition-level deficiencies while the AOs missed comparable deficiencies in seven facilities. The disparity rate is 41 percent and the disagreement rate is 78 percent.

  JC: The validation sample includes 16 surveys. The disparity rate is 35 percent based on the SAs finding condition-level deficiencies in eight facilities and the AO citing comparable deficiencies for only two facilities. The disagreement rate is 75 percent.

  AOA: The validation sample includes only one facility. Disparity rate and disagreement rate are not presented due to the small sample size.

- **HHA:** Of the 21 validation surveys conducted, the SA identified condition-level deficiencies in five HHAs. The AOs did not cite comparable deficiencies in three HHAs. Therefore, the disparity rate is 14 percent and the disagreement rate is 60 percent. SAs found a somewhat lower percentage of condition-level deficiencies in HHAs (24 percent) as opposed to other types of facilities (47 percent of sample hospitals, 53 percent of sample CAHs, and 45 percent of sample ASCs).

  JC: The validation sample includes 16 HHAs. The SAs found deficiencies in five HHAs. The JC missed comparable deficiencies in three HHAs, resulting in a disparity rate of 19 percent and a disagreement rate of 60 percent.

  ACHC: The validation sample includes one HHA survey. The SA did not find deficiencies on the validation survey, making a disparity or disagreement rate moot.

  CHAP: Four validation surveys were conducted. The SA did not identify condition-level deficiencies on the validation surveys, making a disparity or disagreement rate moot.

- **ASC:** Of the 38 ASC validation surveys conducted, the SAs identified condition-level deficiencies in 17 facilities. The AOs did not cite comparable findings in 16 facilities, for a disparity rate of 42 percent and a disagreement rate of 94 percent.

  JC: The validation sample includes 12 surveys. The SAs identified condition-level deficiencies in four facilities. The JC did not cite any comparable deficiencies. The disparity rate is 33 percent and the disagreement rate is 100 percent.

  AAAHC: The validation sample includes 24 surveys. SAs identified condition-level deficiencies in 11 facilities. The AO missed comparable deficiencies in 10 facilities, resulting in a disparity rate of 42 percent and a disagreement rate of 91 percent.

  AAAASF: The validation sample includes two surveys. The disparity and disagreement rates are not presented due to the small sample size.

Table 12 presents the history of JC's hospital validation disparity rate for FY 2000 through 2008. The disparity rate more than doubles between FY 2007 and 2008 from 25.4 percent to 40 percent. However, the disparity rate has declined 20 percent in FY 2008. Table 12 also present the disparity rates for surveys cited for health and safety CoPs/CfCs only, physical environment CoPs/CfCs only, and both health and safety and physical environment CoPs/CfCs on survey. The disparity rate also increased (63 percent) for those surveys with physical environment cited only between FY 2007 and 2008, but also has declined (55 percent) in FY for a disparity rate of 13.2 percent.

TABLE 12
The Joint Commission Hospital Validation Disparity Rates (FY 2000–2008) (Percentage)

Fiscal Year	Total Disparity Rate	Health and Safety CoPs/CfCs only*	Physical Environment CoPs/CfCs only*	Health/Safety Physical Environment CoPs/CfCs*
2000	26.6	NA	NA	NA
2001	24.0	NA	NA	NA
2002	22.3	NA	NA	NA
2003	26.3	NA	NA	NA
2004	27.2	NA	NA	NA
2005	27.6	4.3	12.7	10.6
2006	25.4	0.0	17.9	7.5
2007	40.0	7.3	29.1	3.6
2008	31.9	13.2	13.2	5.5

*Data not available for FY 2000 through 2004

Validation Performance Results: Conditions of Participation (CoPs) Cited

Examining the specific condition-level deficiencies cited by the SAs across all AO validation surveys provides an indication of the types of quality problems that exist in those facilities found to have serious deficiencies. Table 13 presents the number of facilities that were cited by SAs for condition-level deficiencies and the number of comparable AO findings.

- **Hospital:** The most prevalent condition-level deficiency cited by the SAs was the Physical Environment CoP. Governing Body, Quality Assurance Performance Improvement, Pharmacy Services and Infection Control were the next most frequently cited CoPs by the SAs.
- **CAH:** The SAs cited condition-level deficiencies in Physical Environment in eight of 17 facilities. Organization Structure, Provision of Services, and Periodic Evaluation/Quality Assurance were the next most frequently cited CoPs.
- **ASC:** The most common source of discrepancy in finding condition-level deficiencies for ASCs is also the Physical Environment CfC, just as it is for hospitals and CAHs.
- **HHAs:** Analysis of the CoPs for HHAs is not presented due to the small number of deficiencies found by SAs and the small sample sizes for some AOs.

In previous annual reports on the JC hospital program, the single largest driver of the disparity rate has been the lack of JC comparable survey findings related to the physical environment CoP, more specifically, the National Fire Protection Association Life Safety Code requirements that CMS has adopted as part of its health and safety standards. This same problem is now evident across all of the AO programs reviewed for this broader report. The CMS has had ongoing dialogue with the JC about measures to improve its performance in assuring compliance with physical environment CoPs. As part of its application review process, CMS has also flagged this issue as an area for

improvement for other AOs as well. The CMS has also examined policies in various AOs that might contribute to this pattern of under-citation, for example, policies that preclude citation of a deficiency at all unless some statistical threshold has been met. As such, policies have been phased out; we are looking to see whether future disparity and disagreement rates improve.

TABLE 13
FY 2008 Condition Level Deficiencies Cited on Validation Survey

Conditions of Participation	Cited by State Agency	Missed by Accreditation Organization
HOSPITAL SAMPLE: 92		
Physical Environment	28	15
Governing Body	8	7
Quality Assurance	5	3
Pharmaceutical	4	2
Infection Control	5	3
Patient Rights	3	3
Nursing Services	3	3
Medical Records	2	0
Emergency Services	1	1
Laboratory Services	2	2
Organ, Tissue, Eye Procurement	2	2
Rehabilitation	1	1
Food/Dietetic	2	2
Respiratory Care	1	1
Radiologic Services	1	1
TOTAL	**68**	**46**

Conditions of Participation/ Conditions for Coverage	Cited by State Agency	Missed by Accreditation Organization
CRITICAL ACCESS HOSPITAL SAMPLE: 17		
Physical Environment	8	6
Organization Structure	2	2
Provision of Services	2	2
Periodic Evaluation	2	2
Clinical Records	1	1
TOTAL	**15**	**13**
AMBULATORY SURGERY CENTER SAMPLE: 38		
Physical Environment	12	12
Governing Body	9	7
Quality Evaluation	7	5
Pharmaceutical	5	3
Surgical Services	5	4
Medical Staff	3	3
Laboratory	2	2
Nursing Services	1	1
TOTAL	**44**	**37**

SECTION 6: Accreditation Organization Improvement Efforts

This section discusses the improvements that the AOs have made to their respective CMS-approved accreditation programs as well as improvements that CMS has made in its oversight of the AOs. There is ongoing communication between CMS and the AOs regarding oversight activities, expectations, AO reporting, validation surveys and other requirements. As a continuation of that process, CMS requested that the AOs submit for inclusion in this annual report a summary of their activities to improve the operations of their approved accreditation programs. Four of the seven AOs responded to this request.

1. Accreditation Association for Ambulatory Health Care

AAAHC has taken the following steps to improve the accuracy of its required reporting to CMS:

- ***Survey Schedule, Deemed Facility List, and ASSURE Export File:*** An electronic calendar has been implemented to ensure that information is submitted timely to appropriate CMS electronic mailboxes.
- ***Deemed Facility List:*** CMS requires specific data elements (e.g., CMS Certification Number) to be included on the deemed facility list. AAAHC continues work to obtain the required information. In addition, any errors reported will be discussed with CMS and investigated within two weeks.
- ***Notification Letters:*** Information technology systems were updated to ensure that all required information is included in the deemed status notification letters. Use of this system began in December 2008. AAAHC believes that this will resolve all compliance issues related to notification letters.

2. American Association for Accreditation of Ambulatory Surgery Facilities

AAAASF reports that it has experienced growth in the past six years and has taken the following steps to support its expanded operation:

- ***Personal Additions:*** A Director of Legislative and External Affairs joined AAAASF senior management in July 2009; the new Director has responsibility for management of the CMS reporting requirements. Additional staff has also been added to support new activities.
- ***Reporting Systems:*** Increased funding has been made available for reporting system development to support timely and accurate data submissions.
- ***National Patient Safety Initiatives:*** AAAASF will continue to collect peer-reviewed patient data to support national patient safety initiatives, e.g., in the area of infection control.
- ***Future Growth:*** AAAASF will continue to add additional personnel to support internal systems development, data management, and future growth.

3. Community Health Accreditation Program

CHAP's rapid growth in its deemed status accreditation programs has led to an analysis of internal operations and development of a plan designed to manage the increased volume of business, including eliminating survey backlogs. Beginning in 2007 and even more aggressively since January 2009, CHAP has focused significant efforts on improving its deemed status accreditation programs for HHAs and hospice. The following specific actions have been taken:

- ***Staffing Issues:*** Extensive staff have been hired and trained, including the following: 40 additional home health and hospice site visitors [surveyors]; a Chief Operating Officer; a Chief Financial Officer; a Scheduler; an additional processing team member; two additional Directors of Professional Services; a Customer Service Representative; an information technology consultant to oversee data systems improvement; and, an Applications Systems Developer. Recruitment of additional staff continues, including, a full time Director of Information Technology, a Quality Analyst, and two additional Customer Relations Representatives.
- ***Systems, Data, Reporting and Oversight:***
  - Created workflow diagrams for all key processes to support analysis and system redesign;
  - Redesigned facility and CMS correspondence tools;
  - Updated deemed accreditation policies;
  - Engaged an information technology development contractor to work with CHAP to plan and execute migration of all accredited organization data into one information system. This will support analysis of survey results to identify best practices, and support education and continuous quality improvement; and,
  - Developing enhancements to computerized accreditation documentation system.

- ***Other Improvements:***
  - Initiated efforts to improve the site visitor [surveyor] development process, including: more frequent training, and more stringent performance-based evaluation system;
  - Began development of a performance indicators dashboard; and,
  - Finalizing process for integrating corrective action plans from organizations for cited deficiencies.

4. The Joint Commission

Section 1875(b) of the Act has required CMS to include results of the validation program for the JC hospital program in its annual report to Congress since FY 2000. Therefore, there is a history of collaborative work between CMS and the JC regarding the results of CMS' validation program. The CMS has made past recommendations to the JC regarding hospital compliance with the *Life Safety Code*. The JC reports the following activities and concerns:

- ***Standards Improvement Initiative:*** As part of the Standards Improvement Initiative (SII), there have been numerous changes to JC standards. The SII enhanced the clarity and relevance of certain standards and elements of performance and tailored language to the specifications of each program. The SII also refined the scoring and decision processes to more accurately reflect the surveyed organization's performance. Beginning in January 2009, the accreditation manuals include a chapter entirely devoted to the Life Safety Code (LSC).
- ***LSC Specialists:*** In 2005, the JC began including a LSC specialist on surveys for all hospitals with 200 beds or more. Beginning in 2008, a LSC specialist was included on all hospital surveys, regardless of the size of the organization. Also, the number of days a LSC engineer was onsite was increased for hospitals greater than 750,000 square feet.
- ***Electronic Systems:*** JC continues to work with its accredited organizations to have a more efficient and effective methodology for managing deficiencies though the use of an electronic Statement of Conditions™. Since September 2007, all accredited facilities are required to use this electronic process, which includes basic building information and an electronic Plan for Improvement.
- ***Building Maintenance Program:*** Beginning in January 2009, the Building Maintenance Program (BMP) was eliminated as an alternative to full compliance with LSC requirements.
- ***Training:*** All surveyors participate in ongoing training and continuing education. In addition to the initial training, preceptor program and annual training conference, the surveyors participate in regular distance-based training. These trainings are utilized by the JC to prepare the surveyors to effectively implement new processes in the field. In addition, to ensure ongoing competence, surveyors receive annual performance evaluations, including observations by a supervisor, peer evaluations, and questionnaires completed by the surveyed organization. To improve efforts to detect non-compliance with environment of care, LSC Specialists received extensive training, including:
  - Online training modules addressing Life Safety, Environment of Care, and Emergency Management standards chapters;
  - A series of training modules that reinforce appropriate documentation protocol for findings of non-compliance, as well as a comprehensive "assess your understanding" module testing understanding of Elements of Performance for each standards chapter;
  - Life Safety requirements and survey process was a primary content focus area for Life Safety Code Specialists at the JC's Annual Invitation Teaching Conference in January 2009; and
  - A DVD demonstrating appropriate environment of care and Life Safety Code survey process.

SECTION 7: Centers for Medicare & Medicaid Services Oversight Improvement

In FY 2008 through 2009, CMS continued strengthening its oversight of national AOs and their CMS-approved accreditation programs. The CMS engaged in a comprehensive re-engineering of the AO oversight program to assure efficient and effective oversight of AOs. The scope of this effort was expanded by enactment of MIPPA and its provision that all national AOs and their approved programs be included in CMS' annual report to Congress.

- **Deeming Application Reviews.** Deeming application and standards reviews are conducted by a team of trained analysts to ensure consistent application of a standardized review methodology. All findings are subject to detailed supervisory review to enhance reliability and consistency. As a result, AO applications and standards are reviewed more comprehensively and consistently, and more areas for improvement are being identified and communicated to the AOs for correction before applications may be approved. In FY 2008 and thru August of FY 2009, the team completed reviews of one initial application for deeming authority and eight renewal applications as well as review of 12 sets of updates to the AOs' standards.
- **Accreditation Organization Reporting on Deemed Facilities.** The CMS continues to focus on obtaining from AOs complete, accurate and timely data regarding deemed facilities. This has been a major challenge for both CMS and the AOs. The CMS initiated developmental work on a first-ever electronic database to inventory and track AO actions that affect the deemed status of a facility. In 2009, CMS has been working with the AOs on beta testing an electronic database to track and monitor deemed facility status, survey activity, survey findings by AO, AO survey follow-up actions, and related factors for each program type. This electronic data base will enable both CMS and AOs to analyze deemed facility data, and will improve CMS oversight of the AOs and their CMS-approved accreditation programs. This electronic database will replace manual, more labor-intensive processes for AO data submissions and CMS tracking and monitoring of deemed facility activity.
- **Ongoing Communications with Accreditation Organizations.** The CMS continues its series of periodic meetings with recognized national AOs, including quarterly teleconferences and an annual meeting. These meetings serve to foster communication between the AOs and CMS and serve as a forum to discuss any issues as they arise, to better assure ongoing provider and supplier compliance with Medicare CoPs/CfCs. The CMS and individual AOs communicate on a weekly, if not daily, basis, either by email or telephone, to address a wide variety of issues related to: deemed facilities, operations, surveys, and data. In addition, CMS implemented dedicated electronic mailboxes for use by AOs when submitting deemed facility notification letters and other required reports to CMS. As of September 1, 2008, CMS required that AOs discontinue use of postal mail and use the electronic mailboxes for all communications with CMS regarding deeming facilities. Finally, CMS standardized the communication of written feedback to AOs during the deeming application review process.
- **Ongoing Education and Support of Accreditation Organizations.** Education of AO staff occurs throughout the deeming application review process. The CMS provides detailed feedback to the AOs as part of the deeming application and data review processes. This feedback includes specific reference to Medicare regulatory requirements as well as State Operations Manual references and attachments. Formal education is provided at the annual CMS-AO meeting as well as periodically at the request of individual AOs. The CMS developed and provided a resource manual to all AOs that contained a wide variety of information on CMS requirements and AO expectations.
- **Methodological Changes to Improve Oversight.** The CMS is assessing approaches to refining and improving upon the current methods for measuring AOs' performance in assuring compliance with the Medicare Conditions. In FY 2008-2009, CMS implemented first-ever

performance measures for the AOs (see Table 4). Implementation of the electronic data in FY 2010 will permit further refinement and expansion of the AO performance measures.

- **Validation Program Sample Size.** The CMS' budget for FY 2008 permitted a larger representative sample validation program than was possible in FY 2005–2007. For FY 2010, MIPPA has provided additional resources to allow further expansion of the program across deemed providers and suppliers.
- **Emergency Preparedness.** The CMS continues to collaborate and communicate with AOs on strategies for improved health care provider emergency preparedness in response to all hazards regardless of the magnitude.
- **Quality Assessment and Performance Improvement and Governance.** In FY 2007 through 2009, CMS has added to its Conditions of Participation, a requirement that hospices, transplant hospitals, dialysis facilities, and ambulatory surgery centers all have effectively-working, internal quality assessment and performance improvement (QAPI) system. Given the existing disparities between CMS and AO surveys for the current hospital QAPI requirement, we will design a plan in FY 2010 for closer work with the AOs on both QAPI and Governance aspects of onsite surveys.
- **Physical Environment.** Given continuing disparities in life safety code surveys, we will initiate a stronger plan for life safety code (LSC) skills-building with AOs for FY 2010 and FY 2011.

CLINICAL LABORATORY IMPROVEMENT VALIDATION PROGRAM

Introduction

This report on the Clinical Laboratory Improvement Validation Program covers the evaluations of fiscal year (FY) 2008 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

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

Validation Reviews

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

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

The organization's inspection findings are compared, case-by-case for each laboratory in the sample, to the CLIA validation survey findings at the condition level. If it is reasonable to conclude that one

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

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 16,000 accredited laboratories received a validation survey in 2008. 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 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: No disparity

Approximately 220 laboratories used their AABB accreditation for CLIA purposes. Five validation surveys were conducted. None of the validation surveys resulted in condition-level deficiencies, thus disparity was precluded. We note that AABB has had no disparities in 11 years of the 13-year history of CLIA validation reviews.

American Osteopathic Association

Rate of disparity: No disparity

For CLIA purposes, approximately 40 laboratories used their AOA accreditation. Eight validation surveys were conducted this year. None of the validation surveys resulted in condition-level deficiencies, thus disparity was precluded. We note that AOA has had no disparities in 12 years of the 13-year history of CLIA validation reviews.

American Society for Histocompatibility and Immunogenetics

Rate of disparity: 17 percent

Approximately 120 laboratories used their ASHI accreditation for CLIA purposes. Six validation surveys were conducted during FY 2008. No condition-level deficiencies were cited in five of the validation surveys.

In one of the validation surveys the laboratory was cited for condition-level deficiencies, and the ASHI inspection resulted in a finding of no deficiencies, thus the case was a disparity.

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

CLIA number	Location	CLIA Conditions
05D0718472	California	Laboratory Director Analytic Systems

When the pool of validation surveys is six, one disparate case causes a mathematical outcome that can be disproportionate, and should be viewed in that context as well as the historical context. This organization has had a history of a zero percentage disparity rate in the 12 annual validation reviews prior to this year. Moreover, this organization has responded to notification of the disparity in a proactive manner, by augmenting surveyor training.

COLA

Rate of disparity: 8 percent

A total of 161 validation surveys were conducted at laboratories accredited by COLA. One survey was removed from the review pool for administrative reasons. Of the remaining 160 surveys, 15 laboratories were cited with condition-level deficiencies. Comparable deficiencies were cited by COLA in two of those laboratories. In 13 of those laboratories, however, COLA noted comparable deficiencies to only some or none of the CLIA condition-level deficiencies cited, thus there were 13 disparate cases.

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

CLIA number	Location	CLIA Conditions
01D0913612	Alabama	Analytic Systems
10D1049124	Florida	Proficiency Testing—Successful Participation
14D0982226	Illinois	Laboratory Director Proficiency Testing—Successful Participation Proficiency Testing—Enrollment
17D0448574	Kansas	Laboratory Testing Personnel—High Complexity
23D0382454	Michigan	Proficiency Testing—Successful Participation
25D1056727	Mississippi	Laboratory Director Technical Consultant—Moderate Complexity
31D0684148	New Jersey	Laboratory Director Hematology
33D0140413	New York	Laboratory Director Hematology
33D1061070	New York	Pre-analytic Systems Analytic Systems
34D0017351	N. Carolina	Bacteriology
34D0247523	N. Carolina	Bacteriology
34D0248425	N. Carolina	Hematology
34D1069905	N. Carolina	Proficiency Testing—Enrollment

College of American Pathologists

Rate of disparity: 12 percent

A total of 110 validation surveys were conducted at laboratories accredited by the College. One survey was removed from the pool for administrative reasons. Of the remaining 109 surveys, 15 laboratories were cited with condition-level deficiencies. Comparable deficiencies were cited by the College in two of those laboratories. In 13 of those laboratories, however, the College noted comparable deficiencies to only some or none of the CLIA condition-level deficiencies cited, thus there were 13 disparate cases.

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
01D1030594	Alabama	Laboratory Director
04D0469263	Arkansas	Testing Personnel—Moderate Complexity Testing
05D0582575	California	Proficiency Testing—Successful Participation
05D0665986	California	Proficiency Testing—Successful Participation
17D0452730	Kansas	Testing Personnel—Moderate Complexity Testing
20D0088538	Maine	Testing Personnel—High Complexity Testing
26D0445429	Missouri	Testing Personnel—High Complexity Testing
32D0671125	New Mexico	Analytic Systems Laboratory Director
34D0655475	N. Carolina	Analytic Systems
45D0484177	Texas	Analytic Systems Hematology
46D0967215	Utah	Testing Personnel—Moderate Complexity Testing
52D0388940	Wisconsin	General Laboratory Systems
52D0393178	Wisconsin	Facility Administration General Laboratory Systems

The Joint Commission

Rate of disparity: 5 percent

During this validation period, a total of 77 validation surveys were conducted at laboratories accredited by the Joint Commission. Eight of the laboratories were cited with CLIA condition-level deficiencies. In four of those laboratories, the Joint Commission noted deficiencies comparable to all of the CLIA condition-level deficiencies cited. In the other four laboratories, the Joint Commission noted comparable deficiencies to only some or none of the CLIA condition-level deficiencies cited, thus there were four disparate cases. 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
04D0049978	Arkansas	Analytic Systems
15D0356753	Indiana	Laboratory Director Laboratory Personnel—Moderate Complexity Laboratory Personnel—High Complexity General Supervisor
17D0450820	Kansas	Laboratory Director
25D0030202	Mississippi	Proficiency Testing—Enrollment

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. This endeavor is two-fold: to verify each organization's capability to assure laboratory performance equal to, or more stringent than, that required by CLIA ("equivalency"); and to gain insight into the effectiveness of the accreditation organization's standards and accreditation process on a laboratory-specific basis.

The CMS recognizes that similarity of accreditation organization findings to CLIA validation survey findings is an important measure of the organization's capability to ensure equivalency. And, as CMS has indicated to the organizations in the last several years, another important measure is an organization's capability to ensure sustained equivalency. That is, when an accredited laboratory's practices and outcomes waiver from full conformance to the accreditation standards, does the accreditation organization's inspection protocol sufficiently identify, bring about correction and monitor for sustained correction, so that the laboratory is again in full conformance with the accreditation standards and equivalency is sustained.

In the interest of furthering the mutual goal of promoting quality testing in clinical laboratories and furthering the goal of sustained equivalency, CMS has formed the Partners in Laboratory Oversight group, which includes the six accreditation organizations, and addresses these issues on an ongoing basis. The Partners in Laboratory Oversight group meets regularly to discuss and resolve issues of mutual interest and to share best practices. This group has improved their overall consistency in application of laboratory standards, coordination, collaboration and communication in both routine and emergent situations, which ultimately improves the level of laboratory oversight.

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.

American Recovery and Reinvestment Act (ARRA) of 2009: An economic stimulus package enacted by the 111th United States Congress in February 2009. The Act of Congress was based largely on proposals made by the President and was intended to provide a stimulus to the U.S. economy in the wake of the economic downturn. The Act includes Federal tax cuts, expansion of unemployment benefits and other social welfare provisions, and domestic spending in education, healthcare, and infrastructure, including energy sector. The new Medicaid Federal Medical Assistance Percentages (FMAPs) reflect the provisions in section 5001 of ARRA, not the impact of section 614 of Children's Health Insurance Program Reauthorization Act (CHIPRA). Once the section 614 impacts on the Medicaid FMAPs are determined all of the amounts due to the states will have to be recalculated and additional grant awards issued to those states which are impacted by section 614 of CHIPRA.

B

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

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

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

C

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

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.

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

Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009: The CHIPRA extends and expands CHIP which was enacted with bi-partisan support a decade ago as part of the Balanced Budget Act of 1997 (BBA). CHIPRA adds $33 billion in Federal funds for children's coverage over the next four and half years, and is expected to provide coverage to 4.1 million children in Medicaid and CHIP who otherwise would have been uninsured by 2013.

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.

Chief Financial Officers Act of 1990 (CFO): The CFO Act of 1990 established a leadership structure, provided for long range planning, required audited financial statements, and strengthened accountability reporting. The aim of the CFO Act is to improve financial management systems and information and requires the development and maintenance of agency financial management systems that comply with: applicable accounting principles, standards, and requirements; internal control standards; and requirements of OMB, the Department of the Treasury, and others.

Corrective Action Plan: The detailed actions that are taken to resolve a finding or internal control deficiency.

Common Working File (CWF): A pre-payment claims validation and Medicare Part A/Part B benefit coordination system, which uses localized databases, maintained by a host contractor.

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 Financial Management Improvement Act of 1996 (FFMIA): The FFMIA requires agencies to have financial management systems that substantially comply with the Federal management systems requirements, standards promulgated by the Federal Accounting Standards Advisory Board (FASAB), and the U.S. Standard General Ledger (USSGL) at the transaction level.

Federal 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.

Federal Information Security Management Act of 2002 (FISMA): A law that outlines a mandate for improving the information security framework of Federal agencies, contractors and other entities that handle Federal data (i.e., state and local governments). Consists of a set of directives governing what security responsibilities Federal entities have, and it outlines oversight and management roles to the implementation of those directives.

Fiscal Intermediary Standard System (FISS): Fiscal Intermediary Standard System—The standard claims adjudication system for Part A Medicare claims.

H

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

been arranged for by the HCPP, he/she is liable for any applicable Medicare deductible and/or coinsurance amounts, and any balance would be paid by the regional Medicare carrier.

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

Hospital Insurance (HI) (Part A): 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.

J

Joint Signature Memorandum (JSM): CMS communication appropriate in the following circumstances: an administrative announcement to all contractors; an emergency alert to contractors; and a one-time request for information from all or a subset of contractors.

M

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

Material Weakness: A significant deficiency, or combination of significant deficiencies, that results in a more than remote likelihood that a material misstatement of the financial statements will not be prevented or detected.

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

Medicare Administrative Contractor (MAC): A private entity that Medicare contracts with under section 1974A of the Social Security Act, as added by the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003. MACs handle Medicare Part A and Medicare Part B claims processing and related services under the MMA.

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

Multi-Carrier System (MCS): The standard claims adjudication system for Part B Medicare claims.

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

N

National Institute of Standards and Technology (NIST): A non-regulatory Federal agency within the U.S. Department of Commerce. The NIST mission is to promote U.S. innovation and industrial competitiveness by advancing measurement science, standards, and technology in ways that enhance economic security and improve our quality of life.

O

Obligation: Budgeted funds committed to be spent.

Office of Management and Budget (OMB) Circular A-123: Circular that provides guidance to Federal managers on improving the accountability and effectiveness of Federal programs and operations by establishing, assessing, correcting, and reporting on management controls. The Circular is issued under the authority of the Federal Managers' Financial Integrity Act of 1982.

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

P

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

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

Part C: Medicare Advantage Program.

Part D: Medicare Prescription Drug Benefit.

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).

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

Statement on Auditing Standards No. 70: A report issued by an independent public accountant in accordance with standards promulgated by American Institute of Certified Public Accountants (AICPA) on the internal controls of a servicing organization. AICPA SAS 70 defines the professional standard used by a service organization's auditor to assess the internal controls at a service organization.

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

Significant Deficiency: Is a control deficiency, or combination of deficiencies, that adversely affects the ability to initiate, authorize, record, process, or report external financial data reliably in accordance with the accounting principles. More than a remote likelihood that a misstatement of the financial statements will not be prevented or detected.

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

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

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.

V

ViPS Medicare System (VMS): The standard claims adjudication system for Medicare Durable Medical Equipment (DME) claims.

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The CMS welcomes comments and suggestions on both the content and presentation of this report. Please send them to Kimberly Pollock 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

Kathleen Sebelius, Secretary

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Charlene Frizzera, Acting Administrator

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

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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