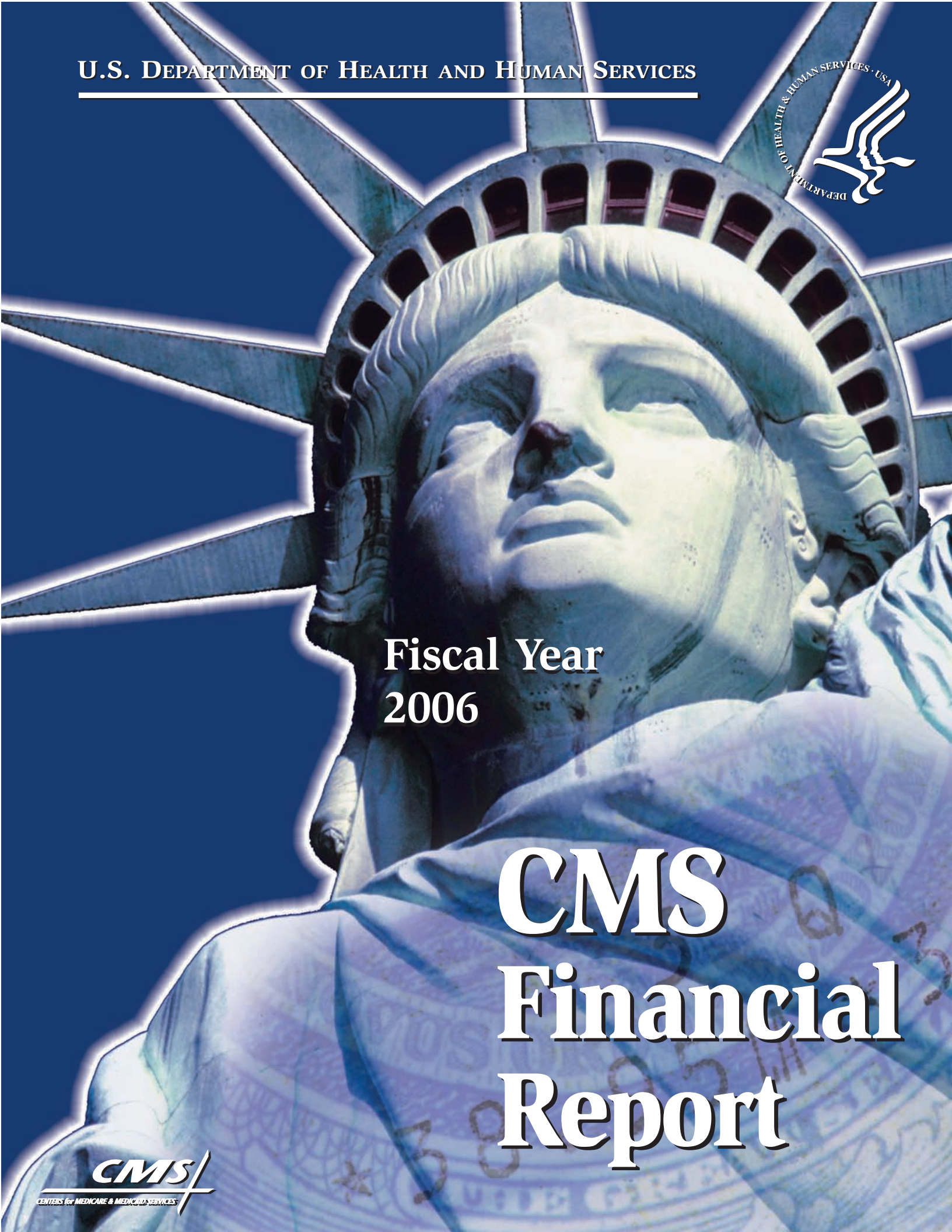
U.S. Department of Health and Human Services



Fiscal Year
2006

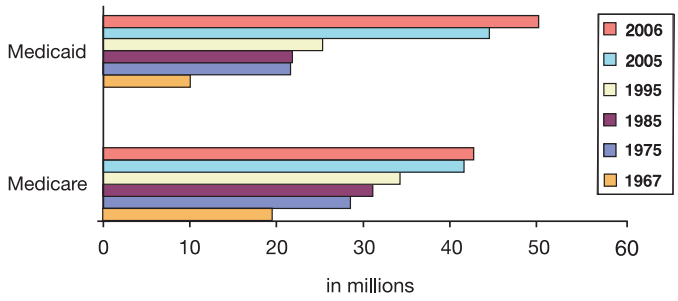
CMS Financial Report

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

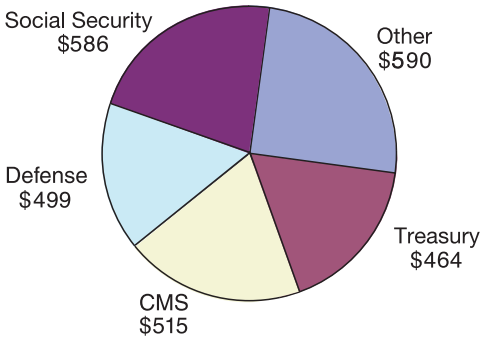
The Centers for Medicare & Medicaid Services At a Glance

The **CMS** is one of the largest purchasers of health care in the world. The Medicare, Medicaid, and State Children's Health Insurance programs that we administer provide health care for one in four Americans. Medicare enrollment has increased from 19 million beneficiaries in 1966 to approximately 43 million beneficiaries. Medicaid enrollment has increased from 10 million beneficiaries in 1967 to over 50.3 million beneficiaries.

2006 Program Enrollment



2006 Federal Outlays



Source: U.S. Treasury

$ in billions

The **CMS** outlayed approximately $515.2 billion (net of offsetting receipts and Payments to the Health Care Trust Funds) in fiscal year (FY) 2006, approximately 19 percent of total Federal outlays. The only agency that outlayed more is the Social Security Administration.

The **CMS** has approximately 4,716 Federal employees, but does most of its work through third parties. The CMS and its contractors process over one billion Medicare claims annually, monitor quality of care, provide the States with matching funds for Medicaid benefits, and develop policies and procedures designed to give the best possible service to beneficiaries. The CMS also assures the safety and quality of medical facilities, provide health insurance protection to workers changing jobs, and maintain the largest collection of health care data in the United States.

Acting Administrator
Washington, DC 20201

A Message from the Acting Administrator

The past fiscal year (FY) has brought significant change to the Centers for Medicare & Medicaid Services (CMS). We have been transforming ourselves and the way we conduct our business, so that we can achieve our mission of ensuring effective, up to date healthcare coverage and promote quality care for the millions of beneficiaries we serve. We are committed to not only meeting this mission, but to improving it as well. The efforts that we have undertaken this year to successfully meet the challenge of creating a modernized healthcare system are presented in the annual ***CMS Financial Report*** for FY 2006, which I am proud to present.

FY 2006 marked an unprecedented year for CMS with the successful implementation of the Medicare Prescription Drug Program, the most far-reaching benefit to be added to Medicare since the program began. The implementation of the new program created an enormous challenge for the Agency. However, it has brought even greater opportunities for our beneficiaries. More than 38 million people with Medicare are now receiving comprehensive prescription drug coverage through Medicare Part D, employer-sponsored retiree health plans, or other creditable coverage.

We also awarded the first 4 of 19 contracts to the Medicare Administrative Contractors (MAC) to fulfill requirements in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 to replace the current contracting authority to administer the Medicare Part A and Part B fee-for-service programs, contained under Sections 1816 and 1842 of the Social Security Act, with the new MAC authority by 2011. These contract awards not only are a major step forward to improve Medicare service for beneficiaries and providers, but also achieve significant cost savings and greater efficiency in managing the Medicare fee-for-service program.

In 2006, Congress passed the Deficit Reduction Act (DRA) to help sustain Medicare and Medicaid by slowing the pace of spending growth in both these programs. Provisions within the DRA will provide much needed reform to these two very important programs. Under the DRA, we have established a new Medicaid Integrity Program that will promote Medicaid integrity through reviews, audits, identification and recovery of overpayments, and education. Additionally, the DRA has made significant changes to the Medicaid program by providing needed flexibility to the states. We have provided considerable guidance to states on these significant changes under very short deadlines, and are working closely with states to help them take full advantage of the changes allowed under the DRA.

Recently, CMS issued its Strategic Plan for 2006-2009, which provides the roadmap for how CMS will work toward achieving our mission. The plan lays out the motivating objectives that we will use to achieve these goals—a skilled, committed and highly motivated workforce; accurate, predictable payment; high-value healthcare; confident, informed consumers; and collaborative partners. These objectives will direct our work over the next few years, while we continue to serve our beneficiaries.

In a time when CMS is attempting to transform itself from the world's largest indemnity insurer to a genuine promoter of the public's health, it is important that our actions as an Agency and as a Nation meet America's healthcare needs. I am proud of CMS' commitment to face our challenges head on while continually fulfilling its mission, and I thank all who have worked so hard to make FY 2006 a successful year. Every step we take moves CMS closer to creating a smarter, more affordable healthcare system that offers the best in American healthcare to our beneficiaries, and to the country overall.

Leslie V. Norwalk, Esq.
November 2006

A Message from the Chief Financial Officer

As the Agency's Chief Financial Officer (CFO), I am pleased again to report that our auditors have issued an unqualified opinion on our financial statements for the eighth straight year. This accomplishment reflects our accountability for the public resources entrusted to us, and the dedication and commitment of our program and financial managers to achieve stronger financial management of the $515 billion in net outlays during fiscal year (FY) 2006. To fully meet our fiduciary and operating responsibilities to our beneficiaries, we carried out a number of new initiatives and have made progress on other existing initiatives in FY 2006, which contributed to significant improvements in our financial management area.

- We successfully implemented the new requirements mandated by the revised OMB Circular A-123, *Management's Responsibility for Internal Control*. In addition, we provided a statement of reasonable assurance regarding the Agency's internal controls over financial reporting.

- As required by new Federal accounting standards, CMS has presented social insurance as a basic financial statement and this statement was audited for the first time in our FY 2006 financial statements. The Statement of Social Insurance (SOSI) is intended to help citizens assess the current financial position of the Medicare trust funds, as well as the sufficiency of future budgetary resources for its programs. The SOSI, which reports financial amounts of the Medicare trust funds in the "trillions of dollars," will be the single, largest audited financial statement in the entire Federal Government.

- Since May 2005, CMS has processed approximately 113 million claims and about $73 billion in payments through the Healthcare Integrated General Ledger Accounting System (HIGLAS). We effectively transitioned two additional contractors to HIGLAS in FY 2006, bringing the total to seven contractors that have successfully transitioned. HIGLAS, when fully implemented across all Medicare contractors and at CMS central office, will strengthen the financial management of CMS' operations by providing timely and reliable financial information to decision makers throughout the Agency.

- During FY 2006, we migrated from our legacy travel system to a new department-wide e-Travel system. Our successful and timely implementation allowed CMS to comply with the Federal Travel Regulations' mandated date for implementation of this e-Gov initiative.

The CMS also implemented a number of improvements in the management of its programs that will create additional efficiencies, improve operational processes, and assist in reducing improper payments.

- During 2006, CMS successfully consolidated and transitioned the majority of its Medicare Secondary Payer (MSP) debt management functions, traditionally performed by Medicare fee-for-service (FFS) contractors, into one MSP recovery contractor. This consolidation will achieve administrative cost savings and operational efficiencies, standardize the debt recovery process, and enhance customer service.

- As required by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), CMS initiated a three year demonstration project which uses recovery audit contractors (RACs) in identifying underpayments and overpayments and recouping overpayments under the Medicare FFS program. Currently, CMS is conducting the demonstration in the three states with the highest Medicare utilization rates: California, Florida, and New York. The CMS RAC demonstration is working on recovering $224 million in payments determined to be improper.

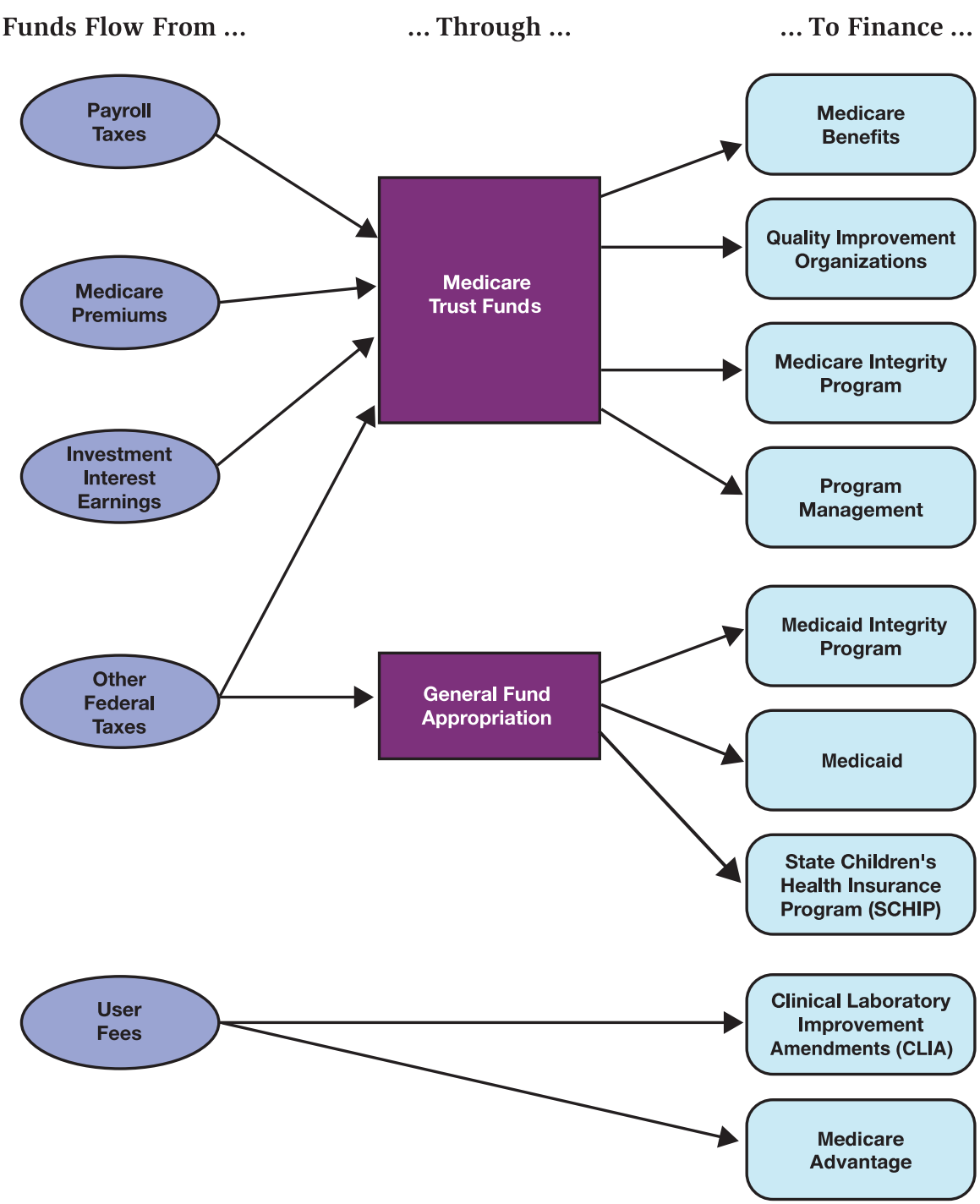
- We continue to build on our success in reducing the number of Medicare FFS payment errors. Our constant monitoring efforts of the Medicare contractors have resulted in a further reduction from last year's rate. This year's error rate is 4.4 percent.

- We have continued our program integrity efforts to improve the oversight of Medicaid and the State Children's Health Insurance Program (SCHIP) payment errors. During FY 2006, CMS reported the results on the FY 2005 Payment Error Rate Measurement (PERM) pilot that included 29 states participating to calculate their error rate in either the SCHIP and/or Medicaid programs. The CMS also published the second interim final rule in August of this FY which invites further public comment on the eligibility review process. The CMS also engaged three Federal contractors to implement the FY 2006 Medicaid FFS claims reviews in 17 states for reporting a national rate in FY 2007.

While receiving an unqualified opinion on our audited financial statements is an outstanding achievement, I recognize we will require a strong corrective action plan to address the audit issues identified by our auditors. We are committed to correcting these issues as quickly as possible. As the CFO, I am proud of our many accomplishments and stress the importance of increasing our efforts to not only reach, but to exceed our high financial management standards. We remain steadfast in maintaining the highest level of accountability for the management of the Agency's financial resources and will strive to improve our financial management performance in all areas.

Timothy B. Hill
November 2006

Financing of CMS Programs and Operations



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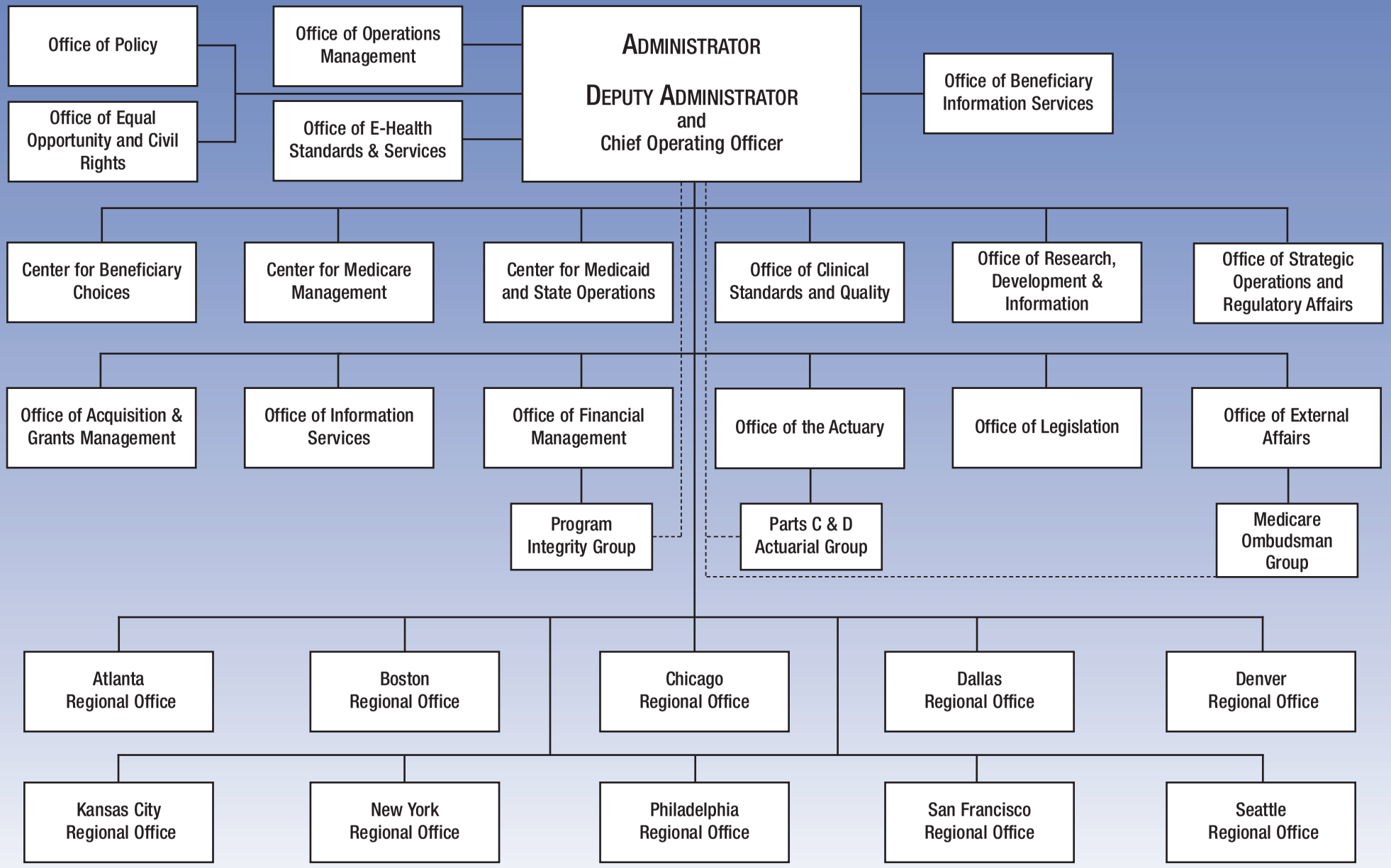
Approved Structure
As of September 1, 2006

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES



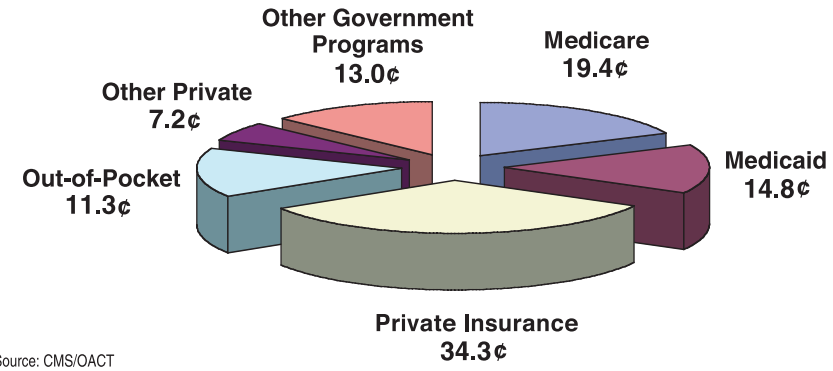
Management's Discussion and Analysis

OVERVIEW

The Centers for Medicare & Medicaid Services (CMS), a component of the Department of Health and Human Services (HHS), administers Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), and the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Along with the Departments of Labor and Treasury, CMS also implements the insurance reform provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The CMS is one of the largest purchasers of health care in the world. Based on the latest projections, Medicare and Medicaid (including State funding), represent 34 cents of every dollar spent on health care in the United States (U.S.)—or looked at from three different perspectives, 59 cents of every dollar spent on nursing homes, 46 cents of

The Nation's Health Care Dollar 2006



Source: CMS/OACT

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

The CMS **outlays** totaled approximately $515.2 billion (net of offsetting receipts and Payments to the Health Care Trust Funds) in fiscal year (FY) 2006. Our **expenses** totaled $574.3 billion, of which $3.4 billion (less than 1 percent) were administrative expenses.

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

The CMS establishes policies for program eligibility and benefit coverage, processes over one billion Medicare claims annually, matches the States with funds for Medicaid and SCHIP, ensures quality of health care for beneficiaries, and safeguards funds from fraud, waste, and abuse. The CMS employs approximately 4,716 Federal employees in Baltimore, Maryland, Washington, DC, and 10 regional offices (ROs) throughout the country. The RO employees mainly provide direct services to Medicare contractors, State agencies, health care providers, beneficiaries, and the general public. The employees in Baltimore and Washington provide funds to Medicare contractors; write policies and regulations; set payment rates; safeguard the fiscal integrity of the Medicare and Medicaid programs to ensure that benefit payments for medically necessary services are paid correctly the first time; recover improper payments; assist law enforcement agencies in the prosecution of fraudulent activities; monitor contractor performance; develop and implement customer service improvements; provide education and outreach activities to Medicare providers, survey hospitals, nursing homes, labs, home health agencies and other health care facilities for compliance with Medicare health and safety standards; work with state insurance companies; and assist the States and Territories with Medicaid and SCHIP. The CMS also maintains the Nation's largest collection of health care data and provides technical assistance to the Congress, the executive branch, universities, and other private sector researchers.

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

PROGRAMS

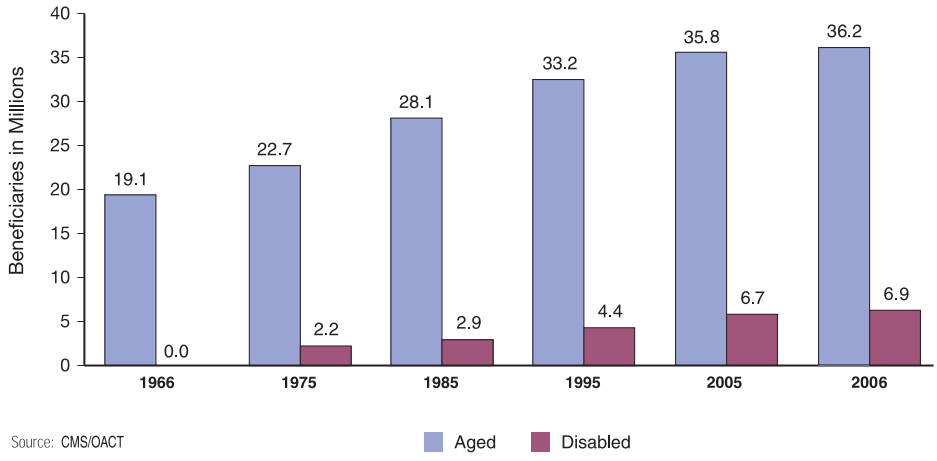
Medicare

Introduction

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

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 13 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 43 million beneficiaries.

Medicare Enrollment



Source: CMS/OACT

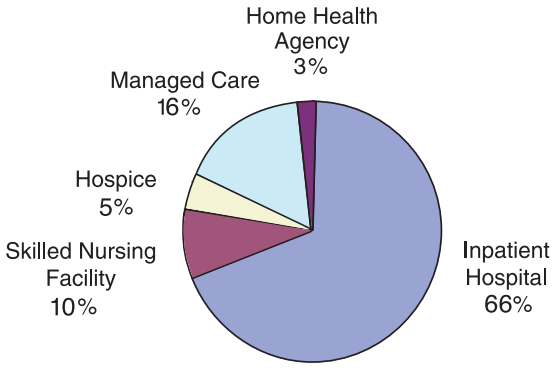
In December 2003, the President signed legislation to improve and modernize the Medicare program, including the addition of a drug benefit. This legislation—the Medicare Prescription Drug, Improvement & Modernization Act of 2003 (MMA)—represents the largest change to the Medicare program since its enactment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

Hospital Insurance

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

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

HI Medicare Benefit Payments



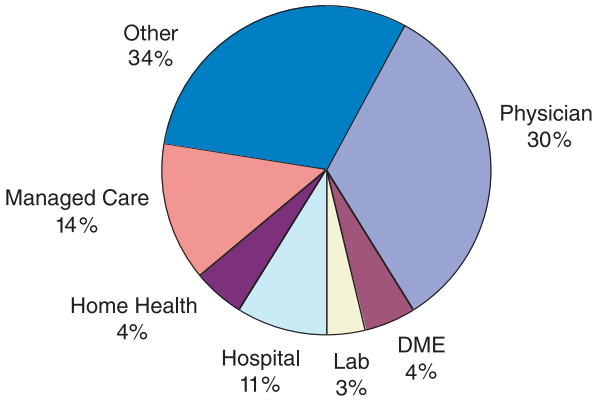
Source: CMS/OACT

Based on estimates from the Mid-Session Review of the FY 2007 President's budget, inpatient hospital spending accounted for 66 percent of HI benefit outlays. Managed care spending comprised 16 percent of total HI outlays. During FY 2006, HI benefit outlays grew by 2.4 percent and the HI benefit outlays per enrollee were projected to increase by 0.8 percent to $4,360.

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 94 percent of HI enrollees elect to enroll in SMI to receive Part B benefits.

SMI Medicare Benefit Payments



Source: CMS/OACT

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

Also based on estimates, SMI benefit outlays grew by 30 percent during FY 2006. Physician services accounted for 30 percent of SMI benefit outlays. During FY 2006, the SMI benefit outlays per enrollee were projected to increase 28.3 percent to $4,860.

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 have their own providers or a network of contracting health care providers who agree to provide health care services for Health Maintenance Organizations (HMO) or prepaid health organizations' members. MA plans currently serve Medicare beneficiaries through coordinated care plans, which include HMOs, point-of-service (POS) plans offered by HMOs, preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), and a private FFS plan. MA demonstration projects, as well as cost and Health Care Prepayment Plans (HCPPs) also exist.

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

Managed care outlays were estimated to be $54.2 billion of the total $381.9 billion in Medicare benefit payment outlays in FY 2006.

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 the most significant change 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 actuarial equivalent. The 2006 standard benefits generally have a $250 deductible and coinsurance of 25 percent after the deductible for coverage limit of $2,250. This is followed by a coverage gap for which beneficiaries pay 100 percent to an out-of-pocket spending limit of $3,600. Once the out-of-pocket spending reaches this level, the plan pays 95 percent of drugs costs for catastrophic coverage.

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

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

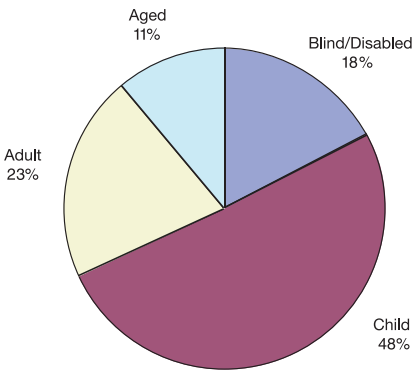
Medicaid

Introduction

Medicaid is the means-tested health care program for low-income Americans, administered by CMS in partnership with the States. Enacted in 1965 as title XIX of the Social Security Act, Medicaid was originally legislated to provide medical assistance to recipients of cash assistance. Over the years, Congress incrementally expanded Medicaid well beyond the traditional population of the low-income elderly, the blind, and disabled. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including poor families, the disabled, and persons with developmental disabilities who require long-term care. The average enrollment for Medicaid was estimated at 50.3 million in FY 2006, about 17 percent of the U.S. population. About 7 million people are dually eligible, that is, covered by both Medicare and Medicaid.

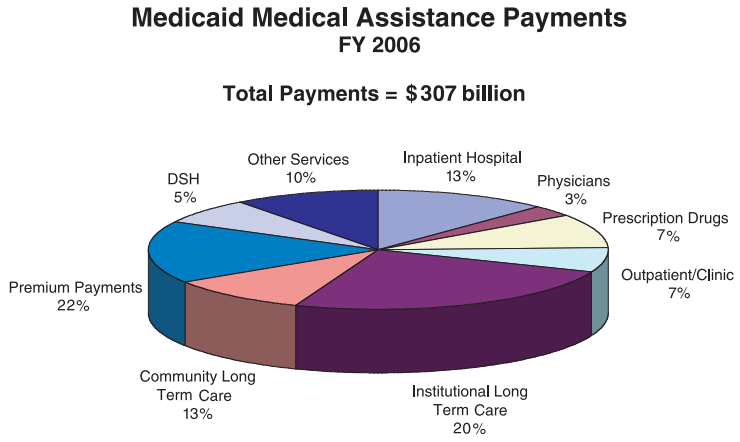
The CMS provides matching payments to the States and territories to cover the Medicaid program and related administrative costs. State medical assistance payments are matched according to a formula relating each State's per capita income to the national average. In FY 2006, the Federal matching rate for Medicaid program costs among the States according to the formula ranged from 50 to 76 percent. The average matching rate for FY 2006 was about 57 percent. Federal matching rates for various state and local administrative costs are set by statute, and currently average about 55 percent. Medicaid payments are funded by Federal general revenues 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.

FY 2006 Medicaid Enrollees



Source: CMS/OACT

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



Source: President's FY 2007 Budget, Midsession Review

population), low-income families, the medically needy, pregnant women, young children, low-income Medicare beneficiaries, and certain other groups; and covering at least 10 services mandated by law, including hospital and physician services, laboratory tests, family planning services, nursing facility services, and comprehensive health services for individuals under age 21. State governments have a great deal of programmatic flexibility to tailor their Medicaid programs to its individual circumstances and priorities. Accordingly, there is a wide variation in the services offered by the States.

Medicaid is the largest single source of payment for health care services for persons with Acquired Immune Deficiency Syndrome (AIDS). Medicaid now serves over 50 percent of all AIDS patients and pays for the health care costs of most of the children and infants with AIDS. Medicaid spending for AIDS care and treatment in FY 2006 is estimated to be about $11.4 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 2006, State and Federal ADM gross outlays are estimated at $17.9 billion, about 5.5 percent of the gross Medicaid outlays. State and Federal MAP gross outlays are estimated at $306.4 billion or 94 percent of total Medicaid gross outlays, an increase of 1.5 percent over FY 2005. Thus, State and Federal MAP and ADM outlays for FY 2006 totaled $324.3 billion. The CMS share of Medicaid outlays totaled $184.9 billion in FY 2006.

Enrollees

Children comprise nearly half of Medicaid enrollees, but account for only 18 percent of Medicaid outlays. In contrast, the elderly and disabled comprise 29 percent of Medicaid enrollees, but accounted for 65 percent of program spending. The elderly and disabled use more expensive services in all categories, particularly nursing home services.

Service Delivery Options

Many States are pursuing managed care as an alternative to the FFS system for their Medicaid programs. Managed health care provides several advantages for Medicaid

beneficiaries, such as enhanced continuity of care, improved preventive care, and prevention of duplicative and contradictory treatments and/or medications. Most States have taken advantage of waivers provided by CMS to introduce managed care plans tailored to their State and local needs, and 48 States now offer a form of managed care. The number of Medicaid beneficiaries enrolled in managed care has grown from slightly under 15 percent in 1993 to 63 percent in 2005.

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

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

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

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

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

State Children's Health Insurance (SCHIP)

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

established so families would not be burdened with out-of-pocket expenses they could not afford. Congress will consider the reauthorization of SCHIP funding during FY 2007.

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.

States have the flexibility to use SCHIP funding to increase health insurance coverage through the Health Insurance Flexibility and Accountability section 1115 initiative. The Deficit Reduction Act of 2005 (DRA) established a prohibition of using Federal SCHIP funds to provide health benefits coverage to nonpregnant childless adults. States that submit a section 1115 demonstration application on or after the October 1, 2005 effective date of this DRA provision can no longer obtain title XXI funds to provide coverage for nonpregnant childless adults.

The CMS works closely with the States, Congress, and other Federal agencies to meet the challenges of implementing this program. The CMS provides extensive guidance and technical assistance so the States can further develop their plans and use Federal funds to provide health care coverage to as many children as possible. Since September 30, 1999, all 50 States, the District of Columbia, and the territories had approved SCHIP State plans, 17 Medicaid expansions, 18 separate SCHIPs, and 21 programs that are combination plans.

Other Activities

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

Survey and Certification Program

We are responsible for assuring the safety and quality of medical facilities, laboratories, providers, and suppliers by setting standards, training inspectors, conducting inspections, certifying providers as eligible for program payments, and ensuring that corrective actions are taken where deficiencies are found. The survey and certification program is designed to ensure that providers and suppliers comply with Federal health, safety, and program standards. We administer agreements with State survey agencies to conduct onsite facility inspections. Funding is provided through the Program Management and the Medicaid appropriations. Only certified providers, suppliers, and laboratories are eligible for Medicare or Medicaid payments. Currently, CMS Survey and Certification staff oversee compliance with Medicare health and safety standards in over 257,000 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. In partnership with the States, we certify and inspect more than 21,300 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, (2) the Centers for Disease Control and Prevention (CDC) provides research and technical support, and (3) the FDA performs test categorization.

Health Care Quality Improvement

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

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

The CMS' vision for quality improvement is the right care for every person every time. To accomplish it, CMS will influence both the health care system and the care that is delivered so it can be made safe, effective, timely, patient-centered, efficient, and equitable—the aims that correspond to the Institute of Medicine's (IOM's) ***Crossing the Quality Chasm*** report.

To achieve these aims, CMS utilizes regulation and enforcement activities, improved consumer information, community-based quality improvement programs, as well as collaboration and partnership. One of CMS' resources is its Quality Improvement Organizations (QIOs), Medicare contractors that work to improve quality of care, measure and reduce the incidence of improper FFS inpatient payments, and address beneficiary complaints and patterns of potentially substandard care.

Congress created the QIO Program in 1982 to provide a nationwide network of health care organizations to help practitioners and providers improve. This year, CMS announced its own extensive internal review and improvements to the QIO Program based on recommendations provided by the IOM. The Program, currently mid-way under a three-year contract, continues to help providers move toward a more dynamic and evolving public reporting and value-based purchasing quality improvement environment. QIOs, working with providers in four priority settings—hospitals, physician offices, nursing homes, and home health—are helping them employ best practices to eliminate errors and improve quality of care.

In order to ensure value to every taxpayer, some studies show that CMS' quality agenda is demonstrating improvement in quality measures and achieving a greater degree of improvement among providers who work with QIOs more intensively. The most recent publication of results reflecting Program value was published in the ***Annuals of Internal Medicine*** on September 5, 2006. As one of the major improvements CMS has outlined for the Program, it is committed to further strengthening the evaluation and impact of the Program.

QIOs also work on CMS' national agenda for the Government Performance and Results Act (GPRA), with goals that include priorities for improving adult immunization rates and diabetes care, optimizing the timing of antibiotics prior to surgery, and increasing vascular access for hemodialysis patients, and reducing the prevalence of pressure ulcers and the use of physical restraints in nursing homes.

Through innovative partnerships, public reporting and its QIOs, CMS has achieved greater momentum toward IOM's six aims. Through its public-private collaboration with the Hospital Quality Alliance (HQA), CMS provides a robust, prioritized, and standardized set of hospital quality measures for use in voluntary public reporting. Medicare beneficiaries, as well as all consumers, can access ***Hospital Compare***, a web tool that provides valid, credible, and user-friendly information about the quality of care delivered in the Nation's hospitals. To date, more than 92 percent of approximately 4,000 participating U.S. hospitals are reporting at least the 10 clinical "starter" measures. Additionally, 36 percent of participating hospitals reporting all 20 measures are posted on ***Hospital Compare***.

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

Kidney dialysis patients stand to benefit from CMS efforts around the Fistula First, a consumer and provider awareness initiative to improve the use of fistulas as the preferred form of vascular access for dialysis. Fistula First is a key component of Medicare's ESRD Quality Initiative.

ESRD is Medicare's only disease-specific program that entitles people of all ages to Medicare coverage on the basis of their diagnosis. The objective of the ESRD Quality Initiative is to stimulate and support significant improvement in the quality of dialysis care. Through partnerships as well as contracts with its 18 ESRD Networks, CMS is collaborating with dialysis providers, primary care physicians, nephrologists, and others to promote the need to double the percentage of patients with fistulas over the next five years.

In the nursing home setting, CMS participated in the formation of a coalition with groups representing healthcare providers, caregivers, medical and quality improvement experts, government agencies, consumers and others to launch a new two-year *Advancing Excellence in America's Nursing Homes* campaign. The campaign seeks excellence in the quality of life and quality of care for the more than 1.5 million American nursing home residents by enhancing choice, strengthening workforce, and improving clinical outcomes. Nursing homes participating in the campaign will work on goals and can access technical assistance and guidance from quality experts, such as QIOs, in reaching their targeted goals.

Consumers participating in the campaign will help to create greater awareness of quality care and the resources available now, and encourage providers to improve the care they deliver. The campaign will report on providers' continuing quality improvement progress overall, and those reports will inform consumer choices for future long term care needs.

In physician offices, QIOs are promoting the CMS quality agenda through their work with doctors to help create systems that better match an individual patient's needs by using technology to track patient histories and treatments. The Doctor's Office Quality Improvement Technology (DOQ-IT) project support physician offices to transform care, improve the management of chronic diseases, and improve preventive healthcare services, such as cancer screening and adult immunizations by reducing human error and automatically identifying risk factors.

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. QIOs are working to improve performance measure results among underserved populations in the clinical areas of breast cancer, adult immunizations, and diabetes.

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 new CMS contract. QIOs are helping home health agencies improve performance measures on CMS' ***Home Health Compare*** and implement telehealth technology—such as video and phone monitoring, or direct access to the information on a monitoring machine in a patient's home.

Coverage Policy

Medicare is a leader in evidence-based decision making for coverage policy. Coverage policy affects every insurer and health care purchaser in today's health care market. The CMS has established a process that provides current information on coverage issues on the CMS coverage web site and also facilitates input from all stakeholders, including beneficiaries and health care experts, through the two public comment processes that occur for every National Coverage Determination. The CMS also involves the public through its Medicare Coverage Advisory Committee (MCAC). The MCAC is comprised of a panel of consumer, industry, and patient advocate members; moreover, each of the 5 to 6 meetings held each year include opportunities for the general public to participate. We also rely on state-of-the-art technology assessment and support from other Federal agencies.

Insurance Oversight and Data Standards

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

We are responsible for implementing and enforcing most of the HIPAA Title II administrative simplification provisions, which are aimed at increasing electronic health transactions to simplify administration and reduce administrative costs. Title II of HIPAA requires HHS to adopt uniform national standards for the electronic transmission of certain health information. As a result, "covered entities" such as health care providers who do business electronically, health plans and clearing houses, and their business

associates must use the same health care transactions, code sets, and identifiers. HIPAA requires that adopted standards be used for any electronic transmission of specified transactions, including claims payment, remittance advice, and coordination of benefits. Title II of HIPAA also requires that patients' personal health information be maintained securely while being stored or transmitted.

In September of 2005, we published a Notice of Proposed Rule Making (NPRM) proposing electronic standards for claims attachments. This is one of the standards required by HIPAA Title II, and involves the sending of "additional" information for specific types of claims and circumstances. The comment period for this ended in January 2006. During FY 2006, we have been reviewing and analyzing comments, and working with the appropriate Standards Developing Organizations (X12 and HL7) to revise the standards based on the comments.

Under enforcement, we continue to operate based on responding to complaints filed against covered entities. Through FY 2006, we have received 491 transaction and code set complaints and completed action on 420, and received 148 security complaints and completed action on 63 of those.

We are also responsible for implementing standards for electronic prescribing in the Medicare Part D program. Three foundation standards for electronic prescribing were effective January 1, 2006, and were required to be supported by Medicare Part D plans.

PERFORMANCE GOALS

GPRA mandates that agencies have strategic plans, annual performance goals, and annual performance reports that make them accountable stewards of public programs. The CMS has embraced that charge and has emphasized the themes of accountability, stewardship, and a renewed focus on the customer with its strategic and annual goals and its mission to "assure health care security for beneficiaries."

The CMS' approach to performance measurement under GPRA is to develop goals that are representative of our vast responsibilities. The CMS performance budget describes its performance goals and their linkage to long-term strategic goals, while also complementing and supporting the CMS budget submission. The performance budget includes the steps to accomplish each performance goal, and establishes a method and data source for measuring and reporting. The CMS uses performance information to identify opportunities for improvement and to shape its programs.

The CMS annual performance goals also reinforce the President's Management Agenda (PMA). For example, the performance goal to reduce the percentage of improper payments made under the Medicare FFS program is reflected in the PMA Improper Payments scorecard. Performance goals are also key to the Office of Management & Budget's Program Assessment Rating Tool (PART) and support the PMA objective of integrating budget and performance.

The FY 2006 performance budget includes 31 goals for CMS programs, highlighting major program areas. The performance budget does not reflect every activity and challenge encountered by the Agency. Instead, it reflects key Administration and CMS

priorities that are representative of the vital activities CMS performs to fulfill its mission. The performance goals reflect a sensitivity to customer needs and an awareness that meeting those needs will require flexibility and imagination as well as sound business sense.

Some of CMS' key FY 2006 performance goals and outcomes are highlighted below. Progress on all of the goals will be submitted with the FY 2008 President's budget request.

Implement the New Medicare Prescription Drug Benefit

The MMA provides all Medicare beneficiaries access to prescription drug coverage and the buying power to reduce the prices they pay for drugs as of January 2006.

The first part of the FY 2006 target was to implement a Part D claims data system, oversight system, and contractor management system. The CMS has completed the implementation of management processes and IT infrastructure necessary to manage the Part D program. The successful implementation of systems addressing claims, oversight, and contractor management enabled CMS to implement the Part D program on time and established the foundation for a strong program management structure that will reliably deliver prescription drugs to Medicare beneficiaries at a reduced price.

The second part of the FY 2006 target was to improve upon the baseline data collected in FY 2005 for the following measures: 1) percentage of Medicare beneficiaries that are aware that Medicare will be/began offering prescription drug coverage starting in 2006 (FY 2006 target—49.4 percent); 2) percentage of beneficiaries that know that out-of-pocket costs will vary by the Medicare prescription drug plan (FY 2006 target—52.5 percent); and 3) percentage of beneficiaries that know that all Medicare prescription drug plans will not cover the same list of prescription drugs (FY 2006 target—28.4 percent). Based on the results from the FY 2006 National Medicare Education Program Assessment Survey, CMS met the targets for each of these measures.

Improve Satisfaction of Medicare Beneficiaries with the Health Care Services they Receive

In order to reliably monitor and measure Medicare beneficiaries' experience and satisfaction with the care they receive, CMS developed the Consumer Assessment Healthcare Providers and Systems (CAHPS). These surveys are fielded annually to representative samples of beneficiaries enrolled in each Medicare managed care (i.e. Medicare Advantage (MA)) plan as well as to those enrolled in Medicare fee-for-service (MFFS).

As a result of the MMA, the focus of this performance goal shifts to MMA-related measures that will track beneficiary experience and satisfaction with the care and services provided through the new Medicare Prescription Drug Plans (PDPs) as well as the MA and MFFS health plans. Planning for the new Medicare CAHPS Surveys began in FY 2005 and continued through FY 2006. The FY 2006 performance target to continue development of survey instruments and sample designs for implementing the revised MA, MFFS, and PDP surveys was met. CMS continued to work with the CAHPS Consortium through the Agency for Healthcare Research and Quality (AHRQ) and developed a field test version of the 2006 Medicare CAHPS survey that was implemented in four states in the summer and fall of 2006. The field test results will be used to finalize the survey instruments that will

then be implemented nationally in early 2007 and ask about enrollees' experiences with the Medicare health and prescription drug plans they had in 2006. This developmental performance goal will generate MMA measures that will be used to create new baselines and targets for subsequent years.

Through FY 2005, measures related to access to care and specialist physicians were collected for beneficiaries in MA plans. Similar measures were collected for enrollees in the MFFS through FY 2004. (Due to competing funds and in light of the future changes to the Medicare CAHPS, the MFFS survey was not fielded in FY 2005.) The FY 2005 MA target for Access to Care was not met with final data at 90 percent (target of 93 percent); however, we maintained our already high level of performance. We exceeded our target for Access to Specialists at 93 percent (target of 86 percent).

Protect the Health of Medicare Beneficiaries Age 65 Years and Older by Increasing the Percentage of those who Receive an Annual Vaccination for Influenza and a Lifetime Vaccination for Pneumococcal

The CMS maintains contracts with independent physician organizations under the Quality Improvement Organization program to ensure that medical care paid for under the Medicare program is reasonable and medically necessary, meets professionally recognized standards of health care, and is provided in the most economical setting.

For all persons age 65 or older, the Advisory Committee on Immunization Practices (ACIP) and other leading authorities recommend lifetime vaccination against pneumococcal disease and annual vaccination against influenza. Through collaboration among CMS, CDC and the National Coalition for Adult Immunization (NCAI), efforts are ongoing to improve adult immunization rates in the Medicare population.

Based on recent challenges concerning influenza vaccine supply and distribution, CMS recently refocused this performance goal from the general Medicare population to nursing home residents, beginning in FY 2006, to achieve greater impact in the long-term care setting. Therefore, our FY 2006 target for nursing home influenza vaccination is 74 percent. Our FY 2006 national pneumococcal vaccination target is 69 percent. Final data on these targets will be available December 2007.

According to the most recent data (FY 2004), at 72.8 percent for influenza vaccination, we met our national target of 72.5 percent, and fell short, at 67.4 percent, of our pneumococcal target of 69 percent. Final FY 2005 data for national influenza and pneumococcal performance will be available December 2006.

In recent years, there have been influenza vaccine shortages and distribution delays, which have impacted the delivery of immunizations. Traditionally, pneumococcal immunizations are given by health care providers along with the influenza immunization, so it is possible that disruptions of influenza vaccine supply also impact pneumococcal vaccination rates.

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

The CMS FY 2006 target was to increase the enrollment of children in SCHIP and Medicaid by 3 percent, or approximately one million, over the FY 2005 level. Final FY 2006 enrollment data will not be available until March 2007. In prior years, CMS has consistently met its enrollment targets.

Through title XXI of the Social Security Act, the States were given the option to expand their Medicaid program, establish a separate SCHIP, or use a combination of both. The SCHIP and Medicaid programs have enhanced the availability of health care coverage to improve the quality of life for millions of vulnerable, uninsured, low-income children. Consistent with the purpose of the programs, CMS has established this goal to increase the number of children enrolled in SCHIP and Medicaid.

Improve the Health Care Quality Across Medicaid and SCHIP

The CMS believes that performance measurement information can improve service delivery to those individuals served by the Medicaid and SCHIP programs. The CMS and the States developed a strategy for the coordinated use of performance measures for Medicaid and SCHIP programs for quality improvement in both FFS and managed care delivery systems. As CMS and the States proceed to implement this mutually agreed upon strategy, multiple approaches to using performance measures to achieve improvements in health care quality will be identified.

The CMS began working with the States to jointly explore a strategy for State and Federal use of performance measures. The Performance Measurement Partnership Project (PMPP) is a course of action developed to use reliable and valid performance measures to quantify and stimulate measurable improvement in the delivery of quality health care. The PMPP is CMS' first effort to develop performance measures based on consensus and voluntary State participation. CMS will use the results from the PMPP, as well as other quality efforts, as the building blocks for the development of a national framework for Medicaid quality. This framework will be developed in collaboration with States and key stakeholders.

The CMS met its FY 2006 Medicaid target to collect on a voluntary basis, 2003 performance measurement data from a minimum of 13 States and to continue to provide technical assistance to the States to continue performance measurement calculation and reporting.

The CMS met its FY 2006 SCHIP target to improve reporting by States on core performance measures in order to have at least 25 percent of States reporting four core performance measures in the FY 2005 SCHIP Annual Report.

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 2006 target for the Medicare FFS error rate was 5.1 percent (gross) with a baseline of 10.1 percent in 2004.

The error rate estimate consists of CMS' two Medicare FFS measurement programs: the Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring Program (HPMP). This year, CMS sampled approximately 139,000 claims for CERT and approximately 41,000 discharges for HPMP. These programs provide CMS with a rigorous set of data that CMS can use to manage Medicare contractors, identify and prevent errors, and educate providers that bill CMS programs.

The CMS analysis for FY 2006 indicates that the gross paid claims error rate is 4.4 percent or $10.8 billion in gross improper payments.

The CMS met its goal for FY 2006. The CMS is continually working with the contractors that pay Medicare claims and the QIOs on aggressive efforts to lower the paid claims error rate, including: (1) developing a tool that generates State-specific hospital billing reports to help QIOs analyze administrative claims data, (2) increasing and refining one-on-one educational contacts with providers found to be billing in error, (3) developing projects with the QIOs to address State-specific admissions necessity and coding concerns, as well as to facilitate the surveillance and monitoring of inpatient payment error trends by error type, and (4) developing new data analysis procedures to assist CMS in identifying aberrant payments and use that information in order to stop improper payments before they occur. The CMS has directed Medicare contractors to develop local efforts to lower the error rate by developing plans that address the problems that result in errors. These plans must specify the steps they are taking to fix the problems and other recommendations that will ultimately lower the error rate.

The CERT program is an important tool in monitoring contractor performance. It provides CMS with the fundamental structure to hold the FFS contractors accountable for the services they provide as CMS moves from contracts that simply pay contractors to process Medicare claims to performance-based contracts.

FINANCIAL ACCOMPLISHMENTS AND STATEMENT HIGHLIGHTS

For the eighth 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. The strategic vision for financial management at CMS is to develop and maintain a strong financial management operation to meet the changing requirements and challenges of the twenty-first century as we continue to safeguard the assets of the Medicare trust funds. To accomplish this vision, CMS implemented many initiatives throughout CMS—although all may not be discussed in detail here. Some of the initiatives were new for FY 2006; some are carry-overs from

prior years. However, 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. These initiatives reflect CMS' efforts to consciously address the annual financial statement audits' results and recommendations and make improvements in its operations.

Healthcare Integrated General Ledger Accounting System

Although the Medicare contractors' claims processing systems are operating effectively in paying claims, they were not designed to meet the requirements of a dual entry, general ledger accounting system. As a result, they do not meet the provisions of the Federal Financial Management Improvement Act of 1996 (FFMIA). Therefore, a key element of our strategic vision is to acquire a FFMIA-compliant financial management system that will include all Medicare contractors. This project is called the Healthcare Integrated General Ledger Accounting System (HIGLAS). As part of this effort, CMS will replace the Financial Accounting and Control System (FACS), which accumulates all of CMS' financial activities, both programmatic and administrative, in its general ledger.

Following the guidance of the Office of Management and Budget (OMB) Circular A-130, *Management of Federal Information Resources*, CMS acquired a commercial off-the-shelf (COTS) product for HIGLAS. IBM is the systems integrator, and is providing application service provider services. Oracle Corporation is providing the financial accounting software. Implementing an integrated general ledger program will give CMS enhanced oversight of contractor accounting systems and provide high quality, timely data for decision making and performance measurement.

The HIGLAS project began as a pilot program with one of the largest Medicare FFS contractors (Palmetto Government Benefit Administrators) that processes primarily hospital and other institutional claims, and another large Medicare contractor (Empire Medicare Services) that processes primarily physician and supplier claims. The pilot phase resulted in the reengineering of the accounting business processes of the pilot Medicare contractors to support the accounting software. The pilot phase culminated with the successful production cut-overs at both Palmetto Government Benefit Administrators—Part A in May 2005, and Empire Medicare Services—Part B in July 2005. Since that time CMS has deployed HIGLAS at five additional Medicare contractors, Empire Medicare Services (Fiscal Intermediary), First Coast Service Options (Fiscal Intermediary), Trailblazer Health Enterprises (Fiscal Intermediary), Mutual of Omaha Insurance Company (Fiscal Intermediary), and TrailBlazer Health Enterprises (Carrier). 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 121 million claims and processed 5.7 million payments worth $78.7 billion. HIGLAS will not only enable CMS' compliance with FFMIA, the new system will also strengthen management of Medicare accounts receivable and allow more timely and effective collection activities on outstanding debts. These improvements in financial reporting by CMS and its contractors are essential to retaining an unqualified opinion on our financial statements, meeting the requirements of key Federal legislation, and safeguarding government assets.

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.

Communication

During FY 2006, CMS continued with its Risk Management and Financial Oversight Committee which holds monthly meetings with designated members of CMS' senior management on issues that have a direct or indirect effect on CMS' financial management processes. The purpose of this committee is three-fold. The committee (1) ensures that any issue causing legal, operational, or financial risk impacting the preparation of accurate and complete financial statements or completion of the CFO audit are discussed and resolved in a timely manner; (2) ensures that detailed corrective action plans addressing all findings from CMS' annual financial statement audit are developed and timely implemented; and (3) assists in the oversight responsibilities for (a) the integrity of the Agency's financial statements, (b) the Agency's compliance with legal and regulatory requirements and (c) the proper functioning of internal controls, including the assessment and documentation of such as outlined in the OMB Circular A-123, *Management's Responsibility for Internal Control*. This committee ensures effective communication and a coordinated process among cross-functional areas within CMS.

Financial Reporting

The CMS continued to prepare "white papers" to ensure that any significant changes/updates to CMS' accounting and financial reporting policies are properly evaluated by the management in the Office of Financial Management and approved in writing. This process ensures that changes are implemented in an effective and efficient manner and that changes/updates to the financial statements conform to generally accepted accounting principles.

We continued preparing automated financial statements directly from FACS, which includes all financial data, including data provided by Treasury's Bureau of Public Debt and other Federal agencies. This enabled the system to produce an audit trail documenting manual adjustments made to accounts that affect the financial statements. We also produced interim financial statements for the quarters ending December 31, 2005, March 31, 2006, and June 30, 2006, and submitted our financial statements through the automated financial statement system implemented by HHS.

As required by the Statement of Federal Financial Accounting Standards (SSFAS) Numbers 25, *Reclassification of Stewardship Responsibilities*, CMS is presenting social insurance as a basic financial statement for the first time in our FY 2006 year end financial statements. 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 2006 reporting requirements for the Federal Agencies Centralized Trial Balance System (FACTS) I and II. We continued to improve the operation of FACS by programming and implementing numerous accounting

enhancements. These changes ensured that we met new program and Treasury requirements, as well as improved our administrative and accounting operations and controls.

Recovery Audit Contractor

The CMS is required under the MMA to conduct a three year demonstration project to demonstrate the use of recovery audit contractors (RACs) in identifying underpayments and overpayments and recouping overpayments under the Medicare FFS program. Currently, CMS is conducting the demonstration in the three states with the highest Medicare utilization rates: California, Florida, and New York.

CMS has provided the RACs with $167 billion worth of claims submitted between FY 2002 and 2005. Depending on their contract, the RACs review the claims to see if they were correctly coded, medically necessary, and consistent with the Medicare billing rules or for potential Medicare Secondary Payer occurrences where a beneficiary had access to another Group Health Plan insurer and Medicare should not have paid the claim as primary. During FY 2006, the recovery audit contractors identified $293 million in overpayments and $10 million in underpayments for a total of less than one percent of the claims available for review. CMS is working on recovering $224 million in payments determined to be improper.

Debt Management

Through our Medicare contractors, we collect the majority of our debt because most overpayments are recognized timely, thus allowing future claims to be offset against current overpayments. 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 cross-servicing. Debts referred for cross-servicing can have a variety of collection activities, 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 2006, we referred about 98 percent of the delinquent debt eligible to be referred to Treasury for cross-servicing.

Administrative Payments

We also made important accomplishments in our administrative payment areas. We continued to pay all of our administrative payments on time in accordance with the Prompt Payment Act. Over 96 percent of our vendor reimbursements and virtually 100 percent of our travel reimbursements are made electronically.

Budget Execution

For FY 2006, CMS' budget execution function continues to be a major strength. The CMS established a Chief Operating Officer who works closely with the Chief Financial Officer to ensure that an operating plan is developed timely and supports CMS' priorities. Strong fund

control procedures ensure resources are only used for those activities in the operating plan that have been approved by the Administrator. The CMS closely monitors available resources throughout the year to ensure the Anti-Deficiency Act is not violated, while at the same time meeting reasonable but aggressive lapse targets.

Medicare Secondary Payer (MSP)

The CMS efforts in the MSP area saved the Medicare trust funds approximately $4.9 billion through the first 9 months of FY 2006. 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 through the first 9 months of FY 2006, about $800.7 million. With the resumption of normal Internal Revenue Service/Social Security Administration/CMS Data Match (DM) operations in FY 2004 through the present, savings attributed to DM increased significantly over the past two years to $483 million for the first 10 months of FY 2006, which annualizes to an estimated FY 2006 total of $580 million. The CMS expects savings attributable to the MSP Program to continue to grow through FY 2007 as improved methods of collecting MSP are expanded.

The CMS continues to pursue Voluntary Data Sharing Agreements (VDSAs) with insurers and large employers to secure health care coverage information on working enrollees and dependents. Currently 161 insurers, large employers, and pharmacy benefit managers have signed VDSAs with CMS. Although CMS suspended the signing of new VDSAs for 6 months while the VDSA process was modified to implement some of the new MMA data collection requirements, interest in the VDSA process is higher than ever. The CMS expects many new agreements to be signed during FY 2007 as more employers, insurers, and pharmacy benefit managers take advantage of the VDSA program to coordinate the new MMA drug benefit with Medicare. Overall savings attributed to this program were $497 million for the first 10 months of FY 2006. This annualizes to a projected FY 2006 total of $597 million and will represent a significant increase over the $476 million in savings achieved in FY 2005. The CMS expects savings from the VDSA program to continue to grow in FY 2007 as more new agreements are signed and implemented.

In addition, the CMS continues to broaden the Workers' Compensation (WC) DM initiative, which involves data sharing agreements with State WC boards and commissions and large WC insurers. The CMS launched this effort in FY 2003 with the signing of the first WC DM agreement with the State of California. The CMS has since executed five more agreements. They have resulted in the creation of many new MSP auxiliary records and represent some $6.8 million in cost avoided savings to the Medicare program. Agreements with the States of Florida and Texas were implemented. We are in negotiations with the States of New Jersey, Pennsylvania, Michigan, Nebraska, and Wisconsin, as well as two large WC insurance firms.

The CMS has a contractor to review proposed Workers' Compensation Medicare Set-aside Arrangements (WCMSA) amounts. During the first ten months of FY 2006, the contractor has approved WCMSA amounts totaling approximately $250 million

(payments that Medicare might have otherwise erroneously made). In FY 2006, CMS invested considerable effort in WC outreach and education for our MSP partners; as a result, submissions of WCMSAs for CMS review and approval continue to increase.

Effective August 15, 2006, the CMS consolidated all of the functions related to recovering MSP Group Health Plan (GHP) and "non-GHP" (Workers' Compensation, no-fault, and liability) debts into one MSP Recovery Contractor (MSPRC). Previously, the Medicare FFS contractors performed these functions. The new contractor is currently working with the outgoing contractors to transition the relevant workload for implementation on October 2, 2006. This consolidation will achieve administrative and operational efficiencies, standardize the recovery process, and enhance customer service.

Medicare Integrity Program

Program Integrity is continuing its aggressive local efforts and adding four new Medicare Drug Integrity Contractors (MEDICs) to 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, and work with key partners to enforce Medicare's rules and protect consumers from potential scams.

Program Safeguard Contractors produced $320 million dollars in savings for Medicare Parts A and B for calendar year 2006 by identifying overpayments, referring more than 320 cases to law enforcement, and taking other administrative actions such as payment suspensions and prepaid claims edit denials. In 2006, Program Integrity expanded its satellite offices in Miami and Los Angeles, providing additional on-the-ground efforts to identify and report fraud, waste, and abuse in Medicare. The satellite offices implemented several fraud and abuse initiatives that have resulted in trust fund savings and recoupments. Some of the satellite office initiatives include the Infusion Taskforce, Beneficiary Identity Theft program, and the Independent Diagnostic Testing Facilities program.

Medicaid Integrity Program

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

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

Medicare Advantage and Prescription Drug Oversight

In 2006, CMS developed a suite of tools to oversee the Medicare Prescription Drug Benefit. This included development of a Part D audit guide; audit checklists and worksheets; a Part D audit discussion guide; and a Part D audit standard operating procedure. These tools assist CMS in ensuring the accuracy of Part D payments.

The CMS recruited staff during FY 2006 to oversee the development of payment error rates for Part C, Part D, and Retiree Drug Subsidy Programs (RDS). The CMS also awarded a contract to assist with the error rate development. During FY 2007, the contractor will perform a risk assessment and develop a pilot methodology to evaluate a selected risk element. Results of the first pilot will be reported in the FY 2008 Performance and Accountability Report (PAR).

Over the past year, the CMS has made several accomplishments to reduce the application processing review time and automate certain functionalities related to the application process. The CMS reduced the number of weeks to review an MA application from 19 weeks to 8 weeks, re-wrote and developed the managed care application standard operating procedures and utilized the Health Plan Management System (HPMS) Application Module to capture application information and communicate with applicants electronically to send automatic notification. The CMS, with a technology vendor, developed a sophisticated computer-based tool to review plan benefit packages for discriminatory benefit designs and review benefits for high cost sharing and other potential benefit problem areas. The CMS also used a contractor to assist in the review of the 2006 Application cycle due to the high volume of applications received due to the implementation of MMA. In addition, during FY 2006, the CMS developed policies and procedures to document critical elements of Managed Care operations related to the acceptance, approval, and monitoring of demonstration projects.

The CMS has also reduced the number of unsettled managed care cost reports. In FY 2006, CMS reduced the backlog of unsettled managed care cost reports by 16. Disallowances resulting from FY 2006 settlement activity amounted to about $33.5 million. For FY 2006, CMS had a rate of return of 36 to 1. The remaining backlog still represents a challenge to CMS because these cost reports have critical issues that must be resolved with Managed Care Organizations. These reports may eventually need many audit adjustments. Thus, many of the more recent cost reports sent to audit have fewer issues.

Enhancements to Part C and D Payment Validation and Authorization Process

The CMS enhanced the procedures used to validate and authorize payments for Medicare Advantage and the Part D benefit by developing a sophisticated payment analyses to support payment authorization. The Beneficiary Payment Validation (BPV) process is conducted to validate payments before each monthly payment decision is made. The BPV is driven by a series of complex SAS programs which are run in a short 3 to 5 day timeframe. The BPV involves first, validating beneficiary level demographic and risk factor information used in the MARx payment calculation, and then second, confirming the accuracy of the monthly MARx payment calculations by recalculating prospective payments outside of the MARx system for 100% of the beneficiary population.

The CMS has improved the process of tracking payments across the different payment systems. An enhanced payment reconciliation process has been added to link MARx payments passed onto the Automated Plan Payment System (APPS) and the Financial Accounting System (FACS.) This process is now being employed to evaluate, on a monthly basis, the accurate transfer of payments across the different payment systems.

The CMS has also expanded and improved the use of controls and documentation in the monthly payment process. New controls include the monthly payment validation tables highlighting payment anomalies, checklists to ensure the completion of validation activities and the routine monthly payment validation and authorization briefing. New documentation includes the monthly Beneficiary Payment Validation Report, the enhanced reconciliation spreadsheet and a cycle memo.

In the process of conducting payment validation, MARx related payment issues are identified and monitored. A management tool, based in Access, has been designed and is used to track and monitor, in tandem with the Remedy system, the resolution of these MARx related payment issues. Routine meetings to manage and schedule the resolution of these payment issues have also been established.

Health Programs Financial Management Systems and Oversight

The CMS has several initiatives to improve the financial management systems and oversight of the Health Programs. One initiative relates to electronically interfacing the current Medicaid Budget and Expenditure System (MBES) with the CMS accounting system, HIGLAS. The CMS also implemented procedures to ensure proper user access to MBES. These procedures include requiring password changes every 60 days and requiring a valid e-mail address, before initial and re-certification access to the system is granted.

To ensure proper oversight of the Health Programs, CMS Central Office (CO) conducts weekly and monthly teleconferences with the ROs. These teleconferences ensure that there is a continuous process to assess and provide training to the ROs, as well as, address any financial management issues. For example, CO used these teleconferences to review requirements for work paper preparation to reiterate the written instructions that had been previously provided. Additionally, CO worked with the ROs to establish a peer and supervisory review process; each RO has incorporated this process. During FY 2006, the Regional Office Review guides were revised and discussed at the conference level.

Medicare Electronic Data Processing (EDP)

The CMS has made some improvements in Medicare EDP and is continuing its effort to strengthen the controls over that area. During FY 2006, CMS' EDP Program Management Office, first established in FY 2005, continued implementation of the CMS strategy and project plan to address current audit findings as well as root causes. To retain executive buy-in and awareness over Medicare EDP, a memorandum was issued to the Medicare contractor community. This memorandum was issued directly to the Medicare contractor Vice-Presidents to establish CMS' expectations and reinforce the importance of addressing and sustaining corrective actions. In addition, CMS has conducted and participated in

conferences—both in person and via teleconference—with the Medicare contractors to emphasize best practices to address audit findings and the root causes.

The CMS has also released updated various policies, procedures, and processes for the Medicare contractors. These included a series of "White Papers" on issues resulting from EDP audits. For example, a White Paper was released on configuration management to the contractors providing direction for configuration management of various technology platforms. The White Papers expanded upon the ***CMS Guidebook for Audits*** developed during FY 2005 to provide further direction to the contractors in meeting control objectives reviewed during the various of audits and reviews which may be performed at a Medicare contractor location.

Medicare Contractor Oversight

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 seven 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 our oversight.

The CMS continues to enhance its analytical tools to provide the steps to identify potential errors, unusual variances, system weaknesses, or inappropriate patterns of financial data accumulation. One example of these analytical tools is the review of 1522 reconciliation procedures. On a monthly basis, Medicare contractors perform a reconciliation of their Form CMS-1522 Funds Expended Report to their paid claims or system reports. The CMS developed a desk review protocol during FY 2006 that required all CMS regional offices to review their Medicare contractors' 1522 reconciliations once 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.

Internal Controls

During FY 2006, CMS contracted with CPA firms to conduct SAS 70 internal control audits of 13 Medicare contractors, three of which received unqualified opinions and the remainder received very few non-material findings. To ensure that the findings are properly addressed in a timely manner, the Medicare contractors develop and submit corrective action plans (CAPs). For FY 2007, CMS will continue to perform these SAS 70 internal control audits and monitor Medicare contactors' progress for implementing CAPs.

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 their material weaknesses identified during the FY. The CMS requires CAPs for all material weaknesses reported in the CPICs. In FY 2006, CPIC protocol reviews were conducted at two Medicare contractors. The CMS also updated manual instructions that

provide guidelines and policies to the Medicare contractors to enable them to strengthen their internal control processes.

Corrective Action Plans (CAPS)

The Medicare contractors are subject to various financial management and EDP audits and reviews performed by the OIG, Government Accountability Office (GAO), independent CPA firms, and CMS staff to provide reasonable assurance that they have developed and implemented sound internal controls. The results of these audits and reviews indicate if the contractors' internal controls are operating as designed and identify 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 CAPs, which describe activities to correct findings and the timeframes for which they will be implemented. The CAP reports consolidate the findings, standardize the format of the CAP submissions, and facilitate our monitoring responsibilities of these reports. Quarterly updates to the CAPs are required and CMS reviews all CAP submissions for adequacy.

We contracted with independent CPA firms to conduct CAP follow-up reviews during the SAS 70 internal control audits that were performed in FY 2006. The CPA firms were able to verify the successful implementation of 173 Medicare contractor CAPs.

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

When the OMB issued on December 21, 2004 its revisions to OMB Circular A-123, *Management's Responsibility for Internal Control*, effective for FY 2006, we began our planning. For example, in January 2005 we established a Risk Management and Financial Oversight Committee chaired by the CMS Chief Operating Officer to ensure that the agency objectives are met in accordance with the revised OMB Circular A-123. We introduced the revised Circular A-123 to the Medicare contractors at the Financial Management Conference in May 2005 and trained Central Office managers in June 2005 on Internal Controls and Circular A-123. We procured an independent CPA firm (with another CPA firm subcontracted) in September 2005 to assist in meeting reasonable assurance on internal controls over financial reporting as of June 30, 2006. We followed the five-step process of the Department for implementing Appendix A of 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. We 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.

Improper Payments

In 2002, Congress passed the Improper Payment Information Act (IPIA) that aims to standardize the way Federal agencies report improper payments in programs they oversee or administer. The IPIA includes requirements for identifying and reporting improper payments and defines improper payments as any payment that should not have been

made or that was made in an incorrect amount (including overpayments and underpayments). Incorrect payments also include payments to ineligible recipients or payments for ineligible services, as well as duplicate payments and payments for services not received. The CMS has begun to implement the requirements of the Improper Payments Information Act of 2002 (IPIA). Although CMS has not fully complied with the OMB's IPIA guidance, CMS has implemented a comprehensive process that measures the payment error rates for the Medicare FFS program. The CMS has initiatives in place to enhance its program integrity efforts and IPIA compliance to include Medicare Advantage Program, Medicare Prescription Drug Program, Medicaid, and SCHIP.

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 2004, Medicare FFS estimates comply with the IPIA requirement to report gross numbers.

The FY 2006 paid claims error rate is lower than our 2006 goal of 5.1 percent gross. The CMS analysis for FY 2006 indicated that the paid claims gross error rate was 4.4 percent or $10.8 billion in gross improper payments. 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 2006 Gross and Net Improper Payments and Error Rates in the Medicare FFS Program

		Gross	
Overpayments	**Underpayments**	**Improper Payment Amount (Overpayments + Underpayments)**	**Error Rate**
$9.8 B	$1.0 B	$10.8 B	4.4%

Medicare Advantage and Prescription Drugs

A key challenge facing CMS in the coming years will be achieving IPIA compliance with the Medicare Advantage and Medicare Prescription Drug Benefit. In FY 2006, CMS took steps to initiate the development of the improper payment methodology by awarding a contract to perform the following tasks:

- Perform a comprehensive risk assessment identifying all risk areas associated with payment; and
- Evaluate each individual risk identified in the assessment by developing a measurement methodology and implementing a pilot measurement test. CMS anticipates initiating a pilot project in late FY 2007 and reporting the results in the FY 2008 HHR PAR.

Medicaid and SCHIP

Medicaid and SCHIP payments are susceptible to erroneous payments as well. Thus, the Federal government and the States have a strong financial interest in ensuring that claims are paid accurately.

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

The CMS is currently using the national contracting strategy to measure Medicaid FFS improper payments in FY 2006 for reporting in the FY 2007 HHS PAR. The CMS plans to measure improper payments in Medicaid and SCHIP FFS, managed care and eligibility in FY 2007 for reporting in the FY 2008 HHS PAR. As such, CMS expects to be fully compliant with the IPIA requirements by FY 2008 for the Medicaid and SCHIP programs.

Financial Statement Highlights

Consolidated Balance Sheet

The Consolidated Balance Sheet presents amounts of future economic benefits owned or managed by CMS (assets), amounts owed (liabilities), and amounts that comprise the difference (net position). The CMS' Consolidated Balance Sheet shows $426.5 billion in assets. The bulk of these assets are in the Earmarked Investments totaling $339.5 billion, which are invested in U.S. Treasury Special Issues, special public obligations for exclusive purchase by the Medicare trust funds. Trust fund holdings not necessary to meet current expenditures are invested in interest-bearing obligations of the U.S. or in obligations guaranteed as to both principal and interest by the U.S. The next largest asset is the Fund Balance with Treasury of $82.8 billion, most of which is for Medicaid and SCHIP. Liabilities of $64.2 billion consist primarily of the Entitlement Benefits Due and Payable of $61.2 billion. The CMS net position totals $362.3 billion and reflects primarily the cumulative results of operations for the Medicare Trust Funds and the unexpended balances for Medicaid and SCHIP.

Consolidated Statement of Net Cost

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

Total Benefit Payments were $568.9 billion for FY 2006. Administrative Expenses were $3.4 billion, less than 1 percent of total net Program/Activity Costs of $524.2 billion.

The net cost of the Medicare program including benefit payments, QIOs, Medicare Integrity Program spending, and administrative costs, was $337 billion. The HI total costs of $188.5 billion were offset by $2.7 billion in revenues. The SMI total costs of $198.5 billion were offset by premiums of $42.5 billion and contributions of $4.8 billion by States and Territories pursuant to the State Phased-Down provisions of the MMA. Medicaid total costs of $179.5 billion represent expenses incurred by the States and Territories that were reimbursed by CMS during the fiscal year, plus accrued payables. The SCHIP total costs were $5.7 billion.

Consolidated Statement of Changes in Net Position

The Consolidated Statement of Changes in Net Position details the increases to and decreases from the Unexpended Appropriations and Cumulative Results of Operations from the beginning to the end of the fiscal year. The line, Appropriations Used, represents the Medicaid appropriations used of $179 billion; $173.6 billion in transfers from Payments to Health Care Trust Funds to HI and SMI; SCHIP appropriations of $5.7 billion; State Grants and Demonstrations appropriations of $2 billion and $78 million for general fund appropriations to program management. Medicaid and SCHIP are financed by a general fund appropriation provided by Congress. Employment tax revenue is Medicare's portion of payroll and self-employment taxes collected under the Federal Insurance Contributions Act (FICA) and Self-Employment Contributions Act (SECA) for the HI trust fund totaling $180.4 billion. The Federal matching contribution is income to the SMI program from a general fund appropriation (Payments to Health Care Trust Funds) of $129.1 billion, which matches monthly premiums paid by beneficiaries.

Combined Statement of Budgetary Resources

The Combined Statement of Budgetary Resources provides information about the availability of budgetary resources, as well as their status at the end of the year. The CMS total budgetary resources were $830.2 billion. Obligations of $773.9 billion leave unobligated balances of $56.3 billion (of which $2.2 billion is not available). Total outlays, net of collections, were $740.9 billion. When offset by $225.7 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 $515.2 billion.

Consolidated Statement of Financing

The Consolidated Statement of Financing is a reconciliation of the preceding statements. Accrual-based measures used in the Consolidated Statement of Net Cost differ from the obligation-based measures used in the Combined Statement of Budgetary Resources, especially in the treatment of liabilities. A liability not covered by budgetary resources may

not be recorded as a funded liability in the budgetary accounts of CMS' general ledger, which supports the Report on Budget Execution and Budgetary Resources (SF 133) and the Combined Statement of Budgetary Resources. Therefore, these liabilities are recorded as contingent liabilities on the general ledger. Based on appropriation language, they are considered "funded" liabilities for purposes of the Consolidated Balance Sheet, Consolidated Statement of Net Cost, and Consolidated Statement of Changes in Net Position. A reconciling item has been entered on the Consolidated Statement of Financing.

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 for the first time. 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 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 ***2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds***, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds.

Limitations of the Financial Statements

The financial statements have been prepared to report the financial position and results of operations of CMS, pursuant to the requirements of 31 U.S.C. 3515(b).

While these financial statements have been prepared from the books and records of CMS in accordance with generally accepted accounting principles for Federal entities and the formats prescribed by OMB, the statements are in addition to the financial reports used to monitor and control budgetary resources that are prepared from the same books and records.

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

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

Principal Statements and Notes

CONSOLIDATED BALANCE SHEET
As of September 30, 2006 and 2005
(in millions)

	FY 2006 Consolidated Totals	FY 2005 Consolidated Totals
ASSETS		
Intragovernmental Assets:		
Fund Balance with Treasury ***(Note 2)***	$82,806	$20,789
Earmarked Investments ***(Note 3)***	339,545	298,444
Accounts Receivable, Net ***(Note 4)***	473	454
Other Assets ***(Note 5)***		14,272
Total Intragovernmental Assets	**422,824**	**333,959**
Cash and Other Monetary Assets	145	204
Accounts Receivable, Net ***(Note 6)***	3,009	1,884
General Property, Plant and Equipment, Net	440	392
Other Assets ***(Note 5)***	124	4,201
TOTAL ASSETS	**$426,542**	**$340,640**
LIABILITIES		
Intragovernmental Liabilities:		
Accounts Payable	$540	$324
Accrued Payroll and Benefits	4	4
Other Intragovernmental Liabilities ***(Note 7)***	434	433
Total Intragovernmental Liabilities	**978**	**761**
Accounts Payable	3	
Federal Employee and Veterans' Benefits	11	10
Entitlement Benefits Due and Payable ***(Note 8)***	61,164	53,754
Accrued Payroll and Benefits	55	54
Other Liabilities ***(Note 7)***	1,986	1,926
TOTAL LIABILITIES *(Note 9)*	**64,197**	**56,505**
NET POSITION		
Unexpended Appropriations—earmarked funds	27,658	
Unexpended Appropriations—other funds	32,521	
Total Unexpended Appropriations	**60,179**	**14,706**
Cumulative Results of Operations—earmarked funds	301,853	
Cumulative Results of Operations—other funds	313	
Total Cumulative Results of Operations	**302,166**	**269,429**
TOTAL NET POSITION	**$362,345**	**$284,135**
TOTAL LIABILITIES AND NET POSITION	**$426,542**	**$340,640**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF NET COST
For the Years Ended September 30, 2006 and 2005
(in millions)

	FY 2006 Consolidated Totals	FY 2005 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS		
GPRA Programs		
Medicare (Earmarked)	$336,969	$295,713
Medicaid	179,481	182,226
SCHIP	5,739	5,135
Net Cost - GPRA Programs	**522,189**	**483,074**
Other Activities		
CLIA	(51)	3
State Grants and Demonstrations	1,940	325
Other	78	
Net Cost - Other Activities	**1,967**	**328**
NET COST OF OPERATIONS *(Notes 10 and 15)*	**$524,156**	**$483,402**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION
For the Years Ended September 30, 2006 and 2005
(in millions)

	Consolidated Earmarked Funds	Consolidated Other Funds	FY 2006 Consolidated Total	FY 2005 Consolidated Total
CUMULATIVE RESULTS OF OPERATIONS				
BEGINNING BALANCES	**$269,147**	**$282**	**$269,429**	**$255,831**
Budgetary Financing Sources:				
Appropriations Used	173,573	186,754	360,327	311,674
Nonexchange Revenue ***(Note 11)***	197,843		197,843	185,793
Transfers-in/out Without Reimbursement ***(Note 12)***	(1,765)	462	(1,303)	(502)
Other Financing Sources (Nonexchange):				
Transfers-out Without Reimbursement	(1)		(1)	1
Imputed Financing	25	2	27	34
TOTAL FINANCING SOURCES	**369,675**	**187,218**	**556,893**	**497,000**
NET COST OF OPERATIONS	**336,969**	**187,187**	**524,156**	**483,402**
NET CHANGE	**32,706**	**31**	**32,737**	**13,598**
CUMULATIVE RESULTS OF OPERATIONS	**$301,853**	**$313**	**$302,166**	**$269,429**
UNEXPENDED APPROPRIATIONS				
BEGINNING BALANCES	**$6,873**	**$7,833**	**$14,706**	**$16,422**
Budgetary Financing Sources:				
Appropriations Received	201,231	222,441	423,672	311,039
Appropriations Transferred-in/out		(1,855)	(1,855)	(1,397)
Other Adjustments ***(Note 13)***	(6,873)	(9,144)	(16,017)	316
Appropriations Used	(173,573)	(186,754)	(360,327)	(311,674)
TOTAL BUDGETARY FINANCING SOURCES	**20,785**	**24,688**	**45,473**	**(1,716)**
TOTAL UNEXPENDED APPROPRIATIONS	**27,658**	**32,521**	**60,179**	**14,706**
NET POSITION	**$329,511**	**$32,834**	**$362,345**	**$284,135**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENT OF BUDGETARY RESOURCES
For the Years Ended September 30, 2006 and 2005

(in millions)

	FY 2006		FY 2005
	Combined Totals Budgetary	Non-Budgetary Credit Reform Financing Accounts	Combined Totals Budgetary
Budgetary Resources:			
Unobligated balance, brought forward, October 1:	$3,098		$11,176
Recoveries of prior year unpaid obligations	14,006		10,557
Budget authority:			
Appropriation	847,368		663,101
Spending authority from offsetting collections:			
Earned			
Collected	156	$140	78
Change in unfilled customer orders:			
Advance received	63		
Without advance from Federal sources	9		(2)
Expenditure transfers from trust funds	3,347		2,920
SUBTOTAL	**850,943**	**140**	**666,097**
Nonexpenditure transfers, net, anticipated & actual	(1,727)		(1,397)
Temporarily not available pursuant to Public Law	(34,525)		(11,150)
Permanently not available	(1,767)		(4,766)
TOTAL BUDGETARY RESOURCES	**$830,028**	**$140**	**$670,517**
Status of Budgetary Resources:			
Obligations incurred ***(Note 16)***:			
Direct	$773,547		$667,338
Reimbursable	211	$140	81
SUBTOTAL	**773,758**	**140**	**667,419**
Unobligated balance:			
Apportioned	54,114		2,647
Unobligated balance not available	2,156		451
TOTAL STATUS OF BUDGETARY RESOURCES	**$830,028**	**$140**	**$670,517**
Change in Obligated Balance:			
Obligated balance, net:			
Unpaid obligations, brought forward, October 1	$55,795		$52,023
Less: Uncollected customer payments from			
Federal sources, brought forward, October 1	1,631		1,699
Total unpaid obligated balance, net	54,164		50,324
Obligations incurred, net	773,758	$140	667,419
Less: Gross Outlays	744,713	140	653,091
Obligated balance transferred, net:			
Less: Recoveries of prior year unpaid obligations, actual	14,006		10,557
Change in uncollected customer payments			
from Federal sources	(199)		(69)
Obligated balance, net, end of period:			
Unpaid obligations	70,834		55,795
Less: Uncollected customer payments			
from Federal sources	1,432		1,631
TOTAL, UNPAID OBLIGATED BALANCE, NET, END OF PERIOD	**69,402**		**54,164**
Net Outlays:			
Net Outlays			
Gross outlays	744,713	140	653,091
Less: Offsetting collections	3,774	140	3,065
Less: Distributed offsetting receipts	225,747		165,730
NET OUTLAYS	**$515,192**		**$484,296**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF FINANCING
For the Years Ended September 30, 2006 and 2005
(in millions)

	FY 2006 Consolidated Totals	FY 2005 Consolidated Totals
RESOURCES USED TO FINANCE ACTIVITIES:		
Budgetary Resources Obligated:		
Obligations incurred	$773,898	$667,419
Less: Spending authority from offsetting collections and recoveries	17,721	13,553
Obligations net of offsetting collections and recoveries	756,177	653,866
Less: Distributed offfsetting receipts	225,747	165,730
NET OBLIGATIONS	**530,430**	**488,136**
Other Resources:		
Transfers in/out without reimbursement	(1)	1
Imputed financing from costs absorbed by others	27	34
NET OTHER RESOURCES USED TO FINANCE ACTIVITIES	**26**	**35**
TOTAL RESOURCES USED TO FINANCE ACTIVITIES	**$530,456**	**$488,171**
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	$(6,011)	$3,153
Resources that fund expenses recognized in prior periods	14,643	15,684
Budgetary offsetting collections and receipts that do not affect net cost of operations	73	
Resources that finance the acquisition of assets	(24)	319
Other resources or adjustments to net obligated resources that do not affect net cost of operations	(2,197)	502
TOTAL RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS	**6,484**	**19,658**
TOTAL RESOURCES USED TO FINANCE THE NET COST OF OPERATIONS	**$523,972**	**$468,513**
COMPONENTS OF THE NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD:		
Components Requiring or Generating Resources in Future Periods:		
Accrued Entitlement Benefit Costs		$9,470
Liability for Unmatched SMI Premiums		5,173
Increase in annual leave liability	$1	2
(Increase) in exchange revenue receivable from the public	(298)	693
Other	(47)	(219)
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL REQUIRE OR GENERATE RESOURCES IN FUTURE PERIODS	**(344)**	**15,119**
Components Not Requiring or Generating Resources:		
Depreciation and amortization	68	48
Other	460	(278)
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES	528	(230)
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD	**184**	**14,889**
NET COST OF OPERATIONS	**$524,156**	**$483,402**

STATEMENT OF SOCIAL INSURANCE
75-Year Projection as of January 1, 2006 and Prior Base Years
(in billions)

		Estimates from Prior Years			
	2006	**2005** unaudited	**2004** unaudited	**2003** unaudited	**2002** unaudited
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: *(Notes 17 and 18)*					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age (age 15–64)					
HI	$5,685	$5,064	$4,820	$4,510	$4,408
SMI Part B	12,446	11,477	10,505	8,796	7,423
SMI Part D	7,366	7,895	7,545	0	0
Have attained eligibility age (age 65 or over)					
HI	192	162	148	128	125
SMI Part B	1,606	1,436	1,310	1,160	1,008
SMI Part D	750	817	713	0	0
Those expected to become participants (under age 15)					
HI	4,767	4,209	4,009	3,773	3,753
SMI Part B	3,562	3,658	3,514	2,817	2,402
SMI Part D	2,134	2,522	2,511	0	0
All current and future participants					
HI	10,644	9,435	8,976	8,411	8,286
SMI Part B	17,613	16,571	15,329	12,773	10,833
SMI Part D	10,250	11,233	10,770	0	0
Actuarial present value for the 75-year projection period of estimated future cost for or on behalf of: *(Notes 17 and 18)*					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age (age 15–64)					
HI	15,633	12,668	12,054	10,028	9,195
SMI Part B	12,433	11,541	10,577	8,845	7,463
SMI Part D	7,338	7,913	7,566	0	0
Have attained eligibility age (age 65 or over)					
HI	2,397	2,179	2,168	1,897	1,747
SMI Part B	1,773	1,622	1,475	1,306	1,132
SMI Part D	792	880	773	0	0
Those expected to become participants (under age 15)					
HI	3,904	3,417	3,246	2,653	2,470
SMI Part B	3,407	3,408	3,277	2,622	2,238
SMI Part D	2,121	2,440	2,431	0	0
All current and future participants					
HI	21,934	18,264	17,468	14,577	13,412
SMI Part B	17,613	16,571	15,329	12,773	10,833
SMI Part D	10,250	11,233	10,770	0	0
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over cost *(Notes 17 and 18)*					
HI	$(11,290)	$(8,829)	$(8,492)	$(6,166)	$(5,126)
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0
Additional Information					
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over cost *(Notes 17 and 18)*					
HI	$(11,290)	$(8,829)	$(8,492)	$(6,166)	$(5,126)
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0
Trust Fund assets at start of period					
HI	285	268	256	235	209
SMI Part B	23	19	24	34	41
SMI Part D	0	0	0	0	0
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over cost *(Notes 17 and 18)*					
HI	$(11,006)	$(8,561)	$(8,236)	$(5,931)	$(4,917)
SMI Part B	23	19	24	34	41
SMI Part D	0	0	0	0	0

Totals do not necessarily equal the sum of the rounded components. The accompanying notes are an integral part of these financial statements.

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity

The CMS is a separate financial reporting entity of HHS. The financial statements have been prepared to report the financial position and results of operations of all the programs administered by CMS, as required by the Chief Financial Officers Act of 1990. The statements were prepared from CMS' accounting records in accordance with accounting principles generally accepted in the United States (GAAP) and the form and content specified by the Office of Management and Budget (OMB) in OMB Circular A-136, *Financial Reporting Requirements* which, effective fiscal year (FY) 2006, supersedes OMB Bulletin 01-09, *Form and Content of Agency Financial Statements*. OMB Circular A-136's most significant changes include new formats for certain financial statements, additional note disclosures and the separate reporting of *earmarked funds* from *other funds* which coincides with CMS' budget functional classifications, Medicare and Health.

Earmarked Funds

Effective FY 2006, The Federal Accounting Standards Advisory Board (FASAB) Statement of Federal Financial Accounting Standards (SFFAS) 27, *Identifying and Reporting Earmarked Funds*, defines earmarked funds and requires that they be shown separately from all other funds on the Statement of Changes in Net Position as well as in the Net Position section of the Balance Sheet. The CMS adopted FASAB SFFAS 27 effective October 1, 2005. The SFFAS 27 does not allow restating of the 2005 reported amounts. The standard also requires that condensed information on assets, liabilities and costs for earmarked funds be disclosed (see Note 14). Earmarked funds are financed by specifically identified revenues, often supplemented by other financing sources, which remain available over time. These specifically identified revenues and other financing sources are required by statute to be used for designated activities, benefits or purposes. CMS has designated the Medicare programs as earmarked funds (and the Health programs as "other funds"). The Medicare programs include:

Hospital Insurance Trust Fund (HI TF)

Supplementary Medical Insurance Trust Fund (SMI TF)

Health Care Fraud and Abuse Control Account

Self-Employment Contributions Act (SECA) credits

Taxation on Old Age Survivors and Disability Insurance (OASDI) Benefits, (HI TF)

Payments to the Health Care Trust Funds

Program Management allocation to the HI and SMI Trust Funds

Medicare Hospital Insurance Trust Fund

Section 1817 of the Social Security Act established the Medicare Hospital Insurance Trust Fund. Medicare contractors are paid by CMS to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI trust fund. The CMS payments to Medicare Advantage plans (previously known as Managed Care plans) are also charged to this fund. The financial statements include HI trust fund activities administered by the Department of the Treasury (Treasury). The HI trust fund has permanent indefinite authority. Employment tax revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under FICA and SECA. Employees and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI trust fund. Self-employed individuals contribute the full 2.9 percent of their net income. (See "Payments to the Health Care Trust Funds Appropriation" and "Permanent Appropriations" below as well as Note 11 for additional descriptions of revenues and financing sources for the HI trust fund).

Medicare Supplementary Medical Insurance Trust Fund

Section 1841 of the Social Security Act established the Supplementary Medical Insurance Trust Fund. Medicare contractors are paid by CMS to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end stage renal disease (ESRD), rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI trust fund. The CMS payments to Medicare Advantage plans are also charged to this fund. The financial statements include SMI trust fund activities administered by Treasury. The SMI trust fund has permanent indefinite authority. SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. (See Note 12 for descriptions of revenues and financing sources for the SMI trust fund).

Medicare Prescription Drug Benefit—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 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 as well as helps those with limited income and resources. Medicare also reimburses States who have paid prescription drug costs for dual eligibles who have had difficulty accessing Part D benefits. Since FY 2004, the Transitional Assistance and Drug Discount Card Programs have provided credits and discounts toward prescription drug coverage for certain eligible beneficiaries, however, with the implementation of Medicare Part D, these programs were phased out in FY 2006. (See "Payments to the Health Care Trust Funds Appropriation" below as well as Note 12 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 (MIP)

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

The Deficit Reduction Act of 2005 created the Medicaid Integrity Program (MIP) which represents a substantial milestone in CMS' strategy to detect and prevent Medicaid fraud and abuse in the program's history. The Medicaid MIP is also funded by the HI trust fund.

Payments to the Health Care Trust Funds Appropriation

The Social Security Act provides for payments to the HI and SMI trust funds for SMI (appropriated funds to provide for Federal matching of SMI premium collections) and HI (for the Uninsured and Federal Uninsured Payments). 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 TF. 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.

Permanent Appropriations

A transfer of general funds to the HI trust fund in amounts equal to Self-Employment Contribution Act (SECA) tax credits and the increase to the tax payment from Old Age Survivors and Disability Insurance (OASDI) beneficiaries is made through 75X0513 and 75X0585, respectively. The Social Security Amendments of 1983 provided credits against the HI taxes imposed by the SECA on the self-employed for calendar years 1984 through 1989. The amounts reported in FY 2006 are adjustments for late or amended tax returns. The Social Security Amendments of 1994 provided for additional tax payments from Social Security and Tier 1 Railroad Retirement beneficiaries.

The Health (Other Funds) programs include:

Medicaid

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

The State Children's Health Insurance Program (SCHIP)

SCHIP, included in the Balanced Budget Act of 1997 (BBA), 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 grant awards, prepared at the beginning of each quarter and amended as necessary, are based on a State approved plan to fund SCHIP. At the end of each quarter, States report their expenses (net of recoveries) for the quarter, and subsequent grant awards are issued by CMS for the difference between approved expenses reported for the period and the grant awards previously issued.

State Grants and Demonstrations

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

The Ticket to Work and Work Incentives Improvement Act of 1999, Public Law 106-170, established two grant programs. The Act provides funding for Medicaid infrastructure grants to support the design, establishment and operation of State infrastructures to help working people with disabilities purchase health coverage through Medicaid. The Act also provides fund-

ing for States to establish Demonstrations to Maintain Independence and Employment, which provide Medicaid benefits and services to working individuals who have a condition that, without medical assistance, will result in disability.

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

Health Care Infrastructure Improvement Program

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

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

This account operates as a revolving fund without fiscal year restriction. The BBA established the Medicare+Choice program, now known as the Medicare Advantage program under the MMA, that requires Medicare Advantage plans to make payments for their share of the estimated costs related to enrollment, dissemination of information, and certain counseling and assistance programs. These user fees are devoted to educational efforts for beneficiaries and outreach partners. The Clinical Laboratory Improvement Amendments of 1988 (CLIA) marked the first comprehensive effort by the Federal government to regulate medical laboratory testing. The CMS and the Public Health Service share responsibility for the CLIA program, with CMS having the lead responsibility for financial management. Fees for registration, certificates, and compliance determination of all U.S. clinical laboratories are collected to finance the program. Other user fees are charged for certification of some nursing facilities and for sale of the data on nursing facilities surveys. Proceeds from the sale of data from the public use files and publications under the Freedom of Information Act (FOIA) are also credited to this fund.

Program Management Appropriation

The Program Management Appropriation provides CMS with the major source of administrative funds to manage the Medicare and Medicaid programs. The funds for this activity are provided from the HI and SMI trust funds, the general fund, and reimbursable activities. The Payments to the Health Care Trust Funds Appropriation reimburses the Medicare HI trust fund to cover the Health programs' share of CMS administrative costs (see Note 12). 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.

Basis of Presentation

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

These financial statements have been prepared from the CMS general ledger in accordance with GAAP and the formats prescribed by the OMB Circular A-136. Some amounts shown will differ from those in other financial documents, such as the *Budget of the U.S. Government* and the annual report of the Boards of Trustees for HI and SMI, which are presented on a cash basis.

Basis of Accounting

The CMS 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.

Balance Sheet

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

Assets

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

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).

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

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

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

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

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

In accordance with Statement of Federal Financial Accounting Standards No. 10, *Accounting for Internal Use Software*, CMS implemented the HHS-wide policy which requires internal use software be capitalized using a threshold of $1 million and an estimated useful life of not less than two and no more than five years, except for the Healthcare Integrated General Ledger Accounting System (HIGLAS), which is amortized over a useful life of ten years. Capitalized costs include all direct and indirect costs and are amortized using the straight-line method. In accordance with HHS policy, enhancements to existing internal use software are capitalized when the life cycle costs of the development stage are $1 million or more, and they result in significant additional capabilities.

The General Services Administration (GSA), which charges rent based on commercial rental rates for similar properties, provides the majority of space and property that CMS occupies. Therefore, the cost of GSA-owned properties is not recorded in CMS' financial statements.

Liabilities

Liabilities represent amounts owed by CMS. A liability for Federal accounting purposes is a probable and measurable future outflow or other sacrifice of resources as a result of past transactions or events. Since CMS is a component of the U.S. Government, a sovereign entity, its liabilities cannot be liquidated without legislation that provides resources to do so. In accordance with Public Law and existing Federal accounting standards, no liability is recorded for any future payment to be made on behalf of current workers contributing to the Medicare HI trust fund.

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

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

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

Federal Employee and Veterans' Benefits consist of the actuarially-determined estimate of future benefits earned by Federal employees and Veterans, but not yet due and payable. These costs include pensions, other retirement benefits, and other post-employment benefits. These benefits programs are normally administered by the Office of Personnel Management (OPM) and not by CMS.

Entitlement Benefits Due and Payable represents the liability for Medicare and Medicaid medical services incurred but not paid as of September 30. The Medicare liability is developed by the Office of the Actuary (OACT) and includes (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (d) periodic interim payments for services rendered in FY 2006 but paid in FY 2007, and (e) an estimate of retroactive settlements of cost reports submitted to the Medicare contractors by health care providers. The Medicare Advantage liability includes amounts incurred related to risk adjustments and other estimates.

The Medicaid estimate represents the net of unreported expenses incurred by the States less amounts owed to the States for overpayment of Medicaid funds to providers, anticipated rebates from drug manufacturers, and settlements of probate and fraud and abuse cases. The FY 2006 estimate was developed based on historical relationships between prior Medicaid net payables and current Medicaid activity.

Accrued Payroll and Benefits consist of salaries, wages, leave, and benefits earned by employees, but not disbursed as of September 30. Annual leave is accrued as earned and reduced as used. The balances of accrued annual leave and credit leave are analyzed and adjusted to reflect current pay rates. Sick leave and other types of nonvested leave are expensed as taken but not accrued when earned.

Contingencies are an existing condition, situation, or set of circumstances involving uncertainty as to possible gain or loss to CMS. The uncertainty will ultimately be resolved when one or more future events occur or fail to occur. A contingent liability is recognized when a past transaction or event has occurred, a future outflow or other sacrifice of resources is probable, and the related future outflow or sacrifice of resources is measurable.

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

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

Net Position

Net Position contains the following components:

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

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

Earmarked funds are shown separately from other funds in each of these lines.

Statement of Net Cost

The Statement of Net Cost shows only a single dollar amount: the actual net cost of CMS' operations for the period by program. Under the Government Performance and Results Act (GPRA), CMS is required to identify the mission of the agency and develop a strategic plan and performance measures to show that desired outcomes are being met. The three major programs that CMS administers are: Medicare, Medicaid, and SCHIP. The bulk of CMS' expenses are allocated to these programs. 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." Although the following terms do not appear in the Statement of Net Cost, they are an integral part in the calculation of a program's net cost of operations:

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

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

Administrative Expenses represent the costs of managing business by CMS and its partners. Such costs include employees' payroll, rent, utilities and depreciation and amortization of property and equipment.

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

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

Revenues billed and collected under the ***State Phase-Down*** provision of the MMA of 2003 (see Note 6) are recognized as exchange revenue.

Net Cost of Operations represents the program's gross costs reduced by its related exchange revenues.

Statement of Changes in Net Position

The Statement of Changes in Net Position (SCNP) reports the change in net position during the fiscal year that occurred in the two components of net position: Cumulative Results of Operations and Unexpended Appropriations. Earmarked funds are shown in a separate column from other funds. The SCNP comprises the following major line items:

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

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

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

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

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

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

Statement of Budgetary Resources

The Statement of Budgetary Resources (SBR) provides information about the availability of budgetary resources as well as their status at the end of the year. Budgetary Statements were developed for each of the budgetary accounts. In this statement, the Program Management and the Program Management User Fee accounts are combined and are not allocated back to the other programs. Also, there are no intra-CMS eliminations in this statement. Effective FY 2006, the format of the SBR has changed and the comparative FY 2005 SBR has been prepared in the new format.

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

Budget Authority represents the funds available through appropriations, direct spending authority, obligations limitations, unobligated balances at the beginning of the period or transferred in during the period, spending authority from offsetting collections, and any adjustments to budgetary authority.

Obligations Incurred consists of expended authority and the change in undelivered orders. Current system limitations prevent CMS from reporting the recoveries of prior year obligations. OMB has exempted CMS from the Circular No. A-11 requirement to report 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 beginning in FY 2005.

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

Statement of Financing

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

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. This projected potential future income and expenditures under current law is not included in the accompanying Balance Sheets, Statements of Net Cost, Statements of Changes in Net Position, Statements of Budgetary Resources, or Statements of Financing.

The Medicare financial projections are developed based on numerous assumptions and are inherently subject to substantial uncertainty. This uncertainty arises from the likelihood of future changes in general economic, regulatory, and market conditions, as well as other more specific future events and contingencies that cannot be reliably anticipated, particularly over more distant timeframes such as the 75-year projection period used for the SOSI. Most of these future conditions and events are beyond our control. Future income and expenditures under current law will be affected by variation in demographic trends (birth rates, mortality rates, and immigration), general economic trends (wage growth, inflation, interest rates, labor force participation, and unemployment), and health-specific trends (growth in the utilization and intensity of health care services, and increases in medical care prices). Recent historical trends in health care have often varied dramatically; consequently, such projections can only indicate the level of expenditures that would occur under current law based on trend assumptions that are considered reasonable from today's viewpoint. Actual future expenditures are likely to differ significantly from the projections shown in the SOSI. Further, it is likely that Congress will pass legislation from time to time modifying the provisions of the Medicare program. Such legislation could also result in differences between actual future income and expenditures from those amounts projected under current law in the accompanying SOSI.

The additional information on the SOSI of actuarial present values of estimated future income (excluding interest) less expenditures plus assets at the start of the period is presented for purposes of additional analysis and is not a required part of the financial statements.

Use of Estimates in Preparing Financial Statements

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

Intra-Governmental Relationships and Transactions

In the course of its operations, CMS has relationships and financial transactions with numerous Federal agencies (See Consolidated Intragovernmental Balances). For example, CMS interacts with the Social Security Administration (SSA) and Treasury. The SSA determines eligibility for Medicare programs, and also allocates a portion of Social Security benefit payments to the Medicare Part B trust fund for Social Security beneficiaries who elect to enroll in the Medicare Part B program. The Treasury receives the cumulative excess of Medicare receipts and other financing sources, and issues interest-bearing securities in exchange for the use of those monies.

Reclassifications

Certain FY 2005 balances have been reclassified to conform to FY 2006 financial statement presentations, the effect of which is immaterial.

Estimation of Obligations Related to Canceled Appropriations

As of September 30, 2006, CMS has canceled over $143 million in cumulative obligations to FY 2001 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 2002 through 2006 related to canceled appropriations, CMS anticipates an additional $1 million will be paid from current year funds for canceled obligations.

NOTE 2:

FUND BALANCE WITH TREASURY *(Dollars in Millions)*

FY 2006	Consolidated Totals
FUND BALANCES:	
Trust Funds	
HI Trust Fund (Earmarked)	$955
SMI Trust Fund (Earmarked)	27,771
Revolving Funds	
CLIA	182
Appropriated Funds	
Medicaid	45,662
SCHIP	6,145
State Grants and Demonstrations	2,077
Other Fund Types	
CMS Suspense Account	14
TOTAL FUND BALANCES	**$82,806**
STATUS OF FUND BALANCES WITH TREASURY:	
Unobligated Balance	
Available	$54,114
Unavailable	2,156
Obligated Balance not yet Disbursed	69,402
Non-Budgetary FBWT	(42,866)
TOTAL STATUS OF FUND BALANCES WITH TREASURY	**$82,806**

FY 2005	Consolidated Totals
FUND BALANCES:	
Trust Funds	
HI Trust Fund (Earmarked)	$366
SMI Trust Fund (Earmarked	1,303
Revolving Funds	
CLIA	118
Appropriated Funds	
Medicaid	10,942
SCHIP	7,275
State Grants and Demonstrations	780
Other Fund Types	
CMS Suspense Account	5
TOTAL FUND BALANCES	**$20,789**
STATUS OF FUND BALANCES WITH TREASURY:	
Unobligated Balance	
Available	$2,647
Unavailable	451
Obligated Balance not yet Disbursed	54,164
Non-Budgetary FBWT	(36,473)
TOTAL STATUS OF FUND BALANCES WITH TREASURY	**$20,789**

Fund Balances are funds with Treasury that are primarily available to pay current expenditures and liabilities. The Unobligated Balance includes $239 million, which is restricted for future use and is not apportioned for current use for Program Management and State Grants and Demonstrations.

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

Medicare Investments *(Earmarked)*

FY 2006	Maturity Range	Interest Range	Value
HI TF			
Certificate	June 2007	4 3/4 - 5 1/4%	$9,360
Bonds	June 2007 to June 2021	3 1/2 - 7 3/8%	292,826
Accrued Interest			3,914
TOTAL HI TF INVESTMENTS			**$306,100**
SMI TF			
Certificate	June 2007	4 3/4 - 5 1/4%	$9,036
Bonds	June 2008 to June 2016	4 1/8 - 6 7/8%	24,025
Accrued Interest			384
TOTAL SMI TF INVESTMENTS			**$33,445**
TOTAL MEDICARE INVESTMENTS			**$339,545**

FY 2005	Maturity Range	Interest Range	Value
HI TF			
Certificate	June 2006	4 1/8 %	$2,257
Bonds	June 2006 to June 2020	3 1/2 - 8 1/8%	275,010
Accrued Interest			3,729
TOTAL HI TF INVESTMENTS			**$280,996**
SMI TF			
Bonds	June 2008 to June 2016	4 1/8 - 6 7/8%	$17,204
Accrued Interest			244
TOTAL SMI TF INVESTMENTS			**$17,448**
TOTAL MEDICARE INVESTMENTS			**$298,444**

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

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

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

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

FY 2006

	Medicare (Earmarked)							
	HI TF	SMI TF	Medicaid	SCHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Expenditure Transfer-in	$385	$919	$98	$1	$13	$1,416	$(1,416)	
Nonexpenditure Transfer-in	19,921	21,300				41,221	(41,221)	
Railroad Retirement Principal	473					473		$473
TOTAL INTRAGOVERNMENTAL ACCOUNTS RECEIVABLE, NET	**$20,779**	**$22,219**	**$98**	**$1**	**$13**	**$43,110**	**$(42,637)**	**$473**

FY 2005

	Medicare (Earmarked)							
	HI TF	SMI TF	Medicaid	SCHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Expenditure Transfer-in	$485	$6,154	$146	$3	$9	$6,797	$(6,797)	
Nonexpenditure Transfer-in	17,039	18,018				35,057	(35,057)	
Railroad Retirement Principal	454					454		$454
TOTAL INTRAGOVERNMENTAL ACCOUNTS RECEIVABLE, NET	**$17,978**	**$24,172**	**$146**	**$3**	**$9**	**$42,308**	**$(41,854)**	**$454**

Intragovernmental accounts receivable represent CMS claims for payment from other Federal agencies. CMS accounts receivable for transfers from the HI and SMI trust funds maintained by the Treasury Bureau of Public Debt (BPD) are eliminated against BPD's corresponding liabilities to CMS in the Consolidated Balance Sheet.

NOTE 5: OTHER ASSETS

Anticipated Congressional Appropriation

In FY 2006, Congress provided CMS with sufficient appropriation amounts to cover the entire Medicaid claims incurred but not reported (IBNR) liability and the matching of SMI premiums from the general fund. Therefore, no Anticipated Congressional Appropriation exists for FY 2006.

As of September 30, 2005, the CMS recorded $14,272 million in anticipated Congressional appropriations to cover liabilities incurred by the Medicaid program and the Payments to the Health Care Trust Funds, as discussed below:

Medicaid

CMS accrues an expense and liability for Medicaid claims incurred but not reported (IBNR) as of September 30. In FY 2005, the IBNR expense exceeded the available unexpended Medicaid appropriations in the amount of $9,099 million. A review of appropriation language by CMS' Office of General Counsel (OGC) resulted in a determination that the Medicaid appropriation's indefinite authority provision allowed for the entire IBNR amount to be reported as a funded liability. Consequently, CMS recorded a $9,099 million anticipated appropriation in FY 2005 for IBNR claims that exceeded the available appropriation.

Payments to the Health Care Trust Funds

The SMI program is financed primarily by the general fund appropriation, Payments to the Health Care Trust Funds, and by monthly premiums paid by beneficiaries. Section 1844 of the Social Security Act authorizes funds to be appropriated from the general fund to match premiums payable and deposited in the SMI Trust Fund. Section 1844 also outlines the ratio for the match and the method to make the trust funds whole if insufficient funds are available in the appropriation to match all SMI premiums received in the fiscal year. The appropriated amount is an estimate calculated annually by CMS' OACT and can be insufficient in any particular fiscal year. In FY 2005, the estimate was insufficient and the matching ceased prior to the close of the fiscal year. At September 30 approximately $5,107 million should have been matched to premiums paid by beneficiaries. OACT calculated an additional $65 million in interest on the unmatched amount, leaving a cumulative liability of about $5,173 million owed to SMI. When this occurs, Section 1844 allows for a reimbursement to be made to the SMI Trust Fund from the Payments to the Health Care Trust Funds appropriation enacted for the following year. Consequently, CMS recorded a $5,173 million anticipated appropriation in FY 2005 for the amount of the unmatched SMI premiums. Although the

actual transfer of funds occurred in FY 2006, CMS reported the $5,173 million as revenues earned in FY 2005.

In addition, the $5,173 million in unmatched SMI premiums was reported as a liability "requiring or generating resources in future periods" on the Consolidated Statement of Financing.

Other—Medicare Advantage Advances

As of September 30, 2006, the CMS had $124 million ($102 million in FY 2005) in Other Assets representing advances made to various contractors and vendors. Medicare Advantage plans were issued an advance payment on September 30, 2005 in the amount of $4,099 million for services that were provided in October 2005. No such advance payment was made in FY 2006.

Direct Loans and Loan Guarantees, Non-federal Borrowers

During Fiscal Year 2006, CMS issued and disbursed $140 million in direct loans for the Health Care Infrastructure Improvement Program established with the passing of the MMA of 2003. The program provides loans 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. $140 million in funding for these loans was obligated and disbursed in FY 2006. The program's subsidy cost is $140 million, equivalent to the full face value of the loans, and the entire principal amount has been authorized by Congress as subsidy budget authority. No assets appear on the balance sheet as the loan subsidy matches the loans receivable so the net asset value is $0. In addition, no Treasury borrowing was required in order to disburse the loans. CMS reasonably expects any loan made under this program to be forgiven as it is anticipated that the borrowers will meet the requirements for forgiveness. As a result, the allowance for loss on accrued interest receivable in the amount of $7 million matches the interest that has accrued for these loans.

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

FY 2006	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	Other Health	Consolidated Total
Provider & Beneficiary Overpayment					
Accounts Receivable Principal	$560	$645		$30	$1,235
Less: Allowance for Uncollectible Accounts	(165)	(308)		(18)	(491)
Accounts Receivable, Net	395	337		12	744
Medicare Secondary Payer (MSP)					
Accounts Receivable Principal	75	37		4	116
Less: Allowance for Uncollectible Accounts	(22)	(9)		(1)	(32)
Accounts Receivable, Net	53	28		3	84
CMPs & Other Restitutions					
Accounts Receivable Principal	779	300		1	1,080
Less: Allowance for Uncollectible Accounts	(672)	(259)		(1)	(932)
Accounts Receivable, Net	107	41			148
Fraud and Abuse					
Accounts Receivable Principal	123	263			386
Less: Allowance for Uncollectible Accounts	(123)	(249)			(372)
Accounts Receivable, Net		14			14
Medicare Advantage					
Accounts Receivable Principal		7		3	10
Less: Allowance for Uncollectible Accounts		(3)		(3)	(6)
Accounts Receivable, Net		4			4
Medicare Premiums					
Accounts Receivable Principal	199	635			834
Less: Allowance for Uncollectible Accounts	(50)	(56)			(106)
Accounts Receivable, Net	149	579			728
State Phased-Down					
Accounts Receivable Principal		1,148			1,148
Less: Allowance for Uncollectible Accounts					
Accounts Receivable, Net		1,148			1,148
Audit Disallowances					
Accounts Receivable Principal	4	9	$246		259
Less: Allowance for Uncollectible Accounts	(1)	(2)	(124)		(127)
Accounts Receivable, Net	3	7	122		132
Other Accounts Receivable					
Accounts Receivable Principal			105	29	134
Less: Allowance for Uncollectible Accounts			(103)	(24)	(127)
Accounts Receivable, Net			2	5	7
TOTAL ACCOUNTS RECEIVABLE PRINCIPAL	**$1,740**	**$3,044**	**$351**	**$67**	**$5,202**
Less: Allowance for Uncollectible Accounts Receivable	(1,033)	(886)	(227)	(47)	(2,193)
TOTAL ACCOUNTS RECEIVABLE, NET	**$707**	**$2,158**	**$124**	**$20**	**$3,009**

FY 2005	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	Other Health	Consolidated Total
Provider & Beneficiary Overpayment					
Accounts Receivable Principal	$550	$701		$26	$1,277
Less: Allowance for Uncollectible Accounts	(189)	(374)		(16)	(579)
Accounts Receivable, Net	361	327		10	698
Medicare Secondary Payer (MSP)					
Accounts Receivable Principal	147	105		8	260
Less: Allowance for Uncollectible Accounts	(65)	(53)		(5)	(123)
Accounts Receivable, Net	82	52		3	137
CMPs & Other Restitutions					
Accounts Receivable Principal	170	359		1	530
Less: Allowance for Uncollectible Accounts	(115)	(287)		(1)	(403)
Accounts Receivable, Net	55	72			127
Fraud and Abuse					
Accounts Receivable Principal	116	226			342
Less: Allowance for Uncollectible Accounts	(116)	(208)			(324)
Accounts Receivable, Net		18			18
Medicare Advantage					
Accounts Receivable Principal	105	85		3	193
Less: Allowance for Uncollectible Accounts	(1)	(3)		(3)	(7)
Accounts Receivable, Net	104	82			186
Medicare Premiums					
Accounts Receivable Principal	212	533			745
Less: Allowance for Uncollectible Accounts	(48)	(46)			(94)
Accounts Receivable, Net	164	487			651
Audit Disallowances					
Accounts Receivable Principal	4	9	$171		184
Less: Allowance for Uncollectible Accounts	(1)	(2)	(119)		(122)
Accounts Receivable, Net	3	7	52		62
Other Accounts Receivable					
Accounts Receivable Principal			104	19	123
Less: Allowance for Uncollectible Accounts			(101)	(17)	(118)
Accounts Receivable, Net			3	2	5
TOTAL ACCOUNTS RECEIVABLE PRINCIPAL	**$1,304**	**$2,018**	**$275**	**$57**	**$3,654**
Less: Allowance for Uncollectible Accounts Receivable	(535)	(973)	(220)	(42)	(1,770)
TOTAL ACCOUNTS RECEIVABLE, NET	**$769**	**$1,045**	**$55**	**$15**	**$1,884**

Medicare accounts receivable are primarily composed of provider and beneficiary overpayments and MSP overpayments. The MSP receivables are composed of paid claims in which Medicare should have been the secondary rather than the primary payer. Claims that have been identified to a primary payer are included in the MSP receivable amount.

Currently Not Reportable/ Currently Not Collectible Debt

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

Recognition of MSP Accounts Receivable

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

Write Offs and Adjustments

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

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

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.

Non-entity Assets

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

The only non-entity assets on CMS' Consolidating Balance Sheet are receivables for interest and penalties, net for the amount of $15 million ($13 million in FY 2005). The accrued interest associated with Provider and Beneficiary, MSP and Medicare Advantage overpayments appear under All Others.

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

FY 2006	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	Other Health	Consolidated Total
Intragovernmental:					
Uncollected Revenue due Treasury	$49	$271		$14	$334
Other	6	10	$2	82	100
TOTAL OTHER INTRAGOVERNMENTAL LIABILITIES	**$55**	**$281**	**$2**	**$96**	**$434**
Deferred Revenue	$101	$263			$364
Suspense Account Deposit Funds				$19	19
Other	475	2	$1,126		1,603
TOTAL OTHER LIABILITIES	**$576**	**$265**	**$1,126**	**$19**	**$1,986**

FY 2005	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	Other Health	Consolidated Total
Intragovernmental:					
Uncollected Revenue due Treasury	$109	$279		$13	$401
Other	8	12	$3	9	32
TOTAL OTHER INTRAGOVERNMENTAL LIABILITIES	**$117**	**$291**	**$3**	**$22**	**$433**
Deferred Revenue	$59	$208			$267
Suspense Account Deposit Funds				$7	7
Other	1,109	543			1,652
TOTAL OTHER LIABILITIES	**$1,168**	**$751**		**$7**	**$1,926**

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

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 Medicaid amount for $1,126 million consists of Medicaid audit and program disallowances of $419 million and $707 million 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.

The following contingent liability for which a loss has been determined to be reasonably possible has not been accrued in the CMS financial statements:

The CMS expects that as of September 30, 2006, it is reasonably possible that a contingent liability could be owed to States in an amount as much as $1,641 million ($1,648 million in FY 2005), for unasserted claims arising from the payment of claims by State Medicaid Programs for beneficiaries who allegedly were eligible for Medicare. In FY 2005, CMS believed this contingent liability was probable, and therefore, recorded it as a liability in the financial statements. However, because no states have filed any claims since CMS first disclosed this issue, no liability has been recorded for FY 2006.

Appeals at the Provider Reimbursement Review Board

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. As of September 30, 2005, there were 5,737 PRRB cases (5,580 in FY 2005) under appeal. A total of 2,422 new cases (2,301 in FY 2005) were filed in FY 2006. The PRRB rendered decisions on 85 cases (72 in FY 2005) in FY 2006 and 2,188 additional cases (2,072 in FY 2005) were dismissed, withdrawn or settled prior to an appeal hearing. The PRRB gets no information on the value of these cases that are settled prior to a hearing. Since data is available for only the 85 cases that were decided in FY 2006, a reasonable liability estimate cannot be projected for the value of the 5,886 (5,737 in FY 2005) cases remaining on appeal as of September 30, 2006. As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

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

FY 2006	Medicare (Earmarked)						
	HI TF	SMI TF	Total	Medicaid	SCHIP	Other Health	Consolidated Total
Medicare Benefits Payable *(1)*	$19,075	$17,553	$36,628				$36,628
Medicare Advantage *(1)*	676	1,007	1,683				1,683
Retiree Drug Subsidy *(1)*		2,377	2,377				2,377
State to Plan Reconciliation Demonstration *(1)*		136	136				136
Undocumented Aliens *(1)*						$170	170
Medicaid/SCHIP/Katrina Relief Waivers *(2)*				$19,182	$284	704	20,170
TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE	**$19,751**	**$21,073**	**$40,824**	**$19,182**	**$284**	**$874**	**$61,164**

FY 2005	Medicare (Earmarked)						
	HI TF	SMI TF	Total	Medicaid	Other SCHIP	Health	Consolidated Total
Medicare Benefits Payable *(1)*	$16,547	$16,337	$32,884				$32,884
Medicare Advantage *(1)*	259	230	489				489
Demonstration Projects		2	2				2
Transitional Assistance		24	24				24
Undocumented Aliens *(1)*						$250	250
Medicaid Benefits Payable *(2)*				$19,786			19,786
Medicaid Audit/Program Disallowances *(3)*				319			319
TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE	**$16,806**	**$16,593**	**$33,399**	**$20,105**		**$250**	**$53,754**

(1) Medicare benefits payable consists of a $36,628 million estimate ($32,884 million in FY 2005) by CMS' Office of the Actuary of Medicare services incurred but not paid, as of September 30, 2006. The liability represents (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (d) periodic interim payments for 2006 that were paid in 2007 and (e) an estimate of retroactive settlements of cost reports.

The Retiree Drug Subsidy (RDS) consists of a $2,377 million estimate of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2006. 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.

Medicare Advantage and Prescription Drug Program benefits payable consist of a $1,683 million estimate for amounts owed to plans relating to risk and other payment related adjustments. Under the Medicare Modernization Act, certain Medicare payments to private Part D insurance plans are ultimately based on the individual claims experiences for each plan enrollee. In particular, Medicare reinsurance amounts are payable if an enrollee's total "true out-of-pocket costs" exceed $3,600 in 2006. Similarly, beneficiaries who have additional assistance through the Medicare low-income subsidy program qualify for payment of much of their Part D cost-sharing liability; the ultimate amount of such assistance will depend on each such beneficiary's individual cost experience.

For administrative practicality, Part D plans are paid an estimated average monthly amount per enrollee for reinsurance and a corresponding estimated average amount per low income subsidy (LIS) enrollee for cost sharing. These monthly payments are based on the plans' estimates of such costs, as included in their actuarial bid submissions to CMS. The bids are prepared by a qualified and credentialed actuary and reviewed by the CMS Office of the Actuary for reasonableness prior to the start of the plan year. Following the end of the plan year, when complete data on enrollees' use of prescription drugs are available, Medicare and the Part D plans will reconcile the estimated monthly payments with the actual experience, and a payment adjustment will be made—either from the program to the plan or vice-versa, as necessary to balance each account.

In practice, it is probable that some plans will have underestimated the average reinsurance and/or LIS cost-sharing amounts, and other plans will have overestimated these amounts. From an actuarial standpoint, it is reasonable to expect that the plans' expectations would be about right *on average*, with the overpayments to some plans tending to offset the underpayments to others. In the absence of actual plan data for the complete year, however, there is no way to reasonably estimate the aggregate amount of overpayments and the aggregate amount of underpayments for either the reinsurance or the LIS cost-sharing subsidies. In practice, each such aggregate amount could be substantial, and the net difference between them could also be very significant.

Thus, because this is the initial year of the prescription drug program and actual data have not been received and reviewed, at this time CMS cannot reasonably estimate financial statement accrual amounts for Part D reinsurance and low-income cost sharing that it will ultimately owe plans. Nor can CMS reasonably estimate such amounts that other Part D plans will owe CMS. These amounts can only be determined with any degree of certainty when the final reconciliations of the 2006 plan year data are performed, which will take place in 2007.

Moreover, because the aggregate amounts payable or receivable at calendar year-end cannot be reasonably estimated, it is not possible to estimate a reliable accrual for the end of the fiscal year. The monthly payments of estimated reinsurance and LIS cost-sharing liabilities are determined as simple averages of the annual amounts. It is reasonable to expect that the cumulative payments at any point during the calendar year would not exactly match the cumulative actual incurred amounts, because the timing of the latter is not uniform throughout the year. However, since the ultimate annual amount cannot be reasonably estimated at this time, it is similarly not possible to reasonably estimate September 30th (or other intermediate) accruals.

A potential gain contingency in the Medicare Advantage and Prescription Drug Program consists of amounts due to CMS resulting from risk and other payment related adjustments. However, these amounts have not been finalized as of year end.

Undocumented aliens consist of a $170 million estimate ($250 million in FY 2005) of emergency health services furnished by providers to eligible aliens but not paid as of September 30, 2006. As part of the MMA, Section 1011, Congress mandated HHS directly pay hospitals, physicians, and ambulance providers for their otherwise un-reimbursed costs of providing services required by section 1867 of the Social Security Act related to undocumented aliens.

The CMS implemented the State to Plan Reconciliation Demonstration project under the authority of Section 402 of the Social Security Amendments of 1967 in order to ensure appropriate care continuation for dual eligibles and other low-income subsidy entitled beneficiaries. The liability of $136 million relating to the demonstration project represents estimated amounts to be paid to States for costs incurred in assisting dual eligible beneficiaries to transition to the Medicare Part D Prescription Drug Benefit. A potential gain contingency exists relating to the State to Plan Reconciliation Demonstration project that represents amounts expected to be recovered from the Part D plans for Medicaid and State Pharmaceutical Assistance Program (SPAP) claims. The actual amount of the expected recoveries will not be known until the reconciliation process is completed. The anticipated outcome of the reconciliation is that CMS anticipates the recovery of funds from the Part D plans.

(2) Medicaid benefits payable of $19,182 million ($19,786 million in FY 2005) 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, 2006. An estimated SCHIP benefits payable of $284 million has been recorded for the net Federal share of expenses that have been incurred by the States but not yet reported to CMS as of September 30, 2006. No such SCHIP accrual was recorded at September 30, 2005 because management deemed the estimate immaterial.

The liability for Katrina relief waivers of $704 million consists of $543 million in actual services rendered but not paid plus a $161 million estimate for services incurred but not paid, as of September 30, 2006, by eligible States with respect to evacuees who do not have other coverage for assistance through insurance under title XIX of the Social Security Act. CMS has this authority under an approved Multi-State Section 1115 Demonstration Project of Public Law 109-171, Subtitle C.

(3) Medicaid audit and program disallowances of $319 million in FY 2005 were contingent liabilities established as a result of Medicaid audit and program disallowances that were being appealed by the States. In all cases, the funds were 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 are deferred under the Medicaid program when there is a reasonable doubt as to the legitimacy of expenditures claimed by a State. There were also outstanding reviews of the State expenditures in which a final determination was not 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.

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

FY 2006	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	SCHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Intragovernmental:								
Accrued Payroll and Benefits	$1	$2				$3		$3
TOTAL INTRAGOVERNMENTAL	**$1**	**$2**				**$3**		**$3**
Federal Employee and Veterans' Benefits	3	7	$1			11		11
Accrued Payroll and Benefits	9	22	2			33		33
Contingent Liabilities		475	1,126			1,601		1,601
TOTAL LIABILITIES NOT COVERED BY BUDGETARY RESOURCES	**$13**	**$506**	**$1,129**			**$1,648**		**$1,648**
TOTAL LIABILITIES COVERED BY BUDGETARY RESOURCES	**$40,864**	**$43,861**	**$19,185**	**$284**	**$992**	**$105,186**	**$(42,637)**	**$62,549**
TOTAL LIABILITIES	**$40,877**	**$44,367**	**$20,314**	**$284**	**$992**	**$106,834**	**$(42,637)**	**$64,197**

FY 2005	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	SCHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Intragovernmental:								
Accrued Payroll and Benefits	$1	$3				$4		$4
Liability for Unmatched SMI Premiums		5,173				5,173	$(5,173)	
TOTAL INTRAGOVERNMENTAL	**$1**	**$5,176**				**$5,177**	**$(5,173)**	**$4**
Entitlement Benefits Due and Payable			$9,470			$9,470		$9,470
Federal Employee and Veterans' Benefits	3	6	1			10		10
Accrued Payroll and Benefits	10	19	3			32		32
Contingent Liabilities	1,107	541				1,648		1,648
TOTAL LIABILITIES NOT COVERED BY BUDGETARY RESOURCES	**$1,121**	**$5,742**	**$9,474**			**$16,337**	**$(5,173)**	**$11,164**
TOTAL LIABILITIES COVERED BY BUDGETARY RESOURCES	**$34,591**	**$36,512**	**$10,640**		**$279**	**$82,022**	**$(36,681)**	**$45,341**
TOTAL LIABILITIES	**$35,712**	**$42,254**	**$20,114**		**$279**	**$98,359**	**$(41,854)**	**$56,505**

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, amounts billed by the Department of Labor for Federal Employee's Compensation Act (FECA) payments, and for portions of the Entitlement Benefits Due and Payable liability for which no obligations have been incurred. For CMS revolving funds, all liabilities are funded as they occur.

As described in Note 5, there were insufficient funds in the Payments to the Health Care Trust Funds (PTF) appropriation for the matching of SMI premiums in FY 2005. Accordingly, CMS recorded a liability for $5,173 million from the PTF to the SMI TF. The liability appears under SMI TF in the intragovernmental section of liabilities not covered by budgetary resources. There is no comparable liability in FY 2006.

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

FY 2006	Medicare (Earmarked)			Health			
	HI TF	SMI TF	Total	Medicaid	SCHIP	Other Health	Consolidated Totals
PROGRAM/ACTIVITY COSTS							
Medicare							
Fee for Service	$157,644	$135,180	$292,824				$292,824
Medicare Advantage	27,879	26,348	54,227				54,227
Prescription Drug (Part D)		34,842	34,842				34,842
Medicaid/SCHIP/State Grants & Demos				$179,254	$5,735	$1,946	186,935
CLIA						74	74
TOTAL PROGRAM/ACTIVITY COSTS	**$185,523**	**$196,370**	**$381,893**	**$179,254**	**$5,735**	**$2,020**	**$568,902**
OPERATING COSTS							
Medicare Integrity Program	$1,068		$1,068				$1,068
Quality Improvement Organizations	332	$68	400				400
Bad Debt Expense and Writeoffs	493	(97)	396	$5		$7	408
Reimbursable Expenses	3	6	9	1			10
Administrative Expenses	1,004	2,068	3,072	215	$4	78	3,369
Depreciation and Amortization	22	39	61	6			67
Imputed Cost Subsidies	7	18	25	2			27
TOTAL OPERATING COSTS	**$2,929**	**$2,102**	**$5,031**	**$229**	**$4**	**$85**	**$5,349**
TOTAL COSTS	**$188,452**	**$198,472**	**$386,924**	**$179,483**	**$5,739**	**$2,105**	**$574,251**
LESS: EXCHANGE REVENUES:							
Medicare Premiums	$2,654	$42,501	$45,155				$45,155
State Phased-Down		4,777	4,777				4,777
CLIA Revenues						$124	124
Other Exchange Revenues	10	13	23	$2		14	39
TOTAL EXCHANGE REVENUES	**$2,664**	**$47,291**	**$49,955**	**$2**		**$138**	**$50,095**
TOTAL NET COST OF OPERATIONS	**$185,788**	**$151,181**	**$336,969**	**$179,481**	**$5,739**	**$1,967**	**$524,156**

FY 2005	Medicare (Earmarked)			Health			
	HI TF	SMI TF	Total	Medicaid	SCHIP	Other Health	Consolidated Totals
PROGRAM/ACTIVITY COSTS							
Medicare							
Fee for Service	$156,597	$128,699	$285,296				$285,296
Medicare Advantage	23,783	20,764	44,547				44,547
Medicaid/SCHIP/State Grants & Demos				$182,438	$5,129	$325	187,892
CLIA						63	63
TOTAL PROGRAM/ACTIVITY COSTS	**$180,380**	**$149,463**	**$329,843**	**$182,438**	**$5,129**	**$388**	**$517,798**
OPERATING COSTS							
Medicare Integrity Program	$1,095		$1,095				$1,095
Quality Improvement Organizations	319	$79	398				398
Bad Debt Expense and Writeoffs	(45)	(7)	(52)	$(483)			(535)
Reimbursable Expenses	2	5	7	1			8
Administrative Expenses	919	1,686	2,605	265	$6		2,876
Depreciation and Amortization	27	18	45	3			48
Imputed Cost Subsidies	10	21	31	3			34
TOTAL OPERATING COSTS	**$2,327**	**$1,802**	**$4,129**	**$(211)**	**$6**		**$3,924**
TOTAL COSTS	**$182,707**	**$151,265**	**$333,972**	**$182,227**	**$5,135**	**$388**	**$521,722**
LESS: EXCHANGE REVENUES:							
Medicare Premiums	$2,303	$35,939	$38,242				$38,242
CLIA Revenues						$60	60
Other Exchange Revenues	11	6	17	$1			18
TOTAL EXCHANGE REVENUES	**$2,314**	**$35,945**	**$38,259**	**$1**		**$60**	**$38,320**
TOTAL NET COST OF OPERATIONS	**$180,393**	**$115,320**	**$295,713**	**$182,226**	**$5,135**	**$328**	**$483,402**

For purposes of financial statement presentation, non-CMS administrative costs are considered expenses to the Medicare trust funds when outlayed by Treasury even though some funds may have been used to pay for assets such as property and equipment. The CMS administrative costs have been allocated to the Medicare, Medicaid, SCHIP and TWI programs based on the CMS cost allocation system. Administrative costs allocated to the Medicare program include $1,544 million ($1,307 million in FY 2005) paid to Medicare contractors to carry out their responsibilities as CMS' agents in the administration of the Medicare program.

NOTE 11: NONEXCHANGE REVENUE *(Dollars in Millions)*

FY 2006	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Consolidated Total
FICA Tax Receipts	$168,564		$168,564
SECA Tax Receipts	11,829		11,829
Trust Fund Investment Interest	15,541	$1,601	17,142
Civil Monetary Penalties and Damages	306		306
Other Income		2	2
TAXES AND OTHER NONEXCHANGE REVENUE	**$196,240**	**$1,603**	**$197,843**

FY 2005	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Consolidated Total
FICA Tax Receipts	$157,702		$157,702
SECA Tax Receipts	11,252		11,252
Trust Fund Investment Interest	15,149	$1,335	16,484
Civil Monetary Penalties and Damages	354		354
Other Income		1	1
TAXES AND OTHER NONEXCHANGE REVENUE	**$184,457**	**$1,336**	**$185,793**

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

NOTE 12: TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT *(Dollars in Millions)*

FY 2006

Transfers-in Without Reimbursement	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	SCHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Medicare Benefit Transfers	$187,218	$195,705				$382,923	$(382,923)	
Transfers to HCFAC	1,169					1,169	(1,169)	
Federal Matching Contributions		129,082				129,082	(129,082)	
Medicare Part D Benefits		28,172				28,172	(28,172)	
Medicare Part D Administrative		174				174	(174)	
Allocation to CMS Programs	799	2,086	$187	$3	$8	3,083	(3,083)	
Fraud and Abuse Appropriation	114					114	(114)	
Transfer-Uninsured Coverage	408					408	(408)	
Prog. Mngmt. Admin. Expense *(1)*	131					131	(131)	
Income Tax OASDI Benefits *(2)*	10,319					10,319	(10,319)	
Railroad Retirement Board	491					491		$491
Criminal Fines	155					155		155
Medicaid Part B Premiums			264			264	(264)	
Interest Adjustment	3	(3)						
Gifts and Miscellaneous	1					1		1
TOTAL TRANSFERS-IN	**$200,808**	**$355,216**	**$451**	**$3**	**$8**	**$556,486**	**$(555,839)**	**$647**

FY 2006

Transfers-out Without Reimbursement	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	SCHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
SSA Administrative Expenses	$(744)	$(1,121)				$(1,865)		$(1,865)
Medicare Benefit Transfers	(187,218)	(195,705)				(382,923)	$382,923	
Transfers to HCFAC	(1,169)					(1,169)	1,169	
Federal Matching Contributions		(129,082)				(129,082)	129,082	
Medicare Part D Benefits		(28,172)				(28,172)	28,172	
Medicare Part D Administrative		(315)				(315)	315	
Transfers to Program Management	(1,030)	(1,912)				(2,942)	2,942	
Fraud and Abuse Appropriation	(114)					(114)	114	
Transfer-Uninsured Coverage	(408)					(408)	408	
Prog. Mngmt. Admin. Expense *(1)*	(131)					(131)	131	
Income Tax OASDI Benefits *(2)*	(10,319)					(10,319)	10,319	
Medicaid Part B Premiums		(264)				(264)	264	
Office of the Secretary	(35)	(33)				(68)		(68)
Payment Assessment Commission	(6)	(4)				(10)		(10)
Railroad Retirement Board		(7)				(7)		(7)
TOTAL TRANSFERS-OUT	**$(201,174)**	**$(356,615)**				**$(557,789)**	**$555,839**	**$(1,950)**
TOTAL TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT	**$(366)**	**$(1,399)**	**$451**	**$3**	**$8**	**$(1,303)**		**$(1,303)**

FY 2005

Transfers-in Without Reimbursement	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	SCHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Medicare Benefit Transfers	$184,531	$151,325				$335,856	$(335,856)	
Transfers to HCFAC	1,057					1,057	(1,057)	
Federal Matching Contributions		113,529				113,529	(113,529)	
Transitional Assistance Benefits		1,125				1,125	(1,125)	
State Low Income Determination		73	$73			146	(146)	
Allocation to CMS Programs	796	1,528	274	$6		2,604	(2,604)	
Fraud and Abuse Appropriation	114					114	(114)	
Transfer-Uninsured Coverage	286					286	(286)	
Prog. Mngmt. Admin. Expense *(1)*	215					215	(215)	
Income Tax OASDI Benefits *(2)*	8,765					8,765	(8,765)	
Railroad Retirement Board	477					477		$477
Criminal Fines	359					359		359
Medicaid Part B Premiums			242			242	(242)	
Interest Adjustment	1	(1)						
Gifts and Miscellaneous	1	1				2		2
TOTAL TRANSFERS-IN	**$196,602**	**$267,580**	**$589**	**$6**		**$464,777**	**$(463,939)**	**$838**

FY 2005

Transfers-out Without Reimbursement	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	SCHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
SSA Administrative Expenses	$(662)	$(577)				$(1,239)		$(1,239)
Medicare Benefit Transfers	(184,531)	(151,325)				(335,856)	$335,856	
Transfers to HCFAC	(1,057)					(1,057)	1,057	
Federal Matching Contributions		(113,529)				(113,529)	113,529	
Transitional Assistance Benefits		(1,125)				(1,125)	1,125	
State Low Income Determination		(73)				(73)	73	
Transfers to Program Management	(895)	(1,783)				(2,678)	2,677	(1)
Fraud and Abuse Appropriation	(114)					(114)	114	
Transfer-Uninsured Coverage	(286)					(286)	286	
Prog. Mngmt. Admin. Expense *(1)*	(215)					(215)	215	
Income Tax OASDI Benefits *(2)*	(8,765)					(8,765)	8,765	
Medicaid Part B Premiums		(242)				(242)	242	
Office of the Secretary	(31)	(28)				(59)		(59)
Office of the Secretary OIG		(25)				(25)		(25)
Payment Assessment Commission	(6)	(4)				(10)		(10)
Railroad Retirement Board		(6)				(6)		(6)
TOTAL TRANSFERS-OUT	**$(196,562)**	**$(268,717)**				**$(465,279)**	**$463,939**	**$(1,340)**
TOTAL TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT	**$40**	**$(1,137)**	**$589**	**$6**		**$(502)**		**$(502)**

(1) During FY 2006, the Payments to the Health Care Trust Funds appropriation paid the HI trust fund $131 million ($215 million in FY 2005) to cover the Medicaid, SCHIP and TWI programs' share of CMS' administrative costs.

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

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 $78.20 from October 2005 through December 2005 and $88.50 from January 2006 through September 2006. Premiums collected from beneficiaries totaled $41,628 million ($35,939 million in FY 2005) and were matched by a $129,082 million ($113,529 million in FY 2005) 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. Approximately $28,346 million has been transferred-in to Part D from the general fund.

NOTE 13: BUDGETARY FINANCING SOURCES: OTHER ADJUSTMENTS *(Dollars in Millions)*

FY 2006	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	SCHIP	Other Health	Consolidated Total
Unexpended Appropriations						
Withdrawal of Expired or Canceled Year Authority		$(1,700)		$(45)		$(1,745)
Net Change in Anticipated Congressional Appropriation		(5,173)	$(9,099)			(14,272)
TOTAL OTHER ADJUSTMENTS		**$(6,873)**	**$(9,099)**	**$(45)**		**$(16,017)**

FY 2005	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	SCHIP	Other Health	Consolidated Total
Unexpended Appropriations						
Withdrawal of Expired or Canceled Year Authority		$(2,105)			$(3)	$(2,108)
Net Change in Anticipated Congressional Appropriation		(472)	$5,496			5,024
Return of Indefinite Authority			(2,600)			(2,600)
TOTAL OTHER ADJUSTMENTS		**$(2,577)**	**$2,896**		**$(3)**	**$316**

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

NOTE 14: EARMARKED FUNDS *(Dollars in Millions)*

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

Balance Sheet as of September 30, 2006

	HI TF	SMI TIF	Total Earmarked Funds
ASSETS			
Fund Balance with Treasury	$955	$27,771	$28,726
Investments	306,100	33,445	339,545
Other Assets	21,674	24,810	46,484
TOTAL ASSETS	**$328,729**	**$86,026**	**$414,755**
Entitlement Benefits Due & Payable	$19,751	$21,073	$40,824
Other Liabilities	21,126	23,294	44,420
TOTAL LIABILITIES	**$40,877**	**$44,367**	**$85,244**
Unexpended Appropriations	$33	$27,625	$27,658
Cumulative Results of Operations	287,819	14,034	301,853
TOTAL LIABILITIES AND NET POSITION	**$328,729**	**$86,026**	**$414,755**

Statement of Net Cost for the Period Ended September 30, 2006

Benefit Expense	$185,523	$196,370	$381,893
Operating Costs	2,929	2,102	5,031
LESS EARNED REVENUES	**$2,664**	**$47,291**	**$49,955**
NET COST OF OPERATIONS	**$185,788**	**$151,181**	**$336,969**

Statement of Changes in Net Position for the Period Ended September 30, 2006

Net Position Beginning of Period	$266,754	$9,266	$276,020
Taxes and Other Non-exchange Revenue	196,240	1,603	197,843
Other Financing Sources	10,646	181,971	192,617
NET COST OF OPERATIONS	**$185,788**	**$151,181**	**$336,969**
CHANGE IN NET POSITION	**$21,098**	**$32,393**	**$53,491**
NET POSITION END OF PERIOD	**$287,852**	**$41,659**	**$329,511**

NOTE 15: INTRAGOVERNMENTAL COSTS AND EXCHANGE REVENUE *(Dollars in Millions)*

FY 2006	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	$514	$187,938	$188,452	$2	$2,662	$2,664	$185,788
SMI TF	181	198,291	198,472	6	47,285	47,291	151,181
Medicaid	19	179,464	179,483	1	1	2	179,481
SCHIP		5,739	5,739				5,739
SUBTOTAL	**$714**	**$571,432**	**$572,146**	**$9**	**$49,948**	**$49,957**	**$522,189**
OTHER ACTIVITIES							
CLIA	$38	$35	$73		$124	$124	$(51)
State Grants & Demonstrations	3	1,951	1,954	$7	7	14	1,940
Other		78	78				78
SUBTOTAL	**$41**	**$2,064**	**$2,105**	**$7**	**$131**	**$138**	**$1,967**
PROGRAM/ACTIVITY TOTALS	**$755**	**$573,496**	**$574,251**	**$16**	**$50,079**	**$50,095**	**$524,156**

FY 2005	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	$380	$182,327	$182,707	$4	$2,310	$2,314	$180,393
SMI TF	167	151,098	151,265	6	35,939	35,945	115,320
Medicaid	26	182,201	182,227	1		1	182,226
SCHIP		5,135	5,135				5,135
SUBTOTAL	**$573**	**$520,761**	**$521,334**	**$11**	**$38,249**	**$38,260**	**$483,074**
OTHER ACTIVITIES							
CLIA	$27	$36	$63		$60	$60	$3
State Grants & Demonstrations		325	325				325
SUBTOTAL	**$27**	**$361**	**$388**		**$60**	**$60**	**$328**
PROGRAM/ACTIVITY TOTALS	**$600**	**$521,122**	**$521,722**	**$11**	**$38,309**	**$38,320**	**$483,402**

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

NOTE 16: 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 2006	Direct	Reimbursable	Combined Totals
Category A	$42,491	$267	$42,758
Category B	368,306	84	368,390
Exempt	362,750		362,750
TOTAL	**$773,547**	**$351**	**$773,898**

FY 2005	Direct	Reimbursable	Combined Totals
Category A	$8,522	$68	$8,590
Category B	312,255	13	312,268
Exempt	346,561		346,561
TOTAL	**$667,338**	**$81**	**$667,419**

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 $292,426 million as of September 30, 2006 ($258,025 million in FY 2005) are included in Investments on the Balance Sheet. The following table presents trust fund activities and balances for FY 2006 and FY 2005 (in millions):

	FY 2006 Combined Balances	FY 2005 Combined Balances
TRUST FUND BALANCES, BEGINNING	**$258,025**	**$246,876**
Receipts	387,889	350,969
Less Obligations	353,488	339,820
Excess of Receipts Over Obligations	34,401	11,149
TRUST FUND BALANCES, ENDING	**$292,426**	**$258,025**

Explanations of Differences Between the Statement of Budgetary Resources and the Budget of the United States Government for FY 2005

(in millions)

	Budgetary Resources	Obligations Incurred	Offsetting Receipts	Net Outlays
Statement of Budgetary Resources	$670,517	$667,419	$165,730	$484,296
Unobligated Balances Not Available	(597)			
Other Adjustments	1,851	1,779		1,659
PRESIDENT'S BUDGET (actual)	**$671,771**	**$669,198**	**$165,730**	**$485,955**

The Other Adjustments Line for Budgetary Resources includes an increase in the amount of $1,920 million for the amounts reported in the President's Budget but reported by the Centers for Disease Control (CDC) and the Department of Treasury (Treasury) and a decrease of $69 million for offsetting collections.

The Other Adjustments Line for Obligations Incurred includes an increase of $1,864 million for the amounts reported in the President's Budget but reported by CDC and Treasury and a decrease of $85 million for expired accounts.

The Other Adjustments Line for Net Outlays includes an increase to net outlays in the amount of $1,659 million for the amounts reported in the President's Budget but reported by the CDC and Treasury.

The President's Budget with actual numbers for FY 2006 has not yet been published. It is expected that the Office of Management and Budget (OMB) will publish the FY 2006 numbers in January 2007 and will be available from OMB.

Undelivered Orders at the End of the Period

The amount of budgetary resources obligated for undelivered orders totaled $7,646 million at the end of September 30, 2006.

NOTE 17: 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 for the year shown and over the 75-year projection period beginning January 1 of that year. They 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 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.

Actuarial present values of estimated future income (excluding interest) and estimated future cost 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, or those who are expected to become participants in the future. Current participants are the "closed group" of individuals who are at least age 15 at the start of the projection period, and are participating in the program as either taxpayers, beneficiaries, or both. Since the projection period consists of 75 years, it 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 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 cost trends for the future, HI income is expected to fall substantially short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar problems because each account is automatically in financial balance every year due to its financing mechanism.

In addition to the actuarial present value of estimated future excess of income (excluding interest) over cost, shown in the basic statement, 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 age 15 through 64. In order to calculate the actuarial net present value of the excess of future income over future costs for the closed group, one could subtract the actuarial present value of estimated future costs for or on behalf of current participants 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, and such changes 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 current law. 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 on the table below. The assumptions underlying the SOSI actuarial projections, and the projections themselves, are drawn from the Social Security and Medicare Trustees Reports for 2006. 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.

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 new (having begun operations in January 2006), and very little actual program data is available. The actual 2006 bid submissions by the private plans offering this coverage, together with preliminary data on beneficiary enrollment, has 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.

Medicare and Economic and Demographic Assumptions

					Annual percentage change in:						
								Per beneficiary cost[8]			
									SMI		
	Fertility rate[1]	Net immigration[2]	Mortality rate[3]	Real-wage differential[4]	Wages[5]	CPI[6]	Real GDP[7]	HI	B	D	Real-interest rate[9]
2006	2.03	1,075,000	848.9	1.2	4.1	2.9	3.4	4.7	8.6	—	1.4
2010	2.03	1,000,000	829.2	1.5	4.3	2.8	2.6	4.7	4.1	7.9	3.1
2020	2.01	950,000	767.1	0.9	3.7	2.8	2.1	4.4	4.5	6.6	2.9
2030	2.00	900,000	707.4	1.1	3.9	2.8	1.9	5.8	5.6	5.3	2.9
2040	2.00	900,000	654.5	1.1	3.9	2.8	2.0	5.8	5.3	5.2	2.9
2050	2.00	900,000	608.0	1.1	3.9	2.8	2.0	4.9	4.8	4.9	2.9
2060	2.00	900,000	566.9	1.1	3.9	2.8	1.9	4.6	4.7	4.6	2.9
2070	2.00	900,000	530.3	1.1	3.9	2.8	2.0	4.5	4.4	4.4	2.9
2080	2.00	900,000	497.6	1.1	3.9	2.8	1.9	4.3	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.

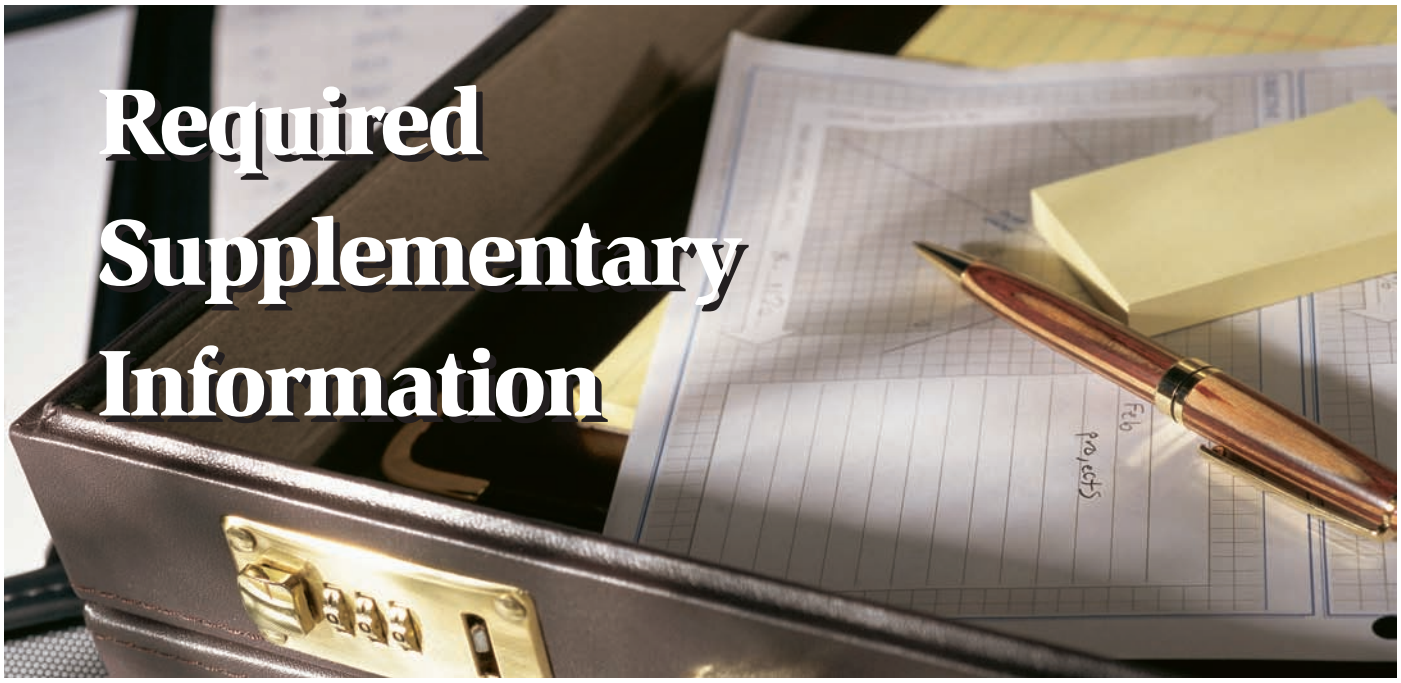
[9] Average rate of interest earned on new trust fund securities, above and beyond rate of inflation.

NOTE 18: 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 37 percent over the next 9 years. Reductions of this magnitude are very unlikely to occur fully in practice. For example, Congress has overridden scheduled negative updates for each of the last 4 years. 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 is likely 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 current law, the projected 75-year present value of future Part B expenditures is $17.6 trillion. 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 $22.3 trillion. Alternatively, 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 $24.4 trillion.

The extent to which actual future Part B costs could 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). 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 would 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.



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 slightly over four decades. The recent Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (known informally as the Medicare Modernization Act, or MMA) introduced the most sweeping changes to the program since its enactment in 1965. The most significant change is that, beginning in 2004, the MMA established a new prescription drug benefit. A separate Part D account within the Supplementary Medical Insurance (SMI) trust fund handles the transactions for this new coverage. A brief description of the provisions of Medicare's Hospital Insurance (HI)(Part A) trust fund and the SMI (Parts B and D) trust fund is included on pages 3-5 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 ***2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds***, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

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

ACTUARIAL PROJECTIONS

Cashflow in Nominal Dollars

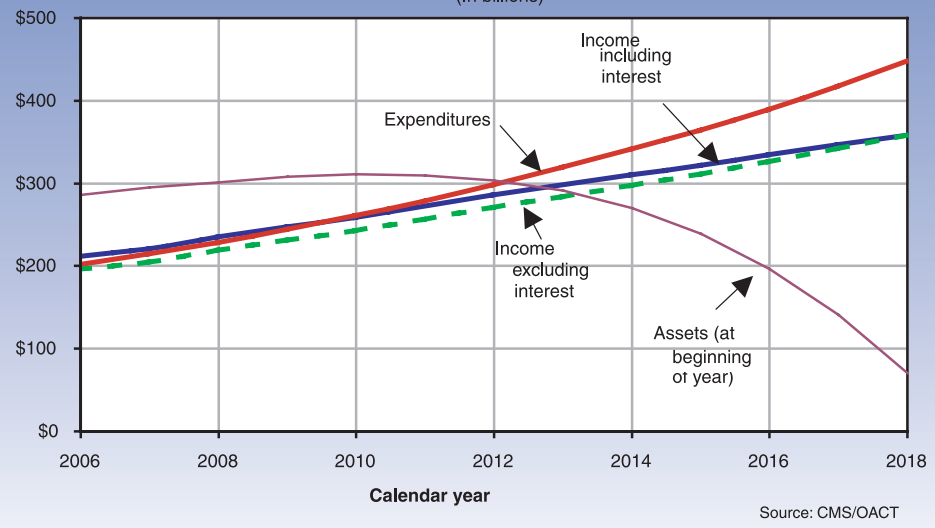
Using nominal dollars[1] for short-term projections paints a reasonably clear picture of expected performance with particular attention on cashflow and trust fund balances. Over longer periods, however, the changing value of the dollar can complicate efforts to compare dollar amounts in different periods and can create severe barriers to interpretation, since projections must be linked to something that 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 here. Instead, nominal-dollar estimates for the HI trust fund are displayed only through the projected date of depletion, currently the year 2018. 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 2006 through 2018, 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 will enter the workforce through 2018. The estimates also include income and expenditures attributable to these current and future workers, in addition to current beneficiaries.

Chart 1—HI Income, Expenditures, and Assets 2006-2018



Source: CMS/OACT

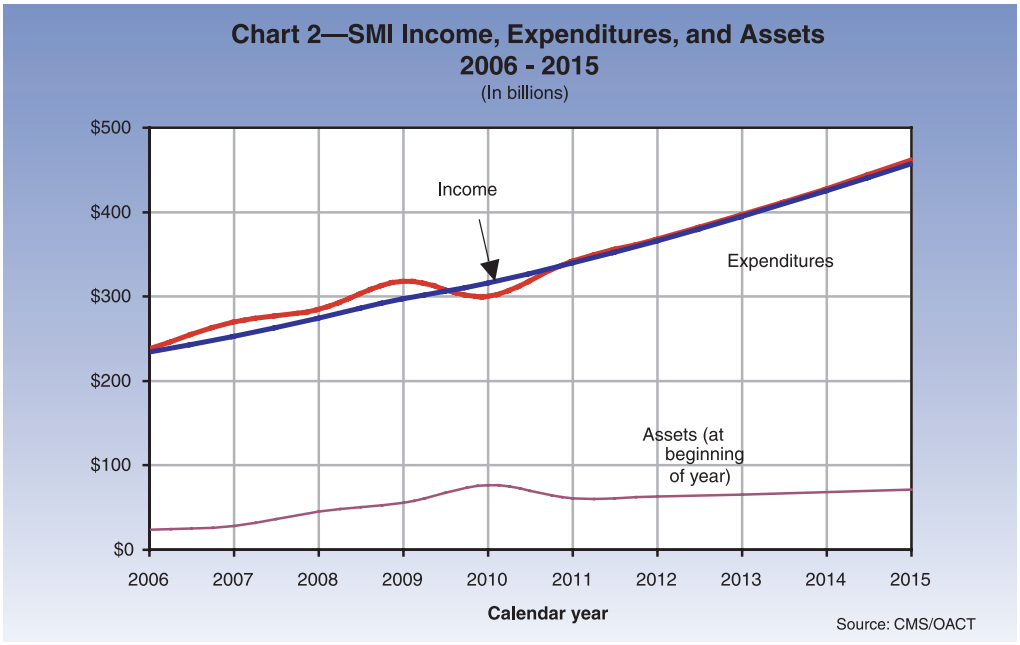
[1] Dollar amounts that are not adjusted for inflation or other factors are referred to as "nominal."

As chart 1 shows, HI expenditures exceeded income excluding interest in 2006 and, under the intermediate assumptions, would begin to exceed income including interest in 2010. This situation arises as a result of health cost increases that are expected to continue to grow faster than workers' earnings. Beginning in 2010, the HI trust fund would start redeeming its assets; by the end of 2018, the assets would be depleted—2 years earlier than estimated in the 2005 Trustees Report. For the third year in a row, the HI trust fund does not meet an explicit test of short-range financial adequacy, as assets are predicted to fall below expenditures within the next 10 years.

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

SMI

Chart 2 shows the actuarial estimates of SMI income, expenditures, and assets, for Parts B and D combined, for each of the years 2006 through 2015, in nominal dollars. Whereas HI estimates are displayed through 2018, SMI estimates cover only the years through 2015, as SMI differs fundamentally from HI in regard to the way it is financed. In particular, financing for SMI Parts B and D is not based on payroll taxes but rather on a combination of monthly beneficiary premiums and income from the general fund of the U.S. Treasury—both of which are established annually to cover the following year's expenditures.[2] Estimates of SMI income and expenditures, therefore, are virtually the same, as illustrated in chart 2, and so are not shown in nominal dollars separately beyond 2015.[3]



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

[3] Delivery of 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. These amounts are excluded from the premium income and general revenue income for 2010.

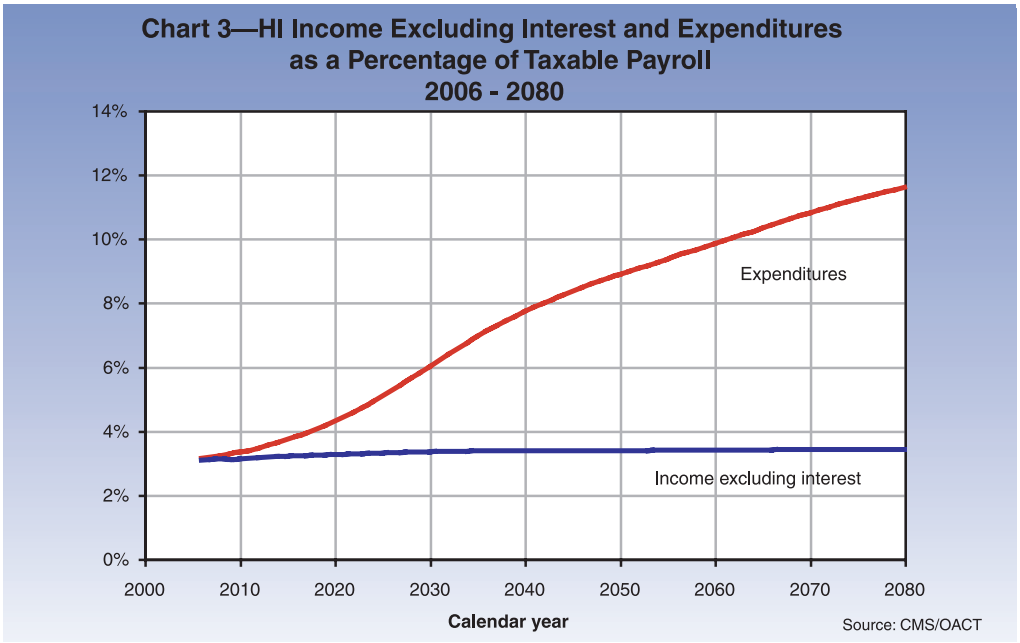
Income includes monthly premiums paid by, or on behalf of, beneficiaries, transfers from the general fund of the U.S. Treasury, certain payments by the states to the Part D account, and interest earned on the U.S. Treasury securities held by the SMI trust fund. Chart 2 displays only total income; it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

As chart 2 indicates, SMI income is very close to expenditures. As mentioned earlier, this is because of the financing mechanism for Parts B and D. Under present law, both accounts are automatically in financial balance every year, regardless of future economic and other conditions.

HI Cashflow as a Percentage of Taxable Payroll

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

Chart 3 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. Prior to this 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. For this year's report, the Board of Trustees has adopted a refinement of these long-range growth assumptions. The refinement provides a smoother and more realistic transition from current Medicare cost



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

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

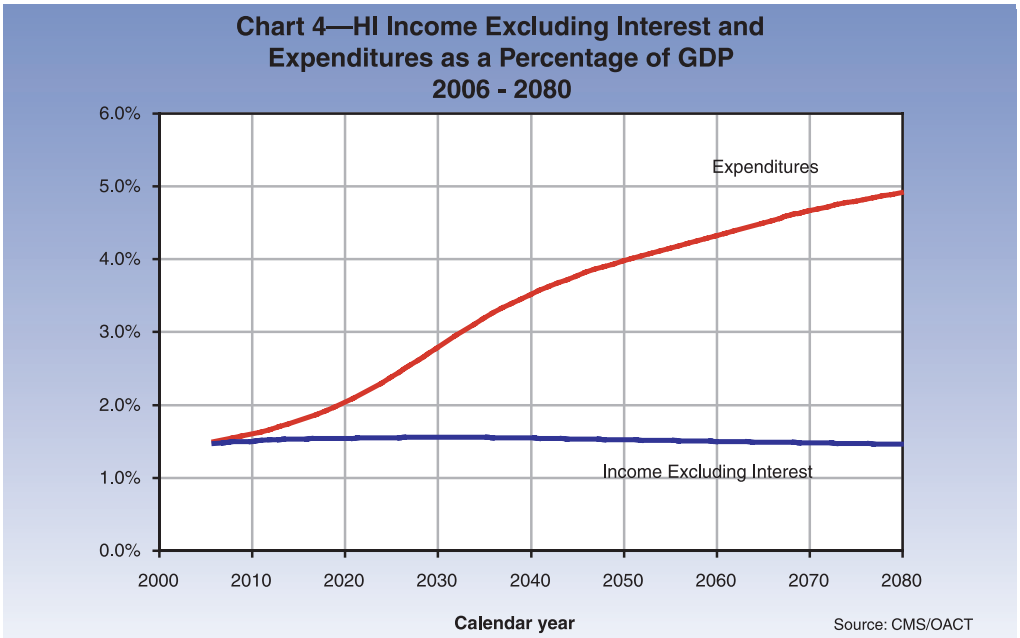
Since HI payroll tax rates are not scheduled to change in the future under present law, payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. Income from taxation of benefits will increase only gradually as a greater proportion of Social Security beneficiaries 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 2005, the expenditures were $182.9 billion, which was 1.5 percent of GDP. This percentage is projected to increase steadily throughout the remainder of the 75-year period.



SMI

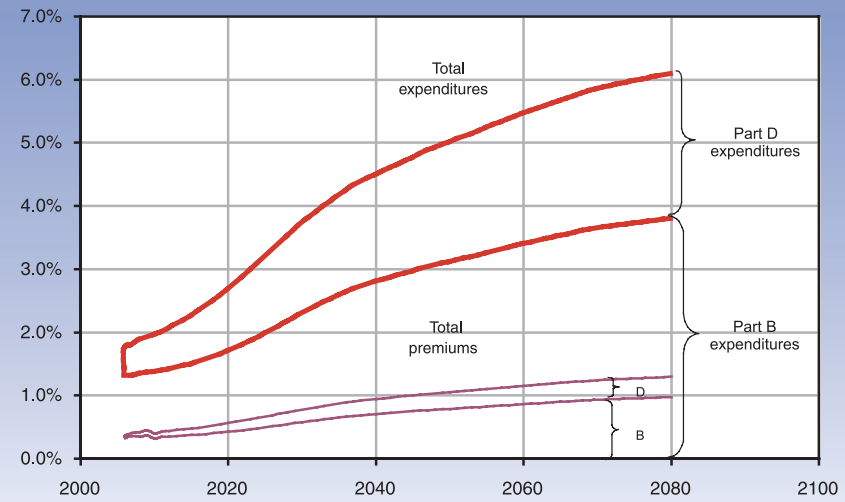
Because of the Part B and D financing mechanism in which income mirrors expenditures, it is not necessary to test for long-range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and Federal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

Chart 5 shows 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 this year's report. This refinement provides a more gradual transition from current health cost growth rates to the ultimate assumed level of GDP plus zero percent just after the 75th year and for the indefinite future. The growth rates are estimated year by year for the next 12 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 13 to 25 is assumed to grade smoothly into the long-range assumption.

Under the intermediate assumptions, annual SMI expenditures would grow from about 1.3 percent of GDP in 2005, to 1.7 percent of GDP in 2006 with the commencement of the full prescription drug coverage. Then, within 25 years, they would grow to almost 4 percent of GDP and to more than 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 new Medicare drug benefit. The percentage is 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the state payments are also expected to increase faster than GDP.

Chart 5—SMI Expenditures and Premiums as a Percentage of GDP 2006 - 2080

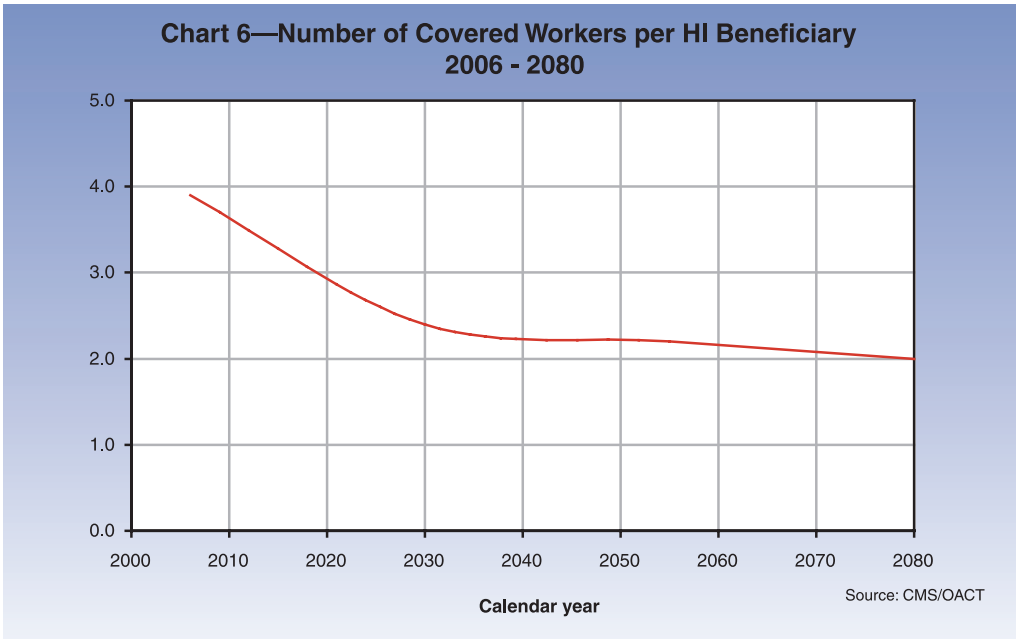


Source: CMS/OACT

Worker-to-Beneficiary Ratio

HI

Another way to evaluate the long-range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 6 illustrates this ratio over the next 75 years. For the most part, current benefits are paid for by current workers. The retirement of the baby boom generation will therefore be financed by the relatively smaller number of persons born after the baby boom. In 2005, every beneficiary had about 3.9 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only 2.4 workers per beneficiary. The projected ratio continues to decline until there are just 2.0 workers per beneficiary by 2080.



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. Because of revisions to these assumptions, due to either changed conditions or more information, estimates made in prior years have sometimes changed substantially. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty.

In order to illustrate the magnitude of the sensitivity of the long-range projections, six of the key assumptions were varied individually to determine the impact on the HI

actuarial present values and net cashflows.[5] The assumptions varied are the health care cost factors, fertility rate, net immigration, real-wage differential, consumer price index (CPI), and real-interest rate.[6]

For this analysis, the intermediate economic and demographic assumptions in the ***2006 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, 2006 and are based on estimates of income and expenditures during the 75-year projection period.

Charts 7 through 12 show the net annual HI cashflow in nominal dollars and the present value of this net cashflow for each assumption varied. In most instances, the charts depicting the estimated net cashflow indicate that, after increasing in the early years, net cashflow decreases steadily through 2080 under all three scenarios displayed. On the present value charts, the same pattern is evident, in most cases, until around 2060, when the present values begin to increase (or become less negative). This occurs as a result of the discounting process used for computing present values, which is used to help interpret the net cashflow deficit in terms of today's dollar. In other words, the amount required today to cover this deficit begins to decrease at the end of the 75-year period.

Health Care Cost Factors

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

TABLE 1
Present Value of Estimated HI Income Less Expenditures under Various Health Care Cost Growth Rate Assumptions

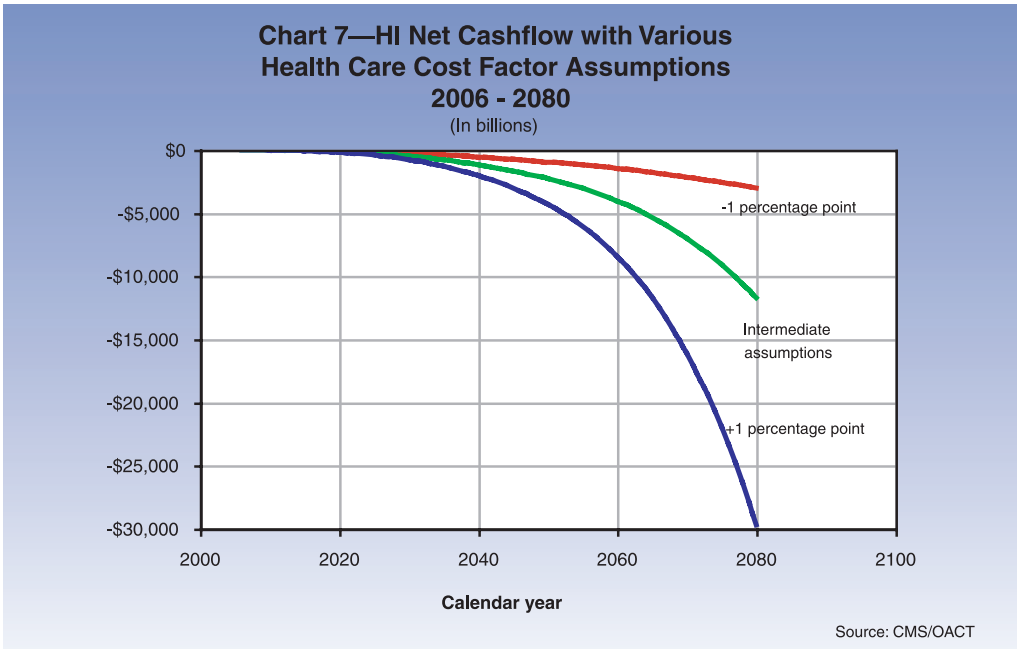
Annual cost/payroll relative growth rate	-1 percentage point	Intermediate assumptions	+1 percentage point
Income minus expenditures *(in billions)*	-$4,459	-$11,290	-$22,387

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $6,831 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 $11,097 billion.

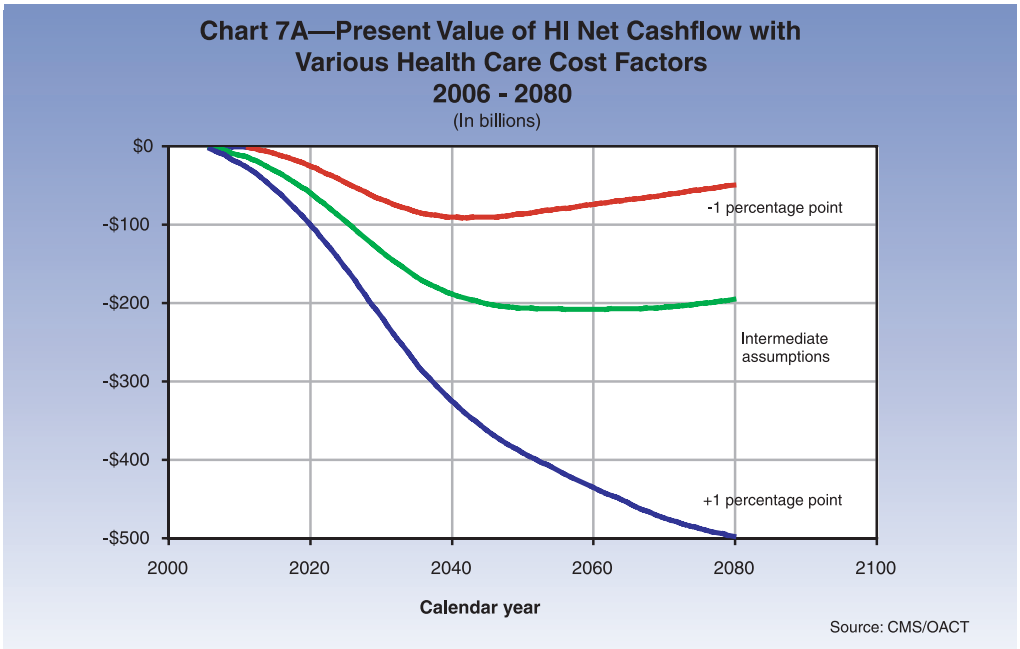
[5] Sensitivity analysis is not done for Parts B or D of the SMI trust fund due to the financing mechanism for each account. Any change in assumptions would have no impact on the net cashflow, since the change would affect income and expenditures equally.

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

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



This assumption has a dramatic impact on projected HI cashflow. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As charts 7 and 7A indicate, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs.



Fertility Rate

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

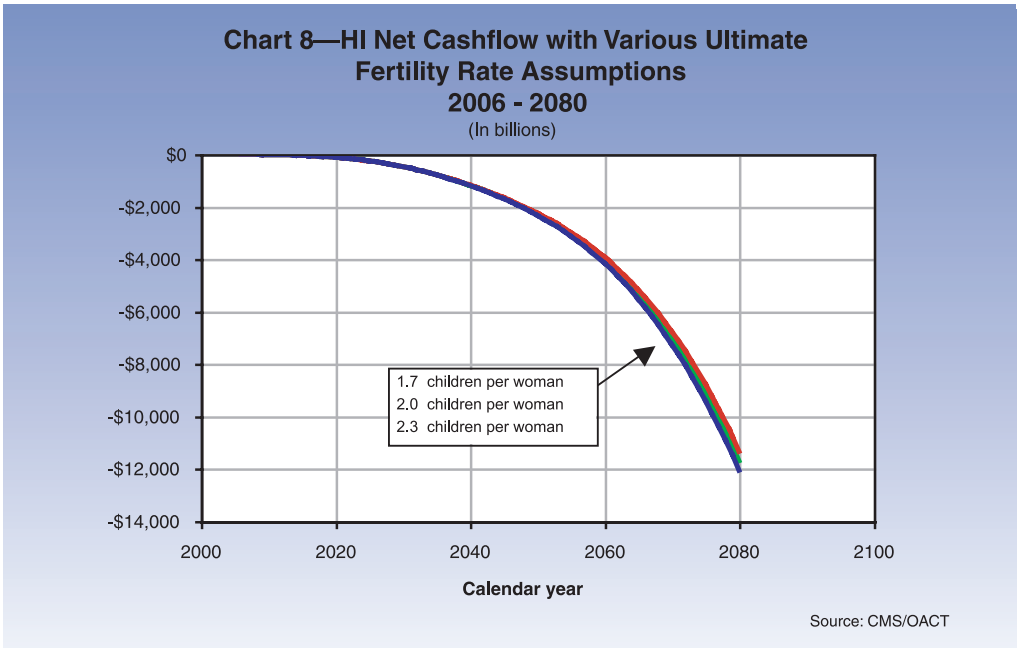
TABLE 2
Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate fertility rate[1]	1.7	2.0	2.3
Income minus expenditures *(in billions)*	-$11,510	-$11,290	-$11,078

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

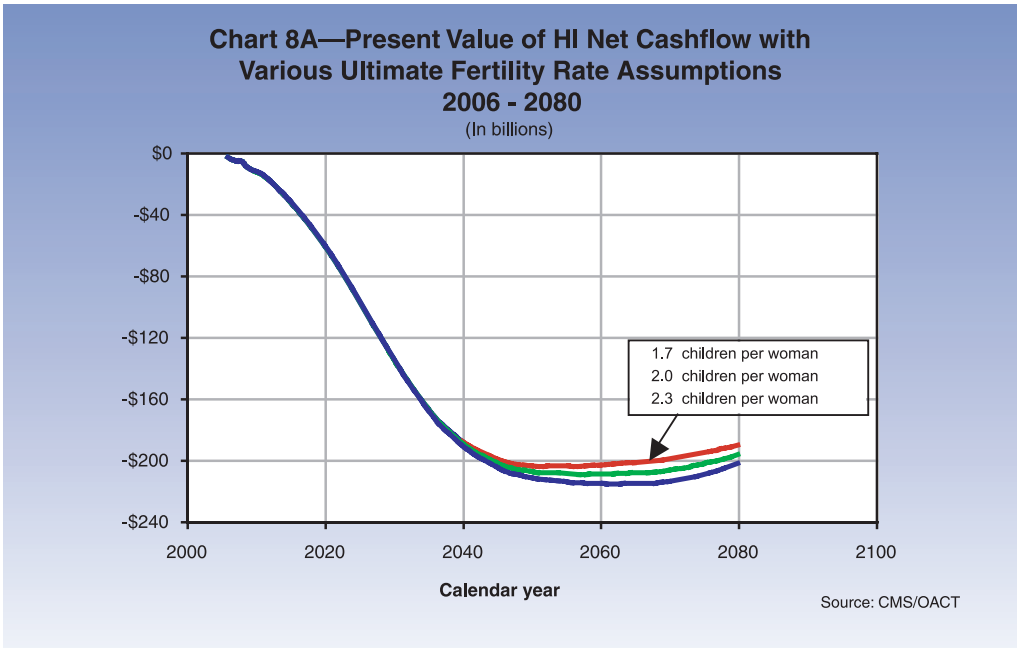
As table 2 demonstrates, for an increase of 0.3 in the assumed ultimate fertility rate, the projected deficit decreases by approximately $220 billion.

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



As charts 8 and 8A indicate, the fertility rate assumption has only a negligible impact on projected HI cashflows. In fact, higher fertility in the first year does not affect the labor force until roughly 20 years have passed (increasing HI payroll taxes slightly) and has virtually no impact on the number of beneficiaries within this period. Over the

full 75-year period, the impacts are expected to be somewhat greater, as illustrated by the present values in table 2.



Net Immigration

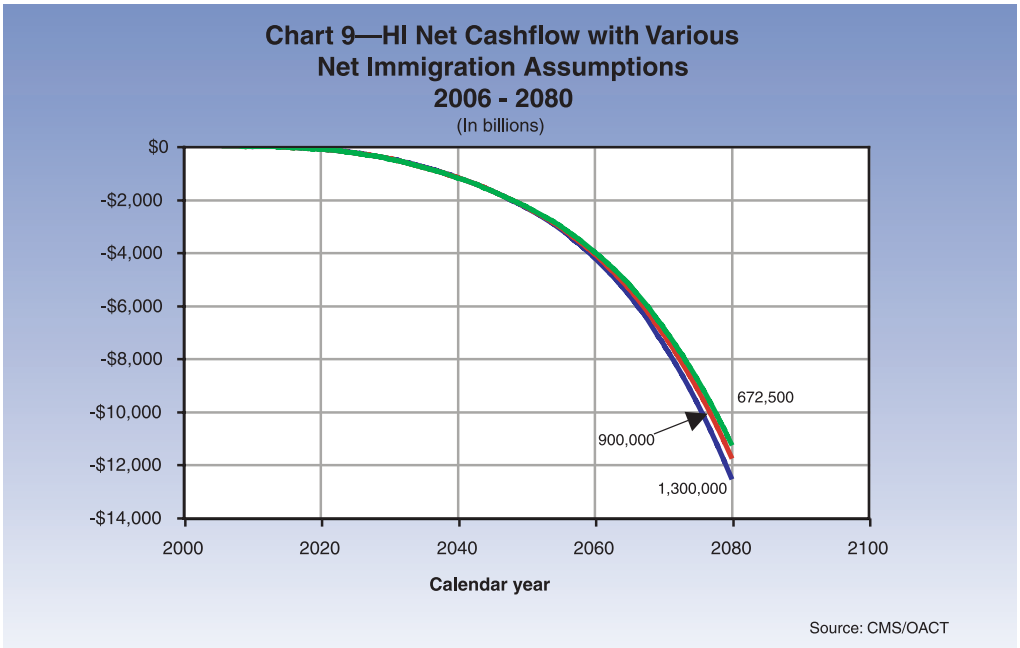
Table 3 shows the net present value of cashflow during the 75-year projection period under three alternative net immigration assumptions: 672,500 persons, 900,000 persons, and 1,300,000 persons per year.

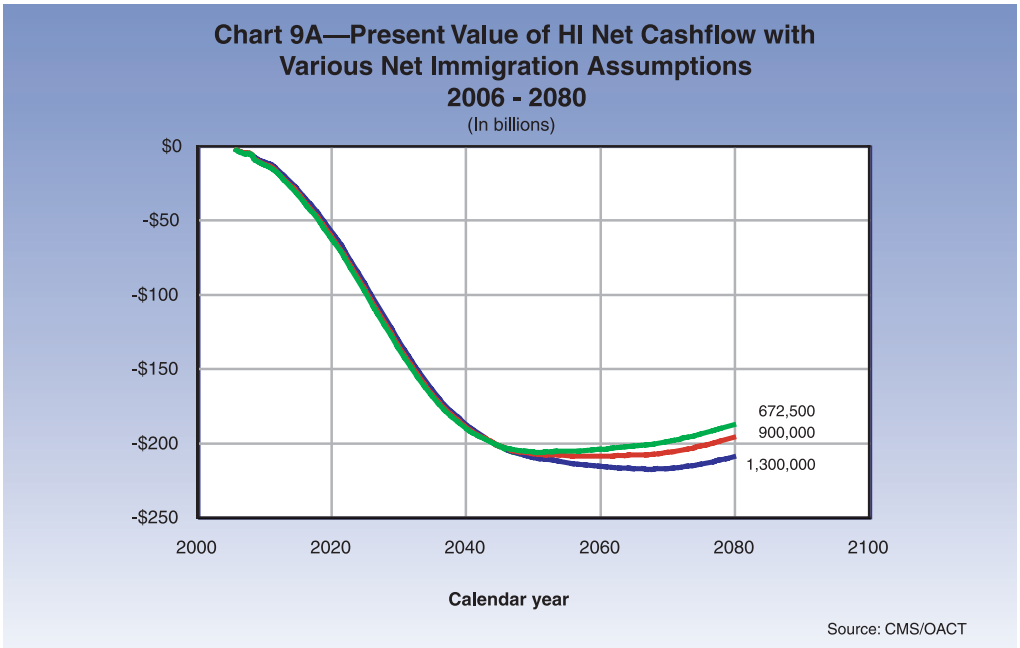
TABLE 3
Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

Ultimate net immigration	672,500	900,000	1,300,000
Income minus expenditures *(in billions)*	-$11,157	-$11,290	-$11,498

As shown in table 3, if the ultimate net immigration assumption is 672,500 persons, the deficit decreases by $133 billion. Conversely, if the ultimate net immigration assumption is 1,300,000 persons, the deficit increases by $208 billion.

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





As charts 9 and 9A indicate, this assumption has an impact on projected HI cashflow starting almost immediately. Because immigration tends to occur among those who work and pay taxes into the system, in the short term payroll taxes increase faster than benefits; in the long term, however, the opposite occurs, as those individuals age and become beneficiaries in a period with much greater health care costs per beneficiary.

Real-Wage Differential

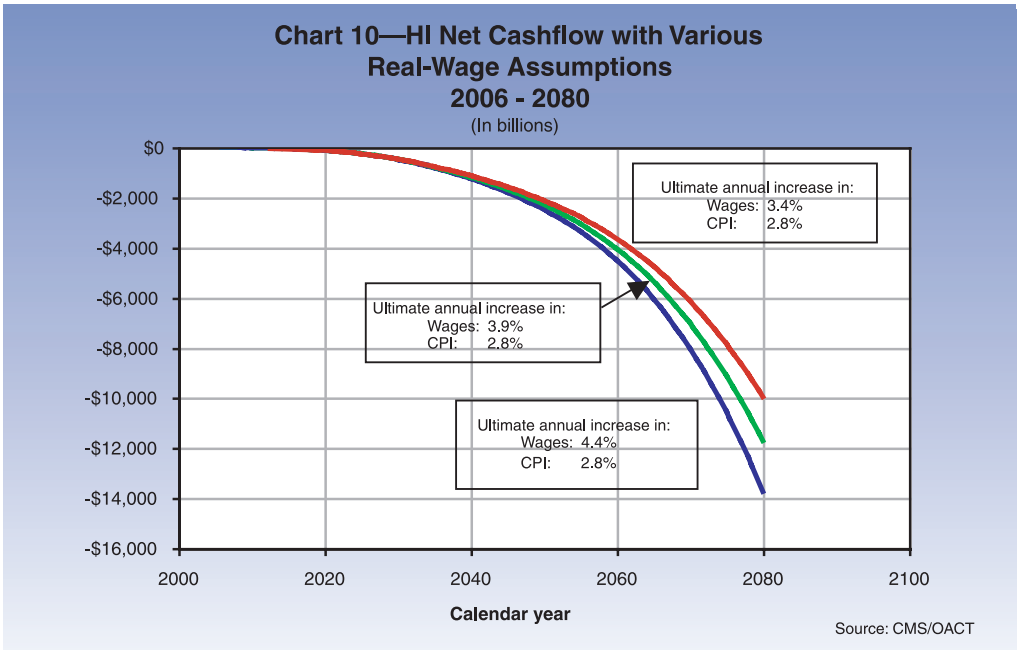
Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential[7] assumptions: 0.6, 1.1, and 1.6 percentage points. In each case, the ultimate CPI-increase is assumed to be 2.8 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.4, 3.9, and 4.4 percent, respectively.

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

Ultimate percentage increase in wages - CPI	3.4 - 2.8	3.9 - 2.8	4.4 - 2.8
Ultimate percentage increase in real-wage differential	0.6	1.1	1.6
Income minus expenditures *(in billions)*	-$10,521	-$11,290	-$12,286

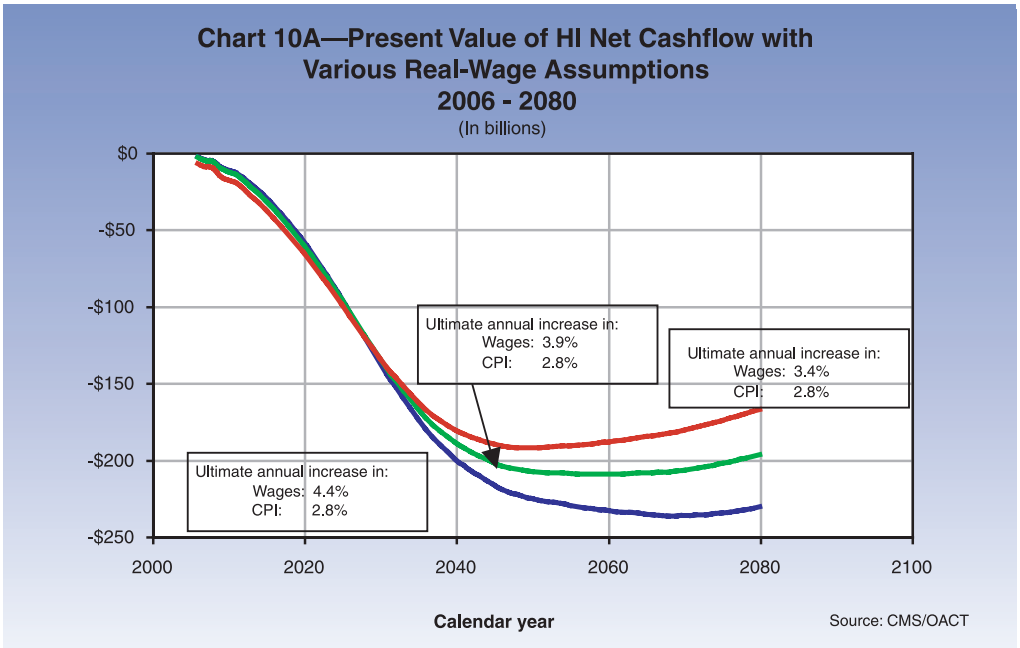
As indicated in table 4, for a half-point increase in the ultimate real-wage differential assumption, the deficit increases by approximately $880 billion.

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



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

As charts 10 and 10A indicate, this assumption has a fairly large impact on projected HI cashflow very early in the projection period. Higher real-wage differential assumptions immediately increase both HI expenditures for health care and wages for all workers. In early years 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. However, in later years, benefits are more fully realized and hence outweigh the impact on wages and payroll taxes, producing larger net cashflows under higher real-wage differential assumptions.



Consumer Price Index

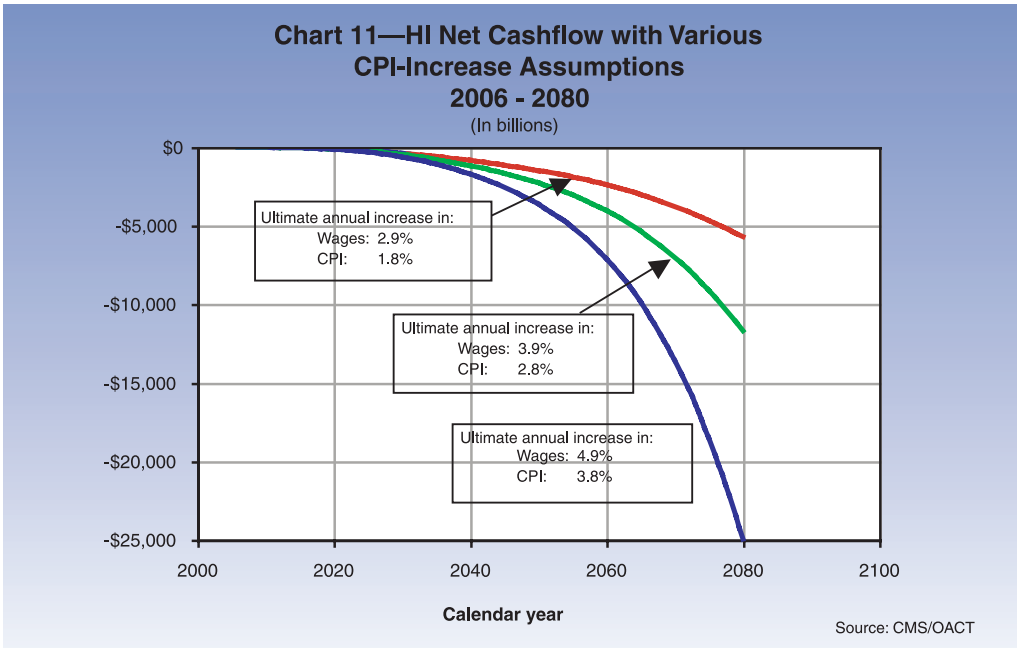
Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 1.8, 2.8, and 3.8 percent. In each case, the ultimate real-wage differential is assumed to be 1.1 percent, yielding ultimate percentage increases in average annual wages in covered employment of 2.9, 3.9, and 4.9 percent, respectively.

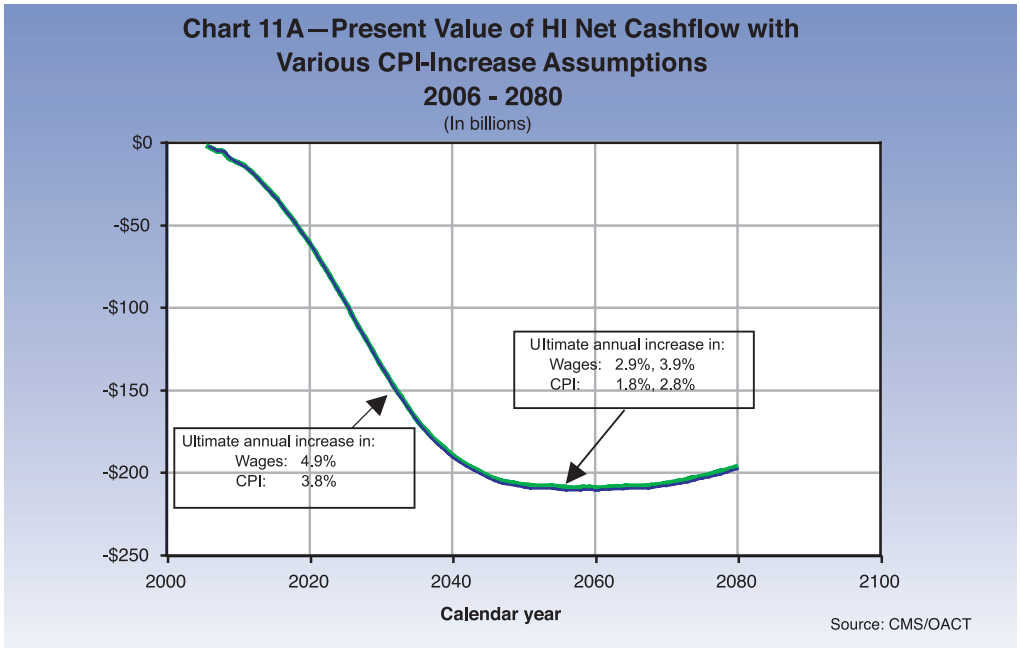
TABLE 5
Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

Ultimate percentage increase in wages - CPI	2.9 - 1.8	3.9 - 2.8	4.9 - 3.8
Income minus expenditures *(in billions)*	-$11,234	-$11,290	-$11,337

Table 5 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit decreases by $56 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit increases by $47 billion.

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





As charts 11 and 11A indicate, this assumption has a large impact on projected HI cashflow in nominal dollars but only a negligible impact when the cashflow is expressed as present values. The relative insensitivity of the projected present values of HI cashflow to different levels of general inflation occurs because inflation tends to affect both income and costs in a similar manner. In nominal dollars, however, a given deficit "looks bigger" under high-inflation conditions but is not significantly different when it is expressed as a present value or relative to taxable payroll. This sensitivity test serves as a useful example of the limitations of nominal-dollar projections over long periods.

Real-Interest Rate

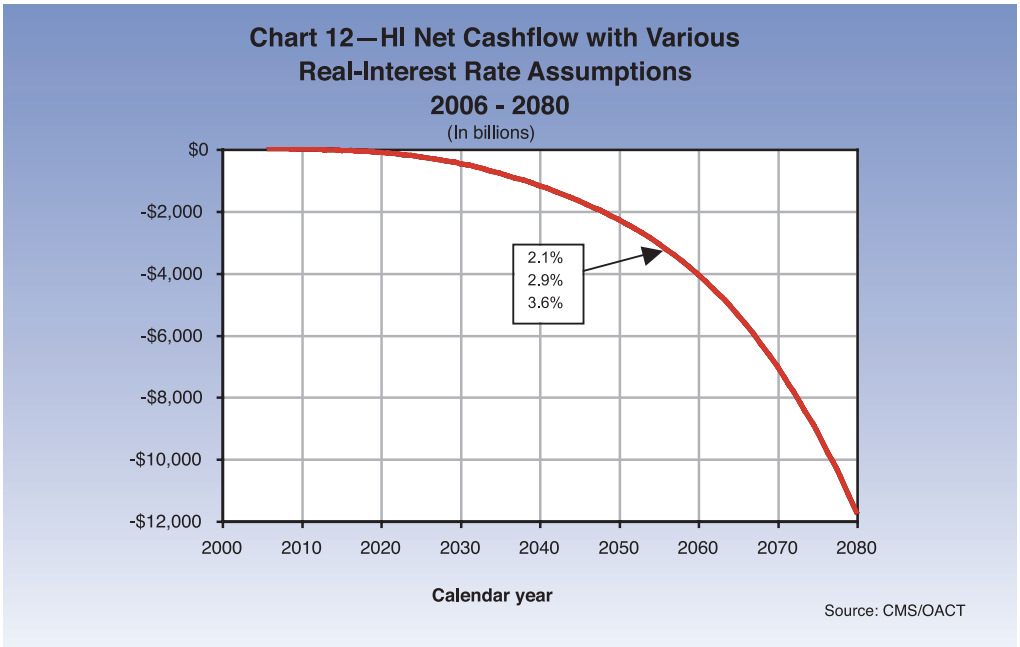
Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.1, 2.9, and 3.6 percent. In each case, the ultimate annual increase in the CPI is assumed to be 2.8 percent, resulting in ultimate nominal annual yields of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

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

Ultimate real-interest rate	2.1 percent	2.9 percent	3.6 percent
Income minus expenditures *(in billions)*	-$15,847	-$11,290	-$8,464

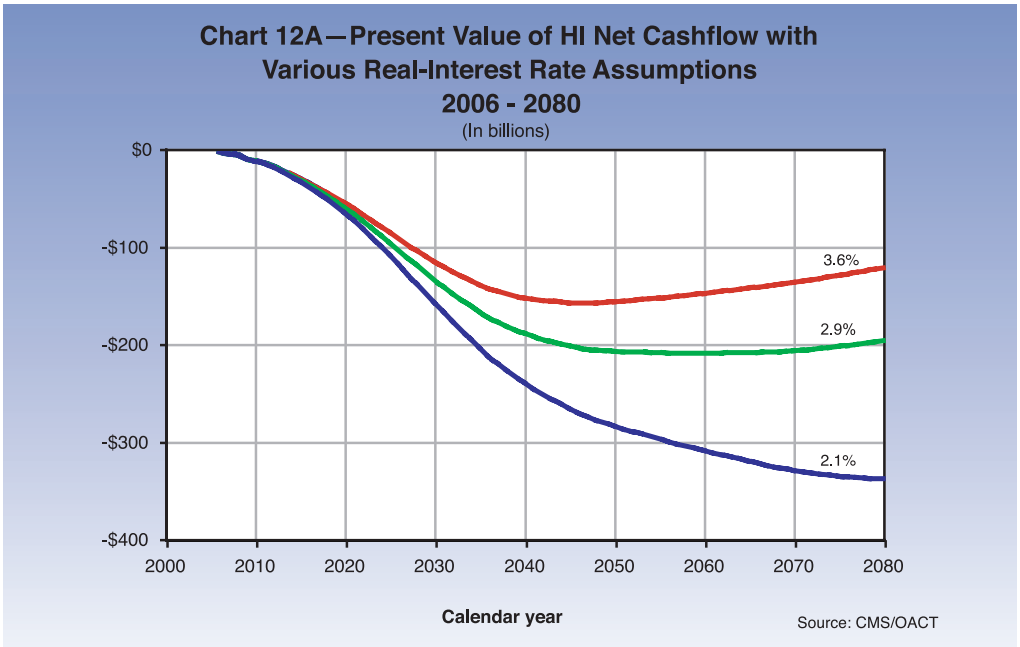
As illustrated in table 6, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $490 billion.

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



As shown in charts 12 and 12A, the projected HI cash flow 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 2018. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.



TRUST FUND FINANCES AND SUSTAINABILITY

HI

Under the Medicare Trustees' intermediate assumptions, the HI trust fund is projected to be exhausted in 2018, 2 years earlier than in last year's report, due primarily to slightly higher costs in 2005 than previously estimated and some upward revisions in the short-range assumptions about utilization of HI services. Income from all sources is projected to exceed expenditures for only the next 4 years and to fall short by steadily increasing amounts in 2010 and later. These shortfalls can be met with increasing reliance on interest payments on invested assets and the redemption of those assets, thereby adding to the draw on the Federal Budget. In the absence of corrective legislation, a depleted HI trust fund would initially produce payment delays, but very quickly lead to a curtailment of health care services to beneficiaries.

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

SMI

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

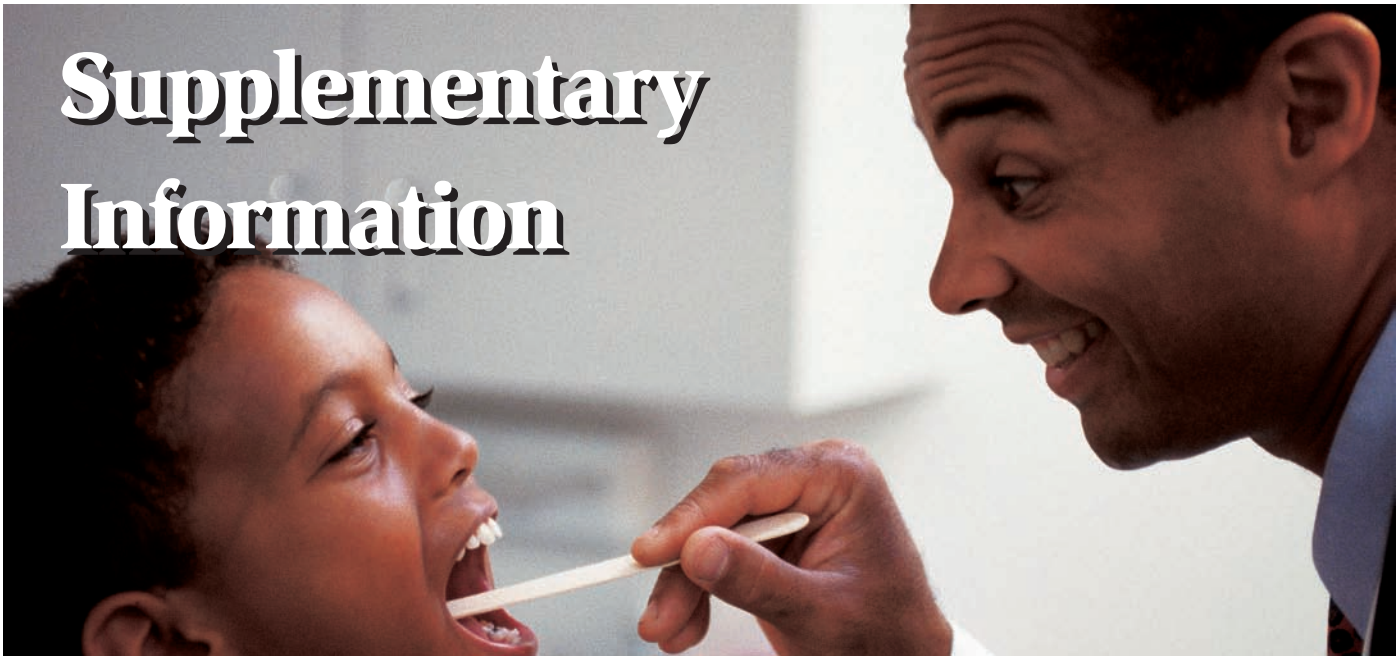
The financing established for the Part B account for calendar year 2006 is estimated to be sufficient to cover expenditures for that year but not to meaningfully increase assets to a more adequate contingency reserve. Part B assets minus liabilities are now at their lowest level, relative to annual outlays, in nearly 30 years. The Part B premium and corresponding general revenue transfers will need to be increased significantly for 2007 to match projected costs and to restore Part B assets to a more adequate reserve level.

No financial imbalance is anticipated for the Part D account, since the general revenue subsidy for this benefit is expected to be drawn on a daily, as-needed basis. The projected Part D costs shown in this section are significantly lower than previously estimated, reflecting the latest data on drug cost trends generally and Part D bid and enrollment levels.

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 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 2006 annual report to Congress, the Medicare Boards of Trustees emphasized the seriousness of these concerns and urged the Nation's policy makers to take "prompt, effective and decisive action…to address these challenges." They also stated: "Consideration of such reforms should occur in the relatively near future."



Supplementary Information

CONSOLIDATING BALANCE SHEET
As of September 30, 2006

(in millions)

	MEDICARE (Earmarked)			HEALTH (Other Funds)			Combined	Intra-CMS	Consolidated
	HI TF	SMI TF	Total	Medicaid	SCHIP	Other Health	Totals	Eliminations	Totals
ASSETS									
Intragovernmental Assets:									
Fund Balance with Treasury	$955	$27,771	$28,726	$45,662	$6,145	$2,273	$82,806		$82,806
Earmarked Investments	306,100	33,445	339,545				339,545		339,545
Accounts Receivable, Net	20,779	22,219	42,998	98	1	13	43,110	$(42,637)	473
Total Intragovernmental Assets	**327,834**	**83,435**	**411,269**	**45,760**	**6,146**	**2,286**	**465,461**	**(42,637)**	**422,824**
Cash & Other Monetary Assets	13	132	145				145		145
Accounts Receivable, Net	707	2,158	2,865	124		20	3,009		3,009
General Property, Plant & Equipment, Net	152	253	405	34	1		440		440
Other Assets	23	48	71	5		48	124		124
TOTAL ASSETS	**$328,729**	**$86,026**	**$414,755**	**$45,923**	**$6,147**	**$2,354**	**$469,179**	**$(42,637)**	**$426,542**
LIABILITIES									
Intragovernmental Liabilities:									
Accounts Payable	$20,475	$22,699	$43,174			$3	$43,177	$(42,637)	$540
Accrued Payroll and Benefits	1	3	4				4		4
Other Intragovernmental Liabilities	55	281	336	$2		96	434		434
Total Intragovernmental Liabilities	**20,531**	**22,983**	**43,514**	**2**		**99**	**43,615**	**(42,637)**	**978**
Accounts Payable	1	2	3				3		3
Federal Employee & Veterans' Benefits	3	7	10	1			11		11
Entitlement Benefits Due & Payable	19,751	21,073	40,824	19,182	$284	874	61,164		61,164
Accrued Payroll & Benefits	15	37	52	3			55		55
Other Liabilities	576	265	841	1,126		19	1,986		1,986
TOTAL LIABILITIES	**40,877**	**44,367**	**85,244**	**20,314**	**284**	**992**	**106,834**	**(42,637)**	**64,197**
NET POSITION									
Unexpended Appropriations—earmarked funds	33	27,625	27,658				27,658		27,658
Unexpended Appropriations—other funds				25,483	5,860	1,178	32,521		32,521
Cumulative Results of Operations—earmarked funds	287,819	14,034	301,853				301,853		301,853
Cumulative Results of Operations—other funds				126	3	184	313		313
TOTAL NET POSITION	**$287,852**	**$41,659**	**$329,511**	**$25,609**	**$5,863**	**$1,362**	**$362,345**		**$362,345**
TOTAL LIABILITIES & NET POSITION	**$328,729**	**$86,026**	**$414,755**	**$45,923**	**$6,147**	**$2,354**	**$469,179**	**$(42,637)**	**$426,542**

SUPPLEMENTARY INFORMATION

CONSOLIDATING STATEMENT OF NET COST
For the Year Ended September 30, 2006

(in millions)

	MEDICARE (Earmarked)			HEALTH (Other Funds)			Consolidated
	HI TF	SMI TF	Total	Medicaid	SCHIP	Other Health	Totals
NET PROGRAM/ACTIVITY COSTS							
GPRA Programs							
Medicare (Earmarked)	$185,788	$151,181	$336,969				$336,969
Medicaid				$179,481			179,481
SCHIP					$5,739		5,739
NET COST—GPRA PROGRAMS	**185,788**	**151,181**	**336,969**	**179,481**	**5,739**		**522,189**
Other Activities							
CLIA						$(51)	(51)
State Grants & Demonstrations						1,940	1,940
Other						78	78
NET COST—OTHER ACTIVITIES						**1,967**	**1,967**
NET COST OF OPERATIONS	**$185,788**	**$151,181**	**$336,969**	**$179,481**	**$5,739**	**$1,967**	**$524,156**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2006

(in millions)

	MEDICARE (Earmarked)			HEALTH (Other Funds)			Consolidated
	HI TF	SMI TF	Total	Medicaid	SCHIP	Other Health	Totals
CUMULATIVE RESULTS OF OPERATIONS							
Beginning Balances	$266,754	$2,393	$269,147	$159	$4	$119	$269,429
Budgetary Financing Sources:							
Appropriations Used	10,972	162,601	173,573	178,995	5,735	2,024	360,327
Nonexchange Revenue	196,240	1,603	197,843				197,843
Transfers-in/out Without Reimbursement	(366)	(1,399)	(1,765)	451	3	8	(1,303)
Other Financing Sources (Nonexchange):							
Transfers-out Without Reimbursement		(1)	(1)				(1)
Imputed Financing	7	18	25	2			27
TOTAL FINANCING SOURCES	**206,853**	**162,822**	**369,675**	**179,448**	**5,738**	**2,032**	**556,893**
NET COST OF OPERATIONS	**185,788**	**151,181**	**336,969**	**179,481**	**5,739**	**1,967**	**524,156**
NET CHANGE	**21,065**	**11,641**	**32,706**	**(33)**	**(1)**	**65**	**32,737**
CUMULATIVE RESULTS OF OPERATIONS	**$287,819**	**$14,034**	**$301,853**	**$126**	**$3**	**$184**	**$302,166**
UNEXPENDED APPROPRIATIONS							
Beginning Balances		$6,873	$6,873		$7,275	$558	$14,706
Budgetary Financing Sources:							
Appropriations Received	$11,005	190,226	201,231	$215,472	4,365	2,604	423,672
Appropriations Transferred-in/out				(1,895)		40	(1,855)
Other Adjustments		(6,873)	(6,873)	(9,099)	(45)		(16,017)
Appropriations Used	(10,972)	(162,601)	(173,573)	(178,995)	(5,735)	(2,024)	(360,327)
TOTAL BUDGETARY FINANCING SOURCES	**33**	**20,752**	**20,785**	**25,483**	**(1,415)**	**620**	**45,473**
TOTAL UNEXPENDED APPROPRIATIONS	**33**	**27,625**	**27,658**	**25,483**	**5,860**	**1,178**	**60,179**
NET POSITION	**$287,852**	**$41,659**	**$329,511**	**$25,609**	**$5,863**	**$1,362**	**$362,345**

COMBINING STATEMENT OF BUDGETARY RESOURCES
For the Year Ended September 30, 2006

(in millions)

	MEDICARE		Payments to			All	Combined	Non-Budgetary
	HI TF	SMI TF	Trust Funds	Medicaid	SCHIP	Others	Totals Budgetary	Credit Reform Financing Accounts
Budgetary Resources:								
Unobligated balance, brought forward, October 1:			$1,700	$317		$1,081	$3,098	
Recoveries of prior year unpaid obligations	$14	$20		12,196	$1,455	321	14,006	
Budget authority:								
Appropriation	211,227	176,662	201,231	215,472	4,365	38,411	847,368	
Spending authority from offsetting collections:								
Earned								
Collected		1				155	156	$140
Change in unfilled customer orders:								
Advance received						63	63	
Without advance from Federal sources						9	9	
Expenditure transfers from trust funds				264		3,083	3,347	
SUBTOTAL	**211,227**	**176,663**	**201,231**	**215,736**	**4,365**	**41,721**	**850,943**	**140**
Nonexpenditure transfers, net, anticipated & actual	44	84		(1,895)		40	(1,727)	
Temporarily not available pursuant to Public Law	(22,091)	(12,434)					(34,525)	
Permanently not available		(5)	(1,700)		(45)	(17)	(1,767)	
TOTAL BUDGETARY RESOURCES	**$189,194**	**$164,328**	**$201,231**	**$226,354**	**$5,775**	**$43,146**	**$830,028**	**$140**
Status of Budgetary Resources:								
Obligations incurred:								
Direct	$189,194	$164,328	$173,573	$199,868	$4,538	$42,046	$773,547	
Reimbursable						211	211	$140
SUBTOTAL	**189,194**	**164,328**	**173,573**	**199,868**	**4,538**	**42,257**	**773,758**	**140**
Unobligated balance:								
Apportioned			27,658	25,844		612	54,114	
Unobligated balance not available				642	1,237	277	2,156	
TOTAL STATUS OF BUDGETARY RESOURCES	**$189,194**	**$164,328**	**$201,231**	**$226,354**	**$5,775**	**$43,146**	**$830,028**	**$140**
Change in Obligated Balance:								
Obligated balance, net: Unpaid obligations, brought forward, October 1	$17,733	$17,580		$10,635	$7,276	$2,571	$55,795	
Less: Uncollected customer payments from Federal sources, brought forward, October 1						1,631	1,631	
Total unpaid obligated balance, net	17,733	17,580		10,635	7,276	940	54,164	
Obligations incurred, net	189,194	164,328	$173,573	199,868	4,538	42,257	773,758	$140
Less: Gross Outlays	185,872	162,393	173,573	179,124	5,451	38,300	744,713	140
Obligated balance transferred, net:								
Less: Recoveries of prior year unpaid obligations, actual	14	20		12,196	1,455	321	14,006	
Change in uncollected customer payments from Federal sources						(199)	(199)	
Unpaid obligations	21,041	19,495		19,183	4,908	6,207	70,834	
Less: Uncollected customer payments from Federal sources						1,432	1,432	
Total, unpaid obligated balance, net, end of period	21,041	19,495		19,183	4,908	4,775	69,402	
Net Outlays:								
Net Outlays								
Gross outlays	185,872	162,393	173,573	179,124	5,451	38,300	744,713	140
Less: Offsetting collections		1		264		3,509	3,774	140
Less: Distributed offsetting receipts	15,880	209,800				67	225,747	
NET OUTLAYS	**$169,992**	**$(47,408)**	**$173,573**	**$178,860**	**$5,451**	**$34,724**	**$515,192**	

CONSOLIDATED INTRAGOVERNMENTAL BALANCES
For the Year Ended September 30, 2006
(in millions)

	*TFM Dept. Code	Fund Balance with Treasury	Investments	Accounts Receivable	Other
INTRAGOVERNMENTAL ASSETS					
Agency					
Department of the Treasury	20, 99	$82,806	$339,545		
Railroad Retirement Board	60			$473	
		$82,806	**$339,545**	**$473**	

	*TFM Dept. Code	Accounts Payable	Environmental & Disposal Costs	Accrued Payroll & Benefits	Other
INTRAGOVERNMENTAL LIABILITIES					
Agency					
Department of Labor	16			$2	
Department of the Treasury	20, 99				$333
Office of Personnel Management	24			2	
Social Security Administration	28	$529			
General Services Administration	47				13
Department of Homeland Security	70				63
Department of Health and Human Services	75	11			
United States Postal Service	18				24
All Other Federal Agencies					1
		$540		**$4**	**$434**

				Nonexchange Revenue	
	*TFM Dept. Code	Earned Revenue	Gross Cost	Transfers-in	Transfers-out
INTRAGOVERNMENTAL REVENUES & EXPENSES					
Agency					
Department of Commerce	13		$3		
Department of Justice	15	$1	115		
Department of Labor	16	1	1		
Department of the Treasury	20, 99		149	$155	
Office of Personnel Management	24		92		
Social Security Administration	28			1	$(1,865)
General Services Administration	47		85		
Railroad Retirement Board	60			491	(7)
Department of Homeland Security	70	7	9		
Department of Health and Human Services	75	6	245		(68)
Department of Veterans Affairs	36	1			
United States Postal Service	18		27		
All Other Federal Agencies			29		(10)
		$16	**$755**	**$647**	**$(1,950)**

* Treasury Financial Manual

Audit Opinion

Department of Health and Human Services

CENTERS FOR MEDICARE & MEDICAID SERVICES

TO: Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

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

SUBJECT: Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2006 (A-17-06-02006)

This memorandum transmits the independent auditors' reports on the fiscal year (FY) 2006 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and regulations applicable to the Centers for Medicare & Medicaid Services (CMS). The CMS audit supports the Department of Health and Human Services audit, as required by the Chief Financial Officers Act of 1990 (Public Law 101-576), as amended.

We contracted with the independent certified public accounting firm of PricewaterhouseCoopers, LLP (PwC), to audit the CMS consolidated balance sheets as of September 30, 2006 and 2005, and the related consolidated statements of net cost, changes in net position and financing, the combined statements of budgetary resources for the years then ended, and the statement of social insurance as of January 1, 2006. 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 06-03, Audit Requirements for Federal Financial Statements.

Results of Independent Audit

Based on its audit, PwC found that the FYs 2006 and 2005 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, 2006, PwC noted certain matters involving internal controls over financial reporting that were reportable, of which one was deemed to be a material weakness under standards issued by the American Institute of Certified Public Accountants. Specifically, PwC reported a significant weakness regarding CMS's Medicare electronic data processing.

The audit noted numerous security weaknesses that would allow internal users to access and update Medicare claims data without proper authorization. The audit also noted that controls over changes to edits and proper edit settings for certain systems were not in use during the majority of the audit period. In the areas of controls over the Entitywide Security Program and Service Continuity Planning and Testing, PwC reported that CMS sustained but did not improve upon the FY 2005 audit results. For systems software, PwC noted some slippage in FY 2006 from the prior year's performance.

Exclusive of the Federal Financial Management Improvement Act of 1996 and the Improper Payments Information Act of 2002, PwC disclosed no instances of noncompliance that are required to be reported under "Government Auditing Standards" and OMB Bulletin 06-03.

Evaluation and Monitoring of Audit Performance

We reviewed the audit of the CMS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the 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.

PwC is responsible for the attached auditors' reports dated November 8, 2006, 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 PwC did not comply, in all material respects, with generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Joseph E. Vengrin, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at Joseph.Vengrin@oig.hhs.gov. Please refer to report number A-17-06-02006.

Attachment

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

Sheila Conley
Deputy Assistant Secretary, Finance

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Report of Independent Auditors

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

We have audited the accompanying consolidated balance sheets of the Centers for Medicare and Medicaid Services (CMS) and its components as of September 30, 2006 and 2005, and the related consolidated statements of net cost, changes in net position and financing, the combined statements of budgetary resources for the years then ended, and the statement of social insurance as of January 1, 2006. These financial statements are the responsibility of CMS's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We did not audit the financial statements as of and for the year ended September 30, 2005 of the Health Programs (as defined in Note 1) which are a major subset of the CMS administered programs, which statements reflect total combined assets of $28,508 million and total combined net costs of $187,689 million. Those statements and financial information were audited by other auditors whose report thereon has been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for the Health Programs as of and for the year ended September 30, 2005, is based solely on the report of the other auditors.

We conducted our audits in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 06-03, *Audit Requirements for Federal Financial Statements*. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits and the report of other auditors provide a reasonable basis for our opinion.

In our opinion, based on our audits and the report of other auditors, the consolidated and combined financial statements referred to above, present fairly, in all material respects, the financial position of CMS and its components as of September 30, 2006 and 2005, and their

net cost, changes in net position, budgetary resources, reconciliation of net cost to budgetary resources for the years then ended, and the financial condition of its social insurance program as of January 1, 2006, in conformity with accounting principles generally accepted in the United States of America.

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

As discussed in Note 1 to the financial statements, CMS adopted Statement of Federal Financial Accounting Standard (SFFAS) No. 27, *Earmarked Funds,* beginning October 1, 2005. This standard does not permit the restatement of prior periods.

As discussed in Note 17 to the financial statements, CMS adopted SFFAS No. 25, *Reclassification of Stewardship Responsibilities and Eliminating the Current Services Assessment*, requiring that the statement of social insurance (SOSI) be presented as basic financial statements beginning in fiscal year 2006. The SOSI presents the projected 75-year actuarial present value of the income and expenditures of CMS's Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds, designed to illustrate the long-term sustainability of this social insurance program. In preparing the SOSI, management considers and selects assumptions and data that it believes provides a reasonable basis for the assertions in the statement. However, because of the large number of factors that affect the SOSI and the fact that such assumptions are inherently subject to substantial uncertainty, arising from the likelihood of future changes in general economic, regulatory, and market conditions, as well as other more specific future events, significant uncertainties and contingencies, many that cannot be reliably anticipated and most of which are beyond CMS's control particularly over more distant timeframes such as the 75-year projection period used for the SOSI, actual future expenditures are likely to differ significantly from the projections, and those differences may be material and could affect the long-term sustainability of this social insurance program. 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 experience upon which to base the estimates.

As discussed in Note 18 to the financial statements, the projected SMI Part B expenditure growth reflected in the accompanying SOSI is likely understated due to the structure of physician payment updates, which under current law would result in multiple years of significant reductions in physician payments, totaling an estimated 37 percent over the next nine years. 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. However, in practice it is not possible to anticipate what actions Congress might take, either in the near or long term, to alter the physician payment updates. For example, Congress has overridden scheduled reductions in physician payments for each of the last four years. The potential magnitude of the understatement of Part B expenditures, due to the physician payment updates can differ materially from the amount presented in the SOSI.

In Note 18, management has illustrated the potential effects using two hypothetical examples of changes to current law. Under current law and as presented in the SOSI, the projected 75-year present value of future Part B expenditures is $17.6 trillion. In management's hypothetical examples, 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 $22.3 trillion. Alternatively, 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 $24.4 trillion. Management's hypothetical examples have not been audited, and accordingly, we express no opinion on them.

Our audit was conducted for the purpose of forming an opinion on the consolidated and combined financial statements of CMS and its components taken as a whole. The supplementary information, which includes the required combining statement of budgetary resources and the consolidating financial statements, is presented for purposes of additional analysis and is not a required part of the consolidated and combined financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated and combined financial statements and, in our opinion, are fairly stated in all material respects in relation to the consolidated and combined financial statements taken as a whole.

The Management's Discussion and Analysis (MD&A) and Required Supplementary Information (RSI) are not a required part of the financial statements but are supplementary information required by the Federal Accounting Standards Advisory Board and OMB Circular A-136, *Financial Reporting Requirements.* We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the MD&A and RSI. However, we did not audit the information and express no opinion on it.

Our audit was conducted for the purpose of forming an opinion on the consolidated and combined financial statements of CMS taken as a whole. The additional information presented on the statement of social insurance is not a required part of the statement and is presented for purposes of additional analysis. Such information has been subjected to the auditing procedures applied in the audit of the consolidated and combined financial statements and, in our opinion, is fairly stated in all material respects in relation to the consolidated and combined financial statements taken as a whole.

The other accompanying information is presented for purposes of additional analysis and is not a required part of the financial statements. Such information has not been subjected to the auditing procedures applied in the audit of the consolidated and combined financial statements and, accordingly, we express no opinion on it.

In accordance with *Government Auditing Standards,* we have also issued reports dated November 9, 2006 on our consideration of CMS's internal control and on its compliance 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 read in conjunction with this report in considering the results of our audits.

November 8, 2006

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Report of Independent Auditors on Compliance and Other Matters

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

We have audited the accompanying consolidated balance sheet of the Centers for Medicare and Medicaid Services (CMS) and its components as of September 30, 2006, and the related consolidated statements of net cost, changes in net position and financing, the combined statement of budgetary resources for the year then ended, and the statement of social insurance as of January 1, 2006, and issued a report thereon dated November 8, 2006. We conducted our audit in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 06-03, *Audit Requirements for Federal Financial Statements.*

The management of CMS is responsible for compliance with laws and regulations. As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we performed tests of the compliance with certain provisions of laws and regulations, non-compliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in OMB Bulletin No. 06-03, including the requirements referred to in the Federal Financial Management Improvement Act of 1996 (FFMIA). Under FFMIA, we are required to report whether the CMS financial management systems substantially comply with the Federal financial management systems requirements, applicable Federal accounting standards, and the United States Government Standard General Ledger at the transaction level. To meet this requirement, we performed tests of compliance with FFMIA section 803(a) requirements. We limited our tests of compliance to these provisions and we did not test compliance with all laws and regulations applicable to CMS. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion.

The results of our tests of CMS's compliance with laws and regulations, described in the preceding paragraph, exclusive of FFMIA or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 06- 03, resulted in one instance of non-compliance as described below.

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

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

In our report on internal control dated November 8, 2006, we reported a material weakness related to Medicare Electronic Data Processing and reportable conditions related to the Managed Care and Prescription Drug Payment Cycles, Medicaid and Other Health Programs Oversight, and Financial Management Systems and Reporting. We believe that these matters, taken together, represent substantial non-compliance with the Federal financial management system requirements under FFMIA. In addition, though operational at six Medicare Contractors, CMS has not yet completed the implementation of the HIGLAS general ledger system and as a result is not compliant with the U.S. Government Standard General Ledger at the transaction level. Further details surrounding these findings, together with our recommendations for corrective action, have been reported separately to CMS in our report on internal control dated November 8, 2006.

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

November 8, 2006

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Report of Independent Auditors on Internal Control

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

We have audited the accompanying consolidated balance sheet of the Centers for Medicare and Medicaid Services (CMS) and its components as of September 30, 2006, and the related consolidated statements of net cost, changes in net position and financing, the combined statement of budgetary resources for the year then ended, and the statement of social insurance as of January 1, 2006, and issued our report thereon dated November 8, 2006. We conducted our audit in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin No. 06-03, *Audit Requirements for Federal Financial Statements*.

In planning and performing our audit, we considered CMS's internal control over financial reporting by obtaining an understanding of CMS's internal control, determined whether internal controls had been placed in operation, assessed control risk, and performed tests of controls in order to determine our auditing procedures for the purpose of expressing our opinion on the consolidated and combined financial statements and not to provide an opinion on the internal controls. We limited our control testing to those controls necessary to achieve the following OMB control objectives that provide reasonable, but not absolute assurance, that: (1) transactions are properly recorded, processed, and summarized to permit the preparation of the consolidated and combined financial statements in accordance with accounting principles generally accepted in the United States of America, and to safeguard assets against loss from unauthorized acquisition, use, or disposition; (2) transactions are executed in accordance with laws governing the use of budget authority and any other laws, regulations, and government-wide policies identified in Appendix E of OMB Bulletin No. 06-03 that could have a direct and material effect on the consolidated and combined financial statements; and (3) transactions and other data that support reported performance measures are properly recorded, processed, and summarized to permit the preparation of performance information in accordance with criteria stated by management. We did not test all internal controls relevant to the operating objectives broadly defined by the Federal Managers' Financial Integrity Act of 1982. Our purpose was not to provide an opinion on CMS's internal control. Accordingly, we do not express an opinion on internal control.

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

While progress has been made during the current year, we continue to note control weaknesses regarding Medicare electronic data processing, the Medicare managed care and prescription drug benefits payment cycle, Medicaid program oversight and reporting, and CMS's financial reporting systems and processes. In addition, as required by FASAB 25, CMS implemented the Statement of Social Insurance (SOSI) as an element of its basic financial statements during FY2006. We noted control weaknesses in the SOSI preparation processes which are also described below.

Material Weakness

Medicare Electronic Data Processing

Overview

CMS relies on extensive information systems operations at its Central Office and Medicare contractor sites to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality and reliability of the Medicare data and to reduce the risk of errors, fraud and other illegal acts.

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

controls include controls over input, processing of data, and output of data from CMS application systems.

Our audit included various general controls testing for thirty contractors and site visits to fourteen data centers supporting Medicare claims processing. We also reviewed application controls at the CMS central office and at Medicare contractors for systems integral to Medicare financial information including the Fiscal Intermediary Shared System (FISS), the Viable Information Processing Systems' (VIPS) Medicare System (VMS), the Multi-Carrier System (MCS) and the Common Working File (CWF). At CMS Central Office we performed procedures over Financial Accounting Control System (FACS), Contractor Administrative Budget and Financial Management System (CAFM), Retiree Drug Subsidy System (RDS), Health Plan Management System (HPMS), Medicare Advantage Prescription Drug System (MARx), Healthcare Integrated General Ledger System (HIGLAS), Medicaid Budget and Expenditure System (MBES), and CHIP Budget and Expenditure System (CBES).

We also conducted vulnerability reviews of network controls at eight data centers sites and CMS headquarters. Further, desktop based audit procedures were conducted to review the high level management controls regarding platform security settings at all data centers supporting Medicare claims processing. The vulnerability reviews included both external and internal penetration testing and network vulnerability assessments at eight sites, and internal penetration testing at CMS headquarters.

Our audit noted numerous issues in the areas of direct update access to Medicare claims data and that controls over changes to edits and proper edit settings for the FISS, VMS and MCS systems were not in use during the majority of the period under audit. We also noted no change in the controls for the Entity wide Security Program and Service Continuity Planning and Testing areas when compared to FY 2005. In both of these areas, we had previously observed improvements during the FY 2005 audit when compared to the FY 2004 audit. This year, CMS sustained but did not improve upon the FY 2005 audit results. For systems software, we noted some slippage in FY 2006 from the FY 2005 performance.

- ***Entitywide Security Program (EWSP*) -** These programs provide the foundation for the security culture and awareness of the organization. A sound EWSP is the cornerstone to ensure effective security controls throughout the organization. We noted that CMS sustained the improvements in its entity-wide security program reported in our FY 2005, but did not improve further on that level of compliance during FY 2006.

- ***Service Continuity Planning and Testing -*** Service continuity relates to the readiness of a site in the case of a system outage or an event that disrupts normal processing of operations. Without approved, documented, and tested business and system continuity plans, there is no assurance that normal operations may be recovered efficiently and timely. We observed that CMS also sustained the improvements in its service continuity planning and testing reported initially last year, but did not improve further on that general level of compliance during FY 2006.

During FY 2006, CMS continued their program to review, analyze and thoroughly discuss the proposed corrective action plans of contractors and those of CMS headquarters. This process included extensive discussions both on-site at CMS headquarters, with contractor management in attendance, and remotely with contractor management. CMS even sponsored two security conferences at which the status of the corrective actions was discussed after hours with the individual Medicare contractors. CMS management deserves great credit for this undertaking.

During FY 2005, to address the weaknesses noted regarding the control of front end system edits for FISS, MCS and VMS, CMS management issued a new change request (CR 3862) which provides guidance on the control of edits for the FISS, MCS and VMS systems. Furthermore, CMS launched a project to determine contractor readiness regarding compliance with CR 3862. CMS solicited help from the contractors and formed key working groups to address the control of edits within the FISS, VMS and MCS systems. Initial results of the testing during September and October of 2005 clearly indicated improved policies and procedures for the control of front end edits for these three systems and enhancements within all three systems which allow automated logging and tracking of edit changes for review, analysis and follow-up. However, the results of the work from these groups and implementation of suggested changes was not accomplished during the period under audit. We support CMS management's efforts in this area and believe that these procedures when combined with the actual implementation of the workgroup recommendations to control edits should provide the foundation to correct the edit weaknesses noted. The completion of this effort should help to greatly resolve issues noted regarding the control of edits for the key front-end Medicare claims processing systems.

During FY 2004, CMS launched a program to evaluate the security levels of all contractors regarding their compliance with the Federal Information Security Management Act (FISMA) under the requirements of the Medicare Prescription Drug, Improvement and Modernization Act for Medicare. This evaluation program includes all nine key areas of FISMA: periodic risk assessments, policies and procedures to reduce risk, systems security plans, security awareness training, periodic testing and evaluation of the effectiveness of IT security policies and procedures, remedial activities, processes and reporting for deficiencies, incident detection, reporting and response, and continuity of operations for IT systems. This program was continued for FY 2005 and FY 2006 and we believe that the evaluations obtained as a result of this effort have served and continue to serve CMS greatly in better understanding the current state of security operations at all Medicare contractors; not just those contractors tested as a consequence of the financial statement audit or for which a SAS-70 audit was conducted.

In addition to the steps noted above, to address the previous year's reportable conditions, CMS continued its program to review the contractors through SAS 70 audits, an extensive contractor self-assessment program, and reporting process and greater Central Office oversight by contractor management. Additionally, CMS continues to request and receive system security plans, risk assessments, contingency plans, self-assessments, and test results of contingency plans from its contractors and has a certification and accreditation program initiative featuring system vulnerability assessments for all contractors.

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

Logical Access Controls

Access controls ensure that critical system assets are physically protected from unauthorized access and logical controls provide assurance that only authorized personnel may access systems data and programs. Our audit noted numerous findings regarding logical access during our controls testing. We noted that numerous security weaknesses existed that would allow internal users to access and update sensitive systems, programs and data without proper authorization. Our review did not disclose any exploitation of critical systems tested; however, clear potential for harm existed. We consistently noted employees who did not require direct access to data and application software programs to perform their job responsibilities, but who nevertheless had been granted inappropriate standing update access to Medicare data and application software programs.

We noted that many contractors had not performed procedures to recertify access granted to employees on an annual basis as required by CMS standards. As a result, we noted inconsistencies regarding access assignments, removal of access for terminated or transferred employees and the enforcement of policies and procedures regarding the administration of access approval and maintenance at the contractor sites. Although this issue was also noted during the FY 2005 audit, our audit noted many more instances where employees who did not require direct access to data and application software programs to perform their job responsibilities had been granted inappropriate standing update access to Medicare data and application software programs without mitigating controls such as logging and review of the use of this access. This issue is particularly relevant to the Medicare Data Centers who host application software on behalf of the Medicare fiscal intermediaries and carriers.

Application Security, Development and Program Change Control

Application security, development and program change controls provide assurance that programs are developed with standards that ensure their effectiveness, efficiency, accuracy, security and maintenance and that only authorized and properly tested programs are implemented for production use. A key element of system changes is the proper use and control of edits within the FISS, VMS and MCS applications which process Medicare claims.

We noted that although CMS and contractor management have created workgroups to determine edits within FISS, VMS and MCS that should be turned on to prevent improper processing, the completion of the suggested changes to edits for the VMS and MCS systems and the implementation of the changes were still in process as of August 2006. Additionally,

for the FISS system, the process of determining edits that should be turned on in the system and the implementation of these edits was still ongoing at September 30, 2006.

Control of edits represents a very important area of concern because the edits are a key control in the prevention of improper processing of Medicare claims. The volume of claims processed requires strong automated preventative controls to ensure proper claims processing. Claims volume is far too great to rely on non-automated controls.

We also noted that automated program code used to process claims did not always provide a proper audit trail to allow review of changes to the program code used to process claims or to review actual changes made by the code to claims data. We also noted that application changes were, in some cases, being implemented without documented testing and approval and that application change control procedures were not followed at all sites tested. Finally, we noted numerous contractor sites at which application programmers had the ability to directly update production data and/or source program code for applications thereby allowing then to bypass application change controls.

During an application specific review we look at Access Controls, Data Input Controls, Data Processing Controls, Data Rejection Controls and Data Output Controls. We noted a number of problems with access controls within the applications at the contractors and CMS headquarters, which included both inappropriate or unsubstantiated access as well as segregation of duties issues. Security violation reports were not being reviewed for many of the applications. Finally, we were unable to obtain evidence of change control for MARx which would allow us to determine whether or not the application was functioning appropriately.

Systems Software

Systems software is a set of computer programs designated to operate and control the processing activities for all applications processed on a specific computer, including network servers, mainframe systems, and personal computers. Controls over access to, and use of, such software are especially critical. We noted that most of the contractor sites audited showed no measurable improvement in this area when compared to the FY 2005 audit and that for two sites, significant issues existed regarding the control of systems software. Further, we noted numerous instances across the 14 data centers audited, where security settings for platforms were not consistent with NIST standards and failed to provide sufficient security settings for computer platforms.

Recommendations

During FY 2006, a number of contractors, upon realizing they would not continue to process Medicare claims and/or act as data centers under future contracts, did not apply the same vigor to ensuring controls and their effectiveness. We recommend the CMS management begin now to address this issue for future years. Management must work to create clear methods to retain cooperation from their contractors during the transition to Medicare contractor reform and data center consolidation. Without a direct intervention by CMS management, we believe that the

trend noted during the FY 2006 audit will worsen and may gain momentum in the coming years.

Additionally, we recommend CMS management should:

- Target contractor access control policies and procedures to ensure their sufficiency and enforcement, including recertification of access annually and assurance of proper segregation of duties for application and systems programmers specifically limiting update access to Medicare data and/or programs.
- Complete the workgroup efforts to determine edits that should be turned on within the FISS, VMS and CMS systems and ensure implementation of the workgroup recommendations promptly.
- Continue the process to assess the enforcement of CR 3862, especially with regard to the approval of changes to shared system coded edits and the use of the newly developed audit trails in the FISS, MCS and VMS systems to analyze the effect of edit modifications on Medicare claims processing and approval. The analysis of edit modifications from the system audit trails should be used to match the results to error trends resulting from contractor claims processed during periods when edits are turned off and include specific matching of error types to contractors from which the errors emanated.
- Work with their contractors and maintainers of the FISS, VMS and CMS systems to ensure add on programs, such as SuperOps and SCF, maintain complete audit trails and that changes to program code associated with these systems follow the rules outlined in CR 3011 for testing and approval.
- Continue to enhance processes to monitor and track compliance with the security configuration models for all platforms maintained within, the CMS contractor sites, the maintainer sites and the CMS Central Office. CMS should greatly encourage the use of automated tools to monitor, detect and report to the CMS Information Security Office, all noncompliance with contractor, maintainer or CMS headquarter platform security configuration standards for distributed servers including WINDOWS, UNIX, router, switches, Web server and Oracle database servers on a quarterly basis.

Reportable Conditions

I. Managed Care (Part C) and Prescription Drug (Part D) Benefits Payment Cycle

During FY 2006, the Centers for Beneficiary Choices (CBC) achieved the following accomplishments: (1) developed a number of tools to oversee the Medicare Prescription Drug Benefit: a Part D audit guide, audit checklists and worksheets, a part D audit discussion guide, a Part D audit standard operating procedure, and a Part D Health Plan Management System (HPMS) audit module; (2) moved forward in the development of error rates for Part C, Part D

and Retiree Drug Subsidy Programs (RDS) and developed policies and procedures to document core and critical elements of Managed Care operations; and (3) executed protocols with Medicare Health Support (MHS) and the Care Management for High Cost Beneficiary (CMHCB) organizations that outline CMS activities to monitor programs and services.

Nonetheless, CMS lacks a comprehensive control environment related to the managed care and prescription drug benefits payment cycle, and the oversight of managed care contractors which include Medicare Advantage Organizations (MAO). The existence of a payment process outside of the Office of Financial Management and lack of integration of accounting processes within operating procedures related to managed care organizations and prescription drug plans contributes to furthering an environment where the risk of inaccurate payments is not sufficiently mitigated.

Overview

The CMS Medicare benefits expenditure is comprised of two major components, fee-for-service and managed care. Fee-for-service expenditures are processed and paid for by the Medicare contractors, while managed care and prescription drug expenditures are processed and paid by the Central Office. In January 2006, CMS completed a system conversion to MARx for payments to the managed care organizations and prescription drug plans for both Part C and Part D.

MARx payment errors have been identified and are in the process of being corrected or accrued for at the plan level, during fiscal year 2006, CMS policies and procedures were not sufficient to adequately reduce the risk of benefit payment errors occurring and not being corrected in a timely manner. System errors have gone for more than seven months, without being rectified.

Inadequate Procedures to Review and Process Managed Care and Prescription Drug Payments (Part C and Part D)

Managed care organizations are paid using two methodologies: (1) a risk-based methodology in which multiple demographic and health factors are used to determine the reimbursement rate for a beneficiary which represents 95% of all Managed Care Payments and (2) a cost-based methodology in which a plan is reimbursed a predetermined amount per beneficiary which is then adjusted to actual cost incurred during the year through the cost settlement process. PwC noted instances of inadequate policies and documentation for risk-based payments as evidenced by the following:

- During the monthly payment validation process, CMS noted that various payments made to the managed care and prescription drug providers were in error. These errors are being tracked and a detailed analysis is performed, but the errors are not corrected in a timely manner. In one instance an error noted with the Working Aged adjustment in the January payment has yet to be corrected. In addition, CMS

identified cases where the amount of Part D Low Income Premium Subsidy included in the Monthly Membership Report was incorrect. These items remain as systems errors and are accounted for via an accrual.

- CMS has not performed a timely reconciliation of beneficiary level payments that are calculated and authorized to the actual payment requests sent to Treasury. The reconciliation for the first quarter of the year was not performed until September 2006. Once the reconciliations were completed and differences were identified no explanations were provided. Differences were noted between the detail calculation of payments and the payments made at the Plan level, as well as, the actual payments made by Treasury and the payments approved for payment.
- CMS did not maintain readily accessible and up-to-date logs of anomalies or errors resulting from their review of plan level payments. In addition, the monthly review binders were not prepared in a timely manner and in some cases documentation supporting the payment approval was not retained.
- For risk based plans, CMS processed manual adjustments for managed care payments without calculating or adjusting the amount at the beneficiary level which is the basis of the transaction (for example, in August 2006 CMS processed approximately $1 billion in manual adjustments). This methodology may lead to inaccurate payments.

Lack of Documentation and Procedures to Determine Eligibility of Organizations

- CMS was not able to provide adequate documentation of organizations that were approved during the fiscal year as either new managed care providers or new prescription drug providers. Exceptions were noted in the following areas where documentation did not meet CMS requirements:
- Business Organization Reviews for Part D applications were not provided for fourteen out of forty-five sample items selected. In addition, we noted one instance where the review tool was incomplete and an additional instance was noted where the reviewer did not sign the business organization review tool.
- Part C transitional applications were approved with no formal review performed when transitioning from a demonstration plan into a managed care provider.
- No application review tools were provided for the review and acceptance of new managed care providers. PwC noted that twelve out of forty-five sample items were not provided.
- No documentation was provided for four out of the forty-five items selected for the testing of new managed care provider applications.
- CMS was unable to provide comprehensive documentation of new managed care organizations that were approved during the fiscal year. We noted exceptions in thirteen of the forty-five contracts reviewed, where documentation did not meet CMS requirements. Examples of missing documentation included: review tools, recommendation reports, site visit letters, and state licensures.

Inadequate Oversight of Managed Care Organizations

The Health Plan Monitoring System (HPMS) used by the Central Office to monitor the execution and status of managed care organization oversight contains inaccurate information. This system lies at the core of the CMS monitoring process for Medicare Advantage Organizations (MAOs). Inaccurate information within HPMS weakens the monitoring of MAOs and may cause CMS to pay plans that are not eligible. The following inaccuracies were noted during the audit for the forty-five monitoring reviews selected for testing:

- The HPMS monitoring review module does not contain all of the managed care organizations receiving payment from CMS. One of the managed care organizations included in our sample was not included in HPMS. Incomplete information in the system may result in missed reviews and the payment of ineligible plans.
- The HPMS monitoring review module was not updated in accordance with the CMS policy for the results of audits conducted during the current fiscal year. The lack of information for management to rely upon in making determinations related to an organization's ability to meet contractual requirements may result in ineligible plans receiving payment.
- CMS was unable to provide sufficient documentation to support the on-going monitoring of managed care organizations by the Regional Offices in accordance with CMS's policies and procedures. During the FY2006 audit, we continued to identify inconsistencies in the documentation. The documentation maintained by the Regional Offices to support the execution of monitoring reviews performed at managed care organizations is inconsistent and in some instances incomplete due to the lack of established documentation policies for Regional Office reviews. In addition, we found instances where the corrective action plans were not received, released, and or approved within the CMS prescribed time frame and in some instances where the review report was issued after the forty-five day time frame.
- CMS Regional Offices did not retain documentation to support exception items noted in the reviews of the managed care organizations. We noted three instances where the documentation noting exceptions were not retained in HMPS.
- CMS lacks comprehensive policies and procedures for monitoring reviews related to demonstration projects. These are specialized health care programs/services established to address the needs of specific beneficiary populations.

Recommendation

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

Specifically, CMS should:

- Ensure that relevant data is updated in a timely manner in order to provide the information necessary for adequate management oversight.

- Ensure that established policies address standard documentation and retention requirements for Regional Office monitoring reviews of the managed care organizations.
- Establish policies for Regional Office monitoring of demonstration projects that include tailored procedures to address the unique requirements or risks of each demonstration project.
- Perform extensive beneficiary data and payment information analysis to identify potential errors, unusual variances or inappropriate payment trends. This analysis should evaluate information such as: demographic make-up of the plan's population as compared to the coverage area's population and enrollment fluctuations as compared to other plans and enrollment in the overall Medicare managed care program.
- Due to the importance of the payment function in ensuring the validity and accuracy of payments to the managed care organizations and to maximize the detection of payment errors, we recommend that CMS perform a timely reconciliation of authorized payments made by Treasury. CMS should also establish a log to document anomalies and errors that are identified and resolved as part of the authorization process in order to further support decisions made as part of the authorization process.
- Develop a process to perform reconciliations of beneficiary level data to plan payments including plan level adjustments.

CMS has established strong controls for monitoring fee-for service contractors in many areas listed in this reportable condition and should consider implementing many of those controls for the managed care and prescription drug programs. In particular, implementing the data analysis methodologies employed by the Medicare Contractors and the Program Safeguard Contractors should provide the Center for Beneficiary Choices (CBC) with a foundation for improving internal control within the managed care benefits payment cycle.

II. Medicaid and Other Health Programs Oversight

Overview

The Health Program's Regional Office oversight of the States is a monitoring control designed to detect potential errors within State-submitted financial information related to Medicaid, SCHIP and other health programs. CMS-64, the Quarterly Medicaid Statement of Expenditures, is a key submission from the States in which Medicaid program expenditures are reported to CMS. The Center for Medicaid and State Operations (CMSO) issued financial review guides to assist the Regional Office analysts in examining budget and expenditure reports as well as to standardize the review procedures performed between analysts and regions. These review guides encompass all areas of the review process yet Region Office adherence to the guides is sporadic.

During FY 2006, CMSO achieved the following accomplishments: (1) conducted initial testing of the automated initial grant award that will use the MBES; (2) revised the Regional Office

Review Guides for forms CMS-64, 37, 21, and 21b to include updated statutory and regulatory citations and to capture the all review steps for the ROs; (3) developed the MBES waiver initiative to capture emergency initiatives such as the Disaster Waiver initiatives involving both Hurricanes Katrina and Rita; (4) developed methodologies to calculate the Medicaid and SCHIP IBNR accruals; and (5) placed the Medicaid and SCHIP IBNR surveys on the MBES platform.

While progress has been made during the current year, we noted control weaknesses regarding Medicaid program oversight and reporting as follows.

Lack of Regional Office Oversight

Within the CMS Regional Offices, analysts are required to follow the CMS Financial Review Guide to assess each State's budget requests, quarterly expenditure reports, and other state activities related to SCHIP and Medicaid funding. We noted that the Regional Offices did not consistently use the review guide (for quarterly and budgetary reviews) and, when the guide was used, the reasons that steps were not performed were not always documented. Additionally, we noted that documentation for certain line items on the CMS-64 supporting the analysts' review was lacking. The line items affected included those relating to adjustments and other expenditures for varying amounts.

An analysis of changes in quarterly budget and expenditure submissions is a major consideration in the Regional Office's recommendation to award a grant or validate expenditures. Furthermore, it is a significant step as required by the CMS Financial Review Guide. During our visit to the Regional Offices, we noted that analysts did not adequately perform trend analyses on Medical Assistance Payments (MAP), Administration (ADM), and SCHIP payments. For certain States, although evidence of trend analysis was available, the scope of the items selected for review was not documented in the workpapers nor was there evidence of which amounts were investigated. In many cases, explanations for variances were not sufficiently documented to assist a reviewer in verifying that CMS gathered appropriate evidence to support the execution of its oversight responsibilities over the Health Programs.

The Regional Offices obtain and review the Medicaid and Other Health Program findings identified in the State Single Audits and Office of Inspector General Audit reports. These reports are entered in the Audit Tracking and Reporting System (ATARS) by each Regional Office as it relates to the particular states within their region. Currently, the agency does not have a central oversight function to ensure that all reports that should be entered in ATARS have been actually entered correctly. In addition, we noted that the status annotated in the system ("Closed versus Open") was not always correct. Finally, we identified several reports in ATARS that were dated with fiscal years prior to 2005 and no action has been taken to follow up on the issues noted.

State Plan Amendments (SPA) and State Plan Waivers (SPW) are processed at the Regional Offices throughout the year. The Regional Offices were provided guidance for processing state plan amendments and waivers in a memorandum from CMSO issued March 19, 2004. During our review, we noted that acknowledgement letters were missing from the files along with other source documents, such as the Form CMS-179. In addition, we noted that approval

letters were signed by someone other than the Associate Regional Administrator as required. In addition, there is no formal guidance regarding how State Plan Amendments should be reviewed and approved.

The Regional Offices process Medicaid and SCHIP deferrals and disallowances. These deferrals and disallowances are entered into the CMS' Financial Accounting Control System (FACS) for reporting purposes. We noted the following observations as a result of our testing: Medicaid and SCHIP deferrals were not consistently being entered into FACS on a timely basis nor were they being consistently captured in the Financial Issues Report (FIR). In addition, disallowance letters could not be made readily available to support approved disallowances.

Lack of Central Office Oversight

The CMS Central Office has outsourced the grant payment process to the HHS Program Service Center, which uses its Payment Management System (PMS) to process and manage CMS payments to the States. CMS does not have policies and procedures in place to review the SAS 70 audits conducted at DPM to assess the impact of exceptions and findings on the CMS financial statements.

In addition, CMS lacks sufficient integration or reconciliation and tracking processes to ensure that obligation and expenditure activity within PMS, which tracks draws for State grants (Medicaid, SCHIP and other), are consistent with activity within the CMS general ledger. Currently for Medicaid, the States use the CMS-64 to report accrued expenditures to CMS while submitting a PMS-272 to report expenditures on a cash basis to PMS resulting in inconsistent expenditure activity between the two systems for the same grant. Although CMS personnel close out grants in the General Ledger once obligations and expenditures match, the obligations are not always de-obligated within PMS, leaving unexpended balances available for draws by the States. During fiscal year 2006 the unexpended balance related to grants eligible for close out exceed $1 billion. In addition, CMS does not perform a detailed review of the information retained within PMS.

CMS does not have formal policies that require periodic reconciliation of State cash draws to the quarterly expenditure reports. During our testing at the Central Office and the Regional Offices, we noted that CMS was not reconciling State cash draws to the State Expenditure Reports. Furthermore, we noted States that exhibited significant variances from the prior year to the current year. We requested an explanation from the Central Office, but the Central Office could not readily provide a response. Periodic reviews are submitted to the Central Office by the Regional Offices; however an overall analysis of the results was not documented at the Central Office.

The Regional Offices are not performing a timely review, within 30 days of submission, and approval of State expenditure and budget submissions, primarily because of late submissions by the States. In many cases, CMS approves grants when prior expenditures reports have been outstanding for six months (two quarters). In addition, the Regional Offices lack formal documented policies identifying alternative analyses that should be performed to support an

approval when routine information is not available. We also noted that the Regional Offices do not have polices and procedures that require documenting follow-up communication with grantees on late expenditure and budget submissions.

During our review, it was noted there is a lack of standardized Regional Office policies and procedures. Throughout the year, multiple requests were made to obtain the guidelines to be followed by the Regional Offices for various key areas being tested. However, this information was not furnished. Instead, information and interpretation of various guidance used by each individual region was obtained during the Regional Office Visits.

It was also noted that there is a significant amount of time taken by the Central Office to approve the Focused Financial Review Reports. As of September 30, 2006, there are still pending reports from fiscal years 2004 and 2005 awaiting approval. This time delay causes some areas that need immediate attention at the State level to be delayed until the draft reports are approved. For 2004, there are 47 outstanding reports and for Fiscal Year 2005, there are also 47 outstanding reports pending approval.

Lack of Controls over the Medicaid Accruals

Approved state plans are the basis for claims that are eligible for federal matching in the Medicaid program. Plans are subject to amendment throughout the year, these amendments are effective the date of submission not the date of approval and may have a payment impact on the financial reimbursement a State receives. CMS lacks formalized policies and procedures to track and calculate accruals for the Medicaid program related to the impact of retroactive state plan amendments. Currently the impact of these waivers is tracked on a spreadsheet maintained by CMSO and is not subject to any type of formalized internal control review.

Recommendations
As a result of not consistently adhering to the CMS Financial Review Guide to assist in monitoring and providing oversight of State Operations, deficiencies in internal controls may allow significant misstatements to occur without being identified. CMS should require the Regional Offices analysts to follow the Financial Review Guide to assess each State's budget requests, quarterly expenditure reports, and other State activities related to SCHIP and Medicaid funding. In addition, standard documentation policies should be established to ensure consistency among regions.

CMS should revise its procedures to provide a mechanism for Central and Regional Offices to monitor states' activities and enforce compliance with CMS financial management policies by:

- Provide specific guidance in the use and preparation of the Financial Review Guides to ensure that the Regional Offices consistently use the guide to document procedures performed during the quarterly expenditure and budgetary reviews and that any decision to expand or curtail the scope of the review or review procedures be documented.

- Develop a specific scope to be used to identify areas for review and that this scope, or any deviations from the scope, is documented within the trend analysis work paper(s) along with explanations.
- Enhance employee training initiatives on records retention and deferral and disallowance reporting. In addition, task responsibilities should be clearly assigned to employees to ensure proper performance.

CMS should enhance their current policies and procedures to ensure that the ATARS is complete and accurate. In addition, these policies and procedures should include steps to closely monitor the findings and ensure that they are resolved within a specified timeframe.

The oversight of SPA and SPW should be improved to ensure Regional Offices are retaining evidential matter to support their reviews and approvals. Similar to State Plan Waivers (3.3 Instructions), the agency should develop and provide guidance on how to review and approve each type of State Plan Waiver.

We recommend CMS management establish a library of policies and procedures to be followed by the Regional Offices (inclusive of the Review Guides). Policies and procedures should clearly annotate the responsibility of the Regional Offices and the specific guidance to be followed.

We recommend the Central Office finalize all outstanding Focused Financial Review reports that relate to prior fiscal years. Furthermore, CMSO should establish a timeframe for reports to be submitted to Central Office to ensure an adequate time for review. A standard operating procedure should be developed to illustrate the timeframe for completing a Focused Financial Review (from inception to final resolution). The status of pending reports should be tracked in a system similar to ATARS.

III. Financial Management Systems and Reporting

Communication

CMS lacks a coordinated end-to-end process among cross-functional teams of financial management, information technology, actuarial and operations personnel to monitor business activities and identify those situations where accounting evaluation or decision-making may be necessary. For example, no structured process exists to communicate program related issues that may have an impact on the financial statements. Further, upon the identification of issues with an accounting impact, no standardized, documented process exists to ensure timely resolution of accounting and reporting questions with the appropriate personnel.

We noted an instance where changes in federal matching rates for claims related to Hurricane Katrina had not been discussed by the Center for Medicaid and State Operations (CMSO) with the Office of Financial Management (OFM) in order to assess its impact. CMS management recorded a liability for the Medicaid program in fiscal year 2006 for the claims it had failed to

accrue for in prior years due the lack of coordination between OFM and CMSO related to changes to State Plans that have retroactive application dates.

In addition, a formal communication process is not in place to track and account for necessary accruals for the Part C managed care program and the Part D prescription drug program. The lack of a formal process to provide OFM with the detailed information to support the need for an accrual of payments due to and from individual managed care and prescription drug program contractors can lead to the misstatement of assets and/or liabilities. We noted that the final accrual methodology was not finalized until October 2006, after fiscal year end.

With respect to the Statement of Social Insurance (SOSI), a new basic financial statement requirement for FY2006, we did not note evidence of proactive involvement of the CMS financial reporting function personnel in designing or executing internal control for the SOSI financial reporting process. While the underlying SOSI assumptions, computations, and processes are driven by the CMS actuarial personnel, effective communication between the actuarial and accounting functions is paramount to accurate financial reporting. Accordingly, there should be standardized, documented policies and procedures that explain the role and responsibility of the financial reporting function personnel in the SOSI financial reporting process.

Lack of Integrated Financial Management System

OMB Circular A-127 requires that financial statements be the culmination of a systematic accounting process. The statements are to result from an accounting system that is an integral part of a total financial management system containing sufficient structure, effective internal control, and reliable data. CMS relies on decentralized processes and complex systems—many within the Medicare Contractor organizations and CMS Regional Offices—to accumulate data for financial reporting. An integrated financial system, a sufficient number of properly trained personnel and a strong oversight function are needed to ensure periodic analyses and reconciliations are completed to detect and resolve errors and irregularities in a timely manner. CMS's financial management systems are not compliant with the Federal Financial Management Improvement Act of 1996 (FFMIA). FFMIA requires agencies to implement and maintain financial management systems that comply with Federal financial management systems requirements as defined by the Joint Financial Management Improvement Program (JFMIP). More specifically, FFMIA requires Federal agencies to have an integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, procedures, controls, and data contained within the systems. The lack of an integrated financial management system continues to impair CMS's ability to efficiently and effectively support and analyze accounts financial reports.

For example, Medicare contractors currently rely on a combination of claims processing systems, personal computer based software applications and other ad hoc systems to tabulate, summarize and prepare information presented to CMS on the 750 – Statement of Financial Position Reports and the 751 – Status of Accounts Receivable Reports. These reports are the primary basis for the accounts receivable amounts reported within the financial statements. Because both CMS and their contractors do not have a JFMIP compliant financial management

system, the preparation of the 750 and 751 reports, and the review and monitoring of individual accounts receivable, are dependent on labor intensive manual processes that are subject to an increased risk of inconsistent, incomplete or inaccurate information being submitted to CMS. Likewise the reporting mechanism used by the CMS contractors to reconcile and report funds expended, the 1522 – Monthly Contractor Financial Report, is heavily dependent on inefficient, labor intensive, manual processes, that are also subject to an increased risk of inconsistent, incomplete, or inaccurate information being submitted to CMS.

The lack of integration in financial reporting was identified during the testing of individual contractor sites. The results clearly demonstrate the potential for problems in placing reliance on the outputs that had not been reviewed by the Regional or Central offices. This prevents the timely use and reliance on this information by both operations and financial reporting personnel. For example, the contractors are not able to report all information required for the completion of quarterly financial statements in accordance with OMB timelines and provides only minimal information at year end which supports the completion of the financial statements but does provide sufficient data for oversight and management of the contractors' activities.

Recommendations

CMS should establish appropriate policies, procedures and a protocol to address situations or transactions that require cross-functional involvement in determining the appropriate accounting treatment. The financial management function should serve as the primary coordinator to facilitate the input and involvement of the other cross-functional units whose involvement and input are important factors to consider in formulating accounting treatment and financial reporting implications.

Management should continue to implement an integrated financial management system for use by Medicare contractors and CMS to promote consistency and reliability in recording and reporting financial information.

IV. Statement of Social Insurance Preparation Processes

Overview

The Statement of Social Insurance (SOSI) is a long-term projection of the present value of income to be received from or on behalf of existing and future participants of social insurance programs, the present value of the benefits to be paid to those same individuals, and the difference between the income and benefits. In prior years, this information was presented as required supplemental information, therefore not subject to a detailed review of internal controls. During our review we noted several areas where controls were not effective.

Lack of Change Controls

During our review of the models used in the SOSI projection process we noted a lack of controls associated with change management. The following items were identified:

- Changes subject to change management policy and procedures are not clearly defined. In fact, the Office of the Actuary (OACT) implemented significant changes to the projection process during the current year that was not subjected to their established change control process.
- The current change management process does not require formal tracking of the status of authorized changes which are in progress.
- The current change management process does not require that the person who requests the change be different from the authorizer.
- Outdated worksheets are kept in the working directory with the updated worksheets, so outdated worksheets could be potentially used in error.

Inadequate change controls may lead to unauthorized changes to the models/spreadsheets which may cause a misstatement in the projection.

Lack of Access Controls

We identified a lack of controls around the access to models and spreadsheets used to calculate the amounts reported on the SOSI. Specifically, quarterly review of user access rights needs to be strengthened and procedures need to be established to terminate user access immediately upon an employee's transfer or termination. In addition, the addition or deletion of user access to working or final directories is not formally documented, and some production directories do not have associated working directories.

Inadequate access controls may allow unintentional and/or intentional errors to be introduced to the models/spreadsheets.

Lack of Formalized Policies and Procedures over Input and Processing Controls

OACT policies and procedures in place over inputs and processing controls are not consistently implemented. The following items where noted:

- Inappropriate controls in place to ensure final assumptions used in the projection are appropriately reviewed, led to instances where assumptions documented and approved by the Chief Actuary did not agree to the assumptions used within the models/spreadsheets. CMS asserts that the correct assumptions were ultimately used in the projection.
- During our review of 123 OACT models and spreadsheets used in the projection process, we noted 184 instances of cells with referencing issues, where the cells reference an invalid location. In addition, we noted 42 instances where formulas are dividing by zero (or blank cells) or where the formulas are referencing cells that

contain erroneous values. Although the anomalies noted did not cause an error in the projection, inaccurate formulas or unused information in the models and spreadsheets could pose a risk to the projection.

Lack of Appropriate Documentation

During our testing of the Statement of Social Insurance the following documentation issues were noted:

- Inconsistencies and errors in the models and spreadsheets inventory exist. The lack of completeness of the list resulted in models/spreadsheets being used during the projection process that were not validated by OACT. In one instance, the lack of appropriate validation of all spreadsheets involved in the projection process resulted in a formula error affecting the projection.
- Inconsistencies and a lack of proper models and spreadsheets documentation regarding the use of outputs (i.e. how and where the output is subsequently used including file, sheet, column etc.) may lead to errors in the projection process.
- A standard file naming convention is not used which may result in version control issues.
- Internally developed sources of significant models/spreadsheets are not always maintained. The lack of retention of source files limits CMS' ability to validate the accuracy and completeness of data introduced into their models.
- OACT did not appropriately document controls in place to ensure the reasonableness of data developed by other CMS departments or by other agencies and outside sources. For example, communications with outside data sources regarding errors or discrepancies are not documented and, as such there is no record of actions taken by OACT to mitigate the risk of errors in their calculations due to inaccurate data sources.
- OACT did not appropriately document or maintain evidence of input controls. We noted that specific steps taken to ensure the accuracy and completeness of data input to the models/spreadsheets were not documented. The lack of appropriate documentation of controls, limits OACT's ability to ensure controls are performed as intended.

Recommendations

CMS should enhance its controls over the preparation of the Statement of Social Insurance through the implementation of formal polices and procedures related to change, access, input and processing controls, and in the formulization of documentation through the following:

- Establish an appropriately defined change control policy and ensure its consistent application.

- Enhance access controls procedures in order to ensure that only authorized individuals have access to OACT directories including production, working directories, and final directories.
- Ensure appropriate controls and documentation exists over approved assumptions, methods and/or techniques.
- Ensure models/spreadsheets used in the projection process are free of formula anomalies, and only contain information used during the current year's projection.
- Create a complete inventory of models used for the projection process, in order to ensure appropriate controls are in place.
- Appropriately document the use of outputs from spreadsheets that serve as the inputs to other spreadsheets.
- Implement a standard file naming convention.
- Implement policies and procedures requiring the retention of all source information used in the preparation of the statement.
- Appropriately document and maintain evidence of input controls in place, including controls in place to ensure the reasonableness of data obtain from sources outside of OACT.

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Internal Control Related to Key Performance Indicators and RSSI

With respect to internal control relevant to data that support reported performance measures in the financial report, we obtained an understanding of the design of significant internal control relating to the existence and completeness assertions, as required by OMB Bulletin No. 06-03. Our procedures were not designed to provide assurance on the internal control over reported performance measures. Accordingly, we do not provide an opinion on such control.

We also identified other less significant matters that will be reported to CMS's management in a separate letter. This report is intended solely for the information and use of the management of CMS and the Department of Health and Human Services, the Office of the Inspector General of the Department of Health and Human Services, OMB, and Congress. This report is not intended to be and should not be used by anyone other than these specified parties.

PricewaterhouseCoopers LLP

November 8, 2006

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

November 8, 2006

PricewaterhouseCoopers, LLP
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Dear Sir:

This letter is in response to your audit report on the Centers for Medicare & Medicaid Services' (CMS) fiscal year 2006 financial statements. Your report identifies one material weakness, Medicare Electronic Data Processing, and four reportable conditions, Managed Care (Part C) and Prescription Drug (Part D) Benefits Payment Cycle, Medicaid and Other Health Programs Oversight, Financial Management Systems and Reporting, and Statement of Social Insurance Preparation Processes. The CMS generally concurs with the findings and description of the material weakness and reportable conditions. As noted in your report, CMS continued to improve its financial management performance in FY 2006 in many areas. This is especially true for those areas that were formerly reported as material weaknesses and are now reported as reportable conditions. For example, CMS is successfully addressing the audit findings in the Managed Care benefits payment cycle.

While receiving an unqualified opinion on our financial statements is an outstanding achievement, we are working on a strong corrective action plan to address the audit issues identified. We are committed to correcting these issues as quickly as possible and are strengthening our efforts to improve the financial management of CMS' operations so that the CMS can fulfill its stewardship responsibilities and exceed our high financial management standards. We will continue to track and report our progress on a regular basis.

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

Sincerely,

Timothy B. Hill
Chief Financial Officer

Other Congressional Reports

SUMMARY OF FEDERAL MANAGERS' FINANCIAL INTEGRITY ACT REPORT AND OMB CIRCULAR A-123 STATEMENT OF ASSURANCE

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

The CMS assesses its management controls and financial management systems through: (1) internal control self-assessments, (2) Office of Management and Budget (OMB) Circular A-123, *Management's Responsibility for Internal Control*, self-assessment, (3) OIG audits, (4) GAO audits and high risk reports, (5) the CFO financial statements audit, (6) SAS 70 internal control audits, and (7) certification and accreditation of our information systems. As of September 30, 2006, the management controls and financial management systems of CMS provided reasonable assurance that the objectives of FMFIA were achieved. However, one material weakness existed and two instances of noncompliance were identified.

Material Weakness—Medicare Electronic Data Processing

The CMS relies on extensive information systems operations at its Central Office and Medicare contractor sites to administer the Medicare program and to process and account for Medicare expenditures. Internal controls over these operations are essential to ensure the integrity, confidentiality and reliability of the Medicare data and to reduce the risk of errors, fraud and other illegal acts.

Medicare Data Centers

The Medicare Data Centers were the focus of the CFO audit. Thirteen of the fourteen data centers were audited on-site and the remaining data center was audited remotely. Vulnerability reviews of network controls were conducted at the majority of the data centers. Findings were identified in logical access controls; application security, development and program change control; and systems software.

Medicare Contractor Access Controls

Access controls ensure that critical system assets are physically protected from unauthorized access and that logical controls provide assurance that only authorized personnel may access data and programs maintained on the systems. Although no exploitation was noted, the audit identified security weaknesses that potentially could allow internal users to access and update sensitive systems, programs and data without authorization.

Medicare Contractor Application/Change Controls

These controls provide assurance that software programs are developed with standards that ensure their effectiveness, efficiency, accuracy, security and maintenance and that only authorized and properly tested programs are implemented for production use. The audit noted two issues: 1) the improper or non-standardized use and control of edits within the shared system software applications that are used to process Medicare claims, and 2) the automated program code used for claims processing not always having a proper audit trail to allow the review of changes to the program code, or to review actual changes made by the code to claims data. This latter issue could result in contractors having the ability to directly update production data and/or source program code for applications thereby bypassing application change controls.

CMS Data Center

Numerous issues were identified at the CMS Data Center, particularly in the areas of systems software and enterprise access controls.

The CMS has initiated corrective action plans for all aspects of the material weakness, including plans to issue instructions to contractors to improve controls around the validation and maintenance of access control lists, to survey contractors to ensure compliance with CMS requirements for testing and approval of add-on programs, to remediate high-risk findings and take both short and mid-term actions needed to correct the remainder of the individual findings at the CMS Data Centers, and to analyze and correct the weaknesses identified at the Medicare Data Centers and take steps to strengthen communications with contractors to reinforce the importance of effective internal controls.

Noncompliance

The CMS financial management systems—because they are not integrated—do not conform to government-wide requirements. We are bringing our financial systems into compliance through our continuing efforts to implement HIGLAS, which will integrate the Medicare contractors' standard claims processing systems and replace the CMS mainframe-based financial system with a web-based accounting system. The CMS has begun to implement the requirements of the IPIA. Although CMS has not fully complied with OMB's IPIA

guidance, CMS has implemented a comprehensive process that measures the payment error rate for the Medicare FFS program.

OMB Circular 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 FMFIA. The CMS conducted its assessment of the effectiveness of internal control over the effectiveness and efficiency of operations and compliance with applicable laws and regulations in accordance with OMB Circular A-123. Based on the results of this evaluation, CMS provided a qualified statement of assurance that its internal control over the effectiveness and efficiency of operations and compliance with applicable laws and regulations, as of September 30, 2006, was operating effectively, except for a material weakness related to Medicare electronic data processing operations at its Central Office and Medicare contractor sites to administer the Medicare program and to process and account for Medicare expenditures. Findings were identified in logical access controls; application security, development and program change control; and systems software.

In addition, CMS conducted its assessment of the effectiveness of internal control over financial reporting, which includes safeguarding of assets and compliance with applicable laws and regulations, in accordance with the requirements of the Department of Health and Human Services' *Guidance Manual to Implement Appendix A of OMB Circular A-123*. Based on the results of this evaluation, CMS provided a qualified statement of assurance that its internal control over financial reporting, as of September 30, 2006, was operating effectively, except for the material weakness and non-conformance with applicable laws and regulations noted above and a scope limitation regarding Medicare Advantage and prescription drug payments. The CMS did not test the internal controls related to Medicare Advantage and prescription drug payments because management decided to focus on remediation of the outstanding material weakness identified by the CFO audit in fiscal year (FY) 2005 related to Medicare Advantage payments that also affects prescription drug payments. While CMS did not test and thus could not determine if the design or operation of the internal control over financial reporting were effective for Medicare Advantage and prescription drug payments, these areas were determined not to be a material weakness, but rather a reportable condition based on the results of the FY 2006 CFO audit.

Other than the exceptions noted above, the internal controls were operating effectively and no other material weaknesses were found in the design or operation of the internal control over financial reporting.

MEDICARE'S VALIDATION PROGRAM FOR JCAHO-ACCREDITED HOSPITALS

Introduction

Section 1865 of the Social Security Act (the Act) provides that hospitals accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) are

deemed to meet the Medicare Conditions of Participation (CoPs). There are 4,237 JCAHO-accredited hospitals, accounting for approximately 81 percent of all hospitals participating in the Medicare program.

The JCAHO accreditation survey assesses a hospital's compliance with the JCAHO standards. Following the completion of an on-site survey, the JCAHO makes an accreditation decision. JCAHO surveys each accredited hospital on a triennial basis, to verify ongoing compliance, and also conducts random unannounced surveys of a sample of accredited hospitals on a more frequent basis.

Although they are not subject to routine Medicare surveys by State agencies (SA), subsection 1864(c) of the Act authorizes the Secretary to enter into an agreement with any such SA to survey JCAHO-accredited hospitals on a selective sample basis, or in response to allegations of significant deficiencies which, if substantiated, would adversely affect the health and safety of patients. The Act further requires, at section 1875, the Secretary to include an evaluation of the JCAHO accreditation process for hospitals in an annual report to Congress. This evaluation is referred to as the hospital validation program. The purpose of the CMS hospital validation program is to determine if the JCAHO accreditation process provides reasonable assurance that accredited hospitals are in compliance with the statutory requirements set forth at subsection 1861(e) of the Act for participation in the Medicare program as hospitals.

The CMS uses three types of SA surveys as evaluation tools in its JCAHO hospital validation program: comprehensive "look-back" surveys, conducted within sixty days of a JCAHO survey; comprehensive "mid-cycle" surveys, conducted on hospitals that JCAHO had previously identified as needing to correct various deficiencies; and focused "allegation," or complaint investigation surveys. The results of these surveys permit CMS to evaluate two important parameters of JCAHO performance: the identification of deficiencies in hospitals' compliance with the Medicare CoPs; and the ability of the JCAHO process to ensure correction of deficiencies previously identified by JCAHO.

Findings from the look-back validation surveys performed in FY 2005 demonstrated that there is an ongoing disparity between JCAHO and SAs in their ability to identify hospital deficiencies, with JCAHO missing 28 percent of the deficiencies identified by SAs. This disparity rate has hovered around 27 percent since FY 2003, and has been consistently above 20 percent since FY 2000. As in previous years, the single largest source of the disparity remains the JCAHO's ability to detect deficient compliance with requirements related to hospitals' physical environment which includes ***Life Safety Code®*** (LSC). While JCAHO's LSC disparity rate improved noticeably in FY 2005, considerable room for further improvement remains.

Findings from the mid-cycle surveys demonstrate that JCAHO's process is generally effective in leading hospitals to correct deficiencies identified by JCAHO. Eighty-four percent of sampled hospitals had eliminated the JCAHO-identified deficiencies when surveyed later by a SA. This is a reduction from the compliance rate of 94 percent achieved in JCAHO hospitals in the FY 2004 mid-cycle survey sample, but the small sample size precludes drawing any conclusions about trends.

Ninety-one percent of complaints that warranted an on-site investigation by a SA of a hospital in FY 2005 involved a JCAHO-accredited hospital. A small percentage,

2.8 percent, of the 4,275 allegation surveys conducted by SAs found condition-level deficiencies, i.e., they were serious enough to warrant CMS' taking enforcement action.

JCAHO Accreditation Activity

In FY 2005, JCAHO surveyed 1,461 hospitals and made four types of accreditation decisions:

- Accreditation—the hospital meets all JCAHO standards and requirements.
- Accreditation with requirements for improvement—the hospital is granted accreditation after providing assurance that the recommendations for improvement identified in the JCAHO survey process will be implemented.
- Conditional accreditation—the JCAHO survey found the hospital was not in substantial compliance with JCAHO standards, but is believed to be capable of achieving acceptable compliance relatively quickly. JCAHO conducts a follow-up survey, during which the hospital must demonstrate substantial correction of the identified deficiencies before it can be considered for full accreditation.
- Accreditation denied. Since there is an appeal process for denials, JCAHO reported both preliminary and final denials.

Table 1 summarizes the JCAHO hospital accreditation decisions reported to CMS for hospitals receiving an initial or triennial survey in FYs 2004 and 2005. In January 2004, JCAHO adopted a new approach to assessing compliance with its standards, Shared Visions/New Pathways, and as this approach has been implemented, JCAHO reports it has been identifying more instances of hospital noncompliance. In January 2005, JCAHO incorporated into this approach the use of unannounced triennial surveys, which now may occur up to five months before or three months after a hospital's triennial accreditation date. Prior to 2005, all JCAHO triennial surveys were scheduled with the hospital in advance. In FY 2005, 91 percent of the hospitals JCAHO surveyed were identified as having requirements for improvement (RFI), an increase of 8.3 percent over FY 2004. In addition, seven hospitals were denied accreditation in FY 2005, compared to none in FY 2004.

TABLE 1
JCAHO Accreditation Decisions
Hospitals Surveyed in FY 2004 and FY 2005

Accreditation Decisions	No. Hospitals, 2004 *(Percent)*	No. Hospitals, 2005 *(Percent)*
Accreditation	244 (14.94)	61 (4.18)
Accreditation with Requirements for Improvement	1,364 (83.53)	1,330 (91.03)
Conditional Accreditation	23 (1.41)	63 (4.31)
Preliminary Denial of Accreditation	2 (0.12)	13*
Accreditation Denied	0 (0)	7 (0.48)
Total Surveyed	1,633 (100)	1,461 (100)

*This is a duplicate count to reflect the changing accreditation status during the JCAHO appeals process.
Source: JCAHO

CMS Validation Program Activity in FY 2005

A total of 66 comprehensive surveys, 47 look-back and 19 mid-cycle surveys, were performed in a sample of JCAHO-accredited hospitals during FY 2005. In these comprehensive surveys a SA independently evaluates a hospital's compliance with all Medicare CoPs through an unannounced survey. The SA is not apprised in advance of any findings from the JCAHO survey. In order to assure that the "look-back" survey is a reasonable assessment of JCAHO's survey process, rather than reflecting changed circumstances within a hospital, it is conducted within 60 days following the hospital's JCAHO accreditation survey. By contrast, the FY 2005 mid-cycle surveys were conducted on hospitals roughly midway through their JCAHO accreditation cycle, whose most recent JCAHO survey had identified having deficiencies. These mid-cycle surveys were primarily intended to assess the effectiveness of the JCAHO accreditation process in assuring correction of identified deficiencies. In selecting the sample of hospitals to be surveyed, CMS used a random sample, stratified by state, of all hospitals surveyed in FY 2005 by JCAHO for look-back surveys, and of all JCAHO-accredited hospitals in the middle of the accreditation cycle that had been previously identified by JCAHO as having deficiencies needing correction. The 66 hospitals surveyed represent a 1.6 percent sample of all JCAHO-accredited hospitals. The 47 look-back surveys represent a 1.1 percent sample of all JCAHO-accredited hospitals, but a 3.2 percent sample of all hospitals surveyed by JCAHO in FY 2005.

In addition to these comprehensive surveys, SAs conducted focused investigations of 4,275 complaints alleging substantial violations of Medicare CoPs in JCAHO-accredited hospitals.

Table 2 summarizes CMS' validation program activity for FY 2005.

TABLE 2
FY 2005 CMS Surveys Completed in JCAHO-Accredited Hospitals

Survey Type	Number	Surveys with Condition-Level Deficiencies
Look-Back Surveys	47	20
Mid-Cycle Surveys	19	11
Allegation Surveys	4,275	120

Validation Program Findings

Look-Back Survey Disparity Rate

The rate of disparity is the percentage of look-back surveys for which a State Survey Agency finds a hospital out of compliance with one or more Medicare CoPs, but no comparable condition-level deficiency was cited by JCAHO. The assumption is that it is reasonable to conclude that the deficiencies were present at the time of the JCAHO survey and should have been identified.

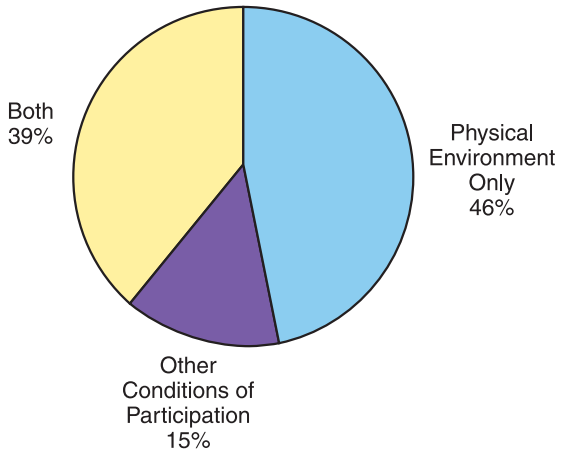
State Survey Agencies found non-compliance with one or more CoPs in 20 of the 47 hospitals that had a look-back survey. Comparison of the JCAHO-accreditation survey reports with the SA survey reports for these 20 hospitals showed that in 13 hospitals the JCAHO survey did not identify deficiencies comparable to the condition-level deficiencies cited by the SA surveyors. This disparity in findings, in 13 of the 47 hospitals sampled, results in a 28 percent disparity rate between JCAHO and SA ability to detect deficiencies. Table 3 illustrates these results.

TABLE 3
Look-Back Survey FY 2005 Results

Deficiency Category	Hospitals where SA cited CoP Non-Compliance	Hospitals with JCAHO Requirements for Improvement	Hospitals in which JCAHO missed CoP-Level Non-Compliance	Total Hospitals Sampled	Disparity Rate (%)
Physical Environment	12	0	6	47	0.127 (13)
Other CoPs	2	3	2	47	0.043 (4)
Both	6	16	5	47	0.106 (11)
Total	**20**	**19**	**13**	**47**	**0.276 (28)**

Chart A graphically illustrates these findings. In 46 percent of the hospitals in which JCAHO missed a condition-level deficiency, the sole condition identified by the SAs was the Physical Environment CoP. Compliance with the LSC was the most common area of discrepancy within the Physical Environment CoP, typically involving fire safety precautions. JCAHO's performance in identifying LSC problems in hospitals has been the subject of frequent communication between CMS and JCAHO in recent years, and JCAHO has implemented various measures to improve its performance in this area. A number of these measures are highlighted later in this report.

Chart A: Hospitals with Findings Missed by JCAHO FY 2005



The frequency for each category of health and safety CoPs where the SA found lack of compliance in the 20 non-complying hospitals is shown in Table 4, along with the number of times JCAHO did or did not make similar findings during the accreditation survey.

TABLE 4
Conditions of Participation Cited During FY 2005 Look-Back Surveys

Conditions of Participation	Cited by the State Agency	Similar Findings Identified by JCAHO	Findings Not Identified by JCAHO
Physical Environment Condition of Participation			
Physical Environment *(Includes Life Safety Code)*	18	7	11
Other Conditions of Participation			
Infection Control	2	1	1
Patient Rights	2	0	2
Nursing Services	1	1	0
Governing Body	1	1	0
Organ, Tissue, Eye	1	0	1
Medical Records	1	0	1
Surgical Services	1	0	1
Anesthesia	1	0	1
Food and Diet	1	0	1
Total	**29**	**10**	**19**

As shown in Table 5, JCAHO's look-back survey disparity rate has hovered around 27 percent since FY 2003, and has been consistently above 20 percent since FY 2000. While it might be argued that the disparity rate is derived from a small sample, creating significant statistical uncertainty when calculating the disparity rate, CMS cannot ignore the fact that JCAHO's disparity rate has consistently exceeded 20 percent for the past six years. Although the regulations at 42 CFR 488.8(d) provide for a deeming authority review when an accrediting organization's disparity rate exceeds 20 percent, current law does not permit application of this standard to the JCAHO hospital accreditation program. The CMS also may not remove the deeming authority from the JCAHO's hospital accreditation program, as would be the case for comparable accreditation organizations underneath said regulation. As we have in previous years, CMS will continue to work closely with JCAHO to minimize differences in the two organizations' standards and survey procedures as a means to reduce the look-back survey disparity rate in the future.

TABLE 5
JCAHO Look-Back Survey Disparity Rates FY 2000–2005

FY	Disparity Rate
2000	27%
2001	24%
2002	22%
2003	26%
2004	27%
2005	**28%**

Mid-Cycle Survey Findings

The mid-cycle comprehensive surveys, first introduced in FY 2003, are intended to assess JCAHO's ability to ensure that hospitals take necessary corrective action to come into compliance with accreditation standards. These surveys are conducted in a sample of JCAHO-accredited hospitals which, at their last triennial survey, were accredited with requirements for improvement. There were 19 mid-cycle surveys conducted in FY 2005.

Sixteen of the 19 hospitals surveyed had corrected the requirements for improvement previously cited by the JCAHO. There were only three hospitals which had not corrected the requirements for improvement previously recommended by the JCAHO. Hence, JCAHO-accredited hospitals achieved a corrective action adherence rate of 84 percent. This compares with a 94 percent adherence rate in the FY 2004 mid-cycle survey sample, where all but one of 17 hospitals had implemented corrective actions. However, the availability of only three years' of mid-cycle survey data, coupled with the small size of the samples in each year, preclude drawing any conclusions about changing trends over time.

Although the JCAHO performed well in ensuring the correction of deficiencies, it should be noted that the SAs identified additional CoP-level deficiencies, unrelated to the requirements for improvement previously cited by the JCAHO, in eight of the 19 hospitals. The CMS does not calculate a disparity rate based on these findings, due to the time lag of roughly 18 months between the original JCAHO and the SA mid-cycle surveys. However, CMS is considering expanding the use of the mid-cycle survey after FY 2007, as a way to evaluate JCAHO performance in ensuring accredited hospitals maintain continued compliance. This would require a larger sample of comprehensive surveys that is beyond the resources available to the validation program at this point. We are working to increase the overall sample size and identify possible alternate methods to evaluate this very important element of JCAHO performance.

Allegation (Complaint) Survey Findings

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

JCAHO-accredited facilities accounted in FY 2005 for approximately 81 percent of the Nation's hospitals and 91 percent of all hospitals where CMS authorized a substantial allegation survey. As was indicated in Table 2, SAs conducted 4,275 allegation surveys in a JCAHO-accredited hospital, and 2.7 percent of these surveys involved condition-level deficiencies, i.e., they were serious enough to warrant CMS taking enforcement action against these hospitals. Table 6 indicates the CoPs with the most frequent violations cited by the SAs.

TABLE 6
Most Frequently Cited Conditions of Participation During Allegation Surveys for JCAHO-Accredited Hospitals, FY 2005

Condition Not Met	Frequency (Percent of allegation surveys)
Patients' Rights	54 (1.3)
Nursing Services	44 (1.0)
Governing Body	28 (0.6)

At present, CMS does not include allegation surveys in the disparity rate calculation, although CMS may develop specific accreditation agency performance measures to apply to complaint data and findings in the future.

JCAHO Improvement Efforts

As discussed in the FY 2004 Report to Congress, CMS made a number of recommendations to JCAHO that we believed would improve JCAHO evaluation of LSC compliance by hospitals. JCAHO reports it has implemented the following recommendations:

- **Completion of the Statement of Conditions (SOC) by Qualified Personnel.** We recommended that JCAHO require hospitals to use personnel with specific credentials and skills to prepare the SOC self-assessment that hospitals prepare as part of the JCAHO accreditation process. JCAHO reports it now requires hospitals to assign responsibility for completing the SOC to someone whose experience is commensurate with the scope of the LSC activities required for the assessment.
- **Set Minimum Standards for the SOC/Projects for Improvement (PFI).** JCAHO reports that all hospital SOC's and PFI's are now reviewed for adequacy by the JCAHO central office staff.
- **Submission of the SOC and PFI documents to JCAHO prior to survey.** JCAHO has required prior submission of these documents since implementation, in 2004, of its comprehensive revision of its survey process, Shared Visions/Shared Pathways.
- **Increase number of LSC experts.** The CMS's initial recommendation focused on JCAHO's increasing the capacity of LSC experts in the central office to evaluate SOCs and PFIs. In FY 2006, JCAHO increased the number of central office professional engineers by 30 percent, to four. In addition, in the fall of 2004, JCAHO hired and trained 50 LSC specialty surveyors to review LSC in hospitals with greater than 200 beds. The LSC specialist surveyors are all certified health care facility managers or certified health care safety professionals. Hospitals with less than 200 beds continue to be surveyed for LSC by general surveyors; however, these surveyors now receive a specialized two-day course covering Environment of Care and Life Safety Code. In addition, there is continuing LSC education throughout the year in the form of written materials.
- **Develop mechanisms for facilities that fail to comply with the timeframes for correction identified in their PFIs.** JCAHO reports its use of conditional accreditation and preliminary denial of accreditation as a mechanism to bring hospitals into compliance with accreditation standards continues to grow. The number of preliminary denials of accreditation increased from 13 in FY 2003, to 25 in FY 2004, and 76 in FY 2005, nearly a five-fold increase. However, CMS is also aware that, in 2006, JCAHO also relaxed its threshold for awarding unconditional accreditation to hospitals. This action may prove counter-productive to JCAHO's other efforts to increase its ability to hold hospitals accountable for implementing required corrections.

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

- **Formation of a joint CMS-JCAHO gap-analysis work group to identify CoPs with no clear counterpart in the JCAHO standards.** This work group continues to analyze the JCAHO's accreditation standards, elements of performance, and evidence of compliance and compare their intent and outcomes to the Medicare CoPs, interpretive guidelines for SAs, and survey procedures in an effort to reduce the gaps between the two sets of standards and processes.
- **Conducting its own "look-back" surveys.** In August 2005, JCAHO began a one-time series of "look back" random announced validation surveys using a survey team with specialized training. Results will be used to identify further areas of improvement in the JCAHO survey process.
- **Implement an electronic SOC and PFI process.** Starting in CY 2007, JCAHO will move the Statement of Condition/Projects for Improvement into an electronic format, similar to CMS' use of the Automated Survey Processing Environment (ASPEN) suite of electronic tools to conduct and manage SA surveys. JCAHO anticipates that use of these electronic tools will improve management of the SOC and PFI processes not only by JCAHO, but also within hospitals.

According to the JCAHO, the above actions have already resulted in a substantial increase in the number of deficiencies identified in the Environment of Care/LSC area in hospitals, as indicated in Table 7.

TABLE 7
Joint Commission Life Safety Code Scoring Trends
CY 2003–2006 ytd

	2003	2004	2005	2006 (Q1/Q2)
Number of Hospitals	1,448	1,425	1,436	730
Environment of Care/LSC RFI	2%	6%	21%	28%

Source: JCAHO

CMS acknowledges the significant efforts that JCAHO has invested in improving its ability to enforce compliance with LSC, and the resulting increase in citations for requirements for improvement in this area, as well as an increased number of conditional accreditations and denials. At the same time, these efforts have not yet had the effect of reducing the disparity found when SAs and JCAHO both survey the same hospitals. It remains to be seen whether JCAHO's investments in enhanced LSC enforcement will succeed in future years in bringing its disparity rate down to a more reasonable level.

CMS Oversight Improvement

In July 2004, the Government Accountability Office (GAO) issued a report on CMS' oversight of the hospital accreditation program.[1] In that report, the GAO made several recommendations that might be used to improve CMS' oversight of the hospital accreditation program, including modifying the method used to calculate the disparity rate,

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

identifying additional indicators of JCAHO performance, and increasing the validation sample size. In response to that report, and our own internal analysis, CMS has undertaken further action to enhance our oversight of JCAHO hospital accreditation. A number of those actions are described below:

- **Ongoing Communication with JCAHO.** The CMS instituted a series of quarterly meetings with all of the accreditation organizations with deeming authority, including the JCAHO. These meetings serve to foster communication between the accrediting organizations and CMS and serve as a forum to discuss any issues as they arise in order to better assure ongoing provider compliance with Medicare CoPs.
- **Emergency Preparedness.** The CMS is increasing its coordination with JCAHO on emergency preparedness for addressing future mass casualty events caused by all hazards. The CMS has also worked closely with JCAHO on recovery efforts of hospitals affected by Hurricane Katrina.
- **Methodological Changes to Improve Oversight.** The CMS is assessing differing approaches to refining and improving upon the current method of measuring JCAHO's performance in assuring compliance with the CoPs. We secured the services of a contractor in FY 2006 to assist in this endeavor. A revised approach to performance assessment may also require regulatory revisions.
- **Hospital Validation Sample Size.** For FY 2006, CMS increased the comprehensive validation survey (both look-back and mid-cycle) sample size to two percent of all JCAHO-accredited hospitals. For FY 2007, the sample size will be further increased if Congress approves the Survey and Certification funding level requested in the President's budget.
- **Mid-Cycle Surveys.** The CMS will continue to pilot test the mid-cycle survey as an additional tool for measuring JCAHO performance and seek to increase the mid-cycle sample size to enhance the degree of confidence we have in the findings.
- **Analysis of Complaint Data.** The CMS is investigating cost-effective approaches to enhancing hospital survey activities, including integration into our overall assessment of JCAHO's performance, the results of complaint investigations conducted in JCAHO-accredited hospitals. An initial analysis of the hospital complaint investigation data for 2002–2004 was conducted in FY 2006, as a first step in determining the extent to which this information can be used as an additional tool.
- **Regular Exchange of Data.** Timely, complete, and readily usable data on JCAHO's accreditation activities is a prerequisite to effective evaluation by CMS of JCAHO's performance. A number of operational barriers have made optimal data exchange challenging for both JCAHO and CMS. We will continue to work with JCAHO to obtain more comprehensive and regular information about the organization's accreditation activities and to expedite the exchange of data and information between the two organizations.

CLINICAL LABORATORY IMPROVEMENT VALIDATION PROGRAM

Introduction

This report on the Clinical Laboratory Improvement Validation Program covers the evaluations of fiscal year (FY) 2005 performance by the six accreditation organizations approved under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The six organizations are as follows:

- AABB[1]
- American Osteopathic Association (AOA)
- American Society of Histocompatibility and Immunogenetics (ASHI)
- COLA[2]
- College of American Pathologists (the College)
- Joint Commission on Accreditation of Healthcare Organizations (Joint Commission)

The CMS appreciates the cooperation of all of the organizations in providing their inspection schedules and results. While an annual performance evaluation of each approved accreditation organization is required by law, CMS sees this as an opportunity to present information about, and dialogue with, each organization 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 the 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.

[1] Formerly known as the American Association of Blood Banks.

[2] Formerly known as the Commission of Laboratory Accreditation.

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,[3] 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

[3] A condition-level requirement pertains to the significant, comprehensive requirements of CLIA, as opposed to a standard-level requirement, which is more detailed and 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.

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

Number of Validation Surveys Performed

As directed by the CLIA statute, the number of validation surveys should be sufficient to "allow a reasonable estimate of the performance" of each accreditation organization. A representative sample of the more than 15,000 accredited laboratories received a validation survey in 2005. 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. Six validation surveys were conducted. No condition-level deficiencies were cited in any of the surveys, thus disparity was precluded.

American Osteopathic Association

Rate of disparity: No disparity

For CLIA purposes, approximately 40 laboratories used their AOA accreditation. Three validation surveys were conducted. No condition-level deficiencies were cited in those surveys, thus disparity was precluded.

American Society of Histocompatibility and Immunogenetics

Rate of disparity: No disparity

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

COLA

Rate of disparity: 5 percent

Validation surveys were conducted at 120 COLA-accredited laboratories. Two surveys were removed from the review pool because they were performed more than 90 days after the COLA inspection. Of the remaining 118 surveys, ten laboratories were cited with condition-level deficiencies. Comparable deficiencies were noted by COLA in four out of the ten laboratories cited with condition-level deficiencies.

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

CLIA number	Location	CLIA Conditions
04D0856062	Arkansas	Analytic Systems; and Technical Consultant
14D0666068	Illinois	Technical Consultant—qualifications
17D0448356	Kansas	Laboratory Director—fulfillment of responsibilities for overall management and direction
26D0446483	Missouri	Laboratory Director—fulfillment of responsibilities for overall management and direction
31D0121631	New Jersey	Analytic Systems
33D0141733	New York	Successful Participation in Proficiency Testing

College of American Pathologists

Rate of disparity: 3 percent

A total of 81 validation surveys were conducted in laboratories accredited by the College. Six of the 81 surveys were cited with condition-level deficiencies. Comparable deficiencies were noted by the College in one of the six laboratories cited with condition-level deficiencies.

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

CLIA number	Location	CLIA Conditions
04D0467253	Arkansas	Enrollment and Testing of Samples—intentional referral of Proficiency Testing for total and direct bilirubin
05D0669064	California	Enrollment and Testing of Samples—testing of samples performed by different individuals than those who perform testing of patient specimens; and Laboratory Director—fulfillment of responsibilities for overall management and direction
18D0648698	Kentucky	Enrollment and Testing of Samples—lack of enrollment in Proficiency Testing program in subspecialty of mycology for the performance of germ tube testing
19D0648901	Louisiana	Analytic Systems; and Laboratory Director—fulfillment of responsibilities for overall management and direction
34D0999116	North Carolina	Immunohematology

Joint Commission on Accreditation of Healthcare Organizations

Rate of disparity: 2 percent

During this validation period, a total of 83 validation surveys were conducted in laboratories accredited by the Joint Commission. Two surveys were removed from the review pool for administrative reasons. Of the remaining 81 validation surveys, four laboratories were cited with condition-level deficiencies. Comparable deficiencies were noted by the Joint Commission in two of the four laboratories cited with condition-level deficiencies.

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

CLIA number	Location	CLIA Conditions
31D0108254	New Jersey	Routine Chemistry
34D0238773	North Carolina	Laboratory Director—fulfillment of responsibilities for overall management and direction

Conclusion

The CMS has performed this validation review in order to evaluate and report to Congress on the performance of the six laboratory accreditation organizations approved under CLIA. The findings of the validation review for fiscal year 2005 indicate that all of the accreditation organizations performed at a level well below the 20 percent disparity threshold that would trigger a deeming authority review. Moreover, there was no indication in the validation review that would raise questions about the overall equivalency of any organization's accreditation standards.

Glossary

A

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

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

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

B

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

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

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

C

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

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

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

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

D

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

Demonstrations: Projects and contracts that CMS has signed with various health care organizations. These contracts allow CMS to test various or specific attributes such as payment methodologies, preventive care, and social care, and to determine if such projects/pilots should be continued or expanded to meet the health care needs of the Nation. Demonstrations are used to evaluate the effects and impact of various health care initiatives and the cost implications to the public.

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

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

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

GLOSSARY

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

E

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

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

F

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

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

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

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

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

H

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

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

GLOSSARY

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

I

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

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

M

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

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

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

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

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

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

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

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA): Legislation passed that established a new program in Medicare to provide a prescription drug benefit, Medicare Part D, which became available on January 1, 2006. Additionally, MMA sets forth numerous changes to existing programs, including a revised managed care program, certain payment reforms, rural health care improvements, and other changes involving administrative improvements, regulatory reduction, administrative appeals, and contracting reform.

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

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

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

O

Obligation: Budgeted funds committed to be spent.

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

P

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

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

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

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

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

Q

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

R

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

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

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

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

S

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

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

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

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

T

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

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The CMS welcomes comments and suggestions on both the content and presentation of this report. Please send them to Lataysheia Lance by email or CMS, Mail Stop N3-11-17, 7500 Security Blvd., Baltimore, MD 21244-1850.

U.S. Department of Health and Human Services

Michael Leavitt, Secretary

Centers for Medicare & Medicaid Services

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