CMS Financial Report

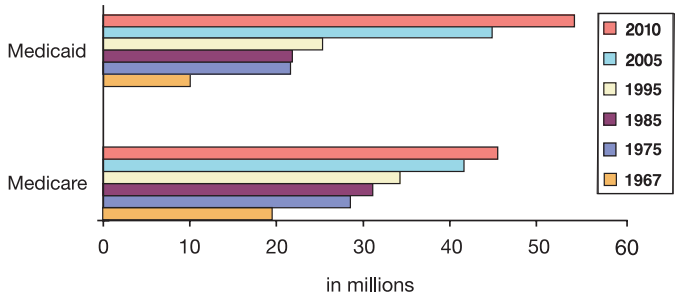
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

FISCAL YEAR 2010

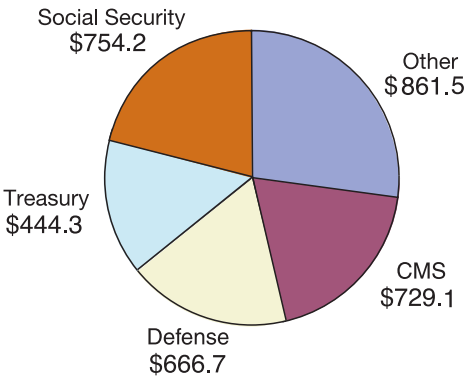
The Centers for Medicare & Medicaid Services At a Glance

The **CMS** is one of the largest purchasers of health care in the world. Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) provide health care for one in four Americans. Medicare enrollment has increased from 19 million beneficiaries in 1966 to approximately 47 million beneficiaries. Medicaid enrollment has increased from 10 million beneficiaries in 1967 to over 54 million beneficiaries.

2010 Program Enrollment



2010 Federal Outlays



Source: U.S. Treasury

$ in billions

The **CMS** had outlays of approximately $729.1 billion (net of offsetting receipts and Payments to the Health Care Trust Funds) in fiscal year (FY) 2010, approximately 21 percent of total Federal outlays.

The **CMS** has approximately 5,000 Federal employees, but does most of its work through third parties. The CMS and its contractors process over one billion Medicare claims annually, monitor quality of care, provide the states with matching funds for Medicaid benefits, and develop policies and procedures designed to give the best possible service to beneficiaries. The CMS also assures the safety and quality of medical facilities, provides health insurance protection to workers changing jobs, and maintains the largest collection of health care data in the United States.

A Message from the Administrator

I am pleased to present the Centers for Medicare & Medicaid Services' (CMS) Financial Report for fiscal year (FY) 2010. This year marks Medicare's 45th year of giving America's seniors and persons with disabilities protection from rising health care costs and access to the best medical care in the world.

Through the leadership shown by President Obama and Congress, the Affordable Care Act was signed into law in March 2010, bringing improvements to Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) which will improve access to and quality of care, and lower costs. This new law is expected to transform health care delivery and provide affordable health care coverage to 30 million Americans, who today are uninsured. Among the key provisions that CMS will advance include free preventive care for Medicare beneficiaries, including an annual wellness visit; reduced costs of prescription medicines under Part D; changes to health care delivery to keep people healthier longer by reducing hospital readmissions and better coordination of care to prevent errors; streamlining the administrative and bureaucratic process to make health care transactions more efficient; and new tools and resources to fight waste, fraud and abuse. These and the many other health care reform provisions will be a major focus for CMS in the next few years.

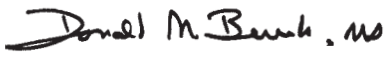
Since the new law was signed, more than 1 million Medicare beneficiaries have received prescription drug cost relief. As part of the Affordable Care Act's step-by-step efforts to close the Medicare Part D prescription drug coverage gap, eligible beneficiaries who fall in the "donut hole" this year are mailed a one-time, tax-free $250 rebate check. Eligible Medicare beneficiaries have already received more than a quarter of the 4 million checks that Medicare expects to distribute.

Closing the donut hole is just one of the ways Medicare beneficiaries benefit from the Affordable Care Act. In addition, the average 2011 Medicare prescription drug plan premiums will remain similar to rates beneficiaries are currently paying this year. This, coupled with new discounts for brand-name drugs through the Affordable Care Act, will help make medications more affordable for Medicare beneficiaries in 2011 and beyond.

The Affordable Care Act will also provide CMS more tools and resources to actively and aggressively fight waste, fraud and abuse in Medicare. Most importantly, the agency will have new tools to focus on prevention—keeping dishonest individuals out of Medicare and Medicaid. New screening and oversight systems, coupled with the incorporation of new technology into CMS fraud fighting efforts will help the agency more readily track and prevent health care fraud. We have also been working closely with the Department of Justice in expanding and enhancing the efforts of the Health Care Fraud Prevention Enforcement Action Team, including Medicare Strike Forces.

Another key step taken by CMS this year is to further States' role in developing a robust national health information technology infrastructure. The Medicaid programs in all 50 States, Puerto Rico and the US Virgin Islands received Federal matching funds for state planning activities necessary to implement the electronic health record (EHR) incentive program established by the American Recovery and Reinvestment Act of 2009. Widespread adoption and meaningful use of EHRs will improve the quality, safety and efficiency of health care for Medicaid beneficiaries. Use of EHRs and health information exchange between providers will provide greater coordination of care, reduce the risk of adverse events and duplicative treatments and testing. Additionally, EHRs will make it easier for patients to access their health information in a timely and efficient manner so they can make informed decisions about their health care.

The CMS takes pride in the many achievements we have accomplished in FY 2010. We will continually do our part to make the Medicare, Medicaid, and CHIP programs more affordable and effective for the millions of Americans who rely on these programs for their health care. Our initiatives demonstrate our commitment and we will work together with our partners, stakeholders, and other key sectors of the healthcare community, to implement health care reform and identify further opportunities that will ensure we aim to provide better health care for individuals, better health for populations, and reduce the cost of health care per capita. We will continue implementing the provisions of the Affordable Care Act and combined with our other ongoing efforts, we will extend the life of the Medicare trust funds for future generations to come.



Donald M. Berwick, M.D.
November 2010

A Message from the Chief Financial Officer

As the Agency's Chief Financial Officer (CFO), I am pleased to present the fiscal year (FY) 2010 CMS Financial Report that includes its audited financial statements with related program and financial information. This year the Agency received an unqualified opinion from its independent auditors on our Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position and the Combined Statement of Budgetary Resources. However, the auditors did not express an opinion on the Statement of Social Insurance, which is also included in the annual report of the Medicare trust funds. The FY 2010 Statement of Social Insurance projections contained in this report incorporate the effects of the Affordable Care Act, and are prepared based on current law, in accordance with the standards required by the Federal Accounting Standards Advisory Board. Although I am satisfied with the results of this year's audit, there are still many challenges we face that will require us to work closely with our auditors to develop the necessary actions to remediate this issue for the future.

One of our successes highlighted during this year's audit was our remediation of a long-standing internal control material weakness related to information systems. While this issue has been downgraded to a significant deficiency, CMS considers this to be a major accomplishment and will continue to implement corrective actions to properly address the auditors' findings regarding this issue.

As an Agency, we continue to meet our fiduciary and operating responsibilities to our beneficiaries. To this end, we carried out a number of new and improved initiatives in FY 2010. An example of one of the Agency's significant financial management achievements this year was the preparation of our first auditable financial statements via the Healthcare Integrated General Ledger Accounting System (HIGLAS) during FY 2010. HIGLAS, CMS' official financial management system of record, has enabled us to become substantially compliant with the Federal Financial Managers Integrity Act of 1996. To strengthen financial management processes even further, we incorporated into HIGLAS the accounting functionality for the Medicare Advantage and Prescription Drug payments, and successfully completed eight additional Medicare Administrative Contractor transitions. These financial management and reporting improvements by CMS are essential in meeting the requirements of key Federal legislation, safeguarding government assets, and maintaining an unqualified opinion on our financial statements.

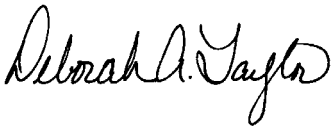
The CMS continued to support the Federal Payment Levy Program (FPLP). Through this program, the IRS can collect overdue taxes through a continuous levy on certain Federal payments. Medicare payments are eligible for levy and as of September 30, 2010, CMS has realized a cumulative total of $87.2 million in tax levy offsets and $19.3 million in non-tax offsets through HIGLAS on behalf of FPLP. The CMS will continue to expand FPLP functionality during FY 2011 for recoupment of administrative offsets for additional Federal non-tax debts.

Banking services for Medicare contractors providing payments to providers was converted from individual banking relationships between the various Medicare contractors and their financial institutions, to a consolidated, commercial banking set of services managed by CMS. As a result of this consolidation of banking services and the redesign of the payment process, CMS has seen a first year savings of $880 million. Utilizing two commercial financial institutions selected through a full and open competition, we were able to redirect $852 million back to the Medicare trust funds for immediate investment. Interest earned on these funds will be credited to the Medicare trust funds in the estimated amount of $24 million annually.

FY 2010 was the first year for the National Recovery Audit Program. While the demonstration program provided valuable information for designing and improving the National program, much of 2010 was focused on education and outreach, and establishing an infrastructure for managing and overseeing the recovery audit contractors. To date, the Recovery Audit Program has demanded approximately $135 million and recovered $75.5 million in improper payments. The CMS expects collections to continue to increase as the Recovery Audit Program continues to expand.

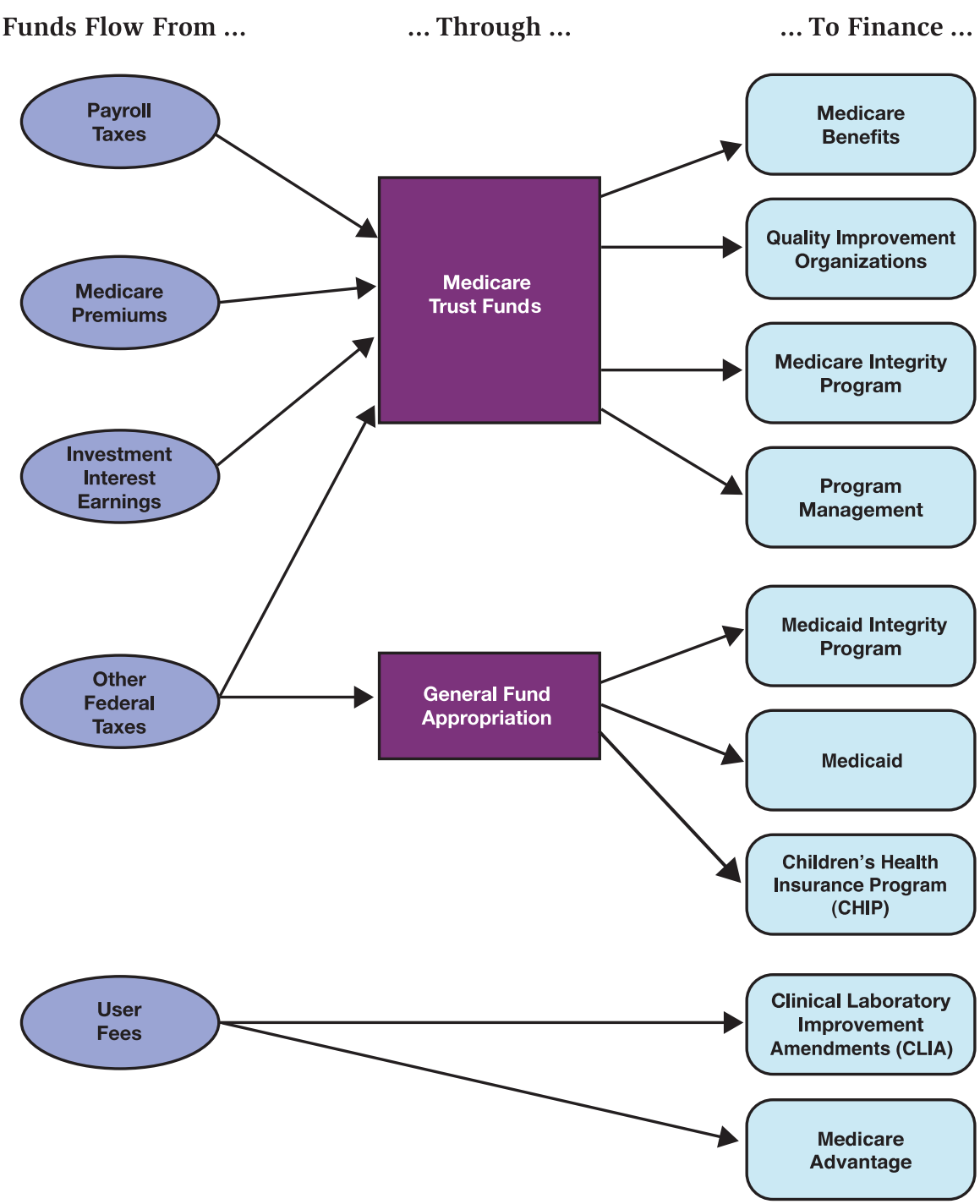
The CMS continues to implement the requirements of the Improper Payments Information Act, which was amended in July of 2010, by the Improper Payments Elimination and Recovery Act (IPERA). We have implemented the necessary requirements and enhance our program integrity efforts to reduce improper payments in all of our programs. As part of our sound financial strategy, we work towards reducing the number of Medicare fee-for-service (FFS) payment errors. This year, the Medicare fee-for-service error rate was 10.5 percent. Furthermore, we can also report a baseline error rate for Medicaid, which is 9.4 percent. This rate is based on a review of FFS, managed care, and eligibility benefits in all 50 states and the District of Columbia measured over a three year period. Going forward, the official reported rate will be a "rolling average" of the most recent three years. We are also in compliance with IPERA for the Children's Health Insurance Program (CHIP). The error rate measurement was temporarily suspended while CMS developed a new final rule for the Payment Error Rate Measurement (PERM) program as required by the Children's Health Insurance Program Reauthorization Act of 2009. The PERM final rule was published in August of 2010 and CMS will reconvene measurement of CHIP improper payments. Since FY 2008, CMS has reported a Part C composite payment error rate, and for FY 2010, the error rate was 14.1 percent. We continue to make significant strides towards achieving full IPERA compliance by preparing measurement methodologies for four components of a composite Prescription Drug Program (Part D) payment error estimate, and we are on track to report a baseline error rate in FY 2011.

Finally, I want to emphasize that even though CMS has established a long track record of strong financial and program management processes, we realize the year ahead will present exciting new challenges and we are confident that we will continue to achieve successful results. I encourage you to read about the Agency and our many accomplishments for FY 2010.



Deborah A. Taylor, CPA
November 2010

Financing of CMS Programs and Operations



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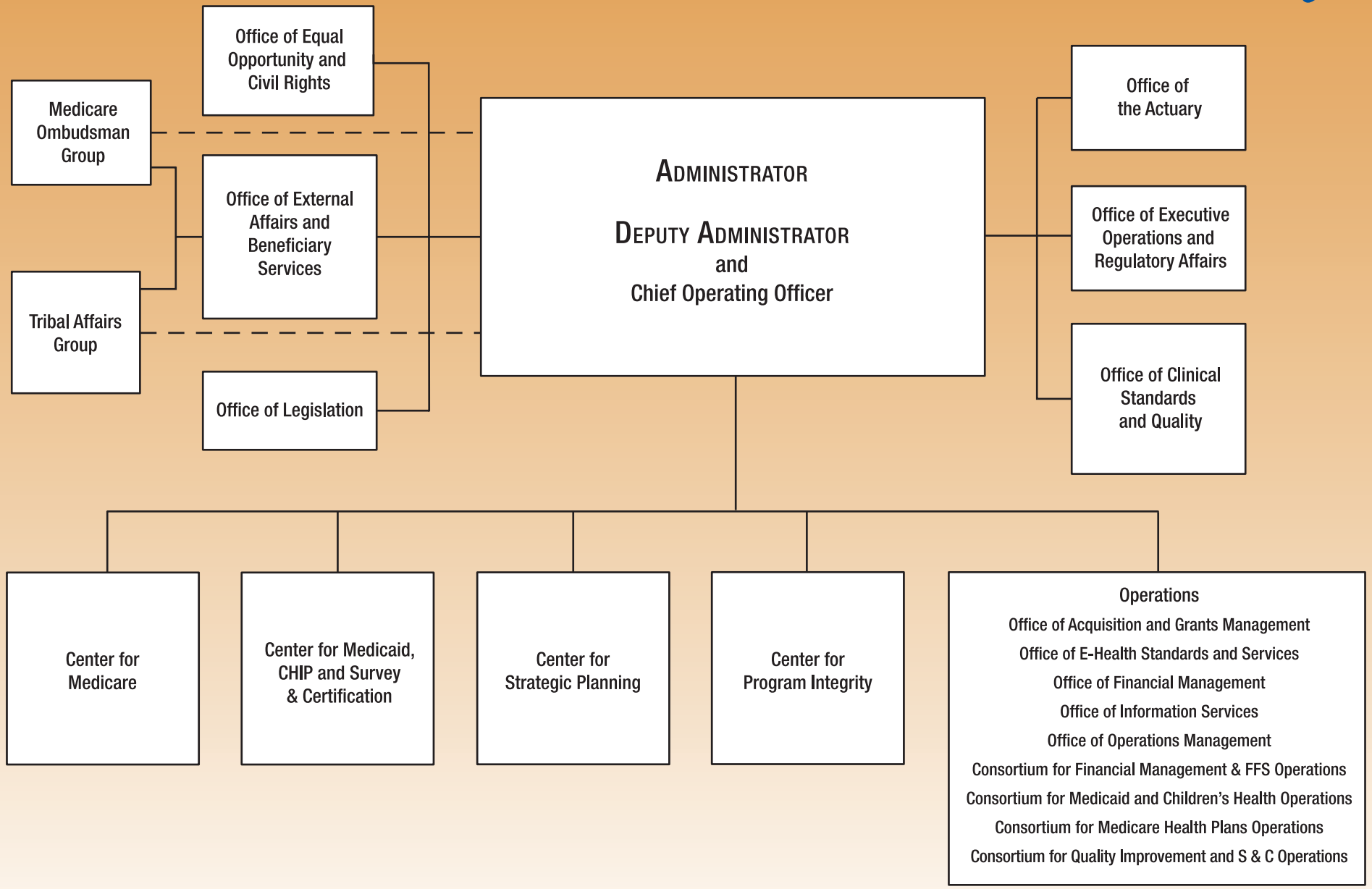
Approved Leadership
As of September 1, 2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES



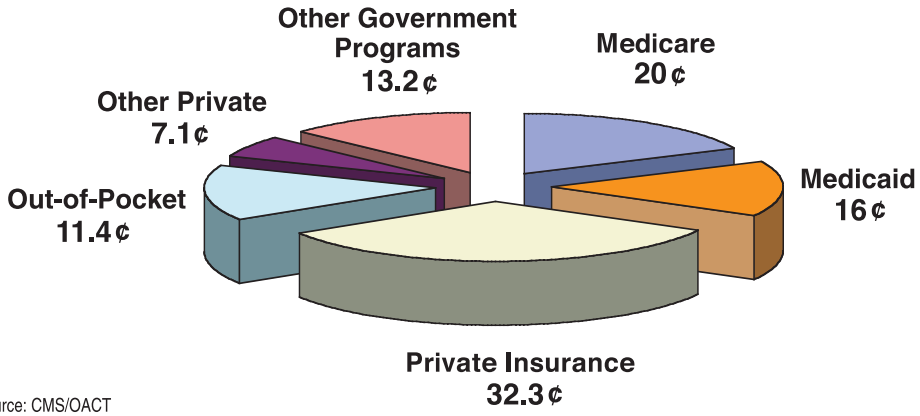
Management's Discussion and Analysis

OVERVIEW

The Centers for Medicare & Medicaid Services (CMS), a component of the Department of Health and Human Services (HHS), administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Along with the HHS, CMS also has begun to implement the provisions of the Affordable Care Act.

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 36 cents of every dollar spent on health care in the United States (U.S.)—or looked at from three different perspectives, 62 cents of every dollar spent on nursing homes, 48 cents of every dollar received by U.S. hospitals, and 28 cents of every dollar spent on physician services.

The Nation's Health Care Dollar 2010



Source: CMS/OACT

The CMS **outlays** totaled approximately $729.1 billion (net of offsetting receipts and Payments to the Health Care Trust Funds) in fiscal year (FY) 2010. Our **expenses** totaled approximately $789.7 billion, of which $3.3 billion (less than 1 percent) were administrative expenses.

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

The CMS establishes policies for program eligibility and benefit coverage, processes over one billion Medicare claims annually, matches State expenditures with funds for Medicaid and CHIP, and ensures quality of health care for beneficiaries, and safeguards funds from fraud, waste, and abuse. The CMS employs approximately 5,000 Federal employees in Baltimore, Maryland, Washington, DC, and 10 regional offices (ROs) throughout the country. The RO employees mainly provide direct services to Medicare Administrative Contractors (MAC) and Durable Medical Equipment Medicare Administrative Contractors (DMAC), State agencies, health care providers, beneficiaries, sponsors of group health plans and Medicare health and prescription drug plans, and the general public. The employees in Baltimore and Washington provide funds to MACs and DMACs; write policies and regulations; set payment rates; safeguard the fiscal integrity of the Medicare, Medicaid, and Children's Health Insurance Programs (CHIP) to ensure that benefit payments for medically necessary services are paid correctly the first time; recover improper payments; assist law enforcement agencies in the prosecution of fraudulent activities; monitor contractor performance; develop and implement customer service improvements; provide education and outreach activities to Medicare providers, survey hospitals, nursing homes, labs, home health agencies and other health care facilities for compliance with Medicare health and safety standards; work with state insurance companies; and assist the states and territories with Medicaid and CHIP. The CMS also maintains the Nation's largest collection of health care data and provides technical assistance to the Congress, the executive branch, universities, and other private sector researchers.

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

PROGRAMS

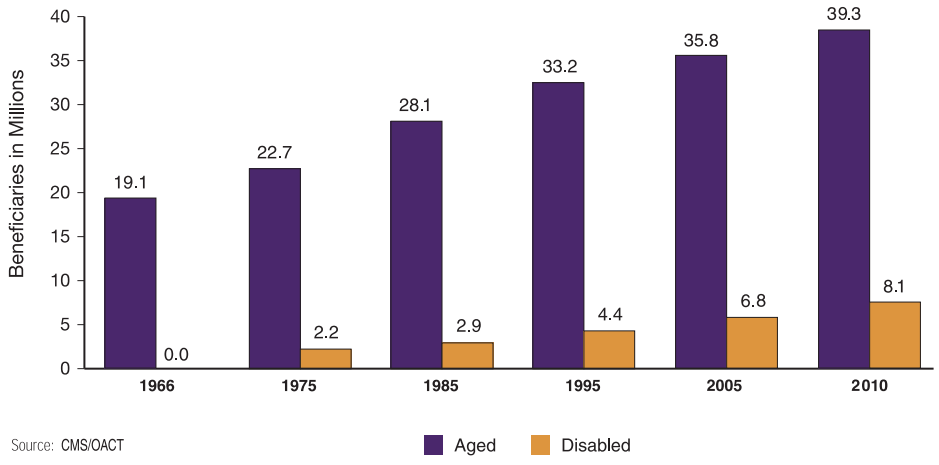
Medicare

Introduction

Established in 1965 as title XVIII of the Social Security Act, Medicare was legislated as a complement to Social Security retirement, survivors, and disability benefits, and originally covered people aged 65 and over. In 1972, the program was expanded to cover the disabled, people with end-stage renal disease (ESRD) requiring dialysis or kidney transplant, and people age 65 or older that elect Medicare coverage. On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148) and the Health Care and Education Reconciliation Act (P.L. 111-152), collectively referred to as the *Affordable Care Act*. The law puts into place comprehensive reforms that strengthen the Medicare program by holding insurance companies more accountable, enhancing the quality of care delivered to Medicare beneficiaries, closing the prescription drug coverage gap, providing certain preventive care services at no charge, and extending the life of the Medicare Trust Fund. This will provide future cost savings on premiums and coinsurance.

Medicare processes over one billion fee-for-service (FFS) claims a year, is the Nation's largest purchaser of managed care, and accounts for approximately 13 percent of the Federal Budget. Medicare is a combination of five programs: Hospital Insurance, Supplementary Medical Insurance, Medicare Advantage, Medicare Prescription Drug Benefit, and CHIP. Since 1966, Medicare enrollment has increased from 19 million to approximately 47 million beneficiaries.

Medicare Enrollment



Source: CMS/OACT

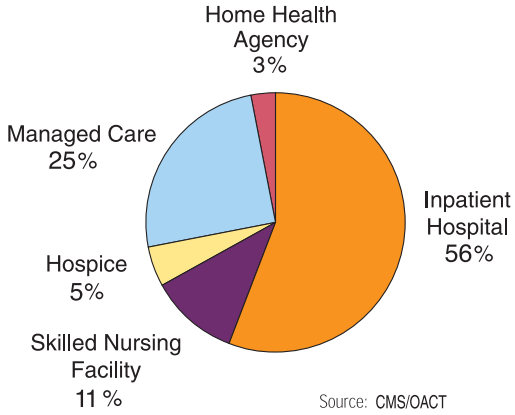
Hospital Insurance

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

benefits for current beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the HI trust fund, and invested in U.S. Treasury securities.

Based on estimates from the midsession review of the FY 2011 President's budget, inpatient hospital spending accounted for 56 percent of HI benefit outlays in FY 2010. Managed care spending comprised 25 percent of total HI outlays. During FY 2010, HI benefit outlays grew by 3.9 percent and the HI benefit outlays per enrollee were projected to increase by 1.7 percent to $5,210.

HI Medicare Benefit Payments



Source: CMS/OACT

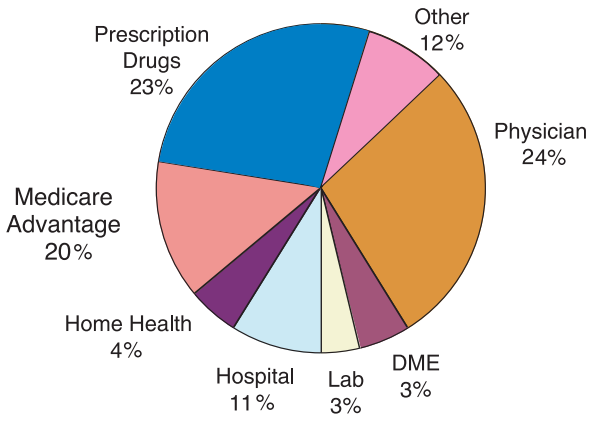
Supplementary Medical Insurance

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

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

Also based on estimates from the Midsession Review of the FY 2011 President's budget, SMI benefit outlays grew by 7.2 percent during FY 2010. Physician services, the largest component of SMI, accounted for 24 percent of SMI benefit outlays. During FY 2010, the SMI benefit outlays per enrollee were projected to increase 4.5 percent to $6,300.

SMI Medicare Benefit Payments



Source: CMS/OACT

Medicare Advantage

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA; P.L. 108 -173) created the Medicare Advantage (MA) program, which is designed to provide more health care coverage choices for Medicare beneficiaries. Those who are eligible because of age (65 or older) or disability may choose to join a MA plan if they are entitled to Part A and enrolled in Part B, if there is a plan available in their area. Those who are eligible for Medicare because of ESRD may join a MA plan only under special circumstances.

Medicare beneficiaries have long had the option to choose to enroll in prepaid health care plans that participate in Medicare instead of receiving services under traditional Fee for Service (FFS)

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

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

Managed care expenses were approximately $115.1 billion of the total $503.6 billion in Medicare benefit payment expenses in FY 2010.

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 benefit constitutes one of the most significant changes to the Medicare program since its inception in 1965. The addition of this program recognizes the vital role of prescription drugs in our health care delivery system, and the need to modernize Medicare to assure their availability to Medicare beneficiaries. The prescription drug benefit is funded through the SMI Trust Fund.

The program was effective January 1, 2006, and 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 is provided under private prescription drug plans (PDPs), which offer only prescription drug coverage, or through Medicare Advantage prescription drug plans (MA PDs), which offer prescription drug coverage that is integrated with the health care coverage they provide to Medicare beneficiaries under Medicare Advantage.

Participating Part D plans must offer a statutorily defined standard benefit or an alternative actuarially equivalent to standard coverage benefit. The 2010 standard benefits generally have a $310 deductible and coinsurance of 25 percent after the deductible up to the initial coverage limit of $2,830 in total drug spending. This is followed by a coverage gap for which beneficiaries pay 100 percent to an out-of-pocket spending limit of $4,550. Once the out-of-pocket spending reaches this level, Medicare pays 80 percent, the plan pays 15 percent, and the beneficiary generally pays 5 percent of drug costs for catastrophic coverage. PDPs and MA PDs submit annual bids to CMS reflecting expected benefit payments plus administrative costs after a deduction for expected reinsurance subsidies. Payment for basic Part D benefits is made using five funding streams. Throughout the benefit year, CMS pays plans monthly prospective payments through a direct subsidy, a prospective payment for the low income cost-sharing subsidy (LICS), a payment for the low income premium subsidy (LIPS), and a prospective payment for the reinsurance subsidy.

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

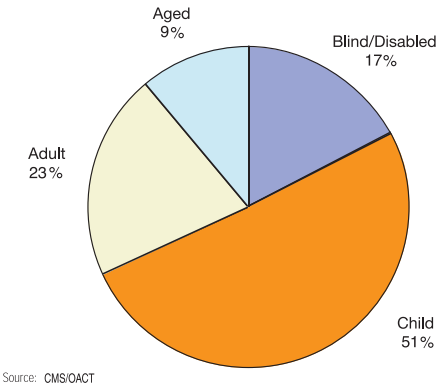
Employer, union, and other Plan Sponsors (PS) of group health plans that offer a prescription drug benefit that is actuarially equivalent to Part D are able to apply for the Retiree Drug Subsidy (RDS) program. A PS may only receive subsidy payments for qualifying covered retirees. All PS that provide a drug benefit plan to their retirees may apply annually for participation in the RDS program. To qualify for the subsidy, PS are required to demonstrate that their coverage is "actuarially equivalent" to defined standard prescription coverage under Medicare Part D. However, the actuarially equivalent standard does not apply to the ACA provisions which fill in the coverage gap.

Medicaid

Introduction

Medicaid is the means-tested health care program for low-income Americans, administered by CMS in partnership with the states. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid was originally legislated to provide medical assistance to recipients of cash assistance. At the time, cash assistance was provided to low-income families and children through the Aid to Families with Dependent Children (AFDC) program, while the Supplemental Security Income (SSI) program provided cash assistance to low-income aged, blind and disabled individuals. Over the years, Congress incrementally expanded Medicaid well beyond these original traditional populations. Today, Medicaid is the primary source of health care for a much larger population of medically vulnerable Americans, including low-income families, pregnant women, people of all ages with disabilities, and people who require long-term care services, who all should receive coordinated, quality care. The average enrollment for Medicaid was estimated at 54 million in FY 2010, about 18 percent of the U.S. population. About 8.6 million people are dually eligible, that is, covered by both Medicare and Medicaid.

FY 2010 Medicaid Enrollees



Source: CMS/OACT

Congress has passed several pieces of legislation that have impacted Medicaid. The Affordable Care Act expanded eligibility for Medicaid to all legal adult residents with incomes below 133 percent of the Federal Poverty Level beginning January 1, 2014, with a state option to begin coverage earlier. The Affordable Care Act also provided additional funding for CHIP. Several provisions of the Affordable Care Act provide substantial new funding for developing a Medicaid adult quality measurement program to complement the Children's Health Insurance Program Reauthorization Act (CHIPRA). In addition, the law includes other provisions that expand the Federal-state partnership in disease prevention and quality improvement in health care.

The American Recovery and Reinvestment Act of 2009 (ARRA) directly affected the Medicaid Program under title XIX of the Social Security Act. ARRA provisions provide Medicaid programs

with temporarily increased Federal match rates and considerable new resources to promote and expand the use of health information technology (HIT) in the health care system. The law provides incentives to encourage the use of electronic health records (EHR) for exchanging information across the health care system. This investment in HIT is key to CMS efforts to better measure, monitor and assure the quality of care provided to children in Medicaid. Finally, CHIPRA established a new foundation for building a comprehensive, high quality system of care for children by addressing key components essential to accessing coverage and implementing quality improvement strategies related to health care.

Medicaid Quality Improvement Initiatives

Recent provisions under Affordable Care Act, ARRA and CHIPRA also expand the federal-state partnership in disease prevention and quality improvement in health care. These initiatives include:

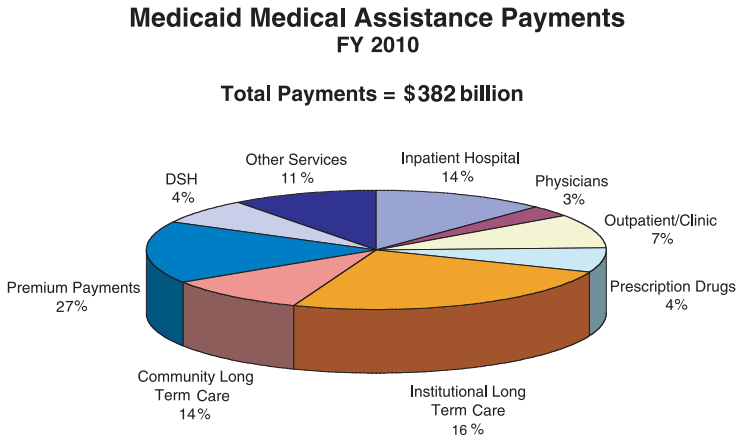
- Establishment of an initial core set of child and adult quality performance measures for voluntary reporting by State programs;
- $100 million across ten grants (that include 18 states) to test innovative approaches to using performance measures, HIT, EHR, and provider delivery models to improve the quality of care for children;
- Establishment of an EHR format specifically for children;
- Establishment of Medicaid incentive payments to states and Medicaid eligible providers to demonstrate meaningful use of EHR—which includes exchange of health information and reporting of clinical quality measures selected by the Secretary of the Department of HHS;
- Improved data collection for measuring, evaluating, and addressing health disparities in Medicaid and CHIP by race, ethnicity, primary language , and disability status;
- Development of performance measures and a Medicaid policy regarding payment for health care acquired conditions;
- Demonstration grants to states to test approaches that encourage healthier lifestyles among Medicaid and CHIP enrollees with chronic health problems;
- Demonstration grants to establish value based incentive payments to hospitals that meet performance standards; and
- Incentive payments to states that eliminate cost-sharing requirements for Medicaid recommended clinical preventive services.

Additionally, CMS is in the early stages of partnering with states to implement several national Medicaid and CHIP quality improvement initiatives:

- A Neonatal Outcomes Improvement Project based on evidence-based clinical intervention strategies;
- A Children's Oral Health Improvement initiative; and
- Improving access, data collection/reporting, and assessment of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Federal Medical Assistance Percentage (FMAP) Increase for States

In ARRA, Congress enacted a temporary increase to state FMAP rates for the 50 states, the District of Columbia, and options for increased funding for the territories during the current recession. Section 5001(a) and (b) of ARRA provide for maintenance of FMAPs for FY 2009 through the



Source: President's FY 2011 Budget, Midsession Review

first quarter of FY 2011, and a general across-the-board increase of 6.2 percent for each of such fiscal years. Section 5001(c) provides for a further increase to the FMAPs for those states that have especially high unemployment rates. In August 2010, Congress acted, through P.L. 111-226, to extend the ARRA FMAP increases through the third quarter of FY 2011, extending provisions for an additional two quarters with a reduction of the across-the-board increases to 3.2 percent and 1.2 percent for the second and third quarters for FY 2011, respectively.

FMAP Increase for Territories

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

Medicaid Disproportionate Share Hospital (DSH) Payments

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

The CMS provides matching payments to the states and territories for Medicaid program expenditures 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 2010, the basic Federal matching rate for Medicaid program costs among the states according to the formula ranged from 50 to 76 percent. However, the ARRA provides states with additional Federal matching funds. As a result, the average matching rate for FY 2010 was about 71 percent. Federal matching rates for various state and local administrative costs are set by statute. The Federal government currently pays about 55 percent of these costs. Medicaid payments to states 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 DSH payments, payments for Part B premiums for Qualifying Individuals (QI), 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 their individual circumstances and priorities. Accordingly, there is a wide variation in the services offered by the states.

Medicaid is the largest single source of payment for health care services for persons with Acquired Immune Deficiency Syndrome (AIDS). Medicaid now serves over 50 percent of all AIDS patients and pays for the health care costs of most of the children and infants with AIDS. In FY 2010, Medicaid spending for persons with AIDS as well as others infected with the Human Immunodeficiency Virus (HIV) is estimated to be about $8.6 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 2010, state and Federal ADM gross outlays are estimated at $19.4 billion, about 5 percent of the gross Medicaid outlays. State and Federal MAP total outlays were $389.0 billion or 95 percent of total Medicaid outlays, an increase of 7.4 percent over FY 2009. Thus, state and Federal MAP and ADM outlays for FY 2010 totaled $408.44 billion. The CMS share of Medicaid outlays totaled $275.0 billion in FY 2010.

Enrollees

Children comprise nearly half of Medicaid enrollees, but account for only an estimated 21 percent of Medicaid outlays. In contrast, the elderly and disabled comprise 26 percent of Medicaid enrollees, but accounted for an estimated 64 percent of program spending. The elderly and disabled use more expensive services in all categories, particularly nursing home services.

Service Delivery Options

Many states are pursuing managed care as an alternative to the FFS system for their Medicaid programs. Managed health care provides several advantages for Medicaid beneficiaries, such as enhanced continuity of care, improved preventive care, and prevention of duplicative and contradictory treatments and/or medications. Most states have taken advantage of waivers provided by CMS to introduce managed care plans tailored to their state and local needs, and 50 states now offer a form of managed care. The number of Medicaid beneficiaries enrolled in managed care has grown from 40 percent in 1996 to 72 percent in 2009[1].

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

[1] 50 states offer managed care, the number includes DC and PR. VI, WY, and AK do not offer managed care. For MS, we counted them as having managed care because they have a capitated transportation program. The June 30, 2009 data is collected from the states and represents that point-in-time.

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. Many of the pioneering efforts to develop Medicaid managed care were authorized as section 1115 demonstrations, and states continue to use this authority to develop innovative programs.
2) Freedom of choice waivers—section 1915(b) of the Social Security Act allows certain provisions of Medicaid law to be waived to allow the states to develop innovative managed health care delivery systems.
3) Other state plan options to implement managed care—section 1932(a) of the Social Security Act allows the states to mandate managed care enrollment for certain groups of Medicaid beneficiaries. Certain populations—including dual eligibles, children receiving SSI, children with special health care needs, and American Indians—are exempted from the state plan option. For these groups, the states require waivers to mandate enrollment into managed care.

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

Medicaid Home and Community-Based Services

Medicaid affords states with opportunities to provide home and community-based services as an alternative to institutional services. Section 1915 (c) Home and Community-Based Services (HCBS) waivers allows states the option to provide HCBS to individuals who would otherwise require services in an institution. Section 1915 (i), implemented under the Deficit Reduction Act (DRA) of 2005 and amended under the Affordable Care Act, provides states with an opportunity to provide HCBS through the Medicaid state plan without the need for a waiver but does not require eligible individuals to meet an institutional level of care.

Children's Health Insurance Program (CHIP)

CHIP was created through the BBA of 1997 to address the fact that at the time nearly 11 million American children—one in seven—were uninsured and therefore at increased risk for preventable health problems. Many of these children were in working families that earned too little to afford private insurance on their own, but too much to be eligible for Medicaid. Congress and the Administration agreed to set aside nearly $40 billion over ten years, beginning in FY 1998, to create CHIP—the largest health care investment in children since the creation of Medicaid in 1965. The original CHIP budget authority expired September 30, 2007, but was extended by Congress through March 31, 2009 in the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007. On February 4, 2009, the CHIPRA was enacted and further extended CHIP through September 30, 2013 and appropriated funds for the purposes of providing allotments to the states for their CHIP programs. CHIPRA also changed the availability of the states' annual CHIP allotments from three to two years beginning with the FY 2009 CHIP allotments. The Affordable Care Act appropriated additional funding for allotment to states by further extending CHIP through September 30, 2015.

CHIP funds cover the cost of insurance, reasonable costs for administration, and outreach services to get children enrolled. To maximize coverage of children, states must cover previously uninsured children, and ensure that CHIP coverage does not replace existing public or private coverage. Important cost-sharing protections in CHIP protect families from incurring unaffordable out-of-pocket expenses.

Title XXI of the Social Security Act outlines the program's structure, and establishes a partnership between the Federal and state governments. States are given broad flexibility in designing their programs. 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 set their own 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 DRA and CHIPRA prohibit the use of Federal CHIP funds to provide health benefits coverage to nonpregnant childless adults. States that submit a section 1115 demonstration application on or after the October 1, 2005 are not eligible to receive title XXI funds to provide coverage for nonpregnant childless adults. CHIPRA expands on this provision by stating that renewal applications for a waiver, experimental, pilot, or demonstration project for nonpregnant childless adults may be approved on or after February 4, 2009 (date of the enactment of CHIPRA).

The CMS works closely with the states, Congress, and other Federal agencies to meet the challenges of implementing this program. The CMS provides extensive guidance and technical assistance so the states can further develop their CHIP state plans and use Federal funds to provide health care coverage to as many children as possible. All 50 states, the District of Columbia, and the territories had approved CHIP state plans. As of July 1, 2010, state programs for CHIP included 13 Medicaid expansions (includes District of Columbia and all of the territories), 17 separate children health programs and 26 combination CHIP programs.

Other Activities

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

Survey and Certification Program

We are responsible for assuring the safety and quality of medical facilities, laboratories; providers, and suppliers by setting standards, training inspectors, conducting inspections, certifying providers as eligible for program payments, and ensuring that corrective actions are taken where deficiencies are found. The survey and certification program is designed to ensure that providers and suppliers comply with Federal health, safety, and program standards. We administer agreements with state survey agencies to conduct onsite facility inspections. Funding is provided through the Program Management and the Medicaid appropriations. Only certified providers, suppliers, and laboratories are eligible for Medicare or Medicaid payments. Currently, CMS Survey and Certification staff oversee compliance with Medicare health and safety standards in approximately 289,000 currently active medical facilities of different types, including hospitals, laboratories, nursing homes, home health agencies, hospices, and end stage renal disease facilities.

Clinical Laboratory Improvement Amendments Program (CLIA)

The CLIA expanded survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing specimens from the human body for health purposes. We regulate all laboratory testing (whether provided to beneficiaries of CMS programs or to others) including those performed in physicians' offices for a total of 227,000 facilities. In partnership with the states, we certify and inspect approximately 20,500 laboratories on a biennial basis. Data from these inspections reflect significant improvements in quality of testing over time. The CLIA program is a 100 percent user-fee financed program. The CLIA program is jointly administered by three HHS components: (1) CMS manages the financial aspects of the program, contracts and trains state surveyors to inspect labs, and oversees program administration including enrollment, fee assessment, regulation development, approval of accrediting organizations and proficiency testing providers, certification, enforcement and data system design, (2) the Centers for Disease Control and Prevention (CDC) provides research and technical support, and (3) the FDA performs test categorization.

Transformation Grants

The DRA authorized the Medicaid Transformation Grants and appropriated $150 million in Federal FY 2007 and 2008 funding. Thirty-five states, the District of Columbia and Puerto Rico were awarded grants. The focus of which includes: health information technology (electronic health records, health information exchange, clinical decision support tools, and e-prescribing); lien/estate recovery and fraud and abuse detection systems; medication risk management; predictive modeling for improved care coordination; streamlined eligibility and citizenship determination; and web-based preauthorization systems for pharmacy and/or home and community-based services. The majority of the grants have been awarded no-cost extensions through 2010. Final project evaluations, those focused on health information technology, will be disseminated broadly to states and other stakeholders via the electronic health record incentive payment program authorized under ARRA.

Health Care Quality Improvement

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

The CMS' quality agenda emphasizes that accelerated change is needed; to achieve it, CMS will use partnerships, public reporting, value-based purchasing, quality education and resources, and the promotion of effective health care technologies.

The CMS' vision is to achieve a transformed and modernized health care system by influencing 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.

Medicare and Quality Improvement Organizations

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

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

The 9th SOW, which extends from August 2008 through July 2011, gives CMS additional tools to better manage the QIOs by linking their work to measurable outcomes that CMS will review and measure throughout the 3-year contract. Now in the third year of the SOW, QIOs are focusing their measurable improvement efforts on protecting beneficiaries, care transitions, patient safety, and prevention of chronic diseases. As QIOs have done in the past, they continue to emphasize utilization review, quality of care review, alternative dispute resolution, review of beneficiary appeals of certain provider notices, and review of potential anti-dumping cases. The QIOs also work on CMS' national agenda for the Government Performance and Results Act (GPRA), with goals that include priorities for improving adult immunization rates and diabetes care, optimizing the timing of antibiotics prior to surgery and increasing vascular access for hemodialysis patients.

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

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

In the nursing home setting, CMS participated in the formation of a coalition with groups representing healthcare providers, caregivers, medical and quality improvement experts, government agencies, consumers and others to launch the *Advancing Excellence in America's Nursing Homes* campaign. The campaign continues today. The campaign seeks excellence in the quality of life and quality of care for the more than 1.8 million American nursing home residents by enhancing choice, strengthening workforce, and improving clinical outcomes. Nursing homes participating in the campaign are working on goals and can access technical assistance and guidance from quality experts, such as QIOs, in reaching their targeted goals. Consumers participating in the campaign help to create greater awareness of quality care and the resources available, and encourage providers to improve the care they deliver. The campaign reports on providers' continuing quality improvement progress overall, and those reports will inform consumer choices for future long-term care needs.

Cultural competency education and technical assistance to physician offices are also part of CMS' quality improvement aim for identifying and addressing unique racial and/or ethnic factors that contribute to an underserved population's disparate burden of disease and disability. Reducing disparities is a cross-cutting theme throughout the 9th SOW. Additionally; some QIOs are working to reduce disparities in the clinical areas of diabetes and chronic kidney disease. In the home health care setting, patients are recovering faster and with less chance of re-hospitalization, a priority focus for QIOs in working with home health agencies under the care transitions theme of the QIOs 9th SOW.

Through innovative partnerships, public reporting and its QIOs, CMS has achieved greater momentum toward six aims. Through its public-private collaboration with the Hospital Quality Alliance (HQA), CMS provides a robust, prioritized, and standard set of hospital quality measures for use in voluntary public reporting. Medicare beneficiaries, as well as all consumers, can access ***Hospital Compare***, a web tool that provides valid, credible, and user-friendly information about the quality of care delivered in the Nation's hospitals. As of July 2010, information on over 4,400 hospitals is available on ***Hospital Compare***.

The data have been expanded to include:

- Inpatient process of care measures in the areas of heart attack, heart failure, pneumonia, pediatric asthma and surgical care,
- Inpatient outcomes of care measures (mortality and re-admission) related to hospitalizations for heart attack, heart failure and pneumonia,
- Inpatient Hospital Consumer Assessment of Health Plans Survey (HCAHPS) that measures patients' perspectives on hospital care,
- Inpatient Medicare Payment and Volume data,
- Outpatient process of care measures in the areas of heart attack an chest pain as well as outpatient surgery, and
- Outpatient Imaging Efficiency Measures.

Medicare and the End-Stage Renal Disease Quality Initiative

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

Additionally, CMS is in the process of implementing the Quality Incentive Program (QIP) for Medicare outpatient ESRD dialysis facilities beginning January 1, 2012, in compliance with the statutory requirement of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) Section 153(c), enacted July 15, 2008. The ESRD QIP would reduce ESRD payments, by up to 2 percent, to dialysis providers and facilities that failed to meet or exceed a total performance score.

Coverage Policy

Medicare's coverage policy affects every insurer and health care purchaser in today's health care market since many third-party payers tend to follow CMS' lead. To that end, CMS has established an open and transparent National Coverage Determination (NCD) process that provides multiple opportunities for public participation. Specifically, CMS holds numerous meetings each year that are open to the public and there are two public comment periods that occur for every open NCD. All public comments, as well as other useful up-to-date coverage issue information, are available on CMS' coverage web site. The CMS also involves the public through its Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) which provides independent guidance and expert advice to CMS on specific clinical topics. The MEDCAC is comprised of experts in the fields of 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. The MEDCAC is used to supplement CMS' internal expertise and to allow an unbiased and current deliberation of "state of the art" technology and science. It 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 and makes recommendations on the quality of the evidence reviewed. Also, CMS relies on state-of-the-art technology assessment and additional support from other Federal agencies.

Insurance Oversight and Data Standards

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

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

In January of 2009, CMS published two final rules to update the HIPAA code set and transactions standards. The first rule adopts the updated X12 standard (Version 5010) and the National Council for Prescription Drug Programs standard (Version D.0) for electronic transactions, such as health care claims. It also adopts a new standard for Medicaid pharmacy subrogation. The compliance date for these changes will take place on January 1, 2012. The second rule adopts the ICD-10 code set for diagnosis and inpatient hospital procedure coding as of October 1, 2013. During FY 2010, CMS conducted outreach activities and worked closely with industry stakeholders on version 5010/ICD-10, planning, messaging, and monitoring to promote industry readiness by compliance dates.

With regard to HIPAA enforcement activities, CMS continues to operate based on a complaint-driven process, addressing transaction and code set complaints filed against covered entities by requesting and reviewing documentation of their compliance status and/or corrective actions. In addition, CMS has the authority to conduct compliance reviews of covered entities. Reviews target covered entities for which CMS had already received and investigated a HIPAA transaction and code set complaint.

The Affordable Care Act included a number of provisions related to Administrative Simplification. Regulations will be written in the next 12 months to adopt a national Health Plan Identifier (HPID) and operating rules for two of the standard transactions. Over the next three years, four to five more regulations will be released adopting additional operating rules, new standards, new compliance requirements and new penalty provisions. The CMS will be responsible for all of these new provisions and will collaborate across the public and private sector on implementation.

PERFORMANCE GOALS

The Government Performance and Results Act (GPRA) of 1993 mandates that agencies have strategic plans, annual performance goals, and annual performance reports that make them accountable stewards of public programs. The CMS' performance measures are included in the Annual Performance Budget and its Online Performance Appendix. The CMS performance measures emphasize the themes of accountability, stewardship, and a renewed focus on the customer with its strategic and annual goals and its mission "To ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries."

The CMS' approach to performance measurement under GPRA is to develop measures that are representative of our vast responsibilities. The Agency GPRA plan does not reflect every activity and challenge it encounters, but reflects key Administration and CMS priorities that represent vital mission-critical activities. The performance budget includes targets for the performance measures depicted, and establishes a method and data source for measuring and reporting progress. The CMS uses performance results to inform budget and operating decisions.

The FY 2010 performance budget includes 33 measures for CMS programs, highlighting major program areas. Some of CMS' key FY 2010 performance measures and outcomes are highlighted below. Progress on all of the measures will be submitted through FY 2012 President's budget request process.

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

The CMS is committed to reducing the percentage of improper payments made under the Medicare FFS program. President Obama recently announced that CMS will cut the Medicare FFS improper payment rate in half by 2012. 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 2010 target for the Medicare FFS error rate was 9.5 percent gross (overpayments plus underpayments) with a baseline of 12.4 percent in 2009. The CMS did not meet its goal for FY 2010.

The CMS analysis for FY 2010 indicated that the paid claims gross error rate was 10.5 percent or $34.3 billion in gross improper payments. In 2010, the CMS continued to review claims according to a significantly revised and improved methodology implemented in 2009. As a result of these improvements and a more complete accounting of improper payments, the 2009 and 2010 overall error rates were higher than 2008; 12.4 percent and 10.5 percent in 2009 and 2010 respectively.

The HHS 2009 Agency Financial Report shows the Medicare FFS error rate as 7.8 percent or $24.1 billion in improper payments, which reflects the old review process used for most of the claims that year. The error rate for claims reviewed under the newer, and more stringent criteria was 12.4 percent, or $35.4 billion in improper payments in 2009. For purposes of setting an estimated baseline for future goals, CMS is using 12.4 percent as the 2009 improper payment rate.

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

In response to Executive Order 13520 *Reducing Improper Payments and Eliminating Waste in Federal Programs*, along with the activities previously mentioned which measure the error rate, CMS is conducting special studies or supplemental study measures that address root causes of errors in high vulnerability areas of Medicare FFS.

Decrease the Prevalence of Restraints in Nursing Homes

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

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

The CMS exceeded its FY 2009 target of 5.1 percent by reaching a rate of 3.3 percent. The FY 2010 target is 3.8 percent. Results will be available in February 2011. The CMS will promote the reduced use of physical restraints through the annual nursing home survey process and through the efforts of the Quality Improvement Organizations, which are dedicated to working directly with individual providers to improve quality of care delivered.

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

The CMS released a Quality Roadmap with the vision for the "right care for every person every time." The Roadmap outlined a plan of action to "implement, in close partnership with states, a strategy to improve the quality of care for Medicaid beneficiaries." The CMS also established a Medicaid Quality Strategy to complement the CMS Quality Roadmap. This commitment allows CMS to provide technical assistance to states regarding quality improvement, quality measurement, and External Quality Review. The aim of the strategy includes supporting states in achieving safe, effective, efficient, timely, equitable, and patient-centered care. The CMS plans to use information gained from these state-level quality improvement initiatives as the building blocks for the development of a larger, national-level quality framework.

This long-term measure tracks the number of states participating in the Medicaid Quality Improvement Program (MQIP), which provides technical assistance to states to bolster their targeted health quality improvement projects. State participation is voluntary. By working with CMS, states can receive technical assistance to help them achieve improvements in health care quality for Medicaid beneficiaries. The CMS will track state participation in quality improvement efforts and disseminate tools to provide guidance in achieving objectives in areas of evidence-based care, health disparities and program evaluation. In FY 2007, our baseline year, CMS reviewed data sources and data collection tools to document state quality activity. Quality Assessment Reports were developed for dissemination to states for both informational purposes and validation of state quality activities. The CMS met its FY 2009 target to complete nine Quality Assessment Reports. The FY 2010 target is for CMS to complete ten Quality Assessment Reports. Results will be available in March 2011.

FINANCIAL ACCOMPLISHMENTS

The CMS has maintained a strong financial management operation, by implementing many initiatives throughout the Agency for FY 2010. Although all may not be discussed in detail below, CMS continues to improve CMS' financial management and reporting processes 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

The Medicare contractors' claims processing systems are operating effectively in adjudicating healthcare claims, however they were not designed to meet the requirements of a dual entry, general ledger accounting system. As a result, they did not meet the provisions of the Federal Financial Management Improvement Act of 1996 (FFMIA). This project is called the Healthcare Integrated General Ledger Accounting System (HIGLAS). As part of this effort, CMS is replacing the Financial Accounting and Control System (FACS), which accumulates all of CMS' financial activities, both programmatic and administrative, in its general ledger.

Following the guidance of the Office of Management and Budget (OMB) Circular A-130, *Management of Federal Information Resources*, CMS acquired a commercial off-the-shelf (COTS) product for HIGLAS. Implementing an integrated general ledger program has given CMS enhanced oversight of contractor accounting systems and provides high quality, timely data for decision making and performance measurement.

The HIGLAS project was first successfully piloted in 2005 at two Medicare contractor locations which resulted in the reengineering of their accounting business processes to support the standard accounting software. Since that time, CMS deployed HIGLAS at thirteen additional Medicare contractors, and in 2009 CMS transitioned the first Medicare Administrative Contractor (MAC) onto HIGLAS. As HIGLAS is now the official system of record, CMS has strengthened our financial management even further in FY 2010, as we have also incorporated into HIGLAS the functionality of Medicare Parts C and D, and successfully completed eight additional Medicare Administrative Contractor (MAC) transitions. Since going "live" at the first pilot contractor in May 2005, HIGLAS has processed more than 1.8 billion claims and processed over 73.5 million payments worth $800.8 billion, as of September 30, 2010.

In FY 2007, HIGLAS began accounting for Federal grants made to states for the Medicaid program as well as CHIP. In addition, during FY 2007, CMS started the process of implementing the Administrative Program Accounting module of HIGLAS that has resulted in major milestone accomplishments which include Medicaid/CHIP Grants accounting in HIGLAS, as well as the ability to produce financial statements in HIGLAS since the second quarter of FY 2009. In FY 2010, HIGLAS also incorporated accounting functionality for Medicare Parts C & D.

For FY 2010, CMS is substantially compliant with the Federal Financial Management Improvement Act (FFMIA). The CMS considers our financial systems to be integrated in accordance with OMB Circular A-127, *Financial Management Systems*, since, as of September 2010, CMS has 88 percent of total Medicare program payments accounted for in HIGLAS. In addition, HIGLAS is CMS' official financial system of record, as we prepared our first auditable financial statements via HIGLAS during the second quarter of FY 2010.

The HIGLAS will enhance CMS' oversight of claims administration contractor financial operations and the accounting and reporting of other CMS activities. HIGLAS will strengthen management of Medicare accounts receivable and allow more timely and effective collection activities on outstanding debts. These financial management and reporting improvements by CMS and its contractors are essential to retaining an unqualified opinion on our financial statements, meeting the requirements of key Federal legislation, and safeguarding government assets.

Federal Payment Levy Program (FPLP)

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

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), enacted by Congress

in July 2008, allowed CMS to take all necessary steps to participate in the FPLP beginning in FY 2009. Specifically, the MIPPA legislation requires that Medicare FFS payments to providers will be offset by a maximum of 15 percent to satisfy payment of delinquent Federal tax debt and 100 percent to satisfy payment of Administrative Offsets for Federal non-tax debt. Non-tax debts include unpaid loans, overpayments or duplicate payments to Federal salary or benefit payment recipients, misused grant funds and fines, penalties or fees assessed by Federal agencies. All (100 percent) of Medicare FFS payments will be subject to FPLP by 2012. The CMS is supporting the FPLP by focusing on implementation of the requirements through HIGLAS. Contractors on the legacy CMS shared systems will participate in FPLP when they transition to HIGLAS. The CMS began participating in the FPLP in October 2008, for Medicare FFS payments made through HIGLAS. The CMS completed FPLP withholding functionality for all the current HIGLAS Medicare contractors on November 7, 2008. As of September 30, 2010, CMS has realized a cumulative total of $87.18 million in tax levy offsets and $19.29 million in non-tax offsets through HIGLAS on behalf of FPLP for FY 2010.

Additional Medicare contractors will continue to be rolled out in conjunction with future MAC transitions to HIGLAS. The CMS will also continue to expand FPLP functionality during FY 2011, for recoupment of administrative offsets for additional Federal non-tax debts as mandated by section 189 of the MIPPA legislation.

Consolidated Medicare Banking Strategy

Previously, banking services were established between an individual contractor and a financial institution for contractors providing payment to Medicare providers. The services provided to each contractor differed, and were paid for by compensating Trust Fund balances deposited at the financial institution. The interest earned on these balances was used to pay for the services required by the individual contractors. In 2010, CMS consolidated the Medicare banking services under banking contracts awarded through full and open competition. The resulting invoiced services are now consistent across contractors and are paid by individual invoice rather than compensating balances. Consequently, CMS was able to return to the trust fund $852 million in funds which had previously been invested at the financial institutions. By consolidating financial services and returning the trust funds CMS is able to reinvest the $852 million on behalf of the Medicare Trust Fund. Previously these funds had been utilized as compensating balances earning a low rate of interest. The interest earned on the compensating balances was used to pay for banking services. Interest earned on these funds will now be credited to the Medicare Trust Fund in the estimated amount of $24 million annually.

The CMS now controls the individual banking services provided to Medicare contractors, streamlining operations by excluding individualized banking services that were not providing CMS an economy of scale in pricing. The CMS has now imposed standard banking services on all providers, leveling the services billed by payment contractors and capitalizing on the volume of standardized services being provided across the network. This single modification has resulted in an estimated and projected savings of $4 million in year one, with savings in subsequent years to increase. The CMS is now providing Medicare payment contractors with secure banking services over the internet which mirrors the highest level of operational efficiencies and securities available to commercial financial networks, and provides substantial decreases in production time, substantive system controls, and cost efficiencies.

Communication & Financial Reporting

During FY 2010, CMS continued to improve its communication through the Risk Management and Financial Oversight Committee. The Risk Management and Financial Oversight Committee, comprised of members of CMS' senior leadership, acts as the conduit for discussing financial management issues impacting the Agency and its financial statements. This committee ensures effective communication and a coordinated process among cross-functional areas within CMS. The Office of Financial Management (OFM) also meets monthly with upper-level management from

various program centers/offices to discuss financial and budget concerns that could impact the CMS audit and day-to-day operations.

The CMS continued to prepare "white papers" to ensure that any significant changes/updates to CMS' accounting and financial reporting policies are properly evaluated by the CMS financial managers (and, for some cases, managers in other CMS components) and approved in writing. This process ensures that changes are implemented in an effective and efficient manner and that changes/updates to the financial statements conform to generally accepted accounting principles and Federal Financial Accounting Standards.

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

Medicare Recovery Audit Contractor (RAC)

Section 302 of the Tax Relief and Health Care Act of 2006 made the RAC Program permanent and requires CMS to implement the program in all fifty states no later than January 1, 2010. Each RAC is responsible for identifying and correcting improper payments in approximately one-quarter of the country.

The CMS completed implementation and began widespread nationwide review in FY 2010. Extensive provider outreach in all fifty states as well as coordination and implementation activities with the Medicare claim processing contractors occurred during implementation. In addition, CMS instituted a gradual implementation process which included limited reviews by the RACs to decrease provider administrative burden and the workload the program places on the claim processing contractors and increased emphasis on system changes which will allow automated adjustments in the future. The outreach and coordination will continue into FY 2011 and the limitations will continue as well. Over time CMS hopes to decrease the number of limitations to allow for increased demands and collections for the Medicare Trust Funds. As of September 30, 2010 the RAC program has demanded approximately $135 million and recovered $75.5 million in FY 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 a 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 2010, we referred to Treasury approximately $716 million delinquent debt eligible for referral. During FY 2010, Treasury collected approximately 5.4% or $38.8 million of the total amount CMS referred.

Administrative Payments

To date in FY 2010, we have continued to make all of our payments on-time in accordance with the Prompt Payment Act. We also continue to have more than 99 percent of our vendor payments made via Automated Clearing House (ACH) and nearly 100 percent of our travel payments via ACH.

Budget Execution

For FY 2010, CMS' budget execution function continues to be a major strength. The CMS Chief Operating Officer works closely with the Chief Financial Officer to ensure that an Administrator approved operating plan is developed timely and supports CMS' priorities. Strong fund control procedures ensure resources are only used for those activities in the operating plan that has been approved by the Administrator. The CMS closely monitors available resources throughout the year to ensure the Anti-Deficiency Act is not violated, while at the same time meeting reasonable but aggressive lapse targets.

Medicare Secondary Payer (MSP)

The CMS efforts in the MSP area saved the Medicare Trust Funds approximately $5.98 billion through the first eleven months of FY 2010. 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 CMS is confident that savings attributable to the MSP Program will continue to grow as new and improved methods of collecting MSP information are implemented.

During calendar year 2008, CMS began implementing section 111 of the Medicare and Medicaid CHIP Extension Act of 2007. Section 111 amended existing MSP provisions, adding a new ***mandatory*** MSP reporting requirement for all Group Health Plan (GHP) insurance and Workers' Compensation, Liability Insurance (including Self-Insurance) and No-Fault insurance. Implementation of the reporting requirements is being phased in over a three year period. Group Health Plans began limited reporting of data in January 2009, and began full reporting in January 2010. Some Workers' Compensation, Liability Insurance (including Self-Insurance) and No-Fault insurance began limited reporting of data in June 2010, and all will be required to fully report in January 2011.

To date, GHP data submitted under section 111 has quickly become the primary source of new MSP information for CMS, representing as much as 95 percent of new MSP records being posted to CMS' systems. Most significantly, with the dramatic increase in the number of insurers reporting data today, the volume of GHP MSP data flowing into CMS has doubled. For example, under the Voluntary Data Sharing Agreement Program, which was developed by CMS to facilitate better coordination of benefits, CMS had entered into data sharing agreements with 95 large GHP insurers. As of October 14, 2010, there are 1,024 GHP insurers reporting data to CMS under section 111.

The incoming MSP data from insurers via the section 111 reporting process makes our initial primary or secondary payment decisions more precise. In turn, receipt of so many new MSP records on a timelier basis reduces the need for CMS post-pay "pay-and-chase" efforts. Finally, in those situations where past mistaken payments are identified as the result of the section 111 data, the more comprehensive section 111 data assists in more efficient recovery operations. The CMS is confident that savings attributable to the MSP Program will continue to grow as the section 111 process becomes fully implemented.

In addition, the CMS continues to contract for the financial and medical review of proposed Workers' Compensation Medicare Set-aside Arrangement (WCMSA) amounts that represent monies earmarked in a workers' compensation settlement for future medical services/items that would otherwise be payable by the Medicare Program. As a result, CMS has calculated and approved WCMSA amounts totaling approximately $1.5 billion over the period October 1, 2009 through August 31, 2010 (payments that Medicare might otherwise erroneously make in terms of beneficiaries' future medical expenses related to their associated accident, illness, or injury). It should be noted that the increase for the first 11 months of FY 2010 is due to CMS' independently pricing for inclusion of prescription Part D drugs in WCMSAs amounts, which began June 2009. This current figure may decrease slightly as CMS has allowed WCMSA

submitters to remove monies from WCMSA amounts for non-covered part D drugs that were wrongfully included in WCMSA amounts.

Finally, with CMS' recovery functions for all new MSP GHP and Non-Group Health Plan (NGHP) debt being consolidated into one MSP Recovery Contractor (the MSPRC) in FY 2007, CMS recoveries realized under the MSPRC have gradually increased each year. Total savings from recoveries were $982 million for the first eleven months of FY 2010. This equates to a projected annual recovery amount of $1.07 billion for all of FY 2010.

Program Integrity

Program Integrity (PI) encompasses the operations and oversight necessary to ensure that accurate payments are made to legitimate providers for appropriate and reasonable services for eligible beneficiaries of the Medicare, Medicaid, and CHIP programs. It spans a range of underlying causes of improper payments, including errors, fraud, waste, and abuse. A critical part of this effort is the creation of the Center for Program Integrity (CPI). In April 2010, CMS consolidated and integrated the Medicare and Medicaid PI functions into the CPI to strengthen existing PI activities and to strategically position the agency to address future PI issues.

Medicare

Medicare Program Integrity functions include the detection and deterrence of fraudulent billing to the Medicare Program. This is accomplished through the use of proactive data analysis, medical record review, and investigation of complaints from various sources, on-site visits, and beneficiary and provider interviews. The key activities CMS undertakes to measure, reduce, and recover improper payments and fight fraud in the Medicare program may be broadly categorized as follows:

- Provider and Supplier Enrollment (PSE)–This function serves to ensure that only eligible providers and suppliers that meet the Medicare enrollment criteria furnish, order, refer or certify services for Medicare beneficiaries. It prevents "bad" providers and suppliers from program entry while also helping to ensure the quality of services provided to Medicare beneficiaries.
- Benefit Integrity (BI)–BI functions to identify, detect, and prevent fraudulent or abusive behavior against the Medicare program. To protect the Trust Fund, BI constantly monitors program trends. Administratively, BI may require corrective action plans, or impose administrative actions such as payment suspensions, overpayment collections, and referrals to law enforcement or sanctions. Other additional BI responsibilities include acting as law enforcement liaisons to ensure coordination on crosscutting issues, as well as conducting compliance audits for the Part C and D programs.

The Medicare Program Integrity Group has developed and is implementing regulations to address a number of the Medicare Program Integrity provisions in Title VI of the Patient Protection and Affordable Care Act. On May 5, 2010, CMS published an Interim Final Rule with Comment Period (IFC) entitled "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements." This IFC provided the foundation for the implementation of Sections 6402, 6405, and 6406 of ACA which require 1) the use of National Provider Identifiers on all claims submitted for Medicare payment and all enrollment applications; 2) that physicians and eligible professionals who order, refer, or certify covered items and services for Medicare beneficiaries be enrolled in Medicare; and 3) that providers, physicians, and other suppliers participating in the Medicare program maintain and provide access to records and documentation relating to written orders or requests for referrals for services, items, or supplies which are at high risk of fraud, waste and abuse including durable medical equipment, prosthetics, orthotics and supplies, home health and other items or services.

The CMS has also issued a Notice of Proposed Rule Making (NPRM) to address other ACA program protection provisions that address provider enrollment screening requirements, establish provider enrollment fraud, waste, and abuse risk levels, establish provider enrollment application fees, and for the first time, define the conditions under which CMS may impose temporary provider enrollment moratoriums, and to further define the payment suspension process. The NPRM also solicited comments on provider compliance programs.

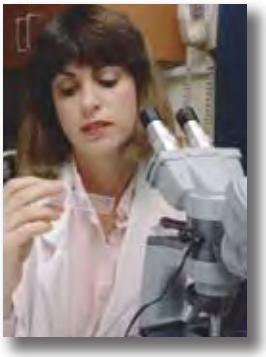
The CMS is further significantly enhancing its approach to fraud and abuse oversight activities in the Medicare Integrity Program. For example, we are targeting our resources to geographic areas of the country where there have been large amounts of previously identified fraud. Our analytic tools have discovered that fraud schemes migrate quickly. As systems edits are created, aberrant providers quickly react and bill new codes, split the claims to evade dollar thresholds and dosage limits, and bill codes up to the maximum number of units possible. Frequently, as CMS' contractors implement prepayment edits in one part of the country for a particular Medicare benefit, the fraudulent perpetrators move to other parts of the country to carry out their scam. By changing our contracting strategy from using Program Safeguard Contractors (PSCs) to Zone Program Integrity Contractors (ZPICs), CMS is able to better target areas of the highest fraud level/risk and fund them accordingly. This new risk-based strategy has allowed for a more efficient and effective contracting model and enhances collaboration between the ZPICs so that they share information on fraudulent schemes on an ongoing basis. Additionally, CMS has been able to fund projects directed at new vulnerabilities, improve the infrastructure required for the data analysis that is the foundation of all PI work, and address the numerous administrative and congressional priorities. Our PSCs/ZPICs continue to produce savings for Medicare Parts A and B by identifying overpayments, referring cases to law enforcement, and by taking an aggressive approach with other administrative actions such as payment suspensions, prepaid claims edit denials, auto denial edits, and revocations.

The CMS is conducting a comprehensive program assessment of fraud and abuse oversight for the Part C and D programs. Based on the assessment, contracting strategies, the structure of the Medicare Drug Integrity Contractors (MEDICs), as well as the manner in which CMS oversees fraud, waste, and abuse, activities will be reevaluated and improvements made. In the coming year, CMS plans to devote resources to the MEDICs for Parts C and D to address new complexities facing law enforcement, contract and plan oversight functions, monitoring, plan performance assessment, surveillance/secret shopper activities, audits of the program, and routine compliance and enforcement tracking.

The designated Program Integrity Field Offices (FOs) in Los Angeles, Miami and New York provide an on-the-ground presence focusing on high risk fraud areas of the country. They conduct data analysis to proactively identify targets and to coordinate efforts among various contractors and agencies to identify local and field level issues and vulnerabilities with national or regional impact. In addition, CMS has also recently instituted a number of targeted efforts in high vulnerability areas such as Miami, Houston and Los Angeles where there are a large number of beneficiaries and providers/suppliers. The CMS and its contractors are conducting special projects focusing on both high fraud provider/supplier types and high fraud areas of the country.

The Miami FO has implemented a comprehensive, multipronged approach to address all aspects of healthcare fraud in South Florida and provides a testing ground for whether some of these efforts may eventually have efficacy on a national level. One of the Miami FO's initiatives has a focus on more intensive provider enrollment screening. Under one strategy in Florida, we have also implemented a fraud hotline with follow-up site visits and prepay review for providers and suppliers on a watch list.

In response to the continued escalation in Durable Medical Equipment (DME) payments and the continued growth in the number of Durable Medical Equipment Prosthetics, Orthotics,



and Supplies (DMEPOS) suppliers, the New York (NY) FO initiated the DME Stop Gap Plan in 2009. Using national data analysis, this project identified seven "high risk" DME areas (New York, North Carolina, Michigan, California, Texas, Florida and Illinois). This project identifies and takes corrective action on the highest billing DME suppliers, highest ordering physicians, highest utilizing beneficiaries, and highest risk types of equipment and supplies. The CMS is utilizing new data analysis reporting to target suppliers, physicians and beneficiaries and changes in billing. These efforts from the DME Stop Gap Plan have been extremely effective and 357 DME suppliers have been revoked or deactivated. The DME Stop Gap Plan has also helped identify where edits were needed for numerous suppliers, beneficiaries, and physicians to ensure claims associated with those individuals were not paid by the DME MAC.

The NY FO also designed and is leading the Compromised Number Contract (CNC) initiative. The CNC is designed to provide a repository for and searchable database of all compromised Medicare beneficiary identification numbers (Health Insurance Claim Numbers (HICNs)) and provider identification numbers (National Provider Identifiers) used to bill or order Medicare services. The CNC contractor and CMS Identity Theft Workgroup collaborate to develop a consistent process to designate when an identifier is "compromised." This consolidation of problem numbers facilitates data analysis for fraud detection and prevention, as will the development of auto-denial or other prepay edits to prevent the continued geographic spread of misused numbers and inappropriate payments. To date, the CNC has identified 5,204 compromised providers/suppliers and approximately 264,000 compromised HICNs. This information is then used by the PSCs/ZPICs to open investigations and implement claims processing edits.

The CMS continues to be a major participant in the Health Care Fraud Prevention and Enforcement Action Team (HEAT). We continue working on the HEAT initiative which brings together HHS and DOJ to collaborate on anti-fraud activities. HEAT has brought a high-level focus on coordination and collaboration across the Administration and has expanded efforts to stop fraud and prevent it from happening in the first place. These efforts include:

- Strengthening existing and creating additional Strike Force teams that fight fraud in various cities;
- Helping State Medicaid officials conduct provider audits and monitor activities to detect fraudulent activities; and
- Using modern technology to complete analysis of electronic evidence, dramatically cutting the time spent on these important fraud-fighting activities.

The HEAT Strike Forces are an important step in the multi-phase HEAT initiative designed to reduce Medicare fraud. The CMS will continue to support the HEAT initiative and expects the expansion of the Strike Force Teams to three additional cities by the end of 2010, budget resources permitting.

Finally, CMS is expanding the scope and character of data sharing across programs to help prevent improper payments. It is implementing several pilots of data analytic approaches designed to identify and detect trends of improper payment activity, including geographic mapping based on fraud reported to 1-800-MEDICARE and predictive modeling techniques (similar to those currently used in the financial sector), that will be used to identify high-risk claims for further review prior to payment. CPI has implemented several pilot projects to develop and test predictive models to determine their efficiency (probability of false positives). Many of these models will be tested with near real-time data in order to ensure that they are effective at identifying high-risk claims. Analyses are specifically underway in the areas of home health, durable medical equipment,

and compromised beneficiary and provider numbers. Any results from the analyses will be referred to appropriate contractors for investigation. Once successful, the long-term plan is to use these models for prepayment risk scoring to identify claims for further review. This moves CMS towards preventing excessive payments before they are made.

Medicaid

The Deficit Reduction Act of 2005 established the Medicaid Integrity Program in section 1936 of the Social Security Act which represents a substantial milestone in CMS' first national strategy to detect and prevent Medicaid fraud and abuse. This program offers a unique opportunity to identify, recover, and prevent inappropriate Medicaid payments. It will also support the program integrity efforts of state Medicaid agencies through a combination of oversight and technical assistance.

Under the leadership of the Medicaid Integrity Group (MIG) within the CPI, CMS continues to make significant progress in developing a strong, effective, and sustainable program to combat Medicaid provider fraud, waste, and abuse. Specifically, the MIG has implemented the following four major functions to accomplish the requirements of the statute: (1) Procurement and oversight of Medicaid Integrity Contractors who conduct reviews, audits and education; (2) Field Operations to provide effective support and assistance to state program integrity efforts through oversight reviews, training, and technical assistance; (3) Fraud Research and Detection to provide statistical data support, identify emerging fraud trends and conduct special studies; and (4) Creation of the annual Report to Congress and the Comprehensive Medicaid Integrity Plan in consultation with internal and external partners to guide CMS' efforts.

In FY 2010, CMS initiated Medicaid provider audits in all 10 CMS regions. The CMS also conducted 17 comprehensive state program integrity reviews. In June 2010, CMS released its fourth Report to Congress for FY 2009. The MIG supports CMS implementation of Executive Order 13520 Reducing Improper Payments. This Executive Order, issued November 23, 2009, which requires Federal agencies with high-priority programs to establish annual or semi-annual measurements for reducing improper payments. For those high-priority programs that already report an annual measurement, agencies were required to develop supplemental measures. Medicaid is designated a high-priority program and currently measures improper payments annually through the Payment Error Rate Measurement (PERM) program; therefore, Medicaid is required to develop supplemental measures. The CMS is assisting states to develop and report on these supplemental measures.

Supplemental measures of reducing improper payments in Medicaid will be calculated based on the results of state collaboration projects. The state collaboration projects are a group of states with a shared identified Medicaid program integrity vulnerability and have a common approach (intervention) that will be tested and evaluated to assess how well it addresses the problem. A pre- and post-intervention measurement is taken to determine its effectiveness and results are reported so that other states can consider adopting the intervention in their state to reduce improper payments. The CMS launched the first state collaboration project to measure improper payments in July 2010, and anticipates publishing the results of this initiative in October 2011.

The MIG supports implementation of several Affordable Care Act Medicaid program integrity provisions, most notably section 6401 regarding provider screening and increased disclosure requirements and section 6411 regarding Expansion of the Recovery Audit Contractor (RAC) Program. Section 6401 requires the Secretary to establish procedures for the screening of providers and suppliers participating in the Medicare, Medicaid and CHIP. Additionally, section 6401 requires the Secretary to impose an application fee on institutional providers and suppliers with respect to which screening is conducted. The MIG is involved in identifying and facilitating a mechanism for which states may validate provider enrollment status in support of the requirement in Section 6401.

Pursuant to section 6411, states are required to establish RAC programs by December 31, 2010. The CMS is providing guidance to states through a letter to State Medicaid Directors on October 1, 2010 and a Notice of Proposed Rule Making was displayed on November 5, 2010.

Medicare Advantage and Prescription Drug Financial Oversight

In 2010, CMS continued its implementation of the financial audit program for examinations of Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs). The financial audit program is designed to examine the health plans' financial records, data relating to costs, Medicare utilization, and the computation of the bids. Previously, CMS awarded contracts for 169 audits for the contract year 2006 and for 200 audits for contract year 2007. The CMS completed all of remaining audits for 2006 and 2007 in 2010. Furthermore, CMS completed the desk reviews of the Risk Sharing Reconciliations for the Regional Preferred Provider Organizations (RPPOs) for contract years 2006 and 2007. In order to satisfy the annual one-third audit requirement, CMS awarded contracts for 234 audits for the contract year 2008. In addition, CMS (through our ROs) conducts audits of the MAOs and PDPs—outside of the one-third audit requirement—to further improve oversight of both Part C and Part D sponsors.

The CMS has also reduced the number of backlogged unsettled managed care cost reports in FY 2010. Disallowances resulting from FY 2010 settlement activity amounted to about $3 million. For FY 2010, CMS had a rate of return of $2.24 to $1. The remaining backlog still represents a challenge to CMS because these cost reports have critical issues that must be resolved with MAOs.

Additionally, CMS continued the development of an error rate reporting program during FY 2010 for the Medicare Advantage and Prescription Drug programs. A composite error rate for the Medicare Advantage program has been reported annually since FY 2008, and CMS is on track to again report this measure for FY 2010. The CMS continues to develop the methodology for a Medicare Prescription Drug (Part D) Composite Payment Error rate. Component error rates have been developed and estimates have been reported annually since FY 2008. In FY 2008, CMS reported two component error estimates. In FY 2009, an additional measure was developed and three component error estimates were reported. For FY 2010, CMS is on track to report four component measures for the Part D program, comprised of the three measures reported in FY 2009 and an additional measure developed this year.

Medicare Information Technology (IT)

During FY 2010, the CMS continued its program to strengthen Medicare IT internal controls, particularly our oversight of the implementation of those controls. Our management approach featured a strategy and project plan to address not just current audit findings but the root or environmental causes of those findings regardless of the source of those findings. In the last year, CMS' information security program has undergone significant change. The creation of the Office of the Chief Information Security Officer (OCISO) to improve independent oversight of information security has helped CMS move from a mostly distributed model to a hybrid model for governing information security. The OCISO is in the process of establishing programs that will enhance continuous monitoring to drive real-time situational awareness, increase the efficiency of the CMS system authorization process and drive ongoing communications with business stakeholders. The CMS has also entered its final stages in establishing a Security Operations Center (SOC) that will develop a "big picture" view into the enterprise and be a key component in driving oversight and monitoring compliance. Steps have also been made to modernize and improve information security vulnerability management with the evaluation and

implementation of the new scanning tools that will allow CMS to gain a near real-time profile of vulnerabilities in the CMS environment and enhance the continuous monitoring process by providing input for ongoing vulnerabilities on CMS systems.

To retain executive buy-in and awareness within CMS, we briefed the status of our progress throughout the year in monthly meetings chaired by the Chief Financial Officer. The contractor executive management was sensitized to the importance for improvements in the Medicare IT controls by our including this as a factor in their annual report of contractor performance. The CMS executives and staff also briefed our expectations and requirements to both Medicare contractor executives as well as the contractor system security officers. The CMS sponsored two security conferences and several teleconferences with the Medicare contractors to emphasize best practices to address individual audit findings and the root causes.

The CMS continues to release updated policies, procedures, and processes for the Medicare contractors that are in line with our internal and third party assessment recommendations. Contractors are required to submit aggressive on-site validation of internal controls for more intensive scrutiny of contractor compliance with requirements. Under this program, Medicare fiscal intermediaries, carriers, MACs, shared systems, and data centers are subjected to on-site reviews by CMS technical support teams, or formal security test and evaluations by our independent testing contractor.

Oversight of Medicare Contractor Financial Operations & Reporting

Medicare contractors administer the day-to-day operations of the Medicare FFS program by paying claims, auditing provider cost reports, and establishing and collecting overpayments. As part of these activities, Medicare contractors are required to maintain a vast array of financial data. The CMS' implementation of new and/or revised policies over the past several years and other key initiatives to train staff and review contractor operations has resulted in significant improvements in the contractors' financial management activities and in the oversight of the Agency. The CMS continues to enhance its analytical tools to provide the steps to identify potential errors, unusual variances, system weaknesses, or inappropriate patterns of financial data accumulation. One example of these analytical tools is the review of 1522 reconciliation procedures.

On a monthly basis, non-HIGLAS Medicare contractors perform a reconciliation of their Form CMS-1522 Funds Expended Report to their paid claims or system reports. HIGLAS contractors are required to complete the HIGLAS Contractor's Monthly Bank Reconciliation Worksheet. The worksheet is designed to provide a monthly reconciliation of the Medicare Contractor's benefit and time account activity to the CMS Monthly Balance Sheet and Summary 2 Trial Balance. The CMS regional offices review their Medicare contractors' 1522 reconciliations and monthly cash reconciliations for one month each quarter. Furthermore, Medicare contractors are required to perform trend analysis on a quarterly basis and maintain supporting documentation to ensure that accounts receivable balances reported are reasonable.

The Medicare contractors are subject to various financial management and IT security audits and reviews performed by the OIG, Government Accountability Office (GAO), independent

CPA firms, and CMS staff to provide reasonable assurance that they have developed and implemented sound internal controls. The results of these audits indicate if the contractors' internal controls have any design or operational 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 , which have been prepared using standardized formats, consolidate the findings and facilitate our monitoring responsibilities. Quarterly updates to the CAPs are required and CMS reviews all CAP submissions for adequacy. The CMS also requires all Medicare contractors to submit an annual Certification Package for Internal Controls (CPIC). In the CPIC, contractors are required to report any material weaknesses and significant deficiencies identified during the FY, along with CAPs to remedy the weaknesses.

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

The CMS continued to build upon our success in implementing OMB's revisions to Circular A-123, *Management's Responsibility for Internal Control.* The Agency again procured an independent CPA firm in FY 2010 to assist in performing management's self-assessment in support of the assurance statement regarding internal controls over financial reporting as of June 30. The scope of the review included CMS central office, four regional offices, and 20 major IT applications. In addition, the CPA firm conducted Circular A-123, Appendix A Internal Control over Financial Reporting (ICOFR) reviews at eight Medicare contractors (including the Retiree Drug Subsidy and the Medicare Secondary Payer Recovery Contractor), 10 data centers, and four shared system maintainers. The CMS also leveraged the work performed under the OMB Circular A-123 ICOFR review to address additional requests from the HHS regarding the ARRA risk assessment and mitigation.

MACs continued to contract with independent CPA firms to conduct Statement on Auditing Standards 70 (SAS 70) internal control audits. As a result, 13 SAS 70 audit reports were leveraged for the FY 2010 ICOFR review. Also, we conducted CAP follow-up reviews related to SAS 70 internal control audits and other reviews conducted in previous years.

To implement the requirements under Appendix A of OMB Circular A-123, we: (1) planned and scoped the evaluation, (2) documented controls and evaluated the design of the controls, (3) tested operating effectiveness, (4) identified and corrected deficiencies, and (5) reported on internal controls. The CMS provided an assurance statement as of June 30 and updated it as of September 30. The results of our self-assessment are provided in the ***Summary of Federal Managers' Financial Integrity Act Report and OMB Circular A-123 Statement of Assurance*** section.

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

Financial Statements Introduction & Highlights

Consolidated Balance Sheets

The Consolidated Balance Sheets present as of September 30, 2010 and 2009, 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 has reported assets of $430.7 billion. The bulk of these assets are in the Earmarked Investments totaling $354.5 billion, which are invested in U.S. Treasury Special Issues, special public obligations for exclusive purchase by the Medicare trust

funds. Trust fund holdings not necessary to meet current expenditures are invested in interest-bearing obligations of the U.S. or in obligations guaranteed as to both principal and interest by the U.S. The next largest asset is the Fund Balance with Treasury of $64.8 billion, most of which is for Medicaid and CHIP. Liabilities of $80.5 billion consist primarily of the Entitlement Benefits Due and Payable of $72.7 billion. The CMS net position totals $350.2 billion and reflects primarily the cumulative results of operations for the Medicare Trust Funds and the unexpended balances for Medicaid and CHIP.

Consolidated Statements of Net Cost

The Consolidated Statements of Net Cost present the net cost of operations for the years ended September 30, 2010 and 2009. The Statement of Net Cost shows only a single dollar amount: the actual net cost of CMS' operations for the period by program. Under the Government Performance and Results Act (GPRA), CMS is required to identify the mission of the agency and develop a strategic plan and performance measures to show that desired outcomes are being met. The three major programs that CMS administers are: Medicare, Medicaid, and CHIP. The bulk of CMS' expenses are allocated to these programs. Both Medicare and Medicaid program integrity funding 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 $785 billion for FY 2010. Administrative Expenses were $3.3 billion, less than 1 percent of total net Program/Activity Costs of $728.7 billion.

The net cost of the Medicare program including benefit payments, QIOs, Medicare Integrity Program spending, and administrative costs, was $447.2 billion. The HI total costs of $247.3 billion were offset by $3.5 billion in revenues. The SMI total costs of $260.6 billion were offset by premiums and other revenues of $57.3 billion. Medicaid total costs of $273.0 billion, of which $40.8 billion were tracked under ARRA, represent expenses incurred by the States and Territories that were reimbursed by CMS during the fiscal year, plus accrued payables. The CHIP total costs were $8 billion.

Consolidated Statements of Changes in Net Position

The Consolidated Statements of Changes in Net Position present the change in net position for the years ended September 30, 2010 and 2009. 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 $272.3 billion; $228.9 billion in transfers from Payments to Health Care Trust Funds to HI and SMI; CHIP appropriations of $7.9 billion and State Grants and Demonstrations and general fund-financed Program Management appropriations of $511 million. Medicaid and CHIP are financed by a general fund appropriation provided by Congress. Employment tax revenue is Medicare's portion of payroll and self employment taxes collected under the Federal Insurance Contributions Act (FICA) and Self Employment Contributions Act (SECA) for the HI trust fund and totaled $183.6 billion. The Federal matching contribution is income to the SMI program from a general fund appropriation (Payments to Health Care Trust Funds) of $161.1 billion, which matches monthly premiums paid by beneficiaries.

Combined Statements of Budgetary Resources

The Combined Statements of Budgetary Resources provide information about the availability of budgetary resources, as well as their status for the years ended September 30, 2010 and 2009. An additional Schedule of Budgetary Resources is provided as Required Supplementary Information

to present each budgetary account. In this statement, the Program Management and the Program Management User Fee accounts are combined and are not allocated back to the other programs. Also, there are no intra-CMS eliminations in this statement.

The CMS total budgetary resources were $1,088 billion. Obligations of $1,057.2 billion leave unobligated balances of $30.8 billion (of which $4.3 billion is not available). Total outlays, net of collections, were $1,032 billion. When offset by $303 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 $729.1 billion.

Statement of Social Insurance (SOSI)

As required by the Statement of Federal Financial Accounting Standards (SSFAS) Number 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, and 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 cash-flow 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 ***2010 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, *Financial Reporting Requirements*, and is unaudited.

Principal Statements and Notes

CONSOLIDATED BALANCE SHEETS
As of September 30, 2010 and 2009

(in millions)

	FY 2010 Consolidated Totals	FY 2009 Consolidated Totals
ASSETS		
Intragovernmental Assets:		
Fund Balance with Treasury ***(Note 2)***	$64,841	$49,340
Investments ***(Note 3)***	356,621	377,948
Accounts Receivable, Net ***(Note 4)***	493	492
Other Assets	5	17
Total Intragovernmental Assets	**421,960**	**427,797**
Cash and Other Monetary Assets		357
Accounts Receivable, Net ***(Note 4)***	7,046	5,165
General Property, Plant and Equipment, Net	398	384
Other Assets	1,309	1,821
TOTAL ASSETS	**$430,713**	**$435,524**
LIABILITIES		
Intragovernmental Liabilities:		
Accounts Payable	$959	$602
Accrued Payroll and Benefits	8	7
Other Intragovernmental Liabilities	803	513
Total Intragovernmental Liabilities	**1,770**	**1,122**
Federal Employee and Veterans' Benefits	13	15
Entitlement Benefits Due and Payable ***(Note 5)***	72,712	72,218
Accrued Payroll and Benefits	71	62
Contingencies ***(Note 6)***	5,391	3,793
Other Liabilities	547	529
TOTAL LIABILITIES *(Note 7)*	**80,504**	**77,739**
NET POSITION		
Unexpended Appropriations—earmarked funds	1,776	3,590
Unexpended Appropriations—other funds	34,377	20,936
Total Unexpended Appropriations	**36,153**	**24,526**
Cumulative Results of Operations—earmarked funds	313,447	332,752
Cumulative Results of Operations—other funds	609	507
Total Cumulative Results of Operations	**314,056**	**333,259**
TOTAL NET POSITION	**$350,209**	**$357,785**
TOTAL LIABILITIES AND NET POSITION	**$430,713**	**$435,524**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF NET COST
For the Years Ended September 30, 2010 and 2009
(in millions)

	FY 2010 Consolidated Totals	FY 2009 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS		
GPRA Programs		
Medicare (Earmarked)	$447,162	$430,025
Medicaid	272,995	253,352
CHIP	7,968	7,610
Net Cost - GPRA Programs	**728,125**	**690,987**
Other Activities		
CLIA	10	(56)
State Grants and Demonstrations	533	498
Other	36	23
Net Cost - Other Activities	**579**	**465**
NET COST OF OPERATIONS *(Notes 8, 12 and 16)*	**$728,704**	**$691,452**

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2010
(in millions)

	Consolidated Earmarked Funds	Consolidated Other Funds	FY 2010 Consolidated Total
CUMULATIVE RESULTS OF OPERATIONS			
BEGINNING BALANCES	**$332,752**	**$507**	**$333,259**
Budgetary Financing Sources:			
Appropriations Used	228,878	280,791	509,669
Nonexchange Revenue:			
FICA and SECA Taxes	183,615		183,615
Interest on Investments	17,251	4	17,255
Other Nonexchange Revenue	616		616
Transfers-in/out Without Reimbursement ***(Note 9)***	(2,542)	844	(1,698)
Other Financing Sources (Nonexchange):			
Imputed Financing	39	5	44
TOTAL FINANCING SOURCES	**427,857**	**281,644**	**709,501**
NET COST OF OPERATIONS	**447,162**	**281,542**	**728,704**
NET CHANGE	**(19,305)**	**102**	**(19,203)**
CUMULATIVE RESULTS OF OPERATIONS	**$313,447**	**$609**	**$314,056**
UNEXPENDED APPROPRIATIONS			
BEGINNING BALANCES	**$3,590**	**$20,936**	**$24,526**
Budgetary Financing Sources:			
Appropriations Received	230,497	298,055	528,552
Appropriations Transferred-in/out		(3,746)	(3,746)
Other Adjustments ***(Note 10)***	(3,433)	(77)	(3,510)
Appropriations Used	(228,878)	(280,791)	(509,669)
TOTAL BUDGETARY FINANCING SOURCES	**(1,814)**	**13,441**	**11,627**
TOTAL UNEXPENDED APPROPRIATIONS	**1,776**	**34,377**	**36,153**
NET POSITION	**$315,223**	**$34,986**	**$350,209**

The accompanying notes are an integral part of these statements.

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

(in millions)

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

The accompanying notes are an integral part of these statements.

COMBINED STATEMENTS OF BUDGETARY RESOURCES
For the Years Ended September 30, 2010 and 2009

(in millions)

	FY 2010 Combined Totals Budgetary	FY 2009 Combined Totals Budgetary
Budgetary Resources:		
Unobligated balance, brought forward, October 1:	$21,079	$23,135
Recoveries of prior year unpaid obligations	15,589	10,410
Budget authority:		
Appropriation	1,064,764	1,008,695
Spending authority from offsetting collections:		
Earned		
Collected	1,274	2,700
Change in unfilled customer orders:		
Advance received		(2)
Without advance from Federal sources	19	(137)
Expenditure transfers from trust funds	3,932	3,936
SUBTOTAL	**1,069,989**	**1,015,192**
Nonexpenditure transfers, net, anticipated & actual	(3,841)	(2,867)
Temporarily not available pursuant to Public Law	(11,238)	(1,215)
Permanently not available	(3,606)	(28,483)
TOTAL BUDGETARY RESOURCES	**$1,087,972**	**$1,016,172**
Status of Budgetary Resources:		
Obligations incurred ***(Note 13)***:		
Direct	$1,056,971	$994,876
Reimbursable	231	217
SUBTOTAL	**1,057,202**	**995,093**
Unobligated balance:		
Apportioned	26,237	19,677
Exempt from apportionment	220	234
SUBTOTAL	**26,457**	**19,911**
Unobligated balance not available	4,313	1,168
TOTAL STATUS OF BUDGETARY RESOURCES	**$1,087,972**	**$1,016,172**
Change in Obligated Balance:		
Obligated balance, net:		
Unpaid obligations, brought forward, October 1	$84,730	$75,184
Uncollected customer payments from		
Federal sources, brought forward, October 1	(2,558)	(2,196)
TOTAL UNPAID OBLIGATED BALANCE, NET	**$82,172**	**$72,988**
Obligations incurred, net	1,057,202	995,093
Gross Outlays	(1,036,937)	(975,137)
Obligated balance transferred, net:		
Recoveries of prior year unpaid obligations, actual	(15,589)	(10,410)
Change in uncollected customer payments		
from Federal sources	(310)	(362)
Obligated balance, net, end of period:		
Unpaid obligations	89,406	84,730
Uncollected customer payments		
from Federal sources	(2,868)	(2,558)
TOTAL, UNPAID OBLIGATED BALANCE, NET, END OF PERIOD	**86,538**	**82,172**
Net Outlays:		
Net Outlays		
Gross outlays	1,036,937	975,137
Offsetting collections	(4,915)	(6,135)
Distributed offsetting receipts	(302,966)	(283,209)
NET OUTLAYS	**$729,056**	**$685,793**

The accompanying notes are an integral part of these statements.

STATEMENT OF SOCIAL INSURANCE
75-Year Projection as of January 1, 2010 and Prior Base Years
(in billions)

	Estimates from Prior Years				
	2010	2009	2008	2007	2006
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: ***(Notes 14 and 15)***	*(Unaudited)*				
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$7,216	$6,348	$6,320	$5,975	$5,685
SMI Part B	12,688	16,323	14,932	12,112	12,446
SMI Part D	6,355	6,144	6,527	7,285	7,366
Have attained eligibility age (age 65 or over)					
HI	248	209	202	178	192
SMI Part B	1,972	1,924	1,785	1,648	1,606
SMI Part D	646	595	581	746	750
Those expected to become participants					
HI	6,944	5,451	5,361	4,870	4,767
SMI Part B	3,077	4,909	4,480	4,460	3,562
SMI Part D	2,714	2,632	2,856	2,735	2,134
All current and future participants					
HI	14,408	12,008	11,883	11,023	10,644
SMI Part B	17,737	23,156	21,197	18,221	17,613
SMI Part D	9,715	9,371	9,964	10,766	10,250
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: ***(Notes 14 and 15)***					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	12,032	18,147	17,365	15,639	15,633
SMI Part B	12,587	16,342	14,949	12,130	12,433
SMI Part D	6,355	6,144	6,527	7,273	7,338
Have attained eligibility age (age 65 or over)					
HI	2,648	2,958	2,747	2,558	2,397
SMI Part B	2,166	2,142	1,986	1,834	1,773
SMI Part D	646	595	581	794	792
Those expected to become participants					
HI	2,411	4,673	4,506	5,118	3,904
SMI Part B	2,984	4,672	4,262	4,257	3,407
SMI Part D	2,714	2,632	2,856	2,699	2,121
All current and future participants					
HI	17,090	25,778	24,619	23,315	21,934
SMI Part B	17,737	23,156	21,197	18,221	17,613
SMI Part D	9,715	9,371	9,964	10,766	10,250
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures ***(Notes 14 and 15)***					
HI	$(2,683)	$(13,770)	$(12,737)	$(12,292)	$(11,290)
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0
Additional Information					
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures ***(Notes 14 and 15)***					
HI	$(2,683)	$(13,770)	$(12,737)	$(12,292)	$(11,290)
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0
Trust Fund assets at start of period					
HI	304	321	312	300	285
SMI Part B	76	59	53	38	23
SMI Part D	1	1	3	1	0
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) and Trust Fund assets at start of period over expenditures ***(Notes 14 and 15)***					
HI	$(2,378)	$(13,449)	$(12,425)	$(11,993)	$(11,006)
SMI Part B	76	59	53	38	23
SMI Part D	1	1	3	1	0

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

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity

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

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

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

Use of Estimates

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

Patient Protection and Affordable Care Act of 2010

The Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) contains the most significant changes to health care coverage since the passing of the Social Security Act. The CMS will feel the full impact of these changes beginning with Fiscal Year (FY) 2014. As of September 30, the impact of this major legislation has been very minimal to the CMS financial statements. Even though the financial statement impact for FY 2010 has been minimal, CMS has identified where the Affordable Care Act legislation has provided additional FY 2010 funding within the major 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 (HI) Trust Fund. Medicare contractors are paid by CMS to process Medicare claims for hospital inpatient services, hospice, and certain skilled nursing and home health services. Benefit payments made by the Medicare contractors for these services, as well as administrative costs, are charged to the HI trust fund. A portion of CMS payments to Medicare Advantage plans are also charged to this fund. The financial statements include HI trust fund activities administered by the Department of the Treasury (Treasury). The HI trust fund has permanent indefinite authority. Employment tax revenue is the primary source of financing for Medicare's HI program. Medicare's portion of payroll and self-employment taxes is collected under the Federal Insurance Contribution Act (FICA) and Self-Employment Contribution Act (SECA). Employees and employers are both required to contribute 1.45 percent of earnings, with no limitation, to the HI trust fund. Self-employed individuals contribute the full 2.9 percent of their net income. The Social Security Act requires the transfer of these contributions from the General Fund of Treasury to the HI trust fund based on the amount of wages certified by the Commissioner of Social Security from SSA records of wages established and maintained by SSA in accordance with wage information reports. The SSA uses the wage totals reported annually by employers via the quarterly Internal Revenue Service Form 941 as the basis for conducting quarterly certification of regular wages. (See "Payments to the Health Care Trust Funds Appropriation" and "Permanent Appropriations" below for additional descriptions of revenues and financing sources for the HI trust fund).

Medicare Supplementary Medical Insurance Trust Fund—Part B

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

Medicare Supplementary Medical Insurance Trust Fund—Part D

The Medicare Prescription Drug Benefit—Part D, established by the Medicare Modernization Act of 2003 (MMA), became effective January 1, 2006. The program makes a prescription drug benefit available to everyone who is in Medicare, though beneficiaries must join a drug plan to obtain coverage. The drug plans are offered by insurance companies and other private companies approved by Medicare

and are of two types: Medicare Prescription Drug Plans (which add the coverage to basic Medicare) and Medicare Advantage Prescription Drug Plans and other Medicare Health Plans in which drug coverage is offered as part of a benefit package that includes Part A and Part B services. In addition, Medicare helps employers or unions continue to provide retiree drug coverage that meets Medicare's standards through the Retiree Drug Subsidy (RDS). In addition, the Low Income Subsidy (LIS) helps those with limited income and resources. (See "Payments to the Health Care Trust Funds Appropriation" below as well as Note 9 for descriptions of revenues and financing sources for the SMI trust fund).

The Affordable Care Act provides for a one-time payment of $250 per beneficiary to those who enter the Part D coverage gap (as described in the Part D prescription drug program) during the 2010 calendar year. Additionally, beneficiary cost sharing is reduced for brand-name drugs from 100 percent in 2010 (minus the $250 rebate) to 25 percent by 2020. For generic drugs, which are not subject to the required 50 percent discount, beneficiary cost sharing in the coverage gap will be reduced to 93 percent in 2011 and phased down to 25 percent in 2020.

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

Medicare and Medicaid Integrity Programs

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

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

Payments to the Health Care Trust Funds Appropriation

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

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

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

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

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

Medicaid

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

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

Children's Health Insurance Program (CHIP)

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

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

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

State Grants and Demonstrations

Several grant programs have been established through the 75-0516 State Grants and Demonstrations appropriation fund group. The passage of the Affordable Care Act extended the availability of funds.

The Ticket to Work and Work Incentives Improvement Act of 1999 established 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 MMA of 2003 appropriates funds annually, from FY 2005 through FY 2009, for the Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens. The Deficit Reduction Act Section 6201 provides Federal payments for several projects, including Hurricane Katrina Relief, the establishment of alternative non-emergency providers, and the expansion of State Long-Term Care Partnerships.

CHIPRA provided for transition grants to provide funding to states to assist them in transitioning to a prospective payment system.

Health Care Infrastructure Improvement Program

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

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

This account operates as a revolving fund without fiscal year restriction. The BBA established the Medicare+Choice program, now known as the Medicare Advantage program under the MMA, that requires Medicare Advantage plans to make payments for their share of the estimated costs related to enrollment, dissemination of information, and certain counseling and assistance programs.

These user fees are devoted to educational efforts for beneficiaries and outreach partners. The Clinical Laboratory Improvement Amendments of 1988 (CLIA) marked the first comprehensive effort by the Federal government to regulate medical laboratory testing. The CMS and the Public Health Service share responsibility for the CLIA program, with CMS having the lead responsibility for financial management. Fees for registration, certificates, and compliance determination of all U.S. clinical laboratories are collected to finance the program. Other user fees are charged for certification of some nursing facilities and for sale of the data on nursing facilities surveys and for coordination of benefits for the Part D program. Proceeds from the sale of data from the public use files and publications under the Freedom of Information Act (FOIA) are also credited to this fund.

Program Management Appropriation

The Program Management Appropriation provides CMS with the major source of administrative funds to manage the Medicare and Medicaid programs. The funds for this activity are provided from the HI and SMI trust funds, the general fund, and reimbursable activities. The Payments to the Health Care Trust Funds Appropriation reimburses the Medicare HI trust fund to cover the Health programs' share of CMS administrative costs (see Note 9). User fees collected from Medicare Advantage plans seeking Federal qualification and funds received from other Federal agencies to reimburse CMS for services performed for them are credited to the Program Management Appropriation.

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

The ARRA provides additional funding for Program Management to manage and operate

health information technology to develop performance measures and payment systems, to make incentive payments, and to validate the appropriateness of those payments.

The Affordable Care Act provides additional funding for Program Management to address activities such as Medicaid adult health quality measures, a nationwide program for national and state background checks on long-term care employees, evaluations of community prevention and wellness programs, quality measurements, State Health Insurance Programs, the Medicare Independence at Home Demonstration program, and the complex diagnostic laboratory tests demonstration project. The effect of which is minimal as of and for the year ended September 30, 2010.

Center for Medicare and Medicaid Innovation Appropriation

The Affordable Care Act provides funding for the establishment of a Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. The effects of this additional funding can be found in the Fund Balance With Treasury and Appropriations Received as no expenses have been incurred as of September 30, 2010.

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

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

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

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

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

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

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

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

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

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

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

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

Unobligated Balances—beginning of period represent funds brought forward from the previous year.

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 2009 balances have been reclassified to conform to FY 2010 financial statement presentations, the effect of which is immaterial.

Estimation of Obligations Related to Canceled Appropriations

As of September 30, 2010, CMS has canceled over $217 million in cumulative obligations related to FY 2005 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 2006 through 2010 related to canceled appropriations, CMS anticipates an additional $4 million will be paid from current year funds for canceled obligations.

NOTE 2:

FUND BALANCE WITH TREASURY *(Dollars in Millions)*

FY 2010	Consolidated Totals
FUND BALANCES:	
Trust Funds	
HI Trust Fund (Earmarked)	$38
SMI Trust Fund (Earmarked)	1,958
Revolving Funds	
CLIA	280
General Funds	
Medicaid	44,878
CHIP	15,172
State Grants and Demonstrations	1,999
Program Management	509
Other Fund Types	
CMS Deposit/Suspense Accounts	7
TOTAL FUND BALANCES	**$64,841**
STATUS OF FUND BALANCES WITH TREASURY:	
Unobligated Balance	
Available	$26,457
Unavailable	4,313
Obligated Balance not yet Disbursed	86,538
Non-Budgetary FBWT	(52,467)
TOTAL STATUS OF FUND BALANCES WITH TREASURY	**$64,841**

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

Fund Balances are funds with Treasury that are primarily available to pay current expenditures and liabilities. The Medicaid balance of $44,878 million, ($33,132 million in FY 2009) includes $8,043 million ($11,339 million in FY 2009) of funds for ARRA. The Unobligated Balance Available includes $6,994 million ($3,566 million in FY 2009), which is restricted for future use and is not apportioned for current use for CHIP, Program Management, State Grants and Demonstrations, and ARRA Health Information Technology.

NOTE 3: INVESTMENTS *(Dollars in Millions)*

Medicare Investments *(Earmarked)*

FY 2010	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2011	2 1/8%	$2,120
Bonds	June 2012 to June 2024	3 1/4 - 6 1/2%	277,355
Accrued Interest			3,319
TOTAL HI TF INVESTMENTS			**$282,794**
SMI TF			
Certificates	June 2011	2 1/4 - 2 1/2%	$5,939
Bonds	June 2012 to June 2025	2 7/8 - 6 7/8%	65,043
Accrued Interest			727
TOTAL SMI TF INVESTMENTS			**$71,709**
TOTAL MEDICARE INVESTMENTS			**$354,503**

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

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

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

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

Medicare Investments *(Non-Earmarked)*

FY 2010

	Maturity Date	Cost	Unamortized Discount	Investments, Net
Treasury Bill	12/16/10	$1,617	$1	$1,616
Treasury Bill	12/16/10	401		401
Treasury Bill	12/16/10	51		51
Treasury Bill	12/16/10	50		50
TOTAL NON-EARMARKED INVESTMENTS		**$2,119**	**$1**	**$2,118**

FY 2009

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

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

CMS Investment Summary

FY 2010

	Medicare (Earmarked)			(Non-Earmarked)	Consolidated
	HI TF	SMI TF	Total	CHIP	Total
Certificates	$2,120	$5,939	$8,059		$8,059
Bonds	277,355	65,043	342,398		342,398
Treasury Bills				$2,118	2,118
Accrued Interest	3,319	727	4,046		4,046
TOTAL INVESTMENTS	**$282,794**	**$71,709**	**$354,503**	**$2,118**	**$356,621**

FY 2009

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

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

FY 2010	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	Other Health	Consolidated Total
INTRAGOVERNMENTAL					
Railroad Retirement Board Principal	$493				$493
WITH THE PUBLIC					
Provider & Beneficiary Overpayments					
Accounts Receivable Principal	$656	$485		$29	$1,170
Less: Allowance for Uncollectible Accounts	(135)	(178)		(13)	(326)
Accounts Receivable, Net	521	307		16	844
Medicare Secondary Payer (MSP)					
Accounts Receivable Principal	115	81		7	203
Less: Allowance for Uncollectible Accounts	(26)	(31)		(5)	(62)
Accounts Receivable, Net	89	50		2	141
Medicare Prescription Drug					
Accounts Receivable Principal		1,395			1,395
Less: Allowance for Uncollectible Accounts					
Accounts Receivable, Net		1,395			1,395
CMPs and Other Restitutions					
Accounts Receivable Principal	373	196			569
Less: Allowance for Uncollectible Accounts	(323)	(189)			(512)
Accounts Receivable, Net	50	7			57
Fraud and Abuse					
Accounts Receivable Principal	37	352	$414		803
Less: Allowance for Uncollectible Accounts	(37)	(333)	(36)		(406)
Accounts Receivable, Net		19	378		397
Medicare Premiums/Medicare Advantage					
Accounts Receivable Principal	288	1,009		4	1,301
Less: Allowance for Uncollectible Accounts	(61)	(113)		(3)	(177)
Accounts Receivable, Net	227	896		1	1,124
State Phased-Down Contributions					
Accounts Receivable Principal		811			811
Less: Allowance for Uncollectible Accounts					
Accounts Receivable, Net		811			811
Medicaid Overpayments					
Accounts Receivable Principal			664		664
Less: Allowance for Uncollectible Accounts			(143)		(143)
Accounts Receivable, Net			521		521
Audit Disallowances					
Accounts Receivable Principal			2,289		2,289
Less: Allowance for Uncollectible Accounts			(543)		(543)
Accounts Receivable, Net			1,746		1,746
Others Accounts Receivable					
Accounts Receivable Principal	3	2		15	20
Less: Allowance for Uncollectible Accounts				(10)	(10)
Accounts Receivable, Net	3	2		5	10
TOTAL ACCOUNTS RECEIVABLE PRINCIPAL	**$1,472**	**$4,331**	**$3,367**	**$55**	**$9,225**
Less: Allowance for Uncollectible Accounts Receivable	(582)	(844)	(722)	(31)	(2,179)
TOTAL ACCOUNTS RECEIVABLE, NET	**$890**	**$3,487**	**$2,645**	**$24**	**$7,046**

FY 2009	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	Other Health	Consolidated Total
INTRAGOVERNMENTAL					
Railroad Retirement Board Principal	$492				$492
WITH THE PUBLIC					
Provider & Beneficiary Overpayments					
Accounts Receivable Principal	$450	$426		$25	$901
Less: Allowance for Uncollectible Accounts	(97)	(173)		(13)	(283)
Accounts Receivable, Net	353	253		12	618
Medicare Secondary Payer (MSP)					
Accounts Receivable Principal	83	49		13	145
Less: Allowance for Uncollectible Accounts	(27)	(25)		(7)	(59)
Accounts Receivable, Net	56	24		6	86
Medicare Prescription Drug					
Accounts Receivable Principal		265			265
Less: Allowance for Uncollectible Accounts					
Accounts Receivable, Net		265			265
CMPs and Other Restitutions					
Accounts Receivable Principal	438	466			904
Less: Allowance for Uncollectible Accounts	(389)	(461)			(850)
Accounts Receivable, Net	49	5			54
Fraud and Abuse					
Accounts Receivable Principal	89	331	$229		649
Less: Allowance for Uncollectible Accounts	(89)	(316)	(60)		(465)
Accounts Receivable, Net		15	169		184
Medicare Premiums/Medicare Advantage					
Accounts Receivable Principal	270	894		3	1,167
Less: Allowance for Uncollectible Accounts	(175)	(100)		(3)	(278)
Accounts Receivable, Net	95	794			889
State Phased-Down Contributions					
Accounts Receivable Principal		1,096			1,096
Less: Allowance for Uncollectible Accounts					
Accounts Receivable, Net		1,096			1,096
Audit Disallowances					
Accounts Receivable Principal			2,532		2,532
Less: Allowance for Uncollectible Accounts			(564)		(564)
Accounts Receivable, Net			1,968		1,968
Others Accounts Receivable					
Accounts Receivable Principal	2			12	14
Less: Allowance for Uncollectible Accounts				(9)	(9)
Accounts Receivable, Net	2			3	5
TOTAL ACCOUNTS RECEIVABLE PRINCIPAL	**$1,332**	**$3,527**	**$2,761**	**$53**	**$7,673**
Less: Allowance for Uncollectible Accounts Receivable	(777)	(1,075)	(624)	(32)	(2,508)
TOTAL ACCOUNTS RECEIVABLE, NET	**$555**	**$2,452**	**$2,137**	**$21**	**$5,165**

Intragovernmental Accounts Receivable

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

Accounts Receivable with the Public

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

Provider and Beneficiary Overpayments

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

Medicare Secondary Payer (MSP)

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

Medicare Prescription Drug

The Medicare Prescription Drug accounts receivable of $1,395 ($265 million in FY 2009) consists of amounts due CMS after completion of the Part D payment reconciliation for calendar year (CY) 2009. The estimate for the first nine months of CY 2010 is reported as an advance of $1,098 ($1,638 million in 2009) in "Other Assets" on the Balance Sheet. The estimated advance is caused by the fact that CMS payments to the plans are made evenly throughout the year while payments made by the plans are more heavily weighted towards the fourth calendar quarter. This advance will be liquidated as claims are incurred and submitted to the plans during the first quarter of FY 2011. As a result, CMS management believes the Part D accrual estimate will become a liability by the end of CY 2010.

Civil Monetary Penalties (CMPs) and Other Restitutions

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

Medicare Premiums

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

State Phased-Down Contributions

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

Medicaid Overpayments

The Medicaid overpayments consist of those states where advances exceeded approved expenditures. Those states that had a remaining advance balance after processing approved expenditures have been reclassified as a receivable. An allowance has been established for this receivable based on the methodology used for the Medicaid audit disallowances.

Audit Disallowances

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

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

Write Offs and Adjustments

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

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

Currently Not Reportable/ Currently Not Collectible Debt

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

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

FY 2010	Medicare (Earmarked)						
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Consolidated Total
Medicare Benefits Payable *(1)*	$20,726	$18,976	$39,702				$39,702
Medicare Advantage/ Prescription Drug Program *(2)*	1,050	2,329	3,379				3,379
Retiree Drug Subsidy *(3)*		1,926	1,926				1,926
Undocumented Aliens						$75	75
Medicaid/CHIP *(4)*				$27,215	$415		27,630
TOTAL ENTITLEMENT BENEFITS DUE AND PAYABLE	**$21,776**	**$23,231**	**$45,007**	**$27,215**	**$415**	**$75**	**$72,712**

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

(1) Medicare benefits payable consists of a $39,702 million estimate ($39,647 million in FY 2009) for Medicare services incurred but not paid as of September 30, 2010. This actuarial liability represents (a) an estimate of claims incurred that may or may not have been submitted to the Medicare contractors but were not yet approved for payment, (b) actual claims that have been approved for payment by the Medicare contractors for which checks have not yet been issued, (c) checks that have been issued by the Medicare contractors in payment of a claim and that have not yet been cashed by payees, (d) periodic interim payments for 2009 that were paid in 2010 and (e) an estimate of retroactive settlements of cost reports. The September 30, 2010 estimate also includes amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals and for amounts which may be due/owed to providers for claims that must be reprocessed due to various provisions of the Affordable Care Act.

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

(2) Medicare Advantage and Prescription Drug Program benefits payable of $3,379 million ($5,063 million in FY 2009) consists of a $2,434 million estimate ($2,480 million in FY 2009) for amounts owed to plans relating to risk and other payment related adjustments, $866 million ($2,583 million in FY 2009) owed to plans after the completion of the Prescription Drug Payment reconciliation, and $79 million for amounts owed to beneficiaries that have qualified for the Part D coverage gap as of September 30, 2010.

(3) The Retiree Drug Subsidy (RDS) consists of a $1,926 million estimate ($2,062 million in FY 2009) of payments to plan sponsors of retiree prescription drug coverage incurred but not paid as of September 30, 2010. As part of MMA (incorporated in Section 1860D-22 of the Social Security Act), the RDS program makes subsidy payments available to sponsors of retiree prescription drug coverage. The program is designed to strengthen health care coverage for Medicare-eligible retirees by encouraging the retention of private, employer- and union-based retiree prescription drug plans.

(4) Medicaid benefits payable of $27,215 million ($24,977 million in FY 2009) 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, 2010. This estimate incorporates claim activity tracked under ARRA of $4,007 million ($3,176 million in FY 2009). An estimated CHIP benefits payable of $415 million has been recorded ($358 million in FY 2009) for the net Federal share of expenses that have been incurred by the States but not yet reported to CMS as of September 30, 2010.

NOTE 6: CONTINGENCIES

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

The Medicaid amount for $5,391 million ($3,793 million in FY 2009) consists of Medicaid audit and program disallowances of $915 million ($1,005 million in FY 2009) and $4,476 million ($2,788 million in FY 2009) 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, CHIP and Survey & Certification (CMCS) Regional Office staff 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 CMCS. The outcome of these reviews is that CMS could be owed funds.

Appeals at the Provider Reimbursement Review Board

Other liabilities do not include all provider cost reports under appeal at the Provider Reimbursement Review Board (PRRB). The monetary effect of those appeals is generally not known until a decision is rendered. However, historical cases that have been appealed and settled by the PRRB are considered in the development of the actuarial Medicare IBNR liability. As of September 30, 2010, 7,833 cases (7,984 in FY 2009) remain on appeal. A total of 1,384 new cases (2,312 in FY 2009) were filed and four cases reopened in FY 2010. The PRRB rendered decisions on 144 cases (93 in FY 2009) in FY 2010 and 1,395 additional cases (1,947 in FY 2009) were dismissed, withdrawn, or settled prior to an appeal hearing. The PRRB receives no information on the value of these cases that are settled prior to a hearing.

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

FY 2010	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	CHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Intragovernmental:								
Accrued Payroll and Benefits	$1	$2				$3		$3
TOTAL INTRAGOVERNMENTAL	**$1**	**$2**				**$3**		**$3**
Federal Employee and Veterans' Benefits	4	8	$1			13		13
Accrued Payroll and Benefits	15	24	2		$2	43		43
Contingencies			5,391			5,391		5,391
TOTAL LIABILITIES NOT COVERED BY BUDGETARY RESOURCES	**$20**	**$34**	**$5,394**		**$2**	**$5,450**		**$5,450**
TOTAL LIABILITIES COVERED BY BUDGETARY RESOURCES	**$47,214**	**$49,939**	**$27,219**	**$415**	**$125**	**$124,912**	**$(49,858)**	**$75,054**
TOTAL LIABILITIES	**$47,234**	**$49,973**	**$32,613**	**$415**	**$127**	**$130,362**	**$(49,858)**	**$80,504**

FY 2009	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	CHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Intragovernmental:								
Accrued Payroll and Benefits	$1	$2				$3		$3
TOTAL INTRAGOVERNMENTAL	**$1**	**$2**				**$3**		**$3**
Federal Employee and Veterans' Benefits	5	9	$1			15		15
Accrued Payroll and Benefits	11	23	2		$1	37		37
Contingencies			3,793			3,793		3,793
TOTAL LIABILITIES NOT COVERED BY BUDGETARY RESOURCES	**$17**	**$34**	**$3,796**		**$1**	**$3,848**		**$3,848**
TOTAL LIABILITIES COVERED BY BUDGETARY RESOURCES	**$46,957**	**$53,224**	**$24,979**	**$360**	**$156**	**$125,676**	**$(51,785)**	**$73,891**
TOTAL LIABILITIES	**$46,974**	**$53,258**	**$28,775**	**$360**	**$157**	**$129,524**	**$(51,785)**	**$77,739**

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

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

FY 2010	Medicare (Earmarked)			Health			Consolidated Totals
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	
PROGRAM/ACTIVITY COSTS							
Medicare							
Fee for Service	$184,412	$151,395	$335,807				$335,807
Medicare Advantage/ Managed Care	60,333	54,759	115,092				115,092
Prescription Drug (Part D)		52,695	52,695				52,695
Medicaid/CHIP/State Grants & Demos				$272,754	$7,943	$474	281,171
CLIA						193	193
TOTAL PROGRAM/ACTIVITY COSTS	**$244,745**	**$258,849**	**$503,594**	**$272,754**	**$7,943**	**$667**	**$784,958**
OPERATING COSTS							
Medicare Integrity Program	$1,201		$1,201				$1,201
Quality Improvement Organizations	280	$56	336				336
Bad Debt Expense and Writeoffs	(81)	(239)	(320)	$99		$17	(204)
Reimbursable Expenses	10	19	29	1		1	31
Administrative Expenses	1,151	1,890	3,041	141	$25	91	3,298
Depreciation and Amortization	13	42	55				55
Imputed Cost Subsidies	14	25	39	2		3	44
TOTAL OPERATING COSTS	**$2,588**	**$1,793**	**$4,381**	**$243**	**$25**	**$112**	**$4,761**
TOTAL COSTS	**$247,333**	**$260,642**	**$507,975**	**$272,997**	**$7,968**	**$779**	**$789,719**
LESS: EXCHANGE REVENUES:							
Medicare Premiums	$3,504	$57,273	$60,777				$60,777
CLIA Revenues						$183	183
Other Exchange Revenues	11	25	36	$2		17	55
TOTAL EXCHANGE REVENUES	**$3,515**	**$57,298**	**$60,813**	**$2**		**$200**	**$61,015**
TOTAL NET COST OF OPERATIONS	**$243,818**	**$203,344**	**$447,162**	**$272,995**	**$7,968**	**$579**	**$728,704**

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

For purposes of financial statement presentation, non-CMS administrative costs are considered expenses to the Medicare trust funds when outlayed by Treasury even though some funds may have been used to pay for assets such as property and equipment. The CMS administrative costs have been allocated to the Medicare, Medicaid, CHIP, and State Grants and Demonstrations programs based on the CMS cost allocation system. Administrative costs allocated to the Medicare program include $1,928 million ($1,772 million in FY 2009) paid to Medicare contractors to carry out their responsibilities as CMS' agents in the administration of the Medicare program.

For reporting purposes, Medicare Part D expense has been reduced by actual and accrued reimbursements made by the States pursuant to the State Phased-Down provision. The FY 2010 Part D expense of $52,695 million ($46,145 million in FY 2009) is net of State reimbursements of $4,205 million ($7,565 million in FY 2009). The gross expense would have been $56,900 million in FY 2010 ($53,710 million in FY 2009).

Of the Medicaid benefit expense of $272,754 million ($252,906 million in FY 2009), $40,774 million were identified under ARRA ($34,803 million in FY 2009).

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

FY 2010

Transfers-in Without Reimbursement	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	CHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
Medicare Benefit Transfers	$249,551	$267,613				$517,164	$(517,164)	
Transfers to HCFAC	1,464					1,464	(1,464)	
Federal Matching Contributions		161,110				161,110	(161,110)	
Medicare Part D Benefits		52,341				52,341	(52,341)	
Medicare Part D Administrative		258				258	(258)	
Allocation to CMS Programs	1,132	2,063	$138	$16	$175	3,524	(3,524)	
Fraud and Abuse Appropriation	126					126	(126)	
Transfer-Uninsured Coverage	(142)					(142)	142	
Prog. Mngmt. Admin. Expense *(1)*	201					201	(201)	
Income Tax OASDI Benefits *(2)*	13,760					13,760	(13,760)	
Railroad Retirement Board	536					536		$536
Criminal Fines	1,225					1,225	(1,225)	
Medicaid Part B Premiums			515			515	(515)	
Medicare Advantage Stabilization	(54)	(54)				(108)	108	
Interest Adjustments	1	1				2		2
Miscellaneous	1	1				2		2
TOTAL TRANSFERS-IN	**$267,801**	**$483,333**	**$653**	**$16**	**$175**	**$751,978**	**$(751,438)**	**$540**

FY 2010

Transfers-out Without Reimbursement	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	CHIP	Other Health	Combined Total	Intra-CMS Eliminations	Consolidated Total
SSA Administrative Expenses	$(1,024)	$(1,083)				$(2,107)		$(2,107)
Medicare Benefit Transfers	(249,551)	(267,613)				(517,164)	$517,164	
Transfers to HCFAC	(1,464)					(1,464)	1,464	
Federal Matching Contributions		(161,110)				(161,110)	161,110	
Medicare Part D Benefits		(52,341)				(52,341)	52,341	
Medicare Part D Administrative		(258)				(258)	258	
Transfers to Program Management	(1,375)	(2,149)				(3,524)	3,524	
Fraud and Abuse Appropriation	(126)					(126)	126	
Transfer-Uninsured Coverage	142					142	(142)	
Prog. Mngmt. Admin. Expense *(1)*	(201)					(201)	201	
Income Tax OASDI Benefits *(2)*	(13,760)					(13,760)	13,760	
Criminal Fines	(1,225)					(1,225)	1,225	
Medicaid Part B Premiums		(515)				(515)	515	
Medicare Advantage Stabilization	54	54				108	(108)	
Office of the Secretary	(41)	(39)				(80)		(80)
Payment Assessment Commission	(6)	(6)				(12)		(12)
AOA MIPPA Expense *(4)*	(16)	(14)				(30)		(30)
Railroad Retirement Board		(9)				(9)		(9)
TOTAL TRANSFERS-OUT	**$(268,593)**	**$(485,083)**				**$(753,676)**	**$751,438**	**$(2,238)**
TOTAL TRANSFERS-IN/OUT WITHOUT REIMBURSEMENT	**$(792)**	**$(1,750)**	**$653**	**$16**	**$175**	**$(1,698)**		**$(1,698)**

FY 2009

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

FY 2009

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

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

(1) During FY 2010, the Payments to the Health Care Trust Funds appropriation paid the HI trust fund $201 million ($281 million in FY 2009) to cover the Medicaid, CHIP, and State Grants and Demonstrations programs' share of CMS' administrative costs.

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

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

(4) During FY 2010, the HI and SMI trust funds recorded expenditure transfers of $16 million ($9 million in FY 2009) and $14 million ($8 million in FY 2009), respectively, to the Administration on Aging for the Medicare Enrollment Assistance Program pursuant to the Affordable Care Act of 2010, Public Law 111-148.§3306. In FY 2009, the transfers were made pursuant to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, Public Law 110-275.§119).

Federal Matching Contributions

SMI benefits and administrative expenses are financed by monthly premiums paid by Medicare beneficiaries and are matched by the Federal government through the general fund appropriation, Payments to the Health Care Trust Funds. Section 1844 of the Social Security Act authorizes appropriated funds to match SMI premiums collected, and outlines the ratio for the match as well as the method to make the trust funds whole if insufficient funds are available in the appropriation to match all premiums received in the fiscal year. The standard monthly SMI premium per beneficiary was $96.40 from October 1, 2009 through December 31, 2009, and $110.50 for January 1, 2010 through September 30, 2010. However, as a result of the zero cost-of-living adjustment (COLA) for Social Security beneficiaries effective for December 2009, about three-fourths of Part B enrollees are "held harmless" and do not have to pay the higher premium amount in 2010. New beneficiaries enrolling on January 1, 2010 and beyond, enrollees subject to an income-related additional premium, and individuals who do not have their premium deducted from their Social Security benefit, including Medicare-Medicaid "dual-eligible beneficiaries," must pay a monthly premium based on the standard premium of $110.50. (Premiums for dual-eligible beneficiaries are paid by the State Medicaid programs). Premiums collected from beneficiaries totaled $54,780 million ($51,860 million in FY 2009) and were matched by a $161,110 million ($150,748 million in FY 2009) 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 Septmeber 30, 2010, approximately $52,599 million has been transferred-in ($43,518 million in FY 2009) to Part D from the general fund.

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

FY 2010	Medicare (Earmarked) HI TF	Medicare (Earmarked) SMI TF	Medicaid	CHIP	Other Health	Consolidated Total
Unexpended Appropriations						
Withdrawal of Expired or Canceled Year Authority	$(60)	$(3,373)		$(56)	$(21)	$(3,510)
TOTAL OTHER ADJUSTMENTS	**$(60)**	**$(3,373)**		**$(56)**	**$(21)**	**$(3,510)**

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

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

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

NOTE 11: EARMARKED FUNDS *(Dollars in Millions)*

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

Balance Sheet as of September 30, 2010

	HI TF	SMI TF	Total Earmarked Funds
ASSETS			
Fund Balance with Treasury	$38	$1,958	$1,996
Investments	282,794	71,709	354,503
Other Assets	26,216	29,715	55,931
TOTAL ASSETS	**$309,048**	**$103,382**	**$412,430**
Entitlement Benefits Due & Payable	$21,776	$23,231	$45,007
Other Liabilities	25,458	26,742	52,200
TOTAL LIABILITIES	**$47,234**	**$49,973**	**$97,207**
Unexpended Appropriations	$702	$1,074	$1,776
Cumulative Results of Operations	261,112	52,335	313,447
TOTAL NET POSITION	**$261,814**	**$53,409**	**$315,223**
TOTAL LIABILITIES AND NET POSITION	**$309,048**	**$103,382**	**$412,430**

Statement of Net Cost for the Period Ended September 30, 2010

Benefit Expense	$244,745	$258,849	$503,594
Operating Costs	2,588	1,793	4,381
TOTAL COSTS	**$247,333**	**$260,642**	**$507,975**
LESS EARNED REVENUES	**$3,515**	**$57,298**	**$60,813**
NET COST OF OPERATIONS	**$243,818**	**$203,344**	**$447,162**

Statement of Changes in Net Position for the Period Ended September 30, 2010

Net Position, Beginning of Period	$292,374	$43,968	$336,342
Taxes and Other Nonexchange Revenue	198,423	3,059	201,482
Other Financing Sources	14,835	209,726	224,561
LESS NET COST OF OPERATIONS	**$243,818**	**$203,344**	**$447,162**
CHANGE IN NET POSITION	**$(30,560)**	**$(9,441)**	**$(21,119)**
NET POSITION, END OF PERIOD	**$261,814**	**$53,409**	**$315,223**

Balance Sheet as of September 30, 2009

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

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

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

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

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

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

FY 2010	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	$668	$246,665	$247,333	$5	$3,510	$3,515	$243,818
SMI TF	195	260,447	260,642	11	57,287	57,298	203,344
Medicaid	13	272,984	272,997	1	1	2	272,995
CHIP	5	7,963	7,968				7,968
SUBTOTAL	**$881**	**$788,059**	**$788,940**	**$17**	**$60,798**	**$60,815**	**$728,125**
OTHER ACTIVITIES							
CLIA	$38	$155	$193		$183	$183	$10
State Grants & Demonstrations	19	531	550		17	17	533
Other	4	32	36				36
SUBTOTAL	**$61**	**$718**	**$779**		**$200**	**$200**	**$579**
PROGRAM/ACTIVITY TOTALS	**$942**	**$788,777**	**$789,719**	**$17**	**$60,998**	**$61,015**	**$728,704**

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

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

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

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

FY 2010

	Direct	Reimbursable	Combined Totals
Category A	$14,077	$230	$14,307
Category B	563,992	1	563,993
Exempt	478,902		478,902
TOTAL	**$1,056,971**	**$231**	**$1,057,202**

FY 2009

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

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 $300,470 million as of September 30, 2010, ($320,064 million in FY 2009) are included in Investments on the Balance Sheets. The following table presents trust fund activities and balances for FY 2010 and FY 2009 (in millions):

	FY 2010 Combined Balance	FY 2009 Combined Balance
TRUST FUND BALANCE, BEGINNING	**$320,064**	**$329,970**
Receipts	445,878	442,286
Less: Obligations	465,472	452,192
Shortage of Receipts Over Obligations	(19,594)	(9,906)
TRUST FUND BALANCE, ENDING	**$300,470**	**$320,064**

Explanations of Differences Between the Statement of Budgetary Resources and the Budget of the United States Government for FY 2009

(in millions)

	Budgetary Resources	Obligations Incurred	Offsetting Receipts	Net Outlays
Statement of Budgetary Resources	$1,016,172	$995,093	$283,209	$969,002
Unobligated Balances Not Available	(904)			
Other Adjustments	3,270	3,201	1	3,172
PRESIDENT'S BUDGET (actual)	**$1,018,538**	**$998,294**	**$283,210**	**$972,174**

The Other Adjustments Line for Budgetary Resources includes an increase in the amount of $3,399 million for the amounts reported in the President's Budget but reported on the Centers for Disease Control (CDC) SBR; amounts that are appropriately reported on the SBR but not included as new budgetary resources in the President's Budget (obligations incurred line for expired accounts) in the amount of ($178) million; cancellations of expired years in HI and SMI in the amount of $50 million; and ($1) million due to rounding.

The Other Adjustments Line for Obligations Incurred includes an increase of $3,383 for the amounts reported in the President's Budget but reported on the CDC SBR; and the obligations incurred line for expired accounts in the amount of ($182) million that are appropriately reported on the SBR but not included as new obligations incurred in the President's Budget.

The Other Adjustments Line for Offsetting Receipts includes $1 million Child Enrollment Contingency Fund CHIP interest collected that was not included on the SBR.

The Other Adjustments Line for Net Outlays includes an increase to net outlays in the amount of $3,171 million for the amounts reported in the President's Budget but reported on the CDC SBR and $1 million due to rounding.

Undelivered Orders at the End of the Period

The amount of budgetary resources obligated for undelivered orders totaled $12,960 million at September 30, 2010 ($9,452 million in FY 2009).

NOTE 14: STATEMENT OF SOCIAL INSURANCE *(Unaudited)*

The Statement of Social Insurance (SOSI) presents the projected 75-year actuarial present values 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 Medicare Board of Trustees*. These assumptions represent the Trustees' best estimate of likely future economic, demographic, and health care-specific conditions.

The SOSI projections are based on current law, and reflect the effects of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010. This legislation, referred to collectively as the "Affordable Care Act," contains roughly 165 provisions affecting the Medicare program by reducing costs, increasing revenues, improving certain benefits, combating fraud and abuse, and initiating a major program of research and development.

The Affordable Care Act improves the financial outlook for Medicare substantially; however, the full effects of some of the new law's provisions on Medicare are not known at this time, with the result that the projections are much more uncertain than normal, especially in the long-range future. It is important to note that the substantially improved results for HI and SMI Part B depend in part on the long-range feasibility of lower increases in Medicare payment rates to most categories of health care providers, as mandated by the Affordable Care Act. Moreover, in the context of today's health care system, these adjustments would probably not be viable indefinitely into the future. As a result, the actual future costs for Medicare are likely to exceed those shown by the current-law projections shown in the SOSI. Please see Note 15 for further information on the impact of the Affordable Care Act.

Actuarial present values are computed as of the year shown and over the 75-year projection period, beginning January 1 of that year. The Trustees' projections are based on the current Medicare laws, regulations, and policies in effect on August 5, 2010, and do not reflect any actual or anticipated changes subsequent to that date. The present values are calculated

by discounting the future annual amounts of non-interest income and expenditures (including benefit payments as well as administrative expenses) at the projected average rates of interest credited to the HI trust fund. HI income includes the portion of *FICA* and *SECA* payroll taxes allocated to the HI trust fund, the portion of Federal income taxes paid on Social Security benefits that is allocated to the HI trust fund, and receipts from fraud and abuse control activities. SMI income includes premiums paid by, or on behalf of, beneficiaries and general revenue contributions made on behalf of beneficiaries. Fees related to brand-name prescription drugs, required by the Affordable Care Act, are included as income for Part B of SMI, and transfers from State governments are included as income for Part D of SMI. Since all major sources of income to the trust funds are reflected, the actuarial projections can be used to assess the financial condition of each trust fund.

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

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

The SOSI sets forth, for each of these three groups, the projected actuarial present values 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 values of future net cash flows for each fund, which are calculated by subtracting the actuarial present value of future expenditures from the actuarial present value of future income. The existence of an 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 short of expenditures over the next 75 years. Neither Part B nor Part D of SMI has similar problems because each account is automatically in financial balance every year due to its statutory financing mechanism.

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

Since its enactment in 1965, the Medicare program has experienced substantial variability in expenditure growth rates. These different rates of growth have reflected new developments in medical care, demographic factors affecting the relative number and average age of beneficiaries and covered workers, and numerous economic factors. The future cost of Medicare will also be affected by further changes in these factors that are inherently uncertain. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and such actual cost could differ materially from the projections shown in the SOSI. Moreover, these differences could affect the long-term sustainability of this social insurance program. Please see Note 15 for important information on the further uncertainty, resulting from the provisions in the Affordable Care Act, associated with the current-law projections presented in the SOSI. In order to make projections regarding the future financial status of the HI and SMI trust funds, various assumptions have to be made. As stated previously, the estimates presented here are based on the assumption that the trust funds will continue to operate under the law in effect on August 5, 2010. In addition, the estimates depend on many economic, demographic, and health care-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 based on current law, used in the projections of Medicare spending displayed in this section, are included in the following table. The assumptions underlying the 2010 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2010. Specific assumptions are made for each of the different types of services provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions. Detailed information, similar to that denoted within Table 1, for the prior years is publicly available on the CMS website at: **http://www.cms.hhs.gov/CFOReport/**.

Table 1: Significant Assumptions and Summary Measures Used for the Statement of Social Insurance 2010

					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]
2010	2.08	1,215,000	784.4	3.1	5.1	2.0	2.3	1.1	3.8	4.3	0.9
2020	2.05	1,125,000	723.8	1.1	3.9	2.8	2.2	3.5	5.0	7.3	2.9
2030	2.01	1,085,000	661.8	1.2	4.0	2.8	2.1	4.7	4.8	5.9	2.9
2040	2.00	1,050,000	606.8	1.2	4.0	2.8	2.2	4.8	4.5	5.3	2.9
2050	2.00	1,035,000	558.6	1.2	4.0	2.8	2.1	3.9	4.1	5.1	2.9
2060	2.00	1,030,000	516.4	1.1	3.9	2.8	2.1	3.7	4.1	4.8	2.9
2070	2.00	1,025,000	479.1	1.1	3.9	2.8	2.1	3.6	3.9	4.6	2.9
2080	2.00	1,025,000	446.1	1.2	4.0	2.8	2.1	3.3	3.8	4.4	2.9

[1]Average number of children per woman.

[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration.

[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year.

[4]Difference between percentage increases in wages and the CPI.

[5]Average annual wage in covered employment.

[6]Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services.

[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth.

[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of services 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 2010–2006

					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 2010	2.0	1,025,000	446.1	1.2	4.0	2.8	2.1	3.3	3.8	4.4	2.9
FY 2009	2.0	1,025,000	458.2	1.1	3.9	2.8	2.1	4.4	4.3	4.3	2.9
FY 2008	2.0	1,025,000	476.8	1.1	3.9	2.8	2.1	4.4	4.3	4.4	2.9
FY 2007	2.0	900,000	496.8	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9
FY 2006	2.0	900,000	497.6	1.1	3.9	2.8	1.9	4.3	4.3	4.3	2.9

[1]Average number of children per woman. The ultimate fertility rate is assumed to be reached in the 25th year of the projection period.

[2]Includes legal immigration, net of emigration, as well as other, non-legal, immigration. For 2008-2010, the ultimate level of net legal immigration was increased from 600,000 to 750,000 persons per year. In addition, the method for projecting annual net other immigration was changed and it now varies throughout the projection period. So for 2008-2010, the assumption presented is the value assumed in the year 2080. For 2006-2007, the ultimate assumption is displayed and is reached by the 20th year of each projection period.

[3]The age-sex-adjusted death rate per 100,000 that would occur in the enumerated population as of April 1, 2000, if that population were to experience the death rates by age and sex observed in, or assumed for, the selected year. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.

[4]Difference between percentage increases in wages and the CPI. Except for minor fluctuations, the ultimate assumption is reached within the first 10 years of the projection period.

[5]Average annual wage in covered employment. Except for minor fluctuations, the ultimate assumption is reached within the first 10 years of the projection period.

[6]Consumer price index represents a measure of the average change in prices over time in a fixed group of goods and services. The ultimate assumption is reached within the first 10 years of the projection period.

[7]The total dollar value of all goods and services produced in the United States, adjusted to remove the impact of assumed inflation growth. The annual rate declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.

[8]These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The annual rate of growth declines gradually during the entire period so no ultimate rate is achieved. The assumption presented is the value assumed in the year 2080.

[9]Average rate of interest earned on new trust fund securities, above and beyond rate of inflation. The ultimate assumption is reached within the first 10 years of each projection period.

Part D Projections

In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the Part D program is still relatively new (having begun operations in January 2006), with relatively little actual program data currently available. The actual 2006 through 2010 bid submissions by the private plans offering this coverage, together with actual data on beneficiary enrollment and program spending through 2009, have been used in the current projections. Nevertheless, there remains a high level of uncertainty surrounding these cost projections, pending the availability of sufficient data on actual Part D expenditures to establish a trend baseline.

NOTE 15: AFFORDABLE CARE ACT AND SMI PART B PHYSICIAN PAYMENT UPDATE FACTOR *(Unaudited)*

The Affordable Care Act improves the financial outlook for Medicare substantially; however, the full effects of some of the new law's provisions on Medicare are not known at this time, with the result that the projections are much more uncertain than normal, especially in the longer-range future. For example, the Affordable Care Act initiative for aggressive research and development has the potential to reduce Medicare costs in the future; however, as specific reforms have not yet been designed, tested, or evaluated, their ability to reduce costs cannot be estimated at this time, and thus no specific savings have been reflected in the projections for the initiative.

Another important example involves lower payment rate updates to most categories of Medicare providers in 2011 and later. These updates will be adjusted downward by the increase in productivity experienced in the economy overall. Since the provision of health services tends to be labor-intensive and is often customized to match individuals' specific needs, most categories of health providers have not been able to improve their productivity to the same extent as the economy at large. Over time, the productivity adjustments mean that the prices paid for health services by Medicare will grow about 1.1 percent per year more slowly than the increase in prices that providers must pay to purchase the goods and services they use to provide health care services. Unless providers could reduce their cost per service correspondingly, through productivity improvements or other steps, they would eventually become unwilling or unable to treat Medicare beneficiaries.

It is possible that providers can improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. Similarly, the implementation of payment and delivery system reforms, facilitated by the Affordable Care Act research and development program, could help constrain cost growth to a level consistent with the lower Medicare payments. These outcomes are far from certain, however. Many experts doubt the feasibility of such sustained improvements and anticipate that over time the Medicare price constraints would become unworkable and that Congress would likely override them, much as they have done to prevent the reductions in physician payment rates otherwise required by the sustainable growth rate formula in current law.

The reductions in provider payments reflected in these updates, if implemented for all future years as required under current law, could have secondary impacts, for beneficiary access to care; utilization, intensity and quality of services; and other factors. These possible impacts are speculative, and at present there is no consensus among experts as to their potential scope. Further research and analysis will help to better inform this issue and may enable the development of specific projections of secondary effects under current law in the future.

The SOSI projections must be based on current law. Therefore, the productivity adjustments are assumed to occur in all future years, as required by the Affordable Care Act. In addition, reductions in Medicare payment rates for physician services, totaling 30 percent over the next 3 years, are assumed to be implemented as required under current law, despite the virtual certainty that Congress will continue to override these latter reductions. Therefore, it is important to note that the actual future costs for Medicare are likely to exceed those shown by these current-law projections.

Illustrative Scenario

The Medicare Board of Trustees, in their annual report to Congress, references an alternative scenario to illustrate, where possible, the potential understatement of Medicare costs and projection results. This alternative scenario assumes that the productivity adjustments are gradually phased out over the 15 years, starting in 2020, and that the physician fee reductions are overridden. These examples were developed for illustrative purposes only; the calculations have not been audited; no endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred; 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 affecting the productivity adjustments and physician payments under Medicare and of the broad range of uncertainty associated with such impacts. The table below contains a comparison of the Medicare 75-year present values of income and expenditures under current law with those under the alternative scenario illustration.

Medicare Present Values

(in billions)

	Current law *(unaudited)*	Alternative scenario[1,2] *(unaudited)*
Income		
Part A	$14,408	$14,408
Part B	17,737	28,284
Part D	9,715	9,715
Expenditures		
Part A	17,090	21,745
Part B	17,737	28,284
Part D	9,715	9,715
Income Less Expenditures		
Part A	(2,683)	(7,337)
Part B	0	0
Part D	0	0

[1] These amounts are not presented in the 2010 Trustees' Report.

[2] At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare trust fund projections that differ from current law. No endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred.

As expected, the differences between the current-law projections and the illustrative alternative are substantial, although both represent a sizable improvement in the financial outlook for Medicare compared to the laws in effect prior to the Affordable Care Act. This difference in outlook serves as a compelling reminder of the importance of developing and implementing further means of reducing health care cost growth in the coming years. All Part A fee-for-service providers are affected by the productivity adjustments, so the current law projections reflect an estimated 1.1 percent reduction in annual Part A cost growth each year. If the productivity adjustments were gradually phased out, as illustrated under the alternative scenario, the present value of Part A expenditures is estimated to be roughly 27 percent higher than the current-law projection. As indicated above, the present value of Part A income is unchanged under the alternative scenario.

The Part B expenditure projections are significantly higher under the alternative scenario than under current law, both because of the assumed gradual phase-out of the productivity adjustments and the assumption that the scheduled physician fee reductions would be overridden and based on annual increases in the Medicare Economic Index. The productivity adjustments are estimated to affect more than half of Part B expenditures at the time their phase-out is assumed to begin.

Similarly, physician fee schedule services are assumed to be roughly 30 percent higher under the alternative scenario than under current law at that time. The combined effect of these two factors results in a present value of Part B expenditures under the alternative scenario that is approximately 59 percent higher than the current-law projection.

The Part D projections are unaffected under the alternative projection because the services are not impacted by the productivity adjustments or the physician fee schedule reductions.

The extent to which actual future Part A and Part B costs exceed the projected current-law amounts due to changes to the productivity adjustments and physician payments depends on both the specific changes that might be legislated and on whether Congress would pass further provisions to help offset such costs. As noted, these examples only reflect hypothetical changes to provider payment rates.

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

NOTE 16: RECONCILIATION OF NET COST OF OPERATIONS TO BUDGET *(Dollars in Millions)*

	FY 2010 Consolidated Totals	FY 2009 Consolidated Totals
RESOURCES USED TO FINANCE ACTIVITIES:		
Budgetary Resources Obligated:		
Obligations incurred	$1,057,202	$995,093
Less: Spending authority from offsetting collections and recoveries	20,814	16,907
Obligations net of offsetting collections and recoveries	1,036,388	978,186
Less: Distributed offsetting receipts	302,966	283,209
NET OBLIGATIONS	**733,422**	**694,977**
Other Resources:		
Imputed financing from costs absorbed by others	44	34
NET OTHER RESOURCES USED TO FINANCE ACTIVITIES	**44**	**34**
TOTAL RESOURCES USED TO FINANCE ACTIVITIES	**$733,466**	**$695,011**
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	$2,964	$3,645
Resources that fund expenses recognized in prior periods		
Budgetary offsetting collections and receipts that do not affect net cost of operations	(71)	(62)
Resources that finance the acquisition of assets	11	40
Other resources or adjustments to net obligated resources that do not affect net cost of operations	1,905	2,322
TOTAL RESOURCES USED TO FINANCE ITEMS NOT PART OF THE NET COST OF OPERATIONS	**4,809**	**5,945**
TOTAL RESOURCES USED TO FINANCE THE NET COST OF OPERATIONS	**$728,657**	**$689,066**
COMPONENTS OF THE NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD:		
Components Requiring or Generating Resources in Future Periods:		
Increase in annual leave liability	$3	$3
Increase/(Decrease) in receivables from the public	(1,761)	2,519
Other	1,596	282
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL REQUIRE OR GENERATE RESOURCES IN FUTURE PERIODS	**(162)**	**2,804**
Components Not Requiring or Generating Resources:		
Depreciation and amortization	55	84
Other	154	(502)
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES	209	(418)
TOTAL COMPONENTS OF NET COST OF OPERATIONS THAT WILL NOT REQUIRE OR GENERATE RESOURCES IN THE CURRENT PERIOD	**$47**	**$2,386**
NET COST OF OPERATIONS	**$728,704**	**$691,452**

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

Required Supplementary Information

Medicare, the largest health insurance program in the country, has helped fund medical care for the nation's aged and disabled for over four decades. 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 in this financial report.

The Required Supplementary Information (RSI) contained in this section is based on current law, and is presented in accordance with the requirements of the Federal Accounting Standards Advisory Board (FASAB). Included are descriptions of 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 ***2010 Annual Report of the Board 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 shown here incorporate the effects of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010. This legislation, referred to collectively as the "Affordable Care Act," contains roughly 165 provisions affecting the Medicare program by reducing costs, increasing revenues, improving certain benefits, combating fraud and abuse, and initiating a major program of research and development for alternative provider payment mechanisms, health care delivery systems, and other changes intended to improve the quality of health care and/or reduce its costs to Medicare.

The Affordable Care Act improved the financial outlook for Medicare substantially, mainly as a result of permanent price update reductions for most fee-for-service providers, substantial reductions in payments to private health plans, and an increase in the Part A payroll tax rate for high-income earners. It is possible that providers can improve their productivity, reduce wasteful expenditures, and take other steps to keep their cost growth within the bounds imposed by the Medicare price limitations. These outcomes are far from certain, however. Many experts doubt the feasibility of such sustained improvements and anticipate that over time the Medicare price constraints would become unworkable and that Congress would likely override them, much as they have done to prevent the reductions in physician payment rates otherwise required by the sustainable growth rate formula in current law. However, the effects of some of the new law's provisions on Medicare are not known at this time, with the result that the projections are much more uncertain than normal, especially in the longer-range future.

As stated previously, the projections in this section are drawn from the annual Medicare Trustees report, which must be based on current law. In addition, the FASAB rules governing the Statement of Social Insurance (SOSI) also require use of projections based on current law. Accordingly, the permanent payment update reductions are assumed to occur in all future years, as required by the Affordable Care Act. In addition, reductions in Medicare payment rates for physician services, totaling

30 percent over the next three years, are assumed to be implemented as required under current law, despite the virtual certainty that Congress will continue to override these latter reductions.

In view of the factors described above, it is important to note that the actual future costs for Medicare are likely to exceed those shown by the current-law projections. Therefore, the Medicare Board of Trustees, in their annual report to Congress, references an alternative scenario to illustrate where possible the potential understatement of Medicare costs and projection results. At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare trust fund projections under this theoretical alternative to current law. No endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred. Additional information on this theoretical alternative to current law is provided in Note 15 in these financial statements, and in an auxiliary memorandum prepared by the CMS Office of the Actuary at the request of the Board of Trustees.

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

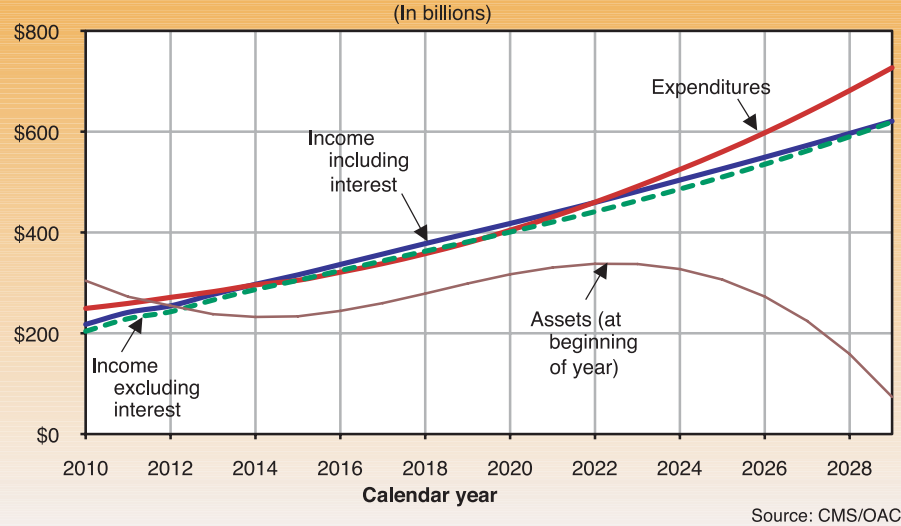
ACTUARIAL PROJECTIONS

Cashflow in Nominal Dollars

Using nominal dollars for short-term projections paints a reasonably clear picture of expected performance with particular attention on cashflow and trust fund balances.[1] 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

Chart 1—HI Income, Expenditures, and Assets 2010-2029



Source: CMS/OACT

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

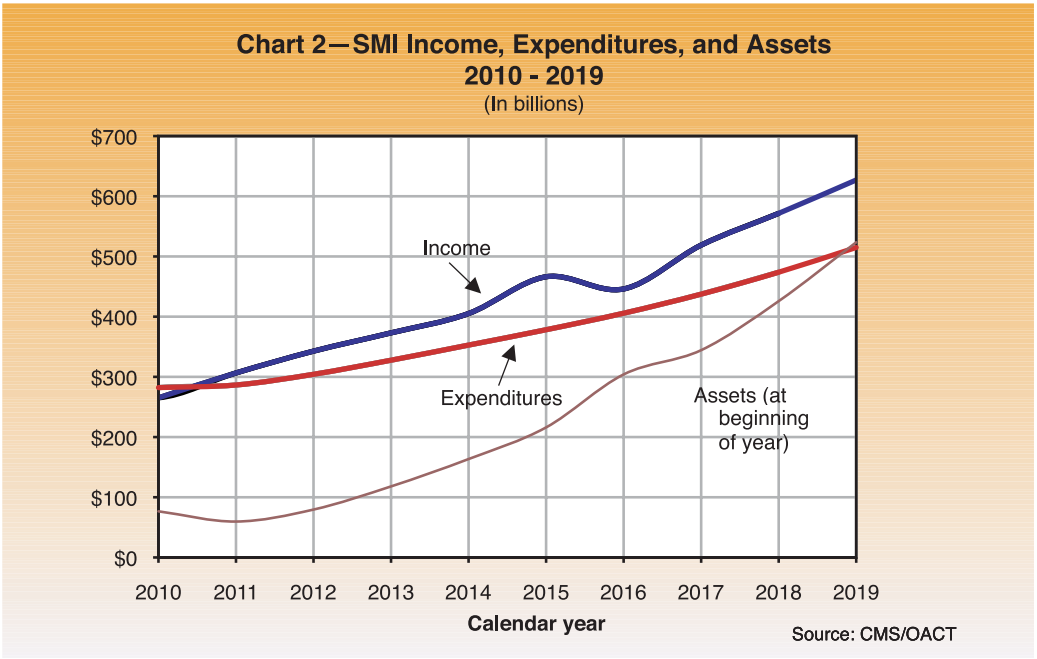
displayed only through the projected date of asset depletion, currently the year 2029. Corresponding estimates for SMI Parts B and D are presented only for the next 10 years, primarily due to the fact that under present law, the SMI trust fund is automatically in financial balance every year.

HI

Chart 1 shows the actuarial estimates of HI income, expenditures, and assets for each of the years 2010 through 2029, 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 2029. The estimates also include income and expenditures attributable to these current and future workers, in addition to current beneficiaries.

HI expenditures initially exceeded income in 2008. As Chart 1 shows, they are expected to continue to do so through 2013, but then are projected to fall just below income each year through 2021 under the intermediate assumptions. This situation arises due to lower expenditures and additional revenues instituted by the Affordable Care Act. The HI trust fund is estimated to again start redeeming its assets in 2022; by the end of 2029, the assets would be depleted. Despite this improvement, the HI trust fund does not meet an explicit test of short-range financial adequacy for the seventh year in a row, since assets are predicted to fall below expenditures within the next 10 years.

The projected year of depletion of the HI trust fund is very sensitive to assumed future economic and other trends. Under less favorable conditions the magnitude of the deficits could be greater and thereby accelerate asset exhaustion.



SMI

Chart 2 shows the actuarial estimates of SMI income, expenditures, and assets, for Parts B and D combined, for each of the years 2010 through 2019, in nominal dollars. Income includes monthly premiums paid by, or on behalf of, beneficiaries, transfers from the general fund of the U.S. Treasury, certain payments by the States to the Part D account, fees related to brand-

name prescription drugs, and interest earned on the U.S. Treasury securities held by the SMI trust fund.[2,3] Chart 2 displays only total income; it does not separately show income excluding interest. The difference between the two depictions of income is not visible graphically since interest is not a significant source of income.[4] Expenditures include benefit payments as well as administrative expenses.

SMI income is normally very close to expenditures because of the financing mechanism for Parts B and D. In particular, income for SMI Part B and Part D includes a combination of monthly beneficiary premiums and transfers from the general fund of the U.S. Treasury—both of which are established annually to cover the following year's expenditures. Under present law, both SMI accounts are automatically in financial balance every year, regardless of future economic and other conditions. The current-law projections shown in Chart 2 reflect the 30-percent reduction in Medicare payment rates for physician services that would be required in 2010-2012. Due to the high probability that these reductions will be overridden by new legislation, it is necessary to maintain a Part B contingency reserve that is much larger than normally required. The projected level of Part B income required for this purpose is significantly larger than the projected level of expenditures under current law, thus leading to the imbalance shown in Chart 2. In practice, either the physician reductions will occur (and a larger contingency reserve will be unnecessary) or, more likely, the reductions will not occur (and actual expenditures will be roughly in line with the projected income amounts shown above).

Maintaining adequate Part B premium and general revenue income, despite the impact of the premium "hold-harmless" provision, would require substantial premium increases for the roughly 25 percent of beneficiaries who are not subject to this provision. Such increases are assumed to occur, since no other mechanism is available under current law to ensure adequate income. The 2010 Medicare Trustees Report provides additional information on this issue.

HI Cashflow as a Percentage of Taxable Payroll

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

Chart 3 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. Prior to the 2006 Trustees Report, the long-range increase in average expenditures per beneficiary was assumed to equal growth in per capita gross domestic product (GDP) plus one percentage point. Beginning with the 2006 report, the Board of Trustees adopted a refinement of these long-range growth assumptions. The refinement provides a smoother and more realistic transition from current Medicare cost growth rates, which have been significantly above the level of GDP growth, to the ultimate assumed level of GDP plus zero percent for the indefinite future.

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[2] Delivery of Social Security benefit checks normally due January 3, 2016 is expected to occur on December 31, 2015. 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, 2015. These amounts are excluded from the premium income and general revenue income for 2016, resulting in the income pattern shown in Chart 2.

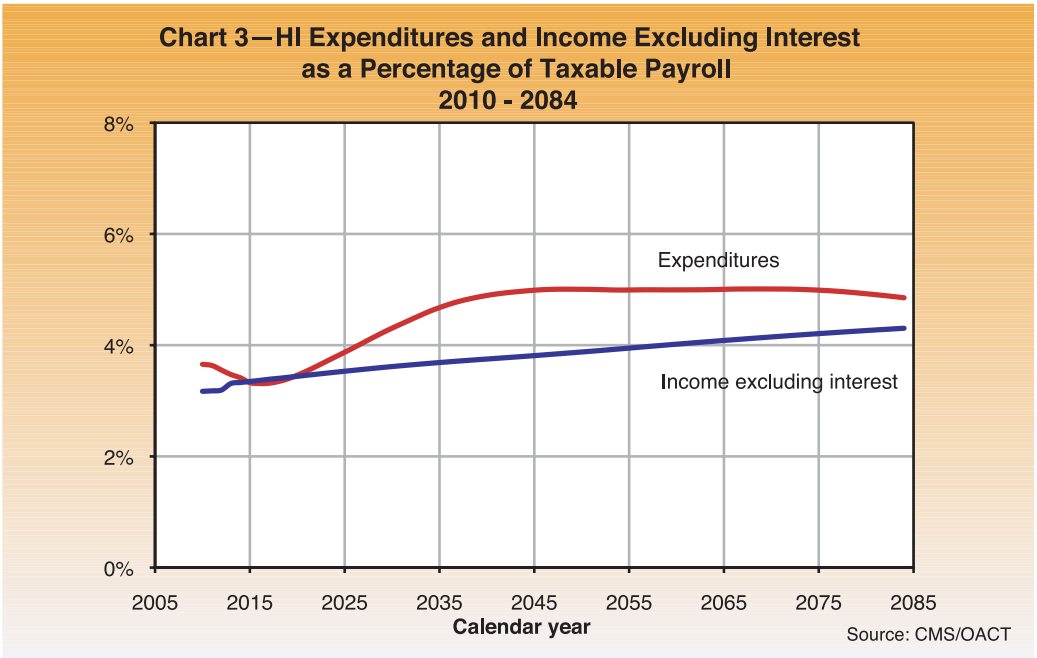
[3] Special payments from the States to the Part D account represent a portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. Beginning in 2011, the Affordable Care Act imposes fees on manufacturers and importers of brand-name prescription drugs; the revenue from these fees is allocated to the Part B account of the SMI trust fund.

[4] Interest income is generally about one to two percent of total SMI income.

This same approach was used to establish "baseline" long-range growth rate assumptions for the 2010 Medicare Trustees Report, prior to the incorporation of the provisions in the Affordable Care Act. Under the Office of the Actuary's economic model, in 2034 the pre-Affordable Care Act growth rate for all Medicare services is assumed to be about 1.3 percentage points above the rate of GDP growth for that year (before demographic impacts). This differential gradually declines to about 0.8 percentage point in 2054 and to 0.3 percentage point in 2084. Compared to a constant "GDP plus one percent" assumption, the pre-Affordable Care Act baseline growth assumption is initially higher, but subsequently lower.

In order to incorporate the effects of the permanent Medicare price update reductions required by the Affordable Care Act, adjustments were made to the per capita growth rates produced by the economic model for Parts A and B.[5] Since all Part A fee-for-service providers are affected, the assumed adjustment in each year is the full update reduction (1.1 percent).

For SMI Part B, only certain provider categories—for example, outpatient hospitals, ambulatory surgical centers, diagnostic laboratories, and most other non-physician services—are affected by the price update reductions. Accordingly, these services are subject to the same assumed long-range growth rate as Part A services. In contrast, Part B physician expenditures per beneficiary are increased at approximately the rate of per capita GDP growth, as required by the sustainable growth rate formula in current law. All other Part B outlays, which constitute an estimated 16.8 percent of total Part B expenditures in 2019, have an assumed average growth rate of per capita GDP plus one percent (adjusted by the economic model), as determined for the pre-Affordable Care Act "baseline" growth trend.



Based on these projections, the Medicare Trustees apply a formal test of "long-range close actuarial balance." The HI trust fund fails this test, as it has for many years.

Since the standard HI payroll tax rates are not scheduled to change in the future under present law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant

[5] The price update reductions do not affect Part D, and therefore the growth assumption for this account continues to be based on the pre-Affordable Care Act baseline growth of GDP plus one percent, as adjusted by the economic model.

at 2.90 percent. Under the Affordable Care Act, however, high-income workers will pay an additional 0.9 percent of their earnings above $200,000 (for single workers) or $250,000 (for married couples filing joint income tax returns) in 2013 and later. Because these income thresholds are not indexed, over time an increasing proportion of workers will become subject to the additional HI tax rate, and consequently, total HI payroll tax revenues will increase steadily as a percentage of taxable payroll. Income from taxation of benefits will also increase as a greater proportion of Social Security beneficiaries become subject to such taxation, since the income thresholds determining taxable benefits are not indexed for price inflation. Thus, as Chart 3 shows, the income rate is expected to gradually increase over current levels.

As indicated in Chart 3, the cost rate will initially decline as the economy recovers from the recent recession and as the savings provisions of the Affordable Care Act take effect. Subsequently, the cost rate will increase significantly due to retirements of those in the baby boom generation and continuing health services cost growth. The effect of these factors will be largely offset in 2045 and later under current law by the accumulating effect of the reduction in provider price updates, which will reduce annual HI cost growth by an estimated 1.1 percent per year. If the slower price updates are not feasible in the long range and are phased out during 2020-2034, then the HI cost rate would be 4.5 percent in 2030 and 8.9 percent in 2080. These levels are about 5 percent and 80 percent higher, respectively, than the current-law estimates under the intermediate assumptions, illustrating the very strong impact of the market basket reductions scheduled in current law.

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

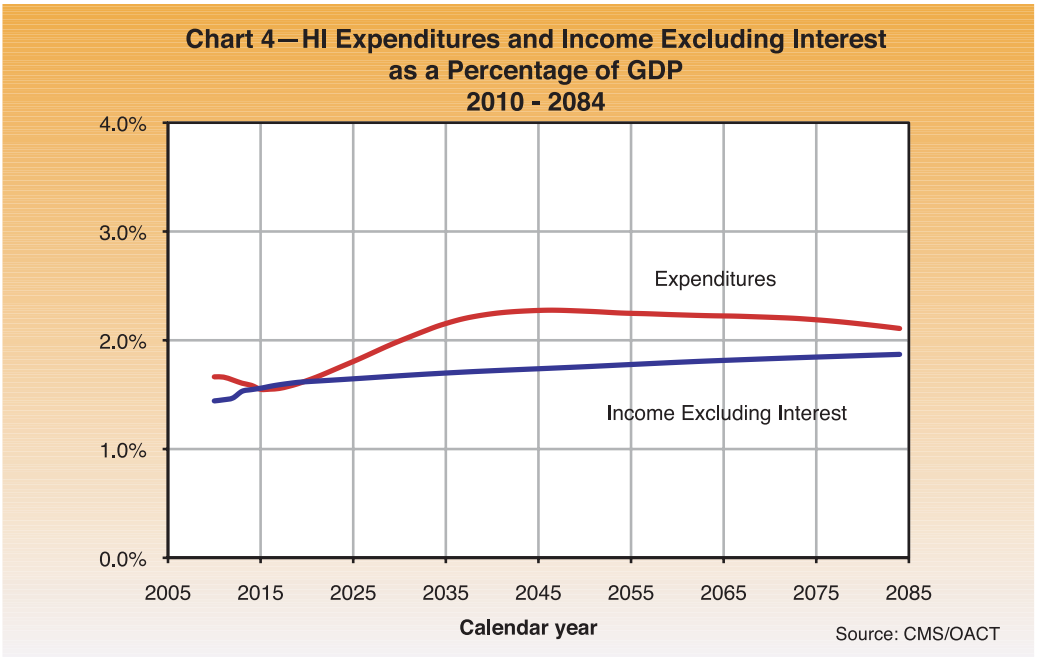
Chart 4 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2009, the expenditures were $242.5 billion, which was 1.7 percent of GDP. This percentage is projected to increase steadily through 2046 and then decrease throughout the remainder of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative projections[6], HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 4.0 percent in 2084.

SMI

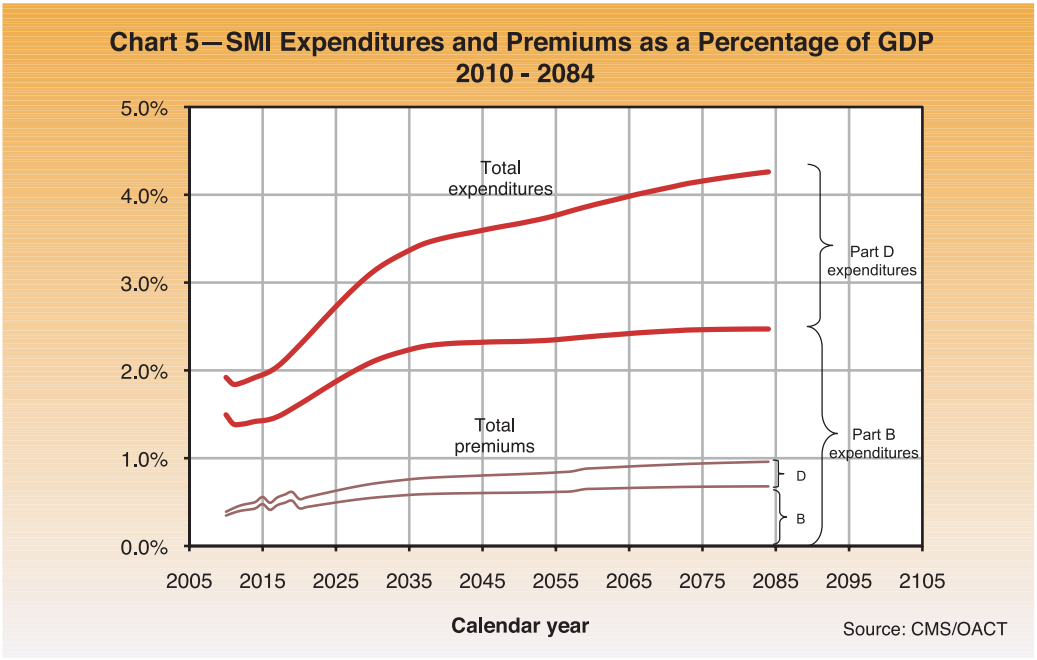
Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long-range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and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

Chart 5 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. As in the projections for HI, the assumed long-range increase in average expenditures per beneficiary incorporates the effects of the Affordable Care Act. The growth rates are estimated year by year for the next 10 years, reflecting the impact of specific statutory provisions. Expenditure growth for years 11 to 25 is assumed to grade smoothly into the long-range assumption described previously.

[6] At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare trust fund projections under this theoretical alternative to current law. No endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred.



Under the intermediate assumptions, annual SMI expenditures were $266.5 billion, or about 1.9 percent of GDP, in 2009. Then, in about 25 years, they would grow to roughly 3.3 percent of GDP and to approximately 4.3 percent by the end of the projection period. Total SMI expenditures in 2084 would be almost 7 percent of GDP under the illustrative alternative projection.[7]



[7] At the request of the Trustees, the Office of the Actuary at CMS has prepared an illustrative set of Medicare trust fund projections under this theoretical alternative to current law, which assumes that (i) physician payment rates would be updated using the Medicare Economic Index, rather than through the sustainable growth rate (SGR) process; and (ii) the productivity adjustments would be gradually phased out starting in 2020. No endorsement of the illustrative alternative to current law by the Trustees, CMS, or the Office of the Actuary should be inferred.

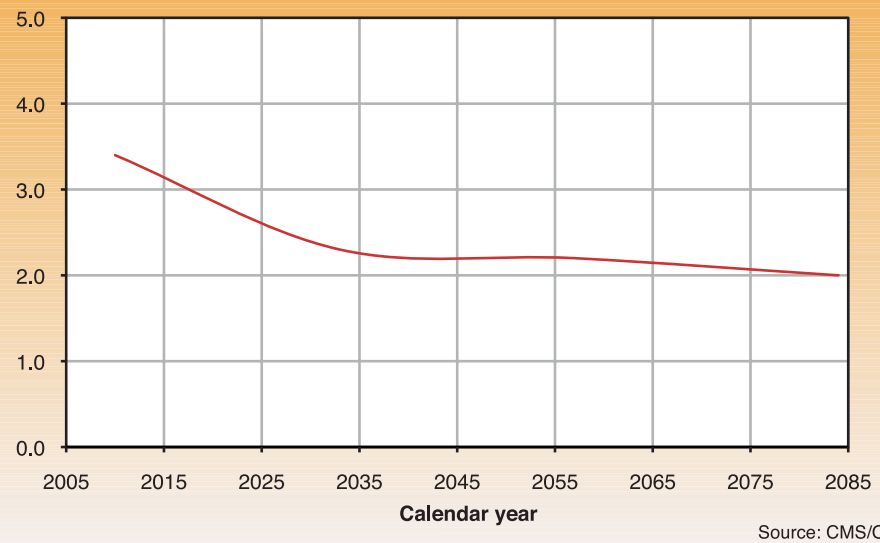
To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time. In fact, average per-beneficiary costs for Part B and Part D benefits are projected to increase after 2011 by about 4.3 percent annually. The associated beneficiary premiums—and general revenue financing—would increase by approximately the same rate. The special State payments to the Part D account are set by law at a declining portion of the States' forgone Medicaid expenditures attributable to the Medicare drug benefit. The percentage was 90 percent in 2006, phasing down to 75 percent in 2015 and later. Then, after 2015, the State payments are also expected to increase faster than GDP.

Worker-to-Beneficiary Ratio

HI

Another way to evaluate the long-range outlook of the HI trust fund is to examine the projected number of workers per HI beneficiary. Chart 6 illustrates this ratio over the next 75 years. For the most part, current benefits are paid for by current workers. The retirement of the baby boom generation will therefore be financed by the relatively smaller number of persons born after the baby boom. In 2009, every beneficiary had 3.5 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.3 workers per beneficiary. The projected ratio continues to decline until there are just 2.0 workers per beneficiary by 2084.

Chart 6—Number of Covered Workers per HI Beneficiary 2010 - 2084



Source: CMS/OACT

SENSITIVITY ANALYSIS

In order to make projections regarding the future financial status of the HI and SMI Trust Funds, various assumptions have to be made. First and foremost, the estimates presented here are based on the assumption that both Trust Funds will continue under present law. In addition, the estimates depend on many economic and demographic assumptions. Because of revisions to these assumptions, due to either changed conditions or updated information, estimates sometimes change substantially compared to those made in prior years. Furthermore, it is important to

recognize that actual conditions may likely 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.[8] The assumptions varied are the health care cost factors, real-wage differential, consumer price index (CPI), real-interest rate, fertility rate, and net immigration.[9]

For this analysis, the intermediate economic and demographic assumptions in the ***2010 Annual Report of the Board 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, 2010, 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.[10] The charts depicting the estimated net cashflow indicate that, for the most part, net cashflow decreases through 2084 under both the intermediate assumptions and the more pessimistic assumptions. However, under the more optimistic assumptions, net cashflow begins to increase at different times throughout the projection period, depending on the assumptions being varied. This increase is the result of the combined effect of (i) lower expenditures due to the continued provider payment update reductions required by the Affordable Care Act, and (ii) higher income as more and more workers become subject to the additional HI payroll tax rate, which is also mandated by the new legislation.

On the present value charts, under all three scenarios the present values initially increase, as the effects of the Affordable Care Act result in trust fund surpluses, and then decrease until about 2040 when they start to increase (or become less negative) once again. This pattern occurs in part because of the discounting process used for computing present values, which is used to help interpret the net cashflow deficit in terms of today's dollar. In other words, the amount required to cover this deficit, if made available and invested today, begins to decrease at the end of the 75-year period, reflecting the long period of interest accumulation that would occur. The pattern is also affected by the accumulating impact of the lower Medicare price updates over time and the greater proportion of workers who will be subject to the higher HI payroll tax rate, as noted above.

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 one percent slower than the intermediate assumptions, the same as the intermediate assumptions, and one 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 demonstrates that if the ultimate growth rate assumption is one percentage point lower than the intermediate assumptions, the deficit decreases by $4,829 billion. On the other hand, if the ultimate growth rate assumption is one percentage point higher than the intermediate assumptions, the deficit increases substantially, by $7,663 billion.

[8] 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 a negligible impact on the net cashflow, since the change would affect income and expenditures equally.

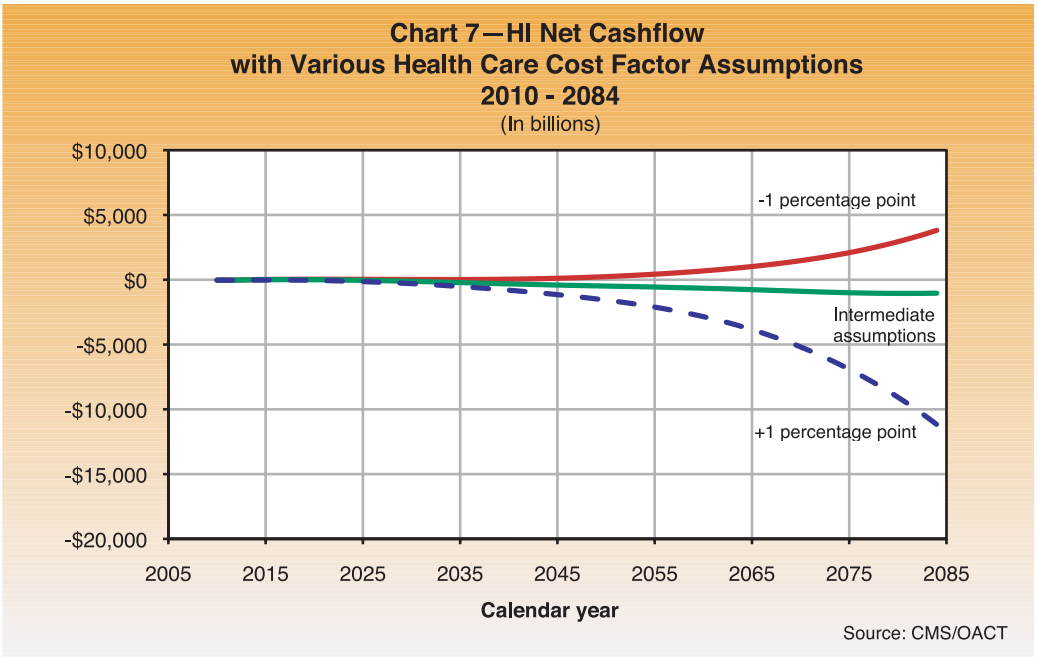
[9] The sensitivity of the projected HI net cash flow to variations in future mortality rates is also of interest. At this time, however, relatively little is known about the relationship between improvements in life expectancy and the associated changes in health status and per beneficiary health expenditures.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

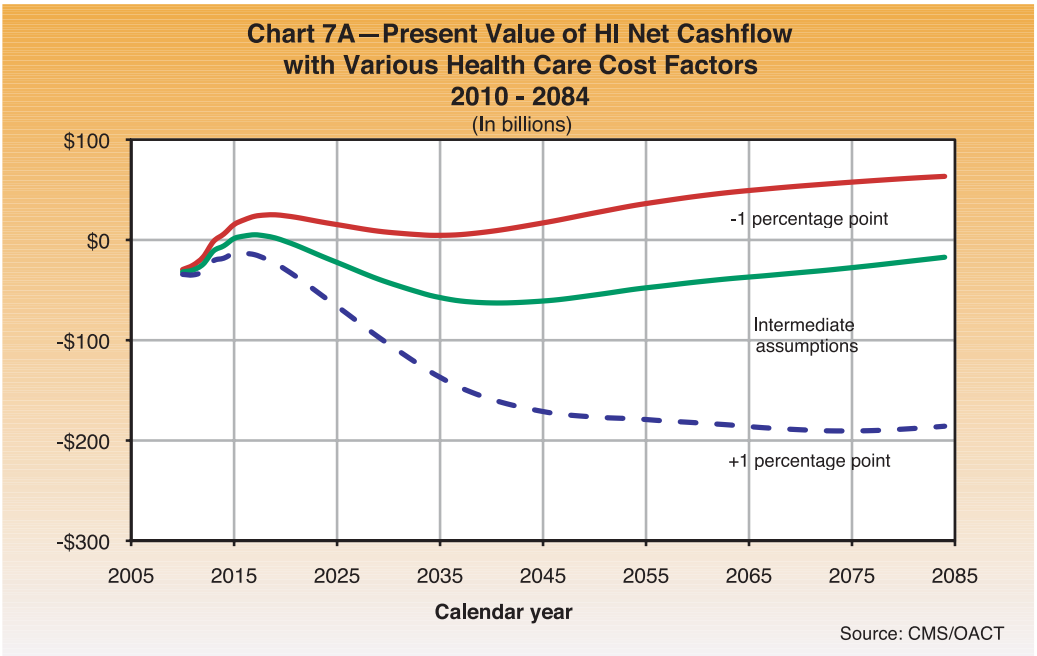
[10] As noted previously, long-range projections expressed in nominal dollar amounts can be very difficult to interpret, due to the changing value of the dollar over time. Amounts expressed in present values are less subject to this difficulty.

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)*	$2,146	$(2,683)	$(10,346)

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





This assumption has a dramatic impact on projected HI cashflow. The net cashflow under the ultimate growth rate assumption of one percentage point lower than the intermediate assumption actually becomes a surplus and remains positive throughout the entire period, due to the improved financial outlook for the HI trust fund as a result of the Affordable Care Act. Several factors, such as the utilization of services by beneficiaries or the relative complexity of services provided, can affect costs without affecting tax income. As Charts 7 and 7A indicate, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs.

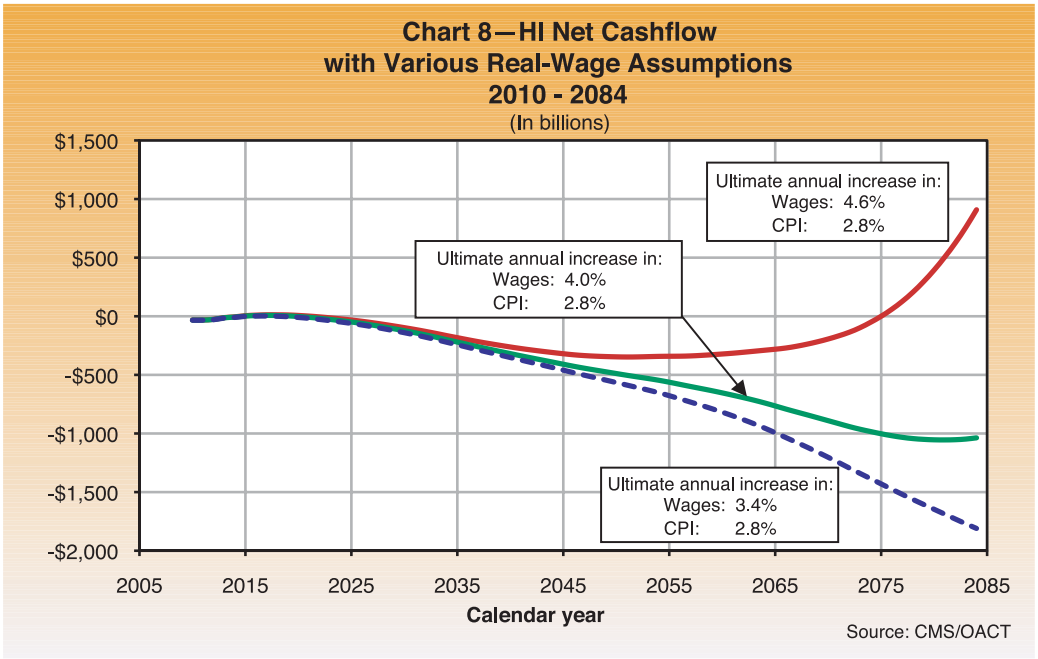
Real-Wage Differential

Table 2 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.6, 1.2, and 1.8 percentage points.[11] 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, 4.0, and 4.6 percent, respectively.

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

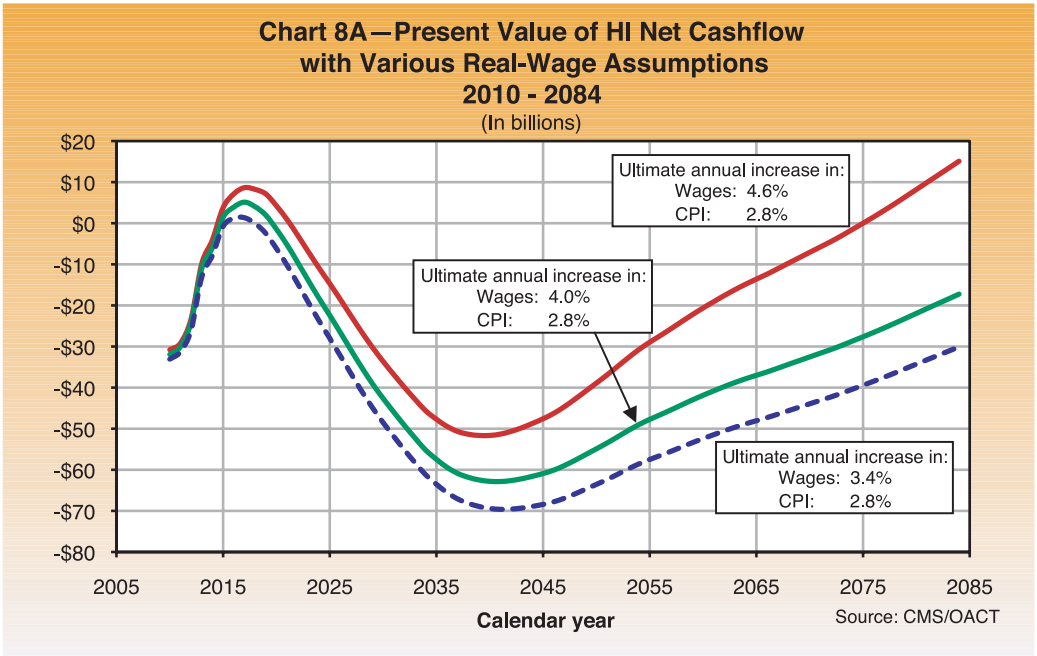
Ultimate percentage increase in wages - CPI	3.4 - 2.8	4.0 - 2.8	4.6 - 2.8
Ultimate percentage increase in real-wage differential	0.6	1.2	1.8
Income minus expenditures *(in billions)*	$(3,284)	$(2,683)	$(1,507)

As indicated in Table 2, for a half-point increase in the ultimate real-wage differential assumption, the deficit—expressed in present-value dollars—increases by approximately $740 billion.



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

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



As illustrated in Charts 8 and 8A, faster real-wage growth results in smaller HI cashflow deficits, when expressed in either nominal or present-value dollars. 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. These results are different than in past reports mainly due to the much closer financial balance under the Affordable Care Act. In prior reports, the deficit was increased under the higher real-wage assumptions on both a nominal-dollar and present-value basis, since the dollar impact on expenditures was higher than the dollar impact on income. This is not the case with this year's projections because (i) expenditures are substantially reduced from last year due to the continued payment update reductions for all HI fee-for-service providers that are required by the new legislation, and (ii) income is higher than last year's projection as a result of the additional HI tax rate for high-income earners, which is also required by the Affordable Care Act. This reversal in the direction of the impact of higher real-wage growth illustrates a limitation of the use of nominal or present-value cashflows as a measure of financial status; in practice, faster real-wage growth always improves the financial status of the HI trust fund, regardless of whether there is a small or large imbalance between income and expenditures. Also, as noted previously, the closer financial balance for the HI trust fund under the Affordable Care Act depends on the long-range feasibility of the lower Medicare price updates for hospitals and other HI providers. There is a strong likelihood that certain of these changes will not be viable in the long range. Specifically, the annual price updates for most categories of non-physician health services will be adjusted downward each year by the growth in economy-wide productivity.

Consumer Price Index

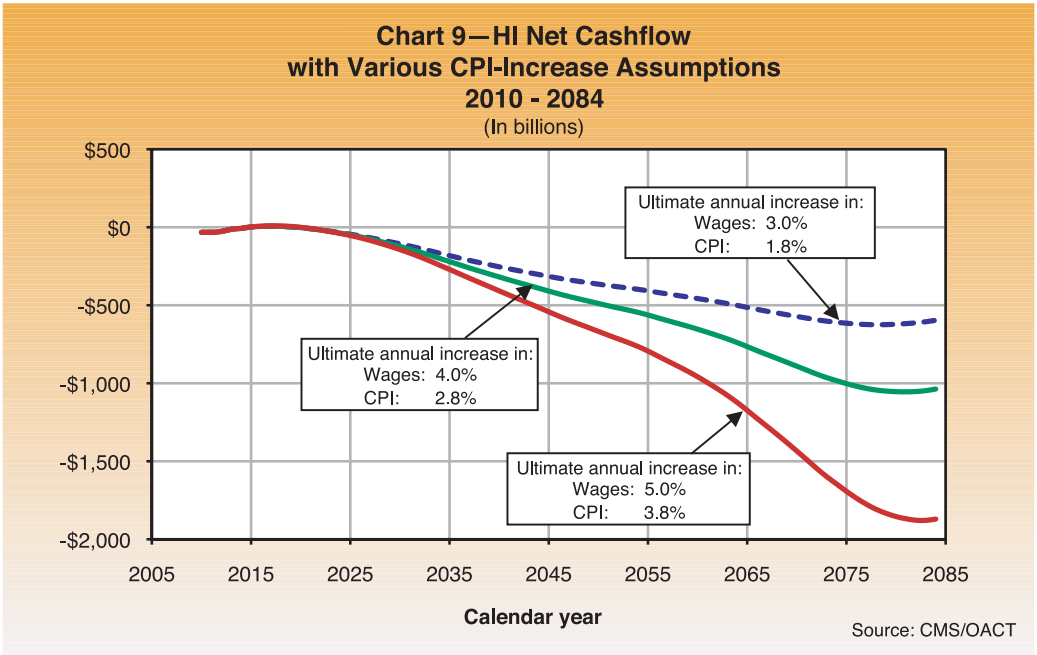
Table 3 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate CPI rate-of-increase assumptions: 1.8, 2.8, and 3.8 percent. In each case, the ultimate real-wage differential is assumed to be 1.2 percent, yielding ultimate percentage increases in average annual wages in covered employment of 3.0, 4.0, and 5.0 percent, respectively.

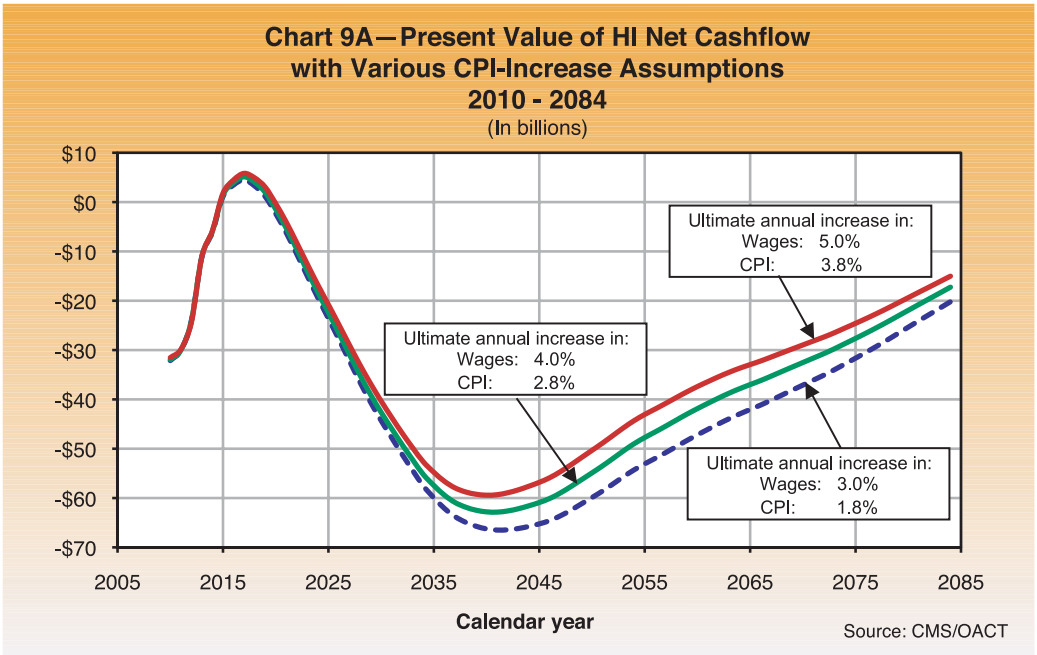
Table 3 demonstrates that if the ultimate CPI-increase assumption is 1.8 percent, the deficit increases by $241 billion. On the other hand, if the ultimate CPI-increase assumption is 3.8 percent, the deficit decreases by $217 billion.

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

Ultimate percentage increase in wages - CPI	3.0 - 1.8	4.0 - 2.8	5.0 - 3.8
Income minus expenditures *(in billions)*	$(2,924)	$(2,683)	$(2,466)

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





As Charts 9 and 9A indicate, this assumption has a large impact on projected HI cashflow in nominal dollars and a much smaller impact when the cashflow is expressed as present values. For the nominal cashflow, Chart 9 appears to suggest that the outlook for the HI trust fund worsens substantially with faster CPI growth. In practice, however, higher or lower long-term trends in inflation have only a modest impact on the financial status of the trust fund. Moreover, the impact is in the opposite direction of that suggested by the nominal cashflow sensitivity. In this instance, the results expressed in nominal dollar terms do not reveal the full implications of faster or slower growth in inflation. That is, under high-inflation conditions, a given deficit "looks bigger" in nominal dollars but is much smaller when 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. 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 present value terms, a smaller deficit results under high-inflation conditions because the present values of HI expenditures are not significantly different under the various CPI scenarios, but under high-inflation conditions the present value of HI income increases as more people become subject to the additional 0.9-percent HI tax rate required by the Affordable Care Act for workers with earnings above $200,000 or $250,000 (for single and joint income-tax filers, respectively). Since the thresholds are not indexed, additional workers become subject to the additional tax more quickly under conditions of faster inflation, and vice-versa.

Real-Interest Rate

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

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

Ultimate real-interest rate	2.1 percent	2.9 percent	3.6 percent
Income minus expenditures *(in billions)*	$(3,603)	$(2,683)	$(2,107)

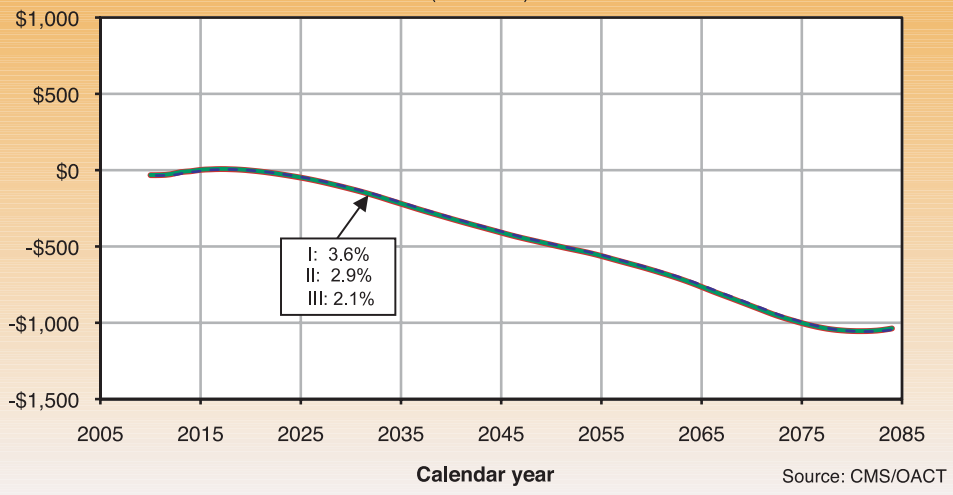
As illustrated in Table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $100 billion.

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

As shown in Charts 10 and 10A, the projected HI cashflow when expressed in present values is more sensitive to the interest assumption than when it is expressed in nominal dollars. This is not an indication of the actual role that interest plays in HI financing. In actuality, interest finances very little of the cost of the HI trust fund because, under the intermediate assumptions, the fund is projected to be relatively low and exhausted by 2029. 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.

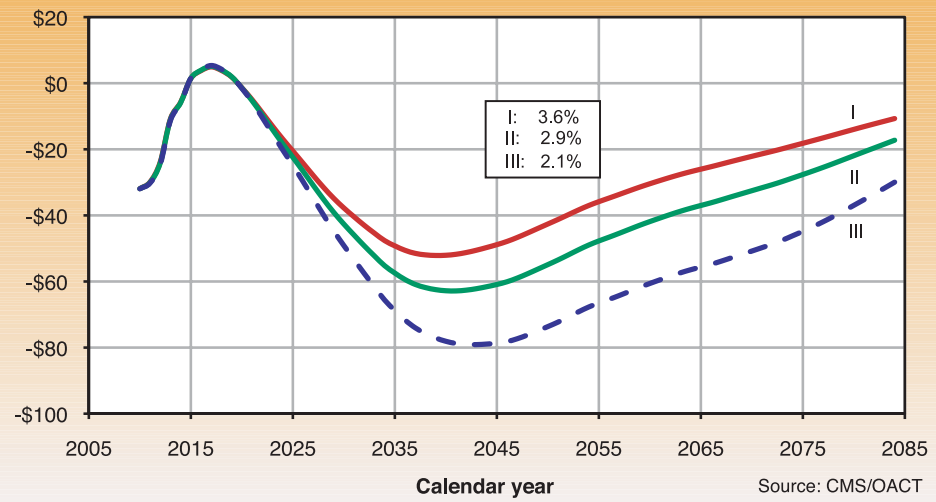
Compared to past reports, however, the sensitivity of present values to different real-interest rate assumptions is substantially reduced as a result of the Affordable Care Act. Under the new legislation, annual deficits would decrease due to the compounding effects of the price update reductions for HI fee-for-service providers. Discounting a relatively level series by high or low interest factors has much less effect than when the series is increasing rapidly, as with the pre-Affordable Care Act projections.

Chart 10—HI Net Cashflow with Various Real-Interest Rate Assumptions 2010 - 2084
(In billions)



Source: CMS/OACT

Chart 10A—Present Value of HI Net Cashflow with Various Real-Interest Rate Assumptions 2010 - 2084
(In billions)



Source: CMS/OACT

Fertility Rate

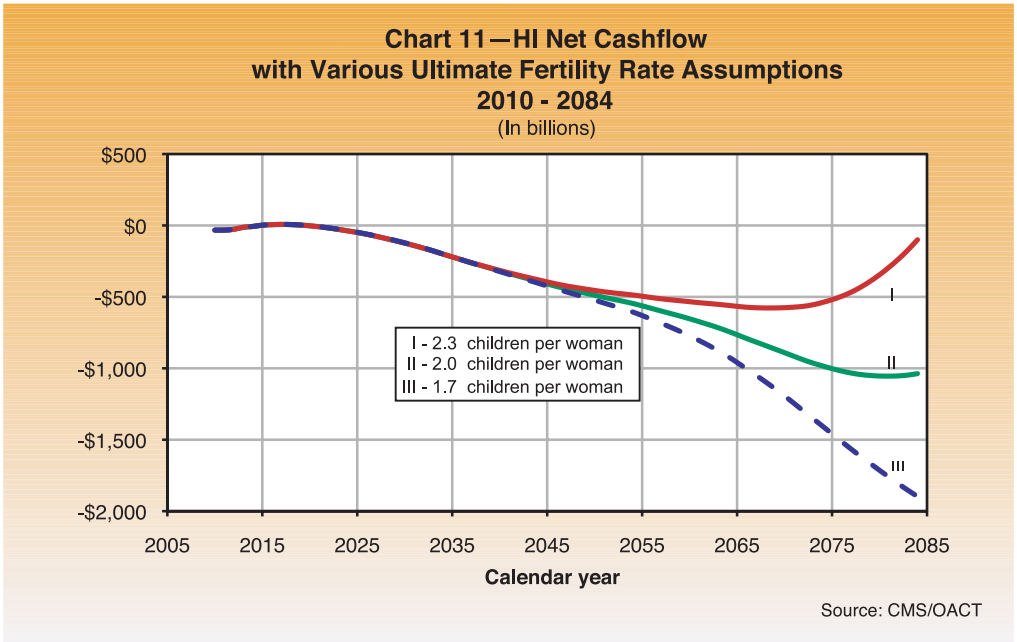
Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.7, 2.0, and 2.3 children per woman.

As Table 5 demonstrates, for an increase of 0.3 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $360 billion.

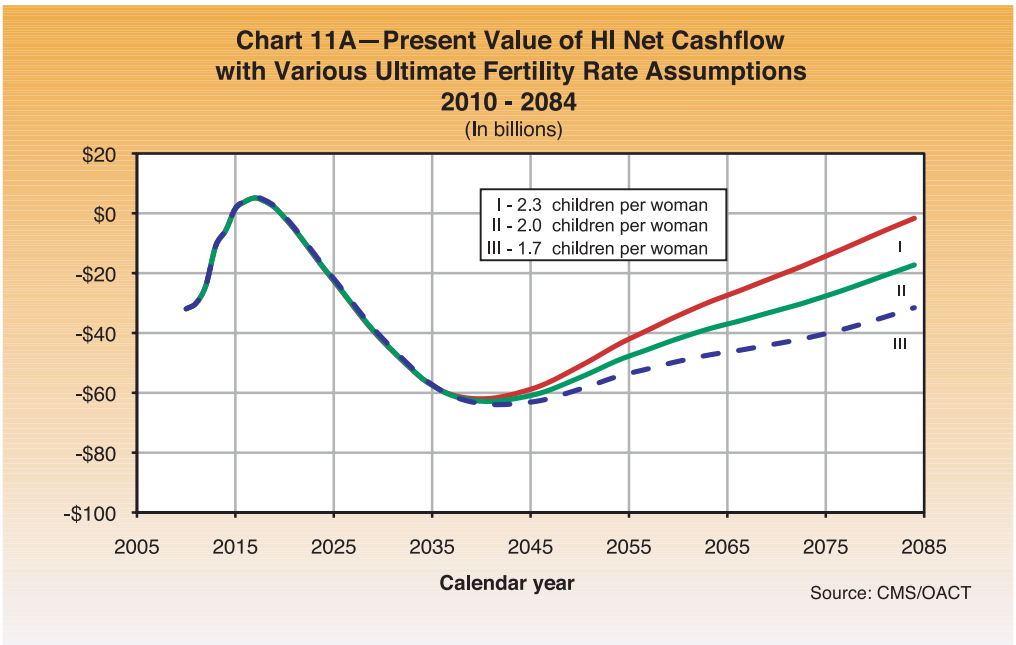
TABLE 5
Present Value of Estimated HI Income Less Expenditures under Various Fertility Rate Assumptions

Ultimate fertility rate[1]	1.7	2.0	2.3
Income minus expenditures *(in billions)*	$(3,035)	$(2,683)	$(2,308)

[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.



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



As Charts 11 and 11A indicate, the fertility rate assumption has a fairly large impact on projected HI cashflows. This result is different than in past reports mainly due to the additional HI tax on high-income earners required by the Affordable Care Act. Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, as in past reports, but their impact on future HI taxes will be relatively greater, since many will become subject to the additional HI tax, thereby lowering the deficit proportionately more on both a nominal- and present-value-dollar basis. Under the lower fertility rate assumptions, on the other hand, there will be fewer workers in the workforce with a smaller number subject to the additional tax, in turn raising the HI deficit.

Net Immigration

Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative average annual net immigration assumptions: 780,000 persons, 1,065,000 persons, and 1,370,000 persons per year.

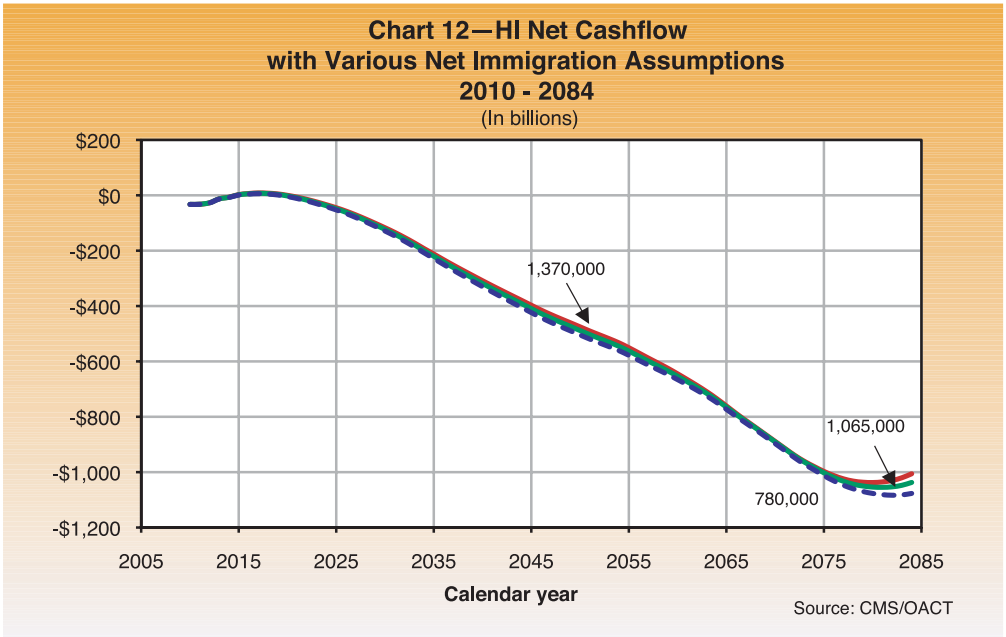
TABLE 6
Present Value of Estimated HI Income Less Expenditures under Various Net Immigration Assumptions

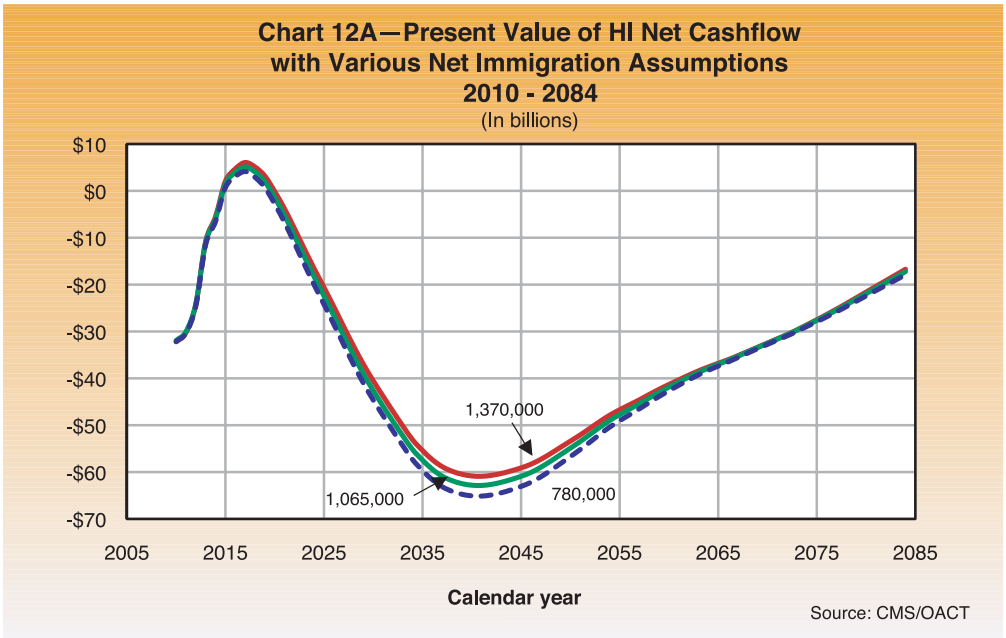
Average annual net immigration	780,000	1,065,000	1,370,000
Income minus expenditures *(in billions)*	$(2,774)	$(2,683)	$(2,605)

As indicated in Table 6, if the average annual net immigration assumption is 780,000 persons, the deficit—expressed in present-value dollars—increases by $91 billion. Conversely, if the assumption is 1,370,000 persons, the deficit decreases by $78 billion.

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

As illustrated in Charts 12 and 12A, higher net immigration results in smaller HI cashflow deficits, when expressed in either nominal or present-value dollars. Since immigration tends to occur most often among people at working ages, who work and pay taxes into the HI system, a change in the net immigration assumption affects revenues from payroll taxes almost immediately. However, the impact on expenditures occurs later as those individuals age and become beneficiaries.





These results are different than in past reports mainly due to the various provisions in the Affordable Care Act. In prior reports, the deficit was increased under the higher-net immigration assumptions on both a nominal-dollar and present-value basis, since the cost of HI benefits for the additional participants was substantially greater than their HI taxes. This is not the case with this year's projections because (i) expenditures are substantially reduced from last year due to the continued payment update reductions for all HI fee-for-service providers required by the Affordable Care Act, and (ii) income is higher than last year's projection as a result of the additional HI tax for high-income earners, which is also mandated by the new health-reform law. As shown in the SOSI, the value of the additional HI payroll taxes paid by new participants in the future, on average, will be greater than the cost of their benefits, assuming that the lower HI price updates can be continued indefinitely. As noted previously, there is a significant likelihood that the reductions in Medicare provider payment updates will not be feasible indefinitely.

TRUST FUND FINANCES AND SUSTAINABILITY

HI

The financial status of the HI trust fund is substantially improved by the lower expenditures and additional tax revenues instituted by the Affordable Care Act. These changes are estimated to postpone the exhaustion of trust fund assets from 2017 under the prior law to 2029 under current law. Despite this significant improvement, however, the fund is still not adequately financed over the next 10 years. HI expenditures have exceeded income annually since 2008 and are expected to continue to do so under current law through 2013 and again after 2021. The shortfalls can be met with increasing reliance on the redemption of trust fund 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.

It is important to note that the improved outlook for the HI trust fund depends in part on the feasibility of the provider payment update reductions. There is a significant likelihood that these providers would not be able to reduce their cost growth rates sufficiently during this period to match the slower increases in Medicare payments per service, in which case they would eventually become unable to continue providing health care services to Medicare beneficiaries. If such a situation occurred, and Congress overrode the productivity adjustments, then actual costs would be higher and the HI trust fund would be depleted somewhat sooner.

The HI trust fund remains 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 significant increases in revenues and/or reductions in benefits. These changes are needed partially as a result of the impending retirement of the baby boom generation. If the productivity adjustments to HI provider price updates cannot be continued in the long run, then the actuarial deficit would be much greater.

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. There is no authority to transfer assets between the Part D and Part B accounts, therefore, it is necessary to evaluate each account's financial adequacy separately.

The financing established for the Part B account for calendar year 2010 is adequate to cover 2010 expected expenditures and to maintain the financial status of the account in 2010 at a satisfactory level. The Part B cost projections are understated as a result of the substantial reductions in physician payments that would be required under current law and are further understated if the reductions in future price updates for most other Part B providers are not feasible. Actual future Part B costs will depend on the steps that Congress might choose to take to address these situations.

No financial imbalance is anticipated for the Part D account, since the general revenue subsidy for this benefit is drawn on a daily, as-needed basis. The projected Part D costs shown in this section are somewhat lower than previously estimated, primarily due to lower assumed growth rates for prescription drug expenditures in the U.S. overall.

For both the Part B and Part D accounts, beneficiary premiums and general revenue transfers will be set to meet expected costs each year. Such financing, however, would have to increase faster than the economy to match expected expenditure growth under current law. Absent legislation, it will probably be necessary to significantly raise Part B premiums for a subset of beneficiaries in 2011 and 2012 to ensure adequate program financing. A critical issue for the SMI trust fund continues to be the impact of the past and expected rapid growth of SMI costs, which place gradually increasing demands on beneficiaries, the Federal Budget, and society at large.

Medicare Overall

The Medicare Modernization Act requires the Board of Trustees to determine whether the difference between Medicare outlays and "dedicated financing sources" is projected to exceed 45 percent of total Medicare outlays within the next 7 fiscal years (2010-2016).[12] This difference first exceeded 45 percent of total expenditures at the end of calendar year 2009 and is expected to do so in fiscal year 2010, which is the first year of the 7-year test period. Consequently, the Trustees issued a determination of projected "excess general revenue Medicare funding," as required by law. Similar determinations were made in their 2006-2009 annual reports to Congress. With this fifth consecutive finding, another "Medicare funding warning" is triggered this year, indicating that the general revenues provided to Medicare under current law are becoming a substantial proportion of total program costs. This finding requires the President to submit to Congress, within 15 days after the release of the next budget, proposed legislation to respond to the warning. Congress is then required to consider this legislation on an expedited basis.[13] This requirement helps to call attention to Medicare's impact on the Federal Budget.

The Medicare financial projections shown in this section represent a substantial, but very uncertain, improvement over those in recent years because of the far-reaching provisions of the Affordable Care Act. In the long range, much of this improvement depends on the feasibility of the Affordable Care Act's downward adjustments to future increases in Medicare prices for most categories of health care providers. Although these projections show substantially improved results over last year's, they continue to demonstrate the need for timely and effective action to address the remaining financial challenges facing Medicare—including the projected exhaustion of the HI trust fund, this fund's long-range financial imbalance, and the issue of rapid growth in Medicare expenditures. Furthermore, if the lower prices payable for health services under Medicare are overridden, the financial challenges in the long range would be much more severe. In their 2010 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to take "prompt action…to address these challenges." They also stated: "Consideration of…further reforms should occur in the near future."

[12] 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; fees allocated to Part B related to brand-name prescription drugs; and any gifts received by the Medicare trust funds.

[13] In January 2009, the House of Representatives passed a resolution (H. Res.5, section 3(e)) stating that section 803 of the Medicare Modernization Act, governing action required by the House in response to a funding warning, would not apply to the 111th Congress.

COMBINING STATEMENT OF BUDGETARY RESOURCES
For the Year Ended September 30, 2010

(in millions)

	MEDICARE		Payments to			Medicare	All	Combined
	HI TF	SMI TF	Trust Funds	Medicaid	CHIP	Part D	Others	Totals Budgetary
Budgetary Resources:								
Unobligated balance, brought forward, October 1:	$54	$54	$3,590	$8,163	$7,221	$342	$1,655	$21,079
Recoveries of prior year unpaid obligations	755	158		14,010	84	254	328	15,589
Budget authority:								
Appropriation	252,119	224,675	230,497	284,500	12,568	57,933	2,472	1,064,764
Spending authority from offsetting collections:								
Earned								
Collected	256	23	41	257		468	229	1,274
Change in unfilled customer orders:								
Without advance from Federal sources							19	19
Expenditure transfers from trust funds	(54)	(54)		515			3525	3,932
SUBTOTAL	**252,321**	**224,644**	**230,538**	**285,272**	**12,568**	**58,401**	**6,245**	**1,069,989**
Nonexpenditure transfers, net, anticipated & actual	(22)	(73)		(3,744)	(2)			(3,841)
Temporarily not available pursuant to Public Law		(11,238)						(11,238)
Permanently not available	5	7	(3,433)		(56)	(88)	(41)	(3,606)
TOTAL BUDGETARY RESOURCES	**$253,113**	**$213,552**	**$230,695**	**$303,701**	**$19,815**	**$58,909**	**$8,187**	**$1,087,972**
Status of Budgetary Resources:								
Obligations incurred:								
Direct	$253,112	$213,552	$228,920	$286,701	$10,721	$58,373	$5,592	$1,056,971
Reimbursable	1						230	231
SUBTOTAL	**253,113**	**213,552**	**228,920**	**286,701**	**10,721**	**58,373**	**5,822**	**1,057,202**
Unobligated balance:								
Apportioned			1,577	14,240	8,318		2,102	26,237
Exempt from apportionment						220		220
SUBTOTAL			**1,577**	**14,240**	**8,318**	**220**	**2,102**	**26,457**
Unobligated balance not available			198	2,760	776	316	263	4,313
TOTAL STATUS OF BUDGETARY RESOURCES	**$253,113**	**$213,552**	**$230,695**	**$303,701**	**$19,815**	**$58,909**	**$8,187**	**$1,087,972**
Change in Obligated Balance:								
Obligated balance, net: Unpaid obligations, brought forward, October 1	$23,762	$21,256		$24,977	$5,444	$5,539	$3,752	$84,730
Uncollected customer payments from Federal sources, brought forward, October 1	(55)	(54)					(2,449)	(2,558)
Total unpaid obligated balance, net	23,707	21,202		24,977	5,444	5,539	1,303	82,172
Obligations incurred, net	253,113	213,552	$228,920	286,701	10,721	58,373	5,822	1,057,202
Gross Outlays	(252,697)	(212,466)	(228,920)	(269,781)	(7,887)	(60,032)	(5,154)	(1,036,937)
Obligated balance transferred, net:								
Recoveries of prior year unpaid obligations, actual	(755)	(158)		(14,010)	(84)	(254)	(328)	(15,589)
Change in uncollected customer payments from Federal sources	54	54					(418)	(310)
Obligated balance, net, end of period:								
Unpaid obligations	23,423	22,184		27,887	8,194	3,626	4,092	89,406
Uncollected customer payments from Federal sources	(1)						(2,867)	(2,868)
Total, unpaid obligated balance, net, end of period	23,422	22,184		27,887	8,194	3,626	1,225	86,538
Net Outlays:								
Net Outlays								
Gross outlays	252,697	212,466	228,920	269,781	7,887	60,032	5,154	1,036,937
Offsetting collections	(256)	(23)	(41)	(772)		(468)	(3,355)	(4,915)
Distributed offsetting receipts	(23,316)	(279,578)			(1)		(71)	(302,966)
NET OUTLAYS	**$229,125**	**$(67,135)**	**$228,879**	**$260,009**	**$7,886**	**$59,564**	**$1,728**	**$729,056**

Supplementary Information

CONSOLIDATING BALANCE SHEET
As of September 30, 2010

(in millions)

	MEDICARE (Earmarked)			HEALTH (Other Funds)			Combined	Intra-CMS	Consolidated
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Totals	Eliminations	Totals
ASSETS									
Intragovernmental Assets:									
Fund Balance with Treasury	$38	$1,958	$1,996	$44,878	$15,172	$2,795	$64,841		$64,841
Investments	282,794	71,709	354,503		2,118		356,621		356,621
Accounts Receivable, Net	25,171	24,844	50,015	113	15	208	50,351	$(49,858)	493
Other Assets	4		4		1		5		5
Total Intragovernmental Assets	**308,007**	**98,511**	**406,518**	**44,991**	**17,306**	**3,003**	**471,818**	**(49,858)**	**421,960**
Accounts Receivable, Net	890	3,487	4,377	2,645		24	7,046		7,046
General Property, Plant & Equipment, Net	129	243	372	21	1	4	398		398
Other Assets	22	1,141	1,163	4		142	1,309		1,309
TOTAL ASSETS	**$309,048**	**$103,382**	**$412,430**	**$47,661**	**$17,307**	**$3,173**	**$480,571**	**$(49,858)**	**$430,713**
LIABILITIES									
Intragovernmental Liabilities:									
Accounts Payable	$25,028	$25,782	$50,810	$1		$6	$50,817	$(49,858)	$959
Accrued Payroll & Benefits	3	5	8				8		8
Other Intragovernmental Liabilities	168	601	769	2		32	803		803
Total Intragovernmental Liabilities	**25,199**	**26,388**	**51,587**	**3**		**38**	**51,628**	**(49,858)**	**1,770**
Federal Employee & Veterans' Benefits	4	8	12	1			13		13
Entitlement Benefits Due & Payable	21,776	23,231	45,007	27,215	415	75	72,712		72,712
Accrued Payroll & Benefits	24	41	65	3		3	71		71
Contingencies				5,391			5,391		5,391
Other Liabilities	231	305	536			11	547		547
TOTAL LIABILITIES	**47,234**	**49,973**	**97,207**	**32,613**	**415**	**127**	**130,362**	**(49,858)**	**80,504**
NET POSITION									
Unexpended Appropriations—earmarked funds	702	1,074	1,776				1,776		1,776
Unexpended Appropriations—other funds				14,926	16,872	2,579	34,377		34,377
Cumulative Results of Operations—earmarked funds	261,112	52,335	313,447				313,447		313,447
Cumulative Results of Operations—other funds				122	20	467	609		609
TOTAL NET POSITION	**$261,814**	**$53,409**	**$315,223**	**$15,048**	**$16,892**	**$3,046**	**$350,209**		**$350,209**
TOTAL LIABILITIES & NET POSITION	**$309,048**	**$103,382**	**$412,430**	**$47,661**	**$17,307**	**$3,173**	**$480,571**	**$(49,858)**	**$430,713**

SUPPLEMENTARY INFORMATION

CONSOLIDATING STATEMENT OF NET COST
For the Year Ended September 30, 2010

(in millions)

	MEDICARE (Earmarked)			HEALTH (Other Funds)			Consolidated
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Totals
NET PROGRAM/ACTIVITY COSTS							
GPRA Programs							
Medicare (Earmarked)	$243,818	$203,344	$447,162				$447,162
Medicaid				$272,995			272,995
CHIP					$7,968		7,968
NET COST—GPRA PROGRAMS	**243,818**	**203,344**	**447,162**	**272,995**	**7,968**		**728,125**
Other Activities							
CLIA						$10	10
State Grants & Demonstrations						533	533
Other						36	36
NET COST—OTHER ACTIVITIES						**579**	**579**
NET COST OF OPERATIONS	**$243,818**	**$203,344**	**$447,162**	**$272,995**	**$7,968**	**$579**	**$728,704**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION
For the Year Ended September 30, 2010

(in millions)

	MEDICARE (Earmarked)			HEALTH (Other Funds)			Consolidated
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Total
CUMULATIVE RESULTS OF OPERATIONS							
Beginning Balances	$292,116	$40,636	$332,752	$125	$25	$357	$333,259
Budgetary Financing Sources:							
Appropriations Used	15,169	213,709	228,878	272,337	7,943	511	509,669
Nonexchange Revenue:							
FICA and SECA Taxes	183,615		183,615				183,615
Interest on Investments	14,193	3,058	17,251		4		17,255
Other Nonexchange Revenue	615	1	616				616
Transfers-in/out Without Reimbursement	(792)	(1,750)	(2,542)	653	16	175	(1,698)
Other Financing Sources (Nonexchange):							
Imputed Financing	14	25	39	2		3	44
TOTAL FINANCING SOURCES	**212,814**	**215,043**	**427,857**	**272,992**	**7,963**	**689**	**709,501**
NET COST OF OPERATIONS	**243,818**	**203,344**	**447,162**	**272,995**	**7,968**	**579**	**728,704**
NET CHANGE	**(31,004)**	**11,699**	**(19,305)**	**(3)**	**(5)**	**110**	**(19,203)**
CUMULATIVE RESULTS OF OPERATIONS	**$261,112**	**$52,335**	**$313,447**	**$122**	**$20**	**$467**	**$314,056**
UNEXPENDED APPROPRIATIONS							
Beginning Balances	$258	$3,332	$3,590	$6,507	$12,306	$2,123	$24,526
Budgetary Financing Sources:							
Appropriations Received	15,673	214,824	230,497	284,500	12,567	988	528,552
Appropriations Transferred-in/out				(3,744)	(2)		(3,746)
Other Adjustments	(60)	(3,373)	(3,433)		(56)	(21)	(3,510)
Appropriations Used	(15,169)	(213,709)	(228,878)	(272,337)	(7,943)	(511)	(509,669)
TOTAL BUDGETARY FINANCING SOURCES	**444**	**(2,258)**	**(1,814)**	**(8,419)**	**4,566**	**456**	**11,627**
TOTAL UNEXPENDED APPROPRIATIONS	**702**	**1,074**	**1,776**	**14,926**	**16,872**	**2,579**	**36,153**
NET POSITION	**$261,814**	**$53,409**	**$315,223**	**$15,048**	**$16,892**	**$3,046**	**$350,209**

Audit Opinion

Department of Health and Human Services

CENTERS FOR MEDICARE & MEDICAID SERVICES

NOV 1 2 2010

TO: Donald M. Berwick, M.D.
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 2010 (A-17-10-02010)

This memorandum transmits the independent auditors' reports on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2010 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and regulations. The Chief Financial Officers Act of 1990 (P.L. No. 101-576), as amended, requires the Office of Inspector General (OIG) or an independent external auditor, as determined by OIG, to audit the CMS financial statements in support of the Department of Health & Human Services audit.

We contracted with the independent certified public accounting firm of Ernst & Young, LLP (E&Y), to audit the CMS consolidated balance sheets as of September 30, 2010 and 2009, and the related consolidated statements of net cost and changes in net position, the combined statement of budgetary resources for the years then ended, and the statement of social insurance as of January 1, 2010. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in the *Government Auditing Standards,* issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 07-04, *Audit Requirements for Federal Financial Statements.*

Results of Independent Audit

Based on its audit, E&Y found that the FY 2010 CMS consolidated balance sheets and the related consolidated statements of net cost and changes in net position and the combined statement of budgetary resources were fairly presented, in all material respects, in conformity with accounting principles generally accepted in the United States of America. E&Y was unable to determine that the statement of social insurance was fairly presented because of the uncertainties reported by the Chief Actuary in the *2010 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.* Furthermore, during testing of internal controls as of September 30, 2010, E&Y noted certain

matters involving internal control and its operation that we consider to be significant deficiencies under standards issued by the American Institute of Certified Public Accountants. Specifically, E&Y reported two significant deficiencies regarding CMS's information systems controls and their financial reporting systems and processes.

Exclusive of the Improper Payment Elimination and Recovery Act of 2010, E&Y disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards* and OMB Bulletin 07-04.

Evaluation and Monitoring of Audit Performance

We reviewed the audit of the CMS financial statements by:

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

E&Y is responsible for the attached auditors' reports dated November 12, 2010, and the conclusions expressed in the reports. Our review, as differentiated from an audit in accordance with U.S. generally accepted auditing standards, was not intended to enable us to express, and accordingly we do not express, an opinion on CMS's financial statements, the effectiveness of internal controls, whether CMS's financial management systems substantially complied with the Federal Financial Management Improvement Act, or compliance with laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which E&Y did not comply, in all material respects, with U.S. generally accepted government auditing standards.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Joseph J. Green, Assistant Inspector General for Financial Management and Regional Operations, at (202) 619-1157 or through e-mail at Joe.Green@oig.hhs.gov. Please refer to report number A-17-10-02010.

Attachment

cc:
Ellen Murray
Acting Assistant Secretary for Resources and Technology

Sheila Conley
Deputy Assistant Secretary, Finance

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Report of Independent Auditors

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

We have audited the accompanying consolidated balance sheets of the Centers for Medicare and Medicaid Services (CMS) as of September 30, 2010 and 2009, and the related consolidated statements of net cost and changes in net position, and the combined statements of budgetary resources for the fiscal years then ended, and the statements of social insurance as of January 1, 2009 and 2008. We were engaged to audit the statement of social insurance as of January 1, 2010. These financial statements are the responsibility of CMS' management. Our responsibility is to express an opinion on these financial statements based on our audits. The statements of Social Insurance as of January 1, 2007 and 2006, were audited by other auditors whose report dated November 9, 2007, expressed an unqualified opinion on those statements.

Except as discussed in the following paragraphs with respect to the accompanying statement of social insurance as of January 1, 2010, we conducted our audits in accordance with auditing standards generally accepted in the United States, the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 07-04*, Audit Requirements for Federal Financial Statements*, as amended. Those standards and bulletin require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. We were not engaged to perform an audit of CMS' internal control over financial reporting. Our audits included consideration of internal control over financial reporting as a basis for designing audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of CMS' internal control over financial reporting. Accordingly, we express no such opinion. An audit also includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

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

In preparing the statement of social insurance, management considers and selects assumptions and data that it believes provide a reasonable basis for the assertions in the statement. However, because of the large number of factors that affect the statement of social insurance and the fact that future events and circumstances cannot be known with certainty, there will be differences between the estimates in the statement of social insurance and the actual results, and those differences may be material. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, the SMI Part D projections have an added uncertainty in that they were prepared using very little program data upon which to base the estimates, and as discussed below, significant additional variability has been introduced by the passage of recent legislation as well as issues regarding the sustainability of the underlying assumptions under current law.

As further described in Note 15 to the financial statements, with respect to the estimates for the CMS social insurance program presented as of January 1, 2010, management has reflected in the projections of the program the direct impact, but not the secondary impacts, if any, of productivity adjustments (reductions in anticipated rates of increase) and reductions in Medicare payment rates for physician services mandated in the Patient Protection and Affordable Care Act (ACA) and current law. Prior legislation mandating reductions in provider payments has been overridden in whole or in part by new legislation, including frequent adjustments to scheduled reductions in physician payments and to prior efforts to adjust payments for inpatient hospital services. Management has noted that actual future costs for Medicare are likely to exceed those shown by the current-law projections, and has developed illustrative alternative scenarios and projections intended to provide additional context to users of the actuarial estimates regarding the long term sustainability of the social insurance program. As a result of these limitations, we were unable to obtain sufficient evidential support for the amounts presented in the statement of social insurance as of January 1, 2010.

Because of the matters discussed in the preceding paragraph, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the financial condition of the CMS social insurance program as of January 1, 2010.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of CMS as of September 30, 2010 and 2009, and its net cost, changes in net position, and budgetary resources for the years then ended, and the financial condition of its social insurance program as of January 1, 2009 and 2008 in conformity with accounting principles generally accepted in the United States.

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 12, 2010 on our consideration of CMS' internal control over financial reporting and on our tests of its compliance with certain provisions of laws and regulations and other matters. The purpose of those reports is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. Those reports are an integral

part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

Our audits were conducted for the purpose of forming opinions on the 2010 and 2009 basic financial statements taken as a whole. The information presented in the Management's Discussion and Analysis, required supplementary information, and other accompanying information is not a required part of the basic financial statements but is supplementary information required by OMB Circular No. A-136. The other accompanying information has not been subjected to the auditing procedures applied in our audits of the basic financial statements and, accordingly, we express no opinion on it. For the remaining information, we have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit the information and, accordingly, we express no opinion on it.

Ernst & Young LLP

November 12, 2010

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Report on Compliance and Other Matters Based on an Audit of the Financial Statements Performed in Accordance with *Government Auditing Standards*

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

We have audited the financial statements of the Centers for Medicare and Medicaid Services (CMS) as of and for the year ended September 30, 2010, and we were engaged to audit the statement of social insurance as of January 1, 2010, and have issued our Report of Independent Auditors thereon dated November 12, 2010. That report states that because of the matters discussed therein, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2010. Except for the matters discussed in the fourth paragraph of the Report of Independent Auditors, we conducted our audit in accordance with auditing standards generally accepted in the United States, the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 07-04, *Audit Requirements for Federal Financial Statements,* as amended.

As part of obtaining reasonable assurance about whether CMS' financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws and regulations, noncompliance with which could have a direct and material effect on the determination of financial statement amounts, and certain other laws and regulations specified in OMB Bulletin No. 07-04, as amended. We limited our tests of compliance to these provisions, and we did not test compliance with all laws and regulations applicable to CMS.

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

The Improper Payments Information Act (IPIA) and Improper Payment Eliminations and Recovery Act (IPERA) (hereinafter the Acts) require federal agencies to identify programs 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 the Acts, but has not yet completed its implementation of a process to fully estimate improper payments. Although CMS has not complied with the Acts, it has implemented a process that measures the payment accuracy rates for the Medicare fee-for-service program.

It is our understanding that management agrees with the facts as presented and that relevant comments from CMS' management responsible for addressing the noncompliance are provided in their letter dated November 12, 2010. We did not audit management's comments and, accordingly, we express no opinion on it.

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

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

Ernst & Young LLP

November 12, 2010

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Report on Internal Control Over Financial Reporting Based on an Audit of the Financial Statements Performed in Accordance with *Government Auditing Standards*

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

We have audited the financial statements of the Centers for Medicare and Medicaid Services (CMS) as of and for the year ended September 30, 2010, and we were engaged to audit the statement of social insurance as of January 1, 2010, and have issued our Report of Independent Auditors thereon dated November 12, 2010. That report states that because of the matters discussed therein, the scope of our work was not sufficient to enable us to express, and we do not express, an opinion on the statement of social insurance as of January 1, 2010. Except for the matters discussed in the fourth paragraph of the Report of Independent Auditors, we conducted our audit in accordance with auditing standards generally accepted in the United States, the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and Office of Management and Budget (OMB) Bulletin No. 07-04, *Audit Requirements for Federal Financial Statements*, as amended.

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

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

Our consideration of internal control over financial reporting was for the limited purpose described in the second paragraph and was not designed to identify all deficiencies in internal control that might be deficiencies, significant deficiencies or material weaknesses. We did not identify any deficiencies in internal control that we consider to be material weaknesses, as defined above. However, we identified certain deficiencies in internal control over financial reporting, as discussed below, that we consider to be significant deficiencies in internal control over financial reporting.

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

Significant Deficiencies

Information Systems Controls

During FY 2010, CMS made investments in additional processes, personnel, and technology to strengthen internal controls over information technology and continues to take proactive steps to improve information assurance at both the Central Office and its business partners, principally Fiscal Intermediaries (FIs) Carriers, Medicare Administrative Contractors (MACs), and Enterprise Data Centers (EDCs), collectively referred to as Medicare contractors. Examples of improvements are described in the context of these investments.

- CMS has strengthened the oversight of its Medicare contractors through improvements to existing and the introduction of new control activities. As such, CMS has:
  - Established the requirement for Medicare contractors to report in compliance with baseline security settings. When exceptions are reported, CMS determines whether the exception can be granted or requires the contractor to communicate a remediation plan.
  - Improved communication of roles and responsibilities between Medicare claims processors and Medicare data centers by requiring the execution of Joint Operating Agreements. These agreements between the data center and claims processor define the roles of each for information security controls and monitoring.
  - Initiated the monitoring of compliance with edit settings for shared system applications by Medicare contractors. Contractors are required to submit reports quarterly and provide business justification for non-compliance.
  - Developed new guidance on compliance requirements for access control over shared systems.

  - Continued efforts to monitor compliance with Medicare data access by contractor personnel.

  - Increased staffing at Central Office to support the monitoring of contractor security compliance reports.

- Strengthened the change control process through further formalization of change control boards for Central Office-managed applications.

- Reinforced enterprise IT vulnerability management through the implementation of new technologies that allows for vulnerability monitoring on a continuous basis.

- Increased awareness and collaboration around information assurance throughout CMS through monthly Security of Excellence meetings and other related activities.

In conjunction with the ongoing consolidation of the overall information processing environment, these activities have helped to reduce CMS' overall exposure to potential information security configuration and access deficiencies.

CMS' Business Environment Overview

Extensive information systems operations are necessary to support CMS' large size and decentralized business model. Substantially all of CMS' Medicare fee-for-service claims and related data are processed by geographically dispersed contractors. Additional key systems are processed at CMS' Central Office. These operations support numerous Medicare and Medicare-related application programs that are intended to assure consistency in administering the Medicare program, in addition to processing, accounting for, and reporting on Medicare expenditures and related assets and liabilities. Internal controls over these operations are essential to manage the integrity, confidentiality, and reliability of Medicare data and application programs and to reduce the risk of errors, frauds, or other illegal acts.

For Medicare fee-for-service claims, CMS has entered into contracts with several organizations known as Fiscal Intermediaries (FIs), Carriers, and Medicare Administrative Contractors (MACs) for claims processing software administration, claims payment, and audit/reimbursement services. CMS also has continued to centralize its ongoing data processing needs into three Enterprise Data Centers (EDCs). Other contractors known as software system maintainers make and test changes to the claims processing software to meet Congressional mandates and/or other business needs as defined by CMS. CMS maintains multiple claims processing systems depending on the type of claim. These systems include the Fiscal Intermediary Shared System (FISS), the Multi-Carrier System (MCS), the ViPS Medicare System (VMS), and the Common Working File (CWF). Collectively these systems are referred to as shared systems. Other important financial systems processed by the CMS Central Office include the Financial Accounting and Control System (FACS), the Healthcare Integrated General

Ledger Accounting System (HIGLAS), and the Medicare Advantage and Prescription Drug System (MARx).

CMS is subject to various federal information security and application software management guidelines. Primary guidance is included in the National Institute of Standards and Technology (NIST) Special Publication 800-53, *Recommended Security Controls for Federal Information Systems,* and NIST Special Publication 800-37, *Guide for Applying the Risk Management Framework to Federal Information Systems*. An independent assessment of CMS' compliance with the NIST guidance is in part accomplished through the performance of an annual review conducted by the HHS Office of Inspector General under the *Federal Information Security Management (FISMA) Act of 2002.*

CMS maintains a Business Partners Systems Security Manual (BPSSM) based on federal guidelines for its application software systems used to direct the information security activities at the Medicare contractors. CMS communicates the requirements of their information assurance program through the requirements of the BPSSM; monitoring compliance with the BPSSM is accomplished through the CMS Certification and Accreditation (C&A) program. Each contractor is required to maintain a System Security Plan (SSP) developed in accordance with the BPSSM that outlines the contractor's plan for maintaining a secure environment for the shared systems. Central Office and contractor personnel are required to receive annual security awareness training.

CMS principally monitors the compliance with its standards through the following processes:

(1) Evaluations of the implementation of information security requirements outlined in Section 912 of the Medicare Modernization Act of 2003,

(2) Annual reports on the MACs' controls placed in operation and tests of operating effectiveness issued by independent auditors in accordance with the AICPA's Statement on Auditing Standards No. 70, *Service Organizations,*

(3) Annual reviews in accordance with Office of Management and Budget (OMB) Circular No. A-123, *Management's Responsibility for Internal Control*, which provides updated internal control standards and specific requirements for conducting management's assessment of the effectiveness of internal control over financial reporting, and

(4) Additional monitoring procedures performed by CMS including ongoing contractor management assessments and regular reviews of computer security configurations submitted by the MACs and the EDCs.

These enterprise-wide CMS activities and our procedures continue to identify instances of non-compliance with CMS IT security and other requirements. While CMS continues to remediate identified findings and weaknesses, these monitoring activities also revealed a number of instances in which the remediation had not been timely implemented.

The complexity of the CMS environment, fast-paced technological changes, and the evolution of threats pose a significant challenge to CMS. The age of the mainframe systems and associated software that CMS employs in its processing of Medicare, Medicaid and financially significant data will become more difficult to maintain and modify when integrating future changes in the Medicare program. CMS also requires constant vigilance in managing information security risks to ensure that weaknesses are identified and remediated timely.

Information Security

When properly designed and implemented, access controls ensure that critical system assets are physically and logically protected from unauthorized usage and that only authorized personnel are granted access to data and programs; such controls include active monitoring of security events for proper assessment and timely remediation.

We identified the following weaknesses in information security that merit continued focus:

- CMS did not ensure that all Medicare contractors performed periodic reviews of user access to sensitive Medicare data and the related application systems. This condition continued at two MACs. Such periodic reviews are essential to ensure that all access continues to be appropriate and authorized.

- Unauthorized wireless access to Medicare networks was observed at the single testing contractor who completes testing on the four shared systems supported by the software maintainers. Such access introduces a vulnerability into the CMS network that is not consistent with the information security control standards of CMS and potentially permits non-authorized external users to access sensitive Medicare data and systems.

- Vulnerabilities in system configurations for contractor networks used to transport Medicare data were identified at two MACs. Providers and other health-care related organizations use these networks for transmission of claims data and other information using Electronic Data Interchange (EDI). These vulnerabilities could result in inappropriate network access and access to application systems connected to the network. At one MAC, the vulnerability identified permitted update access to the server supporting the Medicare EDI application.

- One EDC and one shared system maintainer had not completed their implementation of CMS-required computer system security configuration settings. At the EDC that processes claims for multiple MACs, security is managed using IBM's Resource Access Control Facility (RACF) software for which security settings were not set in accordance with the CMS security standards for RACF. Without full implementation of these settings, unauthorized access and usage of Medicare data and systems could occur.

- User security administration for access to shared systems was not effectively performed at three MACs. This could result in potentially unauthorized access to Medicare data and systems.

- SSPs for the single testing contractor and one MAC were incomplete. In addition, the single testing contractor's SSP had not been timely reviewed or approved by CMS.

- Data backup tapes managed by the EDCs contain unencrypted personally identifiable information (PII) related to Medicare information. CMS has not fully implemented HHS Standard for Encryption 2008-0007.001S, dated December 23, 2008. Such encryption is also required by OMB Memorandum No. M-06-16, *Protection of Sensitive Agency Information.* CMS has not obtained a waiver from OMB related to this weakness.

- Pending the decommissioning of FACS and the full implementation of HIGLAS, segregation of duties conflicts continued to exist at Central Office between the business fu*nction and information security administratio*n function of CMS' Office of Financial Management (OFM) for FACS. OFM has assigned personnel the function of system and security administrators; these personnel also were able to grant access to the FACS application and perform and process business transactions.

- CMS has not provided guidance to the MACs on how to establish segregation of duties between business processes for the shared systems applications. Since the systems are developed by the shared system maintainers and tested by the STC, the MACs do not have sufficient knowledge of the application processing to design appropriate segregation of duties controls. These controls are key to the effective administration of user access to the shared systems that process Medicare claims and are required by the NIST standards.

Application Configuration Management

Configuration management is the process used to ensure that the Medicare applications used by the Central Office and Medicare contractors operate as intended by CMS. Configuration management depends on the consistent application of program change management processes and policies to the Medicare systems to ensure the continued integrity and security of financial and claims data.

CMS has contracted with several software system maintainers to provide software development and testing support for the majority of the systems used to process Medicare claims. Some of these maintainers provide services for the shared systems that include system development, system documentation, training, and testing. The MACs that use the shared systems are responsible for the configuration of programmed edits (e.g., a valid provider type was entered for the medical service rendered), the customization of automated adjudication software (AAS or "scripts"), and local information security user administration procedures.

We identified the following weaknesses:

- Change control boards are important in an organization as complex as CMS to oversee the interfacing of Medicare and financial data across numerous applications. While CMS has instituted several change control boards for these applications, there is no overall change control board or process to coordinate efforts to integrate necessary application interfaces. Further, CMS has developed a process requiring Interface Control Documents (ICDs) but these are not standardized in content and not used by all relevant programming groups. Without appropriate integration and proper data interfacing among the many business applications used by CMS, the accuracy and reporting of financial and beneficiary data may be impacted.

- Automated Adjudication Software (AAS) scripts and configurable edits implement the business rules for processing Medicare claims. MACs have the ability to develop and implement AAS scripts. MACs are also responsible for ensuring the configuration edits are set to CMS standards. We noted at two MACs that AAS scripts are not being tested when the programs that process these scripts change by the shared systems maintainer. We also noted at two MACs that configurable edits are not being managed in accordance with CMS requirements. If these tools for implementing business claims processing policies are not tested and configured in accordance with CMS policy, the exposure exists that claims will not be processed correctly resulting in improper payments.

- The shared systems (FISS, MCS, and VMS) use thousands of data edits to adjudicate claims against Medicare policies. However, CMS has not identified all the data edits that should be activated and accurately functioning in accordance with Medicare policies. This deficiency may result in inaccurate adjudication of Medicare claims.

- CMS has implemented a quarterly edit compliance process for all FIs, Carriers, and MACs. We found that for one quarter, the compliance process did not function properly and such errors were not identified timely. CMS was not able to determine the monetary impact of the edit compliance process not functioning for the quarter.

Recommendation

Through its added oversight procedures, CMS has made progress in identifying, monitoring, and remediating specific control weaknesses related to information security and its business applications. CMS should continue its efforts to increase contractor compliance by enhancing and consistently applying oversight activities, including proactive monitoring of contractor compliance with security settings and related directives for data access and the shared systems. A particular focus should be placed on reviewing and evaluating instances of non-compliance with stated Medicare policies, including the documentation of conclusions and approvals of instances of non-compliance and evaluating their impact on the financial statements.

To achieve these objectives, CMS should continue to coordinate and implement control processes that will enhance the overall integrity of the Medicare information systems. Such coordination will require further integration of efforts by the Office of Financial Management (OFM), the Office of Information Services (OIS), and those charged with governance over the MACs in the Center for Medicare (CM).

We recommend that CMS:

- Further the implementation of enhanced and required information security policies and techniques developed by OIS over the Medicare information systems, including:
  - Periodic and timely information system user access reviews at the Central Office, FIs, Carriers, MACs, and EDCs.
  - Increased oversight of contractors' use of newer technologies, including wireless access and publicly accessible networks.
  - Consistent and enforceable policies for the encryption of PII on its information systems, including portable devices, as required by OMB and HHS.
  - Consistent and complete system security plans prepared by all system owners, MACs, EDCs, and software system maintainers.
  - Continued implementation of system and security settings at the Central Office and the EDCs in accordance with CMS policies, related monitoring procedures, and timely remediation of identified errors.
- Oversee an integrated effort by OIS and CM to ensure that:
  - Appropriate segregation of duties is established in all systems that support Medicare and financial processing at the FIs, Carriers, and MACs to prevent excessive or inappropriate access. In addition, access to all systems should be periodically reviewed to ensure that access remains appropriate and no incompatible duties exist.
  - Compliance detection systems for the timely implementation and activation of new Medicare claims edits are monitored timely and appropriate system corrections are made for identified errors.
  - All application changes to the Medicare systems, including FISS, MCS, VMS, and CWF, are tested adequately and completely.
  - All AAS programs (scripts), new or old, are documented, validated as to business need, and adequately tested prior to implementation at the MACs or whenever the Medicare applications that use the scripts are changed.

- Continue efforts by all three organizations (OFM, OIS, CM) to require that all changes to Medicare and related financial applications be subject to review by a designated enterprise-wide change control board. System interfaces should be identified and ICDs should be consistently completed and used for all systems. In addition, relevant NIST guidance should be applied in the review and approval of changes. Documentation should be prepared for all phases of the change management process.

Financial Reporting Systems and Processes

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

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

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

Changes in CMS management structures flowing from the recent reorganization and passage of Patient Protection and Affordable Care Act, as amended by the Healthcare Reconciliation Act of 2010, collectively referred to as the "Affordable Care Act" or ACA, which will require close coordination within CMS and with HHS, provide opportunities to challenge and continuously improve financial management processes.

The Chief Operating Officer chairs the Risk Management and Financial Oversight Committee (the Committee) and the Committee is comprised of directors and deputy directors of certain Centers and Offices. The Committee has played, and continues to play, a critical role in focusing senior management's attention on those activities identified in financial and other audit, inspection and assessment activities as weaknesses or vulnerabilities and ensuring that corrective action plans were developed and implemented to address the Agency's deficiencies in an effective manner. These efforts have assisted in developing continued improvement in processes. With the reorganization of the Agency, and challenges which will flow from implementing ACA in the coming years, we encourage the Committee to continue sponsoring studies of other potential business, accounting and reporting risks; challenging the design of accounting and financial controls to support the financial and operational needs of the organization; and enforcing timely investigation, response and remediation of all findings from external audits, OIG investigations and A-123 testing. As the Agency continues its efforts to enhance internal controls, the following items noted in connection with the current year audit merit continued focus:

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

Considering the recent realignment of the Agency and the passage of significant legislation in the current year, CMS should critically assess its process for managing the cross-functional teams of financial management, information technology, actuarial, general counsel, operations, and other personnel to better monitor business activities, generate and share financial and other information and identify situations where accounting evaluation or decision-making may be required to arrive at and document an appropriate conclusion in a timely manner. Critical accounting matters such as accruals and contingencies require a robust process on a quarterly basis including the documentation of these critical accounting matters through a series of white papers. Albeit that CMS has strengthened its ability to identify contingencies on a quarterly basis, these white papers supporting the conclusions on several critical accounting matters had not been timely prepared and approved to effectuate a change in policies or procedures. In addition, the white papers were either not finalized or not available for review until after the fiscal year end. The dispersed nature of the environment leaves CMS vulnerable to delays in the financial management implications of issues being recognized and addressed. Additional examples of these include:

- While the most significant legal matters are properly recorded, CMS does not ensure that the legal accrual is recorded in accordance with generally accepted accounting principles in the United States.

- During the FY 2009 budgetary closing process, CMS did not return $8.1 billion in indefinite authority related to its Medicaid ARRA funds. CMS and Department of Health and Human Services (DHHS) management indicated that the authority had not been returned due to several miscommunications between the CMS budget and finance offices, DHHS and OMB. In January 2010, through and after discussions with OMB and

Treasury, DHHS requested a negative warrant to be processed to return the funds. For the FY 2009 financial statement purposes, no restatement of balances was required as they represented the actual relative positions of the entities, as they stood at the time. Although CMS drafted a white paper document to address financial and budgetary accounting and reporting issues, the document never was finalized and no documentation was prepared to support the concurrence by the various entities of the corrective actions to be taken. During FY 2010, CMS identified and implemented corrective actions, including reviews of subsequent period apportionments to ensure that funds not available for carryover would be returned during the year-end closing process.

- Insufficient communications within the organization resulted in understatement/ overstatement of accounts receivable and related interest from, and payables to, the States for Medicaid and ARRA advances. For example, in the prior year a state was in an overdrawn position that should have resulted in an accounts receivable; however, it was not reflected in the financial statement until the current fiscal year. In addition, the finalization of grant awards is not performed consistently or timely for all States. Efforts to continuously monitor State draws and reinforce applicable cash management and grant oversight activities, including working to resolve issues with disclaimed or qualified opinions reflected in grantee compliance audit reports (States' A-133 compliance reports) merit continued focus.

- Contemporaneously addressing the financial reporting implications in connection with the deliberations ultimately reflected in the Trustees Report and accompanying Office of the Actuary (OACT) reports and projections might have been useful in mitigating the impact on the Statement of Social Insurance reporting.

- As CMS continues to enhance its data analyses capability, further improvement can be made by developing robust analytical procedures or measures against benchmarks to monitor and mitigate risks associated with the decentralized nature of CMS operations. To the extent more robust analysis occurs within Centers and Offices, cataloging and reviewing such analysis would assist in ensuring that a perspective which incorporates a financial reporting point of view is captured and considered.

II. Enhancement of Financial Management Analysis Function

The dispersed nature of the financial management environment requires a high degree of coordination between the financial and program management personnel to ensure the effective operation of the controls. The decentralized nature of the organization results in a significant number of controls being performed at the contractors, regional offices, Centers and Offices outside of OFM. Critical accounting matters identified within the organization require a robust review process, including timely documentation to capture CMS' considerations, analyses and ultimate conclusions.

Consistent with the prior years, we noted that CMS does not perform a claims-level detailed look-back analysis for the Medicaid Entitlement Benefits Due and Payable (EBDP) to determine the reasonableness of the various state calculations of incurred but not reported (i.e., unpaid claims) liability. The Medicaid EBDP is approximately $27.0 billion as of September 30, 2010 and is a significant liability on the financial statements. Currently, CMS is not able to validate its methodology in a manner similar to the Medicare methodology by using a claims-based approach. CMS continues to rely on its estimation methodology (which is based on using a historical three-year average) to record the Medicaid EBDP without the ability to confirm the reasonableness of its methodology.

All individuals within the organization are responsible for establishing, managing and maintaining an effective control environment. A good control environment not only ensures accountability but provides oversight and reasonable assurance that the organization's goals are met. During the internal control tests, errors were noted that were not detected by the organization's monitoring and review function, and accordingly, the control was not functioning as designed or intended. The errors identified by our audit procedures at the central office, regional offices and Medicare contractor locations may be summarized, including an example for each category, as follows: (i) activity or accounts for which no formal, documented review or monitoring function was established (identified as a design deficiency) (for example, no documentation or certification of the review that the premium calculation spreadsheets are reviewed for accuracy prior to publication of the premium); (ii) review or monitoring function was established but was not performed or effective (for example, reconciling items identified in the benefit payment reconciliation were not investigated and resolved timely); and (iii) the review or monitoring function was not performed timely (for example, the monthly National Claims History (NCH) validation process, which compares the NCH paid claims to the Medicare contractor reported draws, was not performed in the current fiscal year).

III. Transition to a Single Integrated Financial Management System

Federal agencies are required to have a single integrated financial management system that provides effective and efficient interrelationships between software, hardware, personnel, processes (manual and automated), procedures, controls, and data necessary to carry out the financial management functions, manage the agency's financial operations and report the agency's financial status. CMS continues their efforts to implement the Healthcare Integrated General Ledger Accounting System (HIGLAS), which will integrate the CMS contractors' standard claims processing system and eventually replace the CMS current mainframe-based financial system with a web-based accounting system (currently, the web-based accounting system has been placed "on top" of the current mainframe-based financial system). As a result, CMS has made considerable progress but the lack of a single integrated financial management system continues to impair CMS' ability to efficiently and effectively support and analyze financial reports for the following reasons.

Certain Medicare contractors have not implemented HIGLAS and continue to rely on a combination of claims processing systems, personal computer-based software applications and

other ad hoc systems to tabulate, summarize and prepare information that is reported to CMS on the *750—Statement of Financial Position Reports*, the *751—Status of Accounts Receivable Reports* and the reporting of funds expended, the *1522—Monthly Contractor Financial Report*. The accuracy of these reports remains heavily dependent on inefficient, labor-intensive, manual processes that are also subject to an increased risk of inconsistent, incomplete, or inaccurate information being submitted to CMS.

Although CMS has begun preparing financial statements using HIGLAS, as further noted below, full functionality of the HIGLAS system has not been implemented.

IV. Business Partner Risk Management

CMS administers an extensive internal control program to protect the Agency's resources from fraud, waste and mismanagement. CMS also relies heavily on third-party contractors as it outsources substantially all the day-to-day operations for its information technology systems, the payment of Medicare fee-for-service and Medicaid claims and certain services related to the Medicare Advantage (Part C) and Part D Drug programs.

CMS has developed internal controls that help prevent fraud and waste from occurring such as edits in the claims processing systems that attempt to identify and filter inappropriate claims. CMS also has developed internal controls that will help detect fraud and waste that may have occurred. Any strong control environment will have a combination of both prevent and detect controls with a greater emphasis on prevent controls.

While we noted during the current year audit that CMS had both prevent and detect controls in operation, we noted several examples of areas where improvements could be made in the overall control environment. This is especially true of CMS' relationships with its third-party contractors referred to herein as "contractors."

- The contracts between CMS and its Medicare contractors include provisions that require the Medicare contractor to develop and follow policies and procedures or objectives established by CMS, as described more fully in the CMS Medicare Financial Reporting Management Manual (Chapter 5). The specific objectives followed at each location are to be documented by the Medicare contractors, supporting documentation must be maintained and available for review and audit, all shared systems must be able to produce any system report required by Medicare contractors on a month-end basis and the Medicare contractor must be able to support all summary amounts reported on any system report with transaction level detail. In addition, Medicare contractors are required to periodically (e.g., monthly) certify to the completeness and accuracy of the financial information transmitted to CMS for their responsible workloads. Through its A-123 process, CMS tests the Medicare contractors' compliance with its policies and procedures and the financial controls established.

While this approach to financial integrity supports monitoring of the Medicare contractors' financial controls, the monitoring process has not been fully effective in identifying and resolving financial recording and reporting issues or ensuring that they are timely remediated by the Medicare contractors. As CMS continues their efforts to transition to the Healthcare Integrated General Ledger Accounting System (HIGLAS) and to implement the provisions of ACA, there will be a greater significance placed on monitoring the Medicare and other contractors, accentuating not only the value, but also the consequences, to the Agency. During our audit activities, we identified weaknesses in financial reporting oversight, including:

- Neither CMS nor the Medicare contractors were able to provide a system-generated subsidiary ledger or detail schedule for the amounts payable to providers or beneficiaries (or amounts owed to CMS) for certain ancillary accounts (e.g., accounts payable other, refunds payable or custodial liabilities) as of a balance sheet date. While account reconciliations are performed for the primary claims payable accounts, because there was no subsidiary ledger available for these ancillary accounts, neither CMS nor the Medicare contractors were able to fully reconcile these accounts on a periodic basis.

- For one Medicare contractor and two workloads, initially neither CMS nor the Medicare contractor were able to provide a system-generated subsidiary report for the adjudicated claims balances reported to CMS because the volume of transactions were greater than the HIGLAS capabilities and the report could not be successfully generated. Ultimately, CMS was able to provide a number of system-generated subsidiary reports by open year and fund (i.e., HI, SMI and general) to support the adjudicated claims balance. These reports reconciled to the balances reported by the Medicare contractor.

- Undelivered Medicare Summary Notices (MSNs) returned to the Medicare contractor were shredded by the Medicare contractor and are not being investigated as there is no existing CMS policy that addresses the actions in this circumstance. The result of the beneficiary not being able to review the MSN and notifying CMS of unusual services or charges may lead to improper payments going undetected.

- The Medicare contractors did not perform a periodic review of claims held (i.e., "invoices on hold" or payables held for specific reasons) and CMS did not monitor that the outstanding balances are properly and timely resolved. If the aged claims are not tracked or monitored by the Medicare contractor periodically, the claims may not be paid or disposed of in a timely manner and the payable balances reported by the Medicare contractor at the end of each reporting period may not be correct. We understand that CMS is in process of developing a policy or guidance that will require the Medicare contractors to perform a periodic review.

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

- The processes designed to prevent errors should be supplemented by controls and analyses that highlight any material errors that may or could occur. In this regard, errors or abuses within the Medicare fee-for-service claim data, if material, should be detected in the annual Comprehensive Error Rate Testing (CERT) process, while for Medicaid the Payment Error Rate Measurement (PERM) process can be useful in this regard. These processes, which are primarily outsourced to contractors, are designed to assess accuracy rates as applicable. Similar processes are used to monitor Part C and D plans, particularly prescription drug event data. These processes continue to evolve and the error rate development processes developed to date, and further steps being taken to verify that only appropriate providers and beneficiaries participate in the programs are important steps forward in this regard. To be fully effective in compensating for inherent risks in the programs, the monitoring activities must be well understood, susceptible to replication and highly credible. We reviewed these error analyses and these analyses quantify the challenges that CMS has regarding improper payments. Our audit procedures also consider the audit activities performed by the OIG and others for the Part C and D programs. Findings, such as timeliness of the plan audits and the accumulation of True-Out-of-Pocket costs (TROOP) and Prescription Drug Event (PDE) data, are inherent risks of the programs.

  In 2008, the OIG recommended revisions to the error rate review methodology, which were implemented by CMS during fiscal year 2009 which resulted in higher projected error rates. Similarly, ensuring that a fully reconciled population of claims is susceptible to testing is an important starting point in the development of PERM error rates. The work previously performed by the OIG in reconciling such populations indicates that further focus on this area is needed.

V. Statement of Social Insurance

The Statement of Social Insurance (SOSI) for CMS presents a long-term projection of the present value, spanning a 75-year time horizon, of the benefits to be paid for the closed and open groups of existing and future participants of the Medicare social insurance programs, less the inflows to be received from or on behalf of those same individuals. The presentation assumes the programs will continue in their current form under current law, albeit with certain economic assumptions that serve to constrain growth of the programs and imply refinements in response to the burden of the programs on economic activity. Departure from the current law construct also is made in assuming that the programs would continue to provide substantially consistent benefits after exhaustion of the Trust Funds, while under current law payment reductions would

otherwise reduce or defer such payments. This approach allows for illustration of the excess of payments beneficiaries may expect over the related funding streams.

The presentation includes estimates not only of the payroll taxes, premiums, and other contributions to be made directly by the participants but also estimates of general fund contributions on their behalf to help finance the programs for which this funding mechanism exists. In contrast, the presentation included in the consolidated annual financial statements of the U.S. government excludes such intragovernmental transfers. The process for preparing the SOSI must comply with appropriate financial reporting internal control requirements and is intended to provide information useful in assessing the financial condition of the programs and related Trust Funds.

In FY 2010, the passage of the Affordable Care Act significantly impacted the projections embodied in the Trustees Report and SOSI. The application of the current law formulation to development of the SOSI projection created significant challenges in applying this legislation. These challenges included considering the impacts of an estimated 165 provisions affecting the Medicare program, including modeling significant changes in provider payments arising from legislative limitations to constrain growth in the cost of the programs, and considering potentially wide ranging impacts from investments in combating fraud and abuse, initiating a major program of research and development, and implementing accountable care organizations to assist in coordinating care.

The projections always have been complex and need considerable care in interpreting the resulting SOSI. The degree of uncertainty regarding the projections increased in FY 2010 and certain matters called into question, and we were unable to assess, whether the presentation of the SOSI was fairly presented and fully useful for its intended purpose. Management has noted that the effects of some of ACA's provisions on Medicare are not known at this time, and the long-range feasibility of certain of the provisions is doubtful. The Trustees Report, related Actuarial Opinion and other materials incorporated by reference in the Trustees Report reflect uncertainty regarding the projections and reflect concerns that certain current law provisions are not sustainable or will, based on prior patterns, likely be modified. The extent to which the SOSI projections as presented are anchored in the current law formulation, are subject to additional uncertainty this year and may not reflect management's reasonable estimate of the ultimate cash flows of the social insurance programs, is discussed in the footnotes to the FY 2010 SOSI.

The disclosure steps taken by management appear to have been reasoned judgments to aid users of the financial statements in interpreting the information pending further refinement of the projections and a more fundamental reexamination of the assumptions underlying the development of the SOSI and Trustee Report. The efforts needed in modeling the impacts of the ACA include work which management anticipates regarding potentially refining the assumptions and narrowing the range of the projected outcomes for the cash flow models and seeking further input in comprehensively considering the secondary impacts of price changes mandated by current law on access and utilization. Enhancing the utility of the projections will require addressing systemic issues regarding patterns of legislative changes in the programs, including

for example the physicians' payment update reduction deferrals of the last several years. It also may require positing sustainable operating models for the programs, their providers and beneficiaries, some of which may require postulating future changes in the legislative or regulatory formulations of the programs needed to sustain the programs. Developing auditable estimates for SOSI that fairly present the financial condition of the Trust Funds may require revisiting provisions of federal accounting standards and potentially reformulating the assumptions used in SOSI and the Trustees Report to help improve the usefulness of the estimates provided.

Certain efforts already underway within CMS will assist in narrowing areas of concern. While appointment of public trustees and a panel of advisors to assist in reviewing the projections and related assumptions came too late for the FY 2010 SOSI presentation and Trustees Report development, these measures will assist CMS during the refinement of future projections and in considering the appropriate response to concerns about the sustainability of current law provisions over the projection period, which are significant enhancements. The investment made by the Office of the Actuary in formulating alternative illustrative scenarios will help inform the process. Similarly, the Federal Accounting Standards Advisory Board departed from a current law formulation when formulating guidance regarding developing analogous projections for sustainability reporting. The work devoted to this effort may also facilitate developing appropriate responses to the unique challenges faced by CMS in developing projections for SOSI under the current law construct referenced in applicable Federal reporting standards.

In addition to the overarching concerns, our work in review of the internal controls for the related models noted continue improvement, considering the magnitude of changes in the current fiscal year, with some areas warranting continued focus. The SOSI models are complex, 75-year projections that contain a high degree of estimation. The lack of robust controls over spreadsheet changes and inputs, and complexity of the models may result in output that varies from management's intentions. We noted the following deficiencies that, if improved, would enhance the reliability and credibility of the SOSI model and process:

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

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

Recommendations

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

- Establish specific policies, procedures and a protocol to address situations or transactions that require cross-functional involvement to ensure interim and year end financial statements are accurate and complete. This includes policies and procedures to ensure changes to critical systems outputs are appropriately discussed and reviewed with all users. The financial management function should serve as the primary coordinator to facilitate the input and involvement of the other cross-functional units whose involvement and input are important factors to consider in formulating accounting treatment and financial reporting implications.

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

- Delegate to and ensure that the Centers or Offices provide robust analytical analyses to OFM on a periodic basis (e.g., quarterly) that would be analyzed and reconciled by OFM in connection with the preparation of the quarterly CMS financial reports and available for use throughout the Agency.

- Establish a process to perform a claims-level detailed look-back analysis on the Medicaid EBDP to determine the reasonableness of the methodology utilized to record the $27.0 billion accrual. One potential method to verify the reasonableness of the Medicaid EBDP balance would be to use the detail claims data from the PERM process to calculate the average days outstanding or sample the largest states and determine if information is available for subsequent analysis.

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

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

- CMS should regularly evaluate its overall directives to contractors to ensure that adequate controls are in place and that appropriate documentation is maintained to support the conduct of those controls. As CMS transitions the contractors to HIGLAS or implements new legislation, CMS should challenge its current policies, procedures and methodologies to determine if such implementation has impacted the financial reporting and internal control processes (examples include generation and reconciliation of

subsidiary ledgers, MSNs and HIGLAS reporting). If current methods are impacted, CMS should provide updated and relevant guidance and communication to, and collaborate with, the contractor to facilitate and properly incorporate the changes.

- Continue the process of enhancing the integrity, improving the process and capturing the benefits of the CERT, PERM, Part C and Part D error rate development and analysis tools. Error rate results should be developed at a sufficient level of detail to analyze, scrutinize and classify errors and identify anomalies to begin separate investigations or studies of the root causes of the errors and appropriate prevention, mitigation and recovery plans. Continue the efforts to further develop the eligibility processes to ensure only appropriate parties participate and use the periodic error rate processes to comprehensively test for eligibility and improper payments.

- Critically assess findings from OIG and other reviews of the Part C and D programs to ensure that the evolving nature of these programs are accompanied by robust internal control processes utilized by CMS to address the inherent risks of these programs. Continue to consider and implement the recommended audit results and modify the processes to hold plan sponsors more accountable for the findings identified. The financial management group should ensure it monitors and maintains oversight over the programs and its activities to identify the appropriate financial statement impact and disclosure. In light of the extraordinary financial crisis that existed in 2008, 2009 and continues in 2010, and the pattern of advances to Part D drug plans and states, we believe that CMS should continue to evaluate its risks with respect to all its grantees, contractors and providers to ensure that the Agency is appropriately protecting its resources.

Developing SOSI projections for use in general purpose financial statements which represent management's reasonable estimate of the cash flows for the programs over a 75-year projection period will continue to be a challenge. The fact pattern presented in FY 2010 in developing the projections raises important issues regarding the role of SOSI reporting, and the merits of departing further from a current law formulation in instances in which management believes that legislative or regulatory changes will be needed to sustain the programs throughout the projection period. Pending resolution of these issues, the disclosures help to partially mitigate the potential adverse impact from presenting information management does not believe will actually occur. In pursuing the ultimate resolution of these matters, we suggest management consider the following:

- Continue efforts initiated late in FY 2010 to engage a panel of advisors to assist in addressing the challenges presented by the passage of ACA in developing and presenting projections for the Medicare programs which are reasonable estimates of the program cash flows.

- Continue and broaden discussions with key stakeholders and standard setting bodies, including the Federal Accounting Standards Advisory Board, to codevelop appropriate recommendations for potential revisions to the approaches used in presenting projections

for the programs in the Trustees Report and standards applicable to presentation of the SOSI to aid in ensuring that the SOSI projection is meaningful and presents fairly the financial condition of the Trust Funds. These consultations should address how patterns of revisions to law, and situations in which a continuation of current law is anticipated to potentially not be feasible should be addressed, if at all, in the projections.

- CMS should verify that all spreadsheets are password protected to avoid unauthorized access or changes.

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

- Adhere to the established policies and procedures to ensure that the verification, review and approval process for the SOSI model occurs in a timely manner.

We have reviewed our findings and recommendations with CMS management. CMS' response to our findings and recommendations is included in their letter dated November 12, 2010. Management will provide a corrective action plan to the Office of Inspector General in accordance with applicable Agency directives. We did not audit CMS' response and accordingly, we express no opinion on it.

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

Ernst & Young LLP

November 12, 2010

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

November 12, 2010

Ernst & Young, LLP
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Dear Sir:

Thank you for your audit report on the Centers for Medicare & Medicaid Services' (CMS) fiscal year (FY) 2010 financial statements. The CMS has reviewed the report prepared by Ernst & Young, LLP (E&Y) and we are pleased that the result of the audit is an unqualified opinion on our Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position and the Combined Statement of Budgetary Resources. However, you did not express an opinion on the Statement of Social Insurance, which is developed using information from the annual report of the Medicare trust funds. The FY 2010 Statement of Social Insurance projections contained in this report incorporate the effects of the Affordable Care Act, and are prepared based on current law, in accordance with the standards issued by the Federal Accounting Standards Advisory Board. While we have complied with Federal accounting standards, we look forward to working closely with you and our partners in the Office of the Inspector General (OIG) to develop the necessary actions to remediate this issue for the future.

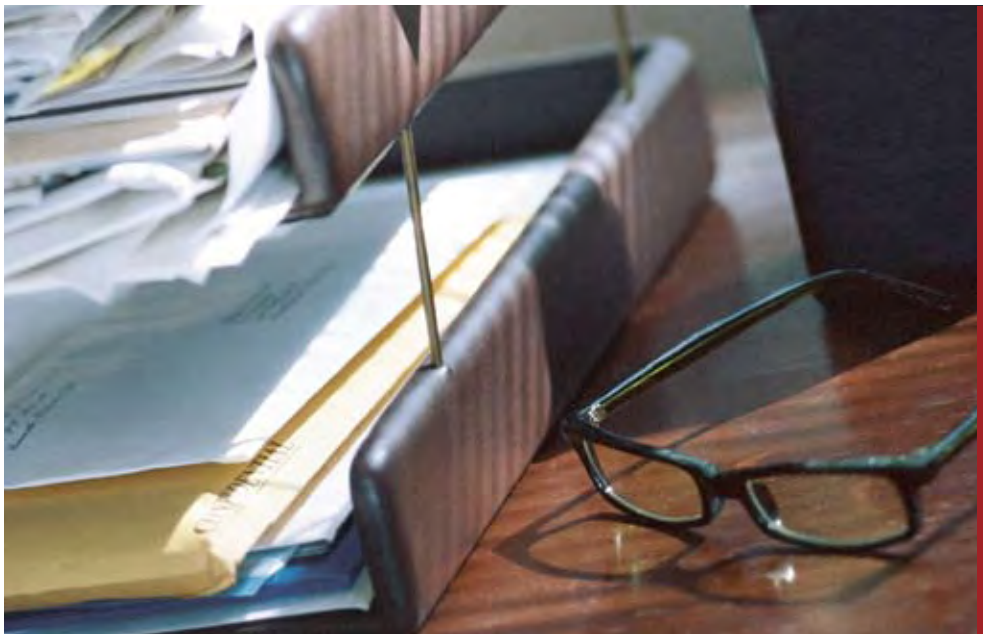
Your review also identified two significant deficiencies, Information Systems Controls and Financial Reporting Systems and Processes. As you noted in your report, CMS made significant progress in strengthening its controls around information systems in FY 2010, as evidenced by the downgrading of the prior year material weakness to a significant deficiency. Your recognition of the Agency's improvements throughout the report are greatly appreciated, and we generally concur with the findings and descriptions of the matters noted. We will continue to focus our efforts in FY 2011, to addressing the remaining significant deficiencies. The CMS is committed to developing corrective action plans to address the audit issues identified

in your report. It is the Agency's intent to assess and address the root causes of these issues as quickly as possible.

In closing, we would like to confirm CMS' commitment to continual improvement in financial management, as well as the production of accurate and reliable financial information. The CMS would like to thank the OIG and the E&Y audit team for the professionalism exhibited throughout the audit process. We look forward to working with you in the next year to resolve these outstanding issues.

Sincerely,

Deborah A. Taylor, CPA
Chief Financial Officer



Other Accompanying Information

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

The CMS assesses its internal controls through: (1) management self-assessments including annual tests of security controls, (2) OMB Circular A-123, Appendix A self-assessment, (3) OIG audits and Government Accountability Office (GAO) audits and High-Risk reports, (4) SAS 70 internal control audits, (5) evaluations and tests of Medicare contractor controls conducted pursuant to Section 912 of the Medicare Modernization Act, (6) the annual Chief Financial Officer (CFO) audit, and (7) certification and accreditation of systems. As of September 30, 2010, the internal controls and financial management systems of CMS provided reasonable assurance that the objectives of FMFIA were achieved, however, one instance of noncompliance was identified.

OMB Circular No. A-123 Statement of Assurance

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

As required by OMB Circular No. A-123, CMS evaluated its internal controls and financial management systems to determine whether these objectives are being met. Accordingly, CMS provided a qualified statement of assurance that its internal controls and financial management systems met the objectives of FMFIA due to its noncompliance with the Improper Payments Elimination and Recovery Act (IPERA).

During FY 2010, CMS believes we have become substantially compliant with the Federal Financial Management Improvement Act (FFMIA) as we have continued our efforts to implement the

Healthcare Integrated General Ledger Accounting System (HIGLAS), which will integrate the CMS claims administration contractors' shared claims processing system and replace the CMS current mainframe-based financial system with a web-based accounting system. The CMS considers our financial systems to be integrated in accordance with OMB Circular A-127 since, as of September 2010, CMS has 88 percent of total Medicare program payments accounted for in HIGLAS. In addition, HIGLAS is CMS' official financial system of record, as we prepared our first auditable financial statements via HIGLAS during the second quarter of FY 2010. HIGLAS will enhance CMS' oversight of claims administration, contractor financial operations and the accounting and reporting of other CMS activities.

Assurance for Internal Control over Operations and Compliance

The CMS conducted its assessment of internal control over the effectiveness and efficiency of operations and compliance with applicable laws and regulations in accordance with OMB Circular No. A-123. Based on the results of this evaluation, as of September 30, 2010, CMS provided reasonable assurance that internal controls over operations were effective and no material weaknesses were found in the design or operation of these internal controls. As of September 30, 2010, we also complied with applicable laws and regulations, except for the noncompliance noted above. While the GAO High-Risk Report includes the Medicare and Medicaid programs as high risk, we do not believe that they constitute a material weakness. As the GAO notes, legislation is likely to be necessary, as a supplement to actions by the executive branch, in order to effectively address these high-risk areas.

Assurance for Internal Control over Financial Reporting

The CMS conducted its assessment of the effectiveness of internal controls over financial reporting, which includes the safeguarding of assets and compliance with applicable laws and regulations, in accordance with the requirements of Appendix A of OMB Circular No. A-123. Based on the results of this assessment, CMS provided reasonable assurance that internal controls over financial reporting as of September 30, 2010, were operating effectively and no material weaknesses were found in the design or operation of the internal controls over financial reporting.

Noncompliance

While we are not fully in compliance with the Improper Payments Information Act (IPIA), amended in July 2010 by the Improper Payments Elimination and Recovery Act (IPERA), we are continuing to implement the requirements of IPERA to enhance our program integrity efforts. Since 2002, we measured the payment error rates for the Medicare fee-for-service (FFS) program. We are also on track to report a baseline error rate for Medicaid in the Department's FY 2010 Agency Financial Report (AFR). Going forward, the reported rate will be a "rolling average" of the most recent three years. Section 601 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) prohibited CMS from calculating or publishing any national or State-specific error rates for CHIP until six months after a new PERM final rule is in effect. The final regulation was published on August 11, 2010, with an effective date of September 10, 2010. Therefore, the final regulation has not been in effect for more than six months. For this reason, CMS is not reporting a national CHIP error rate for the FY 2009 cycle. The next CHIP error rate will be published in 2012. We are in compliance with IPERA for the Part C Medicare Advantage program; we reported a calendar year (CY) 2006 Part C composite payment error rate in the Department's FY 2008 AFR, and a CY 2007 Part C composite payment

error rate in the Department's FY 2009 AFR. We continue to make significant progress toward the development of a composite payment error rate for the Part D Prescription Drug program. We reported two Part D component payment error rates in the Department's FY 2008 AFR, and three Part D component payment error rates in the Department's FY 2009 AFR.

Information System Control Deficiencies Noted in the FY 2010 OMB Circular A-123, Appendix A Review

During FY 2010, we developed and implemented corrective actions to address the information systems controls material weakness identified during the FY 2009 CFO audit. We believe the results of our FY 2010 OMB Circular No. A-123, Appendix A self-assessment provides evidence to support our position that the CFO audit material weakness is reduced to a significant deficiency. Additionally, based on the results of the FY 2010 SAS 70 internal control audits of CMS claims administration contractors; CPICs submitted by CMS claims administration contractors; and FMFIA Self-Assessment Tracking and Reporting System (F-STARS) management self-assessments, CMS has concluded that no information systems controls material weakness exists because it was not found that there was a reasonable possibility that a material misstatement of CMS' financial statements would not be prevented, or detected and corrected on a timely basis.

The CMS is continuing to work diligently to address the systemic control deficiencies in information systems controls noted in the ***FY 2009 CMS Financial Report***. The CMS has enhanced and strengthened existing controls, as well as introduced a number of new controls. The CMS has introduced controls to enhance oversight of the information security by providing guidance and direction to the Medicare Contractors in development and implementation of configuration baselines standards. Additionally, CMS has established controls over application configuration management for shared systems by establishing enhanced processes for review, validation, and approval of shared system edits, as well as ensuring change control processes are in place for the auto adjudication software. Documentation for each shared system has been developed and reviewed. The CMS has instituted frequent on-site monitoring at the claims administration contractors to assess compliance with technical direction related to these issues from prior year audits.

The OMB Circular A-123, Appendix A assessment determined that the CMS claims administration contractors (MACs, carriers, and fiscal intermediaries), Enterprise Data Centers, and Shared System Maintainers have complied with the requirements of Joint Signature Memorandum (JSM) 09107 *Baseline Secure Configuration* as well as the control objectives delineated in the CMS Internet Only Manual (IOM), Publication 100-6, Chapter 7, *Medicare Financial Management Manual*, Control Objective Area A, Information Systems. These CMS contractors have demonstrated reasonable assurance in the areas of data access, configuration management, and in the general IT control environment as required by OMB Circular A-123.

IMPROPER PAYMENTS

In July 2010, Congress amended the Improper Payment Information Act (IPIA), which is now known as the Improper Payment Eliminations and Recovery Act (IPERA) (Public Law 111-204), to aim in standardizing the way Federal agencies report improper payments in programs they oversee or administer. The IPERA includes requirements for identifying and reporting improper

payments and defines improper payments as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments). Incorrect payments also include payments to ineligible recipients or payments for ineligible services, as well as duplicate payments and payments for services not received. Although CMS has not fully complied with the OMB's IPERA guidance, CMS has implemented comprehensive processes that measure the payment error rates for the Medicare FFS, Medicaid, CHIP, and Medicare Advantage programs. The CMS is continuing its initiatives to measure the payment error rate for the Medicare Prescription Drug program.

Medicare

The identification and reporting of improper payments has been in place for Medicare FFS since FY 1996 as a part of CMS' financial reporting. The Office of Inspector General estimated the Medicare FFS rate from 1996 through 2002. With the passage of the Improper Payments Act of 2002 (IPIA), CMS took responsibility for the error rate program beginning with fiscal year 2003. 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 IPERA requirement to report gross numbers.

The CMS analysis for FY 2010 indicated that the paid claims gross error rate was 10.5 percent or $34.3 billion in gross improper payments. In 2010, CMS continued to review claims according to a significantly revised and improved methodology implemented in 2009. As a result of these improvements and a more complete accounting of improper payments, the 2009 and 2010 overall error rates were higher than 2008; 12.4 percent and 10.5 percent in 2009 and 2010 respectively.

The HHS 2009 Agency Financial Report shows the Medicare FFS error rate as 7.8 percent or $24.1 billion in improper payments, which reflects the old review process used for most of the claims that year. The error rate for claims reviewed under the newer, and more stringent criteria was 12.4 percent, or $35.4 billion in improper payments in 2009. For purposes of setting an estimated baseline for future goals, CMS is using 12.4 percent as the 2009 improper payment rate.

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 2010 Gross Improper Payments and Error Rates in the Medicare FFS Program

		Gross	
Overpayments	Underpayments	Improper Payment Amount (Overpayments+ Underpayments)	Error Rate
$33.2 B	$1.1 B	$34.3 B	10.5%

Medicare Advantage and Prescription Drugs

The CMS has reported a Part C composite payment error rate since FY 2008, thus achieving IPERA compliance. The Part C composite payment error rate combines two component error rates into a single composite measure for total Part C payments: (1) the Medicare Advantage and Prescription Drug System (MARx) payment error (MPE) rate for Part C; and (2) the Part C risk adjustment error (RAE) rate. We will report an IPERA Part C composite payment error rate of 14.1 percent in the FY 2010 HHS Agency Financial Report (AFR).

CMS continues to progress toward achieving IPERA compliance for the Medicare Prescription Drug Benefit, a new Medicare benefit effective CY 2006. In FY 2010, CMS made significant strides toward this goal by preparing measurement methodologies for four components of a composite Prescription Drug (Part D) program payment error estimate, and reporting these estimates. For IPERA reporting in the FY 2010 HHS AFR, CMS calculated four components of payment error: (1) the MARx payment error (MPE) rate for Part D; (2) a Payment Error related to the Low Income Subsidy (PELS) payments; (3) a Payment Error related to Medicaid Status (PEMS); and (4) a Payment Error Related to Prescription Drug Event (PDE) Validation (PEPV). For FY 2010, the Part D MPE error rate is 0.10 percent, the PELS rate is 0.12 percent, the PEMs rate is 1.76 percent, and the PEPV rate is 12.8 percent.

Medicaid and CHIP

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

The CMS measured improper payments in Medicaid FFS, managed care and eligibility from FY 2009 is reported in HHS' FY 2010 AFR. The national Medicaid error rate is 9.4 percent, or $22.5 billion in gross improper payments, which reflects a three-year weighted average national error rate including data from 2008, 2009, and 2010. The weighted national error components rates are as follows: Medicaid FFS: 4.4 percent; Medicaid managed care: 1.0 percent; and Medicaid eligibility: 5.9 percent. However, as required under Section 601 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA P.L. 111-3), CMS published a final rule on August 11, 2010 which revised the PERM eligibility review to be consistent with state policies for eligibility validation. Based on current regulations, certain undetermined cases identified from 2008-2010 would no longer be included as errors.

Section 601 of CHIPRA had prohibited HHS from calculating or publishing any national or state-specific error rates for CHIP until six months after a new PERM final rule is in effect. The new final rule for PERM was effective on September 10, 2010; therefore, CMS is not reporting a national CHIP error rate in 2010 and 2011. However, CMS will begin CHIP measurement in 2010 and report an error rate in the FY 2012 AFR.

REVIEW OF MEDICARE'S PROGRAM FOR OVERSIGHT OF ACCREDITATION ORGANIZATIONS

SECTION 1: Overview

In order to be eligible to receive Medicare reimbursement, health care facilities must demonstrate compliance with Medicare Conditions of Participation (CoPs) or Conditions for Coverage (CfCs). Section 1865 of the Social Security Act (the Act) allows health care facilities to demonstrate this compliance through accreditation by an approved, private national Accreditation Organization (AO)[1]. The Centers for Medicare & Medicaid Services (CMS) has the responsibility for oversight and approval of the AOs' programs, and for ensuring that providers or suppliers that are accredited by the AO meet the quality and patient safety standards required by the Medicare CoPs or CfCs.[2] A thorough review of each AO is conducted by CMS including equivalency of their accreditation requirements, survey processes and procedures, training, oversight, and enforcement. Also reviewed are the qualifications of the surveyors, staff, and the AO's fiscal fitness. Upon approval, any provider or supplier accredited by the AO's approved program would be deemed to meet the Medicare conditions.

The CMS has a comprehensive approach to the review and approval of an AO's accreditation program and the ongoing oversight of AO activities. Currently CMS has approved accreditation programs for the following facility types: hospitals, critical access hospitals (CAHs), home health agencies (HHAs), hospices, and ambulatory surgery centers (ASCs)[3]. The primary goal of this review is to ensure that the AO's standards meet or exceed the Medicare CoPs or CfCs for each program type and that the organization has the capacity to adequately administer the program. During the past several years, CMS has implemented a comprehensive program to strengthen and enhance ongoing oversight of AOs including:

- Rigorous review of AO's programs to ascertain that the AO can adequately ensure that facilities comply with Medicare requirements (deeming application reviews),
- Building systems for AO reporting on their activities related to deemed facilities,
- Implementing measures which reflect each AO's compliance with administrative reporting requirements (performance measures); and
- Expanding the validation survey program which measures the effectiveness of the AO survey process in identifying areas of serious non-compliance with Medicare conditions.

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[1] Accreditation is voluntary and not required for Medicare participation provider entities covered by Section 1865. Accreditation by an approved, national AO is an alternative to being subject to certification and ongoing surveys by the State Agency. Note that "provider entities" does not include imaging centers or durable medical equipment suppliers, which are required to be accredited under Section 1834(a)(2) and Section 1834(e), respectively, of the Act. These accreditation programs are administered separately by CMS and are not covered by the Section 1875 reporting requirement.

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

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

Other Accompanying Information

In order to support this enhanced oversight, CMS has also strengthened and expanded existing administrative systems and processes over the past several years. Substantial improvements have been made to CMS' systems for monitoring AO survey activities and decisions including the following: building electronic systems for AOs to submit information; communicating detailed standards for AO data submissions; providing electronic mailboxes and explicit requirements for AO communications to CMS; and implementing formal performance measures to evaluate AO compliance and providing feedback to each AO on its performance. During the last year, the major CMS initiatives for administrative systems have been implementation of the electronic system for tracking AO activities, and use of more complex measures to monitor AO performance.

This report reviews AO activities and CMS oversight of recognized accreditation programs as follows:

- ***Scope of AO activities (Section 2)***: Describes the role of AOs in Medicare's deeming program and the changes in CMS' oversight of AOs required by Section 125 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).
- ***The CMS approval of accreditation programs (Section 3)***: Describes the process for CMS approval of AO deeming programs, including the applicable regulatory citations.
- ***AO survey activities and assessment of compliance (Section 4)***: Describes the fiscal year (FY) 2009 survey activities of each AO, the most recent application review by CMS for each AO program, as well as scores on administrative performance measures. The results indicate that performance on these administrative measures has improved but that further improvements for some measures are essential.
- ***Survey validation performance for each AO (Section 5)***: Describes the CMS program for validation of AO survey findings and gives performance results for FY 2008 and FY 2009 for each AO; results indicate some issues with the effectiveness of AO surveys in identifying areas of serious non-compliance with Medicare conditions over this time period.
- ***Planned improvements as reported by the AOs (Section 6)***: Presents each AO's self-report of its recent management improvement activities.
- ***The CMS' management and oversight of AOs (Section 7)***: Describes the changes CMS has made in its AO oversight activities.

SECTION 2: Scope of Accreditation Organization Medicare Deeming Programs

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

TABLE 1
Approved Accreditation Organization Programs (FY 2010)

	Hospital	Critical Access Hospital	Home Health Agency	Hospice	Ambulatory Surgery Center	Total
AAAHC					X	1
ACHC			X	X		2
AAAASF					X	1
AOA/HFAP	X	X			X	3
CHAP			X	X		2
DNVHC	X					1
JC	X	X	X	X	X	5
Total	3	2	3	3	4	15

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

These accreditation programs are responsible for assuring compliance with Medicare CoPs and CfCs for 34 percent of all Medicare-certified providers and suppliers in the five categories of institutional providers/suppliers for which there is an approved AO program, as described in Table 2. The AOs are responsible for monitoring compliance with health and safety standards for varying percentages of each facility type, ranging from a high of 82 percent for hospitals to a low of 15 percent for hospice providers. The total number of Medicare-certified institutional healthcare providers and suppliers in these five categories has increased from 24,752 in FY 2008 to 25,873 in FY 2009, a 5 percent increase. The majority of this growth has been in HHAs, which increased by 9 percent. Hospice providers and ASCs increased by 3 percent and 2 percent respectively, while the numbers of hospitals and CAHs were essentially unchanged.

The AOs charge fees to facilities that seek their accreditation, and generally offer facilities two accreditation options, accreditation alone or accreditation for Medicare deemed status. The CMS reviews, and approves or denies recognition of an accreditation program only for an AO's Medicare deemed status programs. Accordingly, this report addresses AO activity as it relates to accreditation with Medicare deemed status only.

TABLE 2
Medicare Certified Institutional Providers/Suppliers (FY 2009)

	Deemed* (percentage)	Non-Deemed** (percentage)	Total (percentage)
Hospital	4,055 (82)	876 (18)	4,931 (100)
CAH	391 (30)	923 (70)	1,314 (100)
HHA	2,555 (24)	8,266 (76)	10,821 (100)
Hospice	515 (15)	2,959 (85)	3,474 (100)
ASC	1,299 (24)	4,034 (76)	5,333 (100)
Total	8,815 (34)	17,058 (66)	25,873 (100)

*As reported by Accreditation Organizations

**Certified by a State Agency as complying with Medicare health and safety standards

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

During the past several years, there have been significant changes in the CMS accreditation deeming program based on Section 125 of MIPPA, enacted on July 15, 2008, which revised Sections 1861, 1865 and 1875 of the Act. The major provisions of Section 125 and subsequent implementation actions are as follows:

- The Joint Commission's (JC) longstanding, unique statutory deeming authority for hospitals was removed, effective July 15, 2010, and the JC may be recognized as a national accreditation body for hospitals based on terms and conditions required by the Secretary. Thus, the JC's hospital program is subject to the same requirements at 42 CFR Part 482 and Part 488, section 488.4 as any other AO accreditation program seeking deeming authority for hospitals. The JC submitted a complete application for renewal of hospital deeming authority on May 1, 2009. After reviewing that application, CMS concluded that the JC's requirements meet or exceed Medicare requirements. Therefore, the JC was approved as an accreditation organization for hospitals effective July 15, 2010 through July 15, 2014. Additional information on the conditions of approval is presented in Section 4 of this report.
- The JC was allowed a 24-month transition period. Therefore, hospitals awarded accreditation by the JC prior to July 15, 2010, continue to be recognized by CMS as having Medicare deemed status until their accreditation expiration date, and CMS approval of the JC's application permits further deemed status if the facility continues to be accredited.
- The CMS' required annual report to Congress on the oversight of accreditation programs was expanded to include all CMS-approved AO programs. Previously, the law required review of only the JC hospital program. The initial expanded annual report covering all AO programs was released in the fall 2009. This is the second expanded annual report to Congress.

SECTION 3: CMS Approval of Accreditation Organization Deeming Programs

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

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

In order to be granted deeming program approval by CMS, an AO must demonstrate its ability to ensure facilities' success at meeting or exceeding the Medicare CoPs or CfCs as cited in the CFR:

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

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

The regulations at 42 CFR 488.4 and 488.8 set forth the requirements an AO must satisfy in order to receive and maintain CMS recognition as a Medicare deeming program, as well as the procedures CMS follows in reviewing AO applications. Approval of an AO's Medicare deeming program is for a specified time period, with a six-year maximum. Renewal applications are subject to the same criteria and scrutiny as initial applications for approval of an AO's Medicare deeming program.

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

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

Once approved, subsequent changes in the AO's program standards and survey process must also be reviewed and approved by CMS to ensure that the accreditation deeming program requirements continue to meet or exceed Medicare requirements. The AO must notify CMS in writing of any proposed changes in its approved accreditation program at least 30 days in advance of the effective date of the changes. Additionally, when CMS adopts changes to the applicable CoPs or CfCs, or to its survey processes, the AO must submit documentation that it has revised its standards and/or survey process to comply with the new requirement(s) within 30 days of CMS' notification to the AO of the change(s). During this review process, an AO may be required to make changes in its accreditation processes in order to maintain or obtain status as a deeming program. Some AOs are given approval on a conditional basis and CMS will review the program during a probationary period in order to determine continued approval status. During FY 2008, 2009 and 2010 (as of August 2010), CMS completed 18 reviews which were published in the *Federal Register* covering all 15 currently operational deeming programs as follows:

- FY 2008: four deeming application reviews (including one initial application);
- FY 2009: ten deeming application reviews (including one conditional approval and one final approval removing conditional approval status); and
- FY 2010: six deeming application reviews as of August 2010 (including one initial application, two conditional approvals and two final approvals removing conditional approval status).

Section 4 of this report includes a *Federal Register* reference for the most recent deeming application approval for each AO program and summarizes the conditions for the most recent approvals.

SECTION 4: Review of Accreditation Organization Survey Activities and Performance

Section 4 reviews AO activities with primary emphasis on survey activities and measures of AO performance. The initial sections summarize the deemed survey activity and performance measure results across all AOs, followed by a section presenting the performance of individual AOs including:

- **AO Deeming Activities:** a review of each AO deemed program's survey activities and decisions during FY 2009.

- **Performance Measures:** performance of each AO in key focus areas between April 2009 and March 2010.
- **Review of Accreditation Programs:** information on the initial CMS approval and most recent approval for each AO program. For approvals published since September 2009, the summary includes a listing derived from the final approval notice concerning actions the AO took or agreed to take. These actions reflect areas of program weakness identified by CMS through its review process which the AO was required to correct.

Overview: Deemed Survey Activity

The AO is responsible for evaluating a facility through an on-site survey to determine whether the facility complies with the health care quality and patient safety standards required by the Medicare CoPs or CfCs. The AO may award accreditation in a Medicare deeming program for up to three years. The evaluation performed by the AO includes, but is not limited to: a review of the care processes in the facility, the physical environment, administrative and patient medical records, and staff qualifications. Table 3 presents a summary of the number of deemed facilities by AO in FY 2009 as well as the number of initial and renewal surveys completed during FY 2009, as reported by the AOs. An initial survey indicates a facility which is being reviewed by this AO for the first time (either a facility which is seeking new Medicare certification or changing from oversight by a SA or another AO).

TABLE 3
Number of Deemed Facilities, Initial, and Renewal Surveys for Each Accreditation Organization by Program Type (FY 2009)

Programs	Accreditation Organization	Total Deemed Facilities*	Initial Surveys	Renewal Surveys
Hospital	AOA/HFAP	170	22	42
	DNVHC	46	46	0*
	JC	3,839	66	1,299
Critical Access Hospital	AOA/HFAP	26	1	10
	JC	365	14	131
Home Health Agency	ACHC	363	220	6
	CHAP	1,101	460	205
	JC	1,091	482	102
Hospice**	CHAP	331	109	73
	JC	184	55	33
Ambulatory Surgery Center	AAAHC	951	205	290
	AAAASF	75	24	17
	AOA/HFAP	16	6	1
	JC	257	34	59

Source: As reported by Accreditation Organizations.

*DNVHC received initial approval of its hospital deeming program in FY 2009, and thus no renewal surveys were due in FY 2009.

**ACHC received initial approval of its hospice deeming program in FY 2010 and is not included.

Most AO Medicare deeming programs experienced significant growth during FY 2008-2009. This is likely attributable in part to CMS' prioritizing of the SAs' workload such that initial surveys for facilities that have a deeming program option are assigned a lower priority compared to complaint investigations and statutorily-required recertification surveys of certain existing providers. Because a number of SAs have been unable to complete their entire workload each

year due primarily to constrained resources), facilities seeking initial Medicare participation have used AO deeming programs to demonstrate their compliance with Medicare requirements in order to obtain a more timely review.

Overview: Performance Measures

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

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

- Implementation in FY 2010 of the ASSURE electronic data base to facilitate timely ongoing AO reporting on deemed status facility activities, after beta testing in FY 2009. The ASSURE application provides a means to collect, analyze, and manage data regarding the deemed facilities accredited by the AOs;
- Dedicated electronic mailboxes for submission to CMS copies of AO notification letters to facilities concerning their deemed status;
- Monthly submission of AO survey schedules to CMS;
- Quarterly submission to CMS of cumulative AO reports on facility deemed status, via a manually generated list in FY 2009, and electronically through ASSURE in FY 2010;
- Development and implementation of template AO notification letters to facilitate AO communication to CMS of all essential elements regarding a facility's accreditation status; and
- Analysis and feedback to AO's on the accuracy and completeness of their notification letters and deemed facility lists, including whether the listed facilities could be matched to facilities in CMS' national Medicare certification data base, and whether the facility lists were consistent with information in the notification letters.

Building on this foundation, formal AO performance measures were implemented in FY 2009 (October 2008) and modified in FY 2010 (October 2009). These basic measures relate to information and data submission requirements which have been a major area of focus in CMS' oversight activities with the AOs. The performance measures are presented in Table 4. These measures focus on the ability of AOs to provide consistent, accurate, complete and timely information related to their deemed status facilities. Such information is essential to support CMS' monitoring of both the health care facilities participating in Medicare via their deemed status and the AO's ability to oversee these facilities. The CMS monitors the AOs' performance on the measures and provides written, individual feedback to each AO on a quarterly basis.

TABLE 4
Performance Measures

ASSURE Data Base
AOs are required to use the ASSURE Electronic Data Base to submit a record of AO accreditation and enforcement activity.
- **Timeliness** of ASSURE export file submission
- **Accuracy and Completeness** of ASSURE export file
- **Deemed Facility Data** used to populate ASSURE is accurate and error free (FY 2010 only)
- **Timely Triennial Surveys** are conducted (FY 2010 only)
- **Participation** in required conference calls regarding ASSURE (FY 2009 only)

Facility Notification Letters
AOs are required to electronically submit facility notification letters for all deemed accreditation actions.
- **Electronic** mailbox use for submission of letters
- **Updating** facility list consistent with facility notification letters
- **Accuracy and Completeness** of letters submitted including: contain all information requested by CMS, effective dates of actions taken and follow-up actions, and no CMS follow-up required to clarify information

Survey Schedule
AOs are required to submit a monthly schedule which covers surveys completed in the past month as well as planned surveys for the next two months.
- **Timeliness** of monthly survey schedule report submission
- **Format** used for the survey schedule report
- **Accuracy and Completeness** of survey schedule report including: two prospective months and one past month, reporting changes in the survey schedule, inclusion of all programs for which the AO has deeming authority and exclusion of information for non-deemed providers/suppliers, no instances of arrival of the SA to conduct a validation survey and being informed that the accreditation survey had not been conducted as indicated on the survey schedule, and in FY 2010 whether the survey schedules changes are submitted on an ongoing basis

Deemed Facility List (FY 2009 only)
AOs are required to electronically submit a quarterly Excel spreadsheet list of all deemed facilities (in FY 2010 was superseded by requirement to update information in ASSURE).
- **Timeliness** of Facility List submission
- **Accuracy and Completeness** of facility list including: proper format, inclusion of all deemed programs, required data elements, inclusion of only deemed facilities, no duplicates, and correction of discrepancies previously identified by CMS

In October 2009, the ASSURE database was implemented for operational use after beta testing the system during FY 2009. This resulted in new measures for FY 2010 which allows more of an accurate reflection of the AO's compliance with reporting requirements. FY 2010 measures also include a measure of the AO's compliance with the requirement to survey each deemed facility every three years. The FY 2009 measures for a deemed facility list were replaced by a requirement to submit quarterly deemed facility updates electronically via the ASSURE data base.

Each measure is scored on a quarterly basis. For survey schedule measures, the quarterly score is calculated based on monthly scores. Measures are scored as Yes (100 percent)/No (0 percent) or as a percentage of correct submissions (e.g., the number of letters containing required information divided by the total number of letters received) for a specific month/quarter. The average performance scores for each AO are presented in Table 5 for the following time frames: April 2009 – March 2010 (Existing measures which did not change during the period); October 2009 – March 2010 (Measures that were newly implemented in October 2009); and, April 2009 – September 2009 (Measures that were discontinued after September 2009 based on implementation of ASSURE).

Other Accompanying Information

The 2009 annual report included performance scores for the January 2009 through June 2009 period. Many AOs have improved performance on these reporting measures since that initial reporting period. For example, all AOs consistently perform at the 100 percent level on the ASSURE measures for timeliness and accuracy for the April 2009-March 2010 timeframe (last two quarters of FY 2009 and first two quarters of FY 2010) as reported in Table 5. Scores for the October 2009-March 2010 timeframe show that other measures have also improved over earlier time periods (e.g., accuracy of facility notification letters and the format of survey schedules). However, substantial opportunities for further improvement remain related to these measures, particularly for updating ASSURE based on information contained in the notification. The performance rates for the first six months of FY 2010 ranged from a low of 32 percent for timeliness of data entry to 83 percent for timely conduct of triennial surveys and 90 percent for accuracy of data. The goal is for all AOs to consistently score at or near 100 percent on all measures.

TABLE 5
Performance Measure Results (Percentage) for Each Accreditation Organization (October 2009–March 2010)

Performance Measures	AAAHC	ACHC	AAAASF	AOA/ HFAP	CHAP	DNVHC	JC	ALL AOs
April 2009-March 2010 (Last two quarters of FY 2009 and first two quarters of FY 2010)								
Existing measures which did not change during the period								
ASSURE Data Base								
Timeliness	100	100	100	100	100	100	100	**100**
Accuracy	100	100	100	100	100	100	100	**100**
Facility Notification Letters								
Electronic	100	100	100	100	100	100	100	**100**
Survey Schedule								
Timeliness	75	100	84	92	100	100	100	**93**
Formatting	100	100	34	75	100	100	100	87
October 2009-March 2010 (First two quarters of FY 2010)								
Measures which were newly implemented in October 2009								
ASSURE Data Base								
Deemed facility data	94	91	85	100	89	96	93	**93**
Timely triennial surveys	85	99	74	63	95	NA	80	**83**
Facility Notification Letters								
Updating	16	0	0	0	53	98	58	**32**
Accuracy	72	81	90	100	92	100	92	**90**
Survey Schedule								
Accuracy	83	83	81	83	81	92	78	**83**
April 2009-September 2009 (Last two quarters of FY 2009)								
Measures which did not continue after September 2009 based on implementation of ASSURE								
ASSURE Data Base								
Participation	100	100	100	100	100	100	100	**100**
Facility Notification Letters								
Updating	32	33	42	50	45	100	50	**50**
Accuracy	22	33	33	33	50	100	28	**43**
Survey Schedule								
Accuracy	100	100	58	96	100	100	97	**93**
Deemed Facility List								
Timeliness	100	50	50	100	100	NA	100	**83**
Accuracy	79	79	72	73	81	NA	55	**73**

Individual Accreditation Organization Summaries

1. Accreditation Association for Ambulatory Health Care (AAAHC)

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

Accreditation Activity (Table 3): AAAHC has a CMS-approved Section 1865 accreditation program for ASCs and was responsible for 951 deemed facilities in FY 2009. During FY 2009, AAAHC reported completing a total of 495 deemed status surveys. Of these, 205 (41 percent) were initial surveys and 290 (59 percent) were re-accreditation surveys of ASCs already participating in Medicare. AAAHC uses the following types of accreditation decisions:

- ***Full Accreditation (three years):*** The organization is in substantial compliance with standards with no reservation about the accuracy of the survey findings or the facility's commitment to providing care consistent with standards;
- ***One Year Accreditation:*** Some of the organization's operations are acceptable and other areas need to be addressed; the organization must have a re-survey within ten months from the previous survey date;
- ***Six Month Accreditation:*** The organization is newly operational. The organization is in substantial compliance but is not well established; must have a re-survey within six months; and
- ***Denial:*** The organization is not in substantial compliance with standards. Facilities subjected to this type of decision are not recommended to CMS for deemed status.

AAAHC recommended full accreditation for 68 percent of the 495 ASCs it surveyed in FY 2009 and accreditation for a shorter period of time for 31 percent of the facilities surveyed.

Accreditation Decisions	Ambulatory Surgery Centers (percentage)
Total Surveys	495
Full Accreditation	335 (68)
1 Year Accreditation	89 (18)
6 Month Accreditation	62 (13)
Denial	9 (2)

Performance Measures (Table 5): AAAHC performs well on measures related to the ASSURE data base submission timeliness and accuracy in both FY 2009 and FY 2010. For the same four quarters, performance is also at the 100 percent level for electronic submission of facility notification letters and survey schedule format. Opportunities for improvement exist with the performance measures related to facility notification letters (updating ASSURE and accuracy) and survey schedules (timeliness and accuracy).

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

2. Accreditation Commission for Health Care (ACHC)

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

Accreditation Activity (Table 3): ACHC has a CMS-approved Section 1865 accreditation program for HHAs and hospices. The hospice program was recently approved and was not operational in FY 2009. ACHC had responsibility for 363 deemed HHAs in FY 2009. ACHC reported completing a total of 226 deemed status surveys, with 220 (97 percent) initial surveys and six (three percent) re-accreditation surveys. The following are the types of accreditation decisions ACHC uses:

- ***Full Accreditation (three years):*** The organization had very minimal or no deficiencies. Accreditation is granted upon receipt of an acceptable plan of correction (PoC) if deficiencies were cited during the survey;
- ***Deferral:*** Enough deficiencies that the organization did not score high enough for accreditation status. The organization will be provided an opportunity to submit a PoC. ACHC will conduct a revisit, as necessary, and grant accreditation when the organization is fully compliant. Facilities subjected to this type of decision are not recommended to CMS for deemed status; and
- ***Denial:*** Many severe deficiencies that cause an organization to be outside of the deferred range. In this instance, the organization is out of compliance with ACHC standards and must reapply for accreditation. Facilities subjected to this type of decision are not recommended to CMS for deemed status.

ACHC awarded a decision of full accreditation for 53 percent of the 226 HHAs surveyed in FY 2009.

Accreditation Decisions	Home Health Agencies (percentage)
Total Surveys	226
Full Accreditation	119 (53)
Deferral	74 (33)
Denial	33 (15)

Performance Measures (Table 5): ACHC performs well on measures related to the ASSURE data base timeliness and accuracy as well as electronic submission of facility notification letters in FY 2009 and 2010. For the same four quarters, performance is also at the 100 percent level for survey schedule timeliness and format. Opportunities for improvement exist with the performance measures related to facility notification letters (accuracy and updating ASSURE) and survey schedule accuracy.

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

Hospice
ACHC submitted an application for initial certification as a hospice program and was awarded a four-year term effective November 27, 2009 through November 27, 2013. The notice appeared

in the *Federal Register* on November 27, 2009, and may be accessed at **http://edocket.access.gpo.gov/2009/pdf/E9-28010.pdf**. The major provisions of the final notice are as follows:

- ACHC modified its survey report to clearly identify whether an identified deficient practice represented condition-level or standard-level noncompliance;
- ACHC revised its accreditation decision letters to ensure that they are accurate and contain all of the required elements for the CMS Regional Office to render a decision regarding the deemed status of an accredited hospice;
- ACHC modified its policies regarding timeframes for sending and receiving a PoC in accordance with section 2728 of the SOM;
- To meet the CMS requirements related to a PoC, ACHC amended its policies to ensure approved PoCs contain all elements specified in section 2728 of the SOM;
- To meet the requirements at § 488.28(a) and section 2726 of the SOM, ACHC developed and implemented new policies that require a written PoC for all deficiencies cited;
- ACHC revised its policies to ensure complaints triaged as immediate jeopardy, are investigated within 2 business days of receipt in accordance with the requirements at section 5075.9 of the SOM;
- To meet the requirements at § 418.3, ACHC revised its standards to include the definitions used in the Medicare hospice CoPs;
- To meet the requirements at § 418.52(a)(3), ACHC revised its standards to require that the hospice obtain the patient's or patient's representative signature confirming that he or she received a copy of the notice of rights and responsibilities;
- To meet the requirements at § 418.54(c)(8), ACHC revised its standards to require that the comprehensive assessment consider the patient's need for referrals and further evaluation by appropriate health professionals;
- To meet the requirements at § 418.58(d)(1), ACHC revised its standards to include the requirement that the hospice governing body determine the number and scope of performance improvement projects conducted annually;
- To meet the requirements at § 418.110(c), ACHC revised its standards to ensure the hospice maintains a safe physical environment free of hazards for patients, staff and visitors; and
- To meet the requirements at § 418.110(m)(15), ACHC revised its standards to require that hospices document in the patient clinical record: the one hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior; a description of the patient behavior and intervention used; alternatives or other less restrictive interventions attempted; the patient condition or symptom(s) that warranted the use of restraint and seclusion; and the patient response to the intervention(s) used, including the rationale for continued use of the intervention.

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

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

Accreditation Activity (Table 3): AAAASF has an approved Medicare deeming program for ASCs and was responsible for 75 deemed ASCs in FY 2009. AAAASF performed a total of 41 deemed status surveys during FY 2009. Of these, 24 (59 percent) were initial surveys and 17 (41 percent) were re-accreditation surveys. The types of accreditation decisions AAAASF uses are as follows:

- ***Full Accreditation (three years):*** The organization is in 100 percent compliance with all standards; and

- ***Denial:*** The organization does not meet full accreditation standards. Facilities subjected to this type of decision are not recommended to CMS for deemed status.

AAAASF awarded full accreditation to 95 percent of the 41 ASCs surveyed in FY 2009.

Accreditation Decisions	Ambulatory Surgery Centers (percentage)
Total Surveys	41
Full Accreditation	39 (95)
Denial	2 (5)

Performance Measures (Table 5): For all four quarters, AAAASF has performed well on measures related to timeliness of submission and accuracy for the ASSURE data base and electronic submission of facility notification letters. Opportunities for improvement remain for ASSURE measures (timely triennial surveys and submission of deemed facility data), updating ASSURE for facility notification letters, and survey schedule formatting and accuracy.

Approval of Accreditation Programs: AAAASF initially received recognition as a national AO for ASCs on December 2, 1998. AAAASF submitted a renewal application in March 2009. CMS reviewed that application and awarded a three year conditional approval with a 180 day probationary period. The final notice appeared in the *Federal Register* on November 27, 2009, and may be found at **http://edocket.access.gpo.gov/2009/pdf/E9-28048.pdf**. The major provisions of that notice are as follows:

- To meet the requirements at § 416.2, AAAASF revised their standards to include the current definition of an ASC;
- To meet the requirements at § 416.41(a), AAAASF revised their standards to ensure contracted services of an ASC are provided in a safe and effective manner;
- To meet the requirements at § 416.41(b)(2) and 416.41(b)(3), AAAASF revised their standards to ensure that an ASC has a transfer agreement with a local Medicare participating hospital and a procedure for transferring patients with emergency needs to a Medicare hospital, or a nonparticipating hospital that meets the requirements for payment at § 482.2;
- To meet the requirements at § 416.41(c)(1), AAAASF revised their standards to ensure ASCs maintain a written disaster preparedness plan;
- To meet the requirements at § 416.42, AAAASF revised their standards to ensure surgical procedures provided in the ASC are performed in a safe manner;
- To meet the requirements at § 416.42(a)(1), AAAASF revised their standards to require a physician examine a patient to evaluate the risk of anesthesia and the procedure to be performed immediately before surgery;
- To meet the requirements at § 416.44(a), AAAASF revised their standards to include the requirement that ASCs provide a functional and sanitary environment for the provision of surgical services;
- To meet the requirements at § 416.44(b)(5)(iii), AAAASF revised their standards to require alcohol-based hand rub dispensers be installed in a manner that adequately protects against inappropriate access;
- To meet the requirements at § 416.44(c), AAAASF revised their standards to ensure that ASCs that utilize an automated external defibrillator (AED) have policies and procedures to indicate an AED is sufficient given the patient population and types of procedures

performed. In addition, AAAASF revised their standards to include the requirement that emergency medical equipment and supplies be available in the operating room;

- To meet the requirements at § 416.46, AAAASF revised their standards to ensure the nursing services of the ASC are directed and staffed to meet all of the patient's nursing needs;
- To meet the requirements at § 416.47 (b), AAAASF revised their standards to include the requirement that every medical record must be accurate and promptly completed;
- To meet the requirements at § 416.47(b)(2), AAAASF revised their standards to require medical records include a significant medical history and results of physical examination;
- To meet the requirements at § 416.49, AAAASF revised their standards to require ASCs that do not provide laboratory services to have procedures for obtaining laboratory services;
- To meet the requirements at § 416.49(b)(1), AAAASF revised their standards to include the requirement that ASCs have procedures for obtaining radiologic services;
- To meet the requirements at § 416.49(b)(2), AAAASF revised their standards to ensure that radiologic services provided in an ASC meet the hospital CoPs for radiologic services specified at § 482.26;
- To meet the requirements at § 416.50, AAAASF revised their standards to include the requirement that an ASC must inform the patient of his or her rights;
- To meet the requirements at § 416.50(b) through § 416.50(d) AAAASF revised their standards to include patient's rights requirements;
- To meet the requirements at § 416.51(a), AAAASF revised their standards to include the requirement that ASCs provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice;
- To meet the requirements at § 416.51(b), AAAASF revised their standards to ensure ASCs maintain an infection control and prevention program;
- To meet the requirements at § 416.52, AAAASF revised their standards to include the requirements that ASCs must ensure each patient has the appropriate pre- and postsurgical assessments completed and that all elements of the discharge requirements are completed;
- To meet the requirements at § 488.4(a)(4), AAAASF developed and implemented internal monitoring procedures to ensure their surveyors are trained and qualified;
- To eliminate any real or perceived conflict of interest between AAAASF's accreditation activities and the financial, consulting and professional activities of AAAASF's surveyors, AAAASF developed and implemented policies and procedures that adequately address conflicts of interest issues for surveyors;
- To meet the requirements at § 488.6(a), AAAASF developed an action plan to ensure that its deemed status survey files are complete, accurate, and consistent;
- To meet the requirements at SOM 2200F, AAAASF revised its survey report to ensure the documentation of cited deficiencies contains a regulatory reference, a clear and detailed description of the deficient practice, and relevant findings;
- To meet the requirements at § 488.20(b) and § 488.28(a), AAAASF developed a policy to ensure that facilities with condition-level noncompliance on a reaccreditation survey submit an acceptable PoC and receive a follow-up onsite focused survey;
- To meet the requirements at § 489.13, AAAASF modified its policies related to the accreditation effective date for new providers;

- AAAASF developed a policy regarding condition-level noncompliance identified during an initial certification survey for participation in Medicare in accordance with section 2005A2 of the SOM;
- To meet the requirements at section 2728 of the SOM, AAAASF modified its policies regarding timeframes for sending and receiving a PoC;
- To meet our requirements related to a PoC, AAAASF amended its policies to ensure approved PoCs contain all elements specified in section 2728 of the SOM;
- To meet the requirements at section 2700A of the SOM, AAAASF developed and implemented new policies and procedures that ensure all surveys are unannounced;
- AAAASF revised its policies to ensure timeframes for investigation of complaints are consistent with the requirements at section 5075.9 of the SOM;
- AAAASF revised its accreditation decision letters to ensure that they are accurate and contain all the required elements for the CMS Regional Office to render a decision regarding the deemed status of an accredited ASC;
- To meet the requirements at § 488.20(b)(1), AAAASF revised its policies to allow resurveys of a provider as frequently as necessary to ascertain compliance and confirm correction of deficiencies;
- AAAASF revised its policies to require that all deficiencies identified during a deemed survey visit be cited and documented, including deficiencies corrected onsite at the time of survey; and
- To ensure AAAASF surveyors are properly trained and can effectively apply knowledge and skills acquired in training, AAAASF expanded its surveyor training program to include a Medicare surveyor handbook, comprehensive interpretive guidelines, random validation surveys to assess surveyor performance, and an onsite preceptor training and evaluation program.

In accordance with the requirements at § 488.8(f)(3)(i), when CMS determines that an AO failed to adopt requirements comparable to CMS requirements during the review of an application for deeming authority, CMS may grant a conditional approval of an AO's deeming program for a period of up to 180 days, during which the AO is expected to adopt comparable requirements. During the 180 day probationary period, CMS conducted a comparison of AAAASF's accreditation requirements for ASCs to the current Medicare CfCs as outlined in the SOM. The CMS also conducted a corporate onsite visit and survey observation to validate proper application of the requirements. AAAASF made the necessary revisions to its program and successfully implemented new requirements to ensure AAAASF's accreditation program for ASCs meets or exceeds the Medicare requirements. On August 20, 2010, CMS published its decision to approve AAAASF's ASC program without condition. This final notice of approval is effective November 27, 2009 through November 27, 2012, and can be accessed at **http://edocket.access.gpo.gov/2010/pdf/2010-19888.pdf**. The major provisions of the final notice are as follows:

- AAAASF's internal survey files were complete, accurate, and consistent with the requirements at § 488.6(a);
- AAAASF's data submissions were accurate, complete and timely in accordance with the requirements at § 488.4(b);
- AAAASF revised its accreditation decision letters to ensure they are accurate and contain all of the elements necessary for the Regional Office to render a decision regarding the deemed status of an accredited ASC;
- AAAASF revised its policies to require its surveyors to use its surveyor tools thus ensuring accurate and complete survey files;

- AAAASF developed surveyors tools to include a medical record review sheet, personnel review sheet, and policy review to assist surveyors with accurate, and complete documentation;
- To meet the Medicare requirements related to unannounced surveys at section 2700A of the SOM, AAAASF modified its policies related to the survey window in which organizations could receive an accreditation survey for deemed status;
- To meet the survey process requirements in Appendix L of the SOM, AAAASF developed a policy outlining the minimum number of medical records that must be reviewed during a certification survey;
- To meet the requirements at SOM section 2200F, AAAASF revised its policies and procedures to ensure documentation of deficiencies contains a regulatory reference, a clear and detailed description of the deficient practice, and relevant finding;
- To meet the requirements at section 2728 of the SOM, AAAASF modified its policies regarding timeframes for sending and receiving a PoC for life safety code surveys; and
- To ensure its surveyors were adequately trained, AAAASF developed a website where surveyors could access a resource library of training webinars, interpretative guidelines, principles of documentation, standards, surveyor handbook, survey forms and other materials to assist surveyors in the field.

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

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

Accreditation Activities (Table 3): AOA/HFAP has CMS-approved accreditation programs for hospitals, CAHs and ASCs. AOA/HFAP was responsible for the following number of deemed facilities in FY 2009: 170 deemed hospitals, 26 deemed CAHs, and 16 deemed ASCs. During FY 2009, AOA/HFAP performed:

- 64 deemed status hospital surveys including 22 (34 percent) initial surveys and 42 (66 percent) re-accreditation surveys;
- 11 deemed status surveys for CAHs including 1 (9 percent) initial surveys and 10 (91 percent) re-accreditation surveys; and
- 7 deemed status surveys for ASCs including 6 (86 percent) initial surveys and 1 (14 percent) re-accreditation survey.

The types of accreditation decisions used were as follows:

- ***Accreditation with Resurvey within three years***: The healthcare facility meets the AOA/HFAP accreditation requirements in all performance areas;
- ***Accreditation with Interim Progress Report***: The healthcare facility generally meets the standards, but certain areas require ongoing monitoring to ensure continued compliance. Evidence of continued compliance for a specified period of time, not to exceed twelve months, must be submitted to AOA/HFAP in order to remain accredited; and
- ***Denial of Accreditation:*** The healthcare facility has been denied accreditation because it does not meet AOA/HFAP requirements. Facilities subjected to this type of decision are not recommended to CMS for deemed status.

AOA/HFAP awarded full accreditation for 100 percent of the 64 hospitals surveyed, 91 percent of the 11 CAHs reviewed and 100 percent of the 7 ASCs reviewed.

Accreditation Decisions	Hospitals (percentage)	Critical Access Hospitals (percentage)	Ambulatory Surgery Centers (percentage)
Total Surveys	64	11	7
Full Accreditation	64 (100)	10 (91)	7 (100)
Accreditation/Interim Progress Report	0	1 (9)	0
Denial	0	0	0

Performance Measures (Table 5): For four quarters, AOA/HFAP performs well on ASSURE measures for timeliness and accuracy and the electronic submission of facility notification letters. In FY 2010, performance is also at the 100 percent level for the new ASSURE measure for deemed facility data. There is also 100 percent performance for the facility notification letter measure for accuracy in FY 2010. Opportunities for improvement exist for timely triennial surveys and updating ASSURE for facility notification letters and survey schedule timeliness and accuracy.

Approval of Accreditation Programs:

Hospital

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

To verify AOA/HFAP's continued compliance with the provisions of this final notice, CMS conducted a follow-up corporate onsite visit in August 2010, and found that problems previously identified remained uncorrected. Subsequently, CMS opened a formal review of AOA/HFAP's hospital deeming authority for this and other reasons.

Critical Access Hospital

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

Ambulatory Surgery Center

AOA/HFAP received initial recognition by CMS as a national AO for ASCs on January 30, 2003. More recently, AOA/HFAP received approval for renewal of its ASC deeming program effective October 23, 2009 through October 23, 2013. The final notice announcing this approval was published in the *Federal Register* on September 25, 2009, and can be accessed at **http://edocket.access.gpo.gov/2009/pdf/E9-22956.pdf**. The major provisions of the final notice are as follows:

- AOA/HFAP modified its policies related to the accreditation effective date in accordance with the requirements at § 489.13;
- AOA/HFAP modified its policies regarding timeframes for sending and receiving a PoC in accordance with section 2728 of the SOM;
- AOA/HFAP revised its policies to include timeframes for investigation of complaints in accordance with the requirements at section 5075.9 of the SOM;

- AOA/HFAP developed and implemented internal monitoring procedures to ensure its surveyors are trained and qualified to meet the requirements at § 488.4(a)(4);
- AOA/HFAP developed an action plan to ensure that internal deemed status survey files are complete, accurate, and consistent with the requirements at § 488.6(a);
- AOA/HFAP developed and conducted surveyor training on the documentation of deficiencies to ensure that all cited deficiencies contain a regulatory reference, a clear and detailed description of the deficient practice, and relevant finding;
- AOA/HFAP developed a policy to ensure that facilities with condition-level non-compliance on a reaccreditation survey submit an acceptable PoC, and receive a follow-up onsite focused survey, in order to meet the requirements at § 488.20(b) and § 488.28(a);
- AOA/HFAP revised its policies and developed an internal tracking tool to ensure that facilities with condition-level non-compliance on an initial survey receive an onsite follow-up full survey, in order to meet the requirements at section 2005A2 of the SOM;
- AOA/HFAP developed and incorporated measures to improve the accuracy and consistency of data submissions to CMS in order to meet the requirements at § 488.4(b);
- AOA/HFAP revised its policies on blackout dates to meet the requirements at section 2700A of the SOM;
- AOA/HFAP revised its accreditation decision letters to ensure that they are accurate and contain all the required elements for the CMS Regional Office to render a decision regarding the deemed status of an accredited ASC;
- AOA/HFAP revised and updated its surveyor team handbook to include references to its ASC deeming program;
- AOA/HFAP extended its onsite survey time allotted for review of the CfCs from 1 day to 2 days in order to meet the requirements at § 488.26; and
- AOA/HFAP removed all references to mandatory consultative services from its policies to avoid a potential conflict of interest issue.

To verify AOA/HFAP's continued compliance with the provisions of this final notice, CMS conducted a follow-up corporate onsite visit in August 2010 and found that problems previously identified remained uncorrected. Subsequently, CMS opened a formal review of AOA/HFAP's ASC deeming authority for this and other reasons.

5. Community Health Accreditation Program (CHAP)

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

Accreditation Activity (Table 3): CHAP has CMS-approved accreditation programs for HHAs and hospices. CHAP was responsible in FY 2009 for 1,101 deemed HHAs and 331 deemed hospice providers. In FY 2009, CHAP conducted a total of 665 HHA surveys. Of these, 460 (69 percent) were initial surveys and 205 (31 percent) were re-accreditation surveys. In FY 2009, CHAP conducted a total of 182 hospice surveys. Of these, 109 (60 percent) were initial surveys and 73 (40 percent) were re-accreditation surveys. The types of accreditation decisions are as follows:

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

CHAP awarded accreditation for 99 percent of the 665 HHAs and 99 percent of the 182 hospice providers surveyed.

Accreditation Decisions	Home Health Agencies (percentage)	Hospices (percentage)
Total Surveys	665	182
Full Accreditation	661 (99)	181 (99)
Denials	4 (1)	1 (1)

Performance Measures (Table 5): CHAP performs well on ASSURE measures for timeliness and accuracy and the facility notification letter measure for electronic submission for FY 2009 and 2010. Performance is also at the 100 percent level for survey schedule timeliness and format over the same time period. Opportunities for improvement exist for updating ASSURE for facility notification letters and accuracy of survey schedule submission.

Approval of Accreditation Programs:

Home Health Agency

CHAP initially received CMS recognition as a national AO for HHAs on August 27, 1992. Most recently, CHAP received a 4-year renewal term, effective March 31, 2008 through March 31, 2012. The final notice announcing this decision was published in the *Federal Register* on March 28, 2008, and can be accessed at **http://edocket.access.gpo.gov/2008/pdf/E8-5073.pdf**. As part of this review, CMS conducted a follow-up corporate onsite one year following the publication of the final notice to assess CHAP's compliance with its own policies and procedures.

In the spring of 2009, CMS opened a formal review of CHAP's HHA deeming authority for several reasons. When CMS conducted its follow-up corporate onsite, it found that numerous problems previously identified remained uncorrected. In addition, perhaps as a result of its focus on conducting initial surveys during FY 2008, CHAP failed to conduct renewal surveys of its already-deemed HHAs as the expiration of their deemed accreditation approached or passed. The CMS completed its formal review on February 19, 2010, and determined that CHAP had fully addressed and resolved these concerns. CHAP's HHA program meets or exceeds the Medicare requirements.

Hospice

CHAP received initial recognition from CMS as a national AO for hospices on April 20, 1999. More recently, CHAP submitted a renewal application for the hospice deeming program in April 2009. CMS reviewed that application and awarded a three-year conditional approval with a 180-day probationary period. The final notice appeared in the *Federal Register* on October 23, 2009, and may be found at **http://edocket.access.gpo.gov/2009/pdf/E9-25072.pdf**. The major provisions of that approval are as follows:

- CHAP modified its policies related to the accreditation effective date in accordance with the requirements at § 489.13;
- CHAP amended its policies to include required timeframes for investigation of complaints in accordance with the requirements at section 5075.9 of the SOM;
- CHAP developed a policy to ensure facilities with condition-level non-compliance on a recertification survey submit an acceptable PoC, and receive a follow-up focused survey, in order to meet the requirements at § 488.20(a) and § 488.28(a);
- CHAP modified its policies surrounding timeframes for sending and receiving PoCs, and to ensure that approved PoCs contain all required elements to meet Medicare requirements at section 2728 of the SOM;
- CHAP developed and incorporated measures to improve the accuracy and consistency of data submissions to CMS, in order to meet the requirements at § 488.4(b);
- CHAP developed an action plan to ensure that internal deemed status survey files are complete, accurate, and consistent with the requirements at § 488.6(a);

Other Accompanying Information

- CHAP developed an action plan to ensure reaccreditation surveys are conducted no later than 36 months after the date of the previous standard survey, in order to meet the requirements at § 488.20(a);
- CHAP amended its policies by eliminating recommendations from the written survey findings, in order to meet the requirements at § 488.28(a) and section 2726 of the SOM;
- CHAP revised its standards to include the definitions used in the revised Medicare hospice CoPs set out at § 418.3;
- CHAP revised its standard to address the requirement that investigations and/or documentation of alleged violations must be conducted in accordance with established procedures, in order to meet the requirements at § 418.52(b)(4)(ii);
- CHAP revised its standards to include the requirement that the hospice document the patient's need for psychosocial, emotional and spiritual care as part of the comprehensive assessment, in order to meet the requirements at § 418.54;
- CHAP revised its standard to include the word "individualized", to meet the requirements at § 418.56(b);
- CHAP revised its standards to address the requirement that the Quality Assessment and Performance Improvement (QAPI) program be capable of showing improvement in hospice services, in order to meet the requirements at § 418.58(a)(1);
- CHAP revised its standards to address the requirement that patient care quality data be included in the QAPI program, in order to meet the requirements at § 418.58(b)(1);
- CHAP revised its standards to address the requirement that the hospice's performance improvement activities must affect palliative outcomes, patient safety, and quality of care, in order to meet the requirements at § 418.58(c)(1)(iii);
- CHAP revised its standards to include the requirement that the number of performance improvement projects must reflect the scope, complexity and past performance of the hospice's services and operations, in order to meet the requirements at § 418.58(d)(1);
- CHAP revised its standards to include the requirement that the hospice's infection control program protect patients, families, visitors and hospice personnel by preventing and controlling infections and communicable diseases, in order to meet the requirements at § 418.60;
- CHAP revised its standards to address the requirement that the infection control program is an integral part of the QAPI program, in order to meet the requirements at § 418.60(b)(1);
- CHAP revised its standards to address the requirement that the hospice's infection control program include a method for identifying infectious and communicable disease problems, in order to meet the requirements at § 418.60(b)(2)(i);
- CHAP revised its standards to address the requirement that the hospice's infection control program include a plan for implementing the appropriate actions that are expected to result in improvement and disease prevention, in order to meet the requirements at § 418.60(b)(2)(ii);
- CHAP revised its standards to include language to address the CMS waiver requirements for physical therapy, occupational therapy, speech-language pathology and dietary counseling in non-urbanized areas, in order to meet the requirements at § 418.74;
- CHAP revised its standards to ensure that the hospice aide training program addressed the requirements of reading, writing and verbally reporting clinical information to patients, caregivers, and other hospice staff, in order to meet the requirements at § 418.76(b)(3)(i);

- CHAP revised its standards to require the hospice aide training program include instruction in appropriate and safe techniques in performing personal hygiene and grooming tasks, in order to meet the requirements at § 418.76(b)(3)(ix)(A) through (F), and § 418.76(b)(3)(x) through (xiii);
- CHAP revised its standards to include the requirement that hospice aide in-service training be supervised by a registered nurse, in order to meet the requirements at § 418.76(d)(1);
- CHAP revised its standards to require a registered nurse, who is a member of the interdisciplinary group, assign patients to hospice aides, in order to meet the requirements at § 418.76(g)(1);
- CHAP revised its standards to address the requirement that hospice aide assignment be ordered by the interdisciplinary group, in order to meet the requirements at § 418.76(g)(2)(i);
- CHAP revised its standards to ensure that the supervising registered nurse assesses an aide's ability to comply with infection control policies and procedures, in order to meet the requirements at § 418.76(h)(3)(iv);
- CHAP revised its standards to ensure the supervising registered nurse assess an aide's ability to report changes in the patient's condition, in order to meet the requirements at § 418.76(h)(3)(v);
- CHAP revised its standards to ensure that the hospice continually monitors and manages all services provided at all locations so that each patient and family receives the necessary care and services, in order to meet the requirements at § 418.100(f)(2);
- CHAP developed a surveyor tool that includes the requirement to review three new hires for documentation of training and competency on the use of restraints and seclusions, in order to meet the requirements at § 418.110(n)(4);
- CHAP revised its standards to ensure all entries in the medical record are legible and appropriately authenticated, in order to meet the requirements at § 418.104(b);
- CHAP revised its standards to ensure necessary medical appliances and durable medical equipment are provided by the hospice, in order to meet the requirements at § 418.106;
- CHAP revised its standards to address the hospice's responsibility to provide adequate staffing to ensure the plan of care outcomes are achieved and negative outcomes are avoided, in order to meet the requirements at § 418.110(a);
- CHAP added new standards to address CMS' ability to waive space and occupancy requirements for facilities occupied by a Medicare-participating hospices on December 2, 2008, in order to meet the requirements at § 418.110(f)(4)(i) through (ii); and
- CHAP revised its accreditation decision letters to ensure they are accurate and contain all the required elements necessary for the CMS Regional Office to render a decision regarding deemed status of a hospice.

In accordance with the requirements at § 488.8(f)(3)(i), when CMS determines that an AO failed to adopt requirements comparable to CMS requirements during the review of an application for deeming authority, CMS may grant a conditional approval of an AO's deeming program for a period of up to 180 days, during which the AO is expected to adopt comparable requirements. CHAP received a conditional approval with 180 day probationary period because review of CHAP's application for renewal of hospice deeming authority revealed an inability to provide accurate and timely data on deemed providers, lack of complete and accurate deemed facility survey files, and failure to ensure that recertification surveys are conducted on an interval not exceeding 36 months.

During the 180 day probationary period, CHAP made the necessary revisions to its program and successfully implemented new requirements to ensure CHAP's accreditation program for hospices meet or exceed the Medicare requirements. On July 16, 2010, CMS published the decision to approve CHAP's hospice program without condition. This final notice of approval

is effective November 20, 2009 through November 20, 2012, and can be accessed at **http://edocket.access.gpo.gov/2010/pdf/2010-17405.pdf**. The major provisions of the final notice are as follows:

- CHAP's internal survey files were complete, accurate, and consistent with the requirements at § 488.6(a);
- CHAP's reaccreditation surveys for hospices are conducted no later than 36 months after the date of the previous standard survey in accordance with the requirements at § 488.20(a);
- CHAP's data submissions were accurate, complete, and timely in accordance with the requirements at § 488.4(b);
- CHAP met the requirements at section 2728 of the SOM by developing an electronic plan of correction that specifically addressed the "who, what, when, and how" the hospice would correct each deficiency cited and ensure ongoing compliance;
- CHAP met the requirements at § 488.28(a) and section 2728 of the SOM as evidenced by review of the survey files; and
- CHAP's policy regarding establishment of an accreditation effective date for new providers is consistent with the requirements at § 489.13.

6. Det Norske Veritas Health Care (DNVHC)

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

Accreditation Activities (Table 3): DNVHC received initial recognition as a national AO for their hospital program on September 29, 2008. During FY 2009, DNVHC conducted 46 initial surveys. The types of accreditation decisions are as follows:

- ***Full Accreditation:*** An organization is currently compliant or has provided corrective action plan(s) to address any nonconformity identified during the survey process, and has provided objective evidence as required to verify corrective action plans have been implemented and determined to be effective; and
- ***Denial:*** An organization has failed to meet the DNVHC requirements. Facilities subjected to this type of decision are not recommended to CMS for deemed status.

DNVHC awarded full accreditation to 100 percent of the 46 hospitals surveyed.

Accreditation Decisions	Hospitals (percentage)
Total Surveys	46
Full Accreditation	46 (100)
Denial	0

Performance Measures (Table 5): DNVHC performed at 100 percent for most measures during the four quarters reported. As a more recently CMS-approved AO, DNVHC used the ASSURE data base exclusively in FY 2009 to submit deemed facility data. Therefore, DNVHC is not scored on the FY 2009 deemed facility list measures. Since no triennial surveys were due, this measure is not scored.

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

7. The Joint Commission (JC)

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

Accreditation Activities (Table 3): The JC has CMS-approved deeming programs for hospitals, CAHs, HHAs, hospices and ASCs. During FY 2009, the JC was responsible for 3,839 deemed hospitals, 365 deemed CAHs, 1091 deemed HHAs, 184 deemed hospice providers, and 257 deemed ASCs. During FY 2009, the JC performed:

- 1,365 deemed status hospital surveys with 66 (5 percent) initial surveys and 1,299 (95 percent) re-accreditation surveys;
- 145 deemed status CAH surveys with 14 (10 percent) initial surveys and 131 (90 percent) re-accreditation surveys;
- 584 deemed status HHA surveys with 482 (83 percent) initial surveys and 102 (17 percent) re-accreditation surveys;
- 88 deemed status surveys for hospice providers with 55 (62 percent) initial surveys and 33 (38 percent) re-accreditation surveys; and
- 93 deemed status surveys for ASCs with 34 (37 percent) initial surveys and 59 (63 percent) re-accreditation surveys.

The JC used the following types of accreditation decisions:

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

Table 6 lists the outcomes of the JC accreditation decisions by provider type: 1,365 hospital surveys with 100 percent resulting in either full accreditation or accreditation with requirements for improvements; 145 CAH surveys with 100 percent approved for accreditation with

improvement requirements; 584 HHA surveys with 100 percent approved for full accreditation or accreditation with improvement requirements; 88 hospice surveys with 100 percent awarded full accreditation or accreditation with improvement requirements; and 93 ASC surveys with 100 percent awarded full accreditation or accreditation with improvements.

TABLE 6
The Joint Commission's Facilities and Accreditation Decisions (FY 2009)

Accreditation Decisions	Hospitals	Critical Access Hospitals	Home Health Agencies	Hospices	Ambulatory Surgery Centers
Total Surveys	1,365	145	584	88	93
Full Accreditation	4	0	29	5	5
Accreditation w/ Improvement Requirements	1,361	145	555	83	88
Conditional Accreditation*	20	2	38	0	0
Preliminary Denial*	1	0	2	0	0
Denial	0	0	0	0	0

*The Conditional Accreditation and Preliminary Denial counts reflect stages in the JC accreditation status review process. Therefore, these numbers are not included in Total Surveys. (Source: The JC)

Performance Measures (Table 5): The JC performed at the 100 percent level for FY 2009 and 2010 on the ASSURE data base measures for timeliness and accuracy as well as survey schedule measures for timeliness and format. Opportunities exist for improving performance on timely triennial surveys and updating ASSURE for the facility notification letters and accuracy of survey schedules.

Approval of Accreditation Programs:
Hospital
As previously noted, the JC's unique statutory deeming authority for hospitals was removed by Section 125 of MIPPA. The JC submitted an application to CMS for recognition of its hospital deeming program February 2009. The CMS reviewed that application and awarded a four-year approval effective July 15, 2010 through July 15, 2014. In order to insure compliance with the provisions of the notice, CMS will conduct a follow-up onsite visit and survey observation within one year of the effective date of the approval. The notice of approval appeared in the *Federal Register* on November 27, 2009, and may be found at **http://edocket.access.gpo.gov/2009/pdf/E9-27973.pdf**. The major provisions of the notice are as follows:

- To meet the requirements at § 482.12(a)(2) and § 482.22(c)(4), the JC revised its elements of performance (EPs) to require that all licensed independent practitioners who provide for the patient's care, treatment ,and services in an accredited hospital via telemedicine are credentialed and privileged at the originating site. If the distant site is a Medicare-participating hospital, the originating site's medical staff may use a copy of the distant site's credentialing packet for privileging purposes. This packet includes all credentialing documents, a list of all privileges granted to the licensed independent practitioner by the distant site, and an attestation signed by an appropriate official of the distant-site hospital, indicating that the packet is complete, accurate, and up-to-date. (Implementation of this revision was delayed until March 1, 2011, at CMS' request, to avoid undue disruption to JC-accredited hospitals' operations, since CMS published

a notice of proposed rulemaking on May 26, 2010, that would change CMS' requirements for credentialing and privileging of telemedicine practitioners. Pursuant to CMS' final rule, survey guidance for both accredited and non-accredited facilities will need to be revised);

- To meet the requirements at § 482.12(a)(7), the JC added a note to its EPs to clarify that an accredited hospital's staff membership and/or professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty board or society;
- To meet the requirements at § 482.12(c)(4), the JC revised its EPs to require that in all accredited hospitals, a doctor of medicine or osteopathy is responsible for the care of each Medicare patient's medical or psychiatric problem;
- To meet the requirements at§ 482.12(e), the JC revised its EPs to require that an accredited hospital's governing body be responsible for the oversight of contracted services;
- To meet the requirements at § 482.12(f)(1), the JC revised its EPs to ensure emergency services provided at an accredited hospital comply with CMS requirements set out at § 482.55;
- To meet the requirements at § 482.13(a)(1), the JC revised its EPs to address an accredited hospital's responsibility to notify patients of their rights;
- To meet the requirements at § 482.13(a)(2)(iii), the JC revised its EPs to require the written notice provided by accredited hospitals to patients in the grievance process contain the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance, and the date of completion;
- To meet the requirements at § 482.13(b)(2), the JC revised its EPs to include the requirement that patients in accredited hospitals have the right to make informed decisions about their care; however, this right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate;
- To meet the requirement at § 482.13(b)(4), the JC revised its EPs to include the requirement that the patient in an accredited hospital has the right to have a family member or representative of his or her choice and his or her own physician notified promptly of his or her admission to the hospital;
- To meet the requirements at § 482.21, the JC revised its EPs to require that an accredited hospital develop and maintain an on-going QAPI program;
- To meet the requirements at § 482.21(b)(3), the JC revised its EPs to require an accredited hospital's governing body to specify the frequency and detail of data collection for the QAPI program;
- To meet the requirements at § 482.21(c)(2), the JC revised its EPs to require that an accredited hospital's performance improvement activities improve patient safety;
- To meet the requirements at § 482.21(d)(3), the JC amended its survey process activities to include review of the hospital's performance improvement projects;
- To meet the requirements at § 482.21(e)(5), the JC revised its EPs to require that an accredited hospital's governing body determine the number of distinct improvement projects conducted annually;
- To meet the requirements at § 482.22, the JC added a new EP to require that an accredited hospital have a single organized medical staff;
- To meet the requirements at § 482.22(c)(6), the JC revised its EPs to require that an accredited hospital's bylaws include criteria for determining when privileges are to be granted to individual practitioners;
- To meet the requirements at § 482.23(c)(4), the JC revised its EPs to require that accredited hospitals have a procedure for reporting transfusion reactions;

- To meet the requirements at § 482.24(b), the JC revised its EPs to require an accredited hospital to maintain a complete and accurate medical record for each individual patient;
- To meet the requirements at § 482.24(b)(1), the JC revised its EPs to require accredited hospitals to retain medical records in their original or legally reproduced form for a period of at least five years;
- To meet the requirements at § 482.24(c)(2)(i)(A), the JC revised its EPs to require that accredited hospitals complete and document a medical history and physical examination no more than 30 days before or 24 hours after a patient's admission or registration;
- To meet the requirements at § 482.24(c)(2)(vii), the JC revised its EPs to require the final progress note for each patient include the outcome of hospitalization, disposition of the case, and provisions for follow-up care;
- To meet the requirements at § 482.25, the JC revised its EPs to require that an accredited hospital's medical staff develop policies and procedures that minimize drug errors;
- To meet the requirements at § 482.25(a)(1), the JC added a new EP to require that an accredited hospital retain a full-time, part-time, or consulting pharmacist to develop, supervise, and coordinate all the activities of the pharmacy department or pharmacy service;
- To meet the requirements at § 482.25(b)(6), the JC revised its EPs to ensure that drug administration errors, adverse drug reactions and incompatibilities are reported to the hospital-wide quality assurance program as appropriate;
- To meet the requirements at § 482.25(b)(7), the JC revised its EPs to require that an accredited hospital report abuses and losses of controlled substances to the chief executive as appropriate;
- To meet the requirements at § 482.26(b)(3), the JC revised its survey process to include observation and interview of staff in radiation areas for utilization of exposure meters and exposure meter data;
- To meet the requirements at § 482.26(c) (2), the JC added a new EP to require an accredited hospital's medical staff to determine the qualifications of the radiology staff;
- To meet the requirements at § 482.28(a)(1)(i), the JC added a note to its EPs to clarify that the director of dietetic services in an accredited hospital must be a full-time employee responsible for the daily management of dietary services;
- To meet the requirements at § 482.28(b)(3), the JC added a new EP to require that an accredited hospital make available to all medical, nursing, and food service staff a current therapeutic diet manual approved by the dietician and medical staff;
- To meet the requirements at § 482.42(a), the JC added a new EP to require that each accredited hospital have an infection control officer responsible for developing and implementing policies governing the control of infections and communicable diseases;
- To meet the requirements at § 482.42(b)(1), the JC added a new EP to require that an accredited hospital delineate the responsibilities of the chief medical officer, medical staff, and director of nursing, to ensure that problems identified by the infection control officer are addressed and that corrective action plans are successfully implemented;
- To meet the requirements at § 482.45(b)(2), the JC added the definition of "organ" to its glossary;
- To meet the requirements at § 482.51(a)(4), the JC added a new EP to address the hospital's responsibility to maintain a roster of practitioners specifying the surgical privileges of each practitioner;
- To meet the requirements at § 482.51(b)(2), the JC revised its EPs to require an accredited hospital to place a properly executed informed consent form in each patient's chart before surgery, except in emergencies;

- To meet the requirements at § 482.51(b)(3), the JC added a note to its standards to clarify that the hospital must have the necessary resuscitation equipment available in the operating room;
- To meet the requirements at § 482.52(a), the JC added a new EP to include the requirements for individuals qualified to administer anesthesia in an accredited hospital;
- To meet the requirements at § 482.52(c), the JC added a new EP to incorporate the permissive exemption from physician supervision of certified registered nurse anesthetists;
- To meet the requirements at § 482.53(a)(2), the JC added a new EP to require that an accredited hospital's service director and medical staff approve the qualifications, training, functions, and responsibilities of nuclear medicine personnel;
- To meet the requirements at § 482.53(c)(2), the JC revised its EPs to require an accredited hospital to inspect, test, and calibrate nuclear medicine equipment annually;
- To meet the requirements at § 482.53(d)(3), the JC added the definition "radiopharmaceuticals" to its glossary;
- To meet the requirements at § 482.54(b)(1), the JC added a new EP to require that an accredited hospital assign responsibility for outpatient services to one individual;
- To meet the requirements at § 488.55(a)(1) and § 482.55(b)(1), the JC added a new EP to require an accredited hospital's emergency services to be directed and supervised by a qualified member of the medical staff;
- To meet the requirements at § 482.56(a)(2), the JC revised its EPs to include qualifications for physical therapy, occupational therapy, speech-language pathology, and audiology services when these services are provided by accredited hospitals;
- The JC revised its accreditation decision letters to ensure that they are accurate and contain all the required elements for the CMS Regional Office to render a decision regarding the deemed status of an accredited hospital;
- To meet the requirements at § 488.28(a), the JC updated its guidelines for submission of Evidence of Standards Compliance (ESC) to emphasize that the person responsible for implementation of corrective action and assessment of ongoing compliance must be documented in the ESC;
- To clearly identify whether an identified deficient practice represented condition-level or standard-level noncompliance, the JC modified its survey report;
- To meet the requirements of section 2728 of the SOM, the JC modified its policies regarding timeframes for sending an ESC;
- To meet the requirements at section 5075.9 of the SOM, the JC revised its policies to ensure complaint surveys triaged as non-immediate jeopardy (IJ) high and non-IJ medium are conducted within 45 calendar days;
- To meet the survey process requirements in Appendix A of the SOM, the JC developed a policy outlining the minimum number of inpatient records required for review during an accreditation survey;
- To meet the requirements at § 488.3(a), section 2026A of the SOM and Appendix A, the JC developed a new policy to ensure all areas and locations covered under the Medicare provider agreement are surveyed as one integrated hospital for compliance with the conditions of participation;
- To meet the requirements at section 2700A of the SOM, the JC revised its survey activity guide to ensure all deemed status surveys are unannounced; and
- To meet the requirements at § 489.18 and section 3210 of the SOM, the JC revised its policies to state that if an accredited hospital acquires a new service, program, or site which requires an

extension survey, the survey will be conducted within 6 months, and the results of the survey will immediately impact the accreditation status of the acquiring organization.

Critical Access Hospital
The JC first received CMS recognition as a national AO for CAHs on November 21, 2002. More recently, CMS published the decision to approve the JC's CAH program in the *Federal Register* on June 26, 2009. The final notice of approval was effective on November 21, 2008 through November 21, 2012, and can be accessed at **http://edocket.access.gpo.gov/2009/pdf/E9-14778.pdf**.

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

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

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

SECTION 5: Accreditation Representative Sample Validation Program

Section 1865(d) of the Act permits validation surveys of all provider and supplier types that may be deemed for Medicare participation under Section 1865(a) of the Act. Section 1864 of the Act authorizes the State Survey Agencies to conduct validation surveys on behalf of CMS accredited facilities participating in Medicare, as a means of validating the AO's accreditation process. The Accreditation Validation Program is a significant component of CMS' oversight of AOs and consists of two types of validation surveys: (1) full surveys of a representative sample of deemed facilities; and (2) allegation surveys, i.e., focused surveys based on complaints which, if found to be true, would suggest serious noncompliance with Medicare CoPs or CfCs. Representative sample validation surveys are generally "look-back" surveys, conducted no more than 60 days after an AO survey of the same facility. In some cases, representative sample surveys may also be "mid-cycle" validations, conducted independent of a preceding AO survey.

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

The CMS' validation analysis compares the condition-level deficiencies (i.e., serious deficiencies) identified by the SA with the deficiencies identified by the AO on its full accreditation survey. The goal is to determine whether the findings of the two surveys are comparable. The premise of the analysis is that condition-level deficiencies identified by the SA during the 60-day look-back validation survey would also have been present 60 days prior during the AO's accreditation survey and should also have been identified by the AO. Following a validation survey, if a provider or supplier is found to have condition-level non-compliance with Medicare requirements, CMS will

notify the facility and the AO that deemed status has been removed and the facility has been placed under SA monitoring. SA monitoring continues until either the deficiencies have been corrected or the facility has been terminated from participating in the Medicare program. Once the deficiencies have been corrected, CMS restores deemed status and the facility is returned to the AO's oversight.

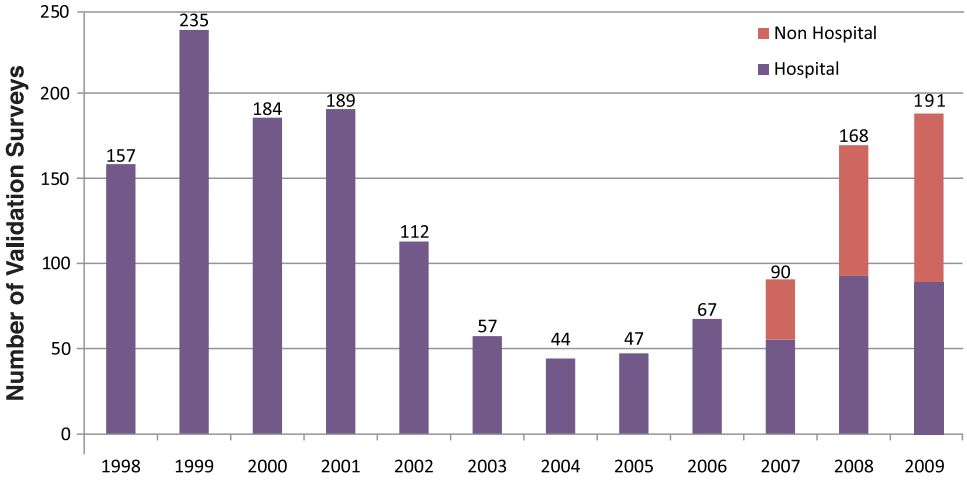
Methodology: Sample Selection Process and Issues

Prior to the enactment of MIPPA, the validation survey component of CMS' annual reporting to Congress was limited to those surveys conducted for the JC hospital program. As a result of Section 125 of MIPPA, the validation program portion of the annual report to Congress has been expanded to include all seven AOs and their approved accreditation programs. The 2009 annual report was the first year that validation studies for AO programs other than hospitals were included. The current report is a continuation of that approach.

In order to support this emphasis on expanded reporting for validation, CMS has increased the number of validation studies. Until recently, federal budget constraints have placed significant limits on the CMS representative sample validation program. Graph 1 presents the number of representative sample validation surveys performed by SAs over the past twelve years. The largest number of validation surveys was conducted in 1999, when 235 hospital validation surveys were conducted. However, since then, the number of validation surveys has declined. In FY 2007, CMS began conducting representative sample validation surveys for non-hospital facilities (i.e., CAHs, HHAs, and ASCs) in addition to the hospital validation surveys. In recent years, more federal resources have been made available for validation surveys. As a result, the total number of validation surveys conducted has increased, but is now spread over multiple provider/supplier types, and still has not reached the 1999 level. An additional constraint on expansion of the validation program in the past few years has been State hiring freezes and furloughs that have limited hiring of additional surveyors as well as requiring mandatory furloughs of existing surveyors. Nevertheless, the validation program has expanded significantly since FY 2007, with a 112 percent increase in the overall number of validation surveys conducted, from 90 in FY 2007 to 191 in FY 2009. During the same time period, the number of non-hospital validation surveys conducted increased by 191 percent, from 35 surveys in FY 2007 to 102 surveys in FY 2009. The number of hospital validation surveys conducted increased by 62 percent, from 55 surveys in FY 2007 to 89 surveys in FY 2009. However, the hospital component of the validation program still remains well below half the 1999 level.

GRAPH 1

Number of Representative Sample Validation Surveys for Both Hospital and Non Hospital Facilities (FY 1998-2009)



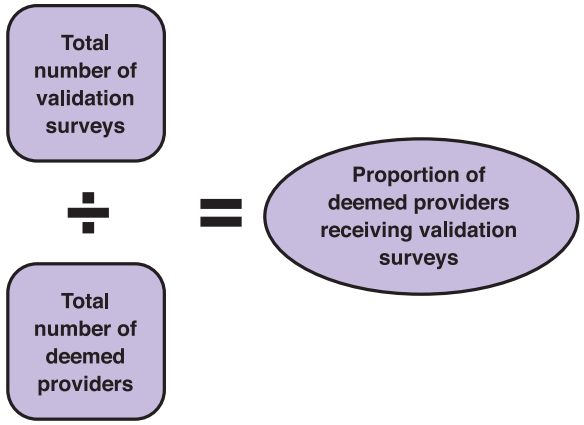
Other Accompanying Information

In FY 2007, 2008 and 2009, CMS selected a representative sample of facilities within each of the following facility types: hospital, CAHS, HHAs, and ASCs. CMS makes decisions on how many validation surveys to perform for each AO based on the number of facilities the AO surveys each month, and the overall budgeted targets, by State and provider type, for validation surveys. CMS then attempts to build a representative national sample for individual accreditation programs. The validation sample is driven by a number of factors including the total number of reaccreditation surveys conducted by the AO and reported on the monthly survey schedules furnished to CMS, the accuracy of those schedules, and individual State validation survey volume targets.

Figure 1 provides the calculation for the proportion of validation surveys completed for deemed providers. The proportion of deemed facilities receiving a validation survey during FY 2008 and FY 2009 are as follows:

- **Hospitals:** Two percent of deemed facilities received a validation survey in FY 2009. The same was true for FY 2008 for a total of 4 percent of deemed facilities receiving surveys over the two-year period.
- **CAHs:** Six percent of CAHs received a validation survey in FY 2009 and four percent received a survey in FY 2008. A total of 10 percent of the deemed facilities received a survey over two years.
- **HHAs:** Two percent of deemed facilities received a survey in FY 2009, with the same percentage receiving a survey in FY 2008. A total of 4 percent received a survey over the two-year period.
- **ASCs:** Two percent of deemed ASCs received a validation survey in FY 2009. Four percent of deemed ASCs received a validation survey during FY 2008, for a 6 percent total over the two years.

FIGURE 1
Proportion of Deemed Providers Receiving Validation Surveys

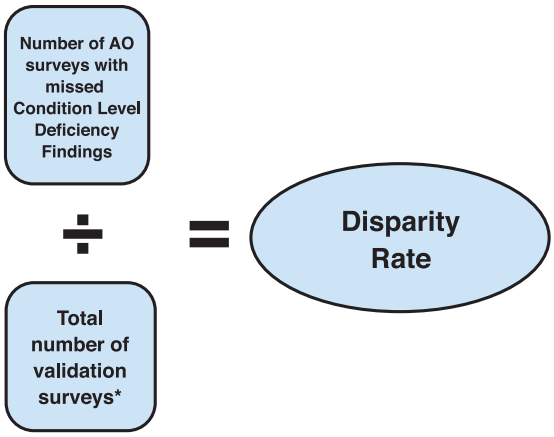


Methodology: Validation Analysis

Each AO received feedback on the results of CMS' analysis of validation surveys for its deemed facilities conducted during FY 2007, 2008 and 2009. The JC has received feedback on the results of the analysis of validation surveys conducted for its accredited hospitals since the beginning of the validation program in FY 1998. Tables 7 through 12 and Graph 2 use the following measures to review the survey results:

Disparity Rate: A lower disparity rate indicates better AO performance. The methodology for the disparity rate is set by regulation at 42 CFR 488.1 and presented in Figure 2. The numerator is the number of surveys where the AO missed at least one serious (conditional-level) deficiency found by the SA. The denominator is the number of surveys in the validation sample. The result is the percentage of validation surveys where the AO missed finding a significant deficiency identified by the SA. If the AO missed at least one serious deficiency in a third of the validation surveys, the disparity rate would be 33 percent.

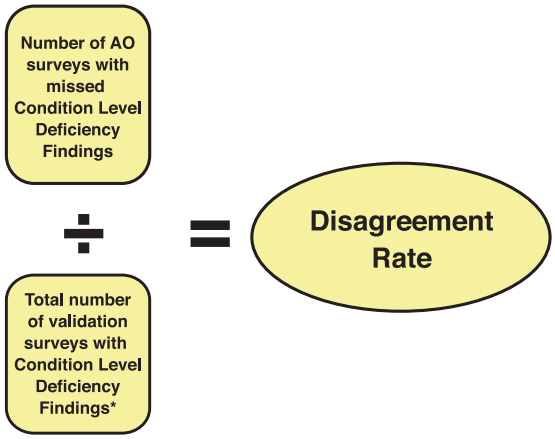
FIGURE 2
Disparity Rate Calculation



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

Disagreement Rate: The disagreement rate is different and sensitive to the measurement of the AO's ability to identify serious deficiencies. The disagreement rate is the percentage of condition-level deficiencies found by the SA that were missed by the AO. A lower disagreement rate indicates better AO performance. The calculation method is presented in Figure 3. The Government Accountability Organization (GAO) recommended in its July 2004 report that CMS employ a similar calculation.[4] The numerator is the number of surveys where the AO missed a serious deficiency found by the SA. The denominator is the number of surveys in which the SA found condition-level deficiencies during a validation survey. If the AO found comparable serious deficiencies in half of the facilities where the SA identified condition-level deficiencies, the disagreement rate would be 50 percent. Because the denominator restricts consideration only to those surveys where the SA found condition-level deficiencies, this measure is more sensitive to the extent of disagreement between the AO and the SA.

FIGURE 3
Disagreement Rate Calculation

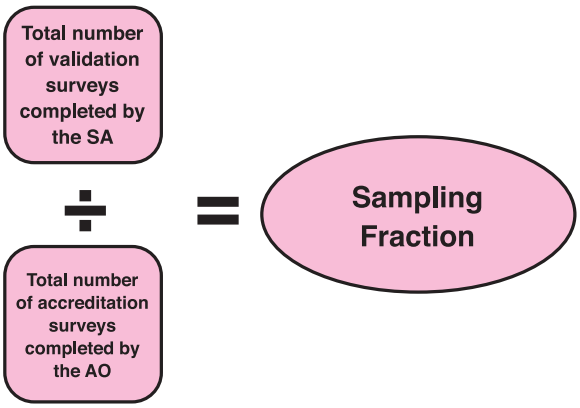


* Does not include those surveys for which the SA found no condition-level deficiencies.

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

Sampling Fraction: The sampling fraction, illustrated in Figure 4, is the proportion of AO surveys during the fiscal year for which a representative sample validation survey was completed. For example, the sampling fraction for CHAP's accreditation program for HHAs is 4 percent, which is the number of FY 2008-2009 validation surveys (37 validation surveys) divided by the number of FY 2008-2009 CHAP HHA surveys (253 accreditation surveys in FY 2008 plus 665 accreditation surveys in FY 2009). The CMS has worked to increase this fraction for each AO and to include a minimum of five validation surveys for each AO program, no matter how small the program.

FIGURE 4
Sampling Fraction Calculation



The *disparity rate* focuses on the number of disparate validation surveys with condition-level deficiencies found by SAs in relation to the total number of validation surveys completed that fiscal year by the SA. In contrast, the disagreement rate reflects only the disparate validation surveys with condition-level deficiencies found by the SAs and whether AOs found similar deficiencies during the AO survey. The sampling fraction is the proportion of validation surveys completed by the SA in relation to the number of accreditation surveys completed by the AO. When the number of validation surveys completed by the SA is less than five surveys, the disparity rate and disagreement rate are not presented. For the FY 2009 report to Congress, the small validation sample sizes limited the analysis of some AO programs. However, this year, the results for FY 2008 and 2009 validation surveys for individual AOs have been combined to provide a more robust estimate of both the disparity and disagreement rates. This action, coupled with the increase in validation sample size in FY 2009, has improved the representativeness of the validation samples for individual AOs. This enables presentation of AO-specific disparity and disagreement rates for most AO programs with only a few exceptions. Nevertheless, it would be desirable to further expand validation samples in future years, to ensure better estimates for all AO programs.

Validation Performance Results: Overall Scores

Table 7 presents the results of the validation reviews for each facility type for FYs 2007, 2008 and 2009. Graph 2 presents the major components of this validation program across the three fiscal years. Tables 8 through 11 present the average results of the validation surveys for individual AO programs in FY 2008 and 2009. The regulations at 42 CFR 488.8(d) require that CMS identify any AO with a disparity rate exceeding 20 percent. In cases where the disparity rate for the AO's accreditation program exceeded the 20 percent threshold, CMS notified the AO of the finding. Results of the validation surveys raise significant concerns about the effectiveness of certain aspects of the AOs' survey processes. In particular, the data identify difficulty on the part of most AOs in identifying deficiencies in the care environment and other aspects of the life-safety code. Subsequent tables (e.g., tables 12 and 13) provide specific information on this issue.

As shown in Table 7 and Graph 2, with the exception of HHAs, the disparity rate score for each facility type exceeds the 20 percent threshold established in the regulation for all three FYs. For example, a

disparity rate of 36 percent in FY 2009 for hospitals means that the AOs did not identify similar serious deficiencies as did the SA for more than three out of ten hospitals. Similarly, based on disparity rates for FY 2009, the AOs missed condition-level deficiencies for 68 percent of CAHs and 41 percent of ASCs. The disparity rates for hospitals are similar for FY 2008 and 2009; the same consistency is found for HHAs and ASCs. The disparity rate for CAHs has increased between FY 2008 and 2009.

Considering only those facilities where the SA found a condition-level deficiency in FY 2009, AOs missed identification of deficiencies for 82 percent of hospitals, 94 percent of CAHs, 89 percent of HHAs and 100 percent of ASCs (i.e., the disagreement rate).

As shown in Tables 8 through 11, presenting the results for individual AO programs averaged across two fiscal years increases the number of validation studies for individual AO programs. Due to the small sample sizes, it is not possible to draw reliable conclusions for several accreditation programs. The disparity rates for sample sizes less than five are not presented. Except for HHAs, the disparity rates for all AO programs are above the 20 percent threshold established in the regulation for the average performance for FY 2008 and 2009. The disagreement rates also indicated that AOs did not identify comparable serious deficiencies identified by the SAs.

TABLE 7
Overall Validation Results for Each Facility Type (FY 2007, 2008 and 2009)

	Hospital	CAH	HHA	ASC	Total
FY 2009					
Validation Sample	89	22	51	29	191
SA: Condition level Deficiencies	39	16	9	12	76
Missed by AO	32	15	8	12	67
Disparity Rate	36%	68%	16%	41%	35%
Disagreement Rate	82%	94%	89%	100%	88%
FY 2008					
Validation Sample	92	17	21	38	168
SA: Condition level Deficiencies	43	9	5	17	74
Missed by AO	30	7	3	16	56
Disparity Rate	33%	41%	14%	42%	33%
Disagreement Rate	70%	78%	60%	94%	76%
FY 2007					
Validation Sample	55	12	6	17	90
SA: Condition level Deficiencies	23	4	1	5	33
Missed by AO	22	3	0	4	29
Disparity Rate	40%	25%	0	24%	32%
Disagreement Rate	96%	75%	0	80%	88%

GRAPH 2
Highlights of Validation Results for Each Facility Type
(FY 2007, 2008 and 2009)

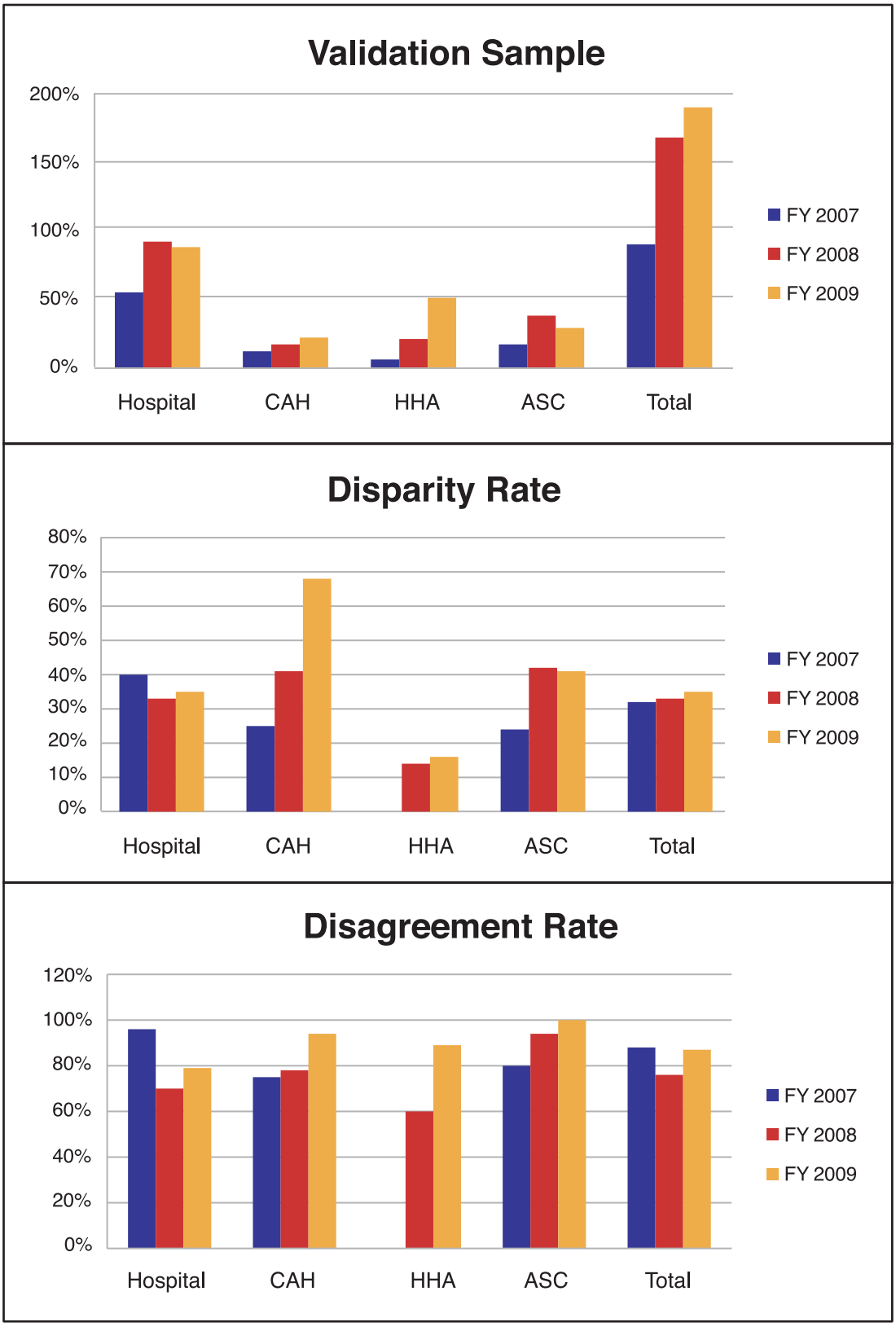


TABLE 8
Hospital Validation Results for each AO (FY 2008 and 2009)

	JC	AOA/HFAP	DNVHC*
Validation Sample	172	5	4
SA: Condition-level Deficiencies	76	4	2
Missed by AO	56	4	2
Disparity Rate	33%	80%	50%
Disagreement Rate	74%	100%	100%
Sampling Fraction	.06	.03	.08

*DNVHC was not operational before FY 2009.

TABLE 9
Critical Access Hospital Validation Results for each AO (FY 2008 and 2009)

	JC	AOA/HFAP
Validation Sample	34	5
SA: Condition-level Deficiencies	21	4
Missed by AO	18	4
Disparity Rate	53%	80%
Disagreement Rate	86%	100%
Sampling Fraction	.13	.29

TABLE 10
Home Health Agency Validation Results for each AO (FY 2008 and 2009)

	JC	ACHC	CHAP
Validation Sample	31	4	37
SA: Condition-level Deficiencies	13	0	1
Missed by AO	10	0	1
Disparity Rate	32%	NA	3%
Disagreement Rate	77%	NA	100%
Sampling Fraction	.03	.01	.04

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

TABLE 11
Ambulatory Surgery Center Validation Results for each AO (FY 2008 and 2009)

	JC	AAAHC	AAAASF
Validation Sample	13	52	2
SA: Condition-level Deficiencies	5	22	2
Missed by AO	5	21	2
Disparity Rate	38%	40%	NA
Disagreement Rate	100%	95%	NA
Sampling Fraction	.07	.06	.03

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

The number of surveys in which the AOs did not cite deficiencies comparable to condition-level deficiencies identified by the SAs suggests significant limitations in the AOs' ability to identify serious non-compliance with the Medicare conditions. This finding is consistent for both FY 2008 and FY 2009. With the exception of the HHA surveys, all disparity rates exceed the 20 percent threshold. Below is a more detailed discussion by type of facility and AO.

- **Hospital:** The FY 2008 and 2009 results indicate that of the 181 validation surveys conducted, SAs identified condition-level deficiencies in 82 hospitals. The AOs did not cite deficiencies comparable to the condition-level deficiencies identified by the SAs in 62 hospitals, for a disparity rate of 34 percent and a disagreement rate of 76 percent. The results for disparity rates are consistent for the three fiscal years reported.

  JC: For FY 2008 and 2009 combined, the disparity rate is 33 percent based on 172 validation surveys. The JC did not cite comparable findings in 56 of the 76 surveys cited for condition-level deficiencies by the SAs. The validation sample was six percent of the surveys completed by the JC during that period. The JC disparity rate has been above 20 percent for the past ten years, as shown in Table 12. Due to statutory reporting requirements, validation studies have been performed for the JC hospital program for a longer time period than for other AO programs.

  AOA/HFAP: The validation sample for FY 2008 and 2009 combined included five hospitals and was a three percent sample of the surveys performed over the two-year period. The SAs found four hospitals with condition-level deficiencies. The AO found none of these deficiencies for a disparity rate of 80 percent. These findings are impaired by the small number of validation surveys conducted by CMS.

  DNVHC: The SAs found two hospitals with condition-level deficiencies for the four hospitals included in the validation sample for FY 2009. DNVHC did not find these deficiencies for a disparity rate of 50 percent. The validation sample included eight percent of the surveys done by DNVHC in FY 2009. DNVHC was not operational during FY 2008 and was not included in the validation analysis for that year. These findings are impaired by the small number of validation surveys conducted by CMS.

- **CAH:** Of the 39 validation surveys conducted in FY 2008 and 2009, the SAs identified 25 facilities with condition-level deficiencies while the AOs missed comparable deficiencies in 22 facilities. The disparity rate is 56 percent and the disagreement rate is 88 percent. The disparity and disagreement rates for FY 2009 are higher than in prior years.

  JC: The combined validation sample for FY 2008 and 2009 includes 34 surveys, a total that represented 13 percent of the surveys performed. The disparity rate is 53 percent based on the

SAs finding condition-level deficiencies in 21 facilities and the AO citing comparable deficiencies for three facilities. The disparity rate in FY 2009 is higher than the disparity rate in FY 2008.

AOA/HFAP: The validation sample for FY 2008 and 2009 combined includes a total of five hospitals. The disparity rate for the two-year period is 80 percent based on a 29 percent sample of the surveys performed.

- **HHA:** Of the 72 validation surveys conducted in FY 2008 and 2009, the SAs identified condition-level deficiencies in 14 HHAs. The AOs did not cite comparable deficiencies in 11 HHAs. Therefore, the disparity rate is 15 percent and the disagreement rate is 79 percent. For FY 2009, SAs found a lower percentage of condition-level deficiencies in HHAs (18 percent) as opposed to other types of facilities (44 percent of validation sample hospitals, 73 percent of sample CAHs, and 41 percent of sample ASCs). The lower rate of condition–level deficiencies found in HHAs is consistent across the three fiscal years presented in Table 7.

  JC: The overall results for FY 2008 and 2009 included 31 HHAs and a disparity rate of 32 percent since the AO missed condition-level deficiencies in ten surveys. These results were based on a three percent sample of the surveys done in the two fiscal years. The FY 2009 disparity rate was higher than in FY 2008.

  ACHC: The validation sample includes one HHA survey for FY 2008 and three surveys for FY 2009. The SAs did not find deficiencies on these validation surveys. Thus, there was no disparity in the findings though the calculation is impaired due to the small number of validation surveys conducted by CMS.

  CHAP: Considering both FY 2008 and 2009, 37 validation surveys represented a four percent sample of the AO's surveys for the year. The SAs found one HHA with a condition-level deficiency which was not found by the AO, resulting in a three percent disparity rate. The 33 validation surveys conducted in FY 2009 constitutes a substantial increase over the four validation surveys included in FY 2008.

- **ASC:** Of the 67 ASC validation surveys conducted for FY 2008 and 2009, the SAs identified condition-level deficiencies in 29 facilities. The AOs did not cite comparable findings in 28 facilities, for a disparity rate of 42 percent and a disagreement rate of 97 percent.

  JC: The validation sample for FY 2008 and 2009 included 13 surveys. The SAs identified condition-level deficiencies in five facilities. The JC did not cite any comparable deficiencies. The disparity rate is 38 percent based on a seven percent sample of the surveys completed over two years.

  AAAHC: The validation sample for FY 2008 and 2009 includes 52 surveys. SAs identified condition-level deficiencies in 22 facilities. The AO missed comparable deficiencies for 21 facilities, resulting in a disparity rate of 40 percent. The results for both years are similar.

  AAAASF: The validation sample for FY 2008 and 2009 includes two surveys. The disparity and disagreement rates are not presented due to the small sample size.

Table 12 presents the history of the JC's hospital validation disparity rate for FY 2000 through 2009. The disparity rates for FY 2007, 2008 and 2009 are higher than the disparity rates for the earlier years. Table 12 also divides the disparity rates into three components: (1) facilities cited for health/safety deficiencies only, (2) facilities cited for physical environment deficiencies only and (3) facilities cites for both health/ safety and physical environment standards.

TABLE 12
The Joint Commission Hospital Validation Disparity Rates (FY 2000–2009)

Fiscal Year	Total Disparity Rate	Health and Safety CoPs/CfCs only*	Physical Environment CoPs/CfCs only*	Health/Safety and Physical Environment CoPs/CfCs*
2000	27%	NA	NA	NA
2001	24%	NA	NA	NA
2002	22%	NA	NA	NA
2003	26%	NA	NA	NA
2004	27%	NA	NA	NA
2005	28%	4%	13%	11%
2006	25%	0%	18%	8%
2007	40%	7%	29%	4%
2008	32%	13%	13%	6%
2009	36%	10%	20%	4%

*Data not available for FY 2000 through 2004

Validation Performance Results: Conditions Cited

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

- **Hospital:** In FY 2009, the most prevalent condition-level deficiency cited by the SAs was physical environment CoP (deficiency cited for 30 of the 88 facilities in the sample). The deficiency was missed by the AO for 14 facilities. Results were similar for FY 2008, where physical environment was cited in 28 of 92 validation surveys, with the AO missing a somewhat lower percentage of deficiencies (15 facilities out of 28 deficiencies cited by SAs). In FY 2009, governing body, patient rights, quality assurance performance improvement and nursing services were the next most frequently cited CoPs by the SAs. Patterns for FY 2008 were similar. While the health care disparities remain within acceptable range, the Joint Commission continues to be challenged by the life-safety code aspect of onsite surveys.
- **CAH:** The SAs cited condition-level deficiencies for physical environment in 14 out of 22 facilities in FY 2009. The pattern was similar for FY 2008, when physical environment was cited for eight out of 17 facilities. Provision of services was the only other CoP cited in FY 2009.
- **ASC:** The most common source of discrepancy in finding condition-level deficiencies for ASCs is also the physical environment CfC, just as it is for hospitals and CAHs. In FY 2009, the SAs cited ten ASCs as out of compliance with the physical environment CfC with the AO finding none of these deficiencies. There were similar results for FY 2008 where SAs found 12 facilities out of compliance with these requirements based on 38 surveys. In FY 2009 deficiencies were also found for governing body, pharmaceutical services, evaluation of quality, and laboratory/radiology.
- **HHA:** Analysis of the condition-level deficiencies for HHAs is not presented in Table 13 due to the small number of deficiencies found by SAs. This may be due, in part, to the fact that there are no physical environment requirements for HHAs. Results for FY 2008 are similar.

In previous annual reports on the JC hospital program, the single largest driver of the disparity rate has been the lack of comparable JC survey findings related to the physical environment CoP, more specifically, the National Fire Protection Association Life Safety Code (LSC) requirements that CMS has adopted as part of its health and safety standards. This same problem is now evident across all of the AO programs reviewed for this broader report. The CMS has had ongoing dialogue

with the JC about actions to improve its performance in assuring compliance with the physical environment CoP. As part of its application review process, CMS has also flagged this issue as an area for improvement for other AOs as well. The CMS has also examined policies in various AOs that might contribute to this pattern of under-citation, for example, policies that preclude citation of a deficiency at all unless some statistical threshold has been met. Since such AO policies have been phased out, this may help to reduce future LSC disparity and disagreement rates.

TABLE 13
Number and Type of Condition-Level Deficiencies Cited on Validation Surveys (FY 2009)

Conditions of Participation	Cited by State Agency	Missed by Accreditation Organization
HOSPITAL SAMPLE: 88		
Physical Environment	30	14
Governing Body	7	6
Patient Rights	5	5
Quality Assurance	4	2
Nursing Services	4	3
Pharmaceutical	3	2
Infection Control	2	0
Anesthesia Services	2	1
Food/Dietetic	1	1
Medical Records	1	0
Medical Staff	1	1
Utilization Review	1	1
Surgical Services	1	1
Patient Safety	1	1
Organ, Tissue, Eye Procurement	1	1
TOTAL	**64**	**39**

Conditions of Participation/ Conditions for Coverage	Cited by State Agency	Missed by Accreditation Organization
CRITICAL ACCESS HOSPITAL SAMPLE: 22		
Physical Environment	14	13
Provision of Services	2	2
TOTAL	**16**	**15**
AMBULATORY SURGERY CENTER SAMPLE: 29		
Physical Environment	10	10
Governing Body	3	3
Pharmaceutical	3	3
Evaluation of Quality	3	3
Laboratory/Radiology	3	3
Surgical Services	2	2
Nursing Services	2	2
Infection Control	1	1
Medical Records	1	1
Basic Requirements	1	1
Medical Staff	1	1
TOTAL	**30**	**30**

SECTION 6: Accreditation Organization Improvement Efforts

There is ongoing communication between CMS and the AOs regarding oversight activities, expectations, AO reporting, validation surveys and other requirements. As a continuation of that process, CMS requested that the AOs submit for inclusion in this annual report a summary of their activities to improve the operations of their approved accreditation programs. The following is the information as provided by each AO:

1. Accreditation Association for Ambulatory Health Care (AAAHC)

- ***2009 Non-Hospital Validation Analysis:*** Currently, AAAHC has over 950 AAAHC/Medicare deemed status ASCs. The CMS data highlight an opportunity for reinforcement, through

training and retraining, of a balanced survey. There has been increased focus on the health and safety requirements based on the revised ASC Conditions for Coverage, effective May 19, 2009. However, the validation survey data suggest that more focus be given for life safety code requirements. AAAHC has developed additional tools for surveyors for assessing life safety code compliance, which include extensive life safety code training at quarterly retraining programs, web-based tutorials, and an informative life safety code DVD. The data will be reviewed as part of AAAHC's overall Medicare training as well. AAAHC looks forward to demonstrating performance improvement and decreased disparity rates in the next CMS Non-Hospital Validation report.

- ***Quality Control Measures:*** AAAHC reviews and takes appropriate action in response to the feedback provided on the performance measures. The AAAHC's dedication to the provision of timely and accurate information is evident in the positive scores of the performance measures.
- ***Deemed Facility List:*** AAAHC would like to emphasize that significant modifications have been made to its information systems to ensure compatibility with CMS ASSURE database. This is evident by the 100 percent compliance score. The ASSURE program has eliminated problems encountered with the facility list in its old format. In addition, AAAHC has been proactive in communication with the CMS Region Offices to obtain accurate CMS Certification Numbers (CCN) to ensure that reporting is complete. The AAAHC has been very successful in obtaining missing CCNs.
- ***Feedback and Notification Letters:*** AAAHC points out that implementation of changes have been completed, but may appear to be delayed in the performance measures. As revised procedures are implemented, changes will not be reflected in the performance measure scores until surveys are processed under the updated procedures. Therefore, there is a short period of time before the modifications are reflected in the performance measure scores. The AAAHC sends the deficiency notification letters separate from the accreditation decision letters. There were opportunities to revise the notification letters to ensure clear understanding by CMS offices that use the information. Changes have been implemented and the AAAHC currently meets all requirements for notification letters.

2. Accreditation Commission for Health Care (ACHC)

The ACHC 2010-11 overall quality improvement objectives include, but are not limited to:

- ***Ongoing Compliance and Certification to ISO 9001:2008:*** ACHC's quality management system promotes accuracy and consistency in accreditation surveys and critical documentation sent to providers and state/federal agencies.
- ***Performance Excellence:*** Malcolm Baldrige Criteria for Performance Excellence is being deployed company-wide. New teams and models are in development to provide better education, tools and best practices for providers to achieve better patient outcomes.
- ***Appeal of Denials:*** All protocols for appeal of denials were restructured to reduce cycle time to communicate final decision to providers, and give guidance for improvement. This new procedure also reinforces provider compliance with Medicare COPs.
- ***ASSURE Interface:*** Continue to improve the database interface between CMS (ASSURE) and ACHC to facilitate reporting of pertinent data by ACHC.

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

AAAASF has made the following improvements to the AAAASF Medicare-deemed Program during the 2009-2010 fiscal years after working closely with the national CMS Survey and Certification leadership. Their guidance and counsel to the AAAASF Staff and Senior Management has been invaluable as AAAASF made these vast changes to our Medicare Program.

- ***Improved Surveyor Education:*** The following AAAASF Medicare Program education enhancements were put in place in 2009-2010:

- Surveyor tools were designed and available to all surveyors;
- Medicare course presentations have been improved and updated for content and presentation appeal;
- On-line webinars were developed and are being used as training aids;
- A comprehensive Surveyor Handbook was developed, and is currently being used by surveyors;
- Surveyor's Web Site was developed and is being used by surveyors for retrieving information and the exchange of ideas and new CMS requirements as they happen;
- AAAASF Web Site with a Medicare information button has been in place and is used daily by web site visitors to obtain more Medicare information; and
- Additional educational vehicles and publications are currently in production, and will be maintained and updated frequently to comply with Medicare's requirements going forward.

- ***Improved Office Procedures and Medicare Administration:*** A physically separate and dedicated Medicare accreditation office space with dedicated, trained Medicare processing staff was arranged by AAAASF. This area is fully operational for Medicare processing only. AAAASF Medicare staff has streamlined the paperwork processing and record keeping including all credentialing and survey documentation into complete, chronologically maintained files. All forms, letters and related AAAASF Medicare correspondence has been converted into a turn-key data system to assure uniformity and accurate compliance with CMS requirements.
- ***Data Tracking Systems:*** AAAASF has and continues to revamp its data tracking systems in several areas. The improvements have had a noticeable positive impact on the Association's ability to retain and report reliable information. The updated data tracking system encompasses three major revisions to the way in which AAAASF processes information pertaining to surveyors, surveys, and facilities respectively. Each of these efforts has consisted of appropriate component updates that are in various stages of completion. The overall goal has been to segregate the records of AAAASF Medicare deemed facilities and to achieve an improved flow of information between AAAASF and CMS.

  The AAAASF Medicare Facilities management system has been rolled out and is currently in use to communicate historical facility data to CMS. Although ongoing efforts continue in an effort to further improve data transfer between the organization's system and CMS, this tool is already responsible for entering and retaining all facility demographic and historical data. Another major effort includes a redesign to improve the maintenance of standards texts, survey histories, and surveyor reporting. These three distinct efforts aim to improve surveyor communication and reporting and reduce the time it takes to process facilities. AAAASF's new survey system better accommodates CMS data fields while improved communication features enhance dialogue with surveyors. Perhaps the single most important feature of the survey system, currently in use, is to more reliably track the severity of deficiencies and track facilities' associated plans of correction as well as proof of implementation. AAAASF is engaged in ongoing efforts to continue improvement efforts and increase the automation of these new features.
- ***AAAASF Medicare Quality Assurance (QA) and Surveyor Oversight Committee:*** The AAAASF QA Surveyor's Oversight Committee was formed in 2009, with four committee members appointed from the AAAASF Board of Directors roster. This Committee of three physicians and one registered nurse provide complete oversight working with AAAASF staff on surveyor performance, surveyor education requirements, and uphold the policies on fair surveyor disciplinary functions. The Quality Assurance Surveyor's Oversight Committee may recommend correction of any notable deficient continuing education areas directly to the AAAASF Standards Committee. The Committee may also recommend specific surveyor re-training in areas found to be deficient. All Medicare Surveyor files are reviewed annually by the Committee for overall surveyor performance and levels of knowledge.

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

- ***Restructure Governing Body:*** : There has been a restructuring of the Bureau of Healthcare Facilities Accreditation (BHFA) to allow for a broader knowledge base. The BHFA is the governing body of HFAP that is responsible for development of standards and accreditation actions. Members now include nurses, pharmacists, and administrators of hospitals, along with the various physician disciplines.
- ***Web-based Survey System:*** AOA reports that development of a web-based survey system is underway and is expected to be completed by the end of 2010. This system includes: an online manual; scoring system for surveyor documentation; application process for facilities; interfaces with ASSURE to ensure prompt and accurate data submission; ability to track and trend quality data and compliance with specific standards; and online surveyor education modules.
- ***Monitoring Facilities:*** Methodological changes have been instituted to include closer follow-up and monitoring of those facilities deemed to be out of compliance with a CoP during the survey process. These changes include a resurvey of the facility found to be out of compliance with a CoP, following the submission of an acceptable corrective action response.
- ***Quality Activities:*** Collaborative activities have been implemented with the Ambulatory Surgery Center Quality Collaborative (ASCQC) initiative. The focus of this quality group is to enhance quality and patient safety through the collection and evaluation of key indicators. HFAP has been gathering quality data from our customers on a voluntary basis and submitting it on a routine basis throughout the past fiscal year.
- ***National Quality Forum (NQF) Safe Practices:*** Standards have been updated to reflect the most current NQF Safe Practices:

- Discharge Process: Most notably has been the inclusion of the checklist for use during the discharge process. The standards were based on evidence provided through the Agency for Healthcare Research and Quality and other entities;
- Glycemic Control: Inclusion of evidence-based practices and interventions to improve outcomes for hospitalized hyperglycemic diabetic patients through their inpatient stays, and incorporates communication with the next provider for continued monitoring of the patient;
- Adverse Event Reporting: Although the reporting of adverse events to HFAP is not mandatory, accredited facilities are strongly encouraged to report all adverse events. HFAP also implemented standards which require the facility to report the occurrence of an adverse outcome to the patient/proxy as soon as it is recognized and the patient is ready physically and psychologically, to receive the information;
- Pharmacy: Pharmacy must be included in facility leadership. HFAP has encouraged the elimination of reporting layers by implementing standards which allow the pharmacy leaders to participate in the decision-making process for the facility, in relation to medication management; and
- Care of the Caregiver: The healthcare organization is required to have mechanisms in place to address the needs of the caregivers involved in an adverse event. The objective is to allow staff to be involved in determining the cause of the event, how to prevent it from occurring in the future and the opportunity to grieve as appropriate, facilitating the safe return to the workplace.

- Worked collaboratively with CMS and other AOs to better define and improve care surrounding the use of standing orders and protocols.

5. Community Health Accreditation Program (CHAP)

During this year CHAP focused on performance improvement. Extensive process redesign, training and continuous monitoring and improvement resulted in significant improvement in CMS' performance measures, and final approval of CHAP's deeming authority for home health,

and renewal for hospice. Actions to address staffing and systems over the previous year resulted in CHAP's ability to perform all surveys on a timely basis, and produce accurate and timely reports on all deemed organizations and all surveys conducted.

- ***Development of Web Based Tool:*** and implementation of a web based electronic tool set for the development of a comprehensive statement of deficiencies, including CMS Conditions of Participation, with an electronic Plan of Correction response. Using email, the tool also contains timeliness monitoring management tools. Accredited organizations received training on the new policy and procedure and tools, and a recorded webinar with frequently asked questions is available 24/7 on CHAP's website. CHAP also changed its Accreditation policy to eliminate "Recommendations" and "Progress Reports" as 2 types of accreditation actions to ensure clear and consistent feedback to accredited organizations and to provide stronger guidance to accredited organizations in methods to improve their performance and adherence to standards.
- ***Timely Visits and Reporting:*** Continued aggressive efforts to improve systems, tools, policies and procedures to ensure accurate, complete and timely visits and reporting, with a significant improvement in all areas of CMS performance measures.
- ***Management Systems:*** Redesign of survey files and documentation management processes to ensure all required documents present and correct.
- ***Life Safety Code:*** Design of new tools to support Life Safety Code surveys. Site Visitor training and education on Life Safety Code, and CMS documentation and survey requirements.
- ***Scheduling Systems:*** Extensive enhancement of scheduling tools and systems to ensure all visits performed within required time frames.
- ***Information Systems:*** Continued enhancement of databases and management of accredited organization information to ensure timely surveys and accurate, complete and timely reporting.

6. Det Norske Veritas Health Care (DNVHC)

The following describes the actions and other measures taken to further develop the effectiveness of the DNVHC accreditation program:

- ***DNVHC SharePoint Site:*** This enables Surveyors and the DNVHC Central Office to share knowledge and maximize productivity to function more collaboratively to facilitate the accreditation and survey process. This provides a secure, scalable, readily accessible environment for team collaboration. The benefits realized from implementing use of the SharePoint site have assisted to:

- Improve internal communication by providing the DNVHC staff and contractors a flexible means for sharing information, posting comments for discussion boards, and listing references to other professional resources;
- Sharing of information, communication, and documents and facilitate team participation in surveys, discussions, and shared document collaboration;
- Share and manage related documents through a library of multiple documents; and
- Posting of key survey documents accessible to quickly locate documents and available at all times and may be accessed while on survey when needed regardless of their location, as all authorized users have password-protected access. This allows for organization of information in one place to review relevant information quickly and efficiently.

- ***Continuing Surveyor Education:*** DNVHC continues to develop and refine training modules through Articulate® and other media to further educate surveyors regarding accreditation requirements and interpretive guidelines, ISO 9001 training, as well as report writing modules, submissions and templates, timelines, to further improve the documentation of findings as a part of the survey process.

- ***DNVHC Mentoring Program: Hospital to Hospital:*** The intent of this program is to connect hospitals that are implementing ISO and NIAHO℠ to seek input into the process with hospitals that have implemented ISO and NIAHO℠ with more mature quality management systems in place. This can benefit hospitals by taking advantage of learning opportunities and sharing of best practices and understanding various approaches applied for developing more effective quality management systems.
- ***Hospital Representative NIAHO℠ Surveyor Training:*** is presented as an option to hospitals that are DNVHC clients. An individual from the client organization can participate in the NIAHO℠ and ISO 9001 Surveyor Training, at no charge. The hospital must agree to allow the staff member to survey three times per year as a fully qualified surveyor and a full member of the survey team. Once they successfully complete the didactic training and observation surveys the individual can participate in surveys and also are involved in subsequent training. This enables the client organization to have a knowledgeable representative in place to further support compliance and development of the quality management system for the hospital. This is our commitment to a totally transparent survey process.
- ***ISO 9001/NIAHO℠ Integration Course:*** A course has now been developed for hospitals in order to provide the history and foundation of ISO 9001 and requirements. This program discusses the aspects of integration between ISO 9001 and the NIAHO℠ standards to ensure effective transition by the hospital. This course also provides key steps for all hospitals to consider when implementing ISO 9001 within their organizations for the development of effective quality management systems. This includes, but not limited to:

- Foundation of ISO 9001;
- Differences between Management Systems as it relates to Healthcare;
- ISO 9001 and NIAHO℠ Integration of the requirements; and
- Components of an ISO 9001 System—Validation and Implementation strategies.

- ***Dedicated Email:*** DNVHC has established a means for client organizations to submit documentation, corrective action plan updates, questions for interpretations and guidance regarding compliance issues and other concerns. This results in improved communication and clarification for the client organizations.
- ***Increase of Dedicated Staff for Accreditation Activities:*** In order to improve the exchange of information and support client organizations, DNVHC has increased the staff dedicated to accreditation activities. This will lead to improved response time and addressing issues that arise from the survey process.
- ***Improve Internal Processes:*** DNVHC continues to improve its internal processes based on communication and feedback from the CMS Survey & Certification Group. This has been very beneficial to refine our methods for reporting and receiving information to further improve our accreditation process and continue meeting the expectations of CMS.

7. The Joint Commission (JC)

In accordance with its mission "*…to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value,*" the JC continues to evaluate and improve its accreditation processes in order to be sure that they are contemporary, comprehensive, objective, and measurable. To that end, improvement activities have increasingly focused on:

- ***Ongoing Monitoring:*** Beginning to use data more throughout an organization's accreditation cycle to monitor their performance and take appropriate action, as opposed to addressing compliance issues during only an on-site survey.

- ***Survey Scheduling:*** Making an organization's full survey more unpredictable based on its performance; i.e., an organization performing poorer will have a survey earlier than other organizations and as often as needed.
- ***Increased Surveys:*** Conducting more for-cause surveys when patient safety and quality of care issues are suspected.
- ***Surveyor Activities:*** Enhancing the tracer methodology techniques and enhancing training to surveyors to ensure that surveyors delve into compliance issues and critically evaluate serious patient safety issues.
- ***Time Allocation:*** Evaluating the time allotted for various activities conducted during a survey so that each activity receives appropriate survey attention.
- ***Survey Duration:*** Evaluating survey duration for sufficient time to do a comprehensive evaluation of all required activities.
- ***Surveyor Management:*** Enhancing the infrastructure to manage and develop surveyors, including the use of technology more to provide training to surveyors on an ongoing basis.
- ***Performance Measures:*** Beginning to plan the integration of additional performance measurement data into the accreditation process.
- ***Life Safety Code (LSC) Specialists:*** Starting in January 2011, all CAH surveys will have 2 LSC specialist survey days; all hospital surveys will have 2 LSC days, and additional LSC specialist days will be provided for extra large hospitals and those entities that provide patient care activities in several buildings as needed.

SECTION 7: Centers for Medicare & Medicaid Services Oversight Improvement

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

- **Deeming Application Reviews.** Deeming application and standards reviews are conducted by a team of trained analysts to ensure consistent application of a standardized review methodology. All findings are subject to detailed supervisory review to enhance reliability and consistency. As a result, AO applications and standards are reviewed more comprehensively and consistently, and more areas for improvement are being identified and communicated to the AOs for correction before applications may be approved. In FY 2009, the team completed one initial and nine renewal applications and submitted final documents for publication. Other deeming program review activity included two 180-day deeming authority reviews, six standards reviews, and four survey process and surveyor guidance revisions. For AOs that receive a four year term of renewal, CMS conducts follow up corporate onsite visits and survey observations within one year to validate continued compliance with the provisions set forth in the final notice. In addition, for AOs that receive a conditional probationary approval, a written plan of correction as well as monthly progress reports are required.
- **Accreditation Organization Reporting on Deemed Facilities.** The CMS continues to focus on obtaining from AOs complete, accurate and timely data regarding deemed facilities. This has been a major challenge for both CMS and the AOs. The CMS initiated developmental work on a first-ever electronic database to inventory and track AO actions that affect the deemed status of a facility. In October 2009, CMS went live with this new electronic database to track and monitor deemed facility status, survey activity, survey findings by AO, AO survey follow-up actions, and

related factors for each program type. The electronic database enables both CMS and AOs to analyze deemed facility data, and will improve CMS oversight of the AOs and their CMS-approved accreditation programs. This electronic database replaced the manual, more labor-intensive processes for AO data submissions and CMS tracking and monitoring of deemed facility activity. When fully populated with deficiency data, this electronic database will enable CMS to track and monitor deemed facility deficiencies at the condition and standard levels.

- **Ongoing Communications with Accreditation Organizations.** The CMS continues its series of periodic meetings with recognized national AOs, including quarterly teleconferences and an annual face-to-face meeting. These meetings serve to foster communication between the AOs and CMS and serve as a forum to discuss any issues as they arise, to better assure ongoing deemed provider and supplier compliance with Medicare CoPs/CfCs. The CMS and individual AOs communicate on a weekly, if not daily, basis, either by email or telephone, to address a wide variety of issues related to: deemed facilities, operations, surveys, and data. In addition, CMS implemented dedicated electronic mailboxes for use by AOs when submitting deemed facility notification letters and other required reports to CMS. Finally, CMS standardized the communication of written feedback to AOs during the deeming application review process.
- **Ongoing Education and Support of Accreditation Organizations.** Education of AO staff occurs throughout the deeming application review process. The CMS provides detailed feedback to the AOs as part of the deeming application and data review processes. This feedback includes specific reference to Medicare regulatory requirements as well as State Operations Manual references and attachments. Formal education is provided at the annual CMS-AO meeting as well as periodically at the request of individual AOs. The CMS developed and provided a resource manual to all AOs that contain a wide variety of information on CMS requirements and expectations of AO performance.
- **Methodological Changes to Improve Oversight.** The CMS is assessing approaches to refining and improving upon the current methods for measuring AOs' performance in assuring compliance with the Medicare requirements. In FY 2008, CMS implemented the first-ever performance measures for the AOs (see Table 4). Implementation of the electronic data base permitted further refinement and expansion of the performance measures in FY 2010. These refinements are reported in this report, such as the addition of the more sensitive "disagreement" rate as well as the long-standing disparity rate.
- **Validation Program Sample Size.** The CMS' budget for FY 2009 permitted a larger representative sample validation program than was possible in FY 2005–2008. For FY 2010, MIPPA and the American Recovery and Reinvestment Act provided additional resources to allow further expansion of the program across deemed providers and suppliers. Consequently, CMS increased the number of validation surveys from 90 in 2007 to 168 in 2008 and then 190 in 2009.
- **Emergency Preparedness.** The CMS continues to collaborate and communicate with AOs on strategies for improved health care facility emergency preparedness in response to all hazards regardless of the magnitude. Close collaboration with the Joint Commission in the aftermath of Hurricane Katrina in 2005 highlighted the valid of close coordination between CMS and the AOs.
- **Quality Assessment and Performance Improvement and Governance.** In FY 2007 through 2009, CMS has added to its CoPs/CfCs, a requirement that hospices, transplant hospitals, dialysis facilities, and ambulatory surgery centers all have an effectively-working, internal quality assessment and performance improvement (QAPI) system. Given the existing disparities between CMS and AO surveys for the current hospital QAPI requirement, CMS will design a plan in FY 2011 for closer work with the AOs on assessment during onsite surveys of both QAPI and Governance.
- **Physical Environment.** Given continuing disparities in LSC surveys, CMS will initiate a stronger plan for LSC skills-building with AOs for FY 2011. The CMS has already begun more detailed analysis of the types of LSC deficiencies that have been overlooked on hospital surveys and will use the information developed to focus AO skills-building.

CLINICAL LABORATORY IMPROVEMENT VALIDATION PROGRAM

Introduction

This report on the Clinical Laboratory Improvement Validation Program covers the evaluations of fiscal year (FY) 2009 performance by the six accreditation organizations approved under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The six organizations are as follows:

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

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

Legislative Authority and Mandate

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

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

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

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

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

Validation Reviews

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

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

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

Number of Validation Surveys Performed

As directed by the CLIA statute, the number of validation surveys should be sufficient to "allow a reasonable estimate of the performance" of each accreditation organization. A representative sample of the more than 16,000 accredited laboratories received a validation survey in 2009. 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 for the accreditation organization it designates for CLIA compliance, 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

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

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: 8 percent

In FY 2009, approximately 220 laboratories used their AABB accreditation for CLIA program purposes. Validation surveys were conducted in 14 AABB-accredited laboratories. One validation survey was removed from the review pool for administrative reasons. Of the remaining 13 validation surveys, 12 had no condition-level deficiency citations. One AABB-accredited laboratory was cited with a condition-level deficiency, and the AABB inspection report did not note comparable findings, so the case was disparate.

The CLIA identification number, location and CLIA Condition are as follows:

CLIA number	Location	CLIA Condition
10D0280710	Florida	Proficiency Testing—Lack of Enrollment

American Osteopathic Association

Rate of disparity: 17 percent

For CLIA purposes, approximately 40 laboratories used their AOA accreditation. Nineteen validation surveys were conducted. One survey was removed from the validation review pool for administrative reasons. Of the remaining 18 validation surveys, 15 had no condition-level deficiency citations. Three AOA-accredited laboratories were cited with condition-level deficiencies, and the AOA inspection reports did not have comparable findings for some or all of the conditions cited, thus those 3 cases were disparate.

Following is a table showing the CLIA identification number, location and CLIA condition-level deficiencies of the laboratories where AOA's inspection findings were disparate:

CLIA number	Location	CLIA Conditions
15D0667167	Indiana	Laboratory Director—Overall Direction and Management
15D0683007	Indiana	Proficiency Testing—Successful Participation Laboratory Director—Overall Direction and Management
17D0449927	Kansas	General Supervisor—Documentation of Qualifications Laboratory Testing Personnel (moderate complexity)—Documentation of Qualifications Laboratory Testing Personnel (high complexity)—Documentation of Qualifications

Other Accompanying Information

American Society for Histocompatibility and Immunogenetics

Rate of disparity: zero percent

Approximately 120 laboratories used their ASHI accreditation for CLIA purposes. Validation surveys were conducted in 9 ASHI-accredited laboratories. No condition-level deficiencies were cited in any of the validation surveys. When each validation survey results in compliance with the CLIA condition-level requirements, as is the case with the ASHI-accredited laboratories this year, disparity is precluded.

COLA

Rate of disparity: 18 percent

A total of 167 validation surveys were conducted in COLA-accredited laboratories. One survey was removed from the review pool for administrative reasons. Of the remaining 166 surveys, 35 laboratories were cited with condition-level deficiencies. In 5 of those laboratories, COLA noted deficiencies comparable to all of the CLIA condition-level deficiencies cited. In 30 of the laboratories, however, COLA noted comparable deficiencies to only some or none of the CLIA condition-level deficiencies cited, thus there were 30 disparate cases.

Following is a table showing the CLIA identification number, location and CLIA condition-level deficiencies of the laboratories where COLA's inspection findings were disparate:

CLIA number	Location	CLIA Conditions
01D0302100	Alabama	Laboratory Director—Overall management and direction
04D0965344	Arkansas	Laboratory Director—Documentation of Qualifications
		Technical Consultant—Fulfillment of Responsibilities
10D0275742	Florida	Proficiency Testing—Successful Participation
10D1059338	Florida	Proficiency Testing—Successful Participation
10D1066940	Florida	Laboratory Director—Overall Management and Direction
14D0435610	Illinois	Proficiency Testing—Successful Participation
19D0461919	Louisiana	Proficiency Testing—Successful Participation
		Pre-analytic Systems
		Laboratory Director—Overall Management and Direction
		Technical Consultant—Documentation of Qualifications and Fulfillment of Responsibilities
		Laboratory Testing Personnel—Documentation of Qualifications
19D0462011	Louisiana	Proficiency Testing—Enrollment & Testing of Samples
		Analytic Systems
		Laboratory Director—Overall Management and Direction
		Laboratory Testing Personnel—Documentation of Qualifications (moderate complexity)
		Laboratory Testing Personnel—Documentation of Qualifications (high complexity)
19D0462635	Louisiana	Laboratory Testing Personnel—Documentation of Qualifications
19D0462758	Louisiana	Pre-analytic Systems

22D0861308	Massachusetts	Laboratory Director—Documentation of Qualifications
23D0374131	Michigan	Analytic Systems
23D1008625	Michigan	Laboratory Director—Overall Management and Direction Analytic Systems
26D0447304	Missouri	Proficiency Testing—Successful Participation
		Routine Chemistry
		Hematology
		Analytic Systems
		Laboratory Testing Personnel—Fulfillment of Responsibilities
28D0700845	Nebraska	Laboratory Testing Personnel—Documentation of Qualifications
31D0121723	New Jersey	Laboratory Director—Overall Management and Direction
33D0143708	New York	Laboratory Director—Overall Management and Direction
		Analytic Systems
		Laboratory Testing Personnel—Documentation of Qualifications
33D0160053	New York	Proficiency Testing—Successful Participation
		Bacteriology
		Hematology
		Laboratory Testing Personnel—Documentation of Qualifications
33D0671282	New York	Laboratory Testing Personnel—Documentation of Qualifications
33D1020241	New York	Laboratory Testing Personnel—Documentation of Qualifications
34D0243602	N. Carolina	Laboratory Director—Overall Management and Direction Analytic Systems
34D0246263	N. Carolina	Laboratory Testing Personnel—Documentation of Qualifications
34D0246722	N. Carolina	Laboratory Director—Overall Management and Direction Analytic Systems
36D0351270	Ohio	Laboratory Director—Overall Management and Direction
37D0473327	Oklahoma	Laboratory Director—Overall Management and Direction Analytic Systems
45D0484065	Texas	Analytic Systems
45D0488454	Texas	Proficiency Testing—Successful Participation
		Facility Administration
		General Laboratory Systems
		Pre-analytic Systems
		Analytic Systems
		Post-analytic Systems
		Technical Consultant—Fulfillment of Responsibilities

45D0497402	Texas	Laboratory Director—Overall Management and Direction
		Proficiency Testing—Enrollment
		Laboratory Testing Personnel—Documentation of Qualifications
49D0720349	Virginia	Laboratory Director—Overall Management and Direction
49D0961491	Virginia	Proficiency Testing—Successful Participation

College of American Pathologists

Rate of disparity: 14 percent

A total of 102 validation surveys were conducted in CAP-accredited laboratories. One survey was removed from the review pool for administrative reasons. Of the remaining 101 surveys, 14 laboratories were cited with CLIA condition-level deficiencies. In all 14 of those laboratories, the College noted comparable deficiencies to only some or none of the CLIA condition-level deficiencies cited; thus, there were 14 disparate cases.

Following is a table showing the CLIA identification number, location and CLIA condition-level deficiencies of the laboratories where the College's inspection findings were disparate:

CLIA number	Location	CLIA Conditions
14D0694820	Illinois	Bacteriology
16D0386985	Iowa	Laboratory Technical Supervisor—Documentation of Qualifications
		Laboratory Testing Personnel—Documentation of Qualifications
17D0698595	Kansas	Laboratory Director—Overall Management and Direction, and —Documentation of Qualifications
		Technical Consultant
		Clinical Consultant
		Laboratory Testing Personnel—Documentation of Qualifications
19D0457577	Louisiana	Laboratory Testing Personnel—Documentation of Qualifications
19D0648840	Louisiana	Preanalytic Systems
		Analytic Systems
		Laboratory Director—Overall Management and Direction
		Laboratory Testing Personnel—Documentation of Qualifications
19D0648988	Louisiana	Preanalytic Systems
		Analytic Systems
		Laboratory Testing Personnel (moderate complexity)—Documentation of Qualifications
		Laboratory Testing Personnel (high complexity) —Documentation of Qualifications

19D0704564	Louisiana	Analytic Systems
		Postanalytic Systems
		Laboratory Testing Personnel (moderate complexity)—Documentation of Qualifications
		General Supervisor—Documentation of Qualifications
22D0966206	Massachusetts	General Supervisor—Documentation of Qualifications
		Laboratory Testing Personnel—Documentation of Qualifications
26D0444355	Missouri	Technical Consultant—Documentation of Qualifications
		Laboratory Testing Personnel—Documentation of Qualifications
32D0653230	New Mexico	Immunohematology
		Analytic Systems
		Laboratory Testing Personnel (moderate complexity)—Documentation of Qualifications
		Laboratory Testing Personnel (high complexity) —Documentation of Qualifications
		Laboratory Director—Overall Management and Direction
34D0239935	N. Carolina	Laboratory Testing Personnel—Documentation of Qualifications
		General Supervisor—Documentation of Qualifications
34D0245811	N. Carolina	Laboratory Testing Personnel—Documentation of Qualifications
		General Supervisor—Documentation of Qualifications
34D0246731	N. Carolina	Facility Administration
		Analytic Systems
		Laboratory Testing Personnel (high complexity) —Documentation of Qualifications
44D0306614	Tennessee	Immunohematology
		Analytic Systems

The Joint Commission

Rate of disparity: 15 percent

During this validation period, a total of 75 validation surveys were conducted in Joint Commission accredited laboratories. Twelve of the laboratories surveyed were cited with CLIA condition-level deficiencies. In 1 of those laboratories the Joint Commission noted deficiencies comparable to all of the CLIA condition-level deficiencies cited. In the other 11 laboratories, the Joint Commission noted comparable deficiencies to only some or none of the CLIA condition-level deficiencies cited; thus, there were 11 disparate cases.

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

Other Accompanying Information

CLIA number	Location	CLIA Conditions
19D0701127	Louisiana	Laboratory Director—Overall Direction and Management
		Laboratory Testing Personnel—Documentation of Qualifications
19D0895993	Louisiana	Routine Chemistry
		Laboratory Director—Overall Direction and Management—not qualified
		Technical Consultant—Overall Direction and Management—not qualified
		Laboratory Testing Personnel—Documentation of Qualifications
26D1029645	Missouri	Laboratory Testing Personnel—Documentation of Qualifications
34D0019219	N. Carolina	Analytic Systems
		Laboratory Director—Overall Management and Direction
34D0245175	N. Carolina	Hematology
34D0655295	N. Carolina	Laboratory Testing Personnel (moderate complexity)—Documentation of Qualifications
		Laboratory Testing Personnel (high complexity)—Documentation of Qualifications
40D0680463	Puerto Rico	Syphilis Serology

Conclusion

The CMS has performed this validation review in order to evaluate and report to Congress on the performance of the six laboratory accreditation organizations approved under CLIA. This endeavor is two-fold: to verify each organization's capability to assure laboratory performance equal to, or more stringent than, that required by CLIA ("equivalency"); and to gain insight into the effectiveness of the accreditation organization's standards and accreditation process on a laboratory-specific basis.

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

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

Glossary

A

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

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

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

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

B

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

Glossary

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 new expenditures during the current period regardless of the fiscal year the service was provided or the expenditure was incurred.

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

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

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

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

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

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

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

D

Deficit Reduction Act of 2005: The Deficit Reduction Act restrains Federal spending for entitlement programs (i.e. Medicare and Medicaid) while ensuring that Americans who rely

on these programs continue to get needed care. Provisions of the act include a requirement for wealthier seniors to pay higher premiums for their Medicare coverage; restrain Medicaid spending by reducing Federal overpayment for prescription drugs so that taxpayers do not have to pay inflated markups; and include increased benefits to students and to those with the greatest need.

Demonstrations: Projects that 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 historically contracted with the Medicare program to process Medicare claims for Durable Medical Equipment (DME). DMERCs have been replaced by DME Medicare Administrative Contractors.

E

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

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

F

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

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

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

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

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

Fiscal Intermediary (FI): A private business—typically an insurance company—that contracts with CMS to process hospital and other institutional provider benefit claims. CMS is in the process of replacing Fiscal Intermediaries with Medicare Administrative Contractors.

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

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

H

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

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

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

I

Improper Payments Elimination and Recovery Act (IPERA): In July 2010, Congress amended the Improper Payment Information Act (IPIA), which is now known as the Improper Payment Eliminations and Recovery Act (IPERA) (Public Law 111-204), to aim to standardize the way Federal agencies report improper payments in programs they oversee or administer. The IPERA 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.

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

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

J

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

M

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

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

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

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

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

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

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

Medicare Integrity Program (MIP): The program established by HIPAA to promote the integrity of the Medicare program, as specified in Section 1893 of the Social Security Act.

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

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

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

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

N

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

O

Obligation: Budgeted funds committed to be spent.

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

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

P

Patient Protection and Affordable Care Act (Affordable Care Act)(P.L. 111-148): In March 2010, Congress passed, and the President signed into law, the Affordable Care Act which puts in place comprehensive health insurance reforms that will hold insurance companies more accountable, lower the deficit, provide more health care choices, and enhance the quality of health care for all Americans. Once fully implemented, the Affordable Care Act will provide Americans with access to affordable health coverage by setting up a new competitive private health insurance market, holding insurance companies accountable by keeping premiums down and preventing many types of insurance industry abuses and denials of care, and ending discrimination against Americans with pre-existing conditions. It also puts the budget on a more stable path, since it is expected to reduce the deficit over the next ten years.

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

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

Part C: Medicare Advantage Program.

Part D: Medicare Prescription Drug Benefit.

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

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

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

Q

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

R

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

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

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

S

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

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

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

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

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

T

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

V

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

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

U.S. Department of Health and Human Services

Kathleen Sebelius, Secretary

Centers for Medicare & Medicaid Services

Dr. Donald Berwick, 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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