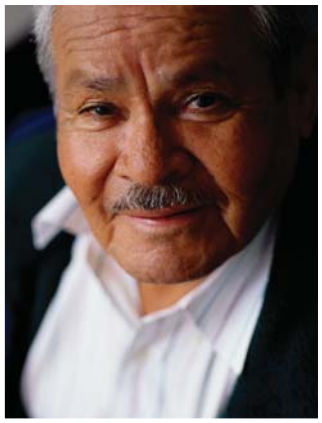
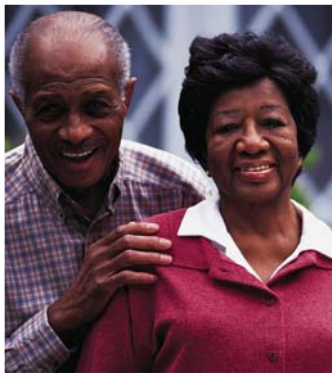
U.S. Department of Health and Human Services

# CMS FINANCIAL REPORT

## FISCAL YEAR 2007



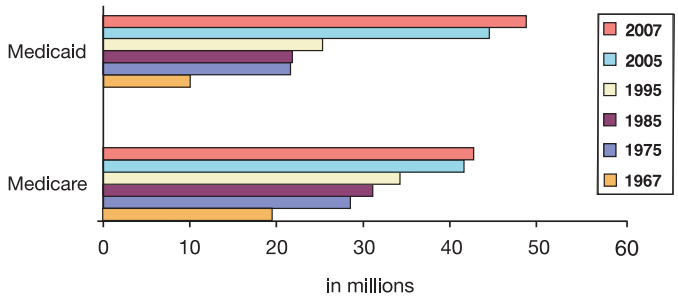




CMS
CENTERS for MEDICARE & MEDICAID SERVICES

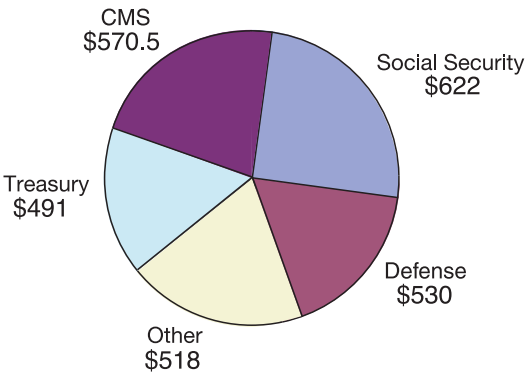
# The Centers for Medicare & Medicaid Services At a Glance

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 44 million beneficiaries. Medicaid enrollment has increased from 10 million beneficiaries in 1967 to over 49 million beneficiaries.

**2007 Program Enrollment**




**2007 Federal Outlays**




Source: U.S. Treasury

$ in billions

The **CMS** had outlays of approximately $570.5 billion (net of offsetting receipts and Payments to the Health Care Trust Funds) in fiscal year (FY) 2007, approximately 21 percent of total Federal outlays. The only agency that outlayed more is the Social Security Administration.

The **CMS** has approximately 4,700 Federal employees, but does most of its work through third parties. The CMS and its contractors process over one billion Medicare claims annually, monitor quality of care, provide the States with matching funds for Medicaid benefits, and develop policies and procedures designed to give the best possible service to beneficiaries. The CMS also assures the safety and quality of medical facilities, provide health insurance protection to workers changing jobs, and maintain the largest collection of health care data in the United States.

## *A Message from the Acting Administrator*

It is with great pleasure that I present the annual ***CMS Financial Report*** for fiscal year (FY) 2007. I am certain you will find the data presented in this report a reliable representation of CMS' activities during the past year.

The Medicare prescription drug benefit is the continuation of the successful advent of the largest expansion of Medicare in 40 years. This new benefit gave CMS an opportunity to improve the health care that is provided to the millions of beneficiaries we serve. The CMS is also proud to state that in 2008 the Part D program will be serving beneficiaries at a far lower cost than originally expected. The estimated premium paid by beneficiaries for standard Part D coverage is projected to be nearly 40 percent lower than originally projected when the benefit was established in 2003. This is in large part due to the strong competitive bidding by health and prescription drug plans and beneficiaries making smart choices.

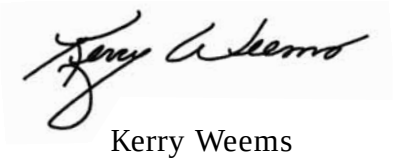
During FY 2007, CMS continued to sustain, transform, and build upon its considerable achievements. Since launching the Medicare prescription drug benefit, CMS has improved its data systems, instructed plans on ways to better serve beneficiaries and work with pharmacists, and dedicated greater CMS resources to addressing enrollee concerns. The CMS is continuing to make the Medicare prescription drug benefit even better with streamlined and more meaningful choices for beneficiaries, and improved relationships with States and pharmacists. The Agency continues to implement program improvements, educate Part D plans and beneficiaries, and monitor plan performance to ensure that beneficiary satisfaction remains high for cost, service, and other factors important to beneficiaries and other stakeholders. These program improvements will ensure that all beneficiaries and their representatives are well informed and have the information needed to choose the best plan and get the best care.

The CMS continues to modernize Medicaid as it introduces ways to ensure that our programs are effective and efficient. The Medicaid Modernization initiative is developing and implementing sustainable Medicaid programs that provide coverage for millions of people who are currently not covered. The CMS is working with its partners to explore innovative ways to make the Medicaid program more sustainable over time. Some Medicaid modernization activities include increasing the number of individuals transitioned from institutions to communities, implementing Long-Term Care Reform (a joint Medicare-Medicaid focus), promoting private long-term care insurance coverage, and working with States to give Medicaid beneficiaries access to modern health insurance products. The Deficit Reduction Act of 2005 (DRA) moves the program

in this direction by mandating reform and giving CMS the flexibilities needed to accomplish these goals. The final rule to implement the Medicaid prescription drug provisions of the DRA and other related matters was published this fiscal year. This new regulation is expected to save the States and the federal government billions over the next five years. In addition, the DRA created the Medicaid Integrity Program which increased CMS' resources to combat fraud and abuse.

Our Agency's initiatives to improve quality of care in Medicare and Medicaid have a great impact on the future of the entire American health care landscape. That is why CMS is working hard to support and collaborate in the development of useful quality measures in virtually all areas of care. The CMS wants to assure quality health care for all Americans through accountability and transparency. As outlined in CMS' Strategic Plan, we want our health care system to deliver the right care, for the right patient, at the right time. In other words, we want to assure high-quality care that is safe, affordable, effective, efficient, patient-centered, timely, and equitable.

I am impressed by the progress the Agency has made toward realizing its goals, and while we are proud of our many accomplishments, we realize there remains much work and opportunity for improvement. We are committed not only to meeting our mission of ensuring effective, up-to-date healthcare coverage and promoting quality care for the millions of beneficiaries we serve, but to improving it as well. The CMS recognizes that its success is dependent on collaborative relationships with a variety of organizations, individuals, and institutions. I thank all who have worked so hard to make FY 2007 a successful year. Our work at CMS is some of the most important facing the country today and touches the lives of millions of beneficiaries. I am confident that together we can continue to build upon the work that has been done to move CMS forward.



Kerry Weems
November 2007

## A Message from the Chief Financial Officer

The Centers for Medicare & Medicaid Services (CMS) completed another successful year, sustaining our unqualified opinion on our fiscal year (FY) 2007 consolidated financial statements. I am pleased to report that this marks the ninth consecutive year of receiving a "clean" audit opinion. We are extremely proud of this accomplishment.

This accomplishment affirms the Agency's commitment to continue to be effective and accountable stewards of the public resources entrusted to us. We are dedicated to managing our programs in a fiscally responsible manner to ensure our resources are used wisely and efficiently. The CMS continues to implement and build upon our sound financial management practices through the individual and collaborative dedication and efforts of managers, employees, business partners, and other stakeholders. Along with our unqualified opinion, the Agency had other noteworthy accomplishments and initiatives that contributed to significant improvements in our financial management area.

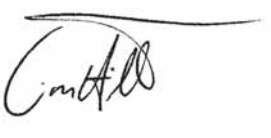
- As part of our sound financial management strategy, we continue to build on our success in reducing the number of Medicare fee-for-service payment errors. Our constant monitoring efforts of the Medicare contractors have resulted in a further reduction from last year's rate. This year's error rate is 3.9 percent, a remarkable achievement on a program as large and complex as Medicare.

- The Healthcare Integrated General Ledger Accounting System (HIGLAS) was implemented at CMS' Central Office (CO) for Medicaid and SCHIP payments. This marks the first step of HIGLAS implementation for CMS' administrative accounting. In addition, three additional Medicare contractors were effectively transitioned to HIGLAS in FY 2007, bringing the total to ten contractors that have successfully transitioned. HIGLAS, when fully implemented across all Medicare contractors and at CMS CO, will strengthen the financial management of CMS' operations by providing timely and reliable financial information to decision makers throughout the Agency. Since going "live" at the first pilot contractor in May 2005, CMS has processed more than 416.9 million claims and about $188.8 billion in payments as of September 30.

- We continued to meet existing and new requirements under the Office of Management and Budget (OMB) Circular A-123, *Management's Responsibility for Internal Control*, which makes our internal control structure more transparent and has improved our internal controls by institutionalizing accountability, and decreasing the risk of financial fraud and errors. As of September 30, we were able

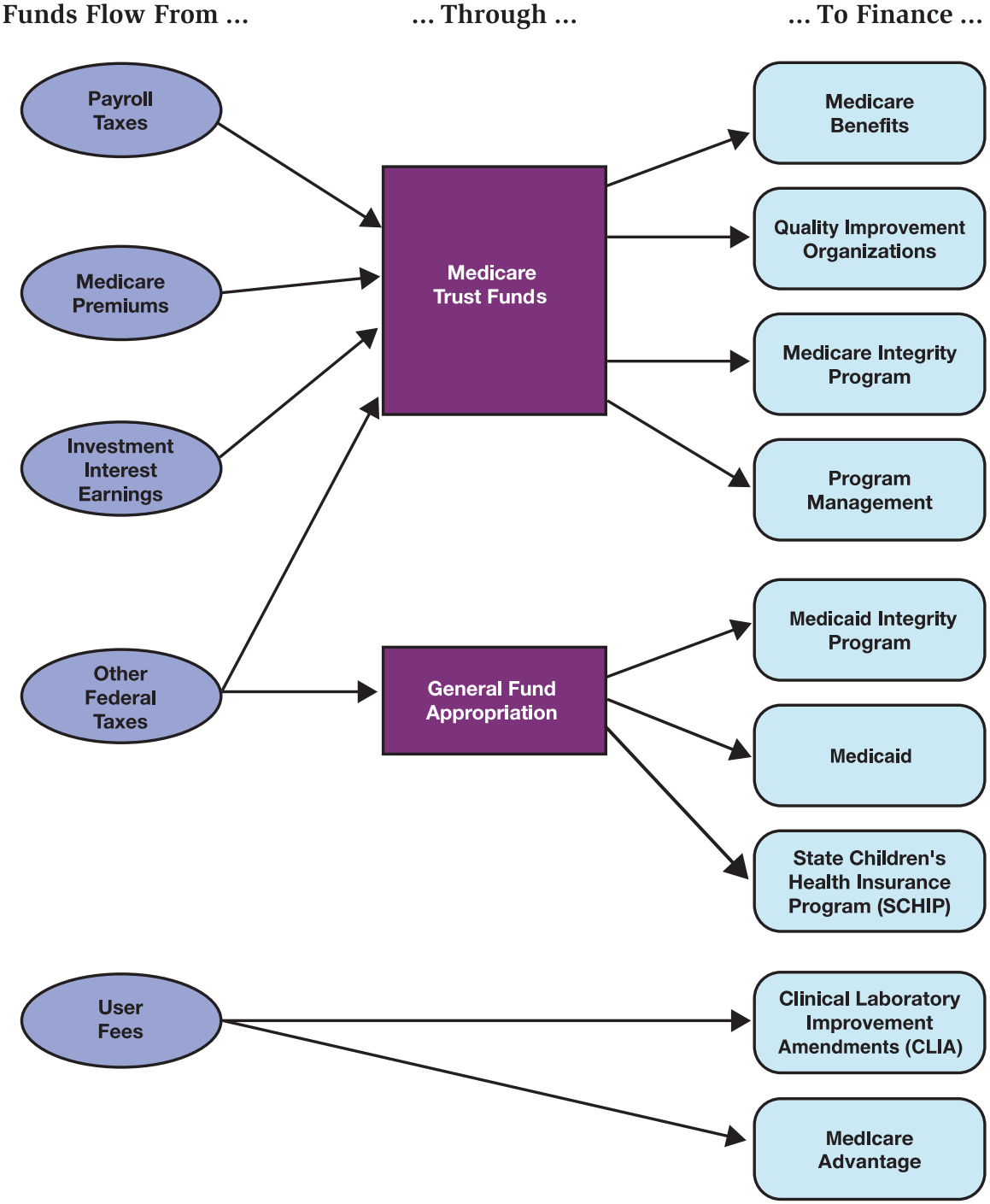
to provide a statement of reasonable assurance regarding CMS' internal controls and financial management systems.

As the Chief Financial Officer (CFO), I am proud of what we have accomplished but we know that receiving an unqualified audit opinion is not the end of our work—it is the beginning. As an agency, we are clearly aware of the importance of our fiduciary and operating responsibilities and the need for continuous monitoring and improvement. The CMS will continually strive to improve our financial stewardship and set goals to improve our performance. We will continue to promote sound business practices and improve accountability while fulfilling our mission to ensure effective, up-to-date health care coverage and to promote quality care for our beneficiaries.



Timothy B. Hill
November 2007

# Financing of CMS Programs and Operations



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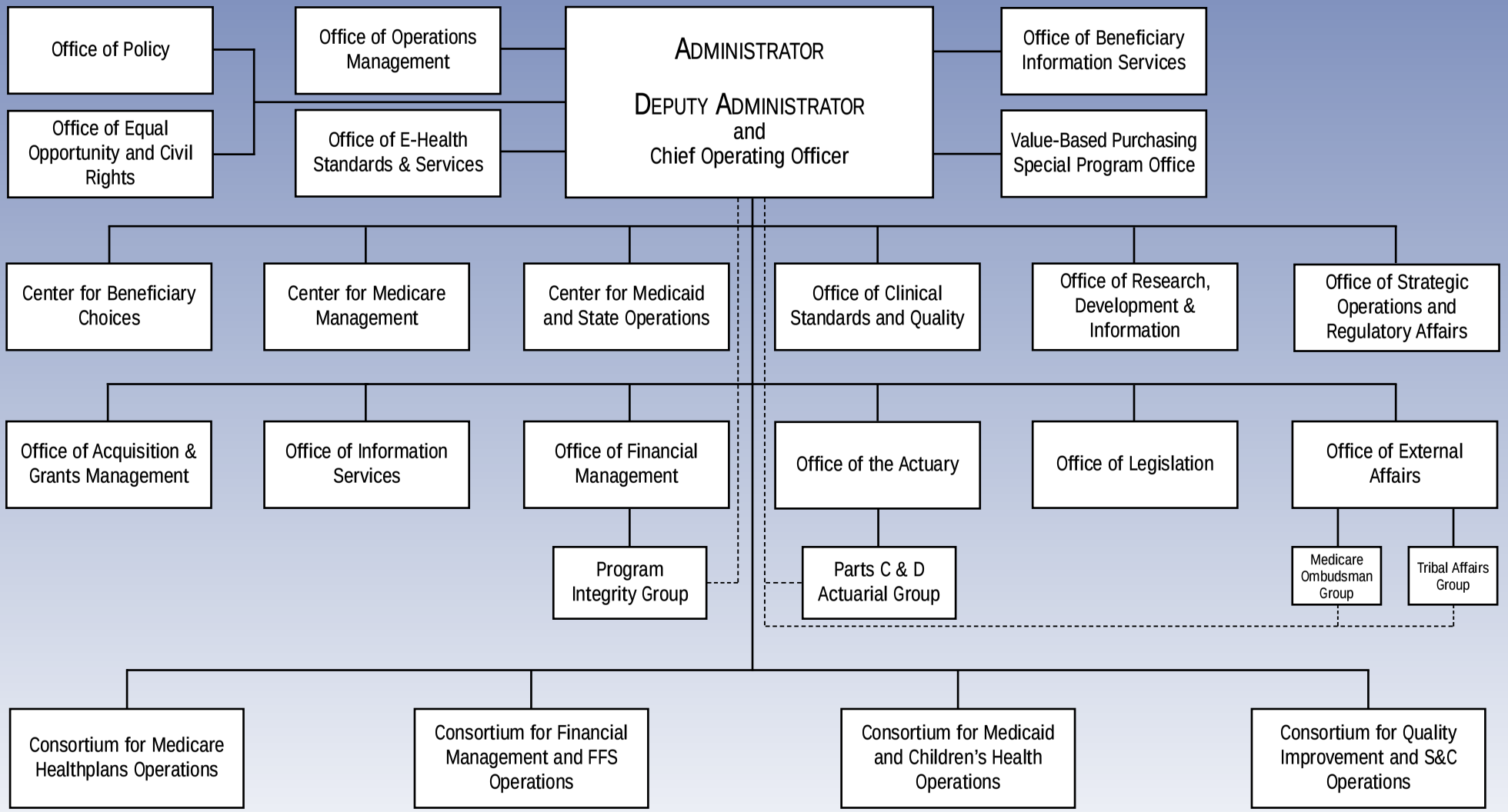
Approved Structure
As of September 6, 2007

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

## CENTERS FOR MEDICARE & MEDICAID SERVICES



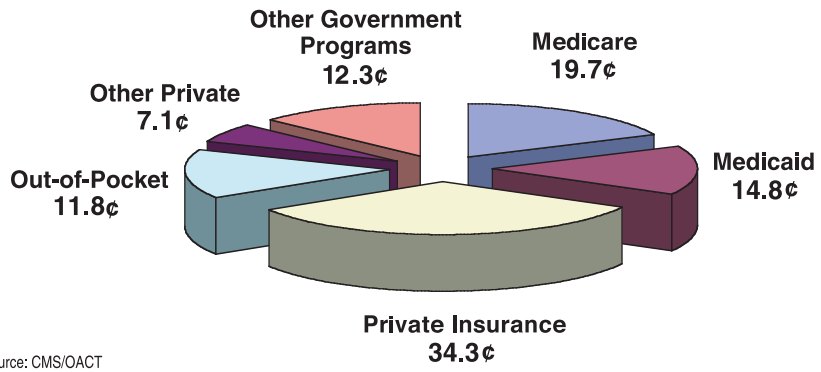
# Management's Discussion and Analysis

## 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 35 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 every dollar

**The Nation's Health Care Dollar 2007**




Source: CMS/OACT

received by U.S. hospitals, and 29 cents of every dollar spent on physician services.

The CMS **outlays** totaled approximately $570.5 billion (net of offsetting receipts and Payments to the Health Care Trust Funds) in fiscal year (FY) 2007. Our **expenses** totaled $612.4 billion, of which $3.1 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 4,700 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.

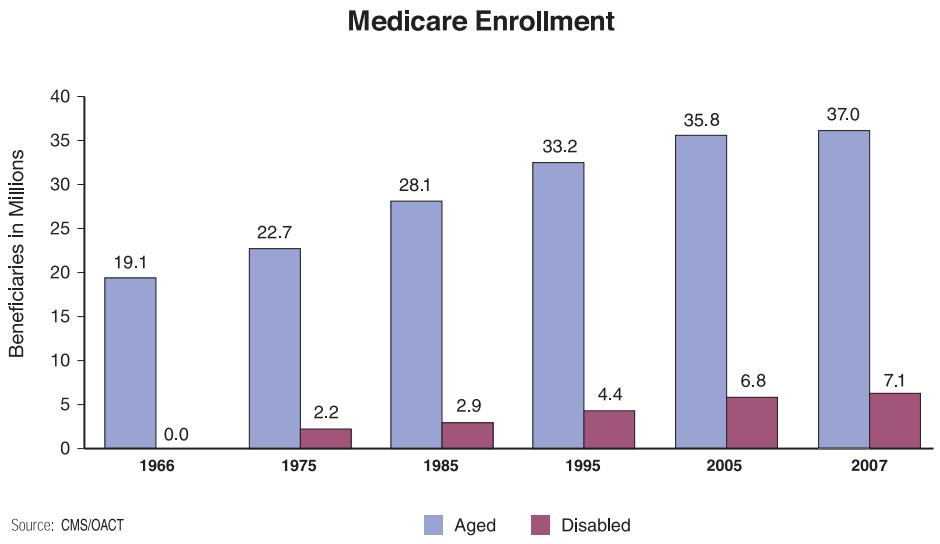
# PROGRAMS

## 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 14 percent of the Federal Budget. Medicare is a combination of four programs: Hospital Insurance, Supplementary Medical Insurance, Medicare Advantage, and Medicare Prescription Drug Benefit. Since 1966, Medicare enrollment has increased from 19 million to approximately 44 million beneficiaries.



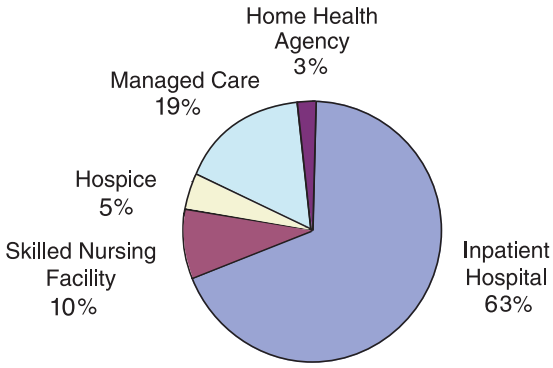

In December 2003, the President signed legislation to improve and modernize the Medicare program, including the addition of a drug benefit. This legislation—the Medicare Prescription Drug, Improvement & Modernization Act of 2003 (MMA)—represents the largest change to the Medicare program since its enactment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

### Hospital Insurance

Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who 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**



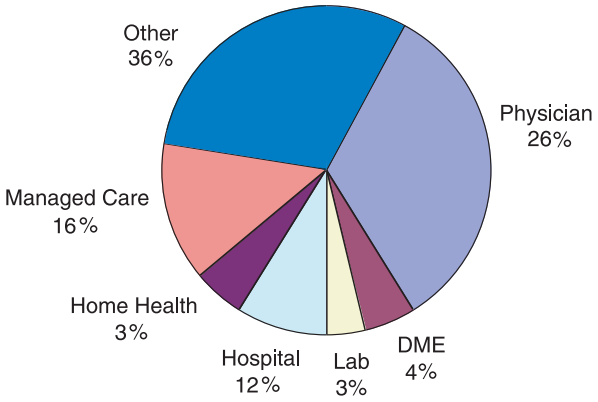

Source: CMS/OACT

Based on estimates from the Mid-Session Review of the FY 2008 President's budget, inpatient hospital spending accounted for an estimated 63 percent of HI benefit outlays in FY 2007. Managed care spending comprised 19 percent of total HI outlays. During FY 2007, HI benefit outlays grew by 10.7 percent and the HI benefit outlays per enrollee were projected to increase by 8.5 percent to $4,610.

## 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 42.9 percent during FY 2007. Physician services, the largest component of SMI, accounted for 26 percent of SMI benefit outlays. During FY 2007, the SMI benefit outlays per enrollee were projected to increase 41.3 percent to $5,560.

## Medicare Advantage

The MMA converted the Medicare+Choice program into the Medicare Advantage (MA) program, which is designed to provide more health care coverage choices for Medicare beneficiaries. Those who are eligible because of age (65 or older) or disability may choose to join a MA plan if they are entitled to Part A and enrolled in Part B, if there is

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

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

All MA plans are currently paid a per capita premium, and must provide all Medicare covered services. Further, with the exception of regional PPOs (RPPOs), MA plans assume full financial risk for care provided to their Medicare enrollees. For 2006 and 2007, RPPOs are offered limited financial protection through risk-corridor provisions. 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 $74.2 billion of the total $412.9 billion in Medicare benefit payment outlays in FY 2007.

## *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 2007 standard benefits generally have a $265 deductible and coinsurance of 25 percent after the deductible for coverage limit of $2,400. This is followed by a coverage gap for which beneficiaries pay 100 percent to an out-of-pocket spending limit of $3,850. Once the out-of-pocket spending reaches this level, the plan pays 95 percent of drugs costs for catastrophic coverage.

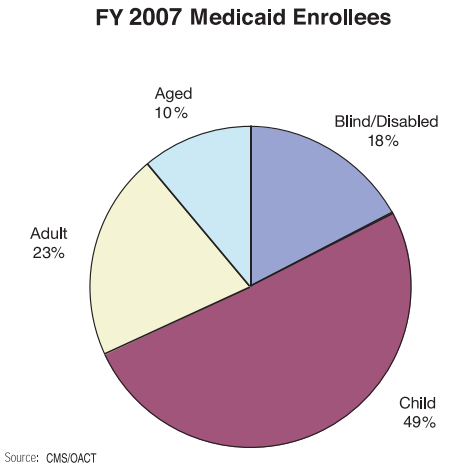
Prescription Drug Plans and MA PDs submit annual bids to CMS reflecting expected benefit payments plus administrative costs after a deduction for expected reinsurance subsidies. Payment for basic Part D benefits is made using four funding streams. Throughout the benefit year, CMS pays plans monthly prospective 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.

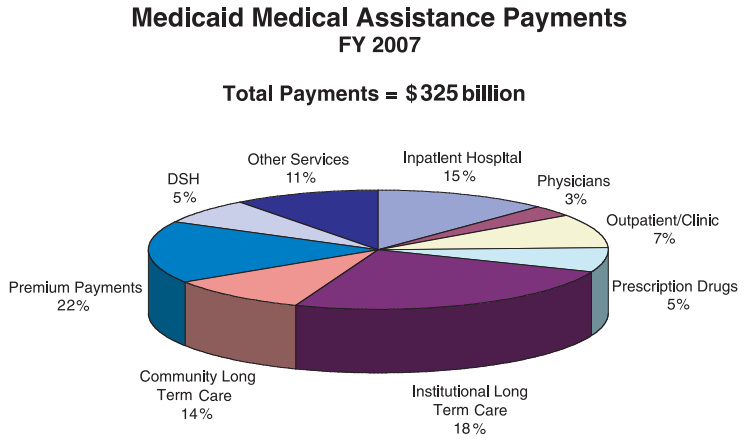
# Medicaid

## *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 49.1 million in FY 2007, about 16 percent of the U.S. population. About 8 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 2007, 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 2007 was about 57 percent. Federal matching rates for various state and local administrative costs are




Source: President's FY 2007 Budget, Midsession Review

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.

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

Medicaid is the largest single source of payment for health care services for persons with Acquired Immune Deficiency Syndrome (AIDS). Medicaid now serves over 50 percent of all AIDS patients and pays for the health care costs of most of the children and infants with AIDS. Medicaid spending for AIDS care and treatment in FY 2007 is estimated to be about $12.4 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 2007, State and Federal ADM gross outlays are estimated at $18.7 billion, about 5.4 percent of the gross Medicaid outlays. State and Federal MAP gross outlays are estimated at $327.0 billion or 95 percent of total Medicaid gross outlays, an increase of 9.2 percent over FY 2006. Thus, State and Federal MAP and ADM outlays for FY 2007 totaled $345.7 billion. The CMS share of Medicaid outlays totaled $188.2 billion in FY 2007.

### Enrollees

Children comprise nearly half of Medicaid enrollees, but account for only 18 percent of Medicaid outlays. In contrast, the elderly and disabled comprise 28 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 40 percent in 1996 to 65 percent in 2006.

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

1) State health reform waivers—Section 1115 of the Social Security Act provides broad discretion to waive certain provisions of Medicaid law for experimental, pilot, or demonstration projects.

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

3) Other State plan options to implement managed care—Section 1932(a) of the Social Security Act allows 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 is currently considering the reauthorization of SCHIP.

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

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

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

The CMS works closely with the States, Congress, and other Federal agencies to meet the challenges of implementing this program. The CMS provides extensive guidance and technical assistance so the States can further develop their plans and use Federal funds to provide health care coverage to as many children as possible. Since September 30, 1999, all 50 States, the District of Columbia, and the territories had approved SCHIP State plans, 14 Medicaid expansions, (includes District of Columbia and all of the territories), 18 separate SCHIPs, and 24 programs that are combination plans.

## Other Activities

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

### *Survey and Certification Program*

We are responsible for assuring the safety and quality of medical facilities, laboratories, providers, and suppliers by setting standards, training inspectors, conducting inspections, certifying providers as eligible for program payments, and ensuring that corrective actions are taken where deficiencies are found. The survey and certification program is designed to ensure that providers and suppliers comply with Federal health, safety, and program standards. We administer agreements with State survey agencies to conduct onsite facility inspections. Funding is provided through the Program Management and the Medicaid

appropriations. Only certified providers, suppliers, and laboratories are eligible for Medicare or Medicaid payments. Currently, CMS Survey and Certification staff oversee compliance with Medicare health and safety standards in approximately 265,000 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 approximately 20,800 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 ***Annals 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 two-year *Advancing Excellence in America's Nursing Homes* campaign. The campaign is currently in its second year. 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, 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 and diabetes.

In the home health care setting, patients are recovering faster and with less chance of rehospitalization, a priority focus for QIOs in working with home health agencies under the 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 Evidence Development Coverage Advisory Committee (MedCAC). The MedCAC reviews and evaluates medical literature, technology assessments, and examines data and information on the effectiveness and appropriateness of medical items and services that are covered under Medicare, or that may be eligible for coverage under Medicare. The MedCAC is comprised of experts in clinical and administrative medicine, biologic and physical sciences, public health administration, patient advocacy, health care data and information management and analysis, health care economics, and medical ethics to serve on the MedCAC. The CMS holds 5 to 6 meetings each year to include opportunities for the general public to participate. We also rely on state-of-the-art technology assessment and support from other Federal agencies.

## Insurance Oversight and Data Standards

The CMS has primary responsibility for implementing and enforcing Federal standards for the Medigap insurance offered to Medicare beneficiaries to help pay the coinsurance and deductibles that Medicare does not cover. We work with the State Insurance

Commissioners' offices to ensure that suspected violations of Federal laws governing the marketing and sales of Medigap are addressed.

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

In December of 2006, CMS issued guidance on HIPAA security with regard to remote use of and access to electronic protected health information (EPHI). This guidance reinforced the obligations of covered entities to comply with the Security Rule and provided specific guidance for protecting EPHI when it is accessed or used outside of the covered entity's physical purview or location. While these issues are encompassed by the general standards contained in the Security Rule, they are not explicitly addressed.

With regard to HIPAA enforcement activities (non-privacy), we continue to operate based on a complaint-driven process, addressing complaints filed against covered entities by requesting and reviewing documentation of their compliance status and/or corrective actions.

The CMS is also responsible for identifying and adopting standards for electronic prescribing in the Medicare Part D program. In December 2006, CMS completed a pilot project for testing both initial e-prescribing standards and their interoperability with previously-adopted e-prescribing foundation standards. The results of the pilot were released in a report to Congress, and will be the basis for final e-prescribing standards which must be adopted by April 2008.

# PERFORMANCE GOALS

The Government Performance and Results Act (GPRA) mandates that agencies have strategic plans, annual performance goals, and annual performance reports that make them accountable stewards of public programs. The CMS has embraced that charge and has emphasized the themes of accountability, stewardship, and a renewed focus on the customer with its strategic and annual goals and its mission to "To ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries."

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

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

The FY 2007 performance budget includes 30 goals for CMS programs, highlighting major program areas. The Agency does not reflect every activity and challenge it encounters but reflects key Administration and CMS priorities that represent vital mission-critical activities CMS performs. The performance goals reflect a sensitivity to customer needs and an awareness that meeting those needs will require flexibility and imagination as well as sound business sense.

Some of CMS' key FY 2007 performance goals and outcomes are highlighted below. Progress on all of the goals will be submitted with the FY 2009 President's budget request.

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

The CMS is committed to reducing the percentage of improper payments made under the Medicare FFS program. One of CMS' key goals is to pay claims properly the first time. This means paying the right amount to legitimate providers for covered services provided to eligible beneficiaries. Paying claims right the first time saves resources required to recover improper payments and ensures the proper expenditure of valuable Medicare trust fund dollars. The CMS FY 2007 target for the Medicare FFS error rate was 4.3 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 133,333 claims for CERT and 41,399 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 2007 indicates that the gross paid claims error rate is 3.9% percent or $10.8 billion in gross improper payments.

The CMS met its goal for FY 2007. The CMS is continually working with the contractors that pay Medicare claims and the Quality Improvement Organizations (QIOs) on aggressive efforts to lower the paid claims error rate, including: (1) developing a tool that generates state-specific hospital billing reports to help QIOs analyze administrative claims data, (2) increasing and refining one-on-one educational contacts with providers found to be billing in error, (3) developing projects with the QIOs to address state-specific admissions necessity and coding concerns, as well as to facilitate the surveillance and monitoring of inpatient payment error trends by error type, and (4) developing new data analysis procedures to assist CMS in identifying payment aberrancies and using that information to stop improper payments before they occur. The CMS has directed Medicare contractors to develop local efforts to lower the error rate by developing plans that address the problems that result in errors. These plans must specify the steps they are taking to fix the problems and other recommendations that will ultimately lower the error rate.

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

For documentation and copies of reports, see the Comprehensive Error Rate Testing (CERT) program website:
**http://www.cms.hhs.gov/CERT/**

Until the final report comes out, see the following link for the FY 2007 Mid-year Report; click on the "Findings" Tab and see Tables 3a and 3b:
**https://www4.cms.hhs.gov/apps/er_report/previewer_report.asp?from = public&which = long&reportID = 4**

## Decrease the Prevalence of Restraints in Nursing Homes

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

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

The CMS met its FY 2006 target of 6.4 percent by reaching a rate of 6.1 percent. The FY 2007 target is 6.2 percent. Results will be available in February 2008. The CMS will promote the reduced use of physical restraints through the annual nursing home survey process and through the efforts of the QIOs, which are dedicated to working directly with individual providers to improve quality of care delivered.

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

The CMS released a Quality Roadmap with the vision for the "right care for every person every time." The Roadmap outlined a plan of action to "implement, in close partnership with states, a strategy to improve the quality of care for Medicaid beneficiaries." The CMS also established a Medicaid Quality Strategy to complement the CMS Quality Roadmap. This commitment allows CMS to provide technical assistance to states regarding quality improvement, quality measurement, and External Quality Review. The aim of the strategy includes supporting states in achieving safe, effective, efficient, timely,

equitable, and patient-centered care. The CMS plans to use information gained from these state-level quality improvement initiatives as the building blocks for the development of a larger, national-level quality framework.

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

# FINANCIAL ACCOMPLISHMENTS

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

## Financial Management and Reporting

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

### *Healthcare Integrated General Ledger Accounting System*

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

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

The HIGLAS project began as a pilot program with one of the largest Medicare FFS contractors (Palmetto Government Benefit Administrators) that processes primarily hospital and other institutional claims, and another large Medicare contractor (Empire Medicare Services) that processes primarily physician and supplier claims. The pilot phase resulted in the reengineering of the accounting business processes of the pilot Medicare contractors to support the accounting software. The pilot phase culminated with the successful production cut-overs at both Palmetto Government Benefit Administrators—Part A in May 2005, and Empire Medicare Services—Part B in July 2005. Since that time CMS has deployed HIGLAS at eight 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), TrailBlazer Health Enterprises (Carrier), Palmetto Government Benefit Administrators—Part B (Carrier), Highmark Medicare Services (Carrier), and United Government Services (Fiscal Intermediary). HIGLAS is now the system of record for these contractor sites. Since going "live" at the first pilot contractor in May 2005, HIGLAS has processed more than 416.9 million claims and processed 18.7 million payments worth $188.8 billion as of September 30, 2007.

In Fiscal Year (FY) 2007, HIGLAS began accounting for federal Grants to States for Medicaid as well as State Children's Health Insurance Program (SCHIP) federal funding. The cumulative federal obligation for these programs as of September 30, 2007 was $200.8 billion for Medicaid and $5.64 billion for SCHIP. In addition, during FY 2007 CMS started the process of implementing the Administrative Program Accounting module of HIGLAS.

HIGLAS will not only enable CMS' compliance with FFMIA, the new system will also strengthen management of Medicare accounts receivable and allow more timely and effective collection activities on outstanding debts. These improvements in financial reporting by CMS and its contractors are essential to retaining an unqualified opinion on our financial statements, meeting the requirements of key Federal legislation, and safeguarding government assets.

## *Communication & Financial Reporting*

During FY 2007, CMS continued with its Risk Management and Financial Oversight Committee. The Risk Management and Financial Oversight Committee, which holds monthly meetings with designated members of CMS' senior management, will act as the conduit for discussing financial management issues. This committee ensures effective communication and a coordinated process among cross-functional areas within CMS. The Office of Financial Management (OFM) met monthly with upper-level management from various program centers/offices to discuss financial and budget concerns that could impact the CMS audit and day-to-day operations.

The CMS continued to prepare "white papers" to ensure that any significant changes/updates to CMS' accounting and financial reporting policies are properly evaluated by the management in the OFM and 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, 2006, March 31, 2007, and June 30, 2007, and submitted our financial statements through the automated financial statement system implemented by HHS.

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

We have also complied with Treasury's FY 2007 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.

The CMS has provided the RACs with all of the claims paid in these three states between FY 2002 and FY 2007. 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. Since the beginning of the demonstration the recovery audit contractors have collected $432.5 million and refunded $17 million in underpayments. The CMS is required under the Tax Relief and Health Care Act of 2006 to expand the use of recovery audit contractors nationwide by January 1, 2010.

## Debt Management

Through our Medicare contractors, we collect the majority of our debt by offsetting claims against the debt. We also pursue recovery of debt through demand letters. Debts that are over 180 days delinquent are subject to the Debt Collection Improvement Act of 1996 (DCIA). Under the DCIA, CMS refers all eligible debts over 180 days delinquent to

Treasury—via the HHS Program Support Center (PSC), which serves as the Debt Collection Center (DCC)—for collection. Treasury uses a variety of collection tools, including sending additional demand letters, referring debts to the Treasury Offset Program (TOP), referring debts to private collection agencies, negotiating repayment agreements, and referring some debts to the Department of Justice for litigation. During FY 2007, we referred to Treasury about 98 percent of the delinquent debt eligible for referral.

## Administrative Payments

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

## Budget Execution

For FY 2007, CMS' budget execution function continues to be a major strength. The CMS Chief Operating Officer works closely with the Chief Financial Officer to ensure that an Administrator approved operating plan is developed timely and supports CMS' priorities. Strong fund control procedures ensure resources are only used for those activities in the operating plan that have been approved by the Administrator. The CMS closely monitors available resources throughout the year to ensure the Anti-Deficiency Act is not violated, while at the same time meeting reasonable but aggressive lapse targets.

## Medicare Secondary Payer (MSP)

The CMS efforts in the MSP area saved the Medicare trust funds approximately $5.4 billion through the first eleven months of FY 2007. 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 $895 million for FY 2007. Savings attributed to the Internal Revenue Service/Social Security Administration/CMS Data Match (DM) operations for the first eleven months of FY 2007 were $459 million. The CMS expects savings attributable to the MSP Program to continue to grow as improved methods of collecting MSP information are expanded.

The CMS continues to pursue Voluntary Data Sharing Agreements (VDSAs) with public and private insurance programs to secure health care coverage information on working Medicare enrollees and dependents. Currently 187 insurers, employers, and pharmacy benefit managers have signed VDSAs with CMS and interest in the VDSA program continues to be high. The CMS expects continued expansion of the VDSA program during FY 2008 as more employers, insurers, and other programs begin to use VDSAs to coordinate their coverage—and their drug coverage, in particular—with Medicare. Overall savings attributed to this program were $392 million in FY 2005, $564 million in FY 2006, $675 million for the first eleven months of FY 2007; savings are on track to

exceed $725 million by fiscal year end. New agreements are being signed, and, as they are implemented during FY 2008, savings from the VDSA program will to continue to grow.

In addition, the CMS continues to broaden the Workers' Compensation (WC) DM initiative. The Medicare program is a secondary payer when WC insurance is responsible for covering a Medicare beneficiary's health care costs. Beginning in 2001, a number of studies revealed that lack of coordination between state WC programs and CMS has caused Medicare to pay for some health care services that were actually the responsibility of the WC system.

In response, starting in FY 2004, CMS began efforts to collect WC payment data directly from the States and from other entities (principally, insurers) that hold WC paid claims data. Although such data collection cannot be compelled (it is provided voluntarily by the States and others), CMS has active WC data sharing agreements with six States: California, Texas, Oregon, Florida, Kansas, and Maryland. The Agency has been in discussion with other States and other entities possessing WC payment data that have indicated interest in the WC data sharing program. Through April 30, 2007, almost 22,000 new WC MSP records were added to the CWF, yielding MSP savings of almost $793,500.

The CMS has also contracted for the legal, financial, and medical review of proposed Workers' Compensation Medicare Set-aside Arrangements (WCMSA) amounts that represent monies earmarked in a WC settlement for future medical services/items that would otherwise be payable by the Medicare Program. As a result, CMS has calculated and approved WCMSA amounts totaling approximately $563 million over the period November 2006–September 2007 (payments that Medicare might otherwise erroneously make in terms of beneficiaries' future medical expenses related to their associated accident, illness, or injury).

Effective October 1, 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 claims processing contractors performed these functions. The MSPRC is fully operational, has completed the transition backlog of work it received from the Medicare claims processing contractors, and is successfully handling a higher level of both telephone and written inquiries than were originally anticipated and budgeted. Operating on 40 percent of the fee-for-service contractors' aggregate postpay MSP budget, the MSPRC is recovering conditional and mistaken primary payments at the rate of approximately one million per business day. The CMS expects additional efficiencies through enhanced automation to be attained in the out years of the contract. This consolidation is achieving administrative and operational efficiencies, standardizing the recovery process, and enhancing customer service.

## *Medicare Integrity Program*

Program Integrity is continuing its aggressive local efforts and adding three new regional 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. In addition to the three regional MEDICs, CMS awarded a fourth MEDIC contract to develop a centralized data repository for program integrity activities.

Program Safeguard Contractors produced an estimated total of $1.7 billion dollars in savings for Medicare Parts A and B for fiscal year 2007 by identifying overpayments, referring more than 447 cases to law enforcement, recouping funds from court determined fines, settlements, and/or restitutions, and by taking an aggressive approach with other administrative actions such as payment suspensions, prepaid claims edit denials, auto denial edits, and revocations. In 2007, Program Integrity opened a new Field Office (FO) in New York, and along with Miami and Los Angeles, provides on-the-ground support by performing beneficiary interviews and on-site visits to provider locations. PSC and FO initiatives included the Tax Evasion Project, Beneficiary Identity Theft Program, and the Referring Physician UPIN/NPI Project. Additionally, FOs have provided support for the Department of Justice (DOJ) Miami Strike Force focusing on Durable Medical Equipment Suppliers.

### *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 2007, CMS developed an audit program for the Medicare Advantage and Prescription Drug programs. The audit program was developed to satisfy the one-third audit requirement, and is designed to audit health plan financial records and data relating to costs, Medicare Utilization, and the computation of the health plans' competitive bids. The CMS has tested the audit program in 2007, and will fully implement the program in 2008. Additionally, CMS developed a Risk-Sharing Reconciliation workbook to assist in the application of risk-sharing arrangements the CMS has with Regional Preferred Provider Organizations (RPPOs) for contract years 2006 and 2007. The 2006 contract year will be reconciled during the 2008 fiscal year.

The CMS has also reduced the number of unsettled managed care cost reports. In FY 2007, CMS reduced the backlog of unsettled managed care cost reports by 47. Dis-allowances resulting from FY 2007 settlement activity amounted to about $54 million. For FY 2007, CMS had a rate of return of 14.8 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.

The CMS initiated several steps towards the development of an error rate reporting program during FY 2007 for the Medicare Advantage and Prescription Drug programs. The CMS prepared an error rate development project plan, a comprehensive mapping of the Part D payment process and comprehensive risk assessments. The CMS also developed a pilot measurement methodology which led to reporting on an element of payment in the FY 2007 HHS Annual Financial Report (AFR).

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 continued to utilize the eight week timeframe to review an MA application, re-wrote and further 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 also allowed some organizations to streamline the application process by submitting a master application. This allowed organizations to reduce duplicative information and focus on providing market-specific details—significantly reducing the amount of time needed to review and approve these applications. In addition, CMS developed an application for the Medical Savings Account plan type, a new organization type that was available for the first time in 2007. During FY 2007, CMS worked to further streamline the application process by allowing some organizations to enter service area information into HPMS. This activity significantly reduced the hours of work required by both the organizations and CMS at the time of service area verification. In addition, CMS continues to improve the MA application process through automation of the entire MA application.

Using HPMS, CMS automated the Prescription Drug Benefit and Employer Group Waiver Only Plan application, reducing the burden on organizations to apply as Part D sponsors and on CMS resources. The success of the Part D application automation process will be used as a model for the Part C application automation scheduled for implementation in the upcoming contract year. The CMS, with a technology vendor, refined the computer based tool used to review plan benefit packages for discriminatory benefit designs, high cost sharing, and other potential benefit problem areas. The CMS reduced its reliance on a contractor to assist in the review of the 2007 Application cycle from 2006 due to the improvement of internal computer systems.

## *Part C and D Payment Validation and Authorization Process*

The CMS has continued to enhance the procedures used to validate and authorize payments for Medicare Advantage and the Part D benefit. Enhancements have been made

to a number of validation functions including the Beneficiary Payment Validation (BPV), the Plan Payment Validation (PPV), and the monitoring and tracking of payment issues.

The BPV function was routinely conducted over the course of the year to validate payments before each monthly payment decision was made. In addition to supporting the monthly payment decision, the BPV reports were used to profile, monitor, and resolve payment issues in the Medicare Advantage and Prescription Drug (MARx) payment system, and to support financial analysis for the FY 2007 accrual.

The BPV function involves validating beneficiary-level demographic and risk factor information used in the MARx payment calculations, and confirming the accuracy of the monthly MARx payment calculations by recalculating prospective payments outside of the MARx system for 100 percent of the beneficiary population. In FY 2007, a third component was added to the BPV function to validate retroactive payment adjustments. Refinements were also made to the BPV data processing programs to improve the efficiency of the monthly data processing and ensure the generation of validation results prior to the payment decision.

The PPV was expanded to provide additional analyses and validation procedures to evaluate the accuracy of the monthly payment data being transferred from the MARx system to the Automated Plan Payment System (AAPS), and to routinely provide more detailed monthly payment validation documentation.

The CMS has also further enhanced the use of controls in the monthly payment process. The cycle memos for Part C and Part D were significantly revised. Payment validation documentation has been improved with the addition of payment adjustment data, payment issue lists, and payment issue monitoring tools. Steps have also been implemented to further formalize the process of resolving payment issues through communications with the MARx contractor.

## 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 Medicaid Budget and Expenditure System (MBES) with the CMS accounting system, HIGLAS. Plans are also being made to integrate Medicaid and SCHIP grant data into the Department-wide system, grantsolutions.gov. The CMS implemented procedures to ensure proper user access to MBES. These procedures include requiring password changes every 60 days, suspension due to inactivity after 90 days, and requiring a valid e-mail address before initial and re-certification access to the system is granted. The CMS is also implementing a grant review checklist to enhance oversight and ensure a consistent review of all grant awards prior to issuance.

To promote proper oversight of the Health Programs, CMS Central Office (CO) conducts routine teleconferences with the ROs. These teleconferences ensure that there is a continuous process to assess and provide training to the ROs and 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. Moreover, during FY 2007, the Regional Offices were re-instructed on the use of

the guides used to conduct reviews of the CMS-37, the CMS-64, the CMS-21b, and the CMS-21. These guides were updated in the prior FY in order to enhance oversight.

## Medicare Electronic Data Processing (EDP)

The CMS continues to make incremental improvements in Medicare EDP internal controls. During FY 2007, CMS retained utilization of its strategy and project plan to address not just current audit findings but the root or environmental causes of those findings. To retain executive buy-in and awareness over the requirement for improvements in Medicare EDP controls, results from audits and evaluations were included as part of our reports of contractor performance. The CMS executives and staff also briefed our expectations and requirements to both Medicare contractor executives as well as the contractor system security officers. Further, CMS sponsored conferences—both in person and via teleconference—with the Medicare contractors to emphasize best practices to address individual audit findings and the root causes. The result of this intervention was improvement in a number of key audit areas at individual data centers and fiscal intermediaries and carriers.

The CMS has also released updated policies, procedures, and processes for the Medicare contractors. These included a new white paper on access control issues resulting from EDP audits. 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 audits and reviews which may be performed at a Medicare contractor location.

## Oversight of Medicare Contractor Financial Operations & Reporting

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

The CMS continues to enhance its analytical tools to provide the steps to identify potential errors, unusual variances, system weaknesses, or inappropriate patterns of financial data accumulation. One example of these analytical tools is the review of 1522 reconciliation procedures. On a monthly basis, non-HIGLAS Medicare contractors perform a reconciliation of their Form CMS-1522 Funds Expended Report to their paid claims or system reports. Effective during FY 2007, HIGLAS contractors are required to complete the HIGLAS Contractor's Monthly Bank Reconciliation Worksheet. The worksheet is designed to provide a monthly reconciliation of the Medicare Contractor's benefit and time account activity to the CMS Monthly Balance Sheet and Summary 2 Trial Balance. The CMS regional offices review their Medicare contractors' 1522 reconciliations and monthly cash reconciliations for one month each quarter. Furthermore, Medicare contractors are required to perform trend analysis on a quarterly basis and maintain supporting

documentation to ensure that accounts receivable balances reported are reasonable.

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

During FY 2007, CMS contracted with CPA firms to conduct SAS 70 internal control audits of 11 Medicare contractors, six of which received unqualified opinions and the remainder received very few non-material findings. In addition, the CPA firms conducted CAP follow-up reviews during the SAS 70 internal control audits that were performed in FY 2007. The CPA firms verified the successful implementation of 53 Medicare contractor 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, along with CAPs to remedy the weaknesses. In FY 2007, CPIC protocol reviews were conducted at two Medicare contractors. We also updated the Medicare Financial Management Manual to provide guidelines and policies to the Medicare contractors to enable them to strengthen their internal control processes.

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

The CMS built upon its successful first year, FY 2006, of implementing OMB's revisions to Circular A-123, *Management's Responsibility for Internal Control*. The Risk Management and Financial Oversight Committee—chaired by the CMS Chief Operating Officer—continued to play a key role in the A-123 assessment process. During the first quarter of FY 2007, CMS held planning strategy meetings and discussed lessons learned from FY 2006 to aid in the FY 2007 assessment. Managers and staff were trained on internal controls and OMB Circular A-123. The Agency again procured an independent CPA firm in September 2006 to assist in meeting reasonable assurance on internal controls over financial reporting as of June 30, 2007. The CMS followed the five-step process of the Department for implementing Appendix A of OMB Circular A-123: (1) Plan and scope the evaluation, (2) Document controls and evaluate design of the controls, (3) Test operating effectiveness, (4) Identify and correct deficiencies, and (5) Report on Internal Controls. The CMS provided an assurance statement as of June 30 and updated it as of September 30. The results of our self-assessment are provided in the ***Summary of Federal Managers' Financial Integrity Act Report and OMB Circular A-123 Statement of Assurance*** section.

# Financial Statement Introduction & Highlights

## Consolidated Balance Sheet

The Consolidated Balance Sheet presents as of September 30, 2007 and 2006, amounts of future economic benefits owned or managed by CMS (assets), amounts owed (liabilities), and amounts that comprise the difference (net position). A consolidating Balance Sheet by Major Program is provided as additional information. The CMS' Consolidated Balance Sheet shows $416.2 billion in assets. The bulk of these assets are in the Earmarked Investments totaling $363.2 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 $39 billion, most of which is for Medicaid and SCHIP. Liabilities of $67 billion consist primarily of the Entitlement Benefits Due and Payable of $61.5 billion. The CMS net position totals $349.2 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 Statements of Net Cost present the net cost of operations for the years ended September 30, 2007 and 2006. The Statement of Net Cost shows only a single dollar amount: the actual net cost of CMS' operations for the period by program. Under the Government Performance and Results Act (GPRA), CMS is required to identify the mission of the agency and develop a strategic plan and performance measures to show that desired outcomes are being met. The three major programs that CMS administers are: Medicare, Medicaid, and SCHIP. The bulk of CMS' expenses are allocated to these programs. Both Medicare and Medicaid MIP are included under the HI trust fund. The costs related to the Program Management Appropriation are cost-allocated to all three major components. The net cost of operations of the CLIA program and other programs are shown separately under "Other Activities." A consolidating Statement of Net Cost is provided to show the earmarked vs. non-earmarked components of net cost as additional information.

Total Benefit Payments were $607.3 billion for FY 2007. Administrative Expenses were $3.1 billion, less than 1 percent of total net Program/Activity Costs of $561.9 billion.

The net cost of the Medicare program including benefit payments, QIOs, Medicare Integrity Program spending, and administrative costs, was $367.6 billion. The HI total costs of $211.5 billion were offset by $2.8 billion in revenues. The SMI total costs of $206.3 billion were offset by premiums of $47.4 billion. Medicaid total costs of $187.9 billion represent expenses incurred by the States and Territories that were reimbursed by CMS during the fiscal year, plus accrued payables. The SCHIP total costs were $6 billion.

## Consolidated Statement of Changes in Net Position

The Consolidated Statements of Changes in Net Position present the change in net position for the years ended September 30, 2007 and 2006. The Statement of Changes in Net Position (SCNP) reports the change in net position during the fiscal year that occurred in the two components of net position: Cumulative Results of Operations and Unexpended Appropriations. Earmarked funds are shown in a separate column from other funds. A consolidating Statement of Changes in Net Position is provided to present the change in net position by major programs as additional information.

The line, Appropriations Used, represents the Medicaid appropriations used of $187.4 billion; $190.7 billion in transfers from Payments to Health Care Trust Funds to HI and SMI; SCHIP appropriations of $6 billion and State Grants and Demonstrations appropriations of $512 million. Medicaid and SCHIP are financed by a general fund appropriation provided by Congress. Employment tax revenue is Medicare's portion of payroll and self- employment taxes collected under the Federal Insurance Contributions Act (FICA) and Self-Employment Contributions Act (SECA) for the HI trust fund and totaled $188 billion. The Federal matching contribution is income to the SMI program from a general fund appropriation (Payments to Health Care Trust Funds) of $137.8 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 for the years ended September 30, 2007 and 2006. An additional Schedule of Budgetary Resources is provided as Required Supplementary Information to present each budgetary account. In this statement, the Program Management and the Program Management User Fee accounts are combined and are not allocated back to the other programs. Also, there are no intra-CMS eliminations in this statement.

The CMS total budgetary resources were $861.4 billion. Obligations of $846.2 billion leave unobligated balances of $15.2 billion (of which $1.5 billion is not available). Total outlays, net of collections, were $826.7 billion. When offset by $256.2 billion relating to collection of premiums and general fund transfers from the Payments to Health Care Trust Funds, as well as refunds of Medicare contractor overpayments, the net outlays were $570.5 billion.

## Statement of Social Insurance (SOSI)

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

The Statement of Social Insurance presents the 75-year actuarial present value of the income and expenditures of the HI and SMI trust funds. Future expenditures are expected

to arise from the formulas specified in current law for current and future program participants. This projection is considered to be important information regarding the potential future cost of the program. These projected potential future obligations under current law are not included in the Balance Sheet, Statement of Net Cost, Statement of Changes in Net Position, Statement of Budgetary Resources, or Statement of Financing.

## Required Supplementary Information (RSI)

As required by the SFFAS Number 17, CMS has included information about the Medicare trust funds—HI and SMI. The Required Supplementary Information (RSI) presents required long-range cashflow projections, the long-range projections of the ratio of contributors to beneficiaries (dependency ratio), and the sensitivity analysis illustrating the effect of the changes in the most significant assumptions on the actuarial projections and present values. The RSI assesses the sufficiency of future budgetary resources to sustain program services and meet program obligations as they come due. The information is drawn from the ***2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds***, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds.

## Limitations of the Financial Statements

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

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

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

# Principal Statements and Notes

## CONSOLIDATED BALANCE SHEET
## As of September 30, 2007 and 2006
*(in millions)*

| | FY 2007 Consolidated Totals | FY 2006 Consolidated Totals |
|---|---|---|
| **ASSETS** | | |
| **Intragovernmental Assets:** | | |
| Fund Balance with Treasury ***(Note 2)*** | $39,005 | $82,806 |
| Earmarked Investments ***(Note 3)*** | 363,195 | 339,545 |
| Accounts Receivable, Net ***(Note 4)*** | 484 | 473 |
| **Total Intragovernmental Assets** | **402,684** | **422,824** |
| Cash and Other Monetary Assets | 129 | 145 |
| Accounts Receivable, Net ***(Note 5)*** | 12,808 | 3,009 |
| General Property, Plant and Equipment, Net | 424 | 440 |
| Other Assets | 161 | 124 |
| **TOTAL ASSETS** | **$416,206** | **$426,542** |
| **LIABILITIES** | | |
| **Intragovernmental Liabilities:** | | |
| Accounts Payable | $436 | $540 |
| Accrued Payroll and Benefits | 4 | 4 |
| Other Intragovernmental Liabilities ***(Note 6)*** | 530 | 434 |
| **Total Intragovernmental Liabilities** | **970** | **978** |
| Accounts Payable | | 3 |
| Federal Employee and Veterans' Benefits | 11 | 11 |
| Entitlement Benefits Due and Payable ***(Note 7)*** | 61,470 | 61,164 |
| Accrued Payroll and Benefits | 55 | 55 |
| Other Liabilities ***(Note 6)*** | 4,500 | 1,986 |
| **TOTAL LIABILITIES** ***(Note 8)*** | **67,006** | **64,197** |
| **NET POSITION** | | |
| Unexpended Appropriations—earmarked funds | 8,978 | 27,658 |
| Unexpended Appropriations—other funds | 9,889 | 32,521 |
| **Total Unexpended Appropriations** | **18,867** | **60,179** |
| Cumulative Results of Operations—earmarked funds | 329,931 | 301,853 |
| Cumulative Results of Operations—other funds | 402 | 313 |
| **Total Cumulative Results of Operations** | **330,333** | **302,166** |
| **TOTAL NET POSITION** | **$349,200** | **$362,345** |
| **TOTAL LIABILITIES AND NET POSITION** | **$416,206** | **$426,542** |

*The accompanying notes are an integral part of these statements.*

## CONSOLIDATED STATEMENT OF NET COST
## For the Years Ended September 30, 2007 and 2006
*(in millions)*

| | FY 2007 Consolidated Totals | FY 2006 Consolidated Totals |
|---|---|---|
| **NET PROGRAM/ACTIVITY COSTS** | | |
| **GPRA Programs** | | |
| Medicare (Earmarked) | $367,551 | $336,969 |
| Medicaid | 187,940 | 179,481 |
| SCHIP | 6,010 | 5,739 |
| **Net Cost - GPRA Programs** | **561,501** | **522,189** |
| **Other Activities** | | |
| CLIA | (18) | (51) |
| State Grants and Demonstrations | 455 | 1,940 |
| Other | | 78 |
| **Net Cost - Other Activities** | **437** | **1,967** |
| **NET COST OF OPERATIONS** ***(Notes 9, 13 and 17)*** | **$561,938** | **$524,156** |

*The accompanying notes are an integral part of these statements.*

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

| | Consolidated Earmarked Funds | Consolidated Other Funds | FY 2007 Consolidated Total |
|---|---|---|---|
| **CUMULATIVE RESULTS OF OPERATIONS** | | | |
| **BEGINNING BALANCES** | **$301,853** | **$313** | **$302,166** |
| **Budgetary Financing Sources:** | | | |
| Appropriations Used | 190,743 | 193,885 | 384,628 |
| Nonexchange Revenue: | | | |
| FICA and SECA Taxes | 187,992 | | 187,992 |
| Interest on Earmarked Trust Fund Investments | 18,369 | | 18,369 |
| Other Nonexchange Revenue | 237 | | 237 |
| Transfers-in/out Without Reimbursement ***(Note 10)*** | (1,737) | 589 | (1,148) |
| **Other Financing Sources (Nonexchange):** | | | |
| Transfers-out Without Reimbursement | (1) | | (1) |
| Imputed Financing | 26 | 2 | 28 |
| **TOTAL FINANCING SOURCES** | **395,629** | **194,476** | **590,105** |
| **NET COST OF OPERATIONS** | **367,551** | **194,387** | **561,938** |
| **NET CHANGE** | **28,078** | **89** | **28,167** |
| **CUMULATIVE RESULTS OF OPERATIONS** | **$329,931** | **$402** | **$330,333** |
| **UNEXPENDED APPROPRIATIONS** | | | |
| **BEGINNING BALANCES** | **$27,658** | **$32,521** | **$60,179** |
| **Budgetary Financing Sources:** | | | |
| Appropriations Received | 199,309 | 174,643 | 373,952 |
| Appropriations Transferred-in/out | | (2,805) | (2,805) |
| Other Adjustments ***(Note 11)*** | (27,246) | (585) | (27,831) |
| Appropriations Used | (190,743) | (193,885) | (384,628) |
| **TOTAL BUDGETARY FINANCING SOURCES** | **(18,680)** | **(22,632)** | **(41,312)** |
| **TOTAL UNEXPENDED APPROPRIATIONS** | **8,978** | **9,889** | **18,867** |
| **NET POSITION** | **$338,909** | **$10,291** | **$349,200** |

*The accompanying notes are an integral part of these statements.*

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

*(in millions)*

| | Consolidated Earmarked Funds | Consolidated Other Funds | FY 2006 Consolidated Total |
|---|---|---|---|
| **CUMULATIVE RESULTS OF OPERATIONS** | | | |
| **BEGINNING BALANCES** | **$269,147** | **$282** | **$269,429** |
| **Budgetary Financing Sources:** | | | |
| Appropriations Used | 173,573 | 186,754 | 360,327 |
| Nonexchange Revenue: | | | |
| FICA and SECA Taxes | 180,393 | | 180,393 |
| Interest on Earmarked Trust Fund Investments | 17,142 | | 17,142 |
| Other Nonexchange Revenue | 308 | | 308 |
| Transfers-in/out Without Reimbursement ***(Note 10)*** | (1,765) | 462 | (1,303) |
| **Other Financing Sources (Nonexchange):** | | | |
| Transfers-out Without Reimbursement | (1) | | (1) |
| Imputed Financing | 25 | 2 | 27 |
| **TOTAL FINANCING SOURCES** | **369,675** | **187,218** | **556,893** |
| **NET COST OF OPERATIONS** | **336,969** | **187,187** | **524,156** |
| **NET CHANGE** | **32,706** | **31** | **32,737** |
| **CUMULATIVE RESULTS OF OPERATIONS** | **$301,853** | **$313** | **$302,166** |
| **UNEXPENDED APPROPRIATIONS** | | | |
| **BEGINNING BALANCES** | **$6,873** | **$7,833** | **$14,706** |
| **Budgetary Financing Sources:** | | | |
| Appropriations Received | 201,231 | 222,441 | 423,672 |
| Appropriations Transferred-in/out | | (1,855) | (1,855) |
| Other Adjustments ***(Note 11)*** | (6,873) | (9,144) | (16,017) |
| Appropriations Used | (173,573) | (186,754) | (360,327) |
| **TOTAL BUDGETARY FINANCING SOURCES** | **20,785** | **24,688** | **45,473** |
| **TOTAL UNEXPENDED APPROPRIATIONS** | **27,658** | **32,521** | **60,179** |
| **NET POSITION** | **$329,511** | **$32,834** | **$362,345** |

*The accompanying notes are an integral part of these statements.*

# COMBINED STATEMENT OF BUDGETARY RESOURCES
## For the Years Ended September 30, 2007 and 2006

*(in millions)*

| | FY 2007 | FY 2006 | |
|---|---|---|---|
| | Combined Totals Budgetary | Combined Totals Budgetary | Non-Budgetary Credit Reform Financing Accounts |
| **Budgetary Resources:** | | | |
| Unobligated balance, brought forward, October 1: | $56,270 | $3,098 | |
| Recoveries of prior year unpaid obligations | 15,972 | 14,006 | |
| Budget authority: | | | |
| Appropriation | 837,011 | 847,368 | |
| Spending authority from offsetting collections: | | | |
| Earned | | | |
| Collected | 221 | 156 | $140 |
| Change in unfilled customer orders: | | | |
| Advance received | (58) | 63 | |
| Without advance from Federal sources | 63 | 9 | |
| Expenditure transfers from trust funds | 3,546 | 3,347 | |
| **SUBTOTAL** | **840,783** | **850,943** | **140** |
| Nonexpenditure transfers, net, anticipated & actual | (2,958) | (1,727) | |
| Temporarily not available pursuant to Public Law | (20,793) | (34,525) | |
| Permanently not available | (27,908) | (1,767) | |
| **TOTAL BUDGETARY RESOURCES** | **$861,366** | **$830,028** | **$140** |
| **Status of Budgetary Resources:** | | | |
| Obligations incurred ***(Note 14)***: | | | |
| Direct | $846,012 | $773,547 | |
| Reimbursable | 194 | 211 | $140 |
| **SUBTOTAL** | **846,206** | **773,758** | **140** |
| Unobligated balance: | | | |
| Apportioned | 13,617 | 54,114 | |
| Unobligated balance not available | 1,543 | 2,156 | |
| **TOTAL STATUS OF BUDGETARY RESOURCES** | **$861,366** | **$830,028** | **$140** |
| **Change in Obligated Balance:** | | | |
| Obligated balance, net: | | | |
| Unpaid obligations, brought forward, October 1 | $70,834 | $55,795 | |
| Uncollected customer payments from | | | |
| Federal sources, brought forward, October 1 | (1,432) | (1,631) | |
| **TOTAL UNPAID OBLIGATED BALANCE, NET** | **$69,402** | **$54,164** | |
| Obligations incurred, net | 846,206 | 773,758 | $140 |
| Gross Outlays | (830,086) | (744,713) | (140) |
| Obligated balance transferred, net: | | | |
| Recoveries of prior year unpaid obligations, actual | (15,972) | (14,006) | |
| Change in uncollected customer payments | | | |
| from Federal sources | (353) | 199 | |
| Obligated balance, net, end of period: | | | |
| Unpaid obligations | 70,983 | 70,834 | |
| Uncollected customer payments | | | |
| from Federal sources | (1,786) | (1,432) | |
| **TOTAL, UNPAID OBLIGATED BALANCE, NET, END OF PERIOD** | **69,197** | **69,402** | |
| **Net Outlays:** | | | |
| **Net Outlays** | | | |
| Gross outlays | 830,086 | 744,713 | 140 |
| Offsetting collections | (3,419) | (3,774) | (140) |
| Distributed offsetting receipts | (256,204) | (225,747) | |
| **NET OUTLAYS** | **$570,463** | **$515,192** | |

*The accompanying notes are an integral part of these statements.*

# STATEMENT OF SOCIAL INSURANCE
## 75-Year Projection as of January 1, 2007 and Prior Base Years
*(in billions)*

| | Estimates from Prior Years | | | | |
|---|---|---|---|---|---|
| | **2007** | **2006** | **2005** unaudited | **2004** unaudited | **2003** unaudited |
| **Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: *(Notes 15 and 16)*** | | | | | |
| Current participants who, in the starting year of the projection period: | | | | | |
| Have not yet attained eligibility age (age 15–64) | | | | | |
| HI | $5,975 | $5,685 | $5,064 | $4,820 | $4,510 |
| SMI Part B | 12,112 | 12,446 | 11,477 | 10,505 | 8,796 |
| SMI Part D | 7,285 | 7,366 | 7,895 | 7,545 | 0 |
| Have attained eligibility age (age 65 or over) | | | | | |
| HI | 178 | 192 | 162 | 148 | 128 |
| SMI Part B | 1,648 | 1,606 | 1,436 | 1,310 | 1,160 |
| SMI Part D | 746 | 750 | 817 | 713 | 0 |
| Those expected to become participants (under age 15) | | | | | |
| HI | 4,870 | 4,767 | 4,209 | 4,009 | 3,773 |
| SMI Part B | 4,460 | 3,562 | 3,658 | 3,514 | 2,817 |
| SMI Part D | 2,735 | 2,134 | 2,522 | 2,511 | 0 |
| All current and future participants | | | | | |
| HI | 11,023 | 10,644 | 9,435 | 8,976 | 8,411 |
| SMI Part B | 18,221 | 17,613 | 16,571 | 15,329 | 12,773 |
| SMI Part D | 10,766 | 10,250 | 11,233 | 10,770 | 0 |
| **Actuarial present value for the 75-year projection period of estimated future cost for or on behalf of: *(Notes 15 and 16)*** | | | | | |
| Current participants who, in the starting year of the projection period: | | | | | |
| Have not yet attained eligibility age (age 15–64) | | | | | |
| HI | 15,639 | 15,633 | 12,668 | 12,054 | 10,028 |
| SMI Part B | 12,130 | 12,433 | 11,541 | 10,577 | 8,845 |
| SMI Part D | 7,273 | 7,338 | 7,913 | 7,566 | 0 |
| Have attained eligibility age (age 65 or over) | | | | | |
| HI | 2,558 | 2,397 | 2,179 | 2,168 | 1,897 |
| SMI Part B | 1,834 | 1,773 | 1,622 | 1,475 | 1,306 |
| SMI Part D | 794 | 792 | 880 | 773 | 0 |
| Those expected to become participants (under age 15) | | | | | |
| HI | 5,118 | 3,904 | 3,417 | 3,246 | 2,653 |
| SMI Part B | 4,257 | 3,407 | 3,408 | 3,277 | 2,622 |
| SMI Part D | 2,699 | 2,121 | 2,440 | 2,431 | 0 |
| All current and future participants | | | | | |
| HI | 23,315 | 21,934 | 18,264 | 17,468 | 14,577 |
| SMI Part B | 18,221 | 17,613 | 16,571 | 15,329 | 12,773 |
| SMI Part D | 10,766 | 10,250 | 11,233 | 10,770 | 0 |
| **Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over cost *(Notes 15 and 16)*** | | | | | |
| HI | $(12,292) | $(11,290) | $(8,829) | $(8,492) | $(6,166) |
| 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 15 and 16)*** | | | | | |
| HI | $(12,292) | $(11,290) | $(8,829) | $(8,492) | $(6,166) |
| SMI Part B | 0 | 0 | 0 | 0 | 0 |
| SMI Part D | 0 | 0 | 0 | 0 | 0 |
| **Trust Fund assets at start of period** | | | | | |
| HI | 300 | 285 | 268 | 256 | 235 |
| SMI Part B | 38 | 23 | 19 | 24 | 34 |
| SMI Part D | 1 | 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 15 and 16)*** | | | | | |
| HI | $(11,993) | $(11,006) | $(8,561) | $(8,236) | $(5,931) |
| SMI Part B | 38 | 23 | 19 | 24 | 34 |
| SMI Part D | 1 | 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 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). The CMS is a separate financial reporting entity of HHS.

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.* GAAP for Federal entities are the standards prescribed by the Federal Accounting Standards Advisory Board (FASAB). The preparation of financial statements, in conformity with GAAP, requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the dates of the financial statements and the reported amounts of revenues and expenses during the reporting periods. Actual results could differ from those estimates.

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

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

### *Earmarked Funds*

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

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

The Medicare **Earmarked** funds include:

### Medicare Hospital Insurance Trust Fund—Part A

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

### Medicare Supplementary Medical Insurance Trust Fund—Part B

Section 1841 of the Social Security Act established the Supplementary Medical Insurance Trust Fund. Medicare contractors are paid by CMS to process Medicare claims for physicians, medical suppliers, hospital outpatient services and rehabilitation, end stage renal disease (ESRD), rural health clinics, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the SMI trust fund. The CMS payments to Medicare Advantage plans are also charged to this fund. The financial statements include SMI trust fund activities administered by Treasury. The SMI trust fund has permanent indefinite authority. SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. (See Note 10 for descriptions of revenues and financing sources for the SMI trust fund).

### Medicare Supplementary Medical Insurance Trust Fund—Part D

The Medicare Prescription Drug Benefit—Part D, established by the Medicare Modernization Act of 2003 (MMA), became effective January 1, 2006. The program makes a prescription drug benefit available to everyone who is in Medicare, though beneficiaries must join a drug plan to obtain coverage. The drug plans are offered by insurance companies and other private companies approved by Medicare and are of two types: Medicare Prescription Drug Plans (which add the coverage to basic Medicare) and Medicare Advantage Prescription Drug Plans and other Medicare Health Plans in which drug coverage is offered as part of a benefit package that includes Part A and Part B services. In addition, Medicare helps employers or unions continue to provide retiree drug coverage that meets Medicare's

standards through the Retiree Drug Subsidy (RDS). In addition, the Low Income Subsidy (LIS) helps those with limited income and resources. Medicare also reimburses States who have paid prescription drug costs for dual eligibles who have had difficulty accessing Part D benefits. (See "Payments to the Health Care Trust Funds Appropriation" below as well as Note 10 for descriptions of revenues and financing sources for the SMI trust fund).

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

### Medicare and Medicaid Integrity Programs

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, *Public Law No. 104-191. § 202*) established the Medicare Integrity Program at section 1893 of the Social Security Act, and codified Medicare program integrity activities previously known as "payment safeguards." HIPAA section 201 also established the Health Care "Fraud and Abuse Control Account, which provides a dedicated appropriation for carrying out the Medicare Integrity Program". Through the Medicare Integrity Program, the CMS contracts with eligible entities to perform such activities as medical and utilization reviews, fraud reviews, cost report audits, and the education of providers and beneficiaries with respect to payment integrity and benefit quality assurance issues. The Medicare Integrity Program is funded by the HI trust fund.

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

### Payments to the Health Care Trust Funds Appropriation

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

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

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

The **Health (Other Funds)** programs include:

### Medicaid

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

### The State Children's Health Insurance Program (SCHIP)

SCHIP, included in the Balanced Budget Act of 1997 (BBA), 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 funding for States to establish Demonstrations to Maintain Independence and Employment, which provide Medicaid benefits and services to working individuals who have a condition that, without medical assistance, will result in disability.

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

### Health Care Infrastructure Improvement Program

The Health Care Infrastructure Improvement Program loan program was enacted into law in December 2003 as part of the Medicare Modernization Act of 2003. The loan program provides a loan to a hospital or entity that is engaged in research in the causes, prevention, and treatment of cancer; and is designated as a cancer center by the National Cancer Institute (NCI) or is designated by the State legislature as the official cancer institute of the State and such designation by the State legislature occurred prior to December 8, 2003 for

payment of the capital costs of eligible projects. CMS expects that any loan made under this provision to be forgiven in five years as it is anticipated that borrowers will meet the requirements for forgiveness.

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

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

### Program Management Appropriation

The Program Management Appropriation provides CMS with the major source of administrative funds to manage the Medicare and Medicaid programs. The funds for this activity are provided from the HI and SMI trust funds, the general fund, and reimbursable activities. The Payments to the Health Care Trust Funds Appropriation reimburses the Medicare HI trust fund to cover the Health programs' share of CMS administrative costs (see Note 10). User fees collected from Medicare Advantage plans seeking Federal qualification and funds received from other Federal agencies to reimburse CMS for services performed for them are credited to the Program Management Appropriation.

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

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

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

**Trust Fund (Earmarked) Investments** are investments (plus the accrued interest on investments) held by Treasury. Sections 1817 for HI and 1841 for SMI of the Social Security Act require that trust fund investments not necessary to meet current expenditures be invested in interest-bearing obligations of the United States or in obligations guaranteed as to both principal and interest by the United States. These investments are carried at face value as determined by Treasury. Interest income is compounded semiannually (June and December) and was adjusted to include an accrual for interest earned from July 1 to September 30. The FASAB SFFAS 27 prescribes certain disclosures concerning earmarked investments, such as the fact that

cash generated from earmarked funds is used by the U.S. Treasury for general Government purposes and that, upon redemption of investments to make expenditures, the Treasury will finance those expenditures in the same manner that it finances all other expenditures (see Note 3).

**Direct Loans and Loan Guarantees, Non-Federal Borrowers** include 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. The program's subsidy cost ($140 million) is 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.

**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.

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

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

**State Phased-Down Contributions** are reimbursements to the SMI trust fund for the Federal assumption of Medicaid prescription drug costs for dually eligible beneficiaries

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

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

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

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

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

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

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

## Reclassifications

Certain FY 2006 balances have been reclassified to conform to FY 2007 financial statement presentations, the effect of which is immaterial.

## Estimation of Obligations Related to Canceled Appropriations

As of September 30, 2007, CMS has canceled over $151 million in cumulative obligations to FY 2002 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 2003 through 2007 related to canceled appropriations, CMS anticipates an additional $5 million will be paid from current year funds for canceled obligations.

## NOTE 2:

## FUND BALANCE WITH TREASURY *(Dollars in Millions)*

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

| FY 2006 | Consolidated Totals |
|---|---|
| **FUND BALANCES:** | |
| **Trust Funds** | |
| HI Trust Fund (Earmarked) | $955 |
| SMI Trust Fund (Earmarked) | 27,771 |
| **Revolving Funds** | |
| CLIA | 182 |
| **General 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** |

Fund Balances are funds with Treasury that are primarily available to pay current expenditures and liabilities. The Unobligated Balance includes $344 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 2007 | Maturity Range | Interest Range | Value |
|---|---|---|---|
| **HI TF** | | | |
| Certificate | June 2008 | 4 1/2% | $7,111 |
| Bonds | June 2008 to June 2022 | 3 1/2 - 7 1/4% | 312,266 |
| Accrued Interest | | | 4,090 |
| **TOTAL HI TF INVESTMENTS** | | | **$323,467** |
| **SMI TF** | | | |
| Certificate | June 2008 | 4 1/2 - 4 3/4% | $5,105 |
| Bonds | June 2008 to June 2019 | 4 1/8 - 6 7/8% | 34,143 |
| Accrued Interest | | | 480 |
| **TOTAL SMI TF INVESTMENTS** | | | **$39,728** |
| **TOTAL MEDICARE INVESTMENTS** | | | **$363,195** |

| 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** |

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 2007**

| | Medicare (Earmarked) | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | HI TF | SMI TF | Medicaid | SCHIP | Other Health | Combined Total | Intra-CMS Eliminations | Consolidated Total |
| Expenditure Transfer-in | $456 | $1,114 | $121 | $3 | $13 | $1,707 | $(1,707) | |
| Nonexpenditure Transfer-in | 20,370 | 31,266 | | | | 51,636 | (51,636) | |
| Railroad Retirement Principal | 484 | | | | | 484 | | $484 |
| **TOTAL INTRAGOVERNMENTAL ACCOUNTS RECEIVABLE, NET** | **$21,310** | **$32,380** | **$121** | **$3** | **$13** | **$53,827** | **$(53,343)** | **$484** |

**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** |

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. The SMI trust fund includes a receivable from the HI trust fund in the amount of $8,484 million for hospice benefits that were incorrectly paid out of the Part B account of the SMI trust fund that should have been paid out of the HI trust fund. This receivable has been eliminated against the corresponding payable established in the HI trust fund.

## NOTE 5: ACCOUNTS RECEIVABLE, NET *(Dollars in Millions)*

| FY 2007 | Medicare (Earmarked) HI TF | Medicare (Earmarked) SMI TF | Medicaid | Other Health | Consolidated Total |
|---|---|---|---|---|---|
| **Provider & Beneficiary Overpayment** | | | | | |
| Accounts Receivable Principal | $552 | $927 | | $38 | $1,517 |
| Less: Allowance for Uncollectible Accounts | (151) | (529) | | (26) | (706) |
| Accounts Receivable, Net | 401 | 398 | | 12 | 811 |
| **Medicare Secondary Payer (MSP)** | | | | | |
| Accounts Receivable Principal | 195 | 125 | | 7 | 327 |
| Less: Allowance for Uncollectible Accounts | (98) | (85) | | (5) | (188) |
| Accounts Receivable, Net | 97 | 40 | | 2 | 139 |
| **Medicare Prescription Drug** | | | | | |
| Accounts Receivable Principal | | 8,409 | | | 8,409 |
| Less: Allowance for Uncollectible Accounts | | | | | |
| Accounts Receivable, Net | | 8,409 | | | 8,409 |
| **CMPs and Other Restitutions** | | | | | |
| Accounts Receivable Principal | 793 | 417 | | 1 | 1,211 |
| Less: Allowance for Uncollectible Accounts | (661) | (401) | | (1) | (1,063) |
| Accounts Receivable, Net | 132 | 16 | | | 148 |
| **Fraud and Abuse** | | | | | |
| Accounts Receivable Principal | 124 | 327 | | | 451 |
| Less: Allowance for Uncollectible Accounts | (124) | (313) | | | (437) |
| Accounts Receivable, Net | | 14 | | | 14 |
| **Medicare Advantage** | | | | | |
| Accounts Receivable Principal | | 5 | | 3 | 8 |
| Less: Allowance for Uncollectible Accounts | | (3) | | (3) | (6) |
| Accounts Receivable, Net | | 2 | | | 2 |
| **Medicare Premiums** | | | | | |
| Accounts Receivable Principal | 250 | 679 | | | 929 |
| Less: Allowance for Uncollectible Accounts | (54) | (64) | | | (118) |
| Accounts Receivable, Net | 196 | 615 | | | 811 |
| **State Phased-Down** | | | | | |
| Accounts Receivable Principal | | 1,024 | | | 1,024 |
| Less: Allowance for Uncollectible Accounts | | | | | |
| Accounts Receivable, Net | | 1,024 | | | 1,024 |
| **Audit Disallowances** | | | | | |
| Accounts Receivable Principal | | | $1,480 | | $1,480 |
| Less: Allowance for Uncollectible Accounts | | | (81) | | (81) |
| Accounts Receivable, Net | | | 1,399 | | 1,399 |
| **Other Accounts Receivable** | | | | | |
| Accounts Receivable Principal | | | 166 | 22 | 188 |
| Less: Allowance for Uncollectible Accounts | | | (118) | (19) | (137) |
| Accounts Receivable, Net | | | 48 | 3 | 51 |
| **TOTAL ACCOUNTS RECEIVABLE PRINCIPAL** | **$1,914** | **$11,913** | **$1,646** | **$71** | **$15,544** |
| Less: Allowance for Uncollectible Accounts Receivable | (1,088) | (1,395) | (199) | (54) | (2,736) |
| **TOTAL ACCOUNTS RECEIVABLE, NET** | **$826** | **$10,518** | **$1,447** | **$17** | **$12,808** |

| 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** |

Accounts receivable are primarily composed of Medicare Prescription Drug overpayments, provider and beneficiary overpayments, Medicare Secondary Payer (MSP) overpayments, Medicare Premiums, and Medicaid Audit Disallowances. 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.

### Medicare Prescription Drug

The Medicare Prescription Drug receivable of $8,409 million consists of amounts due CMS after completion of the first Part D payment reconciliation of calendar year 2006 and an estimate for the first nine months of calendar year 2007. The gross receivable for calendar year 2006 is $5,189 million, and the estimate for first nine months of calendar year 2007 is $3,220 million.

### 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

Non-entity assets are assets the agency holds but does not have authority to use in its operations. The only non-entity assets on CMS' Consolidating Balance Sheet are receivables for interest and penalties, net for the amount of $14 million ($15 million in FY 2006). The accrued interest associated with Provider and Beneficiary, MSP and Medicare Advantage overpayments appear under All Others.

## NOTE 6: OTHER LIABILITIES *(Dollars in Millions)*

| FY 2007 | Medicare (Earmarked) HI TF | Medicare (Earmarked) SMI TF | Medicaid | Other Health | Consolidated Total |
|---|---|---|---|---|---|
| Intragovernmental: | | | | | |
| Uncollected Revenue due Treasury | $134 | $332 | | $14 | $480 |
| Other | 13 | 24 | $3 | 10 | 50 |
| **TOTAL OTHER INTRAGOVERNMENTAL LIABILITIES** | **$147** | **$356** | **$3** | **$24** | **$530** |
| Deferred Revenue | $62 | $267 | | | $329 |
| Suspense Account Deposit Funds | | | | $54 | 54 |
| Contingent Liabilities | 1,813 | 596 | $1,702 | | 4,111 |
| Other | 3 | 3 | | | 6 |
| **TOTAL OTHER LIABILITIES** | **$1,878** | **$866** | **$1,702** | **$54** | **$4,500** |

| 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 |
| Contingent Liabilities | 475 | | $1,126 | | 1,601 |
| Other | | 2 | | | 2 |
| **TOTAL OTHER LIABILITIES** | **$576** | **$265** | **$1,126** | **$19** | **$1,986** |

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 $1,702 million consists of Medicaid audit and program disallowances of $463 million and $1,239 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.

As of September 30, 2007, CMS recorded $1,742 million for a contingent liability for asserted and unasserted claims that could be owed to States arising from the payment of claims by State Medicaid Programs for beneficiaries who allegedly were eligible for Medicare. In FY 2006, CMS believed this contingent liability to be reasonably possible and disclosed it in the footnotes. On September 24, 2007, one state asserted a claim in a civil action brought in federal district court. The agency intends to defend against this claim. Because appropriation law requires Congress to authorize the transfer of funds out of the Medicare trust funds into an appropriation account, the Medicare trust funds cannot reimburse the Health Program accounts in the general fund of the Treasury absent Congressional authorization. The CMS does not intend to seek such Congressional authorization and there will be no transactions recorded between the trust funds and the Health Programs' accounts in the general fund.

The CMS has accrued $667 million as of September 30, 2007, for a contingent liability to providers for previous years' disputed cost report adjustments for disproportionate share hospitals.

### 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, 2006, there were 5,886 PRRB cases (5,737 in FY 2006) under appeal. A total of 2,901 new cases (2,422 in FY 2006) were filed in FY 2007. The PRRB rendered decisions on 119 cases (85 in FY 2006) in FY 2007 and 2,024 additional cases (2,188 in FY 2006) 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 119 cases that were decided in FY 2007, a reasonable liability estimate cannot be projected for the value of the 6,644 cases (5,886 in FY 2006) remaining on appeal as of September 30, 2007. As cases are decided, the settlement value paid is considered in the development of the actuarial liability estimate.

## NOTE 7: ENTITLEMENT BENEFITS DUE AND PAYABLE *(Dollars in Millions)*

| FY 2007 | Medicare (Earmarked) | | | | | Other | Consolidated |
|---|---|---|---|---|---|---|---|
| | HI TF | SMI TF | Total | Medicaid | SCHIP | Health | Total |
| Medicare Benefits Payable *(1)* | $18,235 | $16,828 | $35,063 | | | | $35,063 |
| Medicare Advantage *(2)* | 1,175 | 2,460 | 3,635 | | | | 3,635 |
| Retiree Drug Subsidy *(3)* | | 2,906 | 2,906 | | | | 2,906 |
| Undocumented Aliens *(5)* | | | | | | $163 | 163 |
| Medicaid/SCHIP *(6)* | | | | $19,414 | $289 | | 19,703 |
| **TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE** | **$19,410** | **$22,194** | **$41,604** | **$19,414** | **$289** | **$163** | **$61,470** |

| FY 2006 | Medicare (Earmarked) | | | | | Other | Consolidated |
|---|---|---|---|---|---|---|---|
| | HI TF | SMI TF | Total | Medicaid | SCHIP | Health | Total |
| Medicare Benefits Payable *(1)* | $19,075 | $17,553 | $36,628 | | | | $36,628 |
| Medicare Advantage *(2)* | 676 | 1,007 | 1,683 | | | | 1,683 |
| Retiree Drug Subsidy *(3)* | | 2,377 | 2,377 | | | | 2,377 |
| State to Plan Reconciliation Demonstration *(4)* | | 136 | 136 | | | | 136 |
| Undocumented Aliens *(5)* | | | | | | $170 | 170 |
| Medicaid/SCHIP/Katrina Relief Waivers *(6)* | | | | $19,182 | $284 | 704 | 20,170 |
| **TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE** | **$19,751** | **$21,073** | **$40,824** | **$19,182** | **$284** | **$874** | **$61,164** |

***(1)*** Medicare benefits payable consists of a $35,063 million estimate ($36,628 million in FY 2006) by CMS' Office of the Actuary of Medicare services incurred but not paid, as of September 30, 2007. 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 2007 that were paid in 2008 and (e) an estimate of retroactive settlements of cost reports.

***(2)*** Medicare Advantage and Prescription Drug Program benefits payable consist of a $2,653 million estimate ($1,683 million in FY 2006) for amounts owed to plans relating to risk and other payment related adjustments in addition to $982 million owed to plans after the completion of the Prescription Drug Payment reconciliation.

***(3)*** The Retiree Drug Subsidy (RDS) consists of a $2,906 million estimate ($2,377 in FY 2006) of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2007. As part of MMA (incorporated in Section 1860D-22 of the Social Security Act), the RDS program makes subsidy payments available to sponsors of retiree prescription drug coverage. The program is designed to strengthen health care coverage for Medicare-eligible retirees by encouraging the retention of private, employer- and union-based retiree prescription drug plans.

***(4)*** During FY 2006, 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. As of September 30, 2006, 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. As of September 30, 2007, no liability exists because the project was completed during FY 2007.

***(5)*** Undocumented aliens consist of a $163 million estimate ($170 million in FY 2006) of emergency health services furnished by providers to eligible aliens but not paid as of September 30, 2007. 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.

***(6)*** Medicaid benefits payable of $19,414 million ($19,182 million in FY 2006) 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, 2007. An estimated SCHIP benefits payable of $289 million has been recorded ($284 million in FY 2006) for the net Federal share of expenses that have been incurred by the States but not yet reported to CMS as of September 30, 2007.

The liability reported at September 30, 2006 for Katrina relief waivers of $704 million which consisted of $543 million in actual services rendered but not paid plus a $161 million estimate for services incurred but not paid by eligible States with respect to evacuees who did not have other coverage for assistance through insurance under title XIX of the Social Security Act does not exist as of September 30, 2007. Services were rendered by September 30, 2006 and the payments were made during FY 2007. CMS has this authority under an approved Multi-State Section 1115 Demonstration Project of Public Law 109-171, Subtitle C.

## NOTE 8:
## LIABILITIES NOT COVERED BY BUDGETARY RESOURCES *(Dollars in Millions)*

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

| 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** | **$488** | **$31** | **$1,129** | | | **$1,648** | | **$1,648** |
| **TOTAL LIABILITIES COVERED BY BUDGETARY RESOURCES** | **$40,389** | **$44,336** | **$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** |

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.

# NOTE 9:
# NET COST OF OPERATIONS *(Dollars in Millions)*

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

| FY 2006 | Medicare (Earmarked) | | | Health | | | Consolidated Totals |
|---|---|---|---|---|---|---|---|
| | HI TF | SMI TF | Total | Medicaid | SCHIP | Other Health | |
| **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) | | 30,065 | 30,065 | | | | 30,065 |
| **Medicaid/SCHIP/State Grants & Demos** | | | | $179,254 | $5,735 | $1,946 | 186,935 |
| **CLIA** | | | | | | 74 | 74 |
| **TOTAL PROGRAM/ACTIVITY COSTS** | **$185,523** | **$191,593** | **$377,116** | **$179,254** | **$5,735** | **$2,020** | **$564,125** |
| **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** | **$193,695** | **$382,147** | **$179,483** | **$5,739** | **$2,105** | **$569,474** |
| **LESS: EXCHANGE REVENUES:** | | | | | | | |
| Medicare Premiums | $2,654 | $42,501 | $45,155 | | | | $45,155 |
| CLIA Revenues | | | | | | $124 | 124 |
| Other Exchange Revenues | 10 | 13 | 23 | $2 | | 14 | 39 |
| **TOTAL EXCHANGE REVENUES** | **$2,664** | **$42,514** | **$45,178** | **$2** | | **$138** | **$45,318** |
| **TOTAL NET COST OF OPERATIONS** | **$185,788** | **$151,181** | **$336,969** | **$179,481** | **$5,739** | **$1,967** | **$524,156** |

For purposes of financial statement presentation, non-CMS administrative costs are considered expenses to the Medicare trust funds when outlayed by Treasury even though some funds may have been used to pay for assets such as property and equipment. The CMS administrative costs have been allocated to the Medicare, Medicaid, SCHIP, and State Grants and Demonstrations programs based on the CMS cost allocation system. Administrative costs allocated to the Medicare program include $1,748 million ($1,544 million in FY 2006) paid to Medicare contractors to carry out their responsibilities as CMS' agents in the administration of the Medicare program.

An error in the implementation of CMS' HIGLAS system created a business rule that incorrectly paid hospice benefits from the Part B account of SMI instead of HI for a period beginning in May 2005 to August 2007. This issue resulted in an overstatement of SMI expenses and an understatement of HI Expenses in the amount of $8,484 million. In order to correctly present the expenses, CMS has reported a payable in HI and a receivable in SMI for the principal amount of $8,484 million to report the hospice benefit expense correctly.

# NOTE 10: TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT *(Dollars in Millions)*

**FY 2007**

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

**FY 2007**

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

**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) | | | | | | |
| 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)** |

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

***(1)*** During FY 2007, the Payments to the Health Care Trust Funds appropriation paid the HI trust fund $175 million ($131 million in FY 2006) to cover the Medicaid, SCHIP and State Grants and Demonstrations programs' share of CMS' administrative costs.

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

### Federal Matching Contributions

SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. The monthly SMI premium per beneficiary was $88.50 from October 2006 through December 2006 and $93.50 from January 2007 through September 2007. Premiums collected from beneficiaries totaled $45,743 million ($41,628 million in FY 2006) and were matched by a $137,822 million ($129,082 million in FY 2006) contribution from the Federal government.

### Part D Transfers-In

Part D benefits and administrative expenses are financed by the general fund appropriation, Payments to the Health Care Trust Funds. As of September 30, 2007, approximately $41,359 million has been transferred-in ($28,346 million in FY 2006) to Part D from the general fund.

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

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

| 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)** |

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

## NOTE 12: EARMARKED FUNDS *(Dollars in Millions)*

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

### Balance Sheet as of September 30, 2007

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

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

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

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

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

## 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 Year 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 Year Ended September 30, 2006

| | | | |
|---|---|---|---|
| Net Position, Beginning of Period | $266,754 | $9,266 | $276,020 |
| Taxes and Other Nonexchange Revenue | 180,699 | 2 | 180,701 |
| Trust Fund Investment Interest | 15,541 | 1,601 | 17,142 |
| 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 13: INTRAGOVERNMENTAL COSTS AND EXCHANGE REVENUE *(Dollars in Millions)*

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

| 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 | 193,514 | 193,695 | 6 | 42,508 | 42,514 | 151,181 |
| Medicaid | 19 | 179,464 | 179,483 | 1 | 1 | 2 | 179,481 |
| SCHIP | | 5,739 | 5,739 | | | | 5,739 |
| **SUBTOTAL** | **$714** | **$566,655** | **$567,369** | **$9** | **$45,171** | **$45,180** | **$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** | **$568,719** | **$569,474** | **$16** | **$45,302** | **$45,318** | **$524,156** |

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

# NOTE 14: 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 2007 | Direct | Reimbursable | Combined Totals |
|---|---|---|---|
| Category A | $59,887 | $148 | $60,035 |
| Category B | 385,088 | 46 | 385,134 |
| Exempt | 401,037 | | 401,037 |
| **TOTAL** | **$846,012** | **$194** | **$846,206** |

| 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** |

## *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 $313,882 million as of September 30, 2007 ($292,426 million in FY 2006) are included in Investments on the Balance Sheet. The following table presents trust fund activities and balances for FY 2007 and FY 2006 (in millions):

| | FY 2007 Combined Balance | FY 2006 Combined Balance |
|---|---|---|
| **TRUST FUND BALANCE, BEGINNING** | **$292,426** | **$258,025** |
| Receipts | 410,518 | 387,889 |
| Less Obligations | 389,062 | 353,488 |
| Less Transfers | | |
| Excess of Receipts Over Obligations | 21,456 | 34,401 |
| **TRUST FUND BALANCE, ENDING** | **$313,882** | **$292,426** |

### Explanations of Differences Between the Statement of Budgetary Resources and the Budget of the United States Government for FY 2006

*(in millions)*

| | Budgetary Resources | Obligations Incurred | Offsetting Receipts | Net Outlays |
|---|---|---|---|---|
| Statement of Budgetary Resources | $830,168 | $773,898 | $225,747 | $515,192 |
| Unobligated Balances Not Available | (1,460) | | | |
| Other Adjustments | 2,238 | 1,981 | (5) | 1,932 |
| **PRESIDENT'S BUDGET (actual)** | **$830,946** | **$775,879** | **$225,742** | **$517,124** |

The Other Adjustments Line for Budgetary Resources includes an increase in the amount of $2,227 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 $11 million for offsetting collections.

The Other Adjustments Line for Obligations Incurred includes an increase of $2,130 million for the amounts reported in the President's Budget but reported by CDC and Treasury and a decrease of $149 million for expired accounts.

The Other Adjustments Line for Offsetting Receipts includes an increase to net outlays in the amount of $1,927 million for the amounts reported in the President's Budget but reported by the CDC and Treasury, and an increase of $5 million for the Budget Clearing Account reported as an offsetting receipt on the SBR but not reported as an offsetting receipt in the President's Budget.

The President's Budget with actual numbers for FY 2007 has not yet been published. It is expected that the Office of Management and Budget (OMB) will publish the FY 2007 numbers in January 2008 and will be available from OMB.

### Undelivered Orders at the End of the Period

The amount of budgetary resources obligated for undelivered orders totaled $7,295 million at September 30, 2007 ($7,646 million in FY 2006).

## NOTE 15: STATEMENT OF SOCIAL INSURANCE

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

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. 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, or on behalf of, beneficiaries and general revenue contributions made on behalf of beneficiaries. Transfers from State governments are also included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

Actuarial present values of estimated future income (excluding interest) and estimated future expenditures are presented for three different groups of participants: (1) current participants who have not yet attained eligibility age; (2) current participants who have attained eligibility age; and (3) new entrants, 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, the period covers virtually all of the current participants' working and retirement years.

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

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

Since its enactment in 1965, the Medicare program has experienced substantial variability in expenditure growth rates. These different rates of growth have reflected new developments in the treatment of medical care, demographic factors affecting the relative number and average age of beneficiaries and covered workers, and numerous economic factors. The future cost of Medicare will also be affected by further changes in these factors, 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 in table 1 below. The assumptions underlying the 2007 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2007. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions. Detailed information for the prior years similar to that denoted within table 1 is publicly available.

## Table 1: Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2007

| | | | | | *Annual percentage change in:* | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Per beneficiary cost[8] | | | |
| | Fertility rate[1] | Net immigration[2] | Mortality rate[3] | Real-wage differential[4] | Wages[5] | CPI[6] | Real GDP[7] | HI | SMI B | SMI D | Real-interest rate[9] |
| 2007 | 2.04 | 1,075,000 | 839.8 | 2.7 | 4.6 | 1.9 | 2.6 | 6.4 | 6.2 | 0.1 | 2.9 |
| 2010 | 2.03 | 1,000,000 | 825.3 | 1.4 | 4.2 | 2.8 | 2.6 | 5.0 | 4.6 | 8.6 | 2.8 |
| 2020 | 2.02 | 950,000 | 764.5 | 1.0 | 3.8 | 2.8 | 2.1 | 4.5 | 4.7 | 7.6 | 2.9 |
| 2030 | 2.00 | 900,000 | 705.4 | 1.1 | 3.9 | 2.8 | 2.0 | 5.8 | 5.6 | 5.5 | 2.9 |
| 2040 | 2.00 | 900,000 | 652.8 | 1.1 | 3.9 | 2.8 | 2.0 | 5.8 | 5.4 | 5.2 | 2.9 |
| 2050 | 2.00 | 900,000 | 606.6 | 1.1 | 3.9 | 2.8 | 2.0 | 4.9 | 4.8 | 4.9 | 2.9 |
| 2060 | 2.00 | 900,000 | 565.7 | 1.1 | 3.9 | 2.8 | 1.9 | 4.7 | 4.8 | 4.6 | 2.9 |
| 2070 | 2.00 | 900,000 | 529.3 | 1.1 | 3.9 | 2.8 | 1.9 | 4.6 | 4.5 | 4.4 | 2.9 |
| 2080 | 2.00 | 900,000 | 496.8 | 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.

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

## Table 2: Significant Ultimate Assumptions Used for the Statement of Social Insurance, FY 2007–2003

| | | | | | *Annual percentage change in:* | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Per beneficiary cost[8] | | | |
| | Fertility rate[1] | Net immigration[2] | Mortality rate[3] | Real-wage differential[4] | Wages[5] | CPI[6] | Real GDP[7] | HI | SMI B | SMI D | Real-interest rate[9] |
| FY 2007 | 2.00 | 900,000 | 496.8 | 1.1 | 3.9 | 2.8 | 1.9 | 4.3 | 4.3 | 4.3 | 2.9 |
| FY 2006 | 2.00 | 900,000 | 497.6 | 1.1 | 3.9 | 2.8 | 1.9 | 4.3 | 4.3 | 4.3 | 2.9 |
| FY 2005 | 1.95 | 900,000 | 495.5 | 1.1 | 3.9 | 2.8 | 1.8 | 5.2 | 5.1 | 5.1 | 3.0 |
| FY 2004 | 1.95 | 900,000 | 497.2 | 1.1 | 3.9 | 2.8 | 1.8 | 5.2 | 5.1 | 5.1 | 3.0 |
| FY 2003 | 1.95 | 900,000 | 447.9 | 1.1 | 4.1 | 3.0 | 1.8 | 5.3 | 5.1 | — | 2.9 |

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

### Part D Projections

In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the Part D program is new (having begun operations in January 2006), with very little actual program data currently available. The actual 2006 and 2007 bid submissions by the private plans offering this coverage, together with preliminary data on beneficiary enrollment, have been used in the current projections. Nevertheless, there remains a high level of uncertainty surrounding these cost projections, pending the availability of sufficient data on actual Part D expenditures to establish a trend baseline.

### Hospice Benefits Mis-Posting

Beginning in May 2005, expenditures for certain Part A hospice benefits were posted to the Part B account of the SMI trust fund, rather than from the HI trust fund. Correction of this mis-posting will increase Part A expenditures and reduce Part B expenditures in 2008 and later years, compared to the projections shown in the 2007 Medicare Trustees Report. It will also result in adjustments to the HI and SMI trust funds to account for the misallocated hospice expenditures during fiscal years 2005 through 2007. The present values displayed in the Statement of Social Insurance have been revised to include the estimated impact of correcting this mis-posting. The impact on the Part A and Part B expenditure projections presented in the Statement of Social Insurance is roughly $465 billion over the entire 75-year period, equivalent to a 2.0-percent increase for Part A and a 2.5-percent decrease for Part B. However, the change in Part A expenditures also resulted in a very slight change to the discount rates used to calculate all of the present values in the SOSI, thereby contributing to a further minor change in the present value amounts for Parts A, B, and D relative to the original Trustees Report projections.

## NOTE 16: SMI PART B PHYSICIAN UPDATE FACTOR

The projected Part B expenditure growth reflected in the accompanying SOSI is significantly reduced as a result of the structure of physician payment updates under current law. In the absence of legislation, this structure would result in multiple years of significant reductions in physician payments, totaling an estimated 41 percent over the next 9 years. Reductions of this magnitude are very unlikely to occur fully. For example, Congress has overridden scheduled negative updates for each of the last 5 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 $18.2 trillion. An alternative scenario indicates that if Congress were to set future physician payment updates at zero percent per year, then, absent other provisions to offset these costs, the projected present value would increase to $22.6 trillion. Similarly, if Congress were to set future physician payment updates equal to the Medicare Economic Index (projected to be 2 to 2.5 percent per year), the present value would be $25.4 trillion.

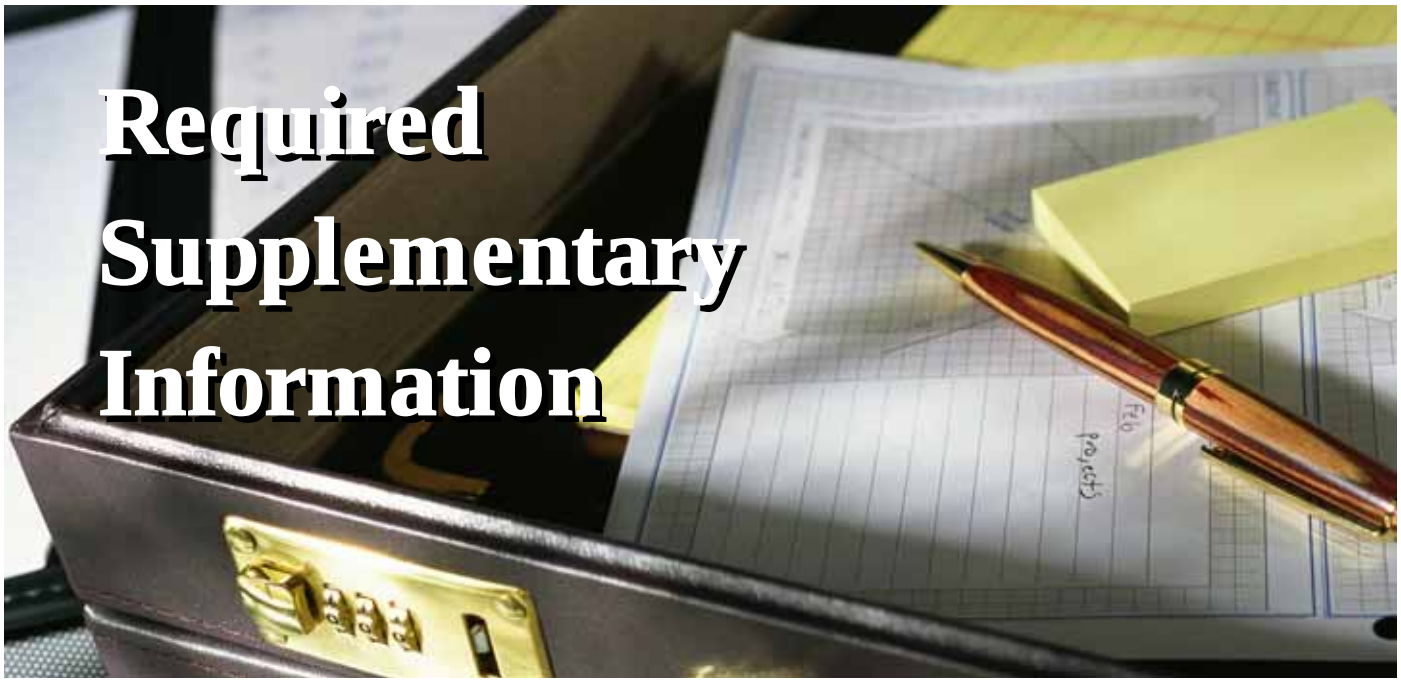
The extent to which actual future Part B costs exceed the projected current-law amounts due to physician payments depends on both the level of physician payment updates that might be legislated and on whether Congress would pass further provisions to help offset such costs (as it did, for example, in the Deficit Reduction Act in 2006). As noted, these examples only reflect hypothetical changes to physician payments.

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

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

| | FY 2007 Consolidated Totals | FY 2006 Consolidated Totals |
|---|---|---|
| **RESOURCES USED TO FINANCE ACTIVITIES:** | | |
| **Budgetary Resources Obligated:** | | |
| Obligations incurred | $846,206 | $773,898 |
| Less: Spending authority from offsetting collections and recoveries | 19,744 | 17,721 |
| Obligations net of offsetting collections and recoveries | 826,462 | 756,177 |
| Less: Distributed offsetting receipts | 256,204 | 225,747 |
| **NET OBLIGATIONS** | **570,258** | **530,430** |
| **Other Resources:** | | |
| Transfers in/out without reimbursement | (1) | (1) |
| Imputed financing from costs absorbed by others | 28 | 27 |
| **NET OTHER RESOURCES USED TO FINANCE ACTIVITIES** | **27** | **26** |
| **TOTAL RESOURCES USED TO FINANCE ACTIVITIES** | **$570,285** | **$530,456** |
| **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 | $(321) | $(6,011) |
| Resources that fund expenses recognized in prior periods | | 14,643 |
| Budgetary offsetting collections and receipts that do not affect net cost of operations | (95) | 73 |
| Resources that finance the acquisition of assets | 57 | (24) |
| Other resources or adjustments to net obligated resources that do not affect net cost of operations | 1,460 | (2,197) |
| **TOTAL RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS** | **1,101** | **6,484** |
| **TOTAL RESOURCES USED TO FINANCE THE NET COST OF OPERATIONS** | **$569,184** | **$523,972** |
| **COMPONENTS OF THE NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD:** | | |
| **Components Requiring or Generating Resources in Future Periods:** | | |
| Increase in annual leave liability | | $1 |
| (Increase) in receivables from the public | $(10,369) | (298) |
| Other | 2,510 | (47) |
| **TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL REQUIRE OR GENERATE RESOURCES IN FUTURE PERIODS** | **(7,859)** | **(344)** |
| **Components Not Requiring or Generating Resources:** | | |
| Depreciation and amortization | 72 | 68 |
| Other | 541 | 460 |
| **TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES** | 613 | 528 |
| **TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD** | **$(7,246)** | **$184** |
| **NET COST OF OPERATIONS** | **$561,938** | **$524,156** |

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



# Required Supplementary Information

Medicare, the largest health insurance program in the country, has helped fund medical care for the Nation's aged and disabled for slightly over four decades. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (known informally as the Medicare Modernization Act, or MMA) introduced the most sweeping changes to the program since its enactment in 1965. The most significant change is that, beginning in 2004, the MMA established a prescription drug benefit. A separate Part D account within the SMI trust fund handles the transactions for this coverage. A brief description of the provisions of Medicare's Hospital Insurance (HI, or Part A) trust fund and Supplementary Medical Insurance (SMI, or Parts B and D) trust fund is included on pages 3-6 of this Financial Report.

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

RSI material is generally drawn from the ***2007 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds***, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions. The projections have been revised slightly since the preparation of the 2007 Trustees Report, to adjust for the impact of an accounting error that was discovered in August of this year. Beginning in May of 2005, Part A hospice expenditures were inadvertently drawn from the Part B account of the SMI trust fund rather than from the HI trust fund. Therefore, Part A expenditures in the 2007 Trustees Report were understated slightly and Part B expenditures were correspondingly overstated.

The Medicare Trustees emphasize that the SMI Part B expenditures projected under current law are significantly understated. Congress is very likely to continue overriding certain statutory provisions that would otherwise require reductions in physician payment rates of about 10 percent in 2008 and another 5 percent per year in 2009 through at least 2016. Additional information on this issue is shown in Note 16 starting on page 62 of this financial statement.

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/ReportsTrustFunds/**.

# ACTUARIAL PROJECTIONS

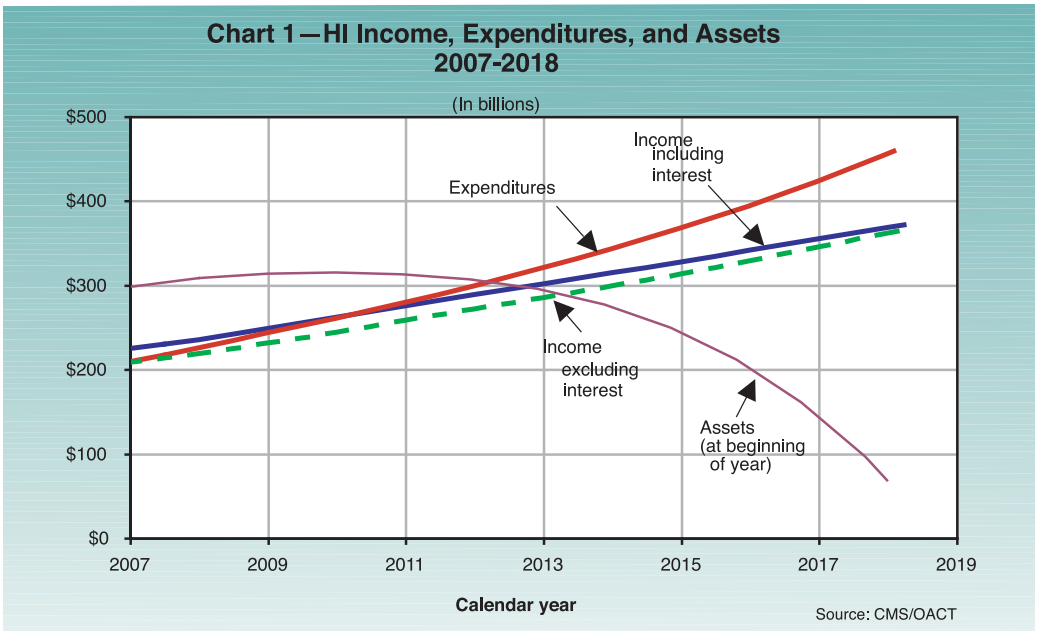
## Cashflow in Nominal Dollars

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

For this reason, long-range (75-year) Medicare projections in nominal dollars are seldom used and are not presented in this section. Instead, nominal-dollar estimates for the HI trust fund are displayed only through the projected date of depletion, currently the year 2018[2]. Corresponding estimates for SMI Parts B and D are presented only for the next 10 years, primarily due to the fact that under present law, the SMI trust fund is automatically in financial balance every year.

### *HI*

Chart 1 shows the actuarial estimates of HI income, expenditures, and assets for each of the years 2007 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 are expected to enter the workforce through 2018. The estimates also include income and expenditures attributable to these current and future workers, in addition to current beneficiaries.




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

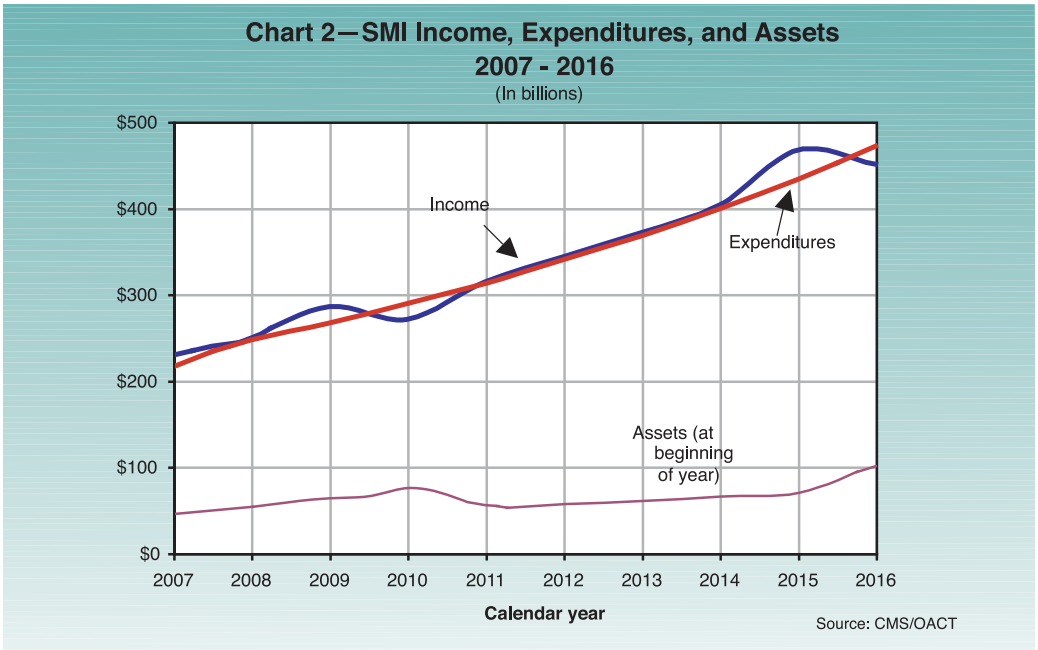
[2] The 2007 Trustees Report projected that the HI trust fund would be depleted in 2019, which was one year later than what was estimated in the 2006 Trustees Report. However, due to the accounting error explained earlier, Part A expenditures were understated in the 2007 Trustees Report. Correcting for this error moves the depletion date from 2019 to 2018.

As chart 1 shows, HI expenditures are expected to exceed income excluding interest in 2007 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. For the fourth year in a row, the HI trust fund does not meet an explicit test of short-range financial adequacy, as assets are predicted to fall below expenditures within the next 10 years.

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

## *SMI*

Chart 2 shows the actuarial estimates of SMI income, expenditures, and assets, for Parts B and D combined, for each of the years 2007 through 2016, in nominal dollars. Whereas HI estimates are displayed through 2018, SMI estimates cover only the years through 2016, 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.[3] 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 2016.[4]




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

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

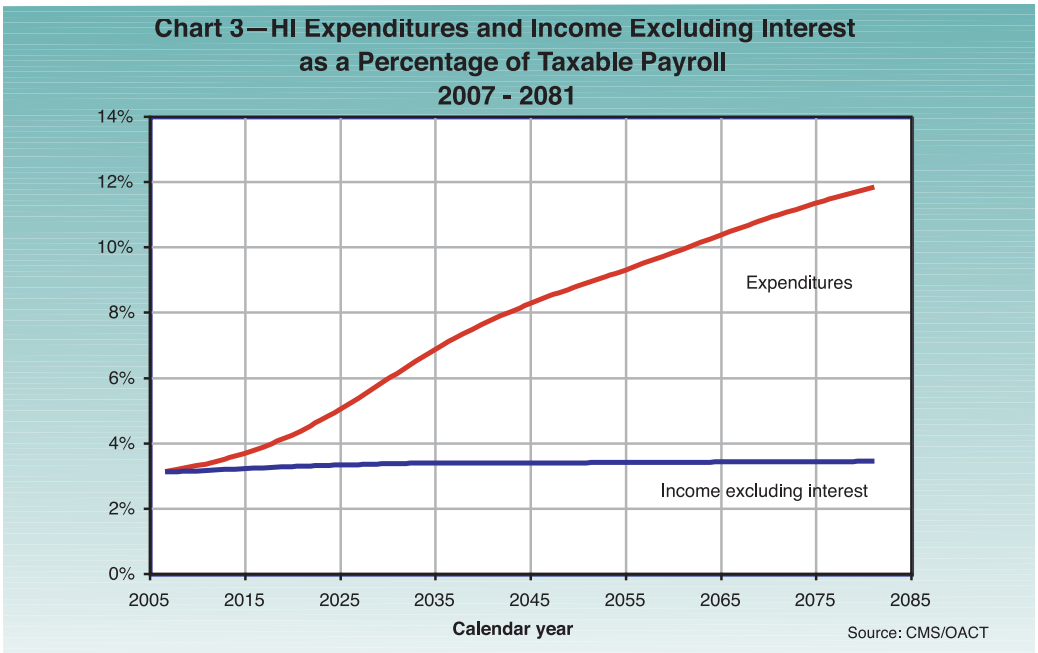
Income includes monthly premiums paid by, or on behalf of, beneficiaries, transfers from the general fund of the U.S. Treasury, certain payments by the States to the Part D account, and interest earned on the U.S. Treasury securities held by the SMI trust fund. Chart 2 displays only total income; it does not separately show income excluding interest. The difference between the two depictions of income is not visible graphically since interest is not a significant source of income.[5] 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 last year's Trustees Report, the long-range increase in average expenditures per beneficiary was assumed to equal growth in per capita gross domestic product (GDP) plus 1 percentage point. Beginning with the 2006 report, the Board of Trustees adopted a refinement of these long-range growth assumptions. The refinement provides a smoother and more realistic transition from current Medicare cost




[5] 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.

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

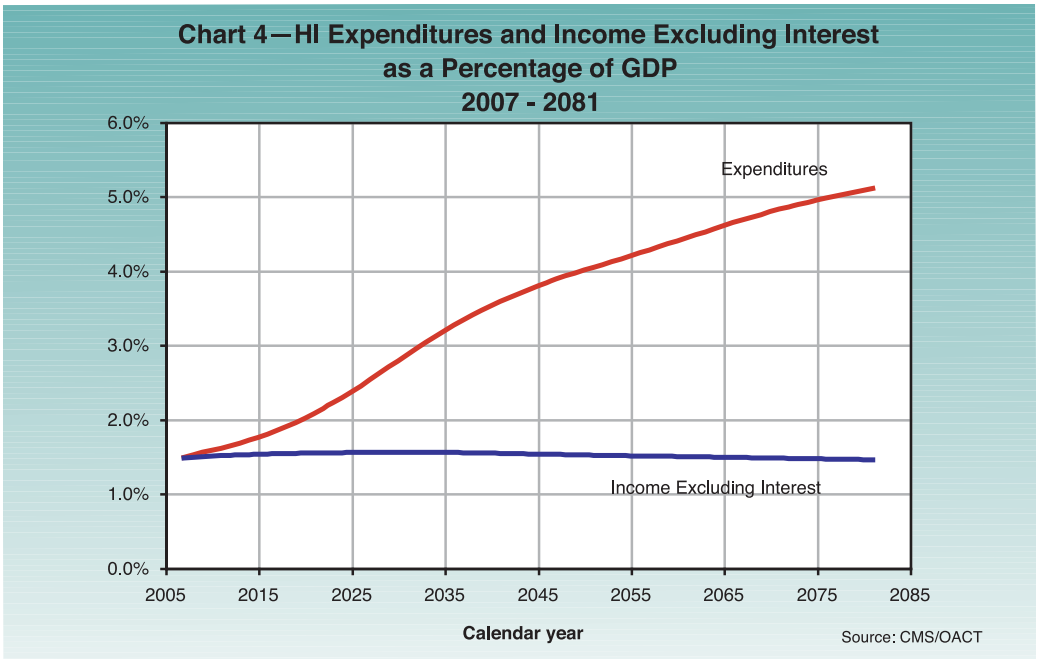
Since HI payroll tax rates are not scheduled to change in the future under present law, payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. Income from taxation of benefits will increase only gradually as a greater proportion of Social Security beneficiaries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

## HI and SMI Cashflow as a Percentage of GDP

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

### *HI*

Chart 4 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2006, the expenditures were $191.9 billion, which was 1.4 percent of GDP. This percentage is projected to increase steadily throughout the remainder of the 75-year period.



## SMI

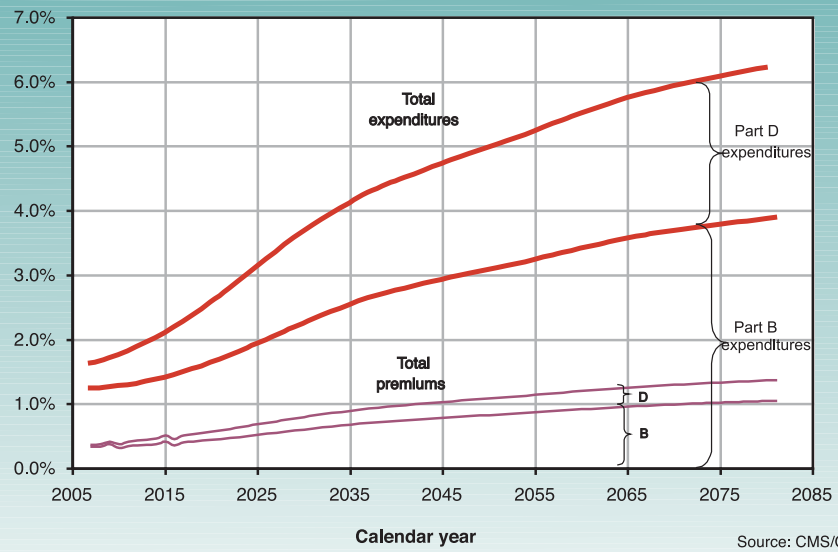
Because of the Part B and D financing mechanism in which income mirrors expenditures, it is not necessary to test for long-range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and Federal 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 last year's Trustees Report. This refinement provides a more gradual transition from current health cost growth rates to the ultimate assumed level of GDP plus zero percent just after the 75th year and for the indefinite future. The growth rates are estimated year by year for the next 12 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 13 to 25 is assumed to grade smoothly into the long-range assumption.

Under the intermediate assumptions, annual SMI expenditures were $216.4 billion, or about 1.6 percent of GDP, in 2006. Then, in about 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 Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the State payments are also expected to increase faster than GDP.

**Chart 5—SMI Expenditures and Premiums as a Percentage of GDP 2007 - 2081**

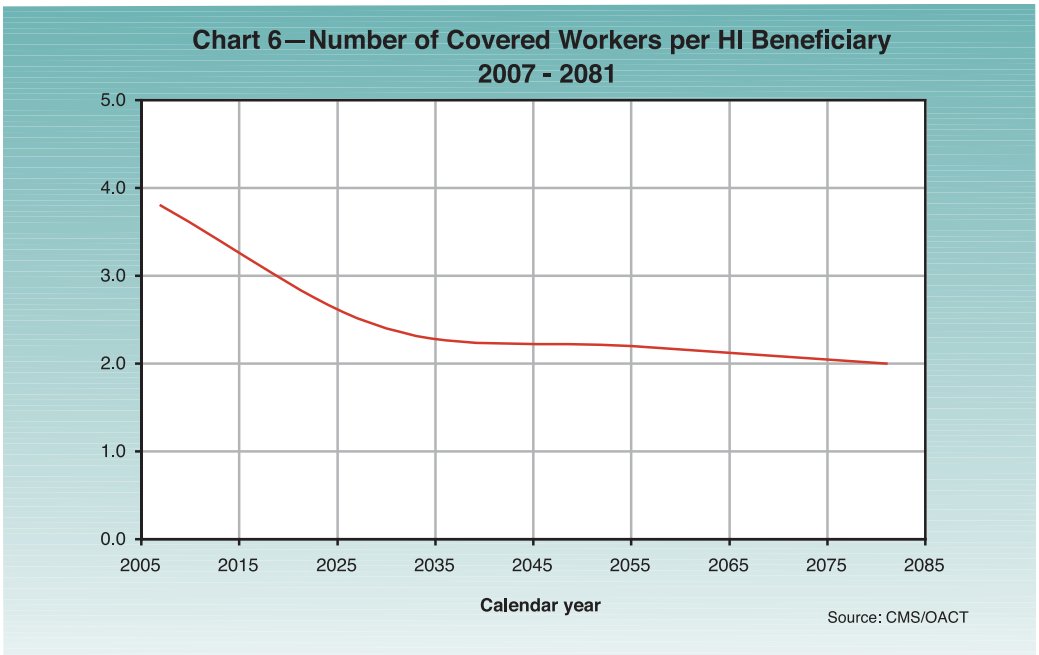



Source: CMS/OACT

## 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 2006, every beneficiary had 3.9 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.4 workers per beneficiary. The projected ratio continues to decline until there are just 2.0 workers per beneficiary by 2081.




# SENSITIVITY ANALYSIS

In order to make projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that both trust funds will continue under present law. In addition, the estimates depend on many economic and demographic assumptions (which are summarized on page 61 of this financial statement). Because of revisions to these assumptions, due to either changed conditions or updated information, estimates sometimes change substantially compared to those made in prior years. Furthermore, it is important to recognize that actual conditions are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty.

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

values and net cashflows.[6] The assumptions varied are the health care cost factors, fertility rate, net immigration, real-wage differential, (CPI), and real-interest rate.[7]

For this analysis, the intermediate economic and demographic assumptions in the ***2007 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, 2007 and are based on estimates of income and expenditures during the 75-year projection period.

Charts 7 through 12 show the net annual HI cashflow in nominal dollars and the present value of this net cashflow for each assumption varied.[8] In most instances, the charts depicting the estimated net cashflow indicate that, after increasing in the early years, net cashflow decreases steadily through 2081 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 for the annual growth rate in the aggregate cost of providing covered health care services to beneficiaries. These assumptions are that the ultimate annual growth rate in such costs, relative to taxable payroll, will be 1 percent slower than the intermediate assumptions, the same as the intermediate assumptions, and 1 percent faster than the intermediate assumptions. In each case, the taxable payroll will be the same as that which was assumed for the intermediate assumptions.

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

| Annual cost/payroll relative growth rate | -1 percentage point | Intermediate assumptions | + 1 percentage point |
|---|---|---|---|
| Income minus expenditures *(in billions)* | -$5,053 | -$12,292 | -$24,051 |

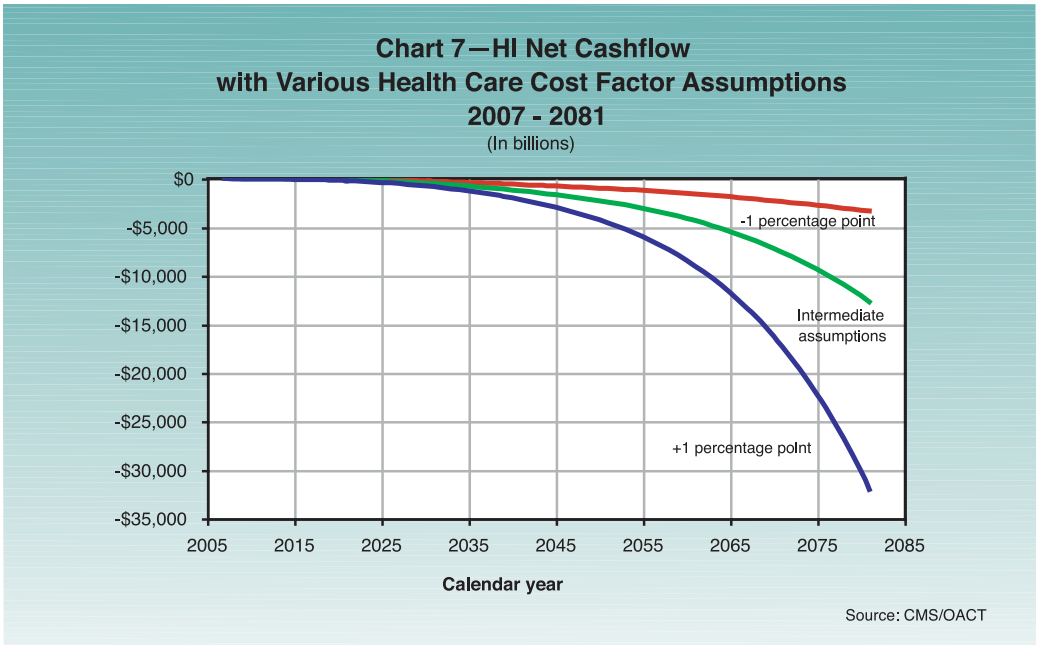
Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $7,240 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases more substantially, by $11,758 billion.

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

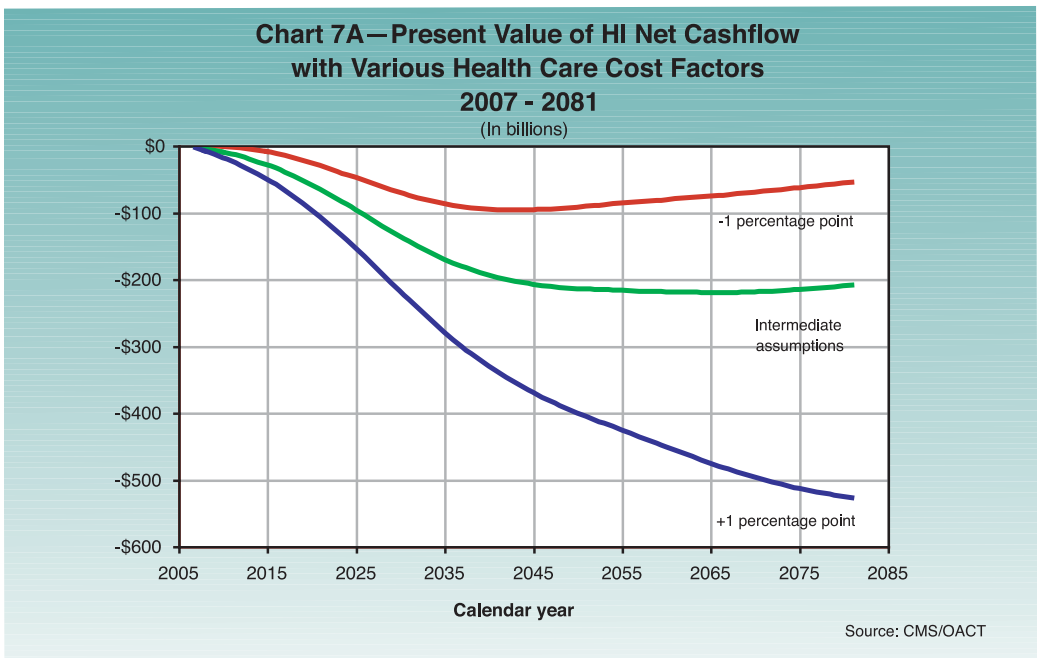
[7] The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures.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

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

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




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



## Fertility Rate

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

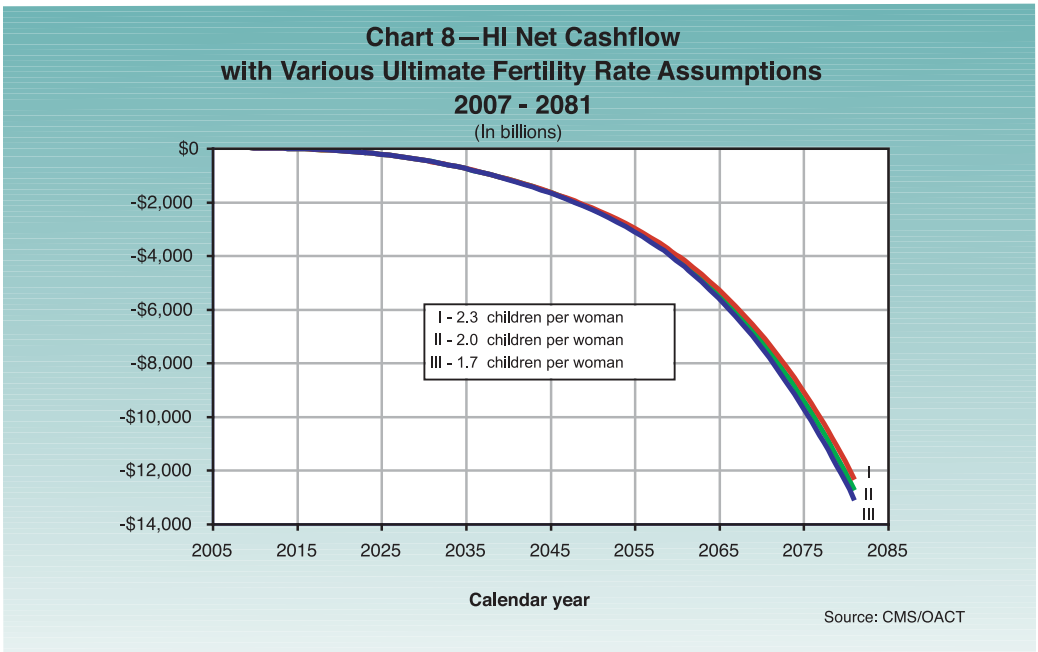
**TABLE 2**
**Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions**

| Ultimate fertility rate[1] | 1.7 | 2.0 | 2.3 |
|---|---|---|---|
| Income minus expenditures *(in billions)* | -$12,503 | -$12,292 | -$12,091 |

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

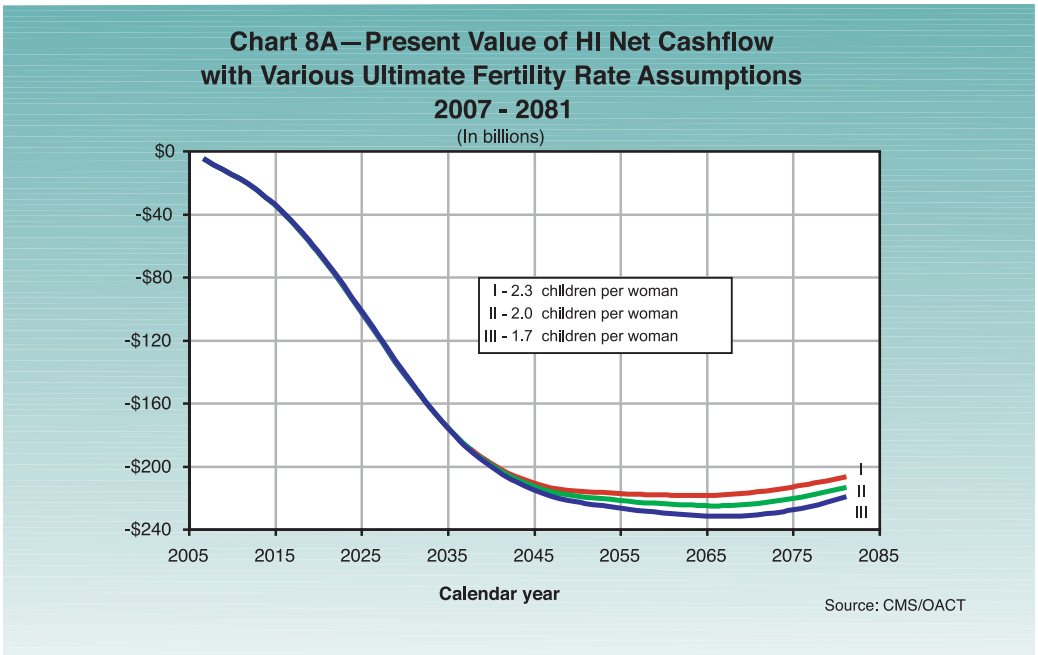
As table 2 demonstrates, for an increase of 0.3 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $205 billion.

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 ultimate annual net immigration assumptions: 672,500 persons, 900,000 persons, and 1,300,000 persons per year.

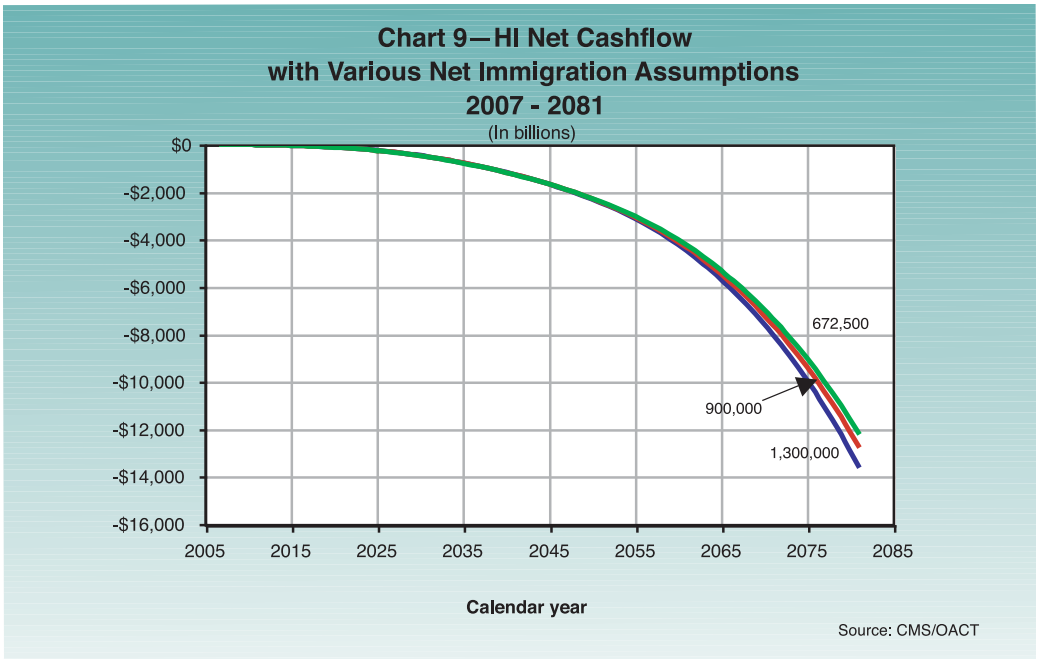
**TABLE 3**
**Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions**

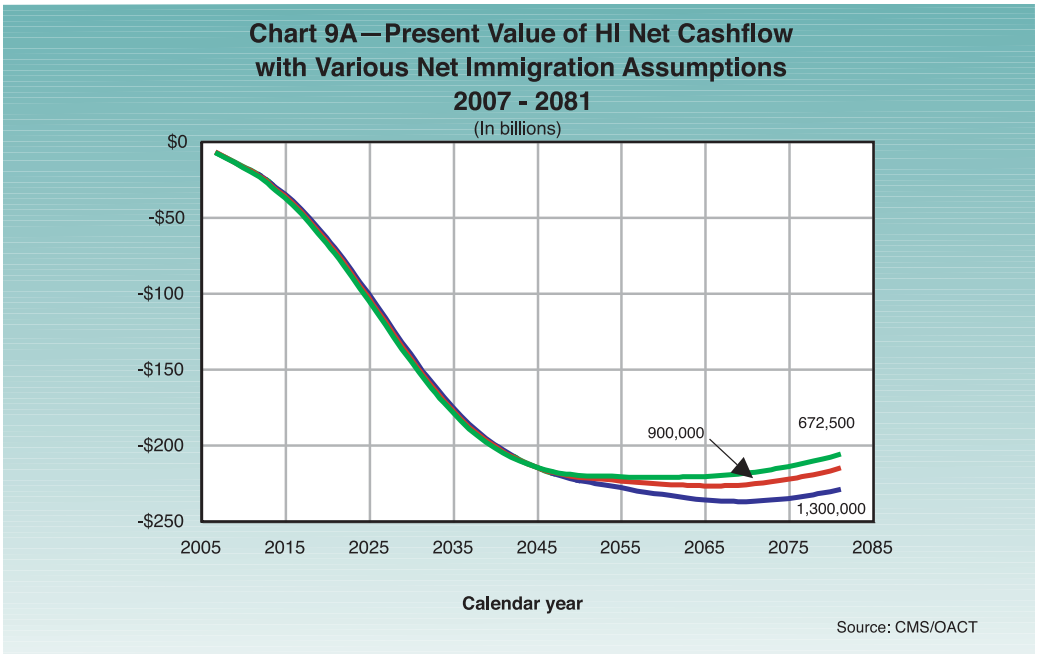
| Ultimate net immigration | 672,500 | 900,000 | 1,300,000 |
|---|---|---|---|
| Income minus expenditures *(in billions)* | -$12,149 | -$12,292 | -$12,516 |

As shown in table 3, if the ultimate net immigration assumption is 672,500 persons, the deficit decreases by $144 billion. Conversely, if the ultimate net immigration assumption is 1,300,000 persons, the deficit increases by $224 billion.

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

As charts 9 and 9A indicate, this assumption has an impact on projected HI cashflow starting almost immediately. Because immigration tends to occur among those who work and pay taxes into the system, in the short term payroll taxes increase faster than




benefits; in the long term, however, the opposite occurs, as those individuals age and become beneficiaries in a period with much greater health care costs per beneficiary.

## Real-Wage Differential

Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential[9] assumptions: 0.6, 1.1, and 1.6

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

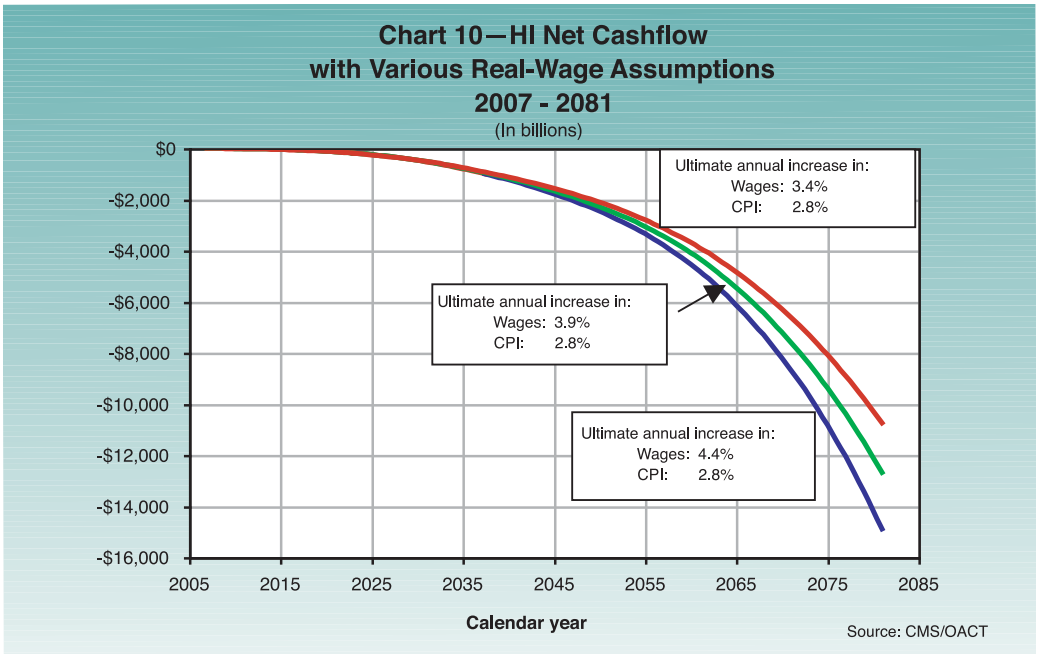
percentage points. In each case, the ultimate CPI-increase is assumed to be 2.8 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.4, 3.9, and 4.4 percent, respectively.

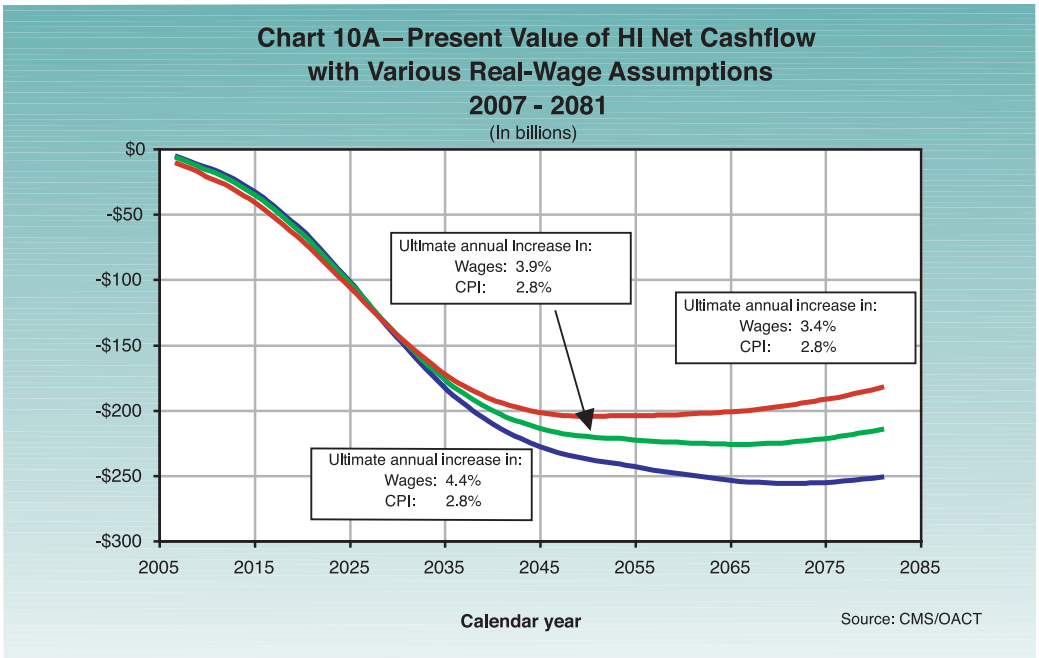
## TABLE 4
## Present Value of Estimated HI Income Less Expenditures under Various Real-Wage Assumptions

| | | | |
|---|---|---|---|
| Ultimate percentage increase in wages - CPI | 3.4 - 2.8 | 3.9 - 2.8 | 4.4 - 2.8 |
| Ultimate percentage increase in real-wage differential | 0.6 | 1.1 | 1.6 |
| Income minus expenditures *(in billions)* | -$11,290 | -$12,292 | -$13,517 |
| Income minus expenditures *(as a percentage of taxable payroll)* | -3.99% | -3.69% | -3.47% |

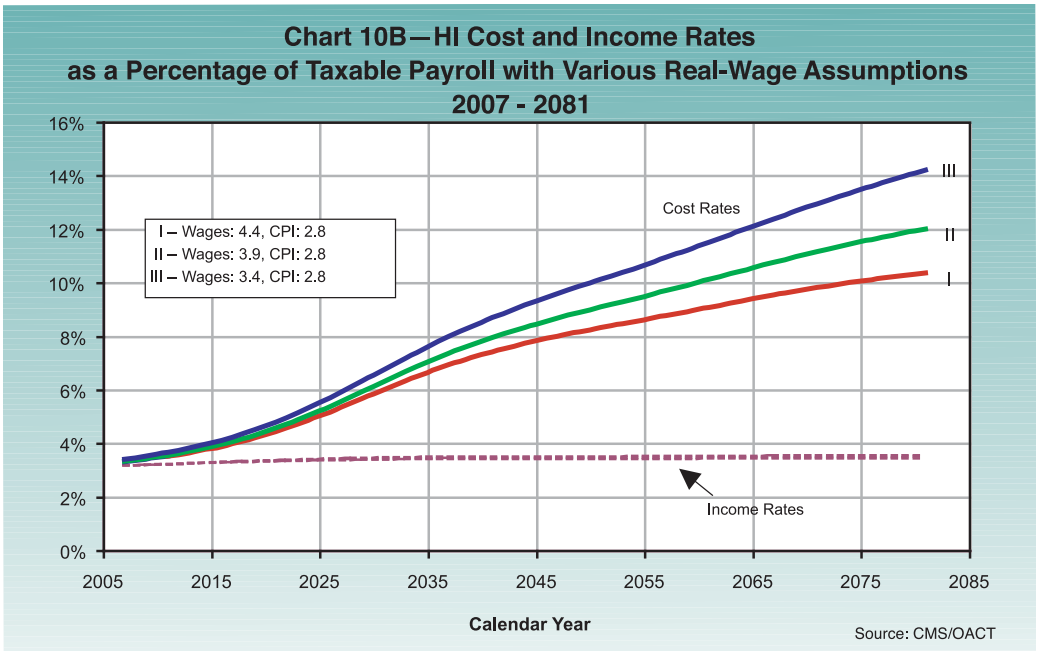
As indicated in table 4, for a half-point increase in the ultimate real wage differential assumption, the deficit—expressed in present-value dollars—increases by approximately $980 billion. In this instance, the results expressed in present-value dollars do not reveal the full implications of faster or slower growth in real wages. While the dollar amount of the trust fund deficit is lower, for a smaller real-wage differential, table 4 also indicates that the deficit represents a higher percentage of taxable payroll. In other words, with slower growth in real wages, a higher tax increase would be necessary to cover the corresponding HI trust fund deficit. In practice, slow growth in real wages worsens the financial status of the HI trust fund, and, conversely, rapid growth in real wages improves the fund's condition. The reasons for the apparent inconsistency between the present-value and taxable-payroll measures are described below.

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






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



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

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

## Consumer Price Index

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

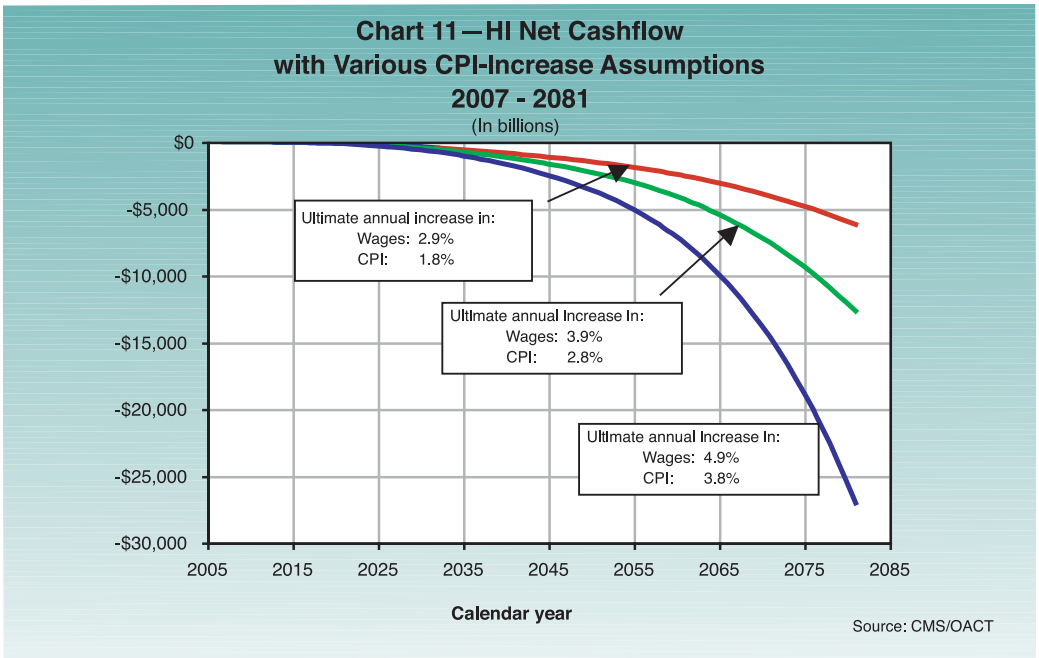
### TABLE 5
### Present Value of Estimated HI Income Less Expenditures under Various CPI-Increase Assumptions

| | | | |
|---|---|---|---|
| Ultimate percentage increase in wages - CPI | 2.9 - 1.8 | 3.9 - 2.8 | 4.9 - 3.8 |
| Income minus expenditures *(in billions)* | -$11,699 | -$12,292 | -$12,605 |

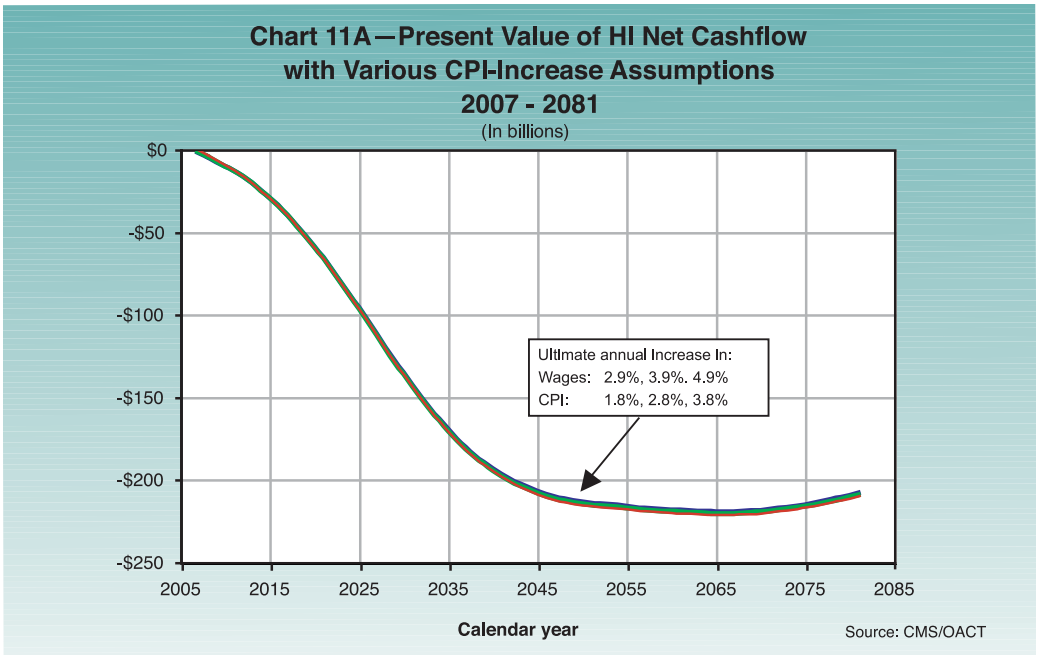
Table 5 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit decreases by $63 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit increases by only $6 billion.

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

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




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



## Real-Interest Rate

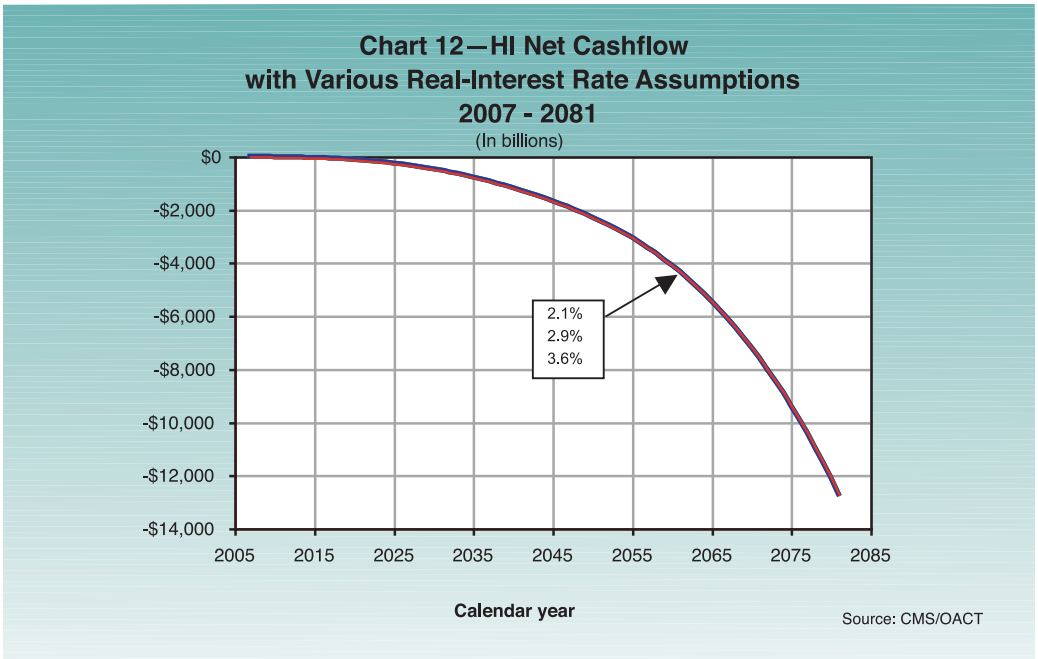
Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-interest assumptions: 2.1, 2.9, and 3.6 percent. In each case, the ultimate annual increase in the CPI is assumed to be 2.8 percent, resulting in ultimate nominal annual yields of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

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

| Ultimate real-interest rate | 2.1 percent | 2.9 percent | 3.6 percent |
|---|---|---|---|
| Income minus expenditures *(in billions)* | -$17,269 | -$12,292 | -$9,264 |

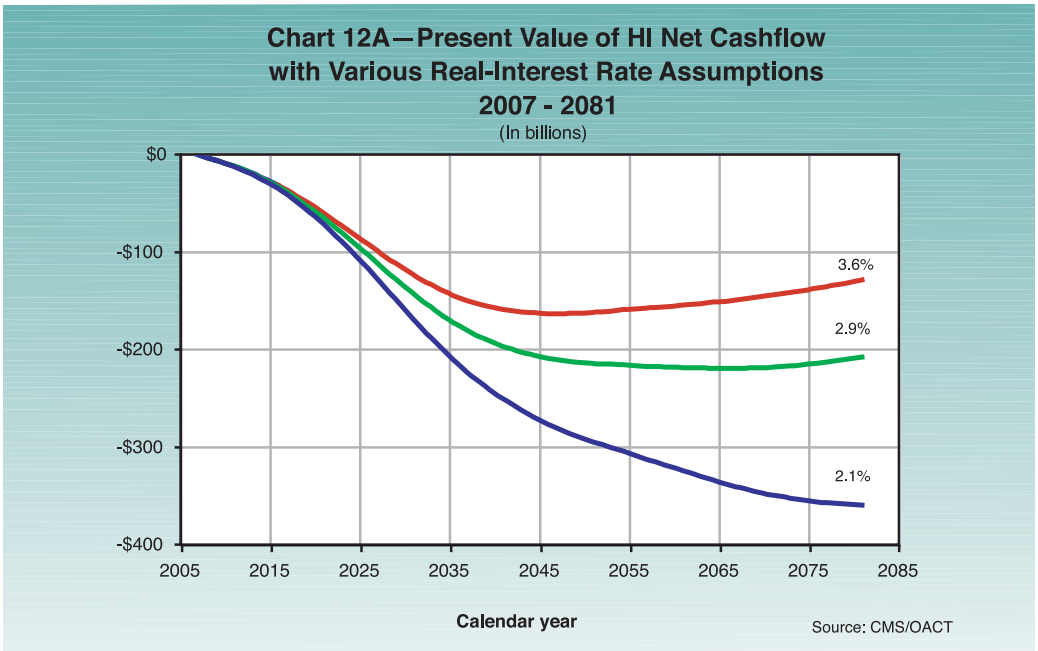
As illustrated in table 6, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $530 billion.

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




As shown in charts 12 and 12A, the projected HI cashflow when expressed in present values is more sensitive to the interest assumption than when it is expressed in nominal dollars. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI trust fund, because under the intermediate assumptions, the fund is projected to be relatively low and exhausted by

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, the same as was estimated in last year's report. Income from all sources is projected to exceed expenditures for only the next 3 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. In practice, Congress has never allowed a Medicare or Social Security trust fund to become fully depleted.

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

## SMI

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

The financing established for the Part B account for calendar year 2007 is adequate to cover 2007 expected expenditures and to restore the financial status of the Part B account in 2007 to a satisfactory level. Because the net trust fund ratio would still be at the lower end of the desirable range, the Part B financing rates for 2008 would have to be increased slightly above the estimated expenditure increase.

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 MMA requires the Board of Trustees to determine whether the difference between Medicare outlays and "dedicated financing sources" is projected to exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2007– 2013).[10] This difference is projected to first exceed 45 percent of total expenditures in 2013, which is within the 7-year test period. Consequently, the Trustees issued a determination of projected "excess general revenue Medicare funding," as required by law. A similar determination was made in their 2006 annual report to Congress. Under the MMA, these two consecutive determinations trigger a "Medicare funding warning," indicating that the general revenues provided to Medicare under current law are becoming a substantial proportion of total program costs. This finding requires the President to submit to Congress, within 15 days after the release of the next budget, proposed legislation to respond to the warning.[11] Congress is then required to consider this legislation on an expedited basis. This new requirement will help call attention to Medicare's impact on the Federal Budget.

The projections shown in this section continue to demonstrate the need for the Administration and the Congress to address the financial challenges facing Medicare—both the long-range financial imbalance facing the HI trust fund and the heightened problem of rapid growth in expenditures. In their 2007 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."

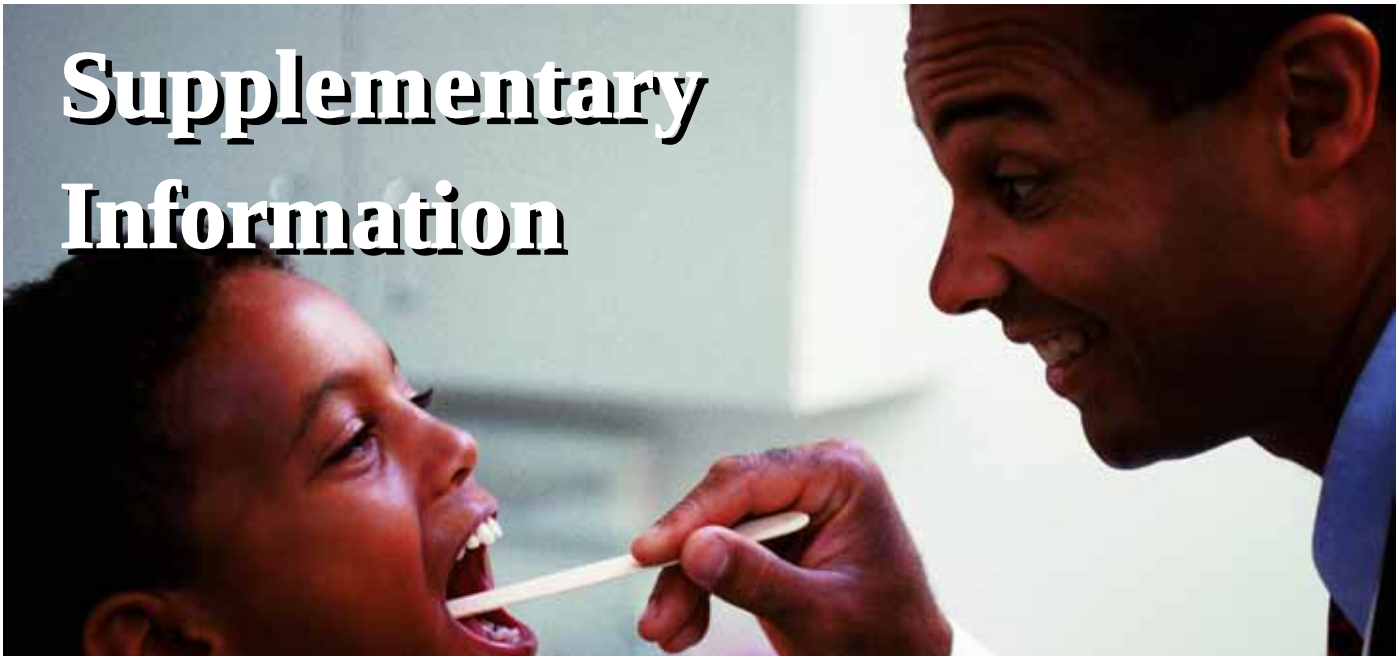
[10] Dedicated Medicare financing sources include HI payroll taxes; income from taxation of Social Security benefits; State transfers for the prescription drug benefit; premiums paid under Parts A, B, and D; and any gifts received by the Medicare trust funds.

[11] The next such budget submission will be the President's Fiscal Year 2009 Budget, which will be released in early February 2008.

# COMBINING STATEMENT OF BUDGETARY RESOURCES
## For the Year Ended September 30, 2007

*(in millions)*

| | MEDICARE | | Payments to | | | Medicare | All | Combined |
|---|---|---|---|---|---|---|---|---|
| | HI TF | SMI TF | Trust Funds | Medicaid | SCHIP | Part D | Others | Totals Budgetary |
| **Budgetary Resources:** | | | | | | | | |
| Unobligated balance, brought forward, October 1: | | | $27,658 | $26,486 | $1,237 | $1 | $888 | $56,270 |
| Recoveries of prior year unpaid obligations | $168 | $485 | | 13,899 | 413 | 543 | 464 | 15,972 |
| Budget authority: | | | | | | | | |
| Appropriation | 222,844 | 187,674 | 199,309 | 168,255 | 5,690 | 51,429 | 1,810 | 837,011 |
| Spending authority from offsetting collections: | | | | | | | | |
| Earned | | | | | | | | |
| Collected | | | | | | | 221 | 221 |
| Change in receivables from Federal sources | | | | | | | | |
| Change in unfilled customer orders: | | | | | | | | |
| Advance received | | | | | | | (58) | (58) |
| Without advance from Federal sources | | | | | | | 63 | 63 |
| Previously unavailable | | | | | | | | |
| Expenditure transfers from trust funds | | | | 359 | | | 3,187 | 3,546 |
| **SUBTOTAL** | **222,844** | **187,674** | **199,309** | **168,614** | **5,690** | **51,429** | **5,223** | **840,783** |
| Nonexpenditure transfers, net, anticipated & actual | (8,614) | 8,036 | | (2,805) | | 425 | | (2,958) |
| Temporarily not available pursuant to Public Law | (8,190) | (12,603) | | | | | | (20,793) |
| Permanently not available | (22) | (37) | (27,247) | | (585) | | (17) | (27,908) |
| **TOTAL BUDGETARY RESOURCES** | **$206,186** | **$183,555** | **$199,720** | **$206,194** | **$6,755** | **$52,398** | **$6,558** | **$861,366** |
| **Status of Budgetary Resources:** | | | | | | | | |
| Obligations incurred: | | | | | | | | |
| Direct | $206,172 | $183,543 | $190,743 | $202,378 | $5,941 | $51,972 | $5,263 | $846,012 |
| Reimbursable | 1 | | | | | | 193 | 194 |
| **SUBTOTAL** | **206,173** | **183,543** | **190,743** | **202,378** | **5,941** | **51,972** | **5,456** | **846,206** |
| Unobligated balance: | | | | | | | | |
| Apportioned | | | 8,977 | 3,644 | 34 | | 962 | 13,617 |
| Unobligated balance not available | 13 | 12 | | 172 | 780 | 426 | 140 | 1,543 |
| **TOTAL STATUS OF BUDGETARY RESOURCES** | **$206,186** | **$183,555** | **$199,720** | **$206,194** | **$6,755** | **$52,398** | **$6,558** | **$861,366** |
| **Change in Obligated Balance:** | | | | | | | | |
| Obligated balance, net: Unpaid obligations, brought forward, October 1 | $21,041 | $19,495 | | $19,183 | $4,908 | $3,122 | $3,085 | $70,834 |
| Uncollected customer payments from Federal sources, brought forward, October 1 | | | | | | | (1,432) | (1,432) |
| Total unpaid obligated balance, net | 21,041 | 19,495 | | 19,183 | 4,908 | 3,122 | 1,653 | 69,402 |
| Obligations incurred, net | 206,173 | 183,543 | $190,743 | 202,378 | 5,941 | 51,972 | 5,456 | 846,206 |
| Gross Outlays | (206,574) | (183,039) | (190,743) | (188,247) | (6,000) | (50,146) | (5,337) | (830,086) |
| Obligated balance transferred, net: | | | | | | | | |
| Recoveries of prior year unpaid obligations, actual | (168) | (485) | | (13,899) | (413) | (543) | (464) | (15,972) |
| Change in uncollected customer payments from Federal sources | | | | | | | (353) | (353) |
| Obligated balance, net, end of period: | | | | | | | | |
| Unpaid obligations | 20,473 | 19,514 | | 19,415 | 4,436 | 4,405 | 2,740 | 70,983 |
| Uncollected customer payments from Federal sources | (1) | | | | | | (1,785) | (1,786) |
| Total, unpaid obligated balance, net, end of period | 20,472 | 19,514 | | 19,415 | 4,436 | 4,405 | 955 | 69,197 |
| **Net Outlays:** | | | | | | | | |
| **Net Outlays** | | | | | | | | |
| Gross outlays | 206,574 | 183,039 | 190,743 | 188,247 | 6,000 | 50,146 | 5,337 | 830,086 |
| Offsetting collections | | | | (359) | | | (3,060) | (3,419) |
| Distributed offsetting receipts | (19,086) | (237,023) | | | | | (95) | (256,204) |
| **NET OUTLAYS** | **$187,488** | **$(53,984)** | **$190,743** | **$187,888** | **$6,000** | **$50,146** | **$2,182** | **$570,463** |



# Supplementary Information

## CONSOLIDATING BALANCE SHEET
## As of September 30, 2007
*(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 | $38 | $8,755 | $8,793 | $23,223 | $5,250 | $1,739 | $39,005 | | $39,005 |
| Earmarked Investments | 323,467 | 39,728 | 363,195 | | | | 363,195 | | 363,195 |
| Accounts Receivable, Net | 21,310 | 32,380 | 53,690 | 121 | 3 | 13 | 53,827 | $(53,343) | 484 |
| **Total Intragovernmental Assets** | **344,815** | **80,863** | **425,678** | **23,344** | **5,253** | **1,752** | **456,027** | **(53,343)** | **402,684** |
| Cash & Other Monetary Assets | 14 | 115 | 129 | | | | 129 | | 129 |
| Accounts Receivable, Net | 826 | 10,518 | 11,344 | 1,447 | | 17 | 12,808 | | 12,808 |
| General Property, Plant & Equipment, Net | 147 | 245 | 392 | 32 | | | 424 | | 424 |
| Other Assets | 22 | 37 | 59 | 4 | | 98 | 161 | | 161 |
| **TOTAL ASSETS** | **$345,824** | **$91,778** | **$437,602** | **$24,827** | **$5,253** | **$1,867** | **$469,549** | **$(53,343)** | **$416,206** |
| **LIABILITIES** | | | | | | | | | |
| **Intragovernmental Liabilities:** | | | | | | | | | |
| Accounts Payable | $29,381 | $24,396 | $53,777 | | | $2 | $53,779 | $(53,343) | $436 |
| Accrued Payroll and Benefits | 1 | 3 | 4 | | | | 4 | | 4 |
| Other Intragovernmental Liabilities | 147 | 356 | 503 | $3 | | 24 | 530 | | 530 |
| **Total Intragovernmental Liabilities** | **29,529** | **24,755** | **54,284** | **3** | | **26** | **54,313** | **(53,343)** | **970** |
| Accounts Payable | | | | | | | | | |
| Federal Employee & Veterans' Benefits | 3 | 7 | 10 | 1 | | | 11 | | 11 |
| Entitlement Benefits Due & Payable | 19,410 | 22,194 | 41,604 | 19,414 | $289 | 163 | 61,470 | | 61,470 |
| Accrued Payroll & Benefits | 15 | 36 | 51 | 4 | | | 55 | | 55 |
| Other Liabilities | 1,878 | 866 | 2,744 | 1,702 | | 54 | 4,500 | | 4,500 |
| **TOTAL LIABILITIES** | **50,835** | **47,858** | **98,693** | **21,124** | **289** | **243** | **120,349** | **(53,343)** | **67,006** |
| **NET POSITION** | | | | | | | | | |
| Unexpended Appropriations—earmarked funds | | 8,978 | 8,978 | | | | 8,978 | | 8,978 |
| Unexpended Appropriations—other funds | | | | 3,565 | 4,960 | 1,364 | 9,889 | | 9,889 |
| Cumulative Results of Operations—earmarked funds | 294,989 | 34,942 | 329,931 | | | | 329,931 | | 329,931 |
| Cumulative Results of Operations—other funds | | | | 138 | 4 | 260 | 402 | | 402 |
| **TOTAL NET POSITION** | **$294,989** | **$43,920** | **$338,909** | **$3,703** | **$4,964** | **$1,624** | **$349,200** | | **$349,200** |
| **TOTAL LIABILITIES & NET POSITION** | **$345,824** | **$91,778** | **$437,602** | **$24,827** | **$5,253** | **$1,867** | **$469,549** | **$(53,343)** | **$416,206** |

# SUPPLEMENTARY INFORMATION

## CONSOLIDATING STATEMENT OF NET COST
## For the Year Ended September 30, 2007
*(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) | $208,686 | $158,865 | $367,551 | | | | $367,551 |
| Medicaid | | | | $187,940 | | | 187,940 |
| SCHIP | | | | | $6,010 | | 6,010 |
| **NET COST—GPRA PROGRAMS** | **208,686** | **158,865** | **367,551** | **187,940** | **6,010** | | **561,501** |
| **Other Activities** | | | | | | | |
| CLIA | | | | | | $(18) | (18) |
| State Grants & Demonstrations | | | | | | 455 | 455 |
| **NET COST—OTHER ACTIVITIES** | | | | | | **437** | **437** |
| **NET COST OF OPERATIONS** | **$208,686** | **$158,865** | **$367,551** | **$187,940** | **$6,010** | **$437** | **$561,938** |

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

| | MEDICARE (Earmarked) | | | HEALTH (Other Funds) | | | Consolidated |
|---|---|---|---|---|---|---|---|
| | HI TF | SMI TF | Total | Medicaid | SCHIP | Other Health | Total |
| **CUMULATIVE RESULTS OF OPERATIONS** | | | | | | | |
| **Beginning Balances** | $287,819 | $14,034 | $301,853 | $126 | $3 | $184 | $302,166 |
| **Budgetary Financing Sources:** | | | | | | | |
| Appropriations Used | 11,562 | 179,181 | 190,743 | 187,368 | 6,005 | 512 | 384,628 |
| Nonexchange Revenue: | | | | | | | |
| FICA and SECA Taxes | 187,992 | | 187,992 | | | | 187,992 |
| Interest on Earmarked Trust Fund Investments | 16,285 | 2,084 | 18,369 | | | | 18,369 |
| Other Nonexchange Revenue | 221 | 16 | 237 | | | | 237 |
| Transfers-in/out Without Reimbursement | (211) | (1,526) | (1,737) | 582 | 6 | 1 | (1,148) |
| **Other Financing Sources (Nonexchange):** | | | | | | | |
| Transfers-out Without Reimbursement | | (1) | (1) | | | | (1) |
| Imputed Financing | 7 | 19 | 26 | 2 | | | 28 |
| **TOTAL FINANCING SOURCES** | **215,856** | **179,773** | **395,629** | **187,952** | **6,011** | **513** | **590,105** |
| **NET COST OF OPERATIONS** | **208,686** | **158,865** | **367,551** | **187,940** | **6,010** | **437** | **561,938** |
| **NET CHANGE** | **7,170** | **20,908** | **28,078** | **12** | **1** | **76** | **28,167** |
| **CUMULATIVE RESULTS OF OPERATIONS** | **$294,989** | **$34,942** | **$329,931** | **$138** | **$4** | **$260** | **$330,333** |
| **UNEXPENDED APPROPRIATIONS** | | | | | | | |
| **Beginning Balances** | $33 | $27,625 | $27,658 | $25,483 | $5,860 | $1,178 | $60,179 |
| **Budgetary Financing Sources:** | | | | | | | |
| Appropriations Received | $11,562 | 187,747 | 199,309 | $168,255 | 5,690 | 698 | 373,952 |
| Appropriations Transferred-in/out | | | | (2,805) | | | (2,805) |
| Other Adjustments | (33) | (27,213) | (27,246) | | (585) | | (27,831) |
| Appropriations Used | (11,562) | (179,181) | (190,743) | (187,368) | (6,005) | (512) | (384,628) |
| **TOTAL BUDGETARY FINANCING SOURCES** | **(33)** | **(18,647)** | **(18,680)** | **(21,918)** | **(900)** | **186** | **(41,312)** |
| **TOTAL UNEXPENDED APPROPRIATIONS** | | **8,978** | **8,978** | **3,565** | **4,960** | **1,364** | **18,867** |
| **NET POSITION** | **$294,989** | **$43,920** | **$338,909** | **$3,703** | **$4,964** | **$1,624** | **$349,200** |

# Audit Opinion

**Department of Health and Human Services**

# CENTERS FOR MEDICARE & MEDICAID SERVICES

NOV - 9 2007

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

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

**SUBJECT:** Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2007 (A-17-07-02007)

This memorandum transmits the independent auditors' reports on the fiscal year (FY) 2007 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, 2007 and 2006, and the related consolidated statements of net cost, changes in net position, the combined statements of budgetary resources for the years then ended, and the statement of social insurance as of January 1, 2007. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in the "Government Auditing Standards," issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 07-04, Audit Requirements for Federal Financial Statements.

**Results of Independent Audit**

Based on its audit, PwC found that the FYs 2007 and 2006 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, 2007, PwC noted certain matters involving internal control and its operation that we consider to be significant deficiencies, of which one is considered to be a material weakness under standards issued by the American Institute of Certified Public Accountants. Specifically, PwC reported a material weakness regarding CMS's Medicare claim-processing controls.

The weakness related primarily to direct update access to Medicare claim data, controls over edit settings in application systems, controls over the use of supplemental software used to process

claims, and lack of CMS oversight. The audit noted that a significant number of Medicare contractor employees had been granted direct access to Medicare claim data but did not require access to perform their job responsibilities. Such access did not undergo comprehensive review or consistent logging. In addition, management could not provide reports to document the volume and nature of claims that bypassed the Common Working File application, and controls over changes to edits and proper edit settings were not always in use at selected contractors. Further, numerous contractors did not comply with established CMS processes for using supplemental software, including methods to establish, test, peer-review, and approve the software. Lastly, CMS lacked sufficient processes and procedures to track compliance with requirements for claim-processing controls.

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 07-04.

**Evaluation and Monitoring of Audit Performance**

We reviewed the audit of the CMS financial statements by:

- evaluating the independence, objectivity, and qualifications of the auditors and specialists;
- reviewing the approach and planning of the audits;
- attending key meetings with auditors and CMS officials;
- monitoring the progress of the audit;
- examining audit documentation related to the review of internal controls over financial reporting;
- reviewing the auditors' reports; and
- reviewing the CMS Management Discussion and Analysis, Financial Statements and Footnotes, and Supplementary Information.

PwC is responsible for the attached auditors' reports dated November 9, 2007, 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 U.S. generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Joseph E. Vengrin, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at Joseph.Vengrin@oig.hhs.gov. Please refer to report number A-17-07-02007.

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 as of September 2007 and 2006, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the years then ended, and the statements of social insurance as of January 1, 2007 and 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 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. 07-04, *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 provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above, present fairly, in all material respects, the financial position of CMS at 2007 and 2006, and its net cost of operations, changes in net position and budgetary resources for the years then ended and its social insurance program as of January 1, 2007 and 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 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.

As discussed in Note 15 to the financial statements, the statements of social insurance present the actuarial present value of the CMS's Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds' estimated future income to be received from or on behalf of the participants and estimated future expenditures to be paid to or on behalf of the participants during a projection period sufficient to illustrate long-term sustainability of the social insurance program. In preparing the statements of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statements. However, because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the SMI Part D projections have an added uncertainty in that they were prepared using very little program data upon which to base the estimates.

As discussed in Note 16 to the financial statements, the projected SMI Part B expenditure growth reflected in the statement of social insurance as of January 1, 2007 (the "2007 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 41 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 2007 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 five 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 2007 SOSI. In Note 16, management has illustrated the potential effects using two hypothetical examples of changes to current law. Under current law and as presented in the 2007 SOSI, the projected 75-year present value of future Part B expenditures is $18.2 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 $22.6 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 $25.4 trillion. Management's hypothetical examples have not been audited, and accordingly, we express no opinion on them.

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.

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

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

In accordance with *Government Auditing Standards,* we have also issued a report dated November 9, 2007 on our consideration of the CMS's internal control and a report dated November 9, 2007 on its compliance and other matters for the year ended 2007. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audits.

PricewaterhouseCoopers LLP

November 9, 2007

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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 financial statements of the Centers for Medicare and Medicaid Services (CMS) as of and for the year ended September 30, 2007 and the statement of social insurance for the year ended January 1, 2007, and have issued our report dated November 9, 2007. 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. 07-04*, 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 laws and regulations including laws governing the use of budgetary authority, laws, regulations, and government-wide policies identified in Appendix E of OMB Bulletin No. 07-04 and other laws, noncompliance with which could have a direct and material effect of the determination of financial statement amounts. 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 the provisions of law and regulation cited in the second paragraph of this report. 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 compliance with the laws and regulations described in the second paragraph of this report disclosed instances of noncompliance with the following laws and regulations or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 07-04, as described below.

The Improper Payments Information Act (IPIA) of 2002 requires Federal agencies to identify the program and activities that may be susceptible to significant improper payments and estimate the amount of the improper payments. CMS has begun to implement the requirements

of IPIA, but has not yet completed its implementation of a process to fully estimate improper payments. Although CMS has not complied with IPIA, it has implemented a process that measures the payment accuracy rates for the Medicare fee-for-service program.

The results of our tests of CMS's compliance with FFMIA requirements disclosed, as described below, that CMS is not in substantial compliance with the requirements of FFMIA section 803(a).

In our report on internal control dated November 9, 2007, we reported a material weakness related to Medicare Claims Processing Controls and significant deficiencies related to Financial Reporting Systems and Processes and Controls Over Trust Fund Draws. We believe these matters, taken together, represent substantial non-compliance with FFMIA requirements. In addition, though operational at some of the Medicare Contractors, CMS has not yet completed the implementation of the HIGLAS general ledger system and as a result is not compliant with the US Government Standard General Ledger at the transaction level. Further details surrounding these findings, together with our recommendations for corrective action, have been reported separately to CMS in our report on internal control dated November 9, 2007.

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 9, 2007

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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 financial statements of the Centers for Medicare & Medicaid Services (CMS) as of and for the year ended September 30, 2007 and the statement of social insurance for the year ended January 1, 2007, and have issued our report dated November 9, 2007. 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. 07-04*, Audit Requirements for Federal Financial Statements.* The management of CMS is responsible for maintaining effective internal control over financial reporting.

In planning and performing our audit, we considered CMS's internal control over financial reporting by obtaining an understanding of the design effectiveness of CMS's internal control, determining whether these controls had been placed in operation, assessing control risk, and performing tests of CMS's controls in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide an opinion on the internal controls. Accordingly, we do not express an opinion on the effectiveness of the CMS's internal control over financial reporting.

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 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 compliance with laws governing the use of budget authority, government-wide policies and laws identified in Appendix E of OMB Bulletin No. 07-04, and other laws and regulations that could have a direct and material effect on the 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.

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

A material weakness is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that a material misstatement of the financial statements will not be prevented or detected by CMS's internal control. Our consideration of internal control was for the limited purpose described in the second paragraph of this report and would not necessarily identify all deficiencies in internal control that might be significant deficiencies or material weaknesses. We noted certain matters, discussed below, involving the internal control and its operation that we consider to be significant deficiencies (of which one is considered to be material weakness).

While progress continues to be made by CMS, we have noted control weaknesses regarding Medicare claims processing, financial reporting systems and processes, statement of social insurance, controls over trust fund draws, and the oversight of Medicare managed care organizations, which are described below.

## Material Weakness

### Medicare Claims Processing Controls

**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. The internal control structure is inclusive of, but not limited to, automated controls. The internal control structure also includes monitoring controls over claims processing.

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 nine contractors and site visits to six 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 the Financial Accounting Control System (FACS), Health Plan Management System (HPMS), Medicare Advantage Prescription Drug System (MARx), Healthcare Integrated General Ledger Accounting System (HIGLAS), Medicaid Budget and Expenditure System (MBES), and Children Budget and Expenditure System (CBES).

We also conducted vulnerability reviews of network controls at six data center sites and CMS Central Office. Further, desktop-based audit procedures were conducted to review the high level management controls regarding direct access to claims data, control over edits within the FISS, MCS and VMS systems, and controls over software supplementing the FISS, MCS and VMS systems used to process Medicare claims. We noted some improvements in each of these 3 areas, which were first identified in FY 2006 or earlier audits, but the progress of these improvements was not sufficient enough to address the concerns expressed below.

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 Modernization Act. This evaluation program includes all eight key areas of FISMA: periodic risk assessments; policies and procedures to reduce risk; systems security plans; security awareness training; periodic testing and evaluation of the effectiveness of IT security policies and procedures; remedial activities, processes and reporting for deficiencies; incident detection, reporting and response; and continuity of operations for IT systems. We believe that 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 result of the financial statement audit or for which a SAS 70 was conducted.

In addition to the steps noted above, to address the material weakness conditions, CMS continues its programs to review the contractors through SAS 70 audits, an extensive contractor self-assessment program, and reporting process and greater central oversight by contractor management. Additionally, CMS 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, the

complexity of fee-for-service processing, the modernization of the claims processing applications and the ongoing contractor transition process related to the legislative mandate under MMA to competitively procure claims administration contractors to replace fiscal intermediaries and carriers by 2011. According to CMS officials, the CMS modernization program to centralize data processing and reduce the number of data centers 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 implementing significant changes to its claims administration contracting environment, which will result in consolidation and reduce the number of contractors and data centers.

**I. Direct Update Access to Medicare Claims Data**

For the direct update access to Medicare claims data control weakness, improvements were noted regarding the number of employees at contractors who had been granted access to directly change claims data, thereby bypassing application controls built into the FISS, MCS and VMS systems. Specifically, the audit showed that fewer employees generally had such access. This progress could be attributable in large measure to further guidance and information that CMS provided to contractors both in a series of briefings, and in writing via joint signature memoranda (JSM) and distributing white papers specifying in detail how to meet the requirement for users of the mainframe ACF2, RACF and Top Secret security packages.

Still, the audit noted significant numbers of contractor employees who had been granted direct access without consistent logging and review. The ability to directly change claims without comprehensive review provides no assurance that changes performed by such employees will result in proper claims payment. We consistently noted employees, particularly those at contractors using the MCS system, who had been granted inappropriate standing update access to Medicare data but who did not require direct access to data and application software programs to perform their job responsibilities. Further, activity was not logged and reviewed.

**II. Control Over Edit Settings in the FISS, VMS and MCS Application Systems**

For controls over edit settings in the FISS, VMS and MCS application systems, CMS management worked diligently during FY 2006 to establish workgroups to determine the proper settings for controlling edits within each of these three applications processing Medicare claims. Additionally, CMS issued a JSM to formally establish procedures to report and control changes to edits in these systems.

During FY 2007, our audit noted general compliance and improvement with the FISS mandated edits (when claims are processed within the common working file software), and the VMS mandated edits. However, our audit noted exceptions at selected contractors. Moreover, we noted that the JSM procedures and CMS suggested workgroup settings for MCS were not correct for numerous edits resulting in incorrect edit setting at contractors.

Additionally, we noted that CMS management could not provide reports to document the volume and nature of claims bypassing the CWF application. Approximately 2,000 edits were not enforced within the FISS application because the edits were redundant in the CWF application. The inability to determine the number of claims bypassing CWF does not allow management to understand the effect of claims not subjected to CWF edits. Thousands of edit controls were built into the Medicare claims processing applications to enforce consistency over claims processing.
The ability of claims to bypass application edit controls may result in inconsistent and uncertain claims processing leading to payment inaccuracies.

**III. Controls Governing the Use of Supplemental Software Used to Process Claims**

We noted a lack of controls with respect to software supplementing the FISS, MCS and VMS systems used to process Medicare claims. The inability of the FISS, MCS and VMS claims processing application systems to efficiently process all Medicare claims types has caused CMS contractors to develop additional programs to effectively process claims. These additional systems, sometimes referred to as automated adjudication systems (AAS), were developed to automate the handling of claims that could not be processed by the standard claims processing applications without human intervention. AAS programs are developed and used independent of the standard application systems to process valid claims rejected by the standard systems. During FY 2006, CMS management established formal control processes for the use of the AAS, including methods to establish, test, peer review and approve AAS programs prior to their use. Our testing noted issues at numerous contractors regarding compliance with these processes. AAS systems provide a powerful tool to process large volumes of Medicare claims rapidly, without human intervention. The use of such programs without the enforcement of strong controls could again result in inconsistent and uncertain claims processing leading to payment inaccuracies.

**IV. Lack of CMS Oversight**

For the areas of direct update access to Medicare claims data, control over edit settings in the FISS, VMS and MCS application systems, and controls over the use of supplemental software used to process claims into the FISS, VMS and MCS application systems, we observed that often CMS Central Office had issued guidance and requirements to address internal control concerns. In each of these areas, we noted instances where contractors simply did not implement the needed controls although they had been directed to do so. In some cases the contractor staff simply did not appear to understand what was needed, for example the direct access to data instructions are of necessity quite technical. In other cases, contractors on the verge of leaving the Medicare program may no longer have the same incentive to comply with requirements. Regardless, CMS lacks sufficient management processes and procedures in place to track compliance with its requirements and to assess the impact of exceptions and findings on the CMS financial statements.

**V. Other Matters**

Of lesser risk, our audit noted the following issues:

***Logical Access Controls***
Access controls ensure that critical system assets are physically protected from unauthorized access and that logical controls provide assurance that only authorized personnel may access data and programs maintained on systems. Besides the access control issues described in the "Direct Update Access to Medicare Claims Data" section, we noted that numerous contractors were not consistently recertifying user access to systems to ensure such access was needed for job requirements. We also noted that contractor management was not effectively performing reviews of violations for the FISS, MCS and VMS application systems. These security weaknesses could allow internal users to access and update sensitive systems, program parameters and data without proper authorization. Our review did not disclose any exploitation of critical systems tested; however, clear potential existed.

We also 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.

***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 again noted inconsistencies in logical security controls over various platforms at contractor sites. Although contractors have established configuration security standards for platforms such as the mainframe, WINDOWS and UNIX, such standards were not consistently established on these platforms and/or monitored to ensure they remained in effect. Of mention, we did not note significant issues at three of the data center locations we audited which shows progress by CMS compared to prior year audits. Guidance issued by CMS for the implementation of controls, configurations, and design of the mainframe OS/390 and z/OS may have contributed to this improvement.

**Recommendation**

During FY 2007, CMS management worked to establish and document consistent controls over the use of direct update access to claims data, control over edits within FISS, MCS and VMS and the use and control of AAS programs. However, the processes to consistently enforce these controls over twenty-eight contractor and thirteen data center locations remains challenging. Although, the controls have not been fully implemented, we encourage CMS management to continue their efforts to gain contractor support for full implementation of these controls. Effective management controls over the use of direct update access to claims, changes to edits within the three major Medicare application processing systems and AAS

programs is imperative to establish a reasonable range of comfort over the accuracy of Medicare claims processing.

Additionally, we recommend CMS management should:

- Establish a process to periodically review and test contractor reports of employees with direct update access to Medicare claims data. The testing should include steps to ensure such access is logged and reviewed by contractors.
- Establish ongoing workgroups to review FISS, MCS and VMS edits that should be turned on or off and establish processes to distribute quarterly the results of these reviews to the contractors to allow them to determine their compliance.
- Establish a formal review process to, on a selected and unannounced basis, obtain and review actual in use edit settings for the FISS, VMS and MCS systems running at the contractor sites.
- Use the results of bullet point three above to identify edit settings not in compliance with the recommended edit settings suggested by the workgroups. For edits not matching the workgroup recommendations, match these differences to error trends resulting from contractor claims processed during periods when edits are turned off (use CWFMQA report results). Document the results, including specific matching of error types to contractors from which the errors emanated, and follow-up with contractors. Alternatively, management may wish to research other methods to more efficiently identify and track errors for subsequent review with contractors.
- Establish reports to determine the volume and reason for claims bypassing the CWF application.
- Work with contractors and maintainers of the FISS, MCS, and VMS systems to ensure AAS programs such as SuperOps and SCF maintain complete audit trails and that changes to programs associated with these systems follow the rules outlined in CR 3011 for testing, peer review and approval.
- Continue to enhance processes for the recertification of contractor employee access and the review of violation reports for the FISS, MCS and VMS application systems.

## Significant Deficiencies

### I. Financial Reporting Systems and Processes

#### I.1. Coordination and 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. The lack of coordination led to the following:

**I.1.1** ***Prescription Drug Program Accrual***

In FY 2006, CMS implemented the Part D Drug Program. The implementation of the new program created an enormous challenge for the agency, not only on the programmatic side but also for accounting challenges, that continues today. CMS management continues to identify and implement processes and controls to enable the agency to reflect the accounting impact of this complex and challenging program within their financial statements.

Throughout the plan contract year (calendar year), CMS makes prospective payments to the Part D plans. In general, the payment amounts are based on information in the approved plan bids, which includes the plans' estimate of direct and indirect remuneration (DIR), and on data provided by CMS that updates payments throughout the year.

Subsequent to the contract year, CMS is required to reconcile the prospective Part D plan payments made during the year to actual drug costs incurred by the plans. Because the Part D program commenced operations in January 2006, the fiscal year ended September 2007 is the first year of the reconciliation. An accrual as of September 2007 was recorded on the books that included the contract year reconciliation (Calendar Year 2006) and estimated payable/receivables covering the fiscal year under audit.

In order to calculate the CY 2006 accruals, CMS developed a mechanism to obtain actual drug cost data from the plans, the Payment Reconciliation System (PRS), to automate the reconciliation process - including robust system documentation - and a SAS program to validate the calculation performed by the PRS system. The systems used to obtain actual drug data from the plans include edit checks that reject invalid data. In addition, management performs several outlier and analytical analyses to ensure the validity of the PRS results including analysis over the DIR amounts submitted by the plans.

The estimated accrual for the period of January 2007 to September 2007 was developed by actuarial analysis. CMS refined the methodology used during FY 2006 to better reflect the cyclical nature of the accrual, documented the methodology used to develop the estimate and retained appropriate evidence of the calculation.

The Part D reconciliation and accrual process, for all intended purposes, was a new process for CMS. This new process has not yet been fully developed and therefore; faced the following challenges during the current year.

- Validation of Actual Drug Costs and DIR
  CMS does not currently have a monitoring control in place to ensure the accuracy of the prescription drug data (PDEs) submitted by the plans which forms the basis for the reconciliation. CMS relies on the plans to certify the accuracy of this data. Unsupported or erroneous drug cost data submitted by the plans could lead to inaccuracies within the reconciliation and erroneous payments.

Similarly, CMS does not currently have monitoring controls in place to ensure the completeness and accuracy of the DIR information (commonly referred to as rebates). Management acknowledges the importance of complete and accurate DIR information due to the significant impact that it has on reimbursements to the plans.

- Timing of Estimate Development
  As of July 2007, CMS had not calculated the 2006 contract year reconciliation which would cover the period of January 2006 to December 2006, nor had CMS calculated the estimated accrual for the period of January 2007 to June 2007. The lack of timely calculation of the estimate resulted in inaccurate reporting within the interim financial statements.

- Documentation of the Estimation Process
  CMS documented the procedures used to develop the 2006 Part D reconciliation within their Part D cycle memo; however, procedures and related controls to develop the FY 2007 Part D estimate, including the estimate related to invalidly rejected PDE data, was not documented within this memo. The calculation of the FY 2007 estimate was based upon an actuarial analysis. The methodology used by CMS to develop this estimate was significantly different from what was used during the prior fiscal year. In addition, as of September 2007, the methodology used by management to develop the estimate related to invalidly rejected PDE data and related controls had not been documented.

  Although all the elements of the estimate were eventually documented, all relevant controls have not yet been documented. According to OMB Circular A-123 *Implementation Guide* the level of detail of documentation should ensure management understands the entire financial reporting process and can identify how processes relate to financial reporting assertions, potential errors or misstatements, and control objectives.

**I.1.2** ***Obsolete Reports/Lack of Data***

With the Contractors transition to HIGLAS, CMS no longer requires the contractors to report certain data. This data which was collected in the Fiscal Intermediary Benefit Payment Report (IBPR) via the Contractor Administrative Budget and Finance Management (CAFM) systems is no longer available for those contractors who have implemented HIGLAS, which resulted in the following:

- Impact on the Statement of Social Insurance (SOSI):
  The IBPR provided data used by CMS to develop aspects of the SOSI projection. A total of six SOSI data sources and one validation source previously provided by the IBPR are no longer reported by contractors who have transitioned to HIGLAS. CMS was able to find suitable replacements for 3 of the data sources; however; it has not yet identified an appropriate source of data for the remaining three sources and for the validation source. Although the lack of data sources does not pose a significant risk to the current year SOSI

calculation, because of the nature of the projection, the risk could increase on future projections.

- Entitlement Benefit Due and Payable Liability:
  The Entitlement Benefit Due and Payable Liability line item on the balance sheet is mainly composed of an estimate of claims incurred but not reported (IBNR). A key report used by CMS in the calculation of the IBNR liability is the National Claims History (NCH) processing report. Before this report is considered reliable and appropriate for use, management performs certain analytical procedures between the data in the report and data obtained from CMS-456 Intermediary Benefit Payment Report. However, since the CMS-456 report was produced from the CAFM system and is no longer submitted by those contractors that transition to HIGLAS, the appropriate NCH processing report validation procedures were not performed. In response to the issue, management has created a special HIGLAS query to generate the data previously reported by the CMS-456 report for the contractors under HIGLAS and is in the process of identifying an appropriate NCH processing report validation source.

**I.2. 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. 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 financial reports.

For example, the majority of 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 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 prevents the contractors from reporting all information required for the completion of accurate and complete quarterly financial statements in accordance with OMB timelines, provides only minimal information at year end which supports the completion of the financial statements, and does not provide sufficient data for oversight and management of the contractors' activities.

**Recommendation**

We recommend that CMS continue to develop and refine its financial reporting systems and processes. Specifically, CMS should:

- Establish appropriate policies, procedures and a protocol to address situations or transactions that require cross-functional involvement in order to ensure interim and year-end financial statements are accurate and complete. This includes policies and procedures to ensure changes to critical systems outputs are appropriately vetted with all users. The financial management function should serve as the primary coordinator to facilitate the input and involvement of the other cross-functional units whose involvement and input are important factors to consider in formulating accounting treatment and financial reporting implications.
- Continue to develop its policies and procedures related to the development, documentation, and validation of the Part D accrual process.
- Continue to implement an integrated financial management system for use by Medicare contractors and CMS to promote consistency and reliability in accounting and financial reporting.

## II. Statement of Social Insurance (SOSI)

The 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.

Starting in FY 2006, the SOSI was required to be presented as part of the basic financial statements rather than as RSSI as previously presented. As such, the process for preparing the SOSI must comply with appropriate financial reporting internal control requirements established by OMB.

CMS has implemented policies, processes, controls and related documentation that will enable them to support the related financial statement assertions. During the current year audit, we noted significant improvements in the areas of change control, access controls, and internal control documentation. However the following control design deficiencies were noted:

- Data are moved within and between spreadsheets by copying the data from cells and pasting the data to new cell locations. Errors from this process could result in significant unintended changes to the SOSI. While the input of data is subjected to secondary validation and review by supervisory actuarial personnel, such manual validation and review processes do not sufficiently mitigate the risk associated with the copying and pasting of data from cell to cell within this complex set of spreadsheets.

- Spreadsheets are named with the same name as the prior version after changes. Further, there are no automated controls to prevent users from inadvertently overwriting changes made by other users. This could result in unintended changes to critical spreadsheets resulting in unreliable outputs.

- Formulae changes are not in all cases independently tested, reviewed and verified. While formulae changes are subjected to secondary validation and review by supervisory actuarial personnel, such manual validation and review processes do not sufficiently mitigate the risk associated with the direct posting of formulae changes into cells by users of this complex set of spreadsheets.

The lack of robust automated controls over spreadsheet changes may result in output that varies significantly from management's intentions.

**Recommendation**

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

- Implement automated controls to ensure that data moved between and within spreadsheets are moved correctly.
- Implement automated controls to prevent the possibility of overwriting critical spreadsheet data or formula cells due to insufficient naming convention protocols.
- Implement automated controls to test, review and verify all formulae changes within and between spreadsheets (e.g. spreadsheet change logging capabilities).

## III. Controls Over Trust Fund Draws

In order to ensure amounts drawn from the HI and SMI trust funds are accurate and complete, management reconciles “cash” payment amounts recorded by CMS and the Department of the Treasury with the corresponding “incurred” claims amounts from CMS claims data. However, this reconciliation is not performed at a level that allows management to detect errors timely.

The lack of a reconciliation at this level affected CMS's ability to identify that payments for hospice services were incorrectly being drawn from the Part B SMI trust fund. Because Hospice care is covered only under Part A of the Medicare program, these payments should have been drawn from the HI trust fund. The error led to an overstatement of benefit expenses attributed to the Part B Medicare program and an understatement of benefit expenses attributed to the Part A SMI program. In addition, the error led to inaccuracies within the SOSI. These errors were corrected within the final financial statements.

**Recommendation**

Management should develop appropriate reconciliation procedures between claims incurred to cash drawn from each of the trust funds that would enable the timely identification of potential errors in Medicare Trust Fund draws.

## IV. Inadequate Oversight of Managed Care Organizations

**Overview**

CMS is responsible for 1) determining which organizations are eligible to contract and participate in the Managed Care (Part C) and Part D programs, 2) making payments to the participating organizations, and 3) providing oversight over the participating organizations.

Our prior year audits identified weaknesses in CMS internal control surrounding the management procedures to review and process Part C and Part D payments, and lack of documentation and procedures to determine eligibility of organizations during the initial application review. During our current year audit, we noted significant improvements in those areas. Specifically, management enhanced the procedures used to validate and authorize payments for Part C and the Part D benefit. Enhancements were made to a number of validation functions including the Beneficiary Payment Validation (BPV), the Plan Payment Validation (PPV), and the monitoring and tracking of payment issues. In addition, management made significant improvements in documentation that evidence their determination of eligibility of organizations during the initial application review.

However, we noted recurring issues with management oversight of the Medicare Advantage Organizations (MAOs). CMS's oversight of MAOs is a monitoring control designed to ensure MAOs are in compliance with regulations established within applicable Medicare law, and therefore eligible to participate in the Managed Care program. Our review of the monitoring procedures in place by CMS over MAOs noted the following:

### IV.1. Monitoring Review Selection Methodology

Because of the significant increase in MAOs in the managed care program and limited resources, management developed a risk-based approach for their oversight of the Managed Care organizations. The risk-based approach was used to identify which plans would be

within the scope of the review, in addition to what organizational eligibility elements would be reviewed. The following inconsistencies were noted with the newly-developed selection approach:

- Management sporadically provided us with a complete set of formal monitoring policies and procedures used throughout the fiscal year. The inability of CMS to readily provide a comprehensive set of the guidance to be used throughout the fiscal year increases the risk of inappropriate execution of the reviews.

- Management did not properly document the rationale and sampling approach for the population or universe used for each element selected for review. In addition, management selected an arbitrary percentage for sampling for the PACE organization reviews, with no documentation of the rationale.

- Management has a process in place for the completion of a standard form if additional elements and/or reviews are performed, by a Regional Office Manager. However, we noted instances where management deviated from the risk-based approach and included or excluded elements of the review without documenting the rationale for inclusion or exclusion.

**IV.2. Monitoring Review Documentation**

CMS has ten Regional Offices that perform the monitoring reviews. CMS issues Standard Operating Procedures and holds training sessions for new releases to the monitoring audit guides.

However, because of a lack of formalized policies and procedures regarding the level of documentation required to evidence the review, management was unable to provide sufficient documentation to evidence the appropriate on going monitoring of managed care organizations by the Regional Offices. The following was noted:

***Evidence of Review***

During the review, the reviewer must identify if organizational requirements are "met" or "not met".

- We noted instances where the reviewer noted that the MAO had "met" the required element; however; documentation supporting the rationale and conclusion were not available.

- We noted significant inconsistencies with how the determination of "met," "met with note," and "not met" was made on different reviews for the same element.

- Documentation available to support the review varied by Regional Office.

***Corrective Actions***

Upon the completion of the review, CMS management is required to communicate non-compliances identified during the review to the organizations and the organizations are required to submit a corrective action plan. Management is required to evaluate the corrective action plan in order to make a final determination of the plan's eligibility.

- We found instances where findings identified during the review and corrective action plans developed by the MAO in response to the review, were not released and/or approved within the prescribed time frame. In some cases, required corrective action plans were not received at all. In these instances, documentation supporting the ultimate conclusion to continue to allow the organization to participate as a MAOs did not exist.

- We noted the acceptance of corrective action plans that did not properly identify how the MAO would correct each of the items identified.

***Oversight Status Tracking***

The Health Plan Management System (HPMS) is used by CMS to monitor the execution and status of managed care organization oversight. This system lies at the core of CMS's management process for MAOs. Inaccurate information within HPMS weakens management ability to monitor the MAOs. We noted the following:

- Management uses a Microsoft Excel spreadsheet and HPMS to monitor the progress of the monitoring reviews, versus one central tracking module. We noted additional reviews were performed that were not tracked within the spreadsheet or HPMS.

- The HPMS monitoring review module was not updated, in accordance with CMS's policy, with the results of review. We noted multiple instances where CMS Regional Offices did not update HPMS with exception items noted during the reviews of the managed care organizations.

**Recommendation**

We recommend that management 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:

- Establish policies for Regional Office monitoring of the various organizations (MA, MA-PD, PDP, PACE, RPPO, etc.) that include tailored procedures to address the unique requirements or risks of each organization.
- Ensure that existing policies and procedures for the monitoring of organizations within the Managed Care program are consistently implemented and applied and that the monitoring

of these organizations is documented in accordance with appropriate standards and guidelines.

- Develop detailed policies and procedures outlining the minimum documentation requirements that must be maintained as part of the monitoring reviews, in order to appropriately support the review outcome.
- Document the compliance with regulations for the monitoring of specific chapters and/or elements for organizations. For example, PACE organizations are required to be monitored every year for the first three years of acceptance into the program, and every other year thereafter.
- Ensure findings, corrective action plans, and acceptance of the provider's correction action plans are provided, reviewed, and released within the proposed time frames.
- Ensure that relevant data are updated timely in order to provide the information necessary for adequate management oversight.

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**Internal Control Related to Key Performance Indicators**

With respect to internal control relevant to data that support reported performance measures, we obtained an understanding of the design of significant controls relating to the existence and completeness assertions, as required by OMB Bulletin No. 07-04. Our procedures were not designed to provide assurance on internal control over reported performance measures. Accordingly, we do not provide an opinion on such controls.

We noted certain matters involving the CMS's internal control that we will communicate to management in a separate letter.

This report is intended solely for the information and use of the management of CMS's 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 9, 2007

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


November 9, 2007

PricewaterhouseCoopers, LLP
1800 Tysons Boulevard
McLean, VA 22102

Dear Sir:

This letter is in response to your audit report on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2007 financial statements. Your report identifies one material weakness, Medicare Claims Processing Controls, and four significant deficiencies, Financial Reporting Systems and Processes, Statement of Social Insurance (SOSI), Controls Over Trust Funds, and Oversight of Managed Care Organizations. The CMS generally concurs with the findings and description of the material weakness and significant deficiencies.

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

As noted in your report, CMS continued to improve its financial management performance in FY 2007 in many areas. For example, CMS continued to show improvement around the Medicare claims processing internal controls. This is true with respect to direct update access to Medicare claims data, compliance with the Fiscal Intermediary Shared System and the Viable Information Progressing Systems' Medicare System mandated edits, and controls over software supplementing the shared systems software.

Although we are pleased with receiving an unqualified opinion on our financial statements, we are already developing 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 we can fulfill our stewardship responsibilities and exceed our high financial management standards. We will continue to track and report our progress on a regular basis to ensure we can resolve these outstanding issues.

I would also like to thank the PricewaterhouseCoopers, LLP audit team for the professional manner in which they conducted their audit.

Sincerely,

Timothy B. Hill
Chief Financial Officer

# Other Accompanying Information

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

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

The CMS assesses its internal controls and financial management systems through: (1) management self-assessments, (2) OMB Circular No. A-123, *Management's Responsibility for Internal Control* Appendix A self-assessment, (3) OIG audits and GAO audits and high risk reports, (4) SAS 70 internal control audits, (5) the annual CFO financial statements audit, and (6) certification and accreditation of our information systems. As of September 30, 2007, the internal 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, one of which is also a nonconformance under Section 4 of FMFIA.

### Material Weakness—Medicare Claims Processing

The CMS relies on extensive information systems operations at its Central Office and Medicare contractor sites to process Medicare claims. Electronic data processing internal controls, as well as financial and management internal controls over claims processing need improvement. This material weakness is based on an assessment of various deficiencies in the aggregate noted at the CMS Central Office and the Medicare contractors which include, but are not limited to the following: Medicare contractor direct update access to claims data; Medicare contractor change controls over the shared

systems; Medicare contractor controls governing the use of supplemental software to process claims; lack of CMS oversight; and change controls over the implementation of a new accounting system (HIGLAS).

## Noncompliance/Nonconformance

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

We are continuing to implement the requirements of the Improper Payments Information Act (IPIA) and overall efforts to reduce improper payments. We already measure the payment error rates for the Medicare fee-for-service (FFS) program. We reported a preliminary FY 2006 paid claims error rate for the Medicaid FFS program in the HHS FY 2007 Agency Financial Report (AFR). We have made significant progress toward the development of an error rate measurement program for the Medicare Advantage and Prescription Drug programs by preparing comprehensive risk assessments for both programs during FY 2007. Additionally, we will report on an element of the Medicare Advantage and Prescription Drug payments in the AFR.

## OMB Circular No. A-123 Statement of Assurance

The CMS management is responsible for establishing and maintaining effective internal control and financial management systems that meet the objectives of FMFIA. These objectives are to ensure: (1) effective and efficient operations, (2) compliance with applicable laws and regulations, and (3) reliable financial reporting. As required by OMB Circular No. A-123, CMS has evaluated its internal controls and financial management systems to determine whether these objectives are being met. Accordingly, CMS provided a qualified statement of assurance that its internal controls and financial management systems met the objectives of FMFIA.

We conducted our 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 No. A-123. Based on the results of this evaluation, as of September 30, 2007, the CMS internal controls over operations were operating effectively and no material weaknesses were found in the design or operation of these internal controls. As of September 30, 2007, we also complied with applicable laws and regulations, except for the noncompliance and nonconformance noted above.

In addition, the CMS conducted its assessment of the effectiveness of internal control over financial reporting, which includes safeguarding of assets and compliance with applicable laws and regulations, in accordance with the requirements of Appendix A of OMB Circular No. A-123. Based on the results of this assessment, CMS identified a material weakness relating to Medicare claims processing subsequent to June 30, 2007.

Other than this material weakness, the internal controls over financial reporting as of June 30, 2007, were operating effectively and no other material weaknesses were found in the design or operation of the internal control over financial reporting.

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

The CMS analysis for FY 2007 indicated that the paid claims gross error rate was 3.9 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 2007 Gross Improper Payments and Error Rates in the Medicare FFS Program**

| Overpayments | Underpayments | Gross | |
|---|---|---|---|
| | | Improper Payment Amount (Overpayments + Underpayments) | Error Rate |
| $9.8 B | $1.0 B | $10.8 B | 3.9% |

## 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 2007, CMS made significant strides towards this goal by completing the following tasks:

- Developed a comprehensive error rate development project plan;
- Developed a comprehensive mapping of the Medicare Advantage and Medicare Prescription Drug Payment Systems;
- Prepared comprehensive risk assessments identifying all risk areas associated with payment; and
- Prepared a measurement methodology and implemented a pilot measurement test.

The CMS will also report on an element of payment in the FY 2007 HHS AFR. Specifically, CMS will report the following for Medicare Advantage. In FY 2007, CMS prepared a Part C Risk Assessment and identified the payment system calculation as one risk susceptible area. The CMS has provided an initial estimate of the Payment System Calculation Discrepancies (PSCD) for FY 2007 Medicare Advantage prospective payments from January–June 2007. The PSCD Estimate is a measure of the accuracy of the payment system calculations of the prospective capitation payments. These discrepancies are not payment errors because a payment error only would occur after final reconciliation amounts have been determined for a given plan year. The PSCD Estimate is not based on final payments and is not a comprehensive measurement of the Part C payment error rate. The CMS calculated a Medicare Advantage PSCD Estimate of 0.642 percent for payment made January–June 2007 and the PSCD gross amount for January–June 2007 totaled $234,267,567.

Additionally, CMS will report the following for Medicare Prescription Drug. In FY 2007, CMS prepared a Part D Risk Assessment and identified the payment system calculation as one risk susceptible area. The CMS has provided an initial estimate of the Payment System Calculation Discrepancies (PSCD) for FY 2007 Prescription Drug prospective payments from January–June 2007. The PSCD Estimate is a measure of the accuracy of the payment system calculations of the prospective capitation payments. These discrepancies are not payment errors because a payment error only would occur after final reconciliation amounts have been determined for a given plan year. The PSCD Estimate is not based on final payments and is not a comprehensive measurement of the Part D payment error rate. The CMS calculated a Part D PSCD Estimate of 0.020 percent for payment made January–June 2007 and the PSCD gross amount for January–June 2007 totaled $4,102,667.

## Medicaid and SCHIP

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

The CMS has developed a multi-faceted strategy to measure the national payment error rate for Medicaid and SCHIP annually. The FFS and managed care components of these programs are measured by national contractors. States will lead the effort to measure errors in the eligibility components of Medicaid and SCHIP. A sample of States have

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

The CMS is currently using the national contracting strategy to measure Medicaid FFS improper payments in FY 2006 and plans to report a preliminary Medicaid FFS component national rate based on quarters 1 and 2 of FY 2006 in the FY 2007 HHS AFR. The preliminary Medicaid fee for service rate is 18.45%. This preliminary error rate is from 17 States for 6 months only and was calculated in September 2007. CMS is completing the remaining 6 months and will report an annual 2006 Medicaid fee-for-service error rate in the 2008 HHS AFR. This preliminary error rate does not reflect the late implementation of policies in the measurement cycle. These factors should be considered when reviewing the preliminary rate and may impact the final calculation of the annual error rate. The CMS is currently measuring improper payments in Medicaid and SCHIP FFS, managed care and eligibility in FY 2007 for reporting, along with the FY 2006 final Medicaid FFS component rate based on all 4 quarters of FY 2006, in the FY 2008 HHS AFR. Finally, CMS has begun measurement of FY 2008 Medicaid and SCHIP FFS, managed care, and eligibility for reporting in the FY 2009 HHS AFR.

# MEDICARE'S VALIDATION PROGRAM FOR JOINT COMMISSION-ACCREDITED HOSPITALS

## Introduction

Section 1865 of the Social Security Act (the Act) provides that hospitals accredited by the Joint Commission (JC) are deemed to meet the Medicare Conditions of Participation (CoPs).[1] There are approximately 4,153 JC-accredited hospitals, accounting for approximately 82 percent of all hospitals participating in the Medicare program. These figures do not include critical access hospitals (CAHs), small rural hospitals that are subject to different CoPs than are hospitals. The JC's statutory accreditation authority does not extend to CAHs.

The JC accreditation survey assesses a hospital's compliance with the JC standards. Following the completion of an on-site survey, the JC makes an accreditation decision.

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

# Other Accompanying Information

The JC surveys each accredited hospital on a triennial basis to verify ongoing compliance. The JC also conducts random unannounced surveys of a sample of accredited hospitals on a more frequent basis.

Hospitals accredited by a CMS-approved accrediting organization (including the JC per section 1865 of the Social Security Act) are not subject to routine Medicare surveys by a State Survey agency (SA). However, the hospitals are subject to investigation of complaints by CMS and the accreditation organizations are subject to certain oversight by CMS. Subsection 1864(c) of the Act authorizes the Secretary to enter into an agreement with any SA to survey such 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. At section 1875, the Act further requires the Secretary to include an evaluation of the JC 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 JC accreditation process provides reasonable assurance that accredited hospitals are in compliance with the statutory requirements set forth at subsection 1861(e) of the Act and related regulatory requirements at 42 CFR Part 482, CoPs, in the Medicare program as hospitals.

The CMS uses three types of SA surveys as evaluation tools in its JC hospital validation program: comprehensive "look-back" surveys, conducted within 60 days of a JC survey; comprehensive "mid-cycle" surveys, conducted with hospitals that the JC 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 the JC performance: the identification of deficiencies in hospitals' compliance with the Medicare CoPs; and the ability of the JC process to ensure correction of deficiencies previously identified by the JC.

The look-back validation surveys performed in FY 2006 found that there is an ongoing disparity between the JC and the SAs in their ability to identify hospital deficiencies, with significant deficiencies identified by SAs and not identified by the JC in 25.4 percent of the 67 hospitals subject to a look-back survey. This disparity rate represents some improvement over the FY 2005 disparity rate of 27.6 percent, but not substantially different from the average disparity rate that has been consistently above 20 percent since FY 2000. As in previous years, the single largest source of the disparity remains the JC's ability to detect deficient compliance with requirements related to hospitals' physical environment, particularly *Life Safety Code*® (LSC) compliance. In 23.9 percent of the 67 hospitals in the validation sample, the SAs found serious deficiencies in physical environment where the JC did not.

The 25 mid-cycle surveys indicated that the JC's process is generally effective in leading hospitals to correct deficiencies identified by the JC. Eighty-eight percent of sampled hospitals had eliminated the JC-identified deficiencies when surveyed later by a SA. This is an increase from 84 percent in the FY 2005 mid-cycle survey sample. However, the small sample size requires that caution be used in drawing any conclusions about trends.

While 99 percent of complaints that warranted an on-site investigation by a SA of a hospital in FY 2006 involved a JC-accredited hospital, 2.3 percent of the 4,101 allegation surveys conducted by SAs found condition-level deficiencies. Condition-level deficiencies are those deficiencies that are serious enough to warrant CMS taking enforcement action, including removal of deemed Medicare status.

# JC Accreditation Activity

In FY 2006, the JC surveyed 1,492 hospitals and rendered six different types of accreditation decisions as follows:

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

For Medicare initial certification, CMS accepts only JC accreditation decisions indicating full standards compliance. For accredited JC hospitals already participating in Medicare, CMS does not take action to terminate the provider agreement of a hospital that the JC puts into a status of accredited with requirements for improvement, conditional accreditation or provisional accreditation, since CMS expects that the JC's oversight process will work to correct the deficiencies identified in these hospitals.

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

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

| **Accreditation Decisions** | **# Hospitals, 2004** *(Percent)* | **# Hospitals, 2005** *(Percent)* | **# Hospitals, 2006** *(Percent)* |
|---|---|---|---|
| Accreditation w/Full Standards Compliance | 244 (14.94) | 61 (4.18) | 27 (1.81) |
| Accreditation with Requirements for Improvement | 1,364 (83.53) | 1,330 (91.03) | 1,400 (93.83) |
| Conditional Accreditation | 23 (1.41) | 63 (4.31) | 51 (3.42) |
| Provisional Accreditation | ——± | ——± | 6 (0.40) |
| Preliminary Denial of Accreditation* | 2 (0.12) | 13* | 3* |
| Accreditation Denied | 0 (0) | 7 (0.48) | 5 (0.34) |
| Total Surveyed | 1,633 (100) | 1,474 (100) | 1,492 (100) |

*The PDA count is a duplicate count to reflect the changing accreditation status during the JC appeals process. *(Source: JC)*
±CMS does not currently have this information.

## Other Accompanying Information

In January 2004, the JC revised its approach to assessing compliance with its standards with the introduction of its *Shared Visions/New Pathways* initiative. In January 2005, the JC incorporated into this approach the use of unannounced periodic surveys. Prior to that date, all JC surveys occurred on an announced triennial schedule, with the hospital aware of the survey date well in advance. As the JC's more outcomes-focused survey approach has been implemented, the JC reports it has been identifying more instances of hospital noncompliance. In FY 2006, 94 percent of the hospitals the JC surveyed were identified as having requirements for improvement (RFI), compared with 91 percent in FY 2005 and 84 percent in FY 2004. In FY 2006, 51 hospitals were also conditionally accredited and 5 hospitals were denied accreditation.

# CMS Validation Program Activity in FY 2006

A total of 92 comprehensive validation surveys were completed by SAs in FY 2006; an increase of 39 percent over FY 2005. Of this total, 67 were look-back surveys and 25 were mid-cycle surveys. Through these unannounced surveys, SAs independently evaluate hospitals' compliance with all Medicare CoPs. The SAs are not apprised in advance of any findings from the JC survey. In order to assure that the "look back" survey is a reasonable assessment of the JC's survey process, rather than reflecting changed circumstances within a hospital, the look-back survey is conducted within 60 days following the hospital's JC accreditation survey.

The FY 2006 mid-cycle surveys were conducted on a sample of those hospitals roughly midway through their JC accreditation cycle whose most recent JC survey had identified their having deficiencies. These mid-cycle surveys were primarily intended to assess the effectiveness of the JC 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 2006 by the JC for look-back surveys, and of all JC-accredited hospitals in the middle of the accreditation cycle that had been previously identified by the JC as having deficiencies. The 92 hospitals surveyed represent a 2.2 percent sample of all JC-accredited hospitals. The 67 look-back surveys represent a 1.6 percent sample of all JC-accredited hospitals, but a 4.5 percent sample of all hospitals surveyed by the JC in FY 2006. In addition to these comprehensive surveys, SAs conducted focused investigations of 4,101 complaints alleging substantial violations of Medicare CoPs in JC-accredited hospitals.

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

**TABLE 2**
**CMS Surveys Completed in JC-Accredited Hospitals**

| | 2005 | | 2006 | |
|---|---|---|---|---|
| **Survey Type** | **Number** | **Surveys with Condition-Level Deficiencies** | **Number** | **Surveys with Condition-Level Deficiencies** |
| Look-Back Surveys | 47 | 20 (42.6%) | 67 | 30 (44.8%) |
| Mid-Cycle Surveys | 19 | 11 (57.9%) | 25 | 12 (48.0%) |
| Allegation Surveys | 4,275 | 120 (2.8%) | 4,101 | 95 (2.3%) |

## Look-Back Surveys—Validation and 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 the JC. The assumption is that it is reasonable to conclude that the deficiencies were present at the time of the JC survey and should have been identified.

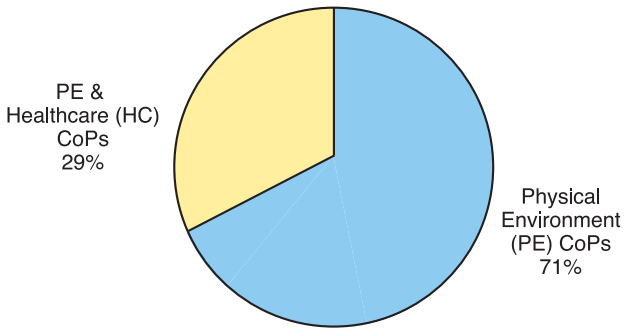
State survey agencies found non-compliance with one or more CoPs in 30 of the 67 hospitals that had a look-back survey. Comparison of the JC-accreditation survey reports with the SA survey reports for these 30 hospitals showed that in 17 hospitals the JC survey did not identify deficiencies comparable to the condition-level deficiencies cited by the State agency surveyors. These data translate into a disparity rate of 25.4 percent between the JC and SA ability to detect deficiencies; a 9 percent reduction from the disparity rate of 27.6 percent found in FY 2005. Table 3 illustrates the FY 2006 results.

**TABLE 3**
**Look-Back Survey FY 2006 Results**

| State Agency Deficiency Citations (CoPs Only) | Hospitals where SA cited CoP Non-Compliance | Hospitals with Comparable JC Requirements for Improvement | Hospitals where JC missed 1 or More CoP-Level Area(s) of Non-Compliance | Total Hospitals Sampled | Disparity Rate |
|---|---|---|---|---|---|
| Physical Environment (PE) | 18 | 6 | 12 | 67 | 0.179 |
| Healthcare (HC) | 4 | 4 | 0 | 67 | 0.000 |
| Both PE & HC | 8 | 3 | 5 | 67 | 0.075 |
| **Total** | **30** | **13** | **17** | **67** | **0.254** |

Graph A illustrates the fact that compliance with the Physical Environment CoP (primarily the LSC involving fire safety precautions) was the most common area of discrepancy. The JC's performance in identifying LSC problems in hospitals has been the subject of frequent communication between CMS and the JC in recent years. In response, the JC has implemented various measures to improve its performance in this area. A number of these measures are highlighted later in this report.

**Graph A: Hospitals with Findings Missed by the JC–FY 2006**



## Other Accompanying Information

Table 4 shows the specific types and frequency of health and safety CoPs that were identified by the SA and where the JC did or did not make similar findings during the JC accreditation survey. Since the disparity rate calculated by CMS is based on the percentage of hospitals with disparate findings, rather than the number of times specific CoPs were missed, the results of this table do not correspond directly with the disparity rate. The table is useful, however, to identify the specific areas where the JC did not identify the types of deficiencies SAs found.

**TABLE 4**
**Conditions of Participation Cited During FY 2006 Look-Back Surveys**

| Conditions of Participation | Cited by the State Agency | Similar Findings Identified by the JC | Findings Not Identified by the JC *(Percentage)* |
|---|---|---|---|
| **Physical Environment Condition of Participation** | | | |
| Physical Environment *(Includes Life Safety Code)* | 26 | 9 | 17 (65%) |
| **Other Conditions of Participation** | | | |
| Infection Control | 5 | 2 | 3 (60%) |
| Patient Rights | 3 | 2 | 1 (33%) |
| Nursing Services | 1 | 0 | 1 (100%) |
| Governing Body | 8 | 0 | 8 (100%) |
| Discharge Planning | 1 | 0 | 1 (100%) |
| Quality Assessment Performance Improvement | 4 | 4 | 0 (0%) |
| Pharmaceutical Services | 4 | 3 | 1 (25%) |
| Emergency Services | 1 | 0 | 1 (100%) |
| Food and Diet | 2 | 0 | 2 (100%) |
| **Total** | **55** | **20** | **35 (64%)** |

The second-largest number of disparate findings between SAs and the JC was in citation of non-compliance with the Governing Body CoP or its JC equivalent. This particular disparity reflects a fundamentally different approach to assessing the performance of the hospital's leadership in maintaining compliance. According to JC representatives, the hospital's leadership is expected to assume responsibility for overall compliance with accreditation standards, and, more specifically, for assuring correction of each of those areas where requirements for improvement have been identified. In the JC's view, it would be double-counting to cite deficiencies in leadership at the same time that other deficiencies are identified. However, federal regulations hold hospital governing bodies to a set of expectations that independently act to ensure accountability at the top management level, and CMS policy holds that very serious and/or pervasive problems are also indicative of failure of the Governing Body of the hospital to fulfill its basic functions. The CMS therefore considers it both appropriate and necessary to cite non-compliance with the Governing Body CoP in such circumstances.

Table 5 shows the look-back disparity rate from FY 2000 through FY 2006. The FY 2006 rate of 25.4 percent is a reduction from the disparity rates of previous years, which have hovered around 27 percent since FY 2003. However, the look-back survey disparity rate has been consistently above 20 percent since FY 2000. While it may be argued that the

relatively small number of look-back surveys (67 in FY 2006) creates some statistical uncertainty when calculating the disparity rate, the JC's disparity rate has consistently exceeded 20 percent for the past seven years and it is unlikely that larger sample sizes would alter this finding. A multi-year rolling average, for example, would substantially increase the sample size without a major difference in the disparity rate.

Regulations at 42 CFR 488.8(d) provide for review and potential CMS action relative to deeming authority when an accrediting organization's disparity rate exceeds 20 percent, including possible removal of deeming authority. While current law does not provide for application of this standard to the JC hospital accreditation program, CMS nonetheless reviews the look-behind survey results with the JC, makes recommendations, and solicits a response from the JC with regard to future actions the JC may take. The CMS will continue to work closely with the JC to minimize differences in the two organizations' standards and survey procedures as a means to reduce the JC's disparity rate in the future.

**TABLE 5**
**Look-Back Survey Disparity Rates**
**FY 2000–2006**

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

## *Mid-Cycle Survey Findings*

The mid-cycle comprehensive validation surveys, first introduced in FY 2003, are intended to assess the JC's ability to ensure that hospitals take necessary corrective action to come into compliance with accreditation standards. These surveys are conducted by SAs in a sample of JC-accredited hospitals which, at their last JC survey, were accredited with requirements for improvement. There were 25 mid-cycle surveys conducted in FY 2006.

Twenty-two of the 25 hospitals surveyed had corrected the requirements for improvement previously cited by the JC. There were only three hospitals which had not corrected the requirements for improvement previously recommended by the JC. Hence, JC-accredited hospitals achieved a corrective action adherence rate of 88 percent. This compares with an 84 percent adherence rate in the FY 2005 mid-cycle survey sample.

The CMS does not calculate a disparity rate based on the mid-cycle survey sample, due to the time lag of roughly 18 months between the original JC and the SA mid-cycle surveys. The SAs confirmed correction of most problems previously identified by the JC, but also found condition-level non-compliance in 36 percent of the hospitals in the mid-cycle sample. Because it is not possible to judge whether this non-compliance was present when the JC was last in the hospital, it would not be appropriate to calculate a disparity rate on the basis of these findings. In addition, the small size of the mid-cycle samples in each year suggests that caution is required in interpretation of this data.

### *Allegation (Complaint) Survey Findings*

In addition to the comprehensive validation surveys, CMS conducts focused surveys through SAs to investigate allegations of serious deficiencies in JC-accredited hospitals. 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 focused on those specific CoPs.

JC-accredited facilities accounted in FY 2006 for approximately 82 percent of the nation's hospitals and 92 percent of all hospitals where CMS authorized a substantial allegation survey. As was indicated in Table 2, SAs conducted 4,101 allegation surveys in a JC-accredited hospital, and 2.3 percent of these surveys involved condition-level deficiencies, (i.e., they were serious enough to warrant CMS taking enforcement action against these hospitals). Table 6 indicates the CoPs with the most frequent violations cited by the SAs.

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

| Condition Not Met | Frequency (Percent of allegation surveys) |
|---|---|
| Physical Environment | 53 (1.1) |
| Patients' Rights | 47 (1.0) |
| Nursing Services | 35 (0.8) |

The Patients' Rights and Nursing Services CoPs were also listed as the most frequently cited CoPs during allegation surveys in JC-Accredited Hospitals in FY 2005. 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.

## JC Improvement Efforts

As discussed in the FY 2005 Report to Congress, CMS made a number of recommendations to the JC that we believed would improve the JC's evaluation of LSC compliance by hospitals. The JC reports it has implemented the following recommendations:

- **Completion of the Statement of Conditions (SOC) by Qualified Personnel.** We recommended that the JC require hospitals to use personnel with specific LSC credentials and skills to contribute to the SOC self-assessment that hospitals prepare as part of the JC accreditation process. The JC reports it now requires hospitals to assign responsibility for completing the physical environment portion of 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).** The JC reports that all hospital SOCs and PFIs are now reviewed for adequacy by the JC central office staff.

- **Submission of the SOC and PFI documents to the JC prior to survey.** The JC 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' initial recommendation focused on the JC increasing the capacity of LSC experts in the central office to evaluate SOCs and PFIs. In the fall of 2004, the JC hired and trained 50 LSC specialty surveyors to review LSC in hospitals with greater than 200 beds. In 2006, the JC increased the number of central office professional engineers by 30 percent, to 4 engineers.

  The LSC specialist surveyors are all certified health care facility managers or certified health care safety professionals. Every year the JC conducts an annual training conference specifically for the LSC specialty surveyors, who also participate in the annual training conference conducted for all JC surveyors.

  Hospitals with less than 200 beds continued to be surveyed for LSC by general surveyors while surveys for larger hospitals included LSC specialists. The general surveyors receive a specialized two-day course covering Environment of Care and Life Safety Code, as well as continuing distance LSC education throughout the year about changes that impact the LSC survey activity.

  In calendar year (CY) 2007, hospitals with greater than 750,000 square feet are being considered on a case-by-case basis for additional LSC specialty survey time. Beginning in CY 2008, all hospitals surveyed will receive at least one day of a LSC survey conducted by a specialist, and those with greater than 750,000 square feet will be assigned two days of LSC specialty survey.

  The JC anticipates that these measures will significantly reduce the disparate findings in the area of physical environment between the JC and SA surveyors.
- **Develop mechanisms for facilities that fail to comply with the timeframes for correction identified in their PFIs.** The JC reports that it has expanded its use of requirements for improvement, conditional accreditation, and preliminary denial of accreditation as a mechanism to bring hospitals into compliance with accreditation standards. The data support these observations and we believe these are positive developments, as discussed below.

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

- **Expanded Use of "Requirements for Improvement" and "Conditional Accreditation."** Use of unannounced surveys, expansion of LSC capability, and other changes in the past few years, have enlarged JC's capability to identify deficiencies. These changes have been accompanied by the JC's expanded use of "requirements for improvement" and "conditional accreditation" based on the JC surveys. For example, the percentage of hospitals accredited with requirements for improvement increased from 83.5 percent in FY 2004 to 94.2 percent in FY 2006, while the number of hospitals accredited with conditions has increased from 1.41 percent to 3.4 percent from FY 2004 to FY 2006.

  Because the JC also raised the number of identified deficiencies that may be evident before a hospital's unconditional accreditation is seriously threatened, it is unclear if

there has been a net change in enforcement itself. Nonetheless, we regard the recent changes in JC survey methods and interpretation as clear improvements that result in better ability to identify deficiencies and provide important feedback to hospitals. The provision of such expanded feedback can be instrumental in setting the stage for improvement in hospital practices.

- **Formation of a joint CMS-JC gap-analysis work group to identify CoPs with no clear counterpart in the JC standards.** This work group continues to analyze the JC'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.
- **Conduct its own "look-back" surveys.** In August 2005, the JC began a one-time series of "look back" random announced validation surveys, using a survey team with specialized training. Results were used to identify further areas of improvement in the JC survey process.
- **Implement an electronic SOC and PFI process.** In CY 2007, the JC is moving the Statement of Condition/Projects for Improvement into an electronic format, similar to CMS' ASPEN suite of electronic tools to conduct and manage SA surveys. The JC anticipates that use of these electronic tools will improve management of the SOC and PFI processes not only by the JC, but also within hospitals.

According to the JC data, the above actions have already resulted in a substantial increase in the number of deficiencies identified in the LSC area in hospitals, as indicated in Table 7. There has been over a 100 percent increase in the number of LSC citations by JC surveyors since the hiring of LSC specialty surveyors by the JC beginning in 2004. Since that time the number of Environment of Care/LSC citations identified by the JC as very serious, i.e., with the implication of threat to life, has more than doubled, as indicated in Table 8.

**TABLE 7**
**Joint Commission Life Safety Code Scoring Trends**
**CY 2004–2006**

| | 2004 | 2005 | 2006 |
|---|---|---|---|
| Number of Surveys | 1,425 | 1,436 | 1,427 |
| Number of Citations for Life Safety | 521 | 1,345 | 1,363 |
| Percentage of Surveys cited by a LSC specialist | N/A | 56% | 55% |

*Source: JC*

**TABLE 8**
**Joint Commission Immediate Threat to Life Comparison**

| Year | Number of Threat to Life Findings | Environment of Care/LSC |
|---|---|---|
| 1993–2004 | 13 | 4 |
| 2005–2006 | 16 | 10 |

The CMS commends the significant efforts that the JC has invested in improving its ability to identify LSC deficiencies and enforce compliance with LSC. Such efforts have yielded much better feedback to hospitals, more effective action to reduce fire risk in particular, and much better communication with States and CMS regarding collaborative action that can be mobilized in response to immediate jeopardy to patients. While these efforts have not yet had the effect of reducing the disparity found when SAs and the JC both survey the same hospitals, we observe that this year's report is based on data from FY 2006, a time period when many of the JC's LSC initiatives had not yet been fully implemented. We expect the FY 2007 data to offer better opportunity to determine whether the JC's investments in enhanced LSC enforcement will succeed in future years in bringing its disparity rate down significantly.

## CMS Oversight Improvement

In July 2004, the Government Accountability Office (GAO) made several recommendations that might be used to improve CMS' oversight of the hospital accreditation program[2]. The recommendations included modifying the method used to calculate the disparity rate, identifying additional indicators of JC performance, and increasing the validation sample size. The CMS initiated action to enhance our oversight of JC hospital accreditation (described below). The President's 2008 budget request for survey and certification will enable more rapid progress.

- **Ongoing Communication with the JC.** The CMS instituted a series of periodic meetings with all of the accreditation organizations with deeming authority, including the JC. These meetings serve to foster communication between the 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 has increased its collaboration and communication on emergency preparedness with the JC for addressing local and national disruptive events caused by all hazards regardless of the magnitude. In addition, CMS continues to work with the JC to apply the lessons learned from Hurricane Katrina.
- **Methodological Changes to Improve Oversight.** The CMS is assessing differing approaches to refining and improving upon the current method of measuring the JC's performance in assuring compliance with the CoPs. The CMS continues to work with the contractor secured in FY 2006 to assist in this endeavor. A revised approach to performance assessment may also require regulatory revisions.
- **Hospital Validation Sample Size.** The CMS has planned to increase the hospital validation sample size to increase the significance of the validation survey analyses. The President's proposed budget for FY 2008 would permit a larger sample size than the level permitted in FY 2007.

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

- **Analysis of Complaint Data.** The CMS is investigating cost-effective approaches to enhancing hospital survey activities, including integration into our overall assessment of the JC's performance, the results of complaint investigations conducted in JC-accredited hospitals. The CMS continues to work with a contractor to explore the utility of the complaint data as a means to assess the performance of the JC.
- **Regular Exchange of Data.** Timely, complete, and readily usable data on the JC's accreditation activities is a prerequisite to effective evaluation by CMS of the JC's performance. A number of operational barriers have made optimal data exchange challenging for both the JC and CMS. We will continue to work with the JC to obtain more comprehensive and regular information about the organization's accreditation activities and to expedite the exchange of data and information between the two organizations.
- **Disparity Rate Methodology.** Action to revise the regulations so as to amend methodologies used to calculate disparity rates will await further learning from analysis of recent data, as well as addition of resources sufficient to enlarge the sample size for validation surveys.

# CLINICAL LABORATORY IMPROVEMENT VALIDATION PROGRAM

## Introduction

This report on the Clinical Laboratory Improvement Validation Program covers the evaluations of fiscal year (FY) 2006 performance by the six accreditation organizations approved under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The six organizations are as follows:

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

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

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

## Legislative Authority and Mandate

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

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

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

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

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

## Validation Reviews

The validation review methodology focuses on the actual implementation of an organization's accreditation program described in its request for approval. The accreditation organization's standards, as a whole, were approved by CMS as being equivalent to, or more stringent than, the CLIA condition-level requirements,[2] as a whole. This equivalency is the basis for granting deeming authority.

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

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

## Number of Validation Surveys Performed

As directed by the CLIA statute, the number of validation surveys should be sufficient to "allow a reasonable estimate of the performance" of each accreditation organization. A representative sample of the more than 15,000 accredited laboratories received a validation survey in 2006. 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.

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

Six validation surveys were conducted. No condition-level deficiencies were cited in those surveys, thus there was no disparity.

### American Osteopathic Association

Rate of disparity: No disparity

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

### American Society of Histocompatibility and Immunogenetics

Rate of disparity: No disparity

Approximately 130 laboratories used their ASHI accreditation for CLIA purposes. One validation survey was conducted. No condition-level compliance was found, thus there was no disparity this year, as in the previous years of CLIA validation review.

### COLA

Rate of disparity: 5 percent

A total of 143 validation surveys were conducted at laboratories accredited by COLA. One survey was removed from the review pool for administrative reasons. Of the remaining 142 surveys, ten laboratories were cited with condition-level deficiencies. Comparable deficiencies were noted by COLA in three out of the ten laboratories cited with condition-level deficiencies.

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

| CLIA number | Location | CLIA Conditions |
|---|---|---|
| 05D0710272 | California | Successful Participation—Proficiency Testing |
| 05D0864381 | California | Laboratory Director—fulfillment of overall responsibilities for management and direction |
| 05D0947605 | California | Analytic Systems; and Laboratory Director—fulfill ment of overall responsibilities for management and direction |
| 05D0980907 | California | Analytic Systems; and Laboratory Director—fulfill ment of overall responsibilities for management and direction |
| 23D0662812 | Michigan | Laboratory Director—fulfillment of overall responsibilities for management and direction |
| 34D0242281 | North Carolina | General Laboratory Systems |
| 44D0975544 | Tennessee | Routine Chemistry |

### College of American Pathologists

Rate of disparity: 6 percent

A total of 104 validation surveys were conducted at laboratories accredited by the College. Two surveys were removed from the pool for administrative reasons. Of the remaining 102 surveys, nine laboratories were cited with condition-level deficiencies. Comparable deficiencies were noted by the College in three of the nine 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 |
|---|---|---|
| 05D0557149 | California | Laboratory Director—fulfillment of overall responsibilities for management and direction |
| 05D0609125 | California | Analytic Systems |
| 06D0680595 | Colorado | General Laboratory Systems<br>Pre-Analytic Systems; and Analytic Systems |
| 19D0935738 | Louisiana | Analytic Systems |
| 19D1004235 | Louisiana | Analytic Systems |
| 46D0684190 | Utah | Technical Consultant—qualification requirements |

A note of correction: The disparity rate for the College was misreported for fiscal year 2005 as 3 percent. The correct disparity rate for that year was 6 percent.

### The Joint Commission

Rate of disparity: 3 percent

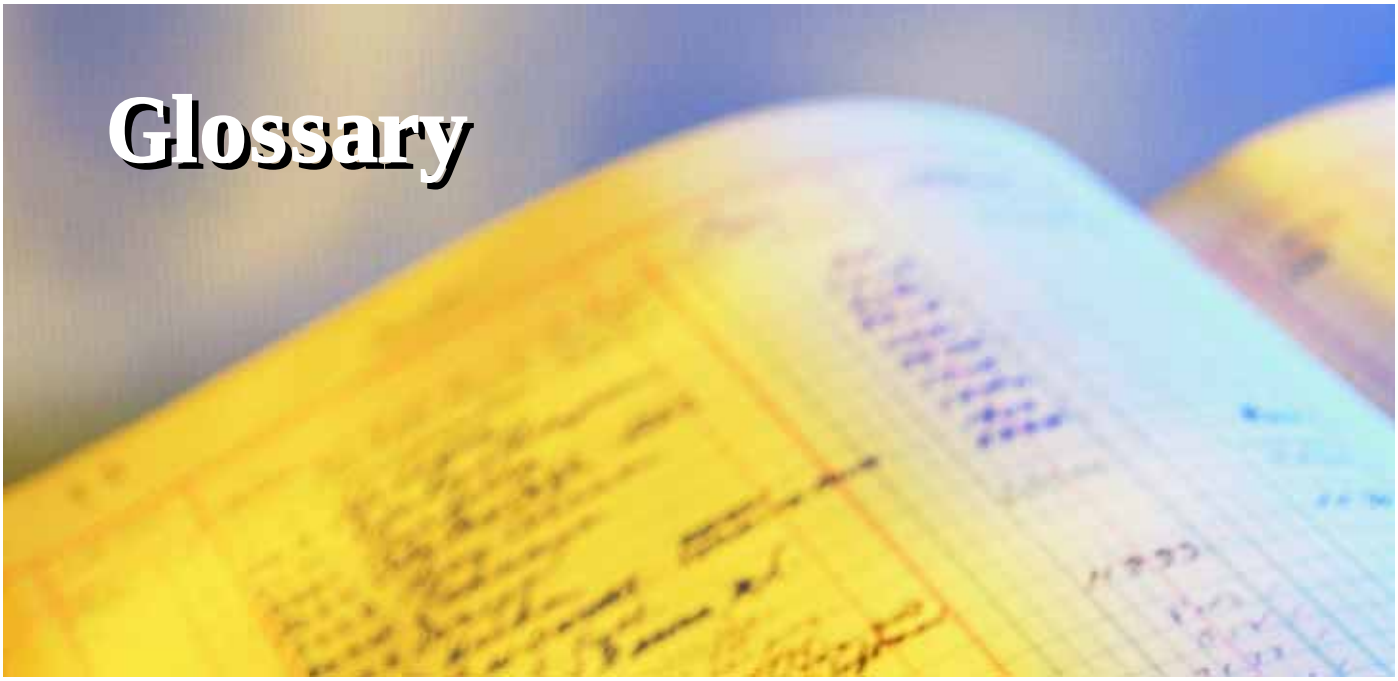
During this validation period, a total of 95 validation surveys were conducted at laboratories accredited by the Joint Commission. Four surveys were removed from the review pool for administrative reasons. Of the remaining 91 validation surveys, six laboratories were cited with CLIA condition-level deficiencies. Comparable deficiencies were noted by the Joint Commission in three of the six laboratories cited with condition-level deficiencies.

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

| CLIA number | Location | CLIA Conditions |
|---|---|---|
| 14D0702520 | Illinois | Analytic Systems |
| 17D0449821 | Kansas | Proficiency Testing—Enrollment and Testing of Samples |
| 18D0326011 | Kentucky | Analytic Systems |

## 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 2006 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.

**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.

# CMS Key Financial Management Officials

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

## *U.S. Department of Health and Human Services*

**Michael Leavitt,** Secretary

### Centers for Medicare & Medicaid Services

**Kerry Weems,** Acting Administrator

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

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