CMS FINANCIAL REPORT

FISCAL YEAR 2015

KEEPING US HEALTHY FOR 50 YEARS

CMS

50 MEDICARE 1965-2015 MEDICAID ANNIVERSARY

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AT A GLANCE

The Centers for Medicare & Medicaid Services (CMS) is an Operating Division within the Department of Health and Human Services (HHS). The CMS Annual Financial Report for FY 2015 presents the agency's detailed financial information relative to our mission and the stewardship of those resources entrusted to us. This report is organized into the following three sections:

1 MANAGEMENT'S DISCUSSION & ANALYSIS:

This section gives an overview of our organization, programs, performance goals, and financial accomplishments.

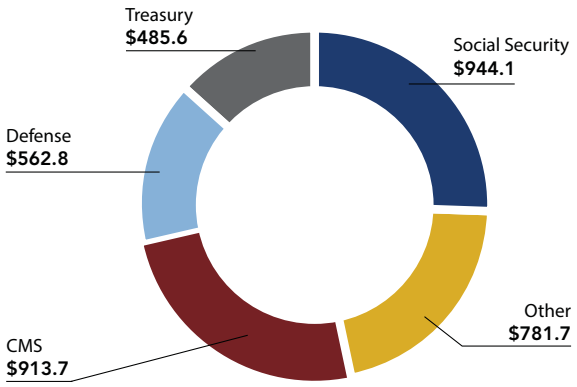
2 FINANCIAL SECTION:

This section contains the message from our Chief Financial Officer, financial statements and notes, required supplementary information, and audit reports.

3 OTHER INFORMATION:

This section includes the Summary of the Federal Managers' Financial Integrity Act and the Office of Management and Budget (OMB) Circular A-123—Statement of Assurance & Improper Payments.

The CMS Annual Financial Reports can be obtained at:
https://www.cms.gov/CFOReport



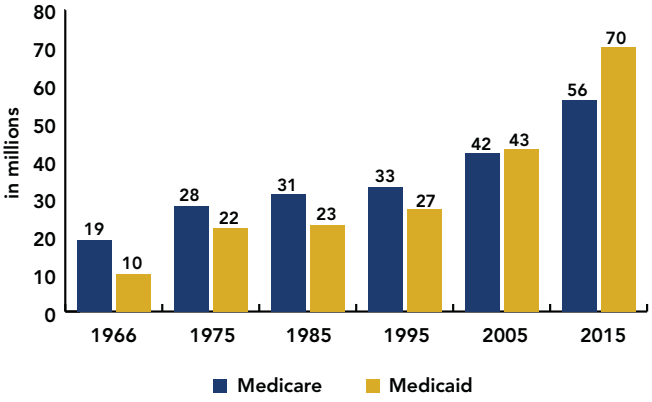
$ in billions

Source: U.S. Treasury

2015 FEDERAL OUTLAYS

CMS has outlays of approximately $913.7 billion (net of offsetting receipts and Payments of the Health Care Trust Funds) in fiscal year (FY) 2015, approximately 25 percent of total Federal outlays.

CMS has over 6,000 Federal employees, but does most of its work through third parties. 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. 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.



2015 PROGRAM ENROLLMENT

CMS is one of the largest purchasers of health care in the world. Medicare, Medicaid, and 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 56 million beneficiaries. Medicaid enrollment has increased from 10 million beneficiaries in 1966 to about 70 million beneficiaries.

A MESSAGE FROM THE ACTING ADMINISTRATOR

ANDREW SLAVITT

As the Acting Administrator of the Centers for Medicare & Medicaid Services (CMS), I am pleased to present the CMS Financial Report for fiscal year (FY) 2015. Millions of Americans rely on the programs CMS administers -- Medicare, Medicaid, CHIP, and the Health Insurance Marketplace -- and millions more invest their tax dollars in them with the expectation that these programs will be there when they need them. Americans expect these programs to provide high levels of service, be transparent, and for CMS to get value for what we spend. Our charge is to do this by efficiently and effectively taking care of people and focusing on making sure Medicare, Medicaid and the Marketplaces thrive today and into the future.

Fiscal Year 2015 was a milestone year for CMS, highlighted by the 50th anniversary of Medicare and Medicaid, and the 5th year since the passage of the Affordable Care Act. Medicaid, our country's largest insurance program, and the Children's Health Insurance Program (CHIP) cares for over 71 million Americans, and one-third of our children; Medicare covers virtually every senior in America; and together these programs provide care for nearly 10 million disabled Americans. Since the passage of the Affordable Care Act, important progress is being made.

- Over 17.6 million people have gained health insurance coverage. As of September 1, 2015, 29 states and the District of Columbia have taken up expansion to provide Medicaid coverage to low-income adults. The nation's uninsured rate has been reduced from 18 percent in 2013, to just over 11 percent in 2015.
- The quality of care provided is improving. We see evidence that CMS's programs and initiatives, combined with provider efforts, have led to a 17 percent reduction in harm for hospitalized patients over a three-year period. This translates into the avoidance of an estimated 1.3 million hospital-acquired conditions and adverse events, and 50,000 lives saved. In addition, 95 out of 100 quality measures have improved across the country over the last seven years.
- And health care costs continue to grow at historically modest levels on a per capita basis. The Medicare Trustees now estimate the Medicare Trust Fund to be depleted in 2030, 13 years longer than they projected in 2009.

Our goal is clear—to help create a better health care system, with smarter spending and healthier people. It takes, and is going to take, the efforts of many people across the health care system to make improvements like we have seen, to solidify them, and to advance them further. We are particularly focused on how to work together with consumers and beneficiaries, health care providers, and those that build the data and technology infrastructure to build on and sustain our progress.

Consumers and Beneficiaries

We are witnessing the changing needs and profile of our beneficiary and consumer base as the population ages and Medicaid and the Marketplace cover people in different life stages. CMS is adapting our programs and our services accordingly. Every day millions of Americans are battling serious illnesses or managing chronic conditions, making decisions on a nursing home for a parent, getting discharge instructions from a hospital, accessing free preventive care services, choosing to be treated at home rather than in an institutional setting, looking for coverage as their employment status changes, and accessing health care in new innovative ways in rural and urban settings. CMS provides resources and support for Americans in these critical times and is committed to staying ahead of these changes even as millions

enter Medicaid and 10,000 people turn 65 every day. CMS is continuously piloting and expanding new tools to help keep Americans healthier and make the health care system simpler by providing automated processes to enroll in Medicaid or Marketplace coverage, 1-800-MEDICARE, and promoting more convenient care, like home and community based care, and telemedicine. We have also expanded and improved the CMS *Compare* websites that offer families useful information about providers, including Five-Star ratings of quality that help their healthcare decision-making.

As we cover more Americans, what makes health insurance especially important are the human costs that come when millions of people are left on the sidelines without access to care. These include a lack of access to primary care and chronic care management, persistent health disparities, hospital bad debt, cost shifting to the private sector, and an economy which discourages new business formation. But coverage alone is not the goal. Through *From Coverage to Care* resources, now available in six languages, CMS is helping individuals who are new to health care coverage understand their benefits and connect to primary care and preventative services that are right for them, so they can live long and healthy lives.

Health Care Providers

As more consumers gain access to care, we must continue to focus on the quality of care our beneficiaries receive and ensure that we are spending taxpayer dollars smarter. Each year we work with the state agencies to conduct unannounced, onsite inspections of providers and investigate complaints made by patients, families and others. CMS also provides technical assistance to support long term care providers in achieving quality care and improving care coordination. But we can also incentivize improvement by changing how we pay for the care that our beneficiaries receive and rewarding providers who provide higher quality and more affordable care. In January of this year, we announced that by 2018, over half of all payments providers receive from the Medicare fee-for-service program will flow through alternative payment models that hold providers accountable for quality and total cost of care. We have committed to have 30 percent of payments in these models by the end of 2016—which is up from zero four years ago. These efforts include testing models such as Accountable Care Organizations, Bundled Payments for Care Improvement initiative and the Comprehensive Primary Care initiative, and launching new models such as the Medicare Care Choices Model that will provide a new option for Medicare beneficiaries to receive both palliative and curative care. And, of course, Medicare Advantage, which will serve nearly 32 percent of Medicare beneficiaries next year, has built in incentives to produce more value-based care. Next year, 65 percent of Medicare Advantage enrollees will be in 4 and 5 Star plans, up from only 17 percent in 2009. In these types of models, care providers are rewarded when quality of care improves, patient engagement increases and populations remain healthier.

CMS is equally focused on working in partnership with states to deliver higher quality care through value-based payment models for Medicaid beneficiaries. Through programs such as the State Innovations Model and the Medicaid Innovation Accelerator Program, CMS supports the development and implementation of innovative payment and delivery reforms such as shared savings programs and patient centered medical homes for Medicaid beneficiaries. Over $250 million in Model Test awards is supporting six states to implement their State Health Care Innovation Plans. Delivery system incentives payment programs (DSRIP) are in use in a number of states as a means to transform the local delivery system and provide the infrastructure necessary to bring better care to Medicaid beneficiaries.

The momentum towards value-based care continued this year, as in April 2015, Congress enacted the Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) of 2015, which requires the creation of the Merit-Based Incentive Payment System for physicians and new rules for financially incentivizing physicians to join eligible alternative payment models. In FY 2015, CMS began efforts to gather input from providers and other stakeholders so we develop models that will encourage participation in new models. These efforts will help CMS achieve the shared goal of transforming our health system into one that pays for value for the patient, rather than on volume.

CMS's goal is to provide more than just payments but tools that help care providers transition to value-based care. CMS provides data to practices in alignment with commercial payers, and significant technical assistance such as awarding $685 million to 39 national and regional collaborative healthcare transformation networks to help equip more than 140,000 clinicians with tools and support needed

A MESSAGE FROM THE ACTING ADMINISTRATOR (CONTINUED)

ANDREW SLAVITT

to improve quality of care, increase patients' access to information, and spend dollars more wisely. Simplification is another important way we can help providers—CMS has focused on fostering simplicity wherever possible, and we have reduced unnecessary paperwork for providers by $3.2 billion over 5 years.

Data and Technology Infrastructure

One key to advancing health care is the creation of a more modern health care infrastructure and a better technical infrastructure in critical places. The Medicaid insurance program has been an important focus area. CMS continues to work with states to streamline application and eligibility determination processes and improve consumer experiences in Medicaid. More states are moving toward real-time or near real-time eligibility determinations and increasing the use of electronic data sources to verify eligibility, which reduces the burden on applicants and increases efficiencies for states. In June 2015, CMS published proposed regulations that would align requirements for managed care plans in Medicaid with Medicare where possible.

Data transparency is a priority for CMS. In November 2014, we named the agency's first Chief Data Officer as part of our commitment to be an information partner, not just a payer. Every year, we release over 200 new and updated data files on **CMS.gov**. We have gone from almost nothing in 2010 to over 400 different public use files in 2015. These files can be used individually, or in combination to better understand how our complex health care system works and what works best.

We are committed to not just making data public, but using it to improve consumer care experience, and to preserving and improving Medicare, Medicaid and the Marketplaces for the long term. We have helped consumers use data to make better decisions and to hold providers and payers accountable for the outcomes they deliver. For example, we strengthened the Five Star Quality Rating System for Nursing Homes on the Nursing Home Compare website to give families more precise and meaningful information on quality when they consider facilities for themselves or a loved one.

We are also using data to improve health equity and to increase understanding and expand awareness of health disparities, and are focused on Medicare populations that experience disproportionately high burdens of disease, lower quality of care, and barriers accessing health care.

We are all just at the beginning of the journey of using information to improve the system and CMS is continuing to leading the way.

Protecting Taxpayer Dollars

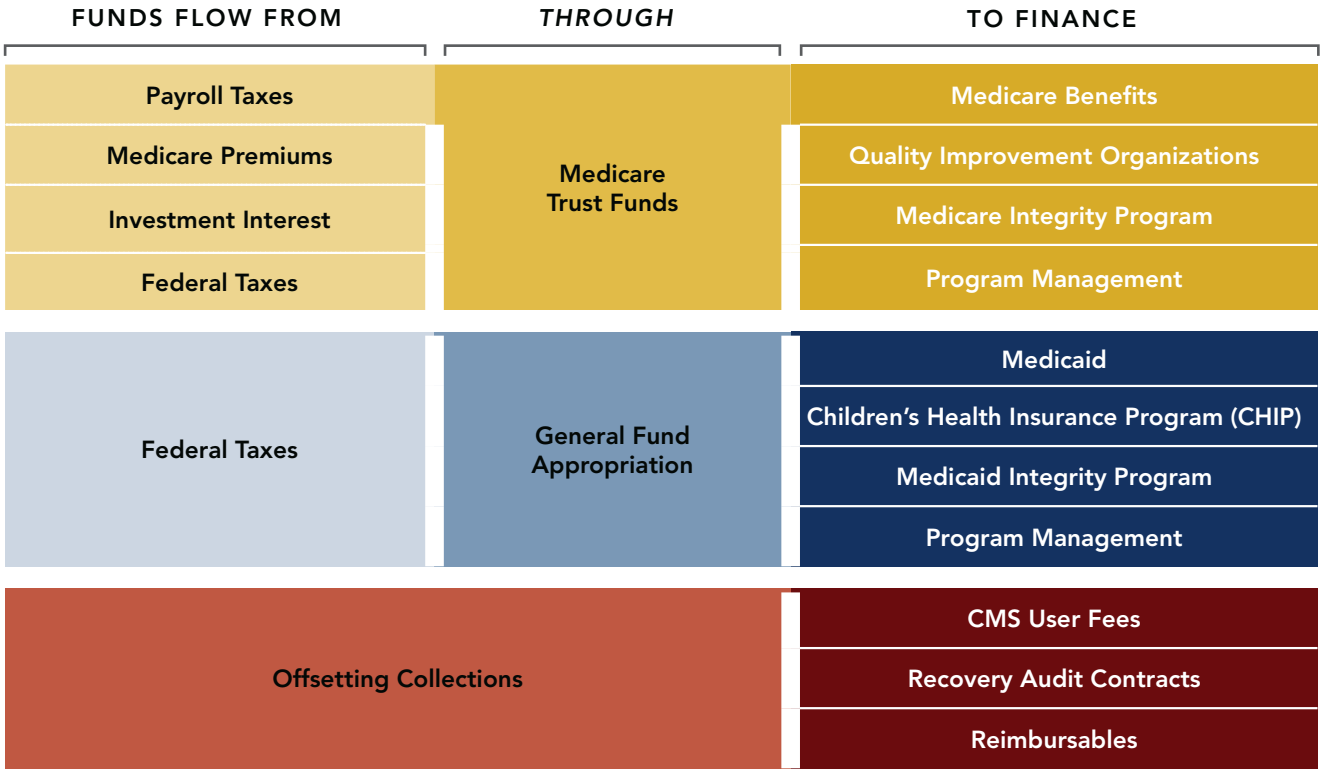
We are managing CMS programs with a comprehensive program integrity strategy. We are using our sophisticated predictive analytics system, the Fraud Prevention System, to identify and prevent inappropriate Medicare payments, and it has identified or prevented $820 million in inappropriate payments in the program's first three years. In Calendar Year 2014 alone (the most recent year for which data are available), the system identified or prevented $454 million, which is an almost $10 to $1 return on investment. Thanks in part to the Affordable Care Act, CMS has improved its provider enrollment process, and we are seeing real results from our efforts. Since March 2011, we have saved over $2.4 billion in avoided costs from these enrollment activities. We are also partnering with commercial payers in the Healthcare Fraud Prevention Partnership to target fraud across Medicare, Medicaid and the private sector. We work closely with the HHS Office of Inspector General and the Government Accountability Office to identify vulnerabilities and implement improvements that increase the efficiency of the programs. These combined efforts are effective in preventing fraud, waste, and abuse and in protecting beneficiaries from harm.

I believe our work is creating meaningful change for consumers and for care providers as we seek to provide our beneficiaries with more access to high quality health care services and keep people healthy and at home. The successes of Medicaid, Medicare, and the Marketplace are a shared effort, and I would like to thank all the health care providers, advocates, elected officials, states, and private sector organizations who have supported and contributed to CMS's work this year and mostly to those who have fully committed to providing quality care to our Nation's seniors, working poor, and uninsured throughout our communities, states, and territories across the country.

I am grateful to the staff of CMS for their commitment, passion, ingenuity, and human touch. Ultimately, in all of our regions throughout the country, CMS's staff is committed to bringing the policies and programs we are charged with to the kitchen tables of Americans who depend on these programs.

ANDREW M. SLAVITT
Acting CMS Administrator
November 2015

FINANCING OF CMS PROGRAMS & OPERATIONS



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OUR MISSION: WE ENVISION OURSELVES AS A MAJOR FORCE AND TRUSTWORTHY PARTNER FOR CONTINUAL IMPROVEMENT OF HEALTH AND HEALTH CARE FOR ALL AMERICANS.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

APPROVED LEADERSHIP
as of September 30, 2015

* Acting
** Reports to Deputy Admin. for Innovation and Quality

1

MANAGEMENT'S DISCUSSION AND ANALYSIS

Overview // Programs // Performance Goals
Financial Highlights

OVERVIEW

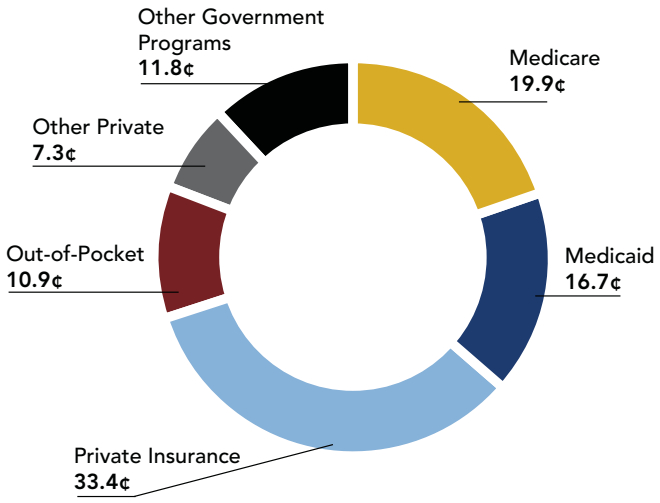
CMS, a component of HHS, administers Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Clinical Laboratory Improvement Amendments of 1988 (CLIA). With the passage of the Affordable Care Act, CMS's role in the larger health care arena has been further expanded beyond our traditional role of administering the Medicare, Medicaid, and CHIP Programs. The Affordable Care Act puts in place comprehensive health insurance reforms. Because of this law, all Americans will have access to affordable health insurance options. The Marketplace allows individuals and small businesses to compare health plans on a level playing field. Middle and low-income families will get advance payments of the premium tax credit that help make insurance coverage more affordable. The Medicaid program was expanded to cover more low-income Americans. These reforms mean that millions of people who were previously uninsured will gain coverage and provide significant steps towards expanding coverage and improving access to health care, while also improving the quality and affordability of health care for all Americans. Over the last 50 years, CMS has evolved into the world's largest purchaser of health care.

As the largest purchaser of health care in the world, CMS maintains the Nation's largest collection of health care data. Based on the latest projections, Medicare and Medicaid (including state funding) represent 37 cents of every dollar spent on health care in the United States (U.S.)—or looked at from three different perspectives: 51 cents of every dollar spent on nursing homes, 44 cents of every dollar received by U.S. hospitals, and 33 cents of every dollar spent on physician services. CMS outlays totaled approximately $914.1 billion (net of offsetting collections and receipts) in fiscal year (FY) 2015. Our expenses totaled approximately $1,011.9 billion, of which $8.5 billion (or less than one percent) were administrative expenses.

CMS employs over 6,000 federal employees in Maryland, Washington, DC, and 10 regional offices (ROs) throughout the country. CMS provides direct services to state agencies, health care providers, beneficiaries, sponsors of group health plans, Medicare health and prescription drug plans, and the general public. Employees also write policies and regulations that establish program eligibility and benefit coverage; set payment rates; safeguard the fiscal integrity of the programs it administers from fraud, waste, and abuse; and develop quality measurement systems to monitor quality, performance, and compliance. CMS also provides technical assistance to Congress, the Executive branch, universities, and other private sector researchers.

Many important activities for which CMS is responsible for are also handled by third parties. Each state administers the Medicaid program and CHIP, as well as inspects hospitals, nursing homes, and other facilities to ensure that health and safety standards are met. The Medicare Administrative Contractors (MACs) 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 is provided to Medicare beneficiaries.

THE NATION'S HEALTH CARE DOLLAR 2015



Source: U.S. Treasury

Outlays refer to cash disbursements made to liquidate an expense regardless of the FY the expense was incurred.

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.

PROGRAMS

Medicare

Medicare was established in 1965 as title XVIII of the Social Security Act. It 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. The Medicare program was further expanded in 2003 to include a prescription drug benefit. In 2010, legislation was signed to develop comprehensive reforms that strengthen the Medicare program—the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act, collectively referred to as the Affordable Care Act. The Affordable Care Act continues to impact CMS's roles and responsibilities.

Medicare processes over one billion fee-for-service (FFS) claims a year, and accounts for approximately 16 percent of the Federal budget. Medicare is a combination of four programs: Hospital Insurance, Supplementary Medical Insurance, Medicare Advantage, and Medicare Prescription Drug Benefit. Since 1966, Medicare enrollment has increased from 19 million to approximately 56 million beneficiaries.

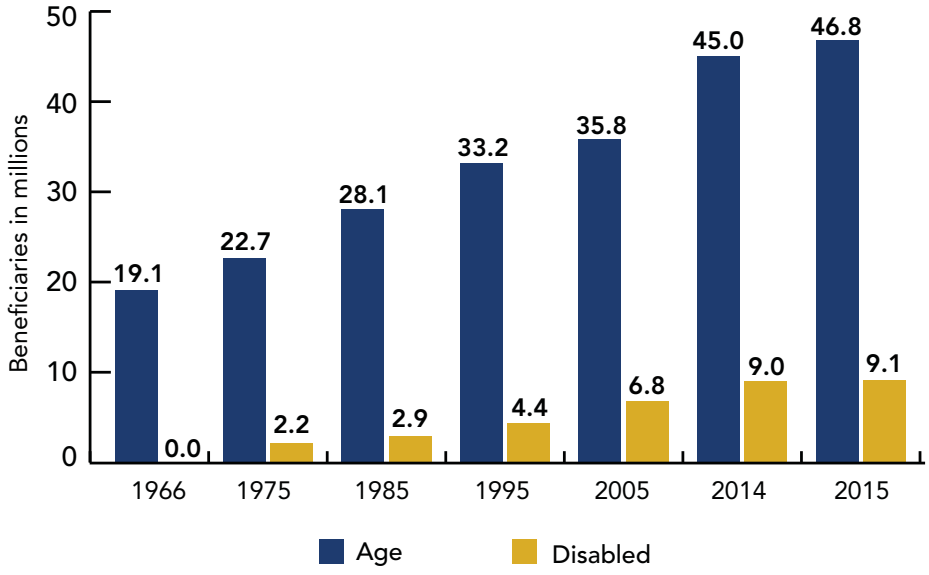
Hospital Insurance

Hospital Insurance, also known as HI or Medicare Part A, is usually provided automatically to people aged 65 and over who have worked long enough to qualify for Social Security benefits and to most disabled people entitled to Social Security or Railroad Retirement benefits. The HI program pays for hospital, skilled nursing facility, home health, and hospice care and is financed primarily by payroll taxes paid by workers and employers. The taxes paid each year are used mainly to pay benefits for current beneficiaries. Funds not currently needed to pay benefits and related expenses are held in the HI Trust Fund and invested in Treasury securities. Based on estimates from the Midsession Review of the FY 2016 President's budget, inpatient hospital spending accounted for 52 percent of HI benefit outlays in FY 2015. Managed care spending comprised 29 percent of total HI outlays. During FY 2015, HI benefit outlays increased by 3.1 percent, and the HI benefit outlays per enrollee were projected to decrease by 0.45 percent to $4,910.

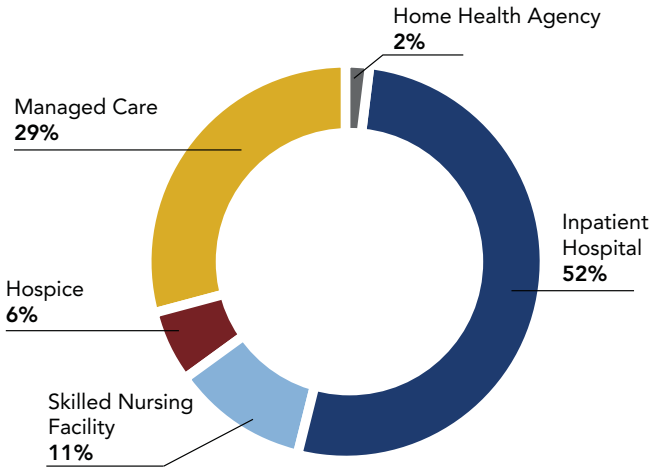
Supplementary Medical Insurance

Supplementary Medical Insurance, also known as SMI or Medicare Part B, 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 (DME), designated

MEDICARE ENROLLMENT

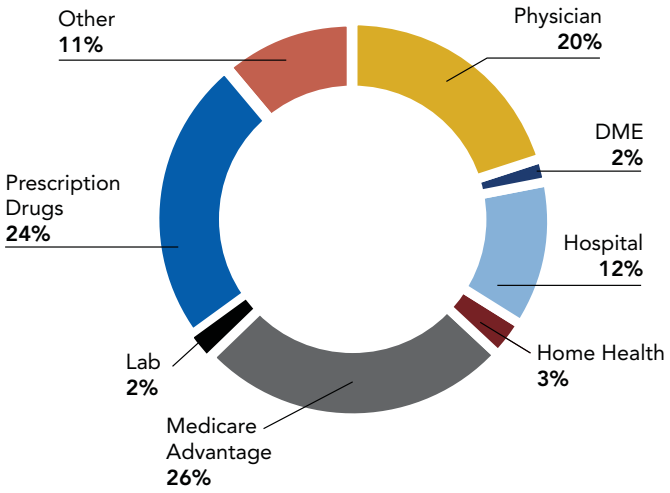


HI MEDICARE BENEFIT PAYMENTS



Source: CMS/OACT

SMI MEDICARE BENEFIT PAYMENTS



Source: CMS/OACT

therapy, some outpatient prescription drugs, and other services not covered by HI. The SMI coverage is optional, and beneficiaries are subject to monthly premium payments. About 92 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 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 Treasury securities.

Also, based on estimates from the Midsession Review of the FY 2016 President's budget, SMI benefit outlays increased by 8.5 percent during FY 2015. Managed care payments, the largest component of SMI, accounted for 26 percent of SMI benefit outlays. During FY 2015, the SMI benefit outlays per enrollee were projected to increase 5.4 percent to $7,070.

Medicare Advantage

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) created the Medicare Advantage (MA) program, which is designed to provide more health care coverage choices for Medicare beneficiaries. Those who are eligible because of age (65 or older) or disability may choose to join a MA plan servicing their area if they are entitled to Part A and enrolled in Part B. 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 contract with CMS instead of receiving services under traditional FFS arrangements offered under original Medicare. The types of MA plans include Health Maintenance Organizations (HMOs), Local Preferred Provider Organizations (LPPOs), Regional Preferred Provider Organizations (RPPOs), Private Fee-For-Service (PFFS) plans, and Medical Savings Account (MSA) 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 payment and must provide all Medicare covered services. 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. In contrast, 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, and may also provide the additional services that some risk MA plans offer. Cost plan enrollees may receive services through the plan's network or through Original Medicare. The HCPPs are paid in a manner similar to cost contractors, but cover only non-institutional Part B Medicare services. There can be no new section 1876 cost based contractors.

Managed care expenses were approximately $169.3 billion of the total $617.3 billion in Medicare benefit payment expenses in FY 2015.

Medicare Prescription Drug Benefit

The addition of the voluntary Prescription Drug Benefit program via MMA 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 or Part B. Beneficiaries who qualify for both Medicare and Medicaid (full-benefit dual-eligibles) are automatically enrolled in the Medicare drug program. 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 that is at least actuarially equivalent to the standard coverage benefit. The 2015 standard benefits generally have a $320 deductible and coinsurance of 25 percent after the deductible up to the initial coverage limit of $2,960 in total drug spending. This was historically followed by a coverage gap for which beneficiaries paid 100 percent to an out-of-pocket spending limit of $4,700. 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. Starting in year 2011, the Affordable Care Act added additional coverage for prescription drugs to gradually eliminate the coverage gap by year 2020 for qualifying beneficiaries. For year 2015, it includes 35 percent plan coverage for generic drugs and a 55 percent discount on the ingredient cost of brand name drugs. 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.

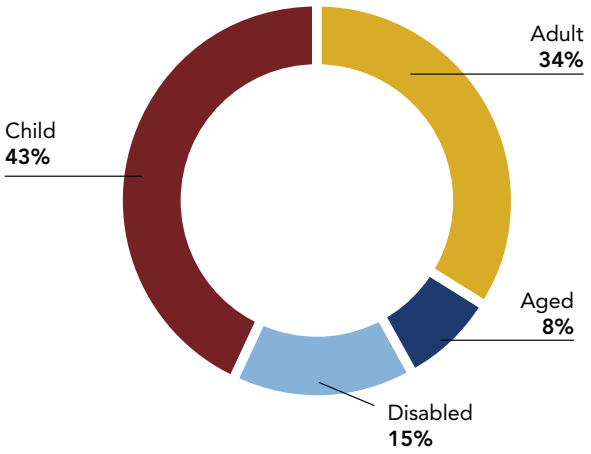
After each plan year, the prospective payments are reconciled with actual plan costs. Either additional payments to plans or refunds to Part D will result from this reconciliation. Since the reinsurance and low-income benefits are fully funded by the Federal Government, the prospective reinsurance and 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 Affordable Care Act provisions which fill in the coverage gap.

Medicaid

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

FY 2015 MEDICAID ENROLLEES



Source: CMS/OACT

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, most recently with the Affordable Care Act. 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 number of individuals in the Medicaid and CHIP programs who are receiving comprehensive benefits was estimated at over 70 million in FY 2015, about 22 percent of the U.S. population. About 10.5 million people are dually eligible, that is, covered by both Medicare and Medicaid.

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 2015, the basic federal matching rate for Medicaid program costs among the states according to the formula ranged from 50 to 73.6 percent, with certain states receiving 100 percent match for the populations covered through an expansion of their programs via the Affordable Care Act to cover adults up to 133 percent of the federal poverty level (FPL). The weighted average matching rate for FY 2015 is expected to be 62.1 percent, which is higher than in previous years, due to the higher matching on the newly eligible Medicaid expansion populations. Federal matching rates for various state and local administrative costs are set by statute. Medicaid payments to states are funded by federal general revenues provided to CMS through an annual appropriation.

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 a minimum, services that are 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 2015, Medicaid spending for persons with AIDS as well as others infected with the Human Immunodeficiency Virus (HIV) is estimated to be about $12 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[1]

Under Medicaid, state payments for both medical assistance payments (MAP) and administrative (ADM) costs are matched with federal funds. In FY 2015, state and federal ADM gross outlays are estimated at $31.4 billion, about 5.7 percent of the gross Medicaid outlays. State and federal MAP total outlays were $516.3 billion or 94.3 percent of total Medicaid outlays, an increase of 8.1 percent over FY 2014. Thus, estimated state and federal MAP and ADM outlays for FY 2015 totaled $547.7 billion. The federal share of Medicaid outlays totaled $341.6 billion in FY 2015.

[1] Payments in this paragraph are estimated, based on the Mid-Session Review of the President's FY 2016 budget.

Enrollees

Children and non-aged, non-disabled adults comprise 77 percent of Medicaid enrollees, and account for only an estimated 44 percent of Medicaid outlays. In contrast, the elderly and disabled comprise 23 percent of Medicaid enrollees, but account for an estimated 56 percent of program spending. The elderly and disabled use more expensive services in all categories, particularly nursing home services.

Service Delivery Options

Many states are pursuing managed care as an alternative to the FFS system for their Medicaid programs. Managed health care provides several advantages for Medicaid beneficiaries, such as enhanced continuity of care, improved preventive care, and prevention of duplicative and contradictory treatments and/or medications. Most states have taken advantage of waivers provided by CMS to introduce managed care plans tailored to their state and local needs, and 49 states and territories now offer a form of managed care. 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 waivers of existing federal statutes and other options through the state plan process to implement managed care delivery systems.

1. **Medicaid demonstrations:** section 1115 of the Social Security Act provides 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. **Voluntary managed care:** section 1915(a) of the Social Security Act allows states to implement a voluntary managed care program to provide individuals a choice between FFS and a managed care delivery system.
3. **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.
4. **Other state plan options to implement managed care:** section 1932(a) of the Social Security Act allows states to mandate managed care enrollment for certain groups of Medicaid beneficiaries. Certain populations—including dual eligibles, children receiving SSI, children with special health care needs, and American Indians—are exempted from the state plan option. For these groups, the states require waivers to mandate enrollment into managed care. Section 1937 of the Social Security Act allows individuals receiving the Alternative Benefit Plan to be enrolled in managed care as well.
5. **Program of All-Inclusive Care for the Elderly (PACE):** states may also elect to include PACE as a state plan option. PACE is a prepaid (per person per month) 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.

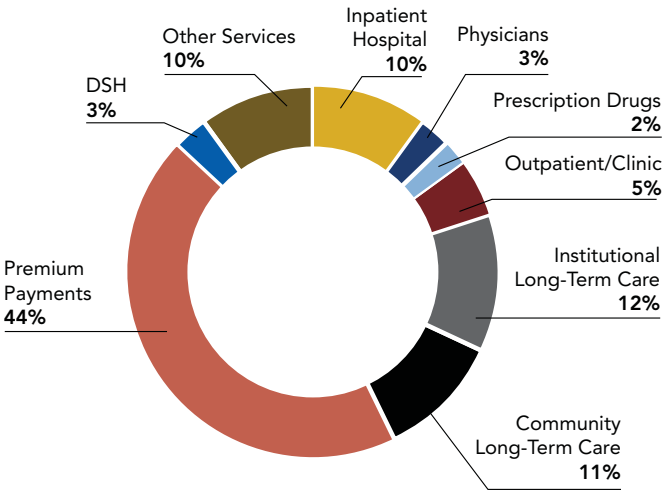
Congress has passed several pieces of legislation that have impacted Medicaid. The Affordable Care Act expanded eligibility for Medicaid to adults with incomes below 133 percent of the FPL beginning January 1, 2014, with a state option to begin coverage earlier. The Affordable Care Act also provided 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.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. The ARRA provisions provided Medicaid programs with temporarily increased federal match rates and considerable new resources to promote and expand the use of health information technology (HIT) and the Health Information Exchange (HIE) 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/HIE is key to CMS's efforts to better measure, monitor and assure the quality of care provided in Medicaid.

MEDICAL ASSISTANCE PAYMENTS BY AGGREGATE SERVICE CATEGORIES

IN BILLIONS

Total Payments: $497 billion



Source: President's FY 2016 Budget, Mid-session Review

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

- Establishing an annual core set of child and adult quality performance measures for voluntary reporting by state Medicaid and CHIP programs
- $100 million across ten grants (that include 18 states) to test innovative approaches to using performance measures, HIT/HIE, EHR, and provider delivery models to improve the quality of care for children;
- Establishing a model EHR format specifically for children;
- A Maternal and Infant Health Initiative that leverages existing partnerships and activities to increase the rate of postpartum visits and increase the use of effective methods of contraception in both Medicaid and CHIP in at least twenty states over a 3-year period;
- A Children's Oral Health Improvement Initiative that has goals to improve the use of preventive dental services over five years and to increase the use of sealants among children;
- Improving access, data collection/reporting, and assessment of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services; and
- Demonstration grants across 26 states to measure and improve the quality of healthcare for adults in Medicaid.

Additionally, CMS has collaborated to identify home and community based service (HCBS) quality measures through a HHS funded partnership with the National Quality Forum (NQF) that will result in recommended measures as well as gaps in measures that need to be addressed.

Federal Medical Assistance Percentages (FMAP) Increases for Territories

Under section 1905 (b) of the Social Security Act, as amended, the FMAP for the territories was increased from 50 percent to 55 percent effective July 1, 2011. The Affordable Care Act also provided for a total increase to the territories of $6.3 billion for the period from July 1, 2011 through September 30, 2019, to be allocated among the territories on the basis of their section 1108 caps as available on the date of enactment of the Affordable Care Act. Section 1323 of the Affordable Care Act, also provided for $1 billion in funding for the territories to be available either to increase the territories' section 1108 cap or to provide for premium and cost-sharing assistance to the residents of the territories who obtain health insurance coverage through an Affordable Insurance Exchange. Under that provision, $925 million of the $1 billion is allocated to Puerto Rico and the remaining $75 million is allocated to the other four territories in accordance with the basis specified by the Secretary of HHS.

Medicaid Home and Community-Based Quality Improvement

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 allow 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 or the need for eligible individuals to meet an institutional level of care.

CMS works closely with our state partners on a continuous quality improvement process for 1915 (c) waiver programs. States are responsible for assuring the health and welfare of individual service recipients, and CMS is responsible for providing guidance to and oversight of the State's Waiver programs. The HCBS continuous quality improvement process starts with a program design focusing on a continuous quality improvement approach to key assurances and culminating with active oversight and reporting by the state.

The DRA authorized the Agency for Healthcare Research and Quality (AHRQ) to address measure development for the HCBS population, and that activity was furthered in the Affordable Care Act. Measure development works are presently being expanded with a focus on a variety of provisions targeting the HCBS populations, and are related to individual outcomes, quality of care, experience of care, and the health care of the HCBS populations.

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 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, CHIPRA further extended appropriating funds through FY 2013 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 through September 30, 2015. The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 extends CHIP funding through September 30, 2017.

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 safeguard 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. CMS works closely with the states, Congress, and other federal agencies to meet the challenges of implementing this program. 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 September 2015 state programs for CHIP included 14 Medicaid expansions (includes District of Columbia and all of the territories), 1 separate CHIP and 29 combination CHIP programs. There are 11 states with separate CHIP programs but for the required transition of children ages 6-18 in families earning under 133 percent of the FPL.

Consumer Information and Insurance Oversight

CMS is charged with implementing many of the provisions of the Affordable Care Act that relate to private health insurance. CMS works to hold insurance companies accountable for compliance with new market reforms, increase industry transparency, and build health insurance Marketplaces where private insurers compete on the basis of price and quality.

CMS works in conjunction with states to ensure compliance with market reforms that protect consumers through policies like prohibiting insurers from denying coverage for pre-existing conditions, prohibiting annual and lifetime dollar limits on essential health benefits, and ensuring that issuers are complying with new rating requirements. CMS also oversees the implementation of rules related to medical loss ratio.

Health Insurance Rate Review/ Medical Loss Ratio

The rate review and medical loss ratio programs are two mechanisms to help ensure that consumers receive a good value for their premium dollar and to make health insurance markets more transparent. Between FY 2010 and FY 2014, CMS has awarded $262.4 million in Health Insurance Rate Review Grants to states, territories and the District of Columbia, to help strengthen and improve their rate review processes. CMS works in conjunction with states to ensure that all proposed rate increases at or above 10 percent (or a state-specific threshold) are based on reasonable cost assumptions and solid evidence. Additionally, beginning January 1, 2014, CMS is also responsible for monitoring all rate increases.

CMS is also charged with enforcing compliance with a federal minimum medical loss ratio (MLR) requiring that issuers spend at least 80 percent (for individuals or small groups) or 85 percent (for large group markets) of premium dollars on patient care or refund the difference to enrollees.

Enforcement

CMS is responsible for ensuring that issuers comply with new insurance market reforms included in the Affordable Care Act, the Mental Health Parity and Addiction Equity Act (MHPAEA), the Health Insurance Portability and Accountability Act (HIPAA), the Women's Health and Cancer Rights Act (WHCRA), the Newborns' and Mothers' Health Protection Act, Michelle's Law, and the Genetic Information Nondiscrimination Act (GINA). While states have primary authority to enforce these provisions with respect to health insurance issuers, CMS assumes enforcement authority if a state notifies CMS that it either lacks the authority to or is not otherwise enforcing one or more of these provisions. CMS currently has authority to directly enforce federal law in five states: Alabama, Missouri, Oklahoma, Texas, and Wyoming. Enforcement activities include reviewing issuers' policy forms, performing market conduct examinations, and conducting other investigatory activities to ensure issuers are compliant with the laws listed above. CMS also has direct enforcement authority over non-Federal Governmental group health plans.

Consumer Information and Support

CMS continues to provide consumers with clear information about their coverage options. One avenue is via **HealthCare.gov**, which houses the Plan Finder—the first central database of health coverage options. The Plan Finder combines information about public programs with pricing and benefits information on the individual/ family market and the small group market private insurance plans. **HealthCare.gov** offers consumers a trusted, noncommercial, user-friendly environment that allows consumers to compare plans, obtain information about products that were previously unavailable on commercial sites (such as the number of applicants denied for a specific plan), and weigh options related to cost sharing and covered and not covered benefits among various plans. Another way CMS supports increased transparency for consumers is by requiring all plans and issuers currently offering health benefits to provide to consumers a Summary of Benefits and Coverage (SBC), including coverage examples with details on costs for distinct treatment scenarios, and a uniform glossary of common health insurance terms. The SBC and uniform glossary help consumers make an "apples to apples" comparison of health insurance products by providing consumers with equivalent information on available coverage options. CMS further protects consumers through the enforcement of a set of uniform standards for internal appeals and external review of claim or coverage denials. Now, consumers in employer-sponsored group health plans and in individual health insurance policies have improved rights to: obtain information about why a claim or coverage has been denied, appeal to the insurance company and have an appeal expedited if necessary, and in some instances, ask an independent third party to review decisions made by their plans and insurance companies.

CMS has direct jurisdictional authority over non-Federal Governmental group health plans and provides some direct health insurance assistance services to consumers enrolled in such plans. Additionally, to support states' efforts to establish or strengthen programs that provide direct services to consumers with questions about health insurance, CMS provides limited direct assistance and referral services to consumers with Affordable Care Act related questions who reside in states without Consumer Assistance Programs (CAPs). CMS provides consumers with casework

assistance to resolve complex Marketplace issues allowing CMS to monitor and track qualified health plan (QHP) issuer compliance, Marketplace operations and in-person enrollment assister behavior. In late FY 2015, CMS awarded additional cooperative agreements to states with a Federally Facilitated Marketplace (FFM) or State Partnership Marketplace (SPM) to conduct public education activities to raise awareness of QHPs; distribute fair, impartial, and linguistically appropriate information concerning enrollment in QHPs and the availability of premium tax credits; facilitate enrollment in QHPs; and provide referrals for any enrollee with a grievance, complaint or question regarding existing coverage. CMS also uses contracted services for the Enrollment Assistance Program (EAP) to provide a multi-dimensional approach to in-person enrollment assistance in the FFM and SPM. CMS develops and updates training content required for the certification and recertification of Navigator and non-Navigator in-person assisters, including Certified Application Counselors (CACs), and in FY 2015 developed a new platform to host the training. CMS launched the Assister Help Resource Center (AHRC), in order to address and track assister inquiries involving complex consumer issues to better serve assisters and consumers.

Coverage to Care Support for Marketplace Activities

In FY 2015, CMS developed and disseminated 14 From Coverage to Care (C2C) resources, each in six additional languages to support persons new to health coverage to understand their insurance and connect to the care they need for longer, healthier lives. With these additional 84 products, C2C now offers products in eight total languages and has an additional Tribal and Customizable version of the Roadmap to Better Care and a Healthier You. The additional languages were chosen based on the most frequently requested languages for the Marketplace Call Center, and based on data from the Census Bureau for the proportion of individuals who speak one of the ten most frequently spoken languages at home other than English, and who speak English less than very well. Along with Spanish, these languages account for more than 80 percent of the 25 million people who speak English less than very well. To ensure a high quality product, all products underwent thorough community reviewer feedback and were edited accordingly. These resources will educate consumers about their coverage and empower them with the necessary tools to use their coverage to navigate the health care system.

Affordable Insurance Marketplaces

CMS is working closely with states to implement the Marketplaces. Since January 1, 2014, Marketplaces have helped individuals and small businesses to better understand their insurance options, and have assisted them in shopping for, selecting, and enrolling in high-quality, competitively-priced private health insurance plans. By providing one-stop shopping, the Marketplaces make purchasing health insurance easy and understandable; giving individuals and small businesses access to increased options for and control over their health insurance purchases. During the first open enrollment period, October 1, 2013 to March 31, 2014, over 8 million individuals selected QHPs through the Marketplaces, and in the second open enrollment period from November 15, 2014 to February 15, 2015, 11.7 million individuals enrolled or selected a new QHP.

To help make health insurance more affordable to consumers, CMS makes payments of the advance premium tax credit (APTC) and cost-sharing reductions (CSR) to health insurance issuers on behalf of consumers who are eligible for financial assistance. APTC and CSR payments (which are not included in CMS's financial statements; see Note 1 for more information) are a critical component of the Marketplace, and approximately $30 billion has been allocated for these payments in FY 2015. In addition to these payments on behalf of consumers, CMS collects Marketplace user fees from issuers participating in the FFM.

As of September 2015, approximately $5.5 billion has been awarded to states to support the establishment of their Marketplace. CMS monitors the progress on establishing the Marketplaces through Establishment Reviews. These reviews assess progress through planning, design, development, implementation, and operations. Grants were awarded through December 31, 2014, for all Marketplace models. Grant funds are available for permissible establishment activities, which include expenses for outreach, testing, and necessary improvements during the establishment phase. Funding can also be used to support states that wish to transition from a State-Partnership Marketplace (SPM) or FFM to a State-based Marketplace (SBM).

Premium Stabilization Programs

To more evenly spread the financial risk borne by issuers and help stabilize premiums, the Affordable Care Act establishes a transitional reinsurance program (in section 1341), a permanent risk adjustment program (in section 1343), and a

temporary risk corridors program (in section 1342), collectively referred to as the premium stabilization programs, to provide payments to health insurance issuers that cover higher-cost and higher-risk populations. These programs are intended to mitigate the potential impact of adverse selection and stabilize the price of health insurance in the individual and small group markets. These programs, together with other reforms of the Affordable Care Act, are making high-quality health insurance affordable and accessible to millions of Americans.

Reinsurance

Section 1341 of the Affordable Care Act established a transitional reinsurance program to stabilize premiums in the individual market inside and outside of the Marketplaces. The transitional reinsurance program collects contributions from contributing entities to fund reinsurance payments to issuers of non-grandfathered reinsurance-eligible individual market plans, the administrative costs of operating the reinsurance program, and the General Fund of the Treasury for the 2014, 2015 and 2016 benefit years. In FY 2015, CMS has collected approximately $8.7 billion in reinsurance contributions for the 2014 benefit year, with approximately $1 billion more scheduled to be collected on or before November 15, 2015. In August 2015, CMS began making over $7.9 billion in reinsurance payments to 437 issuers nationwide.

Risk Adjustment

The risk adjustment program, established by section 1343 of the Affordable Care Act, provides payments to health insurance issuers that attract high-risk enrollees, such as those with chronic conditions. The program also reduces the incentives for issuers to avoid those enrollees, and lessens the potential influence of risk selection on the premiums that plans charge. The program therefore incentivizes issuers to provide coverage with an appropriate level of benefits and services at an affordable premium. On June 30, 2015, CMS announced the determination of Risk Adjustment receipts (charges) and expenditures (payments), collectively known as transfers. Risk Adjustment is a budget neutral program meaning payments must equal charges. Starting in August 2015, CMS began collecting charges and making payments. In FY 2015 (benefit year 2014), CMS transferred $1.7 billion for risk adjustment transfers.

Risk Corridors

Section 1342 of the Affordable Care Act directs the Secretary to establish a temporary risk corridors program that protects against inaccurate rate setting in the 2014 through 2016 benefit years. The risk corridors program applies to qualified health plans (QHPs) in the individual and small group markets. The temporary risk corridors program protects QHPs from uncertainty in rate setting from 2014 to 2016 by limiting the extent of issuer losses and gains. In FY 2015, no amounts have been collected or paid.

Access to Affordable Health Benefits Coverage

To help increase consumer access to affordable benefits coverage options today, CMS oversees the Early Retiree Reinsurance Program (ERRP) and the Consumer Operated and Oriented Plan (CO-OP) program.

ERRP, a temporary program that ended January 1, 2014, provided reimbursement to sponsors of qualified employment-based health plans for a portion of the cost of health benefits for early retirees and their spouses, surviving spouses, and dependents. ERRP reimbursed 80 percent of the actual cost of health benefit expenses (paid by the plan or paid by or on behalf of an individual) between a cost threshold and cost limit. ERRP supported the availability of affordable health benefits coverage to early retirees and their families by making reinsurance payments to approximately 2,900 plan sponsors. Participating plan sponsors included commercial, non-profit, union and religious organizations as well as state and local governments.

The CO-OP program fosters and encourages the creation of new non-profit, consumer-governed health insurance companies to provide more competition and choice in the Affordable Insurance Marketplace that is responsive to consumer needs. The CO-OP program provided low-interest loans to eligible nonprofit groups to help set up and maintain these new health insurance issuers. CO-OPs that improve the coordination of care, can operate statewide, and have private support are more likely to be funded. After a rigorous selection process, 24 CO-OPs were established, 23 of which were subsequently licensed to operate in 22 states in every region of the country, coast-to-coast and border-to-border. As of September 30, 2015, CMS awarded $2.5 billion in CO-OP loans with $2.1 billion disbursed.

Other Program Initiatives and 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. CMS continues to make progress toward strengthening and modernizing the Nation's health care to provide access to high quality and improved health at lower costs. CMS's strategy outlines the critical work that the Agency conducts in achieving—(1) better care and lower costs; (2) prevention and improved population health; (3) expanded health care coverage; and (4) enterprise excellence.

Business Transformation

The role of CMS in the American health care system is evolving rapidly. New legislative mandates and changes in the external environment—including budgetary pressures, demographic changes and technological advances—have dramatically expanded CMS's responsibilities and placed new operational demands on the Agency. As a result, CMS must find methods for carrying out its current activities more efficiently while simultaneously developing a host of new capabilities.

CMS embraces these changes and the expanded responsibilities that come with them as an opportunity to strengthen the U.S. health care system and increase access to affordable, high-quality care. In order to do so, CMS is undertaking a comprehensive, long-term transformation of its business operations as part of its CMS Strategy. Transformations are defined as high-priority, complex operations initiatives that require coordinated, cross-component management and oversight.

The CMS Strategy and its business transformation objective lay the foundation to manage a coordinated, Agency-wide transformation of critical operational capabilities that will enable CMS to:

- Align business operations with the Agency's key strategic objectives;
- Develop new capabilities required to meet the changing demands posed by regulatory requirements and the rapidly evolving health care landscape;
- Guide and prioritize investments;
- Enhance enterprise excellence by improving performance and operational efficiency; and
- Promote increased transparency, collaboration, and agility.

Business transformation was developed following a comprehensive review of the Agency's internal capabilities and future needs, as well as best practices in transformation programs.

CMS Alliance to Modernize Healthcare (CAMH) Federally Funded Research Development Center (FFRDC)

In September 2012, CMS established the CAMH. The CAMH is sponsored by CMS and is a FFRDC operated by the MITRE Corporation, a not-for-profit organization that operates research and development centers sponsored by the Federal Government. The CAMH FFRDC is an objective, independent advisor for HHS as well as other governmental and non-profit entities to advance the Nation's progress toward an integrated healthcare system with improved access and quality at a sustainable cost. In FY 2015, CMS awarded task orders to support various critical projects and initiatives to advance CMS's and HHS's mission and progress towards meeting strategic goals and objectives. The following are the capabilities of the CAMH FFRDC:

- Strategic and Tactical Planning and Analysis;
- Conceptual Planning and Proof of Concept;
- Acquisition Assistance;
- Organizational Planning and Relationship Management;
- Continuous Process Improvement;
- Strategic Technology Evaluation; and
- Feasibility Analysis and Design.

Medicare and Medicaid Innovation

CMS continually tests innovative payment and service delivery models that have the potential to reduce Medicare, Medicaid and CHIP expenditures while preserving or enhancing quality of care for beneficiaries. The Affordable Care Act provides $10 billion in budget authority for fiscal years 2011 through 2019 for the design, implementation, and evaluation of these payment and service delivery model tests. CMS's efforts, coupled with transformational payment changes instituted by the Affordable Care Act, will help drive continual improvement of health and health care for Medicare, Medicaid and CHIP beneficiaries and achieve better value for our health care dollars.

CMS is transforming itself from a claims payer in a fragmented care system into a partner working with health care providers and the Nation's healthcare delivery system to achieve better care, smarter spending, and healthier people by supporting the adoption of alternative payment models. CMS envisions a people-centered health care system where individuals receive the right care, in the right setting, at the right time, every time.

In order to promote innovation in health care payment and delivery, CMS actively consults with a wide array of stakeholders from the health care community, including sister agencies, health care providers and organizations, clinical researchers, insurers, academic medical systems, advocacy groups, the health care industry, and State Medicaid Directors. CMS also posts Requests for Information (RFIs) to learn more about health care community interests and needs, and holds listening sessions for targeted groups, call-in "Open Door Forums" for both providers and beneficiaries, and webinars and conference calls about new health care model tests and initiatives.

CMS has actively sought to partner with professional societies, health care education and research institutions, the media, and other organizations to disseminate best practices and encourage further innovation, and has developed a significant online presence in support of these efforts, including a website devoted to Medicare and Medicaid Innovation (**http://innovation.cms.gov**). CMS tests and evaluates new models of health care payment and delivery in three primary ways: through initiatives designed to advance and diffuse best practices, through the development and oversight of Congressionally-mandated demonstrations, and through the development and testing of new payment and service delivery models based on ideas from the caregiver community.

Medicaid Innovation Accelerator Program

To spur innovation between CMS and the states, CMS created the Medicaid Innovation Accelerator Program (IAP) with the goal of improving health and health care for Medicaid beneficiaries by supporting states' ongoing payment and service delivery reforms efforts. Through the IAP, states can receive targeted program support designed around their ongoing delivery and payment system innovations efforts. CMS launched the four year program in July 2014.

Medicare and Medicaid Coordination

Under the Affordable Care Act, CMS brings together Medicare and Medicaid in order to more effectively integrate benefits and improve the coordination between the Federal Government and states to ensure access to quality services for Medicare-Medicaid enrollees. Medicare-Medicaid enrollees have significant health needs and account for a disproportionate share of Medicare and Medicaid program expenditures. Improved care coordination for this population could dramatically improve their health outcomes, but the current lack of alignment between the two programs often creates barriers to better care coordination, improved quality, and lower costs. To date, CMS has implemented a number of initiatives to assure it meets the statutory goals and responsibilities in section 2602 of the Affordable Care Act. CMS's ongoing initiatives support three main areas: Program Alignment; Data and Analytics; and Demonstrations and Models.

Program Alignment

CMS's goals include eliminating regulatory conflicts between Medicare and Medicaid programs and reducing or eliminating incentives to shift costs between Medicare and Medicaid and among providers. To foster progress in these goals and better coordinate benefits and services, CMS acts as a catalyst to align laws, rules, requirements, and policies among the programs. CMS is continually making progress toward maximizing program alignment in areas such as beneficiary appeals and managed care.

Data and Analytics

A major barrier for states in providing integrated care for Medicare-Medicaid enrollees has been lack of access to Medicare data. CMS established a process for states to access Medicare data to support care coordination for Medicare-Medicaid enrollees and monitor program integrity, while also protecting beneficiary privacy and confidentiality, which is used by thirty eight states. In addition, in FY 2015, CMS developed a free, de-identified public use version of its Medicare-Medicaid Linked Enrollee Analytic Data Source (MMLEADS) that is housed in the Chronic Condition Warehouse. Taken together, these data and tools will assist an even broader range of researchers and federal and state policymakers to better identify regions, populations, or necessary interventions to improve the quality, cost, and utilization of services for Medicare-Medicaid enrollees, as well as promote the integrity of the two programs.

As part of our efforts to better coordinate the Medicare and Medicaid programs, CMS has continued to release analytical reports to help provide policymakers, researchers, and other interested parties with a greater understanding and awareness of the population to foster program improvement. CMS has also worked with the National Quality Forum (NQF) to develop a recommended core set of quality measures, as well as priority gaps in measurement and measure stratification for high leverage areas that are responsive to the unique needs of Medicare-Medicaid enrollees.

Demonstrations and Models

The Affordable Care Act gives CMS the ability to test innovative payment and service delivery models that have the potential to improve the coordination and quality of care furnished to beneficiaries while also reducing program expenditures in Medicare and Medicaid. CMS has several initiatives underway utilizing this authority to promote the development of well-coordinated, person-centered, more efficient care delivery systems. CMS launched the Medicare-Medicaid Financial Alignment Initiative to more effectively integrate the Medicare and Medicaid programs to improve the overall beneficiary experience, improve quality, and reduce costs. Through this work, CMS is partnering with states to test two models—a capitated model and a managed fee-for-service model—to align the service delivery and financing between the Medicare and Medicaid programs, while preserving or enhancing the quality of care furnished to Medicare-Medicaid enrollees. CMS is currently testing these new models in 12 states.

The Balancing Incentive Program, authorized by Section 10202 of the Affordable Care Act, assists states in transforming their long-term care systems by lowering costs through improved systems performance and efficiency, creating tools to facilitate person-centered assessment and care-planning, and improving quality measurement and oversight. In addition, the Balancing Incentive Program provides new opportunities to serve individuals in home and community-based settings. The Balancing Incentive Program provides enhanced Federal Medical Assistance Percentages (FMAP) to states that spend less than 50 percent on long-term care dollars on care provided in home and community-based settings. CMS authorized approximately $2.4 billion in federal matching payments to twenty participating states. The Balancing Incentive Program performance period ended September 30, 2015.

The Money Follows the Person (MFP) Rebalancing demonstration program, initiated through section 6071 of the Deficit Reduction Act of 2005, was amended and expanded through section 2403 of the Affordable Care Act. The MFP program is aimed at assisting states to balance their long-term care systems, helping Medicaid enrollee's transition from institutions to the community, and is designed to help states shift Medicaid's long-term care spending from institutional care to home and community-based services (HCBS). Congress authorized $4 billion in federal funds through FY 2016 to:

- Increase the use of HCBS and reduce the use of institutionally-based services;
- Eliminate barriers and mechanisms in state law, state Medicaid plans, or state budgets that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive long-term care in the settings of their choice;
- Strengthen the ability of Medicaid programs to assure continued provision of HCBS to those individuals who choose to transition from institutions; and
- Ensure that procedures are in place to provide quality assurance and continuous quality improvement of home and community-based long-term care services.

The Testing Experience and Functional Tools (TEFT) demonstration grant initiative advances section 2701 of the Affordable Care Act by making available national adult quality measurement tools for the populations of individuals using Community Based–Long Term Services & Supports (CB-LTSS) where there is a lack of adequately tested measurement tools. Most quality measurement tools are population or state specific, and in general, not endorsed by any professional body such as the National Quality Forum. The TEFT Demonstration Grant Program (herein referred to as TEFT Demonstration) aims to expand the availability of national and rigorously tested tools for use with all beneficiaries using CB-LTSS. More specifically, the primary goals of the TEFT Demonstration are to: (1) Field test a beneficiary experience survey within multiple CB-LTSS programs for validity and reliability; (2) Field test a modified set of HCBS Functional Assessment Standardized Items (FASI) measures, formerly known as the Continuity Assessment Record and Evaluation (CARE) tool for use with beneficiaries of CB- LTSS programs; (3) Demonstrate use of personal health record (PHR) systems with beneficiaries of CB-LTSS; and (4) Identify, evaluate and harmonize an electronic Long Term Services and Supports (e-LTSS) standard in conjunction with the Office of National Coordinator's (ONC) Standards and Interoperability (S&I) Framework.

Medicare Shared Savings Program

The Medicare Shared Savings Program (Shared Savings Program) facilitates coordination and cooperation among providers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by participating in an

Accountable Care Organization (ACO). The program will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first.

Over the course of the agreement period, ACOs will better coordinate care, engage their beneficiaries, report on quality, and promote evidence-based medicine. CMS will measure ACOs' performance on quality measures relating to care coordination and patient safety, appropriate use of preventive health services, improved care for at-risk populations, and patient and caregiver experience of care. CMS will also monitor ACOs' activity throughout the length of the agreement period.

On June 9, 2015, CMS issued a final rule that will update and improve policies governing the Shared Savings Program. The changes improve the program in a number of areas including: adding a new performance-based risk option that includes prospective beneficiary assignment, a higher sharing rate and additional flexibility for ACOs to coordinate care and improve quality, refining the benchmark resetting policies to continue to provide strong incentives for ACOs to improve patient care and generate savings, increasing the emphasis on primary care services in beneficiary assignment, and streamlining data sharing to provide improved access to data necessary for ACO healthcare operations.

Health Care Quality Improvement

CMS seeks to improve health and health care for all Medicare beneficiaries and promote quality of care to ensure the right care at the right time, every time. HHS has developed the National Quality Strategy (NQS), which begins to establish national priorities to achieve these goals and proposes as its foundation three broad aims of 1) better health care; 2) better health for people and communities; and 3) affordable care through lowering costs by improvement. The strategy also articulates six priorities that build on the broad aims, including:

- Making care safer;
- Promoting effective coordination of care;
- Assuring care is person and family-centered;
- Promoting the best possible prevention and treatment of the leading cases of mortality, starting with cardiovascular disease;
- Helping communities support better health; and
- Making care more affordable for individuals, families, employers, and governments by reducing the costs of care through continual improvement.

The NQS notes that an effective national strategy must support effective local strategies. National standards and consistency in their measurement are essential components of the NQS. At the same time, the unique needs and characteristics of local communities must be supported to ensure activities are responsive to and driven by local circumstances, needs and capabilities.

The Physician Feedback Program and Value-Based Payment Modifier (Value Modifier)

The Physician Feedback and Value Modifier (VM) programs provide comparative performance information to physicians and medical practice groups and make claim by claim payment adjustments based on that performance, as part of Medicare's efforts to improve the quality and efficiency of medical care. The programs build upon the Physician Quality Reporting System (PQRS) and include other quality and cost outcome measures that support the NQS. By providing meaningful and actionable information to physicians so they can improve the care they deliver and recognizing and rewarding physician groups and physicians based on their performance, CMS is moving toward physician payment that rewards value rather than volume.

CMS Quality Strategy

The CMS Quality Strategy is built on the foundation of the CMS Strategy, and the HHS NQS. Like the NQS, the CMS Quality Strategy was developed through a participatory, transparent, and collaborative process that included the input of a wide array of stakeholders. The goals of the CMS Quality Strategy are based on the six priorities outlined in the NQS. A group of leaders from across CMS met and developed the strategy. This group also sought out advice and input from other HHS agencies, the community, and CMS beneficiaries to support their efforts.

Quality Improvement Organizations (QIO)

CMS's QIO Program is the largest federal program dedicated to improving health quality at the state and local levels. Created by Congress in 1982, QIOs provide a nationwide network of health organizations aimed at helping practitioners and providers improve healthcare quality.

In 2014, CMS restructured the QIO program to improve patient care, health outcomes, and save taxpayer resources. The new structure separated medical case review from quality improvement work creating two separate structures: (1) medical case review to be performed by Beneficiary Family

Centered Care Quality Improvement Organizations (BFCC-QIOs) and (2) quality improvement and technical assistance to be performed by Quality Innovation Network Quality Improvement Organizations (QIN-QIOs). QIN-QIOs drive quality by providing technical assistance, convening learning and action networks for sharing best practices, and collecting and analyzing data for improvement, while BFCC-QIOs will review beneficiary and hospital appeals of discharge decisions, and beneficiary complaints. All QIOs are authorized to work to improve services to Medicare beneficiaries with a focus on effectiveness, efficiency, economy and quality. CMS administers the program through a national network of 14 QIN-QIOs, and two BFCC QIOs that maintain a local presence in each of the 50 states, the District of Columbia, Puerto Rico and the Virgin Islands.

The QIO program has supported health care providers nationwide in delivering safer, more effective care to Medicare beneficiaries. Through these efforts hospitals, nursing homes and physicians have worked with QIOs with the goals of preventing health care-associated infections; reducing health care-acquired conditions such as adverse drug events, pressure ulcers, and physical restraints; improving rates of preventive services; reducing health care disparities; decreasing avoidable re-hospitalizations; and establishing a foundation for related future QIO Program Initiatives.

CMS calls upon the QIOs to fulfill its statutory requirement of promoting the quality of services by securing commitments and by being conveners, organizers, motivators and change agents; and providing a call to action through outreach, education and social marketing; serving as a trusted partner in improvement with beneficiaries, health care providers, practitioners, and stakeholders; achieving measurable quality improvement results through data collection, analysis, education, and monitoring for improvement; facilitating information exchange within the healthcare system; and disseminating and spreading of best practices.

On September 8, 2015, CMS released a four-year strategy entitled *The CMS Equity Plan for Improving Quality in Medicare*, to partner with QIOs and other stakeholders to reduce disparities in the quality of Medicare data, access, care and outcomes. Major components of this strategic roadmap include an action plan aligned to the CMS Quality strategy that will position CMS to support QIOs, providers, researchers, policymakers, beneficiaries and other stakeholders, with the important goal of improving health and health care quality for racial and ethnic minorities, sexual and gender minorities, and populations with disabilities.

The Priority areas identified are:

- Expand the collection and analysis of standardized data;
- Assess the impact of CMS program and demonstrations on disparities;
- Test promising approaches to reduce health disparities;
- Strengthen the health care workforce;
- Improve language access for beneficiaries; and
- Increase the accessibility of health care facilities.

Survey and Certification Program

CMS is 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. CMS administer agreements with state survey agencies to conduct onsite facility inspections. Funding is provided through 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 329,971 medical facilities of different types, including hospitals, laboratories, nursing homes, home health agencies, hospices, rural health clinics, ambulatory surgical centers, organ transplant centers, and end stage renal disease facilities that are active during the year.

Clinical Laboratory Improvement Amendments (CLIA) Program

The 1988 CLIA legislation expanded survey and certification of clinical laboratories from Medicare-participating and interstate commerce laboratories to all facilities testing human specimens for health purposes, regardless of location. CMS regulates all laboratory testing (whether provided to beneficiaries of CMS programs or to others), including those performed in physicians' offices, for a total of 264,073 facilities. The CLIA standards are based on the complexity of testing; thus, the more complex the test is to perform, the more stringent the requirements. There are three categories of tests: waived, moderate and high complexity. Waived laboratories are not subject to the quality

standards or routine oversight. Laboratories which perform moderate and high complexity testing are subject to routine onsite surveys. These laboratories have a choice of the agency they wish to survey their laboratory. They can select CMS via the state agencies or a CMS-approved accrediting organization. CMS partners with the states to certify and inspect approximately 19,980 laboratories on a biennial basis. CMS-approved accrediting organizations conduct onsite surveys of an additional 17,400 laboratories biennially. Data from these inspections reflect significant improvements in the quality of testing over time. The CLIA program is 100 percent user-fee financed and is jointly administered by three HHS components: (1) CMS manages the financial aspects, contracts and trains state surveyors to inspect labs, and oversees program administration including enrollment, fee assessment, regulation and policy development, approval of accrediting organizations, exempt states and proficiency testing providers, certificate generation, enforcement and data system design; (2) the Centers for Disease Control and Prevention (CDC) provides research and ¬technical support, and coordinates the Secretary's Clinical Laboratory Improvement Advisory Committee (CLIAC); and (3) the Food and Drug Administration (FDA) performs test categorization.

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's 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 with 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's coverage web site. 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's 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

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. CMS works with the State Insurance Commissioners' offices to ensure that suspected violations of federal laws governing the marketing and sales of Medigap are addressed.

On behalf of HHS, CMS is 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 administrative transactions to increase efficiency and reduce administrative costs across all sectors of the health care industry. Title II of HIPAA requires HHS to adopt uniform national standards for the electronic transmission of certain health information. As a result, "covered entities" such as health 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 administrative 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 2009, HHS published a final rule to adopt the International Classification of Diseases, 10th Edition (ICD-10) code set for diagnosis and inpatient hospital procedure coding with a compliance date of October 1, 2013. On September 5, 2012, HHS published a final rule that changed the ICD-10 compliance date to October 1, 2014, in order to give covered health care providers and other covered entities more time to prepare and fully test their systems to ensure a smooth and coordinated transition by all covered entities. On April 1, 2014, the Protecting Access to Medicare

Act of 2014 (PAMA) was enacted, which said that HHS may not adopt ICD-10 prior to October 1, 2015. Accordingly, HHS released a final rule on July 31, 2014, requiring the use of ICD-10 beginning October 1, 2015. The rule also requires HIPAA covered entities to continue to use ICD-9-CM through September 30, 2015.

The Administrative Simplification provisions of the Affordable Care Act included several new, expanded, or revised provisions. To implement the Administrative Simplification provisions, HHS published an interim final rule on July 8, 2011, that adopted operating rules regarding eligibility for health plans and health care claim status transactions, with a compliance date of January 1, 2013. On January 10, 2012, HHS adopted standards for health care electronic funds transfers (EFT) and remittance advice transactions through an interim final rule, and on August 10, 2012, HHS adopted operating rules for the same transactions. Both the standards and the operating rules for EFT and remittance advice transactions had a compliance date of January 1, 2014. Over the next three years, more regulations will be released adopting operating rules or new standards. CMS will be responsible for all of the new provisions and will collaborate across the public and private sector on implementation.

On September 5, 2012, CMS adopted a standard health plan identifier (HPID). Effective October 31, 2014, CMS announced a delay, until further notice in enforcement of regulations for obtaining and using HPID in HIPAA transactions adopted in the HPID final rule. The HPID standard evaluates industry recommendations issued by the National Committee on Vital and Health Statistics. A request for information was issued to industry with a 60 day comment period ended on July 28 to obtain public comments on the inclusion of the health plan identifier in HIPAA administrative transactions. 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. CMS is also exploring additional opportunities to expand the enforcement process.

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. CMS's performance measures are included in the Annual Performance Budget. HHS released a **FY 2014 – 2018 Strategic Plan**, as required by the GPRA Modernization Act of 2010 (GPRAMA). Consistent with GPRA principles, the CMS FY 2015 performance plan is structured to reflect the HHS mission: To enhance the health and well-being of Americans by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health and social services. Our measures link to the HHS Strategic Goal 1: Strengthen Health Care and Goal 4: Ensure Efficiency, Transparency, Accountability and Effectiveness of HHS programs.

Our FY 2015 performance measures track progress in our major program areas through measuring error rates. In addition, we measure quality improvement initiatives geared toward elderly, disabled and child populations as they are served by the Medicare, Medicaid, CHIP, and the QIO programs. We continue to develop metrics to track progress of health reform efforts as we work to make affordable health insurance available to all Americans. Detailed information and available results about the FY 2015 measures are included in the **FY 2016 HHS Annual Performance Plan and Performance Report** (formerly known as the Online Performance Appendix), and progress on our measures will be reported through the FY 2017 President's Budget process.

Our future plans will be revised to reflect the requirements of the GPRAMA, which retains and amplifies some aspects of the original 1993 law. Performance measurement results provide valuable information about the success of CMS's programs and activities. CMS uses performance information to identify opportunities for improvement and to shape its programs. The use of our performance measures also provides a method of clear communication of CMS programmatic objectives to our partners, such as states and national professional organizations. Performance data are extremely useful in shaping policy and management choices in both the short and long term. We look forward to the challenges represented by our performance goals and are optimistic about our ability to meet them.

FINANCIAL HIGHLIGHTS

CMS maintains strong financial management operations and continues to improve upon its financial management and reporting processes to provide timely, reliable, and accurate financial information that CMS management and other decision makers use to make timely and accurate program and administrative decisions. CMS's Risk Management and Financial Oversight Committee, comprised of members of CMS's senior leadership, is responsible for overseeing financial management issues and budget concerns impacting the day-to-day operations of the Agency, its financial statements, and the Chief Financial Officer (CFO) audit.

CMS prepares "white papers" to ensure that any significant changes/updates to CMS's accounting and financial reporting policies are properly evaluated and approved by CMS financial managers. This process ensures that changes are implemented in an effective and efficient manner; that changes/updates to accounting policy conform to Generally Accepted Accounting Principles prescribed by the Federal Accounting Standards Advisory Board; and are transparent to the public.

During FY 2015, CMS realized several initiatives that ensured accurate and reliable financial management and reporting that contributed to the solvency of the Medicare Trust Funds.

Budget Execution

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

Administrative Payments

During FY 2015, we 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 made via ACH.

Debt Management

CMS is committed to maximizing the collection of Medicare overpayments. CMS identifies debt in numerous ways, including payment reviews performed by MACs, Zone Program Integrity Contractors (ZPICs), RACs, and the Office of Inspector General (OIG). Once a debt is identified, CMS's contractors follow established collection processes to collect the debt. These processes include issuing demand letters, making telephone calls, recouping subsequent Medicare payments to the debtor, and when appropriate, establishing repayment plans to allow payment over an extended period of time. When payment is not made, CMS refers uncollected debt to the U.S. Department of the Treasury's Bureau of Fiscal Service for further collection activities. From October 1, 2014 to September 23, 2015, the total amount of delinquent debt referred by CMS to the Program Support Center to process and transfer to Fiscal Service is approximately $1.2 billion.

Healthcare Integrated General Ledger Accounting System

CMS's Healthcare Integrated General Ledger Accounting System (HIGLAS) is a single, integrated dual-entry accounting system that standardizes and centralizes federal financial accounting functions for all of CMS's programs. In FY 2015, HIGLAS was upgraded to the most current version of Oracle's federal financial software, Release R12. HIGLAS continues to enhance CMS's oversight of all financial operations in order to achieve accurate, reliable, and timely financial accounting and reporting for all of CMS's programs and activities.

Oversight of Medicare Contractor Financial Operations and Reporting

Medicare Administrative Contractors (MACs) administer the day-to-day operations of the Medicare FFS program by paying claims, auditing provider cost reports, and establishing and collecting overpayments. MACs are required to maintain a vast array of financial data. CMS continues to revise and implement new policies and other key initiatives to train staff and to review contractor operations. The availability of real time financial data provided by HIGLAS has resulted in significant improvements in the MACs' financial management activities and in the oversight of the agency. CMS continues to enhance its analytical tools to provide the steps to identify and mitigate potential errors, unusual fluctuations, system

weaknesses, and inappropriate patterns of financial data accumulation.

Audit resolution is a top priority at CMS, and correcting the agency's deficiencies is essential to improving financial management. MACs are subject to various financial management and information technology (IT) security audits and reviews performed by the OIG, Government Accountability Office (GAO), independent Certified Public Accountant (CPA) firms, and CMS staff to provide reasonable assurance that they have developed and implemented effective and efficient internal controls. The results of the audits and reviews indicate whether the MACs' internal controls have significant design or operational deficiencies. MACs are required to develop corrective action plans (CAPs), which define activities to remediate findings and the timeframes for which they will be implemented. CMS also requires all MACs to submit an annual self-certification known as a Certification Package for Internal Controls (CPIC). In the CPIC, MACs are required to report any material weaknesses and significant deficiencies identified during the FY, along with CAPs to remedy the weaknesses. The CPIC provides CMS with assurance that contractors are in compliance with the Federal Managers' Financial Integrity Act, Office of Management and Budget (OMB) Circular A-123, and the CFO Audit Act of 1990.

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

CMS continued to build upon its success in implementing OMB's revisions to Circular A-123, Management's Responsibility for Internal Control. The Agency procured an independent CPA firm in FY 2015 to assist in performing management's self-assessment in support of the assurance statement regarding internal control over financial reporting as of June 30. The MACs also continued to contract with independent CPA firms to conduct Statement on Standards for Attestation Engagements No. 16 (SSAE 16) internal control audits. The results of our comprehensive self-assessment are provided in the ***Summary of Federal Managers' Financial Integrity Act Report and OMB Circular A-123 Statement of Assurance*** section.

Federal Payment Levy Program

In July 2000, the Internal Revenue Service (IRS), in conjunction with the Department of the Treasury, 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. Using the automated FPLP program, the IRS can collect overdue taxes through a continuous levy on certain federal payments; similarly, the FPLP can be used to collect non-tax delinquent debt.

CMS began participating in the FPLP in October 2008, for Medicare FFS payments made through HIGLAS. Specifically, the Medicare Improvements for Patients and Providers Act legislation required that Medicare FFS payments to providers be offset by a maximum of 15 percent (30 percent began in June 2015) 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 receipts, misused grant funds and fines, penalties, or fees assessed by federal agencies. In December 2014, the Internal Revenue Code Section 6331 (h) was amended by the Tax Increase Prevention Act of 2014 Section 209 (a), which mandated an increase of the tax levy to 30 percent. Then, in April 2015, the tax levy was increased to 100 percent by the Medicare Access and CHIP Reauthorization Act of 2015, Section 413 (a). As of September 30, 2015, CMS has collected a cumulative total of over $314 million in tax levy offsets and $180 million in non-tax offsets through HIGLAS on behalf of the FPLP.

Recovery Audit Program

Medicare FFS

Section 302 of the Tax Relief and Health Care Act of 2006 required HHS to implement the Medicare FFS Recovery Audit Program in all 50 states no later than January 1, 2010. HHS awarded contracts to four recovery auditors. Each recovery auditor is responsible for identifying and correcting improper payments in approximately 25 percent of the country.

In FY 2015, the Medicare FFS Recovery Audit program demanded approximately $390.85 million and recovered approximately $359.73 million from post-payment reviews of claims. Recoveries can include amounts identified and demanded in prior fiscal years. During FY 2015, the majority of collections were from Diagnosis Related Group (DRG) validations and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) provided while the beneficiary was in an inpatient setting. This is consistent with CMS's focus to lower the Medicare error rate. CMS expects that implementation of certain corrective actions will

lower collections for some types of claims; however, collections may also decrease as a result of the delay in awarding new recovery auditor contracts.

CMS continues to monitor the Recovery Audit program and make continuous improvements to activities, such as the appeals process, feedback to providers, and system improvements. CMS remains focused on taking the findings identified by the recovery auditors and putting actions into place to prevent future improper payments. In FY 2015, CMS released 4 Provider Compliance Newsletters that provided detailed information on 17 findings identified by the recovery auditors. CMS also implemented local and/or national system edits to automatically prevent improper payments.

The Medicare FFS Recovery Audit Program's 3-year Prepayment Review Demonstration ended in August 2015. Prepayment reviews had been conducted in the 7 Health Care Fraud Prevention and Enforcement Action Team (HEAT) states (Florida, California, Michigan, Texas, New York, Louisiana, Illinois) and four states with the highest number of inpatient stays (Pennsylvania, Ohio, North Carolina, Missouri), with the last additional documentation request letters going out on February 28, 2014. Claim selection criteria was initially based on the Medicare Severity Diagnosis Related Groups (MS-DRG) selected by CMS with the highest payment error rate, identified through the Comprehensive Error Rate Testing (CERT). However, those claims were removed from selection on September 30, 2013 in response to the new Inpatient Prospective Payment System (IPPS) Rule that was going into effect on October 1, 2013.

No prepayment reviews were performed under the Medicare FFS Recovery Audit Program in FY 2015. CMS began a new procurement process, and anticipates releasing Requests for Proposals in November 2015.

Medicare Parts C and D Recovery Audit Contractors

Section 6411(b) of the Affordable Care Act expanded the Recovery Audit Contractor (RAC) program to Medicare Parts C and D. As part of the procurement process to secure a Medicare Part C RAC, CMS posted a Request for Quote in June 2014; however, no responses were received as a result of that solicitation. CMS continues its implementation efforts, and anticipates awarding a Part C RAC contract in FY 2016.

In Janurary 2011, CMS contracted with a Part D RAC, which became fully operational in FY 2012. In FY 2015, the Part D RAC recouped $4.5 million in overpayments (total plan payment minus contingency fee) made as a result of prescriptions written by excluded providers or unauthorized prescribers. In addition, in FY 2015, the Part D RAC identified improper payments for refill errors of Drug Enforcement Agency schedule drugs for calendar years 2010 through 2011. Notifications of improper payments for refill errors totaling $2.76 million were sent to plan sponsors in February 2015, and recoupments are expected to occur in FY 2016. In the future, the Part D RAC may expand its reviews to additional audit areas. CMS anticipates awarding a new Part D RAC contract in FY 2016.

Medicare Secondary Payer

The Medicare Secondary Payer (MSP) Commercial Recovery Center (CRC) recovers Medicare Part A and Part B payments mistakenly made when a beneficiary has coverage through an employer-sponsored Group Health Plan (GHP). The mistaken payments are recovered from the entity that had primary payment responsibility for those services (typically the employer, insurer, claims processing administrator, or other plan sponsor. The MSP CRC recovered $149.6 million in FY 2015. The MSP CRC is also developing enhancements to the GHP paper-based recovery process. These planned enhancements are designed to improve customer service, increase efficiency, and ultimately increase recoveries for the program.

Medicaid

Section 6411(a) of the Affordable Care Act required states to establish Medicaid Recovery Audit contractor programs by submitting state plan amendments, attesting that their programs meet the statutory requirements. HHS published a final rule titled, "Medicaid Program: Recovery Audit Contractors" in the Federal Register on September 16, 2011, that implemented section 6411(a) of the Affordable Care Act. The final rule, effective January 1, 2012, required states to implement recovery audit contractor programs in an effort to identify and recover improper payments in their Medicaid programs. The final rule aligns the state Medicaid Recovery Audit contractor requirements to existing Medicare Recovery Audit contractor FFS program requirements, where feasible, and provides each state the flexibility to tailor its Recovery Audit contractor program where appropriate. As of September 2015, forty-seven states and the District of Columbia have implemented Medicaid Recovery Audit contractor programs, but one of these states ended its recovery audit contractor program when CMS

approved an exception due to high managed care penetration. At the end of FY 2015, four states have CMS-approved exceptions due to small beneficiary populations or high managed care penetration.

Medical Review Program

Medicare Administrative Contractors

Consistent with sections 1833(e), 1842(a)(2)(B), and 1862(a)(1) of the Social Security Act, CMS is required to protect the Medicare Trust Fund against inappropriate payments that pose the greatest risk to the Trust Fund and take corrective actions. To meet this requirement, CMS contracts with Part A and Part B MACs, DME MACs, and others to perform analysis of FFS claims data to identify atypical billing patterns and perform claims review. Medical review is the collection of information and clinical review of medical records to ensure that payment is made only for services that meet all Medicare coverage, coding, and medical necessity requirements. Medical review activities are directed toward areas where data analysis, Comprehensive Error Rate Testing results, Office of Inspector General/Government Accountability Office findings, and Recovery Audit findings indicate questionable billing patterns. CMS continues to enhance medical review efforts and has encouraged MACs to incorporate increased provider feedback processes, such as one-on-one education and more detailed review results notification, in an effort to increase proper billing.

Prior Authorization of Power Mobility Devices Demonstration

CMS implemented a prior authorization process for scooters and power wheelchairs (together known as power mobility devices) for people with FFS Medicare who reside in seven states with high populations of fraud- and error-prone providers (California, Illinois, Michigan, New York, North Carolina, Florida and Texas). CMS believes this demonstration will lead to reductions in improper payments for power mobility devices, which will help ensure the sustainability of the Medicare Trust Funds and protect beneficiaries who depend upon the Medicare program. In addition, this demonstration is designed to develop and demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act.

Since implementation, CMS has observed a decrease in the expenditures for power mobility devices in the demonstration states and non-demonstration states. Based on claims submitted as of August 2015, monthly expenditures for the power mobility device Healthcare Common Procedure Coding System codes included in the demonstration decreased from $22 million in September 2012 to $5 million in June 2015 in the demonstration states and from $10 million to $3 million in the non-demonstration states. Prior authorization reviews are being performed timely, industry feedback has been positive. On October 1, 2014, CMS expanded the demonstration to 12 additional states. The demonstration has also been extended for an additional 3 years, and will now end on August 31, 2018. We will continue to closely monitor and evaluate the effectiveness of the demonstration and plan to analyze demonstration data to assist in the investigation and prosecution of fraud.

Prior Authorization of Non-Emergent Repetitive Scheduled Ambulance Transports and Hyperbaric Oxygen Therapy

In FY 2015 CMS began two models testing whether prior authorization helps reduce expenditures, while maintaining or improving quality of care. In December 2014, CMS implemented a prior authorization model for repetitive, scheduled non-emergent ambulance transport in New Jersey, Pennsylvania, and South Carolina, for transports occurring on or after December 15, 2014. Previous analysis of non-emergent ambulance transports to and from dialysis facilities have grown noticeably in recent years and represent a large share of non-emergent ambulance claims. The model establishes a prior authorization process for repetitive scheduled non-emergent ambulance transport to reduce utilization of services that do not comply with Medicare policy while maintaining or improving quality of care. Section 515 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) expands the prior authorization model for repetitive scheduled non-emergent ambulance transports effective no later than January 1, 2016 to six additional states: North Carolina, Virginia, West Virginia, Maryland, Delaware, and the District of Columbia.

In March 2015, CMS implemented a prior authorization model for the non-emergent hyperbaric oxygen model in New Jersey, Illinois and Michigan. Previous experience indicates that hyperbaric oxygen therapy has a high potential for improper payments and raises concerns about beneficiaries receiving medically unnecessary care. The model establishes a prior authorization process for hyperbaric oxygen therapy for certain covered conditions to reduce utilization of services that do

not comply with Medicare policy while maintaining or improving quality of care. CMS believes using a prior authorization process will help ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before services are rendered and claims are paid.

Medicare Secondary Payer (MSP)

CMS's efforts in the MSP area saved the Medicare Trust Funds approximately $8.5 billion during FY 2015. 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 recoveries of Medicare conditional payments. One of the more significant initiatives is the ongoing implementation of the MSP provisions of the Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012 (the SMART Act). CMS is working to consolidate many MSP information technology systems into one system. Both the implementation of the SMART Act and MSP systems consolidation activities will further streamline coordination of benefit and recovery operations.

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. PI activities target the range of causes of improper payments, including errors, fraud, waste, and abuse.

Strategic Direction

CMS's Program Integrity direction has six key strategies for becoming more effective while reducing the burden on legitimate providers and suppliers. The first is moving beyond "pay and chase" operations to innovative prevention and detection activities. The second shift is to develop a risk-based approach for program integrity requirements, rather than operating as if "one size fits all." The third strategy is to rethink legacy processes with innovation as a requirement. The fourth strategy—to become more transparent and accountable—complements the fifth strategy of meaningfully engaging our public and private partners. Finally, CMS is dedicated to continuing to coordinate and integrate Medicare and Medicaid program integrity activities.

The four major approaches CMS uses to organize its key anti-fraud activities:

1. **Fraud Prevention:** Providing enrollment and screening, engaging Medicare beneficiaries, educating state Medicaid program integrity staff, antifraud marketing, and improving payment accuracy through the National Fraud Prevention Program;
2. **Fraud Detection:** Significant enhancing data analytics, partnering with providers, law enforcement, Part C and D compliance activities, Medicaid data analytics and audit activities;
3. **Transparency and Accountability:** Increasing coordination with law enforcement, collaborating with the private sector and states; including the Healthcare Fraud Prevention Partnership (HFPP) and the OPEN PAYMENTS (Affordable Care Act section 6002: Physician Payments Sunshine Act) transparency program; and
4. **Recovery:** Collaborating with law enforcement (HEAT) and implementation of the Medicaid and Medicare Part C/D RACs.

The Affordable Care Act

CMS has implemented many of the important Program Integrity (PI) provisions included in the Affordable Care Act. These are helping not only to move the PI strategy beyond "pay and chase," toward a more proactive, prevention-focused strategy, but also to better align Medicare and Medicaid program integrity requirements and processes. CMS continues its work in revalidating the enrollments of all existing 1.5 million Medicare suppliers and providers, under the new Affordable Care Act screening requirements. CMS initiated the revalidation of all 1.5 million existing providers and suppliers beginning March 2011 and all revalidation notices were mailed by the March 23, 2015 deadline. These efforts will ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries, and bill the Medicare program. In FY 2015, the revalidation initiative has contributed to 128,331 deactivations and 4,723 revocations as of September 30, 2015.

CMS also continues to use its authority to suspend payments pending the investigation of a credible allegation of fraud, assess provider enrollment application fees, and impose temporary provider enrollment moratoria when the Secretary of HHS determines there is a risk of fraud. The Affordable Care Act also requires the termination of providers from Medicaid if they have been revoked for cause from Medicare or terminated from any other

Medicaid program; and enables CMS to revoke from Medicare if the provider has been terminated from any Medicaid program.

CMS also published a final rule in April 2012 that implements the provisions of section 6405 of the Affordable Care Act, "Physicians Who Order Items Or Services Required To Be Medicare Enrolled Physicians Or Eligible Professionals." This rule codified CMS requirements and processes associated with validating that physicians who order or certify the need for DMEPOS, home health care, and services of independent diagnostic testing facilities and clinical laboratories are enrolled in Medicare or have validly opted out of the Medicare program. Effective January 2014, CMS began denying DMEPOS, home health care, and Part B clinical laboratory and imaging claims if the provider listed on the claim did not meet the ordering and referring requirements. In addition, CMS published a final rule in May 2014, including a requirement that individuals who prescribe Part D drugs must be enrolled in or validly opted out of Medicare. In this way we can assure that only those eligible professionals who meet Medicare requirements can prescribe Part D drugs for Medicare beneficiaries. Pursuant to other provisions in the same final rule, CMS now has authority to revoke the Medicare enrollment of any physician or eligible professional that exhibits a pattern of abusive prescribing.

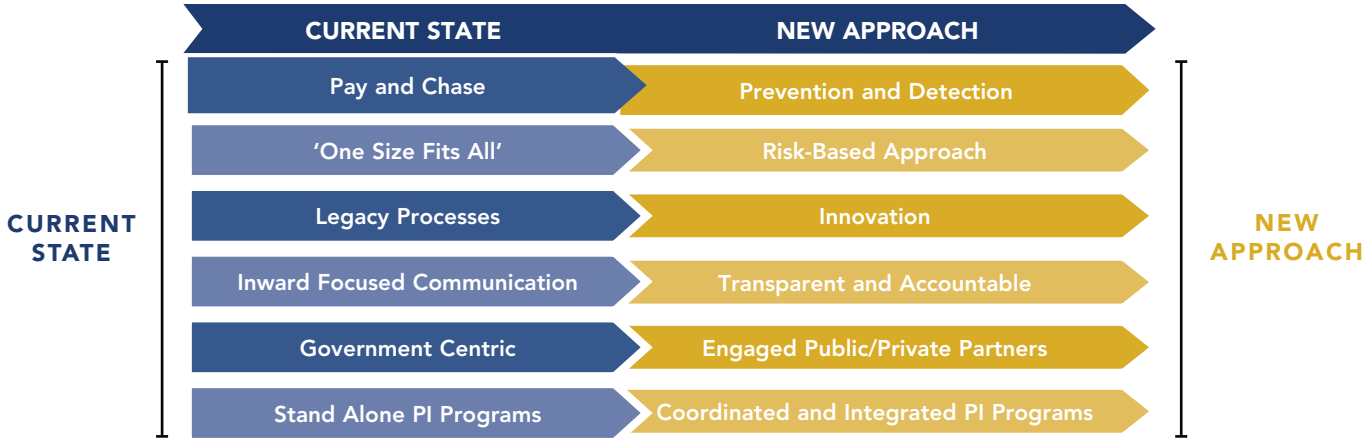
In September 2014, CMS released the first round of Open Payments data (section 6002 of the Affordable Care Act, or the Physician Payment Sunshine Act), providing the public more information about the financial relationships between physicians and teaching hospitals and applicable manufacturers and group purchasing organizations. This release included consulting fees, research grants, travel reimbursements, and other gifts the health care industry—such as medical device manufacturers and pharmaceutical companies—provided to physicians and teaching hospitals during the last five months of 2013. The data contained 4.3 million payments totaling $3.43 billion. Payment data for all of 2014 was published in June 2015. This latest publication included information about 11.4 million financial transactions attributed to over 600,000 physicians and more than 1,100 teaching hospitals, totaling $6.49 billion. The Open Payments data requires transparency in the financial relationships between physicians, teaching hospitals and industry manufacturers, discouraging the development of inappropriate relationships and preventing increased and potentially unnecessary health care costs.

In April 2015, CMS delivered the first annual Report to Congress on the Open Payments Program for Fiscal Year 2014. The report included an overview of the Open Payments program, highlights from the first year of implementation, data submission, data collection and publication. In addition to summarizing financial transaction information, this report included plans for program improvement and CMS's compliance strategy.

Medicare Program Integrity

The Medicare Program Integrity functions include the detection and deterrence of improper and/or fraudulent billing in the Medicare FFS program. This is accomplished through the use of enhanced provider enrollment activities; proactive data analysis; close collaboration among law enforcement, subject matter experts and program integrity contractors; the investigation of complaints from various sources; provider on-site visits; and beneficiary interviews.

- **Provider and Supplier Enrollment:** Provider enrollment is the gateway to the Medicare program, and 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. This function prevents "ineligible" providers and suppliers from program entry while also helping to ensure the quality of services provided to Medicare beneficiaries.

- **Benefit Integrity (BI):** Program Integrity activities identify, detect, and prevent payment of fraudulent or otherwise improper claims. Responsibilities include managing CMS's program integrity contractors (ZPICs and Program Safeguard Contractors) and acting as law enforcement liaisons to ensure coordination on crosscutting issues.

Enhancing program integrity is a top priority for the Agency, and we have made important strides in reducing fraud, waste, and improper payments across the government. This past year, CMS used its powerful new anti-fraud tools, as well as designed and implemented large-scale, innovative improvements to our Medicare program integrity strategy to shift beyond a "pay and chase" approach to preventing fraud and abuse. CMS reported on the completion of the third implementation year of the Fraud Prevention System, the predictive analytic technology that identified potential fraud before payment, which resulted in an estimated $454 million in identified savings. Temporary provider enrollment moratoria are in place under the Affordable Care Act in several geographic areas at high risk of fraud, waste, and abuse.

The Agency also continued to demonstrate its commitment to being effective financial stewards in FY 2015. We have developed a Unified Program Integrity Contractor strategy, with an overarching goal to integrate the program integrity functions for audits and investigations across Medicare and Medicaid by implementing a contracting strategy that rationalizes our relationships with providers, leverages existing resources, and enhances our cooperative efforts with partners.

Healthcare Fraud Prevention Partnership (HFPP)

One of the Secretary's key health care fraud prevention initiatives is to establish an ongoing partnership with the private sector to fight fraud across the health care sector. HFPP is a public-private partnership among the Federal Government, states and private health insurance companies and associations to prevent and detect fraud across the healthcare industry. Data collected and shared across payers can assist payers in evaluating trends, recognizing patterns consistent with potential fraud, and potentially uncover schemes or bad actors they could not otherwise identify using only their own information.

Several key milestones occurred in FY 2015:

- Procurement of a Trusted Third Party (TTP) to conduct data studies of various degrees of complexity; and,
- Expanding the data-sharing paradigm to expand sharing as broadly and as close to real-time as possible.

Eight additional partners have joined the HFPP in 2015, bringing total membership to 45. The TTP is targeting further expansion of the partnership to include additional willing public and private payers.

Medicare Drug Integrity Contractor (MEDIC)

There are two MEDIC contractors, each with distinct responsibilities related to Medicare Advantage and Part D benefits.

- The **National Benefit Integrity (NBI) MEDIC** is responsible for processing and tracking all Medicare Advantage and Part D complaints, requests for information (RFIs), proactive data analysis, conducting investigations, and referrals to law enforcement.
- The **Outreach and Education (O&E) MEDIC** is responsible for conducting outreach and education activities for Medicare Advantage and Part D stakeholders.

Through July of FY 2015, the NBI MEDIC received an average of 762 actionable complaints per month, processed an average of 54 requests for information from law enforcement per month, and referred an average of 48 cases to law enforcement per month. NBI MEDIC referrals have resulted in sentences ordering restitution of $41.4 million, forfeitures of $13.6 million, and $12.2 million in civil settlements according to FY 2015 notifications from law enforcement. The NBI MEDIC was responsible for assisting the OIG and the Department of Justice (DOJ), through data analysis and investigative case development, in achieving 68 convictions, 35 arrests, and 45 indictments from FY 2015 notifications. In one case, the NBI MEDIC investigated complaints concerning out-of-country beneficiary enrollments in Nicaragua and the Dominican Republic alleging that a Medicare plan was advertising improper inducements for Medicare-eligible beneficiaries to sign up for the plan. Ten subjects involved were charged with multiple counts of health care fraud and have pled guilty. As of July 2015, six of the ten have been sentenced for their involvement in a transnational

health care fraud scheme and ordered to pay restitution in the amount of $14.5 million.

The O&E MEDIC was responsible for many other outreach activities in FY 2015. In July 2015, CMS released two Program Integrity Online Courses; one for beginners and one for advanced course students. These courses are comprehensive fraud fighting tools, providing Medicare Advantage Organizations and Part D sponsors with industry an understanding of how to find detect and fight correct fraud, best practices regarding processes, and resources to support fraud prevention, detection, preliminary investigation, and referral activities. The courses are online in an on-demand webcast format.

The FWA Triage Tool was introduced in February 2015, and guides Medicare Advantage organization and Prescription Drug plan new employees and customer service representatives on how to identify fraudulent beneficiary calls as fraud related. It was our most successful resource in FY 2015. In addition, there have been several other job aids, FAQs, Prescriber enrollment videos, Explanation of Benefits Fraud Inserts and weekly alerts, newsletters and HPMS memos which we have shared with our O&E MEDIC website members.

Program Integrity Field Offices

CMS's designated Program Integrity Field Offices (FOs) in Los Angeles, Miami, Chicago and New York provide a boots-on-the-ground presence in high risk fraud areas of the country. The FOs have many functions including conducting data analysis to identify local vulnerabilities and coordinate special projects with contractors and agencies on issues that have a national or regional impact. For example, the Miami FO has implemented a comprehensive, multi-agency approach to address Medicare and Medicaid aspects of health care fraud in South Florida and has served as a testing ground for efforts that have been expanded to a national level. As another example of FY 2015 field investigations, the Chicago FO investigated a lead about possible false front providers and conducted site visits along with the National Site Visit Contractor to over 65 Medicare providers across 4 states, resulting in revocation of Medicare billing privileges for 22 providers. Program Integrity FO participation in Medicaid field projects in New York and Florida are described below in the section on Support and Assistance to the States.

Health Care Fraud Prevention and Enforcement Team (HEAT)

CMS is a major participant in the HEAT, the joint initiative between HHS and DOJ to target tools and resources to fight fraud. HEAT has resulted in cabinet-level coordination and collaboration on efforts to prevent and detect health care fraud. These efforts include:

- **Coordination of nationwide takedowns:** CMS has used its new payment suspension authority from the Affordable Care Act in coordination with two law enforcement multi-state takedowns.
- **Supporting the Medicare Fraud Strike Forces:** The Strike Forces are a key component of the HEAT strategy designed to reduce Medicare fraud. The Strike Forces combine data analysis capabilities of CMS and the investigative resources of the Federal Bureau of Investigation (FBI) and HHS/OIG with the prosecutorial resources of the DOJ Criminal Division, Fraud Section and the United States Attorney Offices. There are currently nine Strike Force cities.
- **Health Care Fraud Prevention Summits:** CMS partnered with the DOJ to host Health Care Fraud Prevention Summits in various cities since 2010. These summits bring together a wide array of federal, state and local partners, beneficiaries, and providers to discuss innovative ways to eliminate fraud across the U.S. health care system. The summits are part of the larger joint effort of the DOJ and HHS through the HEAT.

Medicaid Program Integrity

The Deficit Reduction Act of 2005 established the Medicaid Integrity Program in section 1936 of the Social Security Act and represents a substantial milestone in CMS's first national strategy to detect and prevent Medicaid provider fraud and abuse. States have primary responsibility for policing fraud, waste, and abuse in their Medicaid programs, and CMS plays a significant role through the provision of technical assistance, guidance, and oversight in the state-based efforts.

CMS is tasked with developing a strong, effective, and sustainable program to combat Medicaid provider fraud, waste, and abuse. Section 1936 of the Social Security Act provides CMS with the authority to fight fraud and abuse by Medicaid providers by requiring CMS to contract with private sector entities to review provider claims data, audit providers, identify overpayments, and educate providers and other individuals about program integrity and quality of care. CMS works with partner agencies at the federal and state levels to enhance

these efforts, including preventing the enrollment of individuals and organizations that would abuse or defraud the Medicaid program and removing fraudulent or abusive providers when detected.

CMS continues to evaluate how best to leverage tools used in Medicare for opportunities to transfer the knowledge and lessons learned to the Medicaid program. As part of the Fraud Prevention System, the Small Business Jobs Act of 2010 added a new requirement for the third implementation year report. The SBJA required CMS to analyze and report on the cost-effectiveness and feasibility of expanding the use of predictive analytics technologies to Medicaid and CHIP, the effect, if any, the application of predictive analytic technologies to claims under Medicaid and CHIP would have on states; and recommendations regarding the extent to which technical assistance may be necessary to expand the application of predictive analytics technologies to claims under Medicaid and CHIP and the type of such assistance.

Medicaid Provider Enrollment

Section 1902 of the Social Security Act was amended by the Patient Protection and Affordable Care Act of 2010, requiring states to comply with new measures to strengthen program integrity, including those found at 42 CFR 455 Subparts B and E concerning Medicaid fee-for-service provider enrollment. Where Affordable Care Act requirements related to provider enrollment are shared across the Medicare and Medicaid programs, CMS likewise has centralized provider enrollment support functions for these programs. Benefits of a centralized support function include decreased burden and increased support to State Medicaid Agencies and fee-for-service providers and improved opportunity for State Medicaid Agencies to leverage Medicare processes and program integrity activities to impact and reduce improper payments.

National Medicaid Audit Program (NMAP)

In FY 2015, CMS's NMAP continued to work collaboratively with states in the development of audits. The collaborative approach allows CMS to work alongside states in identifying areas that warrant further investigation and to develop audit targets. Through this process, CMS has been able to more effectively support a state's program integrity efforts. In addition, the corresponding data for the collaborative audits is typically provided or supplemented by the states, making the data more complete and thus increasing the accuracy of audit findings. The number of collaborative audits has progressively increased since the first collaborative audits were assigned in January 2010, resulting in a cumulative total of 911 collaborative audits assigned in 41 states as of the end of June 2015. These 41 states represent approximately 89 percent of all Medicaid expenditures. The most common collaborative audits have been conducted in the areas of hospice services, Medicaid credit balances, emergency services to non-citizens, early prescription refills, and duplicate prescription billings to Medicare facilities and the Medicaid program. As of June 2015, there have been 299 Final Audit Reports related to collaborative audits issued to states valued at roughly $61 million. Overall, a total of $91.6 million in estimated overpayments has been identified by the efforts of CMS and the Audit Medicaid Integrity Contractors (MICs) as of June 2015. CMS renewed or extended all five of the Audit MIC task orders in FY 2015.

Improper Payments

CMS has implemented Executive Order 13520, Reducing Improper Payments, which requires federal agencies with high-priority programs to establish annual or semi-annual measurements for reducing improper payments, or if the programs already reported 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. CMS is required to develop the supplemental measures for the Medicaid program, and CMS is collaborating with states on the development and reporting of these supplemental measures.

The supplemental measures will be calculated based on the results of state Payment Accuracy Improvement Groups (PAIG). A PAIG is a group of states with a shared, identified Medicaid program integrity vulnerability and a common approach or intervention to address the problem. CMS launched the first PAIG project in the area of pharmacy education to target physicians with aberrant prescribing practices to reduce the number of prescriptions that exceed recommended dosages. The education program developed materials designed to reduce overprescribing for five therapeutic drug classes identified as having the highest potential improper payment rates. The educational initiative was completed in the three participating states, with targeted prescribers receiving educational materials and/or personal contacts. CMS has initiated a second PAIG project aimed at reducing improper payments in the high

risk area of home and community based services (HCBS), using the results produced by the FY 2012 PERM program to target the root causes of errors. With the support of states, CMS plans to launch an education program aimed at a targeted audience of physicians, direct care staff, home health agencies, and beneficiaries in FY 2016.

Education for States

To address Medicaid's structure as a federal-state partnership, CMS has developed initiatives specifically designed to assist states in strengthening their own efforts to combat fraud, waste, and abuse. The Medicaid Integrity Institute (MII) is one of CMS's most significant achievements in Medicaid program integrity. The MII provides for the continuing education of state program integrity employees, including specific coursework focused on Medicaid managed care and predictive analytics. At the MII, CMS has a unique opportunity to offer substantive training, technical assistance, and support to states in a structured learning environment. From its inception in 2008 through June 2015, CMS has provided training to state employees from 50 states, the District of Columbia, and Puerto Rico with over 6,000 enrollments in 132 courses and 9 workgroups at no cost to the states. These state employees are able to learn and share information with program integrity staff from other states on topics such as emerging trends in Medicaid fraud, data collection, and fraud detection skills, along with other helpful topics. As of July 2015, the MII conducted 19 courses and 1 workgroups, with 3 courses scheduled for the remainder of the fiscal year.

MII began offering a credentialing program for state Medicaid program integrity employees to certify professional qualifications. As of July 2015, 226 state employees in 44 states have received the credential of Certified Program Integrity Professional (CPIP). The MII also supports state access to the DOJ's Regional Information Sharing System (RISS)—a secure web-based portal where states can exchange documents, tips, and best practices about Medicaid program integrity issues.

The Education Medicaid Integrity Contractor (MIC) has developed educational resources through collaboration with key stakeholders such as state subject matter experts. Products Resources include print and electronic media, toolkits, train-the-trainer guides, webinars, videos, and other innovative strategies. CMS maintains an online repository for Medicaid program integrity education. All educational products are available to the public which provides access to all educational products covering topics, including drug diversion, dental professional compliance, beneficiary card sharing, non-emergency transportation services, and safeguarding one's medical identity. New toolkits released in FY 2015 cover program integrity education on hospice, self-audit and electronic health records.

Through the Education MIC, CMS presents its program integrity materials at national Medicaid stakeholder conferences as well as state training activities and events. CMS offers training to state program integrity staff on how to utilize customizable presentation materials fraud education of provider and beneficiary audiences. CMS also enhances awareness of program integrity issues through outreach to providers at regional conferences and continuing education courses to enhance awareness of program integrity issues. Products such as webinars, train-the-trainer activities, fact sheets, resource handouts, and referral guidelines are developed in collaboration with key stakeholders, including some states.

Support and Assistance to the States

CMS provides substantial oversight of state program integrity activities and effective support and assistance to states to combat Medicaid fraud, waste, and abuse. To gauge states' efforts in this regard, CMS has conducted comprehensive reviews of each state's program integrity activities as well as reviews focusing on specific high-risk areas. From FY 2007 through FY 2013, CMS completed at least two separate comprehensive reviews of every state, the District of Columbia, and Puerto Rico. In response to the Medicaid expansion in FY 2014, CMS conducted focused reviews in 10 expansion states, directed toward three high-risk program integrity areas: operations of the special investigations unit of managed care entities, state implementation of provider enrollment and screening provisions of the Affordable Care Act, and personal care services. During FY 2015, CMS conducted and focused reviews in 10 additional states with an emphasis on program integrity in Medicaid managed care, and also addressing non-emergency medical transportation or personal care services in certain states.

CMS also works to enhance opportunities for states to share ideas and network with peers and other program integrity stakeholders. For example, the Agency provides staff support to the Medicaid Fraud and Abuse Technical Advisory Group, which provides a monthly forum for the exchange of

information on Medicaid integrity issues between CMS and representative state program integrity directors. In addition, CMS sponsors quarterly calls for the Program Integrity Directors of each region as well as monthly calls for the Program Integrity Directors from small state Medicaid programs. CMS's New York Regional Office also hosts semi-annual regional meetings of program integrity stakeholders from Medicaid, Medicare, and law enforcement to discuss current fraud issues and recent cases. In addition, each year CMS routinely fulfills requests for technical assistance from state employees, attorneys, providers and others in a variety of program integrity-related areas.

To assist states in targeting high-fraud areas during FY 2015, CMS participated in Medicaid integrity field projects in both New York and Florida.

- CMS collaborated with the Florida Medicaid agency, the Florida Department of Health, and the Florida Division of Insurance Fraud to investigate and take action against problem providers. By combining efforts, the various agencies have been able to identify and use the most effective tools to take action on the evidence brought to light in each case. Once one agency has issued a sanction against the provider based on a deficiency within that agency's purview, other agencies are able to take further action against the provider based on the first agency's sanction. For example, after a joint investigation with CMS, the Florida Department of Health suspended the license of a physician, after which CMS was able to revoke the physician's Medicare billing privileges. Likewise, when Medicare revoked a provider's billing privileges, Florida was able to terminate the physician from the Medicaid program based on the Medicare revocation in accordance with section 6501 of the Affordable Care Act.
- Also in Florida, CMS used a similar collaborative effort between Medicare and the Florida Medicaid program in FY 2015 to take action against Home Health Agencies that are attempting to circumvent a regional moratorium by billing for services delivered in areas where they are not licensed.
- In another FY 2015 field investigation, CMS staff assisted the New York State Office of the Medicaid Inspector General in conducting inventory audits of pharmacies. These investigations resulted in fines, referrals to the New York Medicaid Fraud Control Unit, and exclusion of a pharmacy by the New York State Medicaid agency.

Medicare Advantage and Prescription Drug Financial Oversight

Sections 1857(d)(1) and 1860D-12(b)(c) of the Social Security Act require the HHS Secretary to provide for the annual audit of financial records of at least one-third of the Medicare Advantage Organizations (MAOs) and Prescription Drug Plans (PDPs). The one-third financial audit program is designed to examine the health plans' financial records, data relating to costs, Medicare utilization, and the computation of the bids. During FY 2015, CMS completed 250 audits of MAOs and PDPs for contract year 2012 and awarded contracts for 255 audits for contract year 2013. In addition, through our ROs, CMS 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.

As of September 2015, disallowances resulting from FY 2015 settlement activity saved about $90.7 million producing a rate of return of $54 to $1.

Information Technology (IT)

CMS is dedicated to protecting sensitive information and information systems through the development of a comprehensive cybersecurity program. By integrating safeguards into the appropriate phase of the organizations lifecycle processes, CMS will continue to mature all aspects of its cybersecurity and privacy program. Enhanced network defenses, coupled with resilient incident response capabilities will help reduce the risk to CMS data and information systems and minimize the time between a successful compromise and the detection and recovery. CMS will also continue to integrate data into the newly implemented tracking system as the central data repository to convey risk in the IT enterprise.

CMS continues to make strides to strengthen its IT internal controls, particularly its oversight of the implementation of those controls. The management approach is built on a strategy to leverage information security processes and technologies to improve the overall security posture of the CMS Enterprise. In recent years, CMS's information security program has undergone, and continues to undergo, significant change that extends security oversight, continuous monitoring, and vulnerability management to the CMS Enterprise. CMS has expanded several programs to enhance continuous monitoring to help drive real-time enterprise-level situational awareness, increase the efficiency of

the CMS system authorization process, and drive ongoing communications with business stakeholders. For example, the recently implemented Beneficiary Data Protection Initiative is focused on improving awareness and response to the most prevalent threats targeting health information.

Specifically, CMS sustainably continues implementation and enhancement of the following information security initiatives:

- **Beneficiary Data Protection Initiative:** focuses on promoting awareness to email scams, stressing the importance of protecting individual information and securing our systems.
- **Introduction of the Cyber Risk Advisor (CRA):** accountable for the cybersecurity and privacy risk management, information assurance and technical subject matter expertise throughout the lifecycle of a portfolio of information systems.
- **Multi Factor Authentication (MFA):** a security system that requires more than one method of authentication from independent categories of credentials to verify the user's identity for a login or other transaction, with the goal of creating a layered defense and making it more difficult for an unauthorized person to access a target such as a physical location, computing device, network or database.
- **CMS Security and Privacy Policies:** streamline and refine security and privacy policies.

Financial Statements Introduction & Highlights

Introduction

The basic financial statements in this report are prepared pursuant to the requirements of the *Government Management Reform Act of 1994* and the *Chief Financial Officer's Act of 1990*. Other requirements include the OMB Circular A-136, *Financial Reporting Requirements*. The responsibility for the integrity of the financial information included in these statements rests with management of CMS. The OIG selects an independent certified public accounting firm to audit the CMS financial statements and related notes.

Consolidated Balance Sheets

The Consolidated Balance Sheets present as of September 30, 2015 and 2014, 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. CMS's Consolidated Balance Sheet has reported assets of $418.6 billion. The majority of these assets are in Investments totaling $266.0 billion, which are invested in 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 (FBwT) of $128.5 billion, most of which is for Medicaid, Other Health, and CHIP. Liabilities of $129.2 billion consist primarily of the Entitlement Benefits Due and Payable of $108.1 billion. CMS's net position totals $289.5 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, 2015 and 2014. The Statement of Net Cost shows only a single dollar amount: the actual net cost of CMS's operations for the period by program. The three major programs that CMS administers are: Medicare, Medicaid, and CHIP. The majority of CMS's 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 under "Other Activities" include: CLIA, State Grants and Demonstrations, Other Health, and Other. A Consolidating Statement of Net Cost is provided to show the funds from dedicated collection versus other fund components of net cost as additional information.

Total Benefit Payments were $1,000.4 billion for FY 2015. Administrative Expenses were $8.5 billion, less than 1 percent of total net Program/Activity Costs of $1,011.9 billion.

The net cost of the Medicare program including benefit payments, QIOs, Medicare Integrity Program spending, and administrative costs, was $547.1 billion. The HI total costs of $278.4 billion were offset by $3.7 billion in revenues. The SMI total costs of $344.5 billion were offset by premiums and other revenues of $72.0 billion. Medicaid total costs of $349.9 billion represent expenses incurred by the states and territories that were reimbursed by CMS during the FY, plus accrued payables. The CHIP total costs were $9.1 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, 2015 and 2014. The Statement of Changes in Net Position reports the change in net position during the FY that occurred in the two components of net position: Cumulative Results of Operations and Unexpended Appropriations. Funds from dedicated collections 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 $350.6 billion; $296.0 billion in transfers from Payments to Health Care Trust Funds to HI and SMI; CHIP appropriations of $9.1 billion and State Grants and Demonstrations, Other Health and general fund-financed Program Management appropriations of $3.7 billion. 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 $237.7 billion. The federal matching contribution is income to the SMI program from a General Fund appropriation (Payments to Health Care Trust Funds) of $194.0 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, 2015 and 2014. 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.

CMS total budgetary resources were $1,401.6 billion ($130 million in non-budgetary). Obligations of $1,345.9 billion ($130 million in non-budgetary) leave unobligated balances of $55.7 billion—none in non-budgetary. Total outlays, net of collections, were $1,293.3 billion. When offset by $379.3 billion relating to collection of premiums and General Fund transfers from the Payments to Health Care Trust Funds, as well as refunds of MAC overpayments, the net outlays were $914.1 billion.

Statement of Social Insurance (SOSI)

The SOSI 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 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 are not included in the Consolidated Balance Sheet, Statements of Net Cost and Changes in Net Position, or Combined Statement of Budgetary Resources.

Actuarial present values are computed under the intermediate set of assumptions specified in the Annual Report of the Medicare Board of Trustees. The basis for the projections in the Trustees Report has changed since last year due to the enactment of the *Medicare Access and CHIP Reauthorization Act* (MACRA) of 2015. This law repealed the sustainable growth rate (SGR) formula that set physician fee schedule payments, which were usually modified, and replaced it with specified payment updates for physicians. The projections shown in last year's report reflected a projected baseline scenario, which assumed an override of the SGR payment provisions. With the enactment of MACRA, the projections in this year's report are based on current law (for more information, see Notes 13 and 14).

The SOSI presents the following estimates:

- The present value of future income (income excluding interest) to be received from or on behalf of current participants who have attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income to be received from or on behalf of current participants who have not yet attained eligibility age and the future cost of providing benefits to those same individuals;
- The present value of future income less future cost for the closed group, which represents all current participants who attain age 15 or older in the first year of the projection period, plus the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period;
- The present value of income to be received from or on behalf of future participants and the cost

of providing benefits to those same individuals;

- The present value of future income less future cost for the open group, which represents all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program, plus the assets in the combined HI and SMI Trust Funds as of the beginning of the valuation period; and
- The present value of future cash flows for all current and future participants over the next 75 years (open group measure) increased from $(3.8) trillion, determined as of January 1, 2014, to $(3.2) trillion, determined as of January 1, 2015.

Including the combined HI and SMI Trust Fund assets increases the present value, as of January 1, 2015, of future cash flow for all current and future participants to $(2.9) trillion for the 75-year valuation period. The comparable closed group of participants, including the combined HI and SMI Trust Fund assets, is $(8.6) trillion.

HI TRUST FUND SOLVENCY

Pay-as-you-go Financing

The HI Trust Fund is deemed to be solvent as long as assets are sufficient to finance program obligations. Such solvency is indicated, for any point in time, by the maintenance of positive trust fund assets. In recent years, current expenditures have exceeded program income for the HI program, and thus, the HI Trust Fund assets have been declining. The following table shows that HI Trust Fund assets, expressed as a ratio of the assets at the beginning of the fiscal year to the expenditures for the year. This ratio has steadily dropped from 107 percent at the beginning of FY 2011 to 74 percent at the beginning of FY 2015.

TRUST FUND RATIO
(Beginning of Fiscal Year)[2]

	2011	2012	2013	2014	2015
HI	107%	95%	86%	77%	74%

Short-Term Financing

The HI Trust Fund is deemed adequately financed for the short term when actuarial estimates of trust fund assets for the beginning of each calendar year are at least as large as program obligations for the year. Estimates in the 2015 Trustees Report indicate that the HI Trust Fund is not adequately financed over the next 10 years. Under the intermediate assumptions of the 2015 Trustees Report, the HI Trust Fund ratio is estimated to continue decreasing through the beginning of 2017 and remain at approximately 70 percent through 2022. From the end of 2014 to the end of 2024, assets are expected to increase, from $197 billion to $290 billion.

Long-Term Financing

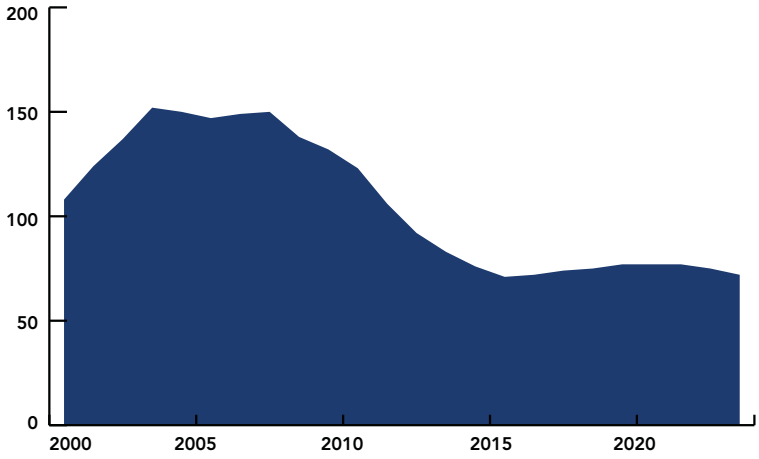
The short-range outlook for the HI Trust Fund is about the same as projected last year. After 2022, the trust fund ratio starts to decline quickly until the fund is depleted in 2030, the same date projected last year. HI financing is not projected to be sustainable over the long term with the tax rates and expenditure levels projected. Program cost exceeded total income in 2014, and thereafter, income is projected to exceed costs for several years before falling below it in 2024 and later. When the HI Trust Fund is exhausted, full benefits cannot be paid on a timely basis. The percentage of expenditures covered by tax revenues is projected to decrease from 86 percent in 2030 to 79 percent in 2039 and then to increase to about 84 percent by the end of the projection period.

The primary reasons for the projected long-term inadequacy of financing under current law relate to the fact that the ratio of the number of workers paying taxes relative to the number of beneficiaries eligible for benefits drops from 3.2 in 2014 to about 2.1 by 2089. In addition, health care costs continue to rise faster than the taxable wages used to support the program. In present value terms, the 75-year shortfall is $3.0 trillion, which translates to about 0.6 percent of taxable payroll and 0.3 percent of Gross Domestic Product (GDP) over the same period.

Significant uncertainty surrounds the estimates for the SOSI. In particular, the actual future values of demographic, economic, and programmatic factors are likely to be different from the near-term and ultimate assumptions used in the projections. The Trustees assume that the various cost-reduction measures—the most important of which are the reductions in the annual payment rate updates for all categories of Part A providers by the growth in economy-wide private nonfarm business multifactor productivity—will occur as the *Affordable Care Act* requires. The Trustees believe that this outcome is achievable if health care providers are able to realize productivity improvements at a faster rate than experienced historically. However, if the health sector cannot transition to more efficient models

[2] Assets at the beginning of the year to expenditures during the year.

HI TRUST FUND RATIO



Source: CMS/OACT

of care delivery and achieve productivity increases commensurate with economy-wide productivity, and if the provider reimbursement rates paid by commercial insurers continue to follow the same negotiated process used to date, then the availability and quality of health care received by Medicare beneficiaries would, under current law, fall over time relative to that received by those with private health insurance.

For more information, please refer to the *Required Supplementary Information: Social Insurance* disclosures required by the Federal Accounting Standards Advisory Board (FASAB).

SMI TRUST FUND SOLVENCY

The SMI Trust Fund consists of two accounts—Part B and Part D. In order to evaluate the financial status of the SMI Trust Fund, each account needs to be assessed individually, since financing rates for each part are established separately, and their program benefits are quite different in nature.

While differences between the two accounts exist, the financing mechanism for each part is similar in that the financing is determined on a yearly basis. The Part B account is generally financed by premiums and general revenue matching appropriations determined annually to cover projected program expenditures and to provide a contingency for unexpected program variation. The Part D account is financed by premiums, general revenues, and transfers from state governments. Unlike the Part B account, Part D appropriation has generally included an indefinite authority provision allowing for amounts to be transferred to the Part D account on an as-needed basis. This provision allows previously apportioned amounts to change without additional Congressional action if those amounts are later determined to be insufficient. Consequently, once an appropriation with this provision has been made, no deficit will occur in the Part D account, and no contingency fund will be necessary to cover deficits.

Since both the Part B and Part D programs are financed on a yearly basis, from a program perspective, there is no unfunded liability in the short or long-range. Therefore, in this financial statement the present value of estimated future excess of income over expenditures for current and future participants over the next 75 years is $0. However, from a government-wide perspective, General Fund transfers as well as interest payments to the Medicare Trust Funds and asset redemption, represent a draw on other federal resources for which there is no earmarked source of revenue from the public. Hence, from a government wide perspective, the corresponding estimate of future income less expenditures for the 75-year projection period is $(24.8) trillion.

Even though from a program perspective, the unfunded liability is $0, there is concern over the rapid growth in SMI expenditures as a percent of GDP. In 2014, SMI expenditures were 2.0 percent of GDP. By 2089, SMI expenditures are projected to grow to 3.8 percent of the GDP.

The following table presents key amounts from our basic financial statements for fiscal year 2013 through 2015.

Statement of Changes in Social Insurance Amounts (SCSIA)

The SCSIA reconciles the change (between the current valuation period and the prior valuation period) in the present value of future tax income less future cost for current and future participants (the open group measure) over the next 75 years. This reconciliation identifies those components of the change that are significant and provides reasons for the changes. In general, an increase in the present value of net cashflow represents a positive change (improving financing), while a decrease in the present value of net cashflow represents a negative change (worsening financing).

The present value as of January 1, 2015, would have decreased by $202 billion due to advancing the valuation date by one year and including the additional year 2089, by $82 billion due to changes in the projection base, and by $35 billion due to the changes in demographic assumptions. However, changes in economic and health care assumptions and legislation changes increased the present value of future cash flows by $755 billion and $201 billion, respectively.

Required Supplementary Information (RSI)

As required by Statement of Federal Financial Accounting Standards (SSFAS) Number 17, *Accounting for Social Insurance* (as amended by SFFAS Number 37, Social Insurance: *Additional Requirements for Management Discussion and Analysis and Basic Financial Statements*), CMS has included information about the Medicare trust funds—HI and SMI. The 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 SFFAS 37 does not eliminate or otherwise affect the SFFAS 17 requirements for the supplementary information, except that actuarial projections of annual cash flow in nominal dollars are no longer required; as such, it will not be reported in the RSI. 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 *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal*

TABLE OF KEY MEASURES[3]

DOLLARS IN BILLIONS

	2015	2014	2013
Net Position (end of fiscal year)			
Assets	$418.6	$380.0	$370.2
Less Total Liabilities	$129.2	$104.7	$88.3
Net Position (assets net of liabilities)	$289.5	$275.3	$281.9
Change in Net Position (end of fiscal year)			
Net Costs	$913.8	$837.8	$779.8
Total Financing Sources	$910.3	$820.4	$756.1
Change in Net Position	$(3.5)	$ (17.4)	$(23.7)
Statement of Social Insurance (calendar year basis)			
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), current year valuation	($3,187)	$(3,823)	$(4,772)
Present value of estimated future income (excluding interest) less expenditures for current and future participants over the next 75 years (open group), prior year valuation	($3,823)	$(4,772)	$(5,581)
Change in present value	$636	$949	$809

[3] The table or other singular presentation showing the measures described above. Although, the closed group measure is not required to be presented in the table or other singular presentation, the CMS presents the closed group measure and open group measure.

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). The financial statements have been prepared from the books and records of CMS in accordance with Generally Accepted Accounting Principles (GAAP) for federal entities and the formats prescribed by OMB and 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 RSI section is unique to federal financial reporting. This section is required under OMB Circular A-136, *Financial Reporting Requirements*, and is unaudited.

2

FINANCIAL SECTION

A Message from the Acting Chief Financial Officer //
Financial Statements // Notes to the Financial Statements //
Required Supplementary Information //
Supplementary Information // Audit Reports

A MESSAGE FROM THE ACTING CHIEF FINANCIAL OFFICER

MEGAN WORSTELL

As the Centers for Medicare & Medicaid Services (CMS) commemorates the 50 year anniversary of the Medicare and Medicaid programs and the 5th year of Marketplace implementation this fiscal year (FY), we must also celebrate our diligence in upholding our financial stewardship. With the passage of the Affordable Care Act, CMS's responsibilities significantly increased from its traditional roles of administering the Medicare program and providing federal oversight of the Medicaid and Child Health Insurance programs to also leading the charge in providing access to affordable health care for our nation's uninsured. Our programs and initiatives were established to provide better care at lower cost, promote smarter spending, and keep Americans healthy. Financial reporting, internal controls, and our financial system have also been transformed to support these program initiatives and efforts. Safeguarding public funds through fighting fraud, waste, and abuse is paramount in fulfilling the Agency's mission and maintaining financial integrity.

We received an unqualified opinion on four of the six principal financial statements with no material weaknesses identified in our internal controls. The independent auditors noted significant deficiencies in two areas: information systems, and financial reporting and oversight. The Agency takes these deficiencies seriously and continues to pursue and implement corrective actions to resolve the issues identified and strengthen our controls. While many of the information system deficiencies are complex and require multi-year efforts, we remain committed to resolving these deficiencies as quickly as possible.

Our auditors have not been able to express an opinion on the Statement of Social Insurance (SOSI) due to the uncertainty of the long-range assumptions used in the SOSI model. As in previous years, CMS remains confident that the FY 2015 SOSI projections fairly represent the effects of the Affordable Care Act and properly disclose the purpose of the projection.

I am pleased to report that we continue to make significant strides in strengthening our internal controls; fighting fraud, waste, and abuse; successfully recouping overpayments; preventing improper payments; and enhancing our financial system to provide consistent and even more reliable financial data. Last year, the Health Care Fraud and Abuse Control (HCFAC) Program secured billions of dollars in health care fraud judgments and settlements. Return on investment for the HCFAC program over the last three years (2012 – 2014) was $7.70 returned for every $1 expended. CMS continues to play a key role assisting HHS and the Department of Justice execute the HCFAC Program.

During FY 2015, CMS completed the third implementation year of the Fraud Prevention System, the predictive analytic technology that identified potential fraud before payment, which resulted in an estimated $454 million in identified savings. CMS also strengthened our provider enrollment rules, and reported that as a result of the targeted screening requirements in the Affordable Care Act and other enrollment activities, the number of provider revocations had doubled compared to the two years prior to the passage of the health law. Referrals to law enforcement made by our program integrity contractors have resulted in sentences ordering restitution of $41.4 million, forfeitures of $13.6 million, and $12.2 million in civil settlements. CMS also continued to work collaboratively with states on targeted audits to be able to more effectively support states' Medicaid program integrity efforts. Overall, a total of $91.6 million in estimated overpayments has been identified by these efforts. These program integrity

successes continue to demonstrate our commitment to developing a strong, effective, and sustainable program to combat fraud, waste, and abuse in our programs.

CMS continually seeks innovative methods to reduce the risk of improper payments, and in FY 2015 we prevented and recovered billions of dollars in improper Medicare payments. One such method is prior authorization. Building on the success of past prior authorization demonstrations, during FY 2015 CMS implemented the following prior authorization initiatives: (1) the expansion of the Power Mobility Device (PMD) demonstration to twelve additional states; (2) a prior authorization demonstration of repetitive, scheduled non-emergent ambulance transport services; and (3) a prior authorization demonstration of non-emergent hyperbaric oxygen services. Prior authorization supports the Agency's ongoing efforts to safeguard beneficiaries' access to medically necessary items and services, while reducing improper Medicare billings and payments. The PMD prior authorization demonstration has successfully reduced monthly PMD spending nationwide from $32 million to $8 million from September 2012 to August 2015.

The Medicare Secondary Payer (MSP) program continues to reflect substantial savings; the Medicare Trust Fund's savings were $8.5 billion. The Commercial Repayment Center's (CRC) net collections were $149.6 million, exceeding its FY 2014 net collections of $59.3 million by more than 100 percent. Our efforts to improve the MSP program will continue in FY 2016 with the expansion of the CRC workload to include the recovery of certain Non-Group Health Plan (NGHP) conditional payments where an NGHP entity has or had primary payment responsibility.

The Agency's core financial system, the Healthcare Integrated General Ledger Accounting System (HIGLAS), was upgraded to the most current version of Oracle's federal financial software. During this upgrade, HIGLAS remained in production without loss of data or interruption of payments. In addition to the software upgrade, CMS also upgraded the HIGLAS hardware to increase performance to meet the ever increasing demands and high volume of transactions necessary to support all of CMS's lines of business. The successful upgrade results in a more efficient financial system that will provide increased internal controls and more efficient processing of our financial transactions and data.

Under the Department of the Treasury's (Treasury) Federal Payment Levy Program (FPLP), delinquent taxpayers are levied for their federal payments disbursed by Treasury. As of September 30, 2015, HIGLAS has collected and remitted $493.9 million of FPLP debts to the Treasury via offset to Medicare Fee-For-Service (FFS) provider payments since the inception of the FPLP in October 2008.

The FY 2015 CMS Financial Report discloses our Agency's financial statements and summarizes our programs and initiatives. The accomplishments for this fiscal year were achieved by loyal hard-working professionals, internal and external stakeholders, and the beneficiaries we serve. We celebrate our successes and continuously evaluate our operations for opportunities for improvement. CMS remains committed to improving our overall financial management performance.

MEGAN WORSTELL
Acting CMS Chief Financial Officer

November 2015

CONSOLIDATED BALANCE SHEETS

as of September 30, 2015 and September 30, 2014

(IN MILLIONS)

	FY 2015 Consolidated Totals	FY 2014 Consolidated Totals
ASSETS		
Intragovernmental Assets:		
Fund Balance with Treasury *(Note 2)*	$128,534	$92,285
Investments *(Note 3)*	266,045	275,386
Accounts Receivable, Net *(Note 4)*	635	613
Other Assets *(Note 5)*	25	26
TOTAL INTRAGOVERNMENTAL ASSETS	**395,239**	**368,310**
Accounts Receivable, Net *(Note 4)*	20,860	9,860
General Property, Plant and Equipment, Net	905	403
Other Assets *(Note 5)*	1,621	1,460
TOTAL ASSETS	$418,625	$380,033
LIABILITIES		
Intragovernmental Liabilities:		
Accounts Payable	$427	$608
Accrued Payroll and Benefits	8	6
Other Intragovernmental Liabilities	1,341	1,833
TOTAL INTRAGOVERNMENTAL LIABILITIES	1,776	2,447
Accounts Payable	142	134
Federal Employee and Veterans' Benefits	12	14
Entitlement Benefits Due and Payable *(Note 6)*	108,149	91,037
Accrued Payroll and Benefits	77	71
Contingencies *(Note 7)*	7,540	9,760
Other Liabilities	11,472	1,239
TOTAL LIABILITIES *(Note 8)*	$129,168	$104,702
NET POSITION		
Unexpended Appropriations–Dedicated Collections	$30,284	$16,315
Unexpended Appropriations–Other Funds	40,353	36,683
TOTAL UNEXPENDED APPROPRIATIONS	70,637	52,998
Cumulative Results of Operations–Dedicated Collections	215,354	220,795
Cumulative Results of Operations–Other Funds	3,466	1,538
TOTAL CUMULATIVE RESULTS OF OPERATIONS	218,820	222,333
TOTAL NET POSITION	$289,457	$275,331
TOTAL LIABILITIES AND NET POSITION	$418,625	$380,033

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENTS OF NET COST

for the Years Ended September 30, 2015 and September 30, 2014

(IN MILLIONS)

	FY 2015 Consolidated Totals	FY 2014 Consolidated Totals
NET PROGRAM/ACTIVITY COSTS		
GPRA Programs		
Medicare (Dedicated Collections)	$547,135	$518,066
Medicaid	349,877	305,359
CHIP	9,105	9,574
Net Cost: GPRA Programs	906,117	832,999
Other Activities		
State Grants and Demonstrations	601	555
Other Health	4,465	3,811
Other	2,643	399
Net Cost: Other Activities	7,709	4,765
NET COST OF OPERATIONS *(Notes 9, 11, and 16)*	$913,826	$837,764

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the Year Ended September 30, 2015

(IN MILLIONS)

	Consolidated Dedicated Collections	Consolidated Other Funds	FY 2015 Consolidated Total
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	**$220,795**	**$1,538**	**$222,333**
Budgetary Financing Sources:			
Appropriations Used	295,986	363,353	659,339
Nonexchange Revenue:			
FICA and SECA Taxes	237,697		237,697
Interest on Investments	10,795	4	10,799
Other Nonexchange Revenue	3,553		3,553
Transfers-in/out Without Reimbursement	(4,659)	3,063	(1,596)
Other	518	(518)	
Other Financing Sources (Nonexchange):			
Transfers-in/out Without Reimbursement		458	458
Imputed Financing	29	22	51
Other		12	12
Total Financing Sources	**543,919**	**366,394**	**910,313**
Net Cost of Operations	**549,360**	**364,466**	**913,826**
Net Change	**(5,441)**	**1,928**	**(3,513)**
CUMULATIVE RESULTS OF OPERATIONS	**$215,354**	**$3,466**	**$218,820**
UNEXPENDED APPROPRIATIONS			
Beginning Balances	**$16,315**	**$36,683**	**$52,998**
Budgetary Financing Sources:			
Appropriations Received	288,636	424,678	713,314
Appropriations Transferred-in/out		(3,815)	(3,815)
Other Adjustments	21,319	(53,840)	(32,521)
Appropriations Used	(295,986)	(363,353)	(659,339)
Total Budgetary Financing Sources	13,969	3,670	17,639
Total Unexpended Appropriations	30,284	40,353	70,637
NET POSITION	$245,638	$43,819	$289,457

The accompanying notes are an integral part of these statements.

CONSOLIDATED STATEMENT OF CHANGES IN NET POSITION

for the Year Ended September 30, 2014

(IN MILLIONS)

	Consolidated Dedicated Collections	Consolidated Other Funds	FY 2014 Consolidated Total
CUMULATIVE RESULTS OF OPERATIONS			
Beginning Balances	**$238,145**	**$1,545**	**$239,690**
Budgetary Financing Sources:			
Appropriations Used	260,360	318,559	578,919
Nonexchange Revenue:			
FICA and SECA Taxes	227,579		227,579
Interest on Investments	11,299	3	11,302
Other Nonexchange Revenue	3,823		3,823
Transfers-in/out Without Reimbursement	(2,381)	1,123	(1,258)
Other Financing Sources (Nonexchange):			
Transfers-in/out Without Reimbursement		(7)	(7)
Imputed Financing	36	13	49
Total Financing Sources	**500,716**	**319,691**	**820,407**
Net Cost of Operations	**518,066**	**319,698**	**837,764**
Net Change	**(17,350)**	**(7)**	**(17,357)**
CUMULATIVE RESULTS OF OPERATIONS	**$220,795**	**$1,538**	**$222,333**
UNEXPENDED APPROPRIATIONS			
Beginning Balances	**$4,569**	**$37,655**	**$42,224**
Budgetary Financing Sources:			
Appropriations Received	273,772	345,593	619,365
Appropriations Transferred-in/out		(3,452)	(3,452)
Other Adjustments	(1,666)	(24,554)	(26,220)
Appropriations Used	(260,360)	(318,559)	(578,919)
Total Budgetary Financing Sources	**11,746**	**(972)**	**10,774**
Total Unexpended Appropriations	**16,315**	**36,683**	**52,998**
NET POSITION	**$237,110**	**$38,221**	**$275,331**

The accompanying notes are an integral part of these statements.

COMBINED STATEMENTS OF BUDGETARY RESOURCES

for the Years Ended September 30, 2015 and September 30, 2014

(IN MILLIONS)

	FY 2015 Combined Totals Budgetary	FY 2015 Non-Budgetary Credit Reform Financing Account	FY 2014 Combined Totals Budgetary	FY 2014 Non-Budgetary Credit Reform Financing Account
Budgetary Resources:				
Unobligated balance, brought forward, October 1:	$29,896		$34,387	
Recoveries of prior year unpaid obligations	23,347		23,985	
Other changes in unobligated balance	20,908		(290)	
Unobligated balance from prior year budget authority, net	74,151		58,082	
Appropriations	1,304,074		1,204,005	
Borrowing authority		$50		$237
Spending authority from offsetting collections	23,285	80	13,314	194
TOTAL BUDGETARY RESOURCES	**$1,401,510**	**$130**	**$1,275,401**	**$431**
Status of Budgetary Resources:				
Obligations incurred	$1,345,762	$130	$1,245,505	$431
Unobligated balance, end of year:				
Apportioned	20,311		25,142	
Exempt from apportionment (Note 12)	(2,805)			
Unapportioned	38,242		4,754	
Total unobligated balance, end of year	**55,748**		**29,896**	
TOTAL BUDGETARY RESOURCES	**$1,401,510**	**$130**	**$1,275,401**	**$431**
Change in Obligated Balance:				
Unpaid obligations:				
Unpaid obligations, brought forward, October 1	$135,768	$1,000	$110,623	$1,249
Adjustment to unpaid obligations	(448)	(2)	($126)	
Obligations incurred	1,345,762	130	1,245,505	431
Outlays (gross)	(1,305,235)	(753)	(1,196,249)	(680)
Recoveries of prior year unpaid obligations	(23,347)		(23,985)	
Unpaid obligations end of year	152,500	375	135,768	1,000
Uncollected Payments:				
Uncollected payments, Federal sources, brought forward, October 1	(7,789)	(429)	(7,754)	(536)
Adjustment to uncollected payments, Federal sources	(29)		156	(10)
Change in uncollected payments, Federal sources	(10,985)	270	(191)	117
Uncollected payments, Federal sources, end of year	(18,803)	(159)	(7,789)	(429)
Memorandum entries:				
Obligated start of year, net	127,979	571	102,869	713
Obligated balance, end of year, net	133,697	216	$127,979	$571
Budgetary Authority and Outlays, Net:				
Budget authority, gross	$1,327,359	$130	$1,217,319	$431
Actual offsetting collections	(12,300)	(350)	(13,123)	(310)
Change in uncollected customer payments from Federal sources	(10,985)	270	(191)	117
Budget authority, net	1,304,074	50	1,204,005	238
Outlays, gross	1,305,235	753	1,196,249	680
Actual offsetting collections	(12,300)	(350)	(13,123)	(310)
Outlays, net	1,292,935	403	1,183,126	370
Distributed offsetting receipts	(379,257)		(358,745)	

The accompanying notes are an integral part of these statements.

STATEMENT OF SOCIAL INSURANCE

75-Year Projection as of January 1, 2015 and Prior Base Years

(IN BILLIONS)	Estimates from Prior Years				
	2015 (unaudited)	2014 (unaudited)	2013 (unaudited)	2012 (unaudited)	2011 (unaudited)
Actuarial present value for the 75-year projection period of estimated future income (excluding interest) received from or on behalf of: (Notes 13 and 14)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	$9,134	$8,398	$8,147	$7,929	$7,581
SMI Part B	17,027	17,127	15,227	14,431	13,595
SMI Part D	6,424	5,928	5,871	5,866	6,438
Have attained eligibility age (age 65 or over)					
HI	382	332	301	302	262
SMI Part B	3,300	2,873	2,620	2,395	2,122
SMI Part D	887	775	722	694	695
Those expected to become participants					
HI	8,386	7,812	7,744	7,367	7,260
SMI Part B	3,668	4,311	3,530	3,333	3,223
SMI Part D	2,845	2,609	2,617	2,568	2,817
All current and future participants					
HI	17,902	16,542	16,192	15,598	15,104
SMI Part B	23,995	24,311	21,377	20,159	18,940
SMI Part D	10,156	9,312	9,211	9,128	9,950
Actuarial present value for the 75-year projection period of estimated future expenditures for or on behalf of: (Notes 13 and 14)					
Current participants who, in the starting year of the projection period:					
Have not yet attained eligibility age					
HI	14,494	14,117	14,629	14,919	12,887
SMI Part B	16,818	17,003	15,075	14,303	13,489
SMI Part D	6,424	5,928	5,871	5,866	6,438
Have attained eligibility age (age 65 and over)					
HI	3,803	3,484	3,422	3,369	2,923
SMI Part B	3,637	3,171	2,887	2,646	2,343
SMI Part D	887	775	722	694	695
Those expected to become participants					
HI	2,791	2,764	2,913	2,891	2,546
SMI Part B	3,540	4,137	3,415	3,211	3,108
SMI Part D	2,845	2,609	2,617	2,568	2,817
All current and future participants:					
HI	21,089	20,365	20,963	21,179	18,356
SMI Part B	23,995	24,311	21,377	20,159	18,940
SMI Part D	10,156	9,312	9,211	9,128	9,950
Actuarial present value for the 75-year projection period of estimated future excess of income (excluding interest) over expenditures (Notes 13 and 14)					
HI	(3,187)	(3,823)	(4,772)	(5,581)	(3,252)
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 13 and 14)					
HI	$(3,187)	$(3,823)	$(4,772)	$(5,581)	$(3,252)
SMI Part B	0	0	0	0	0
SMI Part D	0	0	0	0	0
Trust Fund assets at start of period					
HI	197	205	220	244	272
SMI Part B	68	74	66	80	71
SMI Part D	1	1	1	1	1
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 13 and 14)					
HI	(2,990)	(3,618)	(4,551)	(5,337)	(2,980)
SMI Part B	68	74	66	80	71
SMI Part D	1	1	1	1	1

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

STATEMENT OF SOCIAL INSURANCE (CONTINUED)

75-Year Projection as of January 1, 2015 and Prior Base Years

(IN BILLIONS)

		Estimates from Prior Years			
	2015 (unaudited)	2014 (unaudited)	2013 (unaudited)	2012 (unaudited)	2011 (unaudited)
MEDICARE SOCIAL INSURANCE SUMMARY					
Current Participants: *Actuarial present value for the 75-year projection period from or on behalf of:*					
Those who, in the starting year of the projection period, have attained eligibility age:					
Income (excluding interest)	$4,569	$3,980	$3,643	$3,391	$3,079
Expenditures	8,328	7,430	7,031	6,709	5,961
Income less expenditures	(3,759)	(3,450)	(3,388)	(3,319)	(2,882)
Those who, in the starting year of the projection period, have not yet attained eligibility age:					
Income (excluding interest)	32,585	31,453	29,244	28,227	27,615
Expenditures	37,736	37,048	35,574	35,088	32,814
Income less expenditures	(5,151)	(5,595)	(6,330)	(6,861)	(5,199)
Actuarial present value of estimated future income (excluding interest) less expenditures (closed-group measure)	(8,909)	(9,045)	(9,718)	(10,180)	(8,081)
Combined Medicare Trust Fund assets at start of period	266	280	288	325	344
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	(8,643)	(8,764)	(9,430)	(9,855)	(7,737)
Future Participants: *Actuarial present value for the 75-year projection period:*					
Income (excluding interest)	14,898	14,732	13,891	13,268	13,300
Expenditures	9,176	9,510	8,945	8,669	8,471
Income less expenditures	5,722	5,222	4,946	4,599	4,829
Open-Group (all current and future participants):					
Actuarial present value of estimated future income (excluding interest) less expenditures	(3,187)	(3,823)	(4,772)	(5,581)	(3,252)
Combined Medicare Trust Fund assets at start of period	266	280	288	325	344
Actuarial present value of estimated future income (excluding interest) less expenditures plus trust fund assets at start of period	$(2,921)	$(3,542)	$(4,484)	$(5,256)	$(2,908)

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

STATEMENT OF CHANGES IN SOCIAL INSURANCE AMOUNTS (UNAUDITED) MEDICARE HOSPITAL AND SUPPLEMENTARY MEDICAL INSURANCE

January 1, 2014 to January 1, 2015

(IN BILLIONS)	Actuarial present value over the next 75 years (open group measure)			Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures		
TOTAL MEDICARE *(Note 15)*					
As of January 1, 2014	$50,166	$53,988	($3,823)	$280	($3,542)
Reasons for change					
Change in the valuation period	2,106	2,308	(202)	(17)	(219)
Change in projection base	1,174	1,256	(82)	3	(79)
Changes in the demographic assumptions	149	184	(35)	0	(35)
Changes in economic and health care assumptions	(1,884)	(2,638)	755	0	755
Changes in law	342	142	201	0	201
Net changes	1,887	1,251	636	(14)	622
As of January 1, 2015	52,053	55,240	(3,187)	266	(2,921)
HI: PART A *(Note 15)*					
As of January 1, 2014	16,542	20,365	(3,823)	205	(3,618)
Reasons for change					
Change in the valuation period	610	812	(202)	(14)	(216)
Change in projection base	(38)	44	(82)	6	(77)
Changes in the demographic assumptions	3	38	(35)	0	(35)
Changes in economic and health care assumptions	784	30	755	0	755
Changes in law	0	(201)	201	0	201
Net changes	1,360	724	636	(8)	628
As of January 1, 2015	17,902	21,089	(3,187)	197	(2,990)
SMI: PART B *(Note 15)*					
As of January 1, 2014	24,311	24,311	0	74	74
Reasons for change					
Change in the valuation period	1,054	1,054	0	(3)	(3)
Change in projection base	360	360	0	(3)	(3)
Changes in the demographic assumptions	82	82	0	0	0
Changes in economic and health care assumptions	(2,168)	(2,168)	0	0	0
Changes in law	356	356	0	0	0
Net changes	(316)	(316)	0	(6)	(6)
As of January 1, 2015	23,995	23,995	0	68	68
SMI: PART D *(Note 15)*					
As of January 1, 2014	9,312	9,312	0	1	1
Reasons for change					
Change in the valuation period	443	443	0	(0)	(0)
Change in projection base	852	852	0	0	0
Changes in the demographic assumptions	63	63	0	0	0
Changes in economic and health care assumptions	(500)	(500)	0	0	0
Changes in law	(13)	(13)	0	0	0
Net changes	844	844	0	0	0
As of January 1, 2015	10,156	10,156	0	1	1

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

STATEMENT OF CHANGES IN SOCIAL INSURANCE AMOUNTS (UNAUDITED) MEDICARE HOSPITAL AND SUPPLEMENTARY MEDICAL INSURANCE (CONTINUED)

January 1, 2013 to January 1, 2014

(IN BILLIONS)	Actuarial present value over the next 75 years (open group measure)			Combined HI and SMI trust fund account assets	Actuarial present value of estimated future income (excluding interest) less expenditures plus combined trust fund assets
	Estimated future income (excluding interest)	Estimated future expenditures	Estimated future income less expenditures		
TOTAL MEDICARE *(Note 15)*					
As of January 1, 2013	$46,779	$51,550	($4,772)	$288	($4,484)
Reasons for change					
Change in the valuation period	1,962	2,201	(239)	(19)	(258)
Change in projection base	(98)	(545)	447	12	458
Changes in the demographic assumptions	180	318	(139)	0	(139)
Changes in economic and health care assumptions	1,293	521	772	0	772
Changes in law	50	(57)	108	0	108
Net changes	3,387	2,438	949	(7)	942
As of January 1, 2014	$50,166	$53,988	($3,823)	$280	($3,542)
HI: PART A *(Note 15)*					
As of January 1, 2013	$16,192	$20,963	($4,772)	$220	($4,551)
Reasons for change					
Change in the valuation period	619	858	(239)	(22)	(261)
Change in projection base	123	(323)	447	7	454
Changes in the demographic assumptions	(45)	93	(139)	0	(139)
Changes in economic and health care assumptions	(346)	(1,118)	772	0	772
Changes in law	0	(108)	108	0	108
Net changes	350	(598)	949	(15)	934
As of January 1, 2014	$16,542	$20,365	($3,823)	$205	($3,618)
SMI: PART B *(Note 15)*					
As of January 1, 2013	$21,377	$21,377	$0	$66	$66
Reasons for change					
Change in the valuation period	894	894	0	3	3
Change in projection base	(391)	(391)	0	4	4
Changes in the demographic assumptions	(203)	(203)	0	0	0
Changes in economic and health care assumptions	2,638	2,638	0	0	0
Changes in law	(2)	(2)	0	0	0
Net changes	2,935	2,935	0	8	8
As of January 1, 2014	$24,311	$24,311	$0	$74	$74
SMI: PART D *(Note 15)*					
As of January 1, 2013	$9,211	$9,211	$0	$1	$1
Reasons for change					
Change in the valuation period	450	450	0	(0)	(0)
Change in projection base	170	170	0	0	0
Changes in the demographic assumptions	428	428	0	0	0
Changes in economic and health care assumptions	(999)	(999)	0	0	0
Changes in law	53	53	0	0	0
Net changes	102	102	0	(0)	(0)
As of January 1, 2014	$9,312	$9,312	$0	$1	$1

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

NOTE 1:

SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity

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

Basis of Accounting and Presentation

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. 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. Further, the estimates are based on current conditions that may change in the future. Actual results could differ materially from the estimated amounts. The financial statements include information to assist in understanding the effect of changes in assumptions to the related information.

Parent/Child Reporting

CMS is a party to allocation transfers with other Federal agencies as both a transferring (parent) entity and/or a receiving (child) entity. Allocation transfers are legal delegations by one agency of its authority to obligate budget authority and outlay funds to another agency. Most financial activity related to these allocation transfers (e.g., budget authority, obligations, outlays) is reported in the financial statements of the parent entity, from which the underlying legislative authority, appropriations and budget apportionments are derived. For example, CMS has a child relationship with the Internal Revenue Service for the payment of APTC, CSR, and Basic Health Program payments; these payments are not included in CMS' financial statements.

Funds from Dedicated Collections

Funds from dedicated collections are financed by specifically identified revenues, often supplemented by other financing sources, which remain available over time. Funds from dedicated collections meet the following criteria:

- A statute committing the Federal Government to use specifically identified revenues and/or other financing sources that are originally provided to the federal government by a non-federal source only for designated activities, benefits or purposes;
- Explicit authority for the 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 fund from the federal Government's general revenues.

CMS's major funds from dedicated collections 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.

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, ambulatory surgical centers (ASC), 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 primarily by monthly premiums paid by Medicare beneficiaries with matching 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.

Medicare Supplementary Medical Insurance Trust Fund – Part D

The Medicare Modernization Act of 2003 (MMA), established the Medicare Prescription Drug Benefit – Part D. 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.

The Affordable Care Act provides that beneficiary cost sharing in the Part D coverage gap is reduced for brand-name and generic drugs from 100 percent in 2010 (including the $250 rebate) to 25 percent by 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) 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), and codified at section 1936 of the Social Security Act. The Medicaid Integrity Program represents the Federal government's first national strategy to detect and prevent Medicaid fraud and abuse. Under the Medicaid Integrity Program, CMS contracts with eligible entities to review provider claims and perform audits, with respect to Medicaid providers, similar to those activities 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 prescribes that funds covering the Medicare Prescription Drug Benefit and associated administrative costs, 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 as well as payments to support FBI activities related to health care fraud and abuse activities. 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 addition, funds are provided by this appropriation to cover CMS' administrative costs that are not related to the Medicare program. 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 (Other Funds) programs managed by CMS 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 Federal (CMS) share of the 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. Medicaid also provides funding for the Health Information Technology for Economic and Clinical Health (HITECH) incentive payments made to the States. Beginning January 1, 2014, the Affordable Care Act expanded eligibility for Medicaid to certain low-income adults with the Federal government paying 100% of those claims for Medicaid expansion for the first three years, phasing down to 90% in 2020 and beyond. The methodology for estimating the Medicaid Entitlement Benefits Due and Payable includes those claims incurred as the result of Medicaid expanded coverage.

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) extended the program through September 2013; the Affordable Care Act extended the program through September 2015; and the Medicare Access and CHIP Reauthorization Act of 2015 extends the program through September 2017. 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. With the passage of the Affordable Care Act, several new grants were included in the account and the availability of funds for other grants was extended.

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 Deficit Reduction Act Section 6201 provided Federal payments for several projects, including the Money Follows the Person demonstration, the Medicaid Integrity Program, and the establishment of alternative non-emergency providers.

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

Program Management User Fees: Medicare Advantage, Clinical Laboratory Improvement Program, Marketplace, 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. Fees for registration, certificates, and compliance determination of all U.S. clinical laboratories are collected to finance the program. Beginning January 1, 2014, the Affordable Care Act requires the collection of a user fee from each issuer offering coverage through a Federally-facilitated Marketplace to offset operating costs. Other user fees are charged for certification of some nursing facilities and for sale of the data on nursing facilities surveys, for coordination of benefits for the Part D program, and for new providers of medical or other items or services. 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. 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 American Recovery and Reinvestment Act of 2009 (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.

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. CMS also maintains lockboxes at commercial banks for the deposit of SMI premiums from the States and third parties.

Trust Fund (Dedicated collections) 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 dedicated collections investments, such as the fact that cash generated from funds from dedicated collections 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).

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

Borrowing Authority increases budgetary resources and enables costs to be financed by borrowing from Treasury. CMS uses indefinite borrowing authority under the Federal Credit Reform Act, as amended, for its CO-OP program. Any unobligated borrowing authority does not carry forward to the next fiscal year. CMS issues direct loans for the CO-OP program. CMS also has debt for the amounts borrowed from and owed to Treasury to finance a portion of the direct loans issued under the CO-OP program. CMS reports direct loans in accordance with the Federal Credit Reform Act. However, due to the immateriality of these direct loans, the related receivables and liabilities are reported in Other Assets and Other Liabilities, respectively. Budgetary related activity is reported separately within the Statement of Budgetary Resources.

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. 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 help finance benefits and administrative expenses. Monthly Part B 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. Other premiums collected are for Part A, Medicare Advantage and Part D.

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.

Estimation of Obligations Related to Canceled Appropriations

As of September 30, 2015, CMS has canceled over $385 million in cumulative obligations related to FY 2010 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 2011 through 2015 related to canceled appropriations, CMS anticipates an additional $3 million will be paid from current year funds for canceled obligations.

The Affordable Care Act

The Affordable Care Act contains the most significant changes to health care coverage since the passing of the Social Security Act. The Affordable Care Act provided funding for the establishment by CMS 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. It also allowed for the establishment of a Center for Consumer Information and Insurance Oversight (CCIIO). The programs under CCIIO include: Affordable Insurance Marketplaces (the "Marketplaces") and the Consumer Operated and Oriented Plan (CO-OP)

program. A brief description of these programs and their impact on the CMS financial statements is presented below.

Affordable Insurance Marketplaces

Grants have been provided to the States to establish Affordable Insurance Marketplaces. The initial grants were made by HHS to the States "not later than one (1) year after the date of enactment." Thus, HHS made the initial grants by March 23, 2011. Subsequent grants were issued by CMS. All Marketplaces were launched on October 1, 2013.

Consumer Operated and Oriented Plan (CO-OP) Program

The CO-OP Program was established to foster and encourage the creation of consumer-governed non-profit health plans in the individual and small group markets, with a goal of having at least one CO-OP in each state. Under this program, assistance is provided to organizations applying to become qualified, nonprofit health insurance issuers through loans to assist in meeting start-up costs, and state solvency requirements. In accordance with proposed regulations, as well as legislative requirements, loans shall be repaid within five years for start-up loans and 15 years for solvency loans, considering state reserve requirements and solvency regulations.

Transitional Reinsurance Program

The Transitional Reinsurance program was established in each state to help stabilize premiums for coverage in the individual market from 2014 through 2016. All health insurance issuers and third party administrators on behalf of self-insured group health plans, must make contributions to support reinsurance payments that cover high-cost individuals in non-grandfathered plans in the individual market, inside and outside the Marketplace. The Transitional Reinsurance program is a critical element in helping to ensure a stabilized individual market in the first years of the Exchange operation of the Marketplace.

Risk Adjustment Program

The Risk Adjustment program is a permanent program. It applies to non-grandfathered individual and small group plans inside and outside the Marketplaces. It provides payments to health insurance issuers that disproportionately attract higher-risk populations (such as individuals with chronic conditions) and transfers funds from plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to protect against adverse selection. States that operate a State-based Exchange are eligible to establish a risk adjustment program. States operating a risk adjustment program may have an entity other than the Exchange perform this function. CMS operates a risk adjustment program for each State that does not operate its own risk adjustment program.

Risk Corridor Program

The temporary Risk Corridors program will operate during the years 2014 through 2016. This program applies to qualified health plans in the individual and small group markets, inside and outside the Marketplaces and protects against inaccurate rate-setting by sharing risk (gains and losses) on allowable costs between CMS and qualified health plans to help ensure stable health insurance premiums.

NOTE 2:

FUND BALANCE WITH TREASURY

(DOLLARS IN MILLIONS)

	FY 2015	FY 2014
FUND BALANCES:		
Trust Funds:		
HI Trust Fund Balance	$1,363	$744
SMI Trust Fund Balance	43,422	18,445
Special Funds:		
Affordable Care Act Risk Programs	2,207	
CHIP Child Enrollment Contingency	53	9
Revolving Funds:		
COOP Financing	113	105
Appropriated Funds:		
Medicaid	41,895	36,781
CHIP	26,119	20,586
State Grants and Demo	3,053	3,156
Other Health	8,800	11,119
Program Management Direct/Reimbursables	1,510	1,320
Other Fund Types:		
CMS Suspense Account	(1)	20
Total Fund Balances	$128,534	$92,285
STATUS OF FUND BALANCES WITH TREASURY:		
Unobligated Balance:		
Available	$17,506	$25,142
Unavailable	38,242	4,754
Obligated Balance not yet Disbursed	133,913	128,550
Non-Budgetary FBWT	(61,127)	(66,161)
Total Status of Fund Balances with Treasury	$128,534	$92,285

Fund Balances are funds with Treasury that are primarily available to pay current expenditures and liabilities. The Unobligated Balance Available includes $14,499 million ($12,374 million in FY 2014), which is restricted for future use and is not apportioned for current use for Affordable Care Act, CHIP, Program Management, and State Grants and Demonstrations.

NOTE 3:

INVESTMENTS

(DOLLARS IN MILLIONS)

FY 2015 MEDICARE INVESTMENTS *(Dedicated Collections)*	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2016	2 1/8%	$10,292
Bonds	June 2016 to June 2025	2 – 5 5/8%	185,166
Accrued Interest			1,960
Total HI TF Investments			**$197,418**
SMI TF			
Certificates	June 2016	2 1/8%	$12,217
Bonds	June 2019 to June 2029	2 1/8 – 5 %	53,911
Accrued Interest			447
Total SMI TF Investments			**$66,575**
Total Medicare Investments			**$263,993**

FY 2014 MEDICARE INVESTMENTS *(Dedicated Collections)*	Maturity Range	Interest Range	Value
HI TF			
Certificates	June 2015	2 1/8%	$9,543
Bonds	June 2016 to June 2024	3 1/4 – 5 5/8%	192,665
Accrued Interest			2,153
Total HI TF Investments			**$204,361**
SMI TF			
Certificates	June 2015	2 1/8 – 2 3/8%	$6,172
Bonds	June 2016 to June 2029	2 1/4 – 5 5/8%	62,219
Accrued Interest			534
Total SMI TF Investments			**$68,925**
Total Medicare Investments			**$273,286**

Trust Fund (Dedicated collections) 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 a fund from dedicated collections 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.

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.

NOTE 3:

INVESTMENTS (CONTINUED)

(DOLLARS IN MILLIONS)

FY 2015 CHIP CHILD ENROLLMENT CONTINGENCY FUND INVESTMENTS *(Non-Dedicated Collections)*	Maturity Date	Cost	Unamortized Discount	Investments, Net
Treasury Bill	01/07/2016	**$2,053**	$1	$2,052

FY 2014 CHIP CHILD ENROLLMENT CONTINGENCY FUND INVESTMENTS *(Non-Dedicated Collections)*	Maturity Date	Cost	Unamortized Discount	Investments, Net
Treasury Bill	01/08/2015	$2,101	$1	$2,100
Total Non-Dedicated Collections Investments		**$2,101**	**$1**	**$2,100**

CMS INVESTMENT SUMMARY

(DOLLARS IN MILLIONS)

	Medicare (Dedicated Collections)			Non-Dedicated Collections	Consolidated Total
FY 2015	HI TF	SMI TF	Total	CHIP	
Certificates	$10,292	$12,217	$22,509		$22,509
Bonds	185,166	53,911	239,077		239,077
Treasury Bills				$2,052	2,052
Accrued Interest	1,960	447	2,407		2,407
Total Investments	**$197,418**	**$66,575**	**$263,993**	**$2,052**	**$266,045**

	Medicare (Dedicated Collections)			Non-Dedicated Collections	Consolidated Total
FY 2014	HI TF	SMI TF	Total	CHIP	
Certificates	$9,543	$6,172	$15,715		$15,715
Bonds	192,665	62,219	254,884		254,884
Treasury Bills				$2,100	2,100
Accrued Interest	2,153	534	2,687		2,687
Total Investments	**$204,361**	**$68,925**	**$273,286**	**$2,100**	**$275,386**

Note 4:

ACCOUNTS RECEIVABLE, NET

(DOLLARS IN MILLIONS)

FY 2015	Accounts Receivable Principal	Interest Receivable	Accounts Receivable Gross	Allowance	Net CMS Receivables
Intragovernmental					
Entity	$635		$635		$635
Total Intragovernmental	$635		$635		$635
With the Public					
Entity					
Medicare FFS	$6,919		$6,919	$(2,031)	$4,888
Medicare Advantage/ Prescription Drug Program	1,887		1,887		1,887
Medicaid	5,828		5,828	(1,722)	4,106
CHIP	6		6	(1)	5
Other	9,964		9,964	(17)	9,947
Non-Entity		$53	53	(26)	27
Total With the Public	$24,604	$53	$24,657	$(3,797)	$20,860

FY 2014	Accounts Receivable Principal	Interest Receivable	Accounts Receivable Gross	Allowance	Net CMS Receivables
Intragovernmental					
Entity	$613		$613		$613
Total Intragovernmental	$613		$613		$613
With the Public					
Entity					
Medicare FFS	$5,723		$5,723	$(1,649)	$4,074
Medicare Advantage/ Prescription Drug Program	2,158		2,158		2,158
Medicaid	5,199		5,199	(1,607)	3,592
CHIP	7		7	(2)	5
Other	24		24	(13)	11
Non-Entity		$39	39	(19)	20
Total With the Public	$13,111	$39	$13,150	$(3,290)	$9,860

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

No allowance for uncollectible amounts is established for intragovernmental accounts receivable because they are considered fully collectible.

Accounts receivable with the public are primarily composed of provider and beneficiary overpayments, Medicare Prescription drug overpayments, Medicare premiums, State phased-down contributions, Medicaid/CHIP overpayments, audit disallowances, civil monetary penalties and restitutions, the recognition of Medicare secondary payer (MSP) accounts receivable, and FY 2015 Marketplace activities. Accounts receivable with the public is presented net of an allowance for uncollectible amounts. The allowance is based on past collection experience and an analysis of outstanding balances. For Medicare accounts receivable, 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. The other accounts receivable have been recorded to account for amounts due related to collections for Marketplace activities.

Note 5:

OTHER ASSETS

(DOLLARS IN MILLIONS)

As of September 30, 2015, CMS has $1,646 million ($1,486 million in FY 2014) in Other Assets. Both federal and nonfederal Other Assets include the direct loans for the CO-OP programs net of subsidy allowance, CDC vaccine program inventory and grant advances.

Note 6:

ENTITLEMENT BENEFITS DUE AND PAYABLE

(DOLLARS IN MILLIONS)

	FY 2015	FY 2014
Medicare FFS	$45,268	$41,311
Medicare Advantage/Prescription Drug Program	20,953	16,280
Medicaid	36,758	32,275
CHIP	773	923
Other	4,397	248
TOTALS	$108,149	$91,037

Entitlement Benefits Due and Payable represents a liability for Medicare FFS, Medicare Advantage and the Prescription Drug Program, Medicaid, and CHIP owed to the public for medical services/claims incurred but not reported (IBNR) as of the end of the reporting period.

The Medicare FFS liability is primarily an actuarial liability which 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 services rendered in the current fiscal year but paid in the subsequent fiscal year and (e) an estimate of retroactive settlements of cost reports. The September 30, 2015 and 2014 estimate also includes amounts which may be due/owed to providers for previous years' disputed cost report adjustments for disproportionate share hospitals and teaching hospitals as well as amounts which may be due/owed to hospitals for adjusted prospective payments.

The Medicare Advantage and Prescription Drug program liability represents amounts owed to plans after the completion of the Prescription Drug payment reconciliation and estimates relating to risk and other payment related adjustments including the estimate for the first nine months of calendar year 2015. In addition, it includes an estimate of payments to plan sponsors of retiree prescription drug coverage incurred but not yet paid as of September 30, 2015.

The Medicaid and CHIP estimates represent the net Federal share of expenses that have been incurred by the States but not yet reported to CMS.

The Other liability line item includes estimates of payments due to those participating in Marketplace activities.

Note 7:

CONTINGENCIES

The contingencies balance as of September 30, 2015 is $7,540 million ($9,760 million in FY 2014). Additionally, CMS may owe amounts to providers for previous years' disputed cost report adjustments for disproportionate share hospitals. 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. CMS accrues contingent liabilities 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. 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, if the future settlement could be material to the financial statements.

The Medicaid amount for $7,530 million ($8,460 million in FY 2014) consists of Medicaid audit and program disallowances of $2,398 million ($2,918 million in FY 2014) and $5,132 million ($5,542 million in FY 2014) 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. The funds could have been returned or CMS can decrease the state's authority. 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 and CHIP Services (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 may result in funds being owed to CMS.

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, 2015, 9,737 cases (9,311 in FY 2014) remain on appeal. A total of 3,473 new cases (4,400 in FY 2014) were filed and 9 cases were reopened (12 in FY 2014). The PRRB rendered decisions on 84 cases (73 in FY 2014) and additional 2,972 cases (2,152 in FY 2014) 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 8:

LIABILITIES NOT COVERED BY BUDGETARY RESOURCES

(DOLLARS IN MILLIONS)

FY 2015 Intragovernmental	Medicare (Dedicated Collections) HI TF	Medicare (Dedicated Collections) SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
Accrued Payroll and Benefits		$1			$1		$2		$2
Other									
Total Intragovernmental		$1			$1		$2		$2
Federal Employee and Veterans' Benefits	$3	4	$1		4		12		12
Accrued Payroll and Benefits	13	19	2		18	$2	54		54
Other					10,419		10,419		10,419
Contingencies		10	7,530				7,540		7,540
Total Liabilities Not Covered by Budgetary Resources	16	34	7,533		10,442	2	18,027		18,027
Total Liabilities Covered by Budgetary Resources	63,202	90,862	36,762	$773	3,023	2,942	197,564	$(86,423)	111,141
TOTAL LIABILITIES	$63,218	$90,896	$44,295	$773	$13,465	$2,944	$215,591	$(86,423)	$129,168

FY 2014 Intragovernmental	Medicare (Dedicated Collections) HI TF	Medicare (Dedicated Collections) SMI TF	Medicaid	CHIP	Other Health	Other	Combined Total	Intra-CMS Eliminations	Consolidated Total
Accrued Payroll and Benefits	$1	$2					$3		$3
Other					$6		6		6
Total Intragovernmental	$1	$2			$6		$9		$9
Federal Employee and Veterans' Benefits	3	8	$1		2		14		14
Accrued Payroll and Benefits	15	25	2		9	$2	53		53
Other					21		21		21
Contingencies		1,300	8,460				9,760		9,760
Total Liabilities Not Covered by Budgetary Resources	19	1,335	8,463		38	2	9,857		9,857
Total Liabilities Covered by Budgetary Resources	57,152	69,281	32,289	$926	1,206	76	160,930	$(66,085)	94,845
TOTAL LIABILITIES	$57,171	$70,616	$40,752	$926	$1,244	$78	$170,787	$(66,085)	$104,702

All CMS liabilities other than contingent 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. 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.

Starting January 1, 2014, the Affordable Care Act provides for a permanent Risk Adjustment program, a transitional Reinsurance program and a temporary Risk Corridors program that will be administered by CMS. With these programs, amounts may be owed to or due from private health insurers who participate in the Marketplace that began on January 1, 2014. The Risk Adjustment and Reinsurance programs will be administered in a budget neutral manner in any calendar year. Risk Adjustment and Reinsurance payments for a year are constrained to amounts collected under the program for a year, and in any event cannot exceed amounts already collected. The Risk Corridors program will be administered over a three-year period, with any deficits or surpluses from earlier years being held over into later years. In the event of a shortfall through the 2016 program year, CMS will explore other sources of funding for risk corridor payments, subject to the availability of appropriations. For

each of the three programs (which are reflected on the Other line above), collections will not be due and payments will not be made until the year following the calendar year for which the program operates. Regarding the Reinsurance program, the Affordable Care Act outlines the amounts that are to be collected for program payments and the General Fund for all three program years—2014, 2015 and 2016. As of September 30, 2015, accruals were recorded to cover future payments, collections, sequestration, and appeals that are still due for/pertain to program years 2014 and 2015 for the Risk Adjustment and Reinsurance programs and for program year 2014 for the Risk Corridors program. However with respect to the Risk Corridors program, any potential liabilities and accounts receivable amounts for the 2015 program year can only be determined with any degree of certainty when data is submitted and calculations are performed. Therefore, CMS cannot reasonably estimate outflows/inflows for the 2015 program year as of September 30, 2015, and no amounts are recorded.

Note 9:

NET COST OF OPERATIONS

(DOLLARS IN MILLIONS)

	Medicare (Dedicated Collections)			Health				
FY 2015	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	Consolidated Total
PROGRAM/ACTIVITY COSTS								
Medicare								
Fee for Service	$197,652	$179,271	$376,923					$376,923
Medicare Advantage/ Managed Care	77,431	91,898	169,329					169,329
Prescription Drug (Part D)		71,097	71,097					71,097
Medicaid/CHIP/State Grants & Demos				$349,590	$9,090		$571	359,251
Other Health						$23,766		23,766
Total Program/Activity Costs	**$275,083**	**$342,266**	**$617,349**	**$349,590**	**$9,090**	**$23,766**	**$571**	**$1,000,366**
OPERATING COSTS								
Medicare Integrity Program	$1,527		$1,527					$1,527
Quality Improvement Organizations	496	$190	686					686
Bad Debt Expense and Writeoffs	247	70	317	$114	$(2)		$1	430
Reimbursable Expenses	57	117	174	11	1	$106	3	295
Administrative Expenses	955	1,774	2,729	160	16	1,403	4,180	8,488
Depreciation and Amortization	8	17	25	1		2		28
Imputed Cost Subsidies	12	17	29	2		18	2	51
Total Operating Costs	**$3,302**	**$2,185**	**$5,487**	**$288**	**$15**	**$1,529**	**$4,186**	**$11,505**
TOTAL COSTS	**$278,385**	**$344,451**	**$622,836**	**$349,878**	**$9,105**	**$25,295**	**$4,757**	**$1,011,871**
Less: Exchange Revenues:								
Medicare Premiums	$3,724	$71,275	$74,999					$74,999
Other Exchange Revenues	4	698	702	$1		$20,830	$1,513	23,046
Total Exchange Revenues	**$3,728**	**$71,973**	**$75,701**	**$1**		**$20,830**	**$1,513**	**$98,045**
TOTAL NET COST OF OPERATIONS	**$274,657**	**$272,478**	**$547,135**	**$349,877**	**$9,105**	**$4,465**	**$3,244**	**$913,826**

Note 9:

NET COST OF OPERATIONS (CONTINUED)

(DOLLARS IN MILLIONS)

	Medicare (Dedicated Collections)			Health				
FY 2014	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	Consolidated Total
PROGRAM/ACTIVITY COSTS								
Medicare								
Fee for Service	$193,625	$173,503	$367,128					$367,128
Medicare Advantage/ Managed Care	73,642	82,266	155,908					155,908
Prescription Drug (Part D)		61,707	61,707					61,707
Medicaid/CHIP/State Grants & Demos				$304,426	$9,555		$486	314,467
Other Health						$3,420		3,420
Total Program/Activity Costs	**$267,267**	**$317,476**	**$584,743**	**$304,426**	**$9,555**	**$3,420**	**$486**	**$902,630**
OPERATING COSTS								
Medicare Integrity Program	$1,462		$1,462					$1,462
Quality Improvement Organizations	438	$148	586					586
Bad Debt Expense and Writeoffs	(17)	61	44	$766	$1	$(1)	$2	812
Reimbursable Expenses	125	272	397	20	2	63	6	488
Administrative Expenses	1,112	2,174	3,286	156	17	464	1,008	4,931
Depreciation and Amortization	25	54	79	4		12	2	97
Imputed Cost Subsidies	12	24	36	2		9	2	49
Total Operating Costs	**$3,157**	**$2,733**	**$5,890**	**$948**	**$20**	**$547**	**$1,020**	**$8,425**
TOTAL COSTS	**$270,424**	**$320,209**	**$590,633**	**$305,374**	**$9,575**	**$3,967**	**$1,506**	**$911,055**
Less: Exchange Revenues:								
Medicare Premiums	$3,538	$68,742	$72,280					$72,280
Other Exchange Revenues	90	197	287	$15	$1	$156	$552	1,011
Total Exchange Revenues	**$3,628**	**$68,939**	**$72,567**	**$15**	**$1**	**$156**	**$552**	**$73,291**
TOTAL NET COST OF OPERATIONS	**$266,796**	**$251,270**	**$518,066**	**$305,359**	**$9,574**	**$3,811**	**$954**	**$837,764**

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. CMS administrative costs have been allocated to programs based on the CMS cost allocation system. Administrative costs allocated to the Medicare program include $2,489 million ($2,480 million in FY 2014) 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 2015 Part D expense of $71,097 million ($61,707 million in FY 2014) is net of State reimbursements of $9,604 million ($8,633 million in FY 2014). The gross expense would have been $80,701 million ($70,340 million in FY 2014).

Note 10:

FUNDS FROM DEDICATED COLLECTIONS

(DOLLARS IN MILLIONS)

Funds from dedicated collections are financed by specifically identified revenues, often supplemented by other financing sources, which remain available over time. CMS has designated as funds from dedicated collections 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 nonexchange revenues and changes in net position appears below.

	Medicare	Other Non-Medicare	Eliminations	Total Dedicated Collections
Balance Sheet as of September 30, 2015				
ASSETS				
Fund Balance with Treasury	$44,785	$3,015		$47,800
Investments	263,993			263,993
Other Assets	92,199	10,415	$(84,872)	17,742
TOTAL ASSETS	$400,977	$13,430	$(84,872)	$329,535
Entitlement Benefits Due and Payable	$66,221	$4,195		$70,416
Other Liabilities	87,893	10,460	$(84,872)	13,481
TOTAL LIABILITIES	$154,114	$14,655	$(84,872)	$83,897
Unexpended Appropriations	$30,284			$30,284
Cumulative Results of Operations	216,579	$(1,225)		215,354
Total Net Position	**246,863**	**(1,225)**		**245,638**
TOTAL LIABILITIES AND NET POSITION	**$400,977**	**$13,430**	**$(84,872)**	**$329,535**
Statement of Net Cost for the year ended September 30, 2015				
Benefit Expense	$617,349	$23,651		$641,000
Operating Costs	5,487	868		6,355
Total Costs	622,836	24,519		647,355
Less Exchange Revenues	75,701	22,294		97,995
Net Cost of Operations	**$547,135**	**$2,225**		**$549,360**
Statement of Changes in Net Position for the year ended September 30, 2015				
Net Position, Beginning of Period	$237,110			$237,110
Taxes and Other Nonexchange Revenue	252,045			252,045
Other Financing Sources	304,843	$1,000		305,843
Less Net Cost of Operations	547,135	2,225		549,360
Change in Net Position	9,753	(1,225)		8,528
NET POSITION, END OF PERIOD	$246,863	$(1,225)		$245,638

Note 10:

FUNDS FROM DEDICATED COLLECTIONS (CONTINUED)

(DOLLARS IN MILLIONS)

	Medicare	Other Non-Medicare	Eliminations	Total Dedicated Collections
Balance Sheet as of September 30, 2014				
ASSETS				
Fund Balance with Treasury	$19,189			$19,189
Investments	273,286			273,286
Other Assets	72,422		$(65,197)	7,225
TOTAL ASSETS	$364,897		$(65,197)	$299,700
Entitlement Benefits Due and Payable	$57,591			$57,591
Other Liabilities	70,196		$(65,197)	4,999
TOTAL LIABILITIES	$127,787		$(65,197)	$62,590
Unexpended Appropriations	$16,315			$16,315
Cumulative Results of Operations	220,795			220,795
Total Net Position	**237,110**			**237,110**
TOTAL LIABILITIES AND NET POSITION	**$364,897**		**$(65,197)**	**$299,700**
Statement of Net Cost for the year ended September 30, 2014				
Benefit Expense	$584,743			$584,743
Operating Costs	5,890			5,890
Total Costs	590,633			590,633
Less Exchange Revenues	72,567			72,567
Net Cost of Operations	**$518,066**			**$518,066**
Statement of Changes in Net Position for the year ended September 30, 2014				
Net Position, Beginning of Period	$242,714			$242,714
Taxes and Other Nonexchange Revenue	242,701			242,701
Other Financing Sources	269,761			269,761
Less Net Cost of Operations	518,066			518,066
Change in Net Position	(5,604)			(5,604)
NET POSITION, END OF PERIOD	$237,110			$237,110

Note 11:

INTRAGOVERNMENTAL COSTS AND EXCHANGE REVENUE (DOLLARS IN MILLIONS)

FY 2015	Gross Cost			Less: Exchange Revenue			
	Intra-governmental	Public	Total	Intra-governmental	Public	Total	Consolidated Net Cost of Operations
PROGRAM/ACTIVITY COSTS							
GPRA Programs							
Medicare (Dedicated Collections)							
HI TF	$787	$277,598	$278,385	$4	$3,724	$3,728	$274,657
SMI TF	239	344,212	344,451	8	71,965	71,973	272,478
Medicaid	12	349,866	349,878	1		1	349,877
CHIP	31	9,074	9,105				9,105
Subtotal	**1,069**	**980,750**	**981,819**	**13**	**75,689**	**75,702**	**906,117**
Other Activities							
State Grants and Demonstrations	25	576	601				601
Other Health	197	25,098	25,295	14	20,816	20,830	4,465
Other	116	4,040	4,156		1,513	1,513	2,643
Subtotal	**338**	**29,714**	**30,052**	**14**	**22,329**	**22,343**	**7,709**
PROGRAM/ ACTIVITY TOTALS	$1,407	$1,010,464	$1,011,871	$27	$98,018	$98,045	$913,826

FY 2014	Gross Cost			Less: Exchange Revenue			
	Intra-governmental	Public	Total	Intra-governmental	Public	Total	Consolidated Net Cost of Operations
PROGRAM/ACTIVITY COSTS							
GPRA Programs							
Medicare (Dedicated Collections)							
HI TF	$835	$269,589	$270,424	$5	$3,623	$3,628	$266,796
SMI TF	217	319,992	320,209	11	68,928	68,939	251,270
Medicaid	13	305,361	305,374	1	14	15	305,359
CHIP	31	9,544	9,575		1	1	9,574
Subtotal	**1,096**	**904,486**	**905,582**	**17**	**72,566**	**72,583**	**832,999**
Other Activities							
State Grants and Demonstrations	16	544	560	1	4	5	555
Other Health	186	3,781	3,967	12	144	156	3,811
Other	46	900	946		547	547	399
Subtotal	**248**	**5,225**	**5,473**	**13**	**695**	**708**	**4,765**
PROGRAM/ ACTIVITY TOTALS	$1,344	$909,711	$911,055	$30	$73,261	$73,291	$837,764

The charts above display 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 12:

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 2015	Direct	Reimbursable	Combined Totals
Category A	$15,631	$391	$16,022
Category B	658,749	1,055	659,804
Exempt	670,066		670,066
Total	**$1,344,446**	**$1,446**	**$1,345,892**

FY 2014	Direct	Reimbursable	Combined Totals
Category A	$13,957	$387	$14,344
Category B	590,681	873	591,554
Exempt	640,038		640,038
Total	**$1,244,676**	**$1,260**	**$1,245,936**

LEGAL ARRANGEMENTS AFFECTING USE OF UNOBLIGATED BALANCES

All trust fund receipts collected in the fiscal year are reported as new budget authority in the Combined Statement of Budgetary Resources (SBR). 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 Temporarily Not Available Pursuant to Public Law and is included in the calculation for appropriations on 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 $201,111 million ($225,453 million in FY 2014) are included in Investments on the Balance Sheets. The following table presents trust fund activities and balances for FY 2015 and FY 2014 (in millions):

TRUST FUND BALANCE, BEGINNING	**$225,453**	**$245,041**
Receipts	542,336	522,641
Less Obligations	566,678	542,229
Excess (Shortage) of Receipts Over Obligations	(24,342)	(19,588)
TRUST FUND BALANCE, ENDING	$201,111	$225,453

EXEMPT FROM APPORTIONMENT

This amount includes the FY 2015 recording of obligations required by law where such obligations are in excess of available funding. These obligations were incurred by operation of law; thus, they are reflected as exempt from apportionment. The Antideficiency Act has not been violated, as "[t]he prohibitions contained in the Antideficiency Act are directed at discretionary obligations entered into by administrative officers." B-219161 (Oct. 2, 1985).

EXPLANATIONS OF DIFFERENCES BETWEEN THE COMBINED STATEMENT OF BUDGETARY RESOURCES AND THE BUDGET OF THE UNITED STATES GOVERNMENT FOR FY 2014

(DOLLARS IN MILLIONS)

CMS reconciled the amounts of the FY 2014 column of the SBR to the actual amounts for FY 2014 from the Appendix in the FY 2015 President's Budget for budgetary resources, obligations incurred, offsetting receipts and net outlays (gross outlays less offsetting collections).

FY 2014	Budgetary Resources	Obligations Incurred	Distributed Offsetting Receipts	Net Outlays
Combined Statement of Budgetary Resources	$1,275,832	$1,245,936	$358,745	$1,183,496
Expired Accounts	(5,360)			
Other	2,993	2,994	1,499	3,815
President's Budget (2014 Actual)	**$1,273,465**	**$1,248,930**	**$360,244**	**$1,187,311**

For the budgetary resources reconciliation, the amount used from the President's Budget was the total budgetary resources available for obligation. Therefore, a reconciling item that is contained in the Combined Statement of Budgetary Resources and not in the President's Budget is the budgetary resources that were not available. The Expired accounts line in the above schedule includes expired authority, recoveries and other amounts included in the Combined Statement of Budgetary Resources that are not included in the President's Budget.

The Other differences in the resources and obligations incurred include amounts reported in the President's Budget for CDC and CCIIO but not in CMS' Combined Statement of Budgetary Resources, return of cancelled funds, and GTAS revision window adjustments that were not in the SBR.

The Other differences in the distributed offsetting receipts are the result of the HI transfer from PTF.

Lastly, the Other differences in the net outlays include outlays reported in the President's Budget for CDC and CCIIO but not in CMS' Combined Statement of Budgetary Resources.

UNDELIVERED ORDERS AT THE END OF THE PERIOD

The amount of budgetary resources obligated for undelivered orders totaled $26,909 million for Budgetary and $374 million for Non-Budgetary at September 30, 2015 ($40,510 million for Budgetary and $998 million for Non-Budgetary at FY 2014). In FY 2015, the Payments to the Health Care Trust Funds was definite, and a payable was recorded for $11,172 million, estimated to be paid to the SMI trust fund for both Part D benefits. In FY 2014, the Payments to the Health Care Trust Funds was definite, and an undelivered order was recorded for $16,314 million, estimated to be paid to the SMI trust fund for both Part D benefits and SMI premium federal matching.

Note 13:

STATEMENT OF SOCIAL INSURANCE (UNAUDITED)

The Statement of Social Insurance (SOSI) presents, for the 75-year projection period, the present values of the income and expenditures of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds for both the open group and closed group of participants. The open group consists of all current and future participants (including those born during the projection period) who are now participating or are expected to eventually participate in the Medicare program. The closed group comprises only current participants—those who attain age 15 or older in the first year of the projection period.

Actuarial present values are computed under the intermediate set of assumptions specified *Annual Report of the Medicare Board of Trustees*. These assumptions represent the Trustees' reasonable estimate of likely future economic, demographic, and health care-specific conditions. As with all of the assumptions underlying the Trustees' financial projections, the Medicare-specific assumptions are reviewed annually and updated based on the latest available data and analysis of trends. In addition, the assumptions and projection methodology are subject to periodic review by independent panels of expert actuaries and economists. The most recent review occurred with the 2010-2011 Technical Review Panel.

The basis for the projections in the Trustees Report has changed since last year due to the enactment of the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. The projections shown in last year's report reflected a *projected baseline* scenario, which assumed an override of the sustainable growth rate (SGR) payment provisions used to set physician fee schedule payments. Since MACRA repealed the SGR formula and replaced it with specified payment updates for physicians, the projections in this year's report are based on current law.

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 July 22, 2015, with one exception, and do not reflect any actual or anticipated changes subsequent to that date. The one exception is that the projections disregard payment reductions that would result from the projected depletion of the Medicare Hospital Insurance trust fund. 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 transfers from the General Fund of the Treasury. 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. Current participants are the closed group of individuals who are at least age 15 at the start of the

projection period and are expected to participate in the program as either taxpayers, beneficiaries, or both.

The SOSI sets forth, for each of these three groups, the projected actuarial present values of all future 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, which are calculated by subtracting the actuarial present value of estimated future expenditures from the actuarial present value of estimated future income. The HI trust fund is expected to have an actuarial deficit indicating 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 deficits 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, the SOSI also sets forth the same calculation for the closed group of participants. The closed group consists of those who, in the starting year of the projection period, have attained retirement eligibility age or have attained ages 15 through 64. In order to calculate the actuarial net present value of the excess of estimated future income over estimated 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 estimated 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 inherently uncertain factors and by the application of future payment updates. Consequently, Medicare's actual cost over time, especially for periods as long as 75 years, cannot be predicted with certainty and could differ materially from the projections shown in the SOSI. Moreover, these differences could affect the long-term sustainability of this social insurance program.

To develop 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 July 22, 2015, except that the projections disregard payment reductions that would result from the projected depletion of the Medicare Hospital Insurance trust fund. 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 following table includes the most significant underlying assumptions used in the projections of Medicare spending displayed in this section. The assumptions underlying the 2015 SOSI actuarial projections are drawn from the Social Security and Medicare Trustees Reports for 2015. Specific assumptions are made for each of the different types of service provided by the Medicare program (for example, hospital care and physician services). These assumptions include changes in the payment rates, utilization, and intensity of each type of service. The projected beneficiary cost increases summarized below reflect the overall impact of these more detailed assumptions. Detailed information, similar to that denoted within table 1, for the prior years is publicly available on the CMS website at **http://www.cms.hhs.gov/CFOReport/**.[1]

1 The notes to the financial statements include URL references to certain websites. The information contained on those websites is not part of the financial statement presentation.

Table 1:

SIGNIFICANT ASSUMPTIONS AND SUMMARY MEASURES USED FOR THE STATEMENT OF SOCIAL INSURANCE 2015

					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		Real-interest rate[9]
									B	D	
2015	1.91	1,465,000	771.3	3.18	3.38	0.20	3.3	–0.9	2.2	2.5	2.1
2020	2.04	1,395,000	730.1	1.73	4.43	2.70	2.7	4.2	5.9	5.7	2.4
2030	2.00	1,190,000	667.6	1.23	3.93	2.70	2.1	4.4	4.9	5.1	2.9
2040	2.00	1,135,000	615.0	1.20	3.90	2.70	2.2	4.9	4.1	4.9	2.9
2050	2.00	1,110,000	568.9	1.21	3.91	2.70	2.1	3.9	3.7	4.8	2.9
2060	2.00	1,095,000	528.2	1.16	3.86	2.70	2.0	3.7	3.7	4.6	2.9
2070	2.00	1,085,000	492.2	1.11	3.81	2.70	2.1	3.9	3.7	4.5	2.9
2080	2.00	1,085,000	460.1	1.13	3.83	2.70	2.1	3.9	3.7	4.5	2.9

1 Average number of children per woman.

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

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

4 Difference between percentage increases in wages and the CPI.

5 Average annual wage in covered employment.

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

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

8 These increases reflect the overall impact of more detailed assumptions that are made for each of the different types of service provided by the Medicare program (for example, hospital care, physician services, and pharmaceutical costs). These assumptions include changes in the payment rates, utilization, and intensity of each type of service.

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

The projections presented in the Statement of Social Insurance are based on various economic and demographic assumptions. The values for each of these assumptions move from recently experienced levels or trends toward long-range ultimate values. These ultimate values assumed for the current year and the prior 4 years, based on the intermediate assumptions of the respective Medicare Trustees Reports, are summarized in table 2 below.

Table 2:

SIGNIFICANT ULTIMATE ASSUMPTIONS USED FOR THE STATEMENT OF SOCIAL INSURANCE, FY 2015–2011

					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		Real-interest rate[9]
									B	D	
FY 2015	2.0	1,085,000	460.1	1.13	3.83	2.70	2.1	3.9	3.7	4.5	2.9
FY 2014	2.0	1,060,000	458.4	1.13	3.83	2.70	2.1	3.8	4.1	4.4	2.9
FY 2013	2.0	1,055,000	419.8	1.13	3.93	2.80	2.1	3.8	3.8	4.5	2.9
FY 2012	2.0	1,030,000	446.0	1.12	3.92	2.80	2.0	3.7	3.8	4.5	2.9
FY 2011	2.0	1,030,000	443.2	1.2	4.0	2.8	2.1	3.3	3.7	4.4	2.9

1 Average number of children per woman. The ultimate fertility rate is assumed to be reached in the 13th year of the projection period.

2 Includes legal immigration, net of emigration, as well as other, non-legal, immigration. The ultimate level of net legal immigration is 790,000 persons per year, and the assumption for annual net other immigration varies throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.

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

4 Difference between percentage increases in wages and the CPI. The value presented is the average of annual real-wage differentials for the last 65 years of the 75-year projection period, is consistent with the annual differentials shown in table 1, and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.

5 Average annual wage in covered employment. The value presented is the average annual percentage change from the 10th year of the 75-year projection period to the 75th year and is displayed to two decimal places. The assumption varies slightly throughout the projection period. Therefore, the assumption presented is the value assumed in the year 2080.

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 soon after the 10th year of each projection period.

Note 14:

ALTERNATIVE SOSI PROJECTIONS (UNAUDITED)

The Medicare Board of Trustees, in their annual report to Congress, references an alternative scenario to illustrate, when possible, the potential understatement of Medicare costs and projection results. This scenario assumes that the various cost-reduction measures—the most important of which are the reductions in the annual payment rate updates for most categories of Medicare providers by the growth in economy-wide multifactor productivity and the specified physician updates put in place by MACRA—will occur as current law requires. The Board of Trustees believes that this outcome is achievable if health care providers are able to realize productivity improvements at a faster rate than experienced historically. The ability of health care providers to sustain the price reductions for those providers impacted by the productivity adjustments and the specified updates to physician payments will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services and that physician costs will grow at a faster rate than the specified updates. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time.

Absent an unprecedented change in health care delivery systems and payment mechanisms, the prices paid by Medicare for health services will fall increasingly short of the costs of providing these services. By the end of the long-range projection period, Medicare prices for many services would be less than half of their level without consideration of the productivity price reductions, and physician payments would be 30 percent lower than they would have been under the SGR. Before such an outcome would occur, lawmakers would likely intervene to prevent the withdrawal of providers from the Medicare market and the severe problems with beneficiary access to care that would result. Overriding the productivity adjustments and specified physician updates, as lawmakers have done repeatedly in the case of physician payment rates, would lead to substantially higher costs for Medicare in the long range than those projected in this report.

To help illustrate and quantify the potential magnitude of the cost understatement, the Trustees asked the Office of the Actuary at CMS to prepare an illustrative Medicare trust fund projection under a hypothetical alternative that assumes that, starting in 2020, the economy-wide productivity adjustments gradually phase down to 0.4 percent and, starting in 2024, physician payments transition from a payment update of 0.0 percent to an increase of 2.3 percent. In addition, the illustrative alternative also assumes that requirements for the Independent Payment Advisory Board would not be implemented.[1] This alternative was developed for illustrative purposes only; the calculations have not been audited; no endorsement of the policies underlying the illustrative alternative 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 updates under Medicare and of the broad range of uncertainty associated with such impacts.

1 The illustrative alternative projections included changes to the productivity adjustments starting with the 2010 annual report, following enactment of the *Affordable Care Act*. The assumption regarding physician payments is being used because the SGR was replaced earlier this year.

The table below contains a comparison of the Medicare 75-year present values of estimated future income and estimated future expenditures under current law with those under the illustrative alternative scenario.

MEDICARE PRESENT VALUES

(IN BILLIONS)

	Current law (Unaudited)	Alternative Scenario[1, 2] (Unaudited)
Income		
Part A	$17,902	$17,929
Part B	23,995	29,605
Part D	10,156	10,246
Expenditures		
Part A	21,089	25,824
Part B	23,995	29,605
Part D	10,156	10,246
Income less expenditures		
Part A	(3,187)	(7,895)
Part B	0	0
Part D	0	0

1 These amounts are not presented in the 2015 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 differs from current law. No endorsement of the illustrative alternative by the Trustees, CMS, or the Office of the Actuary should be inferred.

The difference between the current law and illustrative alternative projections is substantial for Parts A and B. All Part A fee-for-service providers and roughly half of Part B fee-for-service providers are affected by the productivity adjustments, so the current-law projections reflect an estimated 1.1-percent reduction in annual cost growth each year for these providers. If the productivity adjustments were gradually phased out and physician updates transitioned to the Medicare Economic Index update of 2.3 percent, as illustrated under the alternative scenario, the estimated present value of Part A and Part B expenditures would be higher than the current law projections by roughly 22 percent and 23 percent, respectively. As indicated above, the present value of Part A income is basically unaffected under the alternative scenario; and the present value of Part B income is also 23 percent higher under the illustrative alternative scenario, since income is set each year to mirror expenditures.

The Part D values are similar under each projection because the services are not affected by the productivity adjustments or the physician updates. The very minor impact is the result of a slight change in the discount rates that are used to calculate the present values.

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

Note 15:

STATEMENT OF CHANGES IN SOCIAL INSURANCE AMOUNTS (UNAUDITED)

The Statement of Changes in Social Insurance Amounts (SCSIA) reconciles the change (between the current valuation and the prior valuation) in the (1) present value of estimated future income (excluding interest) for current and future participants; (2) present value of estimated future expenditures for current and future participants; (3) present value of estimated future noninterest income less estimated future expenditures for current and future participants (the open-group measure) over the next 75 years; (4) assets of the combined Medicare Trust Funds; and (5) present value of estimated future noninterest income less estimated future expenditures for current and future participants over the next 75 years plus the assets of the combined Medicare Trust Funds. The SCSIA shows the reconciliation from the period beginning on January 1, 2014 to the period beginning on January 1, 2015, and the reconciliation from the period beginning on January 1, 2013 to the period beginning on January 1, 2014. The reconciliation identifies several components of the change that are significant and provides reasons for the changes.

Because of the financing mechanism for Parts B and D of Medicare, any change to the estimated future expenditures has the same effect on estimated total future income, and vice versa. Therefore, any change has no impact on the estimated future net cashflow. In order to enhance the presentation, the changes in the present values of estimated future income and estimated future expenditures are presented separately.

The five changes considered in the Statement of Changes in Social Insurance Amounts are, in order:

- change in the valuation period,
- change in projection base,
- changes in the demographic assumptions,
- changes in economic and health care assumptions, and
- changes in law.

All estimates in the Statement of Changes in Social Insurance Amounts represent values that are incremental to the prior change. As an example, the present values shown for demographic assumptions, represent the additional effect that these assumptions have, once the effects from the change in the valuation period and projection base have been considered. In general, an increase in the present value of net cashflow represents a positive change (improving financing), while a decrease in the present value of net cashflow represents a negative change (worsening financing).

Assumptions Used for the Statement of Changes in Social Insurance Amounts

The present values included in the Statement of Changes in Social Insurance Amounts are for the current and prior year and are based on various economic and demographic assumptions used for the intermediate assumptions in the Trustees Reports for those years. Table 1 of note 13 summarizes these assumptions for the current year.

Period beginning on January 1, 2014 and ending January 1, 2015

Present values as of January 1, 2014 are calculated using interest rates from the intermediate assumptions of the 2014 Trustees Report. All other present values in this part of the Statement are calculated as a present value as of January 1, 2015. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are determined using the interest rates under the intermediate assumptions of the 2014 Trustees Report. Since interest rates are economic assumptions, the estimates of the present values of changes in economic and health care assumptions are presented using the interest rates under the intermediate assumptions of the 2015 Trustees Report.

Period beginning on January 1, 2013 and ending January 1, 2014

Present values as of January 1, 2013 are calculated using interest rates from the intermediate assumptions of the 2013 Trustees Report. All other present values in this part of

the Statement are calculated as a present value as of January 1, 2014. Estimates of the present value of changes in social insurance amounts due to changing the valuation period, projection base, demographic assumptions, and law are determined using the interest rates under the intermediate assumptions of the 2013 Trustees Report. Since interest rates are economic assumptions, the estimates of the present values of changes in economic and health care assumptions are presented using the interest rates under the intermediate assumptions of the 2014 Trustees Report.

Change in the Valuation Period

From the period beginning on January 1, 2014 to the period beginning on January 1, 2015

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2014-88) to the current valuation period (2015-89) is measured by using the assumptions for the prior valuation period and applying them, in the absence of any other changes, to the current valuation period. Changing the valuation period removes a small negative net cashflow for 2014 and replaces it with a much larger negative net cashflow for 2089. The present value of estimated future net cashflow (including or excluding the combined Medicare Trust Fund assets at the start of the period) was therefore decreased (made more negative) when the 75-year valuation period changed from 2014-88 to 2015-89. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2014 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

From the period beginning on January 1, 2013 to the period beginning on January 1, 2014

The effect on the 75-year present values of changing the valuation period from the prior valuation period (2013-87) to the current valuation period (2014-88) is measured by using the assumptions for the prior valuation period and applying them, in the absence of any other changes, to the current valuation period. Changing the valuation period removes a small negative net cashflow for 2013 and replaces it with a much larger negative net cashflow for 2088. The present value of estimated future net cashflow (including or excluding the combined Medicare Trust Fund assets at the start of the period) was therefore decreased (made more negative) when the 75-year valuation period changed from 2013-87 to 2014-88. In addition, the effect on the level of assets in the combined Medicare Trust Funds of changing the valuation period is measured by assuming all values projected in the prior valuation for the year 2013 are realized. The change in valuation period decreased the level of assets in the combined Medicare Trust Funds.

Change in Projection Base

From the period beginning on January 1, 2014 to the period beginning on January 1, 2015

Actual income and expenditures in 2014 were different than what was anticipated when the 2014 Trustees Report projections were prepared. Part A income was very slightly lower and expenditures were very slightly higher than anticipated, based on actual experience. Part B total income and expenditures were also higher than estimated based on actual experience. For Part D, actual income and expenditures were both higher than prior estimates. The net impact of the Part A, B, and D projection base changes is a decrease in the estimated future net cashflow. Actual experience of the Medicare Trust Funds between January 1, 2014 and January 1, 2015 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

From the period beginning on January 1, 2013 to the period beginning on January 1, 2014

Actual income and expenditures in 2013 were different than what was anticipated when the 2013 Trustees Report projections were prepared. Part A income was slightly higher and expenditures were lower than anticipated, based on actual experience. Part B total income and expenditures were also lower than estimated based on actual experience. For Part D, actual income and expenditures were both slightly higher on an incurred basis than prior estimates. The net impact of the Part A, B, and D projection base changes is an increase in the estimated future net cashflow. Actual experience of the Medicare Trust Funds between January 1, 2013 and January 1, 2014 is incorporated in the current valuation and is slightly more than projected in the prior valuation.

Changes in the Demographic Assumptions

From the period beginning on January 1, 2014 to the period beginning on January 1, 2015

The demographic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2015) are the same as those for the prior valuation. However, the starting demographic values and the way these values transition to the ultimate assumptions were changed.

- Final birth rate data for 2012 and preliminary data for 2013 indicated lower birth rates than were expected in the prior valuation. In this year's projections the total fertility rate reaches the ultimate in 2027, which is eleven years earlier than in last year's projections.
- Incorporating mortality data obtained from Medicare experience at ages 65 and older for 2012 resulted in slightly higher death rates for 2012 and a slightly slower rate of decline in mortality over the next 25 years than were projected last year. Incorporating mortality data obtained from the National Centers for Health Statistics at ages under 65 for 2011 resulted in slightly lower death rates for 2011 and a slightly faster rate of decline in mortality over the next 25 years than were projected last year.
- Historical legal immigration was revised to include single age data (rather than 5-year age groups); including more recent marriage, legal immigration, and other-than-legal immigration data; historical data since 2001 was revised to be more consistent with the most recent estimates from the Census Bureau.

These changes slightly lowered overall Medicare enrollment for the current valuation period resulting in a decrease in the estimated future net cashflow, and had a very minor impact on the present value of estimated income and estimated expenditures for Part A, Part B, and Part D.

From the period beginning on January 1, 2013 to the period beginning on January 1, 2014

The demographic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

The ultimate demographic assumptions for the current valuation (beginning on January 1, 2014) are the same as those for the prior valuation. However, the starting demographic values, and the way these values transition to the ultimate assumptions, were changed.

- Preliminary birth rate data for 2012 indicated lower birth rates than were expected in the prior valuation. During the period of transition to their ultimate values, the birth rates in the current valuation are generally lower than they were in the prior valuation.

There was one change in demographic methodology:

- The modeling of the other immigrant population was divided into three distinct groups for the current valuation: (1) those with temporary legal status; (2) those never authorized to be in the country; and (3) those who had temporary legal status previously but are no longer authorized to be in the country.

These changes slightly lowered overall Medicare enrollment for the current valuation period resulting in a decrease in the estimated future net cashflow, and had a very minor impact on the present value of estimated income and estimated expenditures for Part A, Part B, and Part D.

A further assumption change was made that resulted in higher Part D enrollment for the current valuation period. The participation rate represents the percentage of beneficiaries assumed to enroll in a Part D plan out of all eligible and, in prior years, was assumed to stay relatively constant at the same rate as the recent historical period. However, since actual participation has consistently been higher than expected, it was decided to increase the participation rate by 1 percent per year for the first 3 years of the projection period, before leveling out. This results in an assumed 62.4 percent participation rate, prior to adjustments for beneficiaries who have retiree drug subsidy coverage and those who are assumed to drop out because they are required to pay an income-related premium, for 2017 and later, which is higher than the 57.2 percent that was assumed for all years in the prior valuation period. This assumption change resulted in an increase in the

present value of estimated future income and estimated future expenditures for Part D, and had no impact on the Part A and Part B present values.

Changes in Economic and Health Care Assumptions

For the period beginning on January 1, 2014 to the period beginning on January 1, 2015

The economic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

For the current valuation (beginning on January 1, 2015), there was one change to the ultimate economic assumptions.

- The ultimate real-wage differential is assumed to be 1.17 percent in the current valuation period, compared to 1.13 percent in the previous valuation period.

The higher real wage differential assumption is more consistent with recent experience and expectations of slower growth in employer sponsored group health insurance premiums from the Office of the Actuary at the Centers for Medicare & Medicaid Services. Because these premiums are not subject to the payroll tax, slower growth in these premiums means that a greater share of employee compensation will be in the form of wages that are subject to the payroll tax.

Otherwise, the ultimate economic assumptions for the current valuation are the same as those for the prior valuation. However, the starting economic values and the way these values transition to the ultimate assumptions were changed.

- The ratio of average taxable earnings to the average wage averages about 0.6 percentage point higher during the long-range period, compared to the previous valuation period.
- The projected suspense file contains fewer wage items, which is consistent with having fewer workers (many of whom are undocumented immigrants) with wages on the suspense file and more of these workers with earnings in the underground economy, compared to the previous valuation.

The health care assumptions are specific to the Medicare projections. The following health care assumptions were changed in the current valuation.

- Lower long-range growth rate assumptions
- Utilization rate assumptions for inpatient hospital services were decreased.
- Lower assumed hospice spending.
- Higher assumed enrollment in Medicare Advantage plans where benefits are more costly.
- Introduction of high-cost specialty drugs used to treat hepatitis C.

The net impact of these changes resulted in an increase in the estimated future net cashflow for total Medicare. For Part A, these changes resulted in an increase to the present value of estimated future expenditures and income, with an overall increase in the estimated future net cashflow. For Part B and Part D, these changes decreased the present value of estimated future expenditures (and also income).

For the period beginning on January 1, 2013 and the period beginning on January 1, 2014

The economic assumptions used in the Medicare projections are the same as those used for the Old-Age, Survivors and Disability Insurance (OASDI) and are prepared by the Office of the Chief Actuary at the Social Security Administration (SSA).

For the current valuation (beginning on January 1, 2014), there was one change to the ultimate economic assumptions:

- The ultimate annual rate of change in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) is assumed to be 2.7 percent per year in the current valuation period, compared to 2.8 percent per year in the previous valuation period. Lowering the ultimate average annual increase in the CPI-W makes it more comparable to recent historical annual increases.

Otherwise, the ultimate economic assumptions for the current valuation are the same as those for the prior valuation. However, the starting economic values, and the way these values transition to the ultimate assumptions, were changed.

- The ratio of average taxable earnings to the average wage index is lower by 1.9 percent

in 2012 and 1.5 percent in 2013, compared to the previous valuation period.

There were two main changes in the economic methodology:

- Projected labor force participation rates for the older population are slightly lower for the current valuation in order to better reflect the difference in participation rates between never-married and married populations and the projected improvement in life expectancy.
- Different earnings levels are assigned to the three distinct groups of the other immigrant population supplied by demography. (This change decreased the present value of future cashflows by about the same amount as the related change in the demography methodology increased the present value of future cashflows).

The health care assumptions are specific to the Medicare projections. The following health care assumptions were changed in the current valuation.

- The projections emphasized in the 2014 Medicare Trustees Report were changed to reflect the projected baseline scenario. This scenario assumes that the physician payment updates required under the current-law sustainable growth rate formula will be overridden by lawmakers. The use of these projections increases the present value of estimated future expenditures, compared to the current law projections, for Part B by roughly 11 percent, and for total Medicare by about 5 percent.
- Utilization rate assumptions for inpatient hospital services were decreased.
- Case mix increase assumptions for skilled nursing facilities and home health agencies were decreased.
- Market basket differential for skilled nursing facilities was lowered.
- Higher assumed enrollment in Medicare Advantage plans where benefits are more costly.
- Higher increases in productivity rates, resulting in lower payment updates.
- The methodology used to transition from the short-range projections to the long-range projections was refined, resulting in smaller increases during this transition period.
- Lower projected prescription drug trend rates.
- Higher assumed rebates from drug manufacturers.

The net impact of these changes resulted in an increase in the estimated future net cashflow for total Medicare. For Part A, these changes resulted in a decrease to the present value of estimated future expenditures and income, with an overall increase in the estimated future net cashflow. For Part B, these changes increased the present value of estimated future expenditures (and also income). On the other hand, the above-mentioned changes lowered the present value of estimated future expenditures (and also income) for Part D.

Changes in Law

For the period beginning on January 1, 2014 to the period beginning on January 1, 2015

Although Medicare legislation was enacted since the prior valuation date, some of the provisions have a negligible impact on the present value of the 75-year estimated future income, expenditures, and net cashflow. The Veteran's Access, Choice, and Accountability Act of 2014 established a temporary program that allows eligible veterans to receive hospital care and medical services from eligible providers outside of the Veteran's Administration (VA) system, rather than waiting for a VA appointment or traveling to a VA facility. The Improving Medicare Post-Acute Care Transformation Act of 2014 standardized the collection of data for post-acute providers and aligned the inflation of the hospice aggregate cap with that of hospice reimbursement. The Tax Increase Prevention Act of 2014 accelerated the start date for the payment adjustment of misvalued codes under the physician fee schedule from 2017 to 2016, and delayed inclusion of oral-only ESRD-related drugs into the ESRD bundled payment system from 2024 to 2025. The Medicare Access and CHIP Reauthorization Act of 2015 included many provisions affecting Medicare spending, including the repeal of the SGR formula for determining payments under the physician fee schedule, the continuation of extensions for several provisions from prior legislation, a reduction in payment updates for most post-acute providers in 2018, the replacement of a 3.2 percent reduction to inpatient hospitals in 2018 with a 0.5 percent reduction in 2018 through 2023, and a revision to the income thresholds for determining the income-related monthly adjustment amounts under Part B and Part D.

Overall these provisions resulted in an increase in the estimated future net cashflow for total Medicare. For Part A, these changes resulted in a decrease to the present value of estimated future expenditures, with an overall increase in the estimated future net cashflow. For Part B, these changes increased the present value of estimated future expenditures (and also income). For Part D, the above-mentioned changes increased the present value of estimated future expenditures (and also income) only very slightly.

For the period beginning on January 1, 2013 to the period beginning on January 1, 2014

Although Medicare legislation was enacted since the prior valuation date, many of the provisions have a negligible impact on the present value of the 75-year estimated future income, expenditures, and net cashflow. The Continuing Appropriations Resolution of 2014 included several provisions that had an impact on the Medicare program, including a 0.5 percent physician payment update for January through March of 2014, extension of the Medicare sequester to FY 2022 and 2023, and payment reform for long-term care hospitals. Further, sections 1 and 3 of Public Law 113-82 included a further extension of the Medicare sequester to FY 2024. Lastly, the Protecting Access to Medicare Act of 2014 extended the 0.5 percent physician update through December 2014, enacted a 0 percent update for January through March of 2015, improved payment policy for clinical diagnostic lab tests, made revisions to the end-stage renal disease (ESRD) prospective payment system and physician fee schedule, and realigned the Medicare sequester in FY 2024. Overall these provisions resulted in an increase in the estimated future net cashflow for total Medicare. For Part A, these changes resulted in an increase to the present value of estimated future expenditures, with an overall increase in the estimated future net cashflow. For Part B, these changes lowered the present value of estimated future expenditures (and also income) only very slightly. For Part D, the above-mentioned changes increased the present value of estimated future expenditures (and also income) also very slightly.

Note 16:

RECONCILIATION OF NET COST OF OPERATIONS TO BUDGET

(DOLLARS IN MILLIONS)

	FY 2015	FY 2014
Resources Used to Finance Activities:		
Budgetary Resources Obligated:		
Obligations incurred	$1,345,892	$1,245,936
Less: Spending authority from offsetting collections and recoveries	46,712	37,492
Obligations net of offsetting collections and recoveries	1,299,180	1,208,444
Less: Distributed offsetting receipts	379,257	358,745
Net obligations	919,923	849,699
Other Resources:		
Transfers-In/Out without Reimbursement	458	
Imputed financing from costs absorbed by others	51	49
Other	12	
Net other resources used to finance activities	521	49
TOTAL RESOURCES USED TO FINANCE ACTIVITIES	$920,444	$849,748
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	$(14,134)	$19,870
Resources that fund expenses recognized in prior periods		(7)
Budgetary offsetting collections and receipts that do not affect net cost of operations	10,898	(5,835)
Resources that finance the acquisition of assets	1,277	839
Other resources or adjustments to net obligated resources that do not affect net cost of operations	3,293	3,447
Total resources used to finance items not part of the net cost of operations	1,334	18,314
TOTAL RESOURCES USED TO FINANCE THE NET COST OF OPERATIONS	$919,110	$831,434
Components of the Net Cost of Operations that will not Require or Generate Resources in the Current Period:		
Components Requiring or Generating Resources in Future Periods:		
Increase in annual leave liability	$2	$1
Decrease/(Increase) in receivables from the public	(10,755)	(101)
Other	8,172	2,339
Total components of Net Cost of Operations that will require or generate resources in future periods	(2,581)	2,239
Components not Requiring or Generating Resources:		
Depreciation and amortization	28	98
Other	(2,731)	3,993
Total components of Net Cost of Operations that will not require or generate resources	(2,703)	4,091
Total components of Net Cost of Operations that will not require or generate resources in the current period	(5,284)	6,330
NET COST OF OPERATIONS	$913,826	$837,764

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 and Budgetary Resources (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 five 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 presented in accordance with the requirements of the Federal Accounting Standards Advisory Board (FASAB). Included are descriptions of the long-term sustainability and financial condition of the program and a discussion of trends revealed in the data.

RSI material is generally drawn from the *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, which represents the official government evaluation of the financial and actuarial status of the Medicare trust funds. Unless otherwise noted, all data are for calendar years, and all projections are based on the Trustees' intermediate set of assumptions.

The basis for the projections has changed since last year due to the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA, Public Law 114-10). This law repealed the sustainable growth rate (SGR) formula that set physician fee schedule payments, which were usually modified. In the 2014 report, the income, expenditures, and assets for Part B reflected the *projected baseline* scenario, which assumed an override of the SGR payment provisions and an increase in the physician fee schedule equal to the average of the most recent 10 years of SGR overrides (through March 2015) or 0.6 percent. Since the new legislation replaced the SGR system with specified payment updates for physicians, the projections in this year's report are based on current law.

While the physician payment updates and new incentives put in place by MACRA avoid the significant short-range physician payment issues that would have resulted from the SGR system approach, they nevertheless raise important long-range concerns. In particular, additional payments of $500 million per year for one group of physicians and 5-percent annual bonuses for another group are scheduled to expire in 2025, resulting in a significant one-time payment reduction for most physicians. In addition, the law specifies the physician payment update amounts for all years in the future, and these amounts do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. The specified rate updates could be an issue in years when levels of inflation are high and would be problematic when the cumulative gap between the price updates and physician costs becomes large. The Trustees anticipate that physician payment rates under current law will be lower than they would have been under the SGR formula by 2048 and will continue to worsen thereafter. Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term under current law.

Incorporated in these projections is the sequestration of non-salary Medicare expenditures as required by the following laws: the Budget Control Act of 2011 (Public Law 112-25, enacted on August 2, 2011), as amended by the American Taxpayer Relief Act of 2012; the Continuing Appropriations Resolution, 2014 (Public Law 113-67, enacted on December 26, 2013); Sections 1 and 3 of Public Law 113-82, enacted on February 15, 2014; and the Protecting Access to Medicare Act of 2014 (Public Law 113-93, enacted on April 1, 2014). The sequestration reduces benefit payments by 2 percent from April 1, 2013 through March 31, 2023, by 2.9 percent from April 1, 2023 through September 30, 2023, by 1.1 percent from October 1, 2023 through March 31, 2024, and by 4 percent from April 1, 2024 through September 30, 2024. Due to sequestration, non-salary administrative expenses are reduced by an estimated 5 percent from March 1, 2013 through September 30, 2024.

These projections also 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*, contained roughly 165 provisions affecting the Medicare program by reducing costs, increasing revenues, improving benefits, combating fraud and abuse, and initiating a major program of research and development to identify alternative provider payment mechanisms, health care delivery systems, and other changes intended to improve the quality of health care and reduce costs.

The financial projections for the Medicare program reflect substantial, but very uncertain, cost savings deriving from provisions of the *Affordable Care Act* and MACRA that lower increases in Medicare payment rates to most categories of health care providers. Without fundamental change in the current delivery system, these adjustments would probably not be viable indefinitely. It is conceivable 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. For such efforts to be successful in the long range, however, providers would have to generate and sustain unprecedented levels of productivity gains—a very challenging and uncertain prospect.

In view of the factors described above, it is important to note that Medicare's actual future costs are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. The current-law cost projections reflect the physicians' payment levels expected under the MACRA payment rules and the *Affordable Care Act*-mandated reductions in other Medicare payment rates. In addition, the Trustees reference in their report an illustrative alternative scenario, which assumes legislative changes that result in (i) physician payment updates that transition from the update specified in current law for 2024 to the rate of growth in the Medicare Economic Index of 2.3 percent for 2039 and later; (ii) a partial phase-out of the *Affordable Care Act* reductions in Medicare payment rates; and (iii) an elimination of the cost-saving actions of the Independent Payment Advisory Board (IPAB). The difference between the illustrative alternative and the current-law projections demonstrates that the long-range costs could be substantially higher than shown throughout much of the report if the MACRA[1] and *Affordable Care Act*[2] cost-reduction measures prove problematic and new legislation scales them back.

Additional information on the current-law and illustrative alternative projections is provided in note 14 in these financial statements, in appendix V.C of this year's annual Medicare Trustees Report, 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

Long-Range Medicare Cost Growth Assumptions

The assumed long-range rate of growth in annual Medicare expenditures per beneficiary is based on statutory price updates and volume and intensity growth derived from the "factors contributing to growth" model, which decomposes the major drivers of historical and projected health spending growth into distinct factors. The Trustees assume that the productivity reductions to Medicare payment rate updates will reduce volume and intensity growth by 0.1 percent below the factors model projection. The Trustees' methodology is consistent with Finding III-2 and Recommendation III-2 of the 2010–2011 Medicare Technical Review Panel[3] and incorporates refinements and improvements based on research conducted by the CMS Office of the Actuary.

[1] Under MACRA, a significant one-time payment reduction is scheduled for most physicians in 2025. In addition, the law specifies physician payment rate updates of 0.75 percent or 0.25 percent annually thereafter. These updates are notably lower than the projected physician cost increases, which are assumed to average 2.3 percent per year in the long range.

[2] Under the *Affordable Care Act*, Medicare's annual payment rate updates for most categories of providers would be reduced below the increase in providers' input prices by the growth in economy-wide private nonfarm business multifactor productivity (1.1 percent over the long range). In addition, the IPAB would be charged with recommending cost savings as are necessary to hold overall per capita Medicare growth to the average of the Consumer Price Index (CPI-U) and CPI-medical increases in 2015-2019 and to the rate of per capita GDP growth plus 1 percentage point thereafter (subject to certain limits). Unless overridden by lawmakers, these recommendations would be implemented automatically.

[3] The Panel's final report is available at **http://aspe.hhs.gov/health/reports/2013/MedicareTech/TechnicalPanelReport2010-2011.pdf**.

In December 2011, the Technical Panel unanimously recommended a new approach that builds off of the longstanding GDP plus 1 percent assumption while incorporating several key refinements (Recommendation III-1).[4] Specifically, the Panel recommended two separate means of establishing long-range growth rates:

- The first approach is a refinement to the traditional GDP plus 1 percent growth assumption that better accounts for the level of payment rate updates for Medicare (prior to the effects of the *Affordable Care Act*) compared to private health insurance and other payers of health care in the U.S. This refinement results in an increase in the long-range pre-*Affordable Care Act* baseline cost growth assumption for Medicare to GDP plus 1.4 percent.
- The "factors contributing to growth" model approach builds upon the key considerations underlying the earlier GDP plus 1 percent assumption. The model is based on economic research that decomposes health spending growth into its major drivers—income growth, relative medical price inflation, insurance coverage, and a residual factor that primarily reflects the impact of technological development.[5] It benefits from additional information that was not available when the 2000 Technical Panel recommended the GDP plus 1 percent assumption.

The Trustees (i) used the statutory price updates and the volume and intensity assumptions from the factors model to derive the year-by-year Medicare cost growth assumptions for the last 50 years of the projection period and (ii) checked the ultimate Medicare cost growth assumptions derived from this approach for reasonableness by comparing them to results produced by an average "GDP plus" approach.

For some time, the Trustees have assumed that it is reasonable to expect over the long range that the drivers of health spending will be similar for the overall health sector and for the Medicare program. This view was affirmed by the 2010–2011 Technical Panel, which recommended use of the same long-range assumptions for the increase in the volume and intensity of health care services for the total health sector and for Medicare. Therefore, the overall health sector long-range cost growth assumptions for volume and intensity are used as the starting point for developing the Medicare-specific assumptions.

Prior to the *Affordable Care Act*, Medicare payment rates for most non-physician provider categories were updated annually by the increase in providers' input prices for the market basket of employee wages and benefits, facility costs, medical supplies, energy and utility costs, professional liability insurance, and other inputs needed to produce the health care goods and services. To the extent that health care providers can improve their productivity each year, their net costs of production (other things being equal) will increase more slowly than their input prices—but the Medicare payment rate updates prior to the *Affordable Care Act* were not adjusted for potential productivity gains. Accordingly, Medicare costs per beneficiary would have increased somewhat faster than for the health sector overall.[6] The *Affordable Care Act* requires that many of these Medicare payment updates be reduced by the 10-year moving average increase in economy-wide private nonfarm business multifactor productivity,[7] which the Trustees assume will be 1.1 percent per year over the long range. The different statutory provisions for updating payment rates require the development of separate long-range Medicare cost growth assumptions for four categories of health care providers:

i. ***All HI, and some SMI Part B, services that are updated annually by provider input price increases less the increase in economy-wide productivity.***

HI services are inpatient hospital, skilled nursing facility, home health, and hospice. The primary Part B services affected are outpatient hospital, home health, and dialysis. Under the Trustees' intermediate economic assumptions, the year-by-year per capita increases for these provider services start at 4.0 percent in 2039, or GDP plus 0.0 percent, declining gradually to 3.6 percent in 2089, or GDP minus 0.3 percent.

[4] For convenience, the increase in Medicare expenditures per beneficiary, before consideration of demographic impacts, is referred to as the Medicare cost growth rate. Similarly, these growth rate assumptions are described relative to the per capita increase in GDP and characterized simply as GDP plus X percent.

[5] Smith, Sheila, Newhouse, Joseph P., and Freeland, Mark S. "Income, Insurance, and Technology: Why Does Health Spending Outpace Economic Growth?" *Health Affairs*, 28, no. 5 (2009): 1276-1284.

[6] Historically, lawmakers frequently reduced the payment updates below the increase in providers' input prices in an effort to slow Medicare cost growth or to offset unwarranted changes in claims coding practices. Prior to the *Affordable Care Act*, the law did not specify any such adjustments after 2009.

[7] For convenience the term *economy-wide private nonfarm business multifactor productivity* will henceforth be referred to as *economy-wide productivity*.

ii. Physician services
Payment rate updates are 0.75 percent per year under the assumption that all physicians would be participating in alternative payment models (APMs). The year-by-year per capita growth rates for physician payments are assumed to be 3.3 percent in 2039, or GDP minus 0.7 percent, declining to 2.8 percent in 2089, or GDP minus 1.1 percent.

iii. Certain SMI Part B services that are updated annually by the CPI increase less the increase in economy-wide productivity.
Such services include durable medical equipment,[8] care at ambulatory surgical centers, ambulance services, and medical supplies. The Trustees assume the per beneficiary year-by-year rates to be 3.3 percent in 2039, or GDP minus 0.7 percent, declining to 2.8 percent in 2089, or GDP minus 1.1 percent.

iv. All other Medicare services, for which payments are established based on market processes, such as prescription drugs provided through Part D and the remaining Part B services.
These Part B outlays constitute an estimated 15 percent of total Part B expenditures in 2024 and consist mostly of payments for laboratory tests, physician-administered drugs, and small facility services. Medicare payments to Part D plans are based on a competitive-bidding process and are not affected by the productivity adjustments. Similarly, payments for the other Part B services are based on market factors.[9] The long-range per beneficiary cost growth rate for Part D and these Part B services is assumed to equal the increase in per capita national health expenditures as determined from the factors model. The corresponding year-by-year per capita growth rates for these services are 4.9 percent in 2039, or GDP plus 0.9 percent, declining to 4.4 percent by 2089, or GDP plus 0.5 percent.

In addition, these long-range cost growth rates must be modified to reflect demographic impacts. For example, beneficiaries at ages 80 and above use Part A skilled nursing and home health services much more frequently than do younger beneficiaries. As the beneficiary population ages, Part A costs will grow at a faster rate due to increased use of these services. In contrast, the incidence of prescription drug use is more evenly distributed by age, and an increase in the average age of Part D enrollees has significantly less of an effect on Part D costs.

After combining the rates of growth from the three long-range assumptions, the weighted average growth rate for Part B is 3.8 percent per year for the last 50 years of the projection period, or GDP minus 0.2 percent, on average. When Parts A, B, and D are combined, the weighted average growth rate is 4.0 percent over this same time period or GDP minus 0.0 percent, while the growth rate in 2089 is 3.7 percent or GDP minus 0.2 percent.

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 1 illustrates income (excluding interest) and expenditures as a percentage of taxable payroll over the next 75 years. The projected HI cost rates shown in the 2015 report are lower than those from the 2014 report for all years in the long range, primarily due to modified income-technology and price elasticity assumptions.

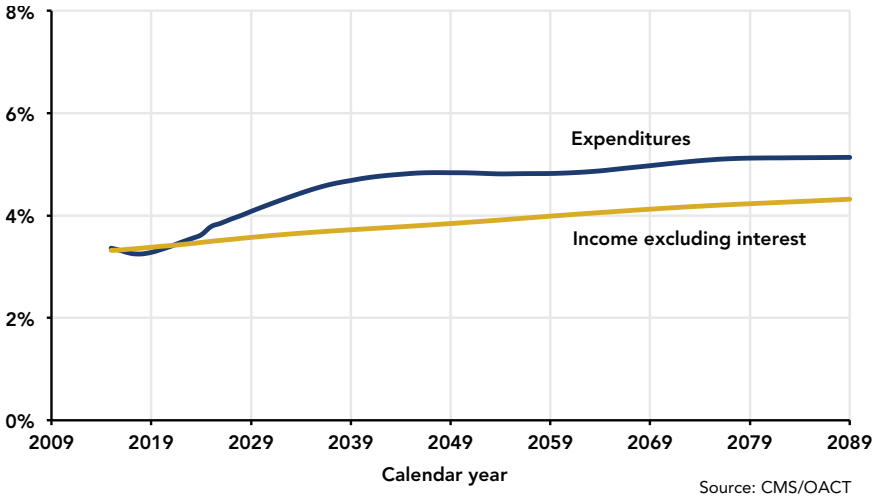
Since the standard HI payroll tax rates are not scheduled to change in the future under present law, most payroll tax income as a percentage of taxable payroll is estimated to remain constant at 2.90 percent. In addition, high-income workers pay an additional 0.9 percent of their earnings above $200,000 (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,

[8] Certain durable medical equipment (DME) is subject to competitive bidding, and the price is assumed to grow by the CPI increase less the increase in economy-wide productivity, the same update specified for DME not subject to bidding.

[9] For example, physician-administered Part B drugs are reimbursed at the level of the average sales price in the market plus 6 percent.

Chart 1

HI EXPENDITURES AND INCOME EXCLUDING INTEREST AS A PERCENTAGE OF TAXABLE PAYROLL // 2015 – 2089



Source: CMS/OACT

as chart 1 shows, the income rate is expected to gradually increase over current levels.

As indicated in chart 1, the cost rate is projected to decline through 2018, largely due to (i) expenditure growth that was constrained in part by the sequester and low payment updates and (ii) a rebound of taxable payroll growth from recession levels. After 2018 the cost rate is projected to rise primarily due to retirements of those in the baby boom generation and partly due to a projected return to modest health services cost growth. This cost rate increase is moderated by the accumulating effect of the productivity adjustments to provider price updates, which are estimated to reduce annual HI per capita cost growth by an average of 1.0 percent through 2024 and 1.1 percent thereafter. Under the illustrative alternative scenario, if the slower price updates were not feasible in the long range and were phased down during 2020–2034, then the HI cost rate would be 4.8 percent in 2035 and 8.1 percent in 2085. These levels are about 7 percent and 58 percent higher, respectively, than the current-law estimates under the intermediate assumptions.

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 2 shows HI income (excluding interest) and expenditures over the next 75 years expressed as a percentage of GDP. In 2014, the expenditures were $269.3 billion, which was 1.5 percent of GDP. This percentage is projected to increase steadily until about 2045 and then remain fairly level throughout the rest of the 75-year period, as the accumulated effects of the price update reductions are realized. Based on the illustrative alternative scenario, HI costs as a percentage of GDP would increase steadily throughout the long-range projection period, reaching 3.6 percent in 2089.

SMI

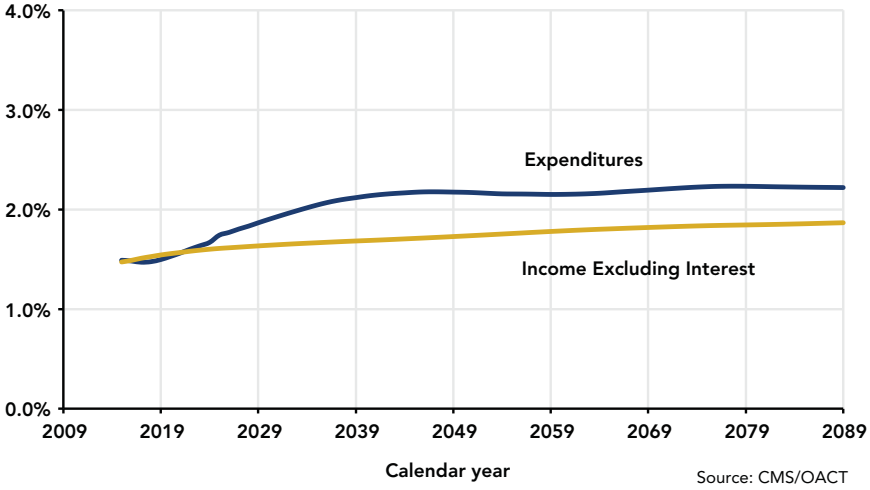
Because of the Part B and Part D financing mechanism in which income mirrors expenditures, it is not necessary to test for long-range imbalances between income and expenditures. Rather, it is more important to examine the projected rise in expenditures and the implications for beneficiary premiums and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

Chart 3 shows projected total SMI (Part B and Part D) expenditures and premium income as a percentage of GDP. 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.

In 2014, SMI expenditures were $344.0 billion, or about 2.0 percent of GDP. Under current law, they would grow to about 3.5 percent of GDP within 25 years and to 3.8 percent by the end of the projection period. (Under the illustrative alternative,

Chart 2

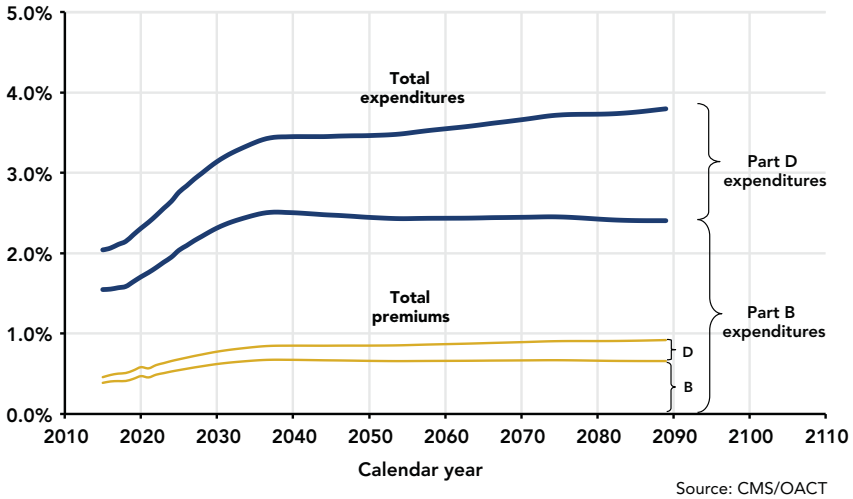
HI EXPENDITURES AND INCOME EXCLUDING INTEREST AS A PERCENTAGE OF GDP // 2015 – 2089



Source: CMS/OACT

Chart 3

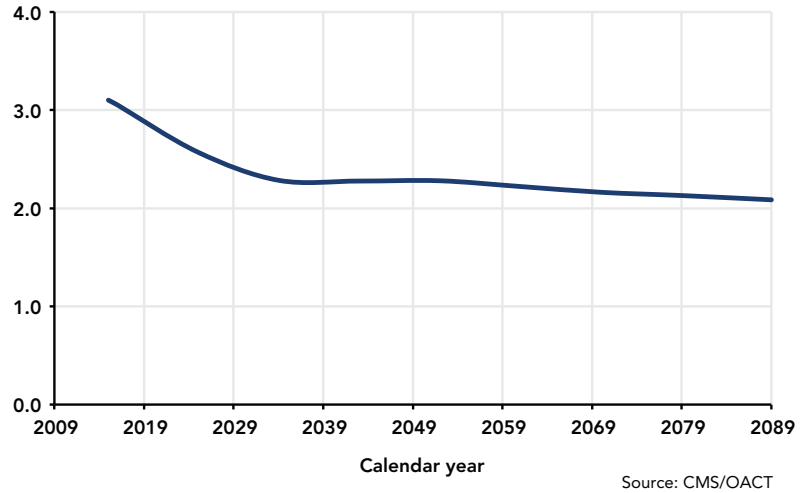
SMI EXPENDITURES AND PREMIUMS AS A PERCENTAGE OF GDP // 2015 – 2089



Source: CMS/OACT

Chart 4

NUMBER OF COVERED WORKERS PER HI BENEFICIARY // 2015 – 2089



Source: CMS/OACT

total SMI expenditures in 2089 would be 5.4 percent of GDP).

To match the faster growth rates for SMI expenditures, beneficiary premiums, along with general revenue contributions, would increase more rapidly than GDP over time but at a slower rate compared to the last 10 years. Average per beneficiary costs for Part B and Part D benefits are projected to increase after 2015 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 4 illustrates this ratio over the next 75 years. For the most part, current workers pay for current benefits. The relatively smaller number of persons born after the baby boom will therefore finance the retirement of the baby boom generation. In 2014, every beneficiary had 3.2 workers to pay for his or her benefit. In 2030, however, after the last baby boomer turns 65, there will be only about 2.4 workers per beneficiary. The projected ratio continues to decline until there are just 2.1 workers per beneficiary by 2089.

SENSITIVITY ANALYSIS

To prepare 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 are very likely to differ from the projections presented here, since the future cannot be anticipated with certainty.

To illustrate the sensitivity of the long-range projections and determine the impact on the HI actuarial present values, six of the key assumptions were varied individually.[10] The assumptions varied are the health care cost factors, real-wage differential, CPI, real-interest rate, fertility rate, and net immigration.[11]

For this analysis, the intermediate economic and demographic assumptions in the *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* are used as the reference point. Each selected assumption is varied individually to produce three scenarios. All present values are calculated as of January 1, 2015 and are based on estimates of income and expenditures during the 75-year projection period.

Charts 5 through 10 show the present value of the estimated net cashflow for each assumption varied. Generally, 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 through the first 25 to 30 years of the projection period, at which point 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.

[10] 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.

[11] 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.

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)	$2,743	–$3,187	–$12,594

Table 2
PRESENT VALUE OF ESTIMATED HI INCOME LESS EXPENDITURES UNDER VARIOUS REAL-WAGE ASSUMPTIONS

Ultimate percentage increase in wages – CPI	3.3 – 2.7	3.9 – 2.7	4.5 – 2.7
Ultimate percentage increase in real-wage differential	0.6	1.2	1.8
Income minus expenditures (in billions)	–$4,365	–$3,187	–$1,326

Table 3
PRESENT VALUE OF ESTIMATED HI INCOME LESS EXPENDITURES UNDER VARIOUS CPI-INCREASE ASSUMPTIONS

Ultimate percentage increase in wages – CPI	4.6 – 3.4	3.9 – 2.7	3.2 – 2.0
Income minus expenditures *(in billions)*	–$2,386	–$3,187	–$4,221

Health Care Cost Factors

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

Table 1 demonstrates that if the ultimate growth rate assumption is 1 percentage point lower than the intermediate assumptions, the deficit decreases by $5,930 billion. On the other hand, if the ultimate growth rate assumption is 1 percentage point higher than the intermediate assumptions, the deficit increases substantially, by $9,407 billion.

Chart 5 shows projections of the present value of the estimated net cashflow under the three alternative annual growth rate assumptions presented in table 1.

This assumption has a dramatic impact on projected HI cashflow. The present value of the net cashflow under the ultimate growth rate assumption of 1 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 chart 5 indicates, the financial status of the HI trust fund is extremely sensitive to the relative growth rates for health care service costs.

Real-Wage Differential

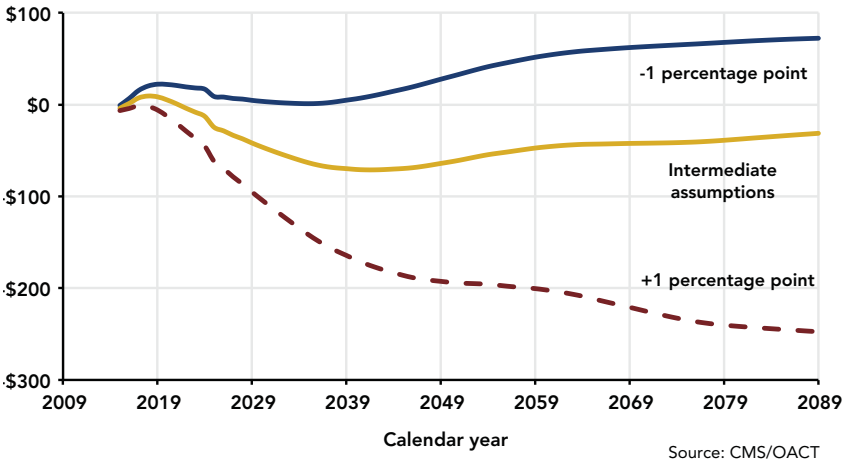
Table 2 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate real-wage differential assumptions: 0.6, 1.2, and 1.8 percentage points.[12] In each case, the assumed ultimate annual increase in the CPI is 2.7 percent, yielding ultimate percentage increases in nominal average annual wages in covered employment of 3.3, 3.9, and 4.5 percent, respectively.

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

Chart 5

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS HEALTH CARE COST FACTORS // 2015 – 2089

in billions



Source: CMS/OACT

As indicated in table 2, for a half-point increase in the ultimate real-wage differential assumption, the deficit—expressed in present-value dollars—decreases by approximately $1,550 billion. Conversely, for a half-point decrease in the ultimate real-wage differential assumption, the deficit increases by about $980 billion.

Chart 6 shows projections of the present value of the estimated net cashflow under the three alternative real-wage differential assumptions presented in table 2.

As illustrated in chart 6, faster real-wage growth results in smaller HI cashflow deficits, when expressed in 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. 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* and MACRA depends critically on the long-range feasibility of the lower Medicare price updates for hospitals and other HI providers. There is a strong possibility that certain payment changes will not be viable in the long range.

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: 3.4, 2.7, and 2.0 percent. In each case, the assumed ultimate real-wage differential is 1.2 percent, which yields ultimate percentage increases in average annual wages in covered employment of 4.6, 3.9, and 3.2 percent, respectively.

Table 3 demonstrates that if the ultimate CPI-increase assumption is 3.4 percent, the deficit decreases by $801 billion. On the other hand, if the ultimate CPI-increase assumption is 2.0 percent, the deficit increases by $1,034 billion.

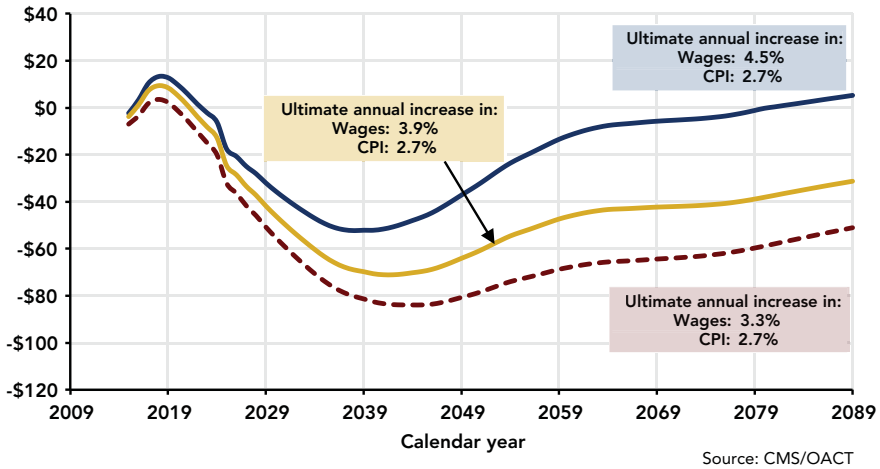
Chart 7 shows projections of the present value of net cashflow under the three alternative CPI rate-of-increase assumptions presented in table 3.

As chart 7 indicates, this assumption has a small impact when the cashflow is expressed as present values. The relative insensitivity of the projected present values of HI cashflow to different levels of general inflation occurs because inflation tends to proportionately 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.

Chart 6

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS REAL-WAGE ASSUMPTIONS // 2015 – 2089

(In billions)

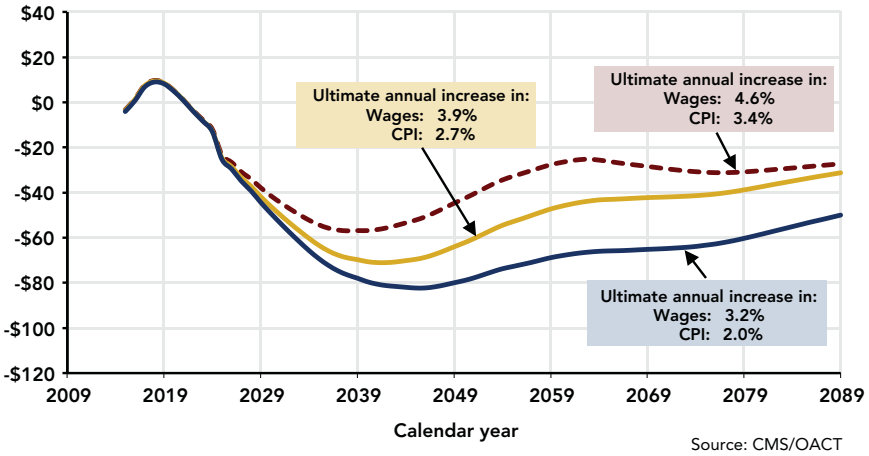


Source: CMS/OACT

Chart 7

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS CPI-INCREASE ASSUMPTIONS // 2015 – 2089

(In billions)

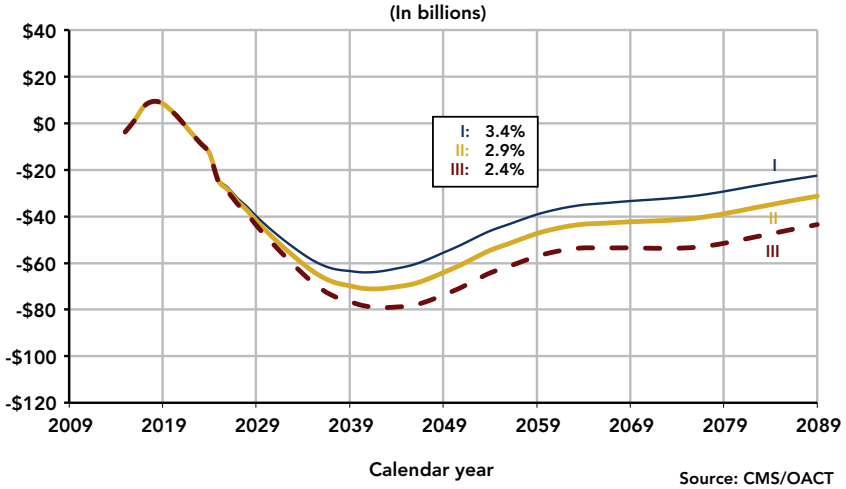


Source: CMS/OACT

Chart 8

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS REAL-INTEREST RATE ASSUMPTIONS // 2015 – 2089

(In billions)



Source: CMS/OACT

Table 4
PRESENT VALUE OF ESTIMATED HI INCOME LESS EXPENDITURES UNDER VARIOUS REAL-INTEREST ASSUMPTIONS

Ultimate real-interest rate	2.4 percent	2.9 percent	3.4 percent
Income minus expenditures *(in billions)*	–$3,774	–$3,187	–$2,704

Table 5
PRESENT VALUE OF ESTIMATED HI INCOME LESS EXPENDITURES UNDER VARIOUS FERTILITY RATE ASSUMPTIONS

Ultimate fertility rate[1]	1.8	2.0	2.2
Income minus expenditures *(in billions)*	–$3,547	–$3,187	–$2,793

[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.

Real-Interest Rate

Table 4 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate annual real-interest assumptions: 2.4, 2.9, and 3.4 percent. In each case, the assumed ultimate annual increase in the CPI is 2.7 percent, which results in ultimate annual yields of 5.1, 5.6, and 6.1 percent, respectively.

As illustrated in table 4, for every increase of 0.1 percentage point in the ultimate real-interest rate, the deficit decreases by approximately $105 billion.

Chart 8 shows projections of the present value of the estimated net cashflow under the three alternative real-interest assumptions presented in table 4.

As shown in chart 8, the projected HI cashflow when expressed in present values is fairly sensitive to the interest assumption. 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 2030. These results illustrate the substantial sensitivity of present value measures to different interest rate assumptions. With higher assumed interest, the very large deficits in the more distant future are discounted more heavily (that is, are given less weight), resulting in a smaller overall net present value.

Fertility Rate

Table 5 shows the net present value of cashflow during the 75-year projection period under three alternative ultimate fertility rate assumptions: 1.8, 2.0, and 2.2 children per woman.

As table 5 demonstrates, for an increase of 0.2 in the assumed ultimate fertility rate, the projected present value of the HI deficit decreases by approximately $375 billion.

Chart 9 shows projections of the present value of the net cashflow under the three alternative fertility rate assumptions presented in table 5.

As chart 9 indicates, the fertility rate assumption has a substantial impact on projected HI cashflows. Under the higher fertility rate assumptions, there will be additional workers in the labor force after 20 years, 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 a present-value-dollar basis. On the other hand, under the lower fertility rate assumptions, there will be fewer workers in the workforce with a smaller number subject to the additional tax, in turn raising the HI deficit. It is important to point out that if a longer projection period were used, the impact of a fertility rate change would be more pronounced.

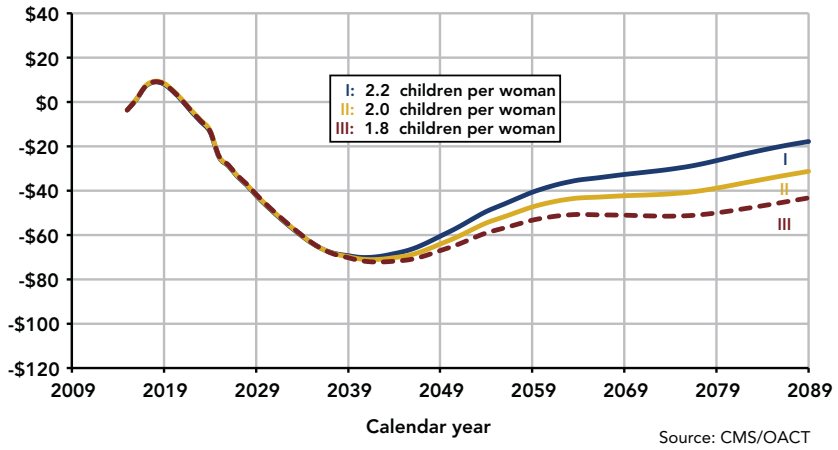
Net Immigration

Table 6 shows the net present value of cashflow during the 75-year projection period under three alternative average annual net immigration assumptions: 850,000 persons, 1,155,000 persons, and 1,465,000 persons per year.

Chart 9

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS ULTIMATE FERTILITY RATE ASSUMPTIONS // 2015 – 2089

(In billions)



Source: CMS/OACT

Table 6

PRESENT VALUE OF ESTIMATED HI INCOME LESS EXPENDITURES UNDER VARIOUS NET IMMIGRATION ASSUMPTIONS

Average annual net immigration	850,000	1,155,000	1,465,000
Income minus expenditures *(in billions)*	–$3,455	–$3,187	–$2,981

As indicated in table 6, if the average annual net immigration assumption is 850,000 persons, the deficit—expressed in present-value dollars—increases by $268 billion. Conversely, if the assumption is 1,465,000 persons, the deficit decreases by $206 billion.

Chart 10 shows projections of the present value of net cashflow under the three alternative average annual net immigration assumptions presented in table 6.

Higher net immigration results in smaller HI cashflow deficits, as illustrated in chart 10. 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.

Trust Fund Finances and Sustainability

HI

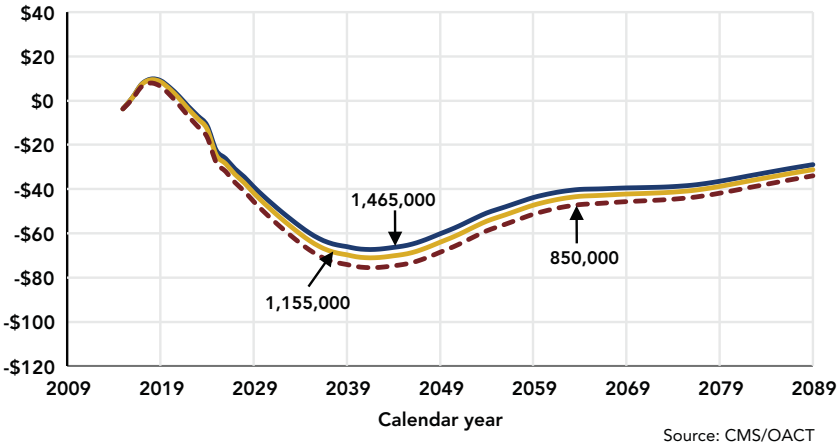
The short-range financial outlook for the HI trust fund is about the same as projected in last year's annual report, as factors causing improved finances are offset by other changes. Under the Medicare Trustees' intermediate assumptions, the estimated depletion date for the HI trust fund is 2030, the same as in last year's report. As in past years, the Trustees have determined that the fund is not adequately financed over the next 10 years. HI tax income in 2014 was somewhat higher than last year's estimate, mostly due to adjustments for prior years,[13] but is projected to be slightly lower through 2019; after 2019, however, projections of earnings throughout the period are higher mostly due to assumptions of slower projected growth in employer-sponsored health insurance—a factor that increases wages. Although HI expenditures in 2014 were nearly equal to the previous estimate, projected expenditures are higher at the end of the 10-year period than shown in last year's report, largely due to increases in provider payment update assumptions that reflect recent trends.

[13] Initial appropriations of payroll taxes are made on an estimated basis, and then each year adjustments are made to the appropriations for prior years to reflect actual tax receipts.

Chart 10

PRESENT VALUE OF HI NET CASHFLOW WITH VARIOUS NET IMMIGRATION ASSUMPTIONS // 2015 – 2089

(In billions)



Source: CMS/OACT

HI expenditures have exceeded income annually since 2008. However, the Trustees project slight surpluses in 2015 through 2023, with a return to deficits thereafter until the trust fund becomes depleted in 2030. If assets were depleted, Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs. Beneficiary access to health care services would rapidly be curtailed. To date, Congress has never allowed the HI trust fund to become depleted.

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. Policy makers should determine effective solutions to ensure the financial integrity of HI in the long term and should also consider the likelihood that the price adjustments in current law may prove difficult to adhere to fully and may require even more changes to address this challenge.

SMI

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 provision in the law for transferring 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 2015 is adequate to cover 2015 expected expenditures but would need to be increased in future years in order to restore the financial status of the Part B account to a satisfactory level.[14] Similarly, Part D income and outgo would remain in balance as a result of the annual adjustment of premium and general revenue income to cover costs. The appropriation for Part D general revenues has generally been set such that amounts can be transferred to the Part D account on an as-needed basis.

The Part B and Part D accounts in the SMI trust fund are adequately financed because premium and general revenue income are reset each year to cover expected costs. Such financing, however, would have to increase faster than the economy to cover expected expenditure growth. A critical issue for the SMI program is the impact of the rapid growth of SMI costs, which places steadily increasing demands on beneficiaries and taxpayers.

[14] In 2016, a hold-harmless provision that restricts Part B premium increases for most beneficiaries is expected to cause a substantial increase in the Part B premium rate for other beneficiaries.

Medicare Overall

The Medicare Modernization Act requires the Board of Trustees to determine whether the difference between Medicare outlays and dedicated financing sources[15] is projected to exceed 45 percent of total Medicare outlays under current law within the next 7 fiscal years (2015–2021). If this level is attained within the 7-year timeframe, Federal law requires a determination of projected excess general revenue Medicare funding. For the 2015 Medicare Trustees Report, this difference is not expected to exceed 45 percent of total expenditures in fiscal years 2015–2021 (the first 7 years of the projection), and therefore the Trustees are not issuing this determination.

The projections shown continue to demonstrate the need for timely and effective action to address Medicare's remaining financial challenges—including the projected depletion of the HI trust fund, this fund's long-range financial imbalance, and the rapid growth in Medicare expenditures. Furthermore, if the growth in Medicare costs is comparable to growth under the illustrative alternative projections, then these further policy reforms will have to address much larger financial challenges than those assumed under current law. In their 2015 annual report to Congress, the Medicare Board of Trustees emphasized the seriousness of these concerns and urged the nation's policy makers to "work closely together with a sense of urgency to address these challenges." They also stated: "Consideration of such reforms should not be delayed."

[15] 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

COMBINING STATEMENT OF BUDGETARY RESOURCES

for the year ended September 30, 2015

(IN MILLIONS)

	Medicare		Payments to Trust Funds	Medicaid	CHIP	Medicare Part D	Other Health	All Others	Combined Totals Budgetary	Non-Budgetary Credit Reform Financing Account
	HI TF	SMI TF								
BUDGETARY RESOURCES:										
Unobligated balance, brought forward, October 1:				$1,375	$15,977	$178	$7,283	$5,083	$29,896	
Recoveries of prior year unpaid obligations	$13		$406	22,148	249	19	147	365	23,347	
Other changes in unobligated balance			21,062	1			(25)	(130)	20,908	
Unobligated balance from prior year budget authority, net	13		21,468	23,524	16,226	197	7,405	5,318	74,151	
Appropriation	285,049	$270,457	288,646	351,098	14,770	80,511	10,885	2,658	1,304,074	
Borrowing authority										$50
Spending authority from offsetting collections	12	11,183	130	763		7	14	11,176	23,285	80
TOTAL BUDGETARY RESOURCES	$285,074	$281,640	$310,244	$375,385	$30,996	$80,715	$18,304	$19,152	$1,401,510	$130
STATUS OF BUDGETARY RESOURCES:										
Obligations incurred	$285,074	$281,640	$283,197	$375,051	$11,548	$80,584	$12,383	$16,285	$1,345,762	$130
Unobligated balance, end of year:										
Apportioned			6,001	205	6,462		5,859	1,784	20,311	
Exempt from Apportionment								(2,805)	(2,805)	
Unapportioned			21,046	129	12,986	131	62	3,888	38,242	
Total unobligated balance, end of year			27,047	334	19,448	131	5,921	2,867	55,748	
TOTAL BUDGETARY RESOURCES	$285,074	$281,640	$310,244	$375,385	$30,996	$80,715	$18,304	$19,152	$1,401,510	$130
CHANGE IN OBLIGATED BALANCE:										
Unpaid obligations:										
Unpaid obligations, brought forward, October 1	$29,341	$22,817	$16,314	$35,407	$6,716	$12,969	$3,880	$8,324	$135,768	$1,000
Adjustment to unpaid obligations	(238)	(192)				(1)		(17)	(448)	(2)
Obligations incurred	285,074	281,640	283,197	375,051	11,548	80,584	12,383	16,285	1,345,762	130
Outlays (gross)	(281,947)	(280,975)	(284,944)	(346,737)	(9,242)	(75,978)	(11,745)	(13,667)	(1,305,235)	(753)
Recoveries of prior year unpaid obligations	(13)		(406)	(22,148)	(249)	(19)	(147)	(365)	(23,347)	
Unpaid obligations end of year	32,217	23,290	14,161	41,573	8,773	17,555	4,371	10,560	152,500	375
Uncollected Payments:										
Uncollected payments, Federal sources, brought forward, October 1							(29)	(7,760)	(7,789)	(429)
Adjustments to uncollected payments, Federal sources, start of year							29	(58)	(29)	
Change in uncollected payments, Federal sources		(11,172)						187	(10,985)	270
Uncollected payments, Federal sources, end of year		(11,172)						(7,631)	(18,803)	(159)
Memorandum entries:										
Obligated balance, start of year, net	$29,341	$22,817	$16,314	$35,407	$6,716	$12,969	$3,851	$564	$127,979	$571
Obligated balance, end of year, net	32,217	12,118	14,161	41,573	8,773	17,555	4,371	2,929	133,697	216
BUDGET AUTHORITY AND OUTLAYS, NET:										
Budget authority, gross	$285,061	$281,640	$288,776	$351,861	$14,770	$80,518	$10,899	$13,834	$1,327,359	$130
Actual offsetting collections	(13)	(10)	(130)	(763)		(6)	(15)	(11,363)	(12,300)	(350)
Change in uncollected customer payments from Federal sources		(11,172)						187	(10,985)	270
Budget authority, net	285,048	270,458	288,646	351,098	14,770	80,512	10,884	2,658	1,304,074	50
Outlays (gross)	281,947	280,975	284,944	346,737	9,242	75,978	11,745	13,667	1,305,235	753
Actual offsetting collections	(13)	(10)	(130)	(763)		(6)	(15)	(11,363)	(12,300)	(350)
Outlays, net	281,934	280,965	284,814	345,974	9,242	75,972	11,730	2,304	1,292,935	403
Distributed offsetting receipts	(29,813)	(349,381)			(3)			(60)	(379,257)	
AGENCY OUTLAYS, NET	$252,121	($68,416)	$284,814	$345,974	$9,239	$75,972	$11,730	$2,244	$913,678	$403

SUPPLEMENTARY INFORMATION

Consolidating Balance Sheet

Consolidating Statement of Net Cost

Consolidating Statement of Changes in Net Position

CONSOLIDATING BALANCE SHEET

as of September 30, 2015

(IN MILLIONS)

	Medicare (Dedicated Collections)			Health (Other Funds)						
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	Combined Totals	Intra-CMS Eliminations	Consolidated Totals
ASSETS										
Intragovernmental Assets:										
Fund Balance with Treasury	$1,363	$43,422	$44,785	$41,895	$26,172	$11,120	$4,562	$128,534		$128,534
Investments	197,418	66,575	263,993		2,052			266,045		266,045
Accounts Receivable, Net	33,678	51,348	85,026	97	8	707	1,220	87,058	$(86,423)	635
Other Assets	24		24			1		25		25
Total Intragovernmental Assets	**232,483**	**161,345**	**393,828**	**41,992**	**28,232**	**11,828**	**5,782**	**481,662**	**(86,423)**	**395,239**
Accounts Receivable, Net	1,122	5,653	6,775	4,106	5	9,569	405	20,860		20,860
General Property, Plant & Equipment, Net	113	195	308	15	1	80	501	905		905
Other Assets	25	41	66	95		1,383	77	1,621		1,621
TOTAL ASSETS	**$233,743**	**$167,234**	**$400,977**	**$46,208**	**$28,238**	**$22,860**	**$6,765**	**$505,048**	**$(86,423)**	**$418,625**
LIABILITIES										
Intragovernmental Liabilities:										
Accounts Payable	$34,341	$52,416	$86,757			$89	$4	$86,850	$(86,423)	$427
Accrued Payroll and Benefits	2	3	5			3		8		8
Other Intragovernmental Liabilities	4		4			1,305	32	1,341		1,341
Total Intragovernmental Liabilities	**34,347**	**52,419**	**86,766**			**1,397**	**36**	**88,199**	**(86,423)**	**1,776**
Accounts Payable	51	24	75	$3		47	17	142		142
Federal Employee and Veterans' Benefits	3	4	7	1		4		12		12
Entitlement Benefits Due and Payable	28,320	37,901	66,221	36,758	$773	1,514	2,883	108,149		108,149
Accrued Payroll and Benefits	19	26	45	3		26	3	77		77
Contingencies		10	10	7,530				7,540		7,540
Other Liabilities	478	512	990			10,477	5	11,472		11,472
TOTAL LIABILITIES	**$63,218**	**$90,896**	**$154,114**	**$44,295**	**$773**	**$13,465**	**$2,944**	**$215,591**	**$(86,423)**	**$129,168**
NET POSITION										
Unexpended Appropriations-Dedicated Collections	$895	$29,389	$30,284					$30,284		$30,284
Unexpended Appropriations-Other Funds				$171	$27,446	$8,821	$3,915	40,353		40,353
Cumulative Results of Operations-Dedicated Collections	169,630	46,949	216,579				(1,225)	215,354		215,354
Cumulative Results of Operations-Other Funds				1,742	19	574	1,131	3,466		3,466
TOTAL NET POSITION	**$170,525**	**$76,338**	**$246,863**	**$1,913**	**$27,465**	**$9,395**	**$3,821**	**$289,457**		**$289,457**
TOTAL LIABILITIES AND NET POSITION	**$233,743**	**$167,234**	**$400,977**	**$46,208**	**$28,238**	**$22,860**	**$6,765**	**$505,048**	**$(86,423)**	**$418,625**

CONSOLIDATING STATEMENT OF NET COST

for the year ended September 30, 2015

(IN MILLIONS)

	Medicare (Dedicated Collections)			Health (Other Funds)				Consolidated Total
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	
NET PROGRAM/ACTIVITY COSTS								
GPRA Programs:								
Medicare (Dedicated Collections)	$274,657	$272,478	$547,135					$547,135
Medicaid				$349,877				349,877
CHIP					$9,105			9,105
Net Cost: GPRA Programs	**274,657**	**272,478**	**547,135**	**349,877**	**9,105**			**906,117**
Other Activities:								
State Grants and Demonstrations							$601	601
Other Health						$4,465		4,465
Other							2,643	2,643
Net Cost: Other Activities						**4,465**	**3,244**	**7,709**
NET COST OF OPERATIONS	**$274,657**	**$272,478**	**$547,135**	**$349,877**	**$9,105**	**$4,465**	**$3,244**	**$913,826**

CONSOLIDATING STATEMENT OF CHANGES IN NET POSITION

for the year ended September 30, 2015

(IN MILLIONS)

	Medicare (Dedicated Collections)			Health (Other Funds)					Consolidated Total
	HI TF	SMI TF	Total	Medicaid	CHIP	Other Health	Other	Dedicated Collections	
CUMULATIVE RESULTS OF OPERATIONS									
Beginning Balances	$179,172	~~$41,623~~	$220,795	$122	$19	$349	$1,048		$222,333
Budgetary Financing Sources:									
Appropriations Used	21,323	274,663	295,986	350,597	9,090	2,931	735		659,339
Nonexchange Revenue:									
FICA and SECA Taxes	237,697		237,697						237,697
Interest on Investments	8,420	2,375	10,795		4				10,799
Other Nonexchange Revenue	550	3,003	3,553						3,553
Transfers-in/out Without Reimbursement	(2,887)	(2,254)	(5,141)	898	11	1,743	411	$482	(1,596)
Other							(518)	518	
Other Financing Sources (Nonexchange):									
Transfers-in/out Without Reimbursement						(14)	472		458
Imputed Financing	12	17	29	2		18	2		51
Other						12			12
Total Financing Sources	265,115	~~277,804~~ 272,478	542,919	351,497	9,105	4,690	1,102	1,000	910,313
Net Cost of Operations	274,657		547,135	349,877	9,105	4,465	1,019	2,225	913,826
Net Change	(9,542)	5,326	(4,216)	1,620		225	83	(1,225)	(3,513)
CUMULATIVE RESULTS OF OPERATIONS	$169,630	$46,949	$216,579	$1,742	$19	$574	$1,131	$(1,225)	$218,820
UNEXPENDED APPROPRIATIONS									
Beginning Balances	$691	$15,624	$16,315	$(331)	$21,769	$11,253	$3,992		$52,998
Budgetary Financing Sources:									
Appropriations Received	21,527	267,109	288,636	402,142	21,061	749	726		713,314
Appropriations Transferred-in/out				(3,818)		3			(3,815)
Other Adjustments		21,319	21,319	(47,225)	(6,294)	(253)	(68)		(32,521)
Appropriations Used	(21,323)	(274,663)	(295,986)	(350,597)	(9,090)	(2,931)	(735)		(659,339)
Total Budgetary Financing Sources	204	13,765	13,969	502	5,677	(2,432)	(77)		17,639
Total Unexpended Appropriations	895	29,389	30,284	171	27,446	8,821	3,915		70,637
NET POSITION	$170,525	$76,338	$246,863	$1,913	$27,465	$9,395	$5,046	($1,225)	$289,457

AUDIT REPORTS

The following reports were prepared by Ernst & Young.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

TO: Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services

NOV 09 2015

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

SUBJECT: Report on the Financial Statement Audit of the Centers for Medicare & Medicaid Services for Fiscal Year 2015 (A-17-15-02015)

This memorandum transmits the independent auditors' reports on the Centers for Medicare & Medicaid Services (CMS) fiscal year (FY) 2015 financial statements, conclusions about the effectiveness of internal controls, and compliance with laws and other matters. 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 U.S. Department of Health and Human Services audit.

We contracted with the independent certified public accounting firm of Ernst & Young, LLP, to audit the CMS (1) consolidated balance sheets as of September 30, 2015 and 2014, and the related consolidated statements of net cost and changes in net position, (2) the combined statement of budgetary resources for the years then ended, and (3) the statement of social insurance as of January 1, 2015 and related statement of changes in social insurance amounts. 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 *Government Auditing Standards*, issued by the Comptroller General of the United States; and Office of Management and Budget (OMB) Bulletin 15-02, *Audit Requirements for Federal Financial Statements*.

Results of the Independent Audit

Ernst & Young found that the FY 2015 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. As presented in notes to the financial statements, with respect to the estimates for the statement of social insurance as of January 1, 2015 and 2014, CMS management noted in the financial statement footnotes the Medicare Board of Trustees alternative scenario to illustrate, when possible, the potential understatement of Medicare cost and projection results. This scenario assumes that the various

cost-reduction measures—the most important of which are the reduction in the annual payment rate updates for most categories of Medicare providers by the growth in economywide multifactor productivity and the specified physician updates put in place by the Medicare Access and CHIP Reauthorization Act of 2015—will occur as current law requires. Also, the Medicare Board of Trustees, in its annual report to Congress, stated:

> The Trustees are hopeful that U.S. health care practices are in the process of becoming more efficient as providers anticipate more modest rates of reimbursement growth, in both the public and private sectors, than those experienced in recent decades. The methodology for projecting Medicare finances assumes a substantial long-term reduction in per capita health expenditure growth rates relative to historical experience, to which the ACA's cost-reduction provisions would add substantial savings. Notwithstanding recent favorable developments, current-law projections indicate that Medicare still faces a substantial financial shortfall that will need to be addressed with further legislation.

The range of the social insurance liability estimates in the alternative scenario was significant. As a result, Ernst & Young was unable to obtain sufficient audit evidence for the particular amounts presented in the statements of social insurance as of January 1, 2015, 2014, 2013, 2012, and 2011, and the related statements of changes in social insurance amounts for the periods ended January 1, 2015 and 2014. Ernst & Young was not able and did not express an opinion on the financial condition of the CMS social insurance program and related changes in the social insurance program for the specified periods.

Ernst & Young also noted two matters involving internal controls with respect to the financial reporting. Under the standards established by the American Institute of Certified Public Accountants and *Government Auditing Standards*, issued by the Comptroller General of the United States, Ernst & Young identified significant deficiencies in CMS's financial reporting processes and information systems controls:

- *Financial Reporting Processes*—Ernst & Young noted that CMS should continue to develop, refine, and adhere to its financial management systems and processes to improve its accounting, analysis, and oversight of financial management activity. During the FY 2015 audit, errors were noted that were not detected by the organization's monitoring and review function, which showed the control was not functioning as designed or intended. There were continued weaknesses in oversight of the Medicaid program. In addition, issues with CMS's third-party contractors were identified. Required actions have not resolved issues or been taken. Also, CMS lacks needed functionality in its Healthcare Integrated General Ledger and Accounting System, which prompts the need for system interventions to properly categorize information in the financial statements. These deficiencies collectively represent a significant deficiency in internal control.

- *Information Systems Controls*—Ernst & Young noted that CMS continues to experience difficulties in implementing its policy of least-privilege access, preventing and monitoring for inconsistencies in access rights, and mitigating the potential impact on

adequate segregation of duties. CMS continues to experience deficiencies in the implementation and monitoring of compliance with its computer security policies. Ernst & Young noted that additional focus is required to minimize the risk of current and unresolved prior-year deficiencies. The deficiencies found continue to constitute a significant deficiency in internal control.

Ernst & Young identified that CMS was not in full compliance with the Improper Payments Information Act of 2002 (P.L. No. 107-300) (IPIA), as amended. Notably, the Medicare Fee-for-Service program error rate exceeded the mandated 10-percent threshold. In addition, CMS's other programs: Medicare Advantage, Medicare Prescription Drugs, Medicaid, and CHIP programs did not meet their targeted reduction rates for FY 2015. Also, CMS was not in compliance with section 6411 of the Patient Protection and Affordable Care Act as CMS had not yet implemented recovery audit activities for the Medicare Advantage program. Ernst & Young disclosed no other instances of noncompliance that are required to be reported under *Government Auditing Standards* and OMB Bulletin 15-02.

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 audit;
- 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 CMS's "Management Discussion and Analysis," "Financial Statements and Footnotes," and "Supplementary Information."

Ernst & Young is responsible for the attached auditors' reports 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 financial management systems substantially complied with the Federal Financial Management Improvement Act of 1996 (P.L. No. 104-208), or compliance with other laws and regulations. However, our monitoring review, as limited to the procedures listed above, disclosed no instances in which Ernst & Young 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 Gloria L. Jarmon, Deputy Inspector General for Audit Services, at (202) 619-3155 or through e-mail at Gloria.Jarmon@oig.hhs.gov. Please refer to report number A-17-15-02015.

Attachment

cc:
Ellen Murray
Assistant Secretary for Financial Resources
and Chief Financial Officer

Sheila Conley
Deputy Assistant Secretary, Finance
and Deputy Chief Financial Officer

Megan Worstell
Acting Director Office of Financial Management
and Chief Financial Officer

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Report of Independent Auditors

The Administrator and Chief Financial Officer of the Centers for Medicare and Medicaid Services and the Inspector General of the U.S. Department of Health and Human Services

Report on the Financial Statements

We have audited the accompanying consolidated balance sheets of the Centers for Medicare and Medicaid Services (CMS) as of September 30, 2015 and 2014, 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 related notes to the financial statements. We were engaged to audit the statements of social insurance as of January 1, 2015, 2014, 2013, 2012 and 2011, the related statements of changes in social insurance amounts for the periods ended January 1, 2015 and 2014, and the related notes to these financial statements.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in conformity with U.S. generally accepted accounting principles; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free of material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express opinions on these financial statements based on our audits. Except as discussed in the Basis for Disclaimer of Opinion paragraphs with respect to the accompanying statements of social insurance as of January 1, 2015, 2014, 2013, 2012 and 2011, the related statements of changes in social insurance amounts for the periods ended January 1, 2015 and 2014, and the related notes to these financial statements, we conducted our audits in accordance with auditing standards generally accepted in the United States and 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 Bulletin No. 15-02, *Audit Requirements for Federal Financial Statements*. 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.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial

statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion on the consolidated balance sheets as of September 30, 2015 and 2014, 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 related notes to these financial statements.

Basis for Disclaimer of Opinion on the Statements of Social Insurance and the related Changes in the Social Insurance Program

As discussed in Note 13 to the financial statements, the statement of social insurance presents the actuarial present value of the 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. 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. Projections of Medicare costs are sensitive to assumptions about future decisions by policymakers and about the behavioral responses of consumers, employers, and health care providers as policies, incentives, and the health care sector change over time. In addition to the inherent variability that underlies the expenditure projections prepared for all parts of Medicare, and as discussed below, significant additional variability and issues regarding the sustainability of the underlying assumptions under current law were introduced by the passage of the Patient Protection and Affordable Care Act (ACA) and the Medicare Access and CHIP Reauthorization Act (MACRA).

As further described in Note 14 to the financial statements, with respect to the estimates for the social insurance program presented as of January 1, 2015, 2014, 2013, 2012 and 2011, management has assumed in the projections of the program that the various cost-reduction measures will occur as the ACA and the specified physician updates established by MACRA require. Management has developed an illustrative alternative scenario and projections intended to quantify the potential understatement of projected Medicare costs to the extent that certain payment provisions were not fully implemented in all future years. The range of the social

insurance liability estimates in the scenarios is significant. As described in Note 14, the ability of health care providers to sustain these price reductions will be challenging, as the best available evidence indicates that most providers cannot improve their productivity to this degree for a prolonged period given the labor-intensive nature of these services. As a result, actual Medicare expenditures are highly uncertain for reasons apart from the inherent difficulty in projecting health care cost growth over time. Absent an unprecedented change in health care delivery systems and payment mechanisms, the prices paid by Medicare for health services will fall increasingly short of the costs of providing these services. For example, overriding the scheduled physician payment updates or the productivity adjustments for most providers, as was done repeatedly with the sustainable growth rate formula in the period leading up to passage of MACRA and may be necessary in the future if cost rates prove inadequate, would lead to substantially higher costs for Medicare in the long range than those projected in this report. As a result of these limitations, we were unable to obtain sufficient audit evidence for the amounts presented in the statements of social insurance as of January 1, 2015, 2014, 2013, 2012 and 2011, and the related statements of changes in social insurance amounts for the periods ended January 1, 2015 and 2014.

Disclaimer of Opinion on the Statements of Social Insurance and the related Changes in the Social Insurance Program

Because of the significance of the matters described in the Basis for Disclaimer of Opinion paragraphs, 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, 2015, 2014, 2013, 2012 and 2011, and the related changes in the social insurance program for the periods ended January 1, 2015 and 2014.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of CMS as of September 30, 2015 and 2014, and its net cost, changes in net position, and budgetary resources for the years then ended in conformity with U.S. generally accepted accounting principles.

Required Supplementary Information

U.S. generally accepted accounting principles require that Management's Discussion and Analysis and Required Supplementary Information as identified on CMS' Annual Financial Report Table of Contents, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Federal Accounting Standards Advisory Board which considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States, which

consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Supplementary and Other Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise CMS' basic financial statements. The Supplementary Information is presented for purposes of additional analysis and is not a required part of the basic financial statements.

The Supplementary Information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the Supplementary Information is fairly stated, in all material respects, in relation to the basic financial statements as a whole.

The Other Information has not been subjected to the auditing procedures applied in the audit of the basic financial statements, and, accordingly, we do not express an opinion or provide any assurance on it.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we also have issued our reports dated November 9, 2015 on our consideration of CMS' internal control over financial reporting and on our tests of its compliance with certain provisions of laws, 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* in considering CMS' internal control over financial reporting and compliance.

Ernst & Young LLP

November 9, 2015

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

The Administrator and Chief Financial Officer 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, in accordance with auditing standards generally accepted in the United States and 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. 15-02, *Audit Requirements for Federal Financial Statements*, the financial statements of the Centers for Medicare and Medicaid Services (CMS), which comprise the consolidated balance sheet as of September 30, 2015 and the related consolidated statements of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal year then ended, and the related notes to the financial statements, and we were engaged to audit the statement of social insurance as of January 1, 2015, and the related statement of changes in social insurance amounts for the period ended January 1, 2015, and have issued our report thereon dated November 9, 2015. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, 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, 2015 and the related statement of changes in social insurance amounts for the period ended January 1, 2015.

Compliance and Other Matters

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, 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. 15-02. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. We limited our tests of compliance to these provisions, and we did not test compliance with all laws and regulations applicable to CMS.

The results of our tests of compliance with the laws and regulations described in the second paragraph of this report disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and OMB Bulletin No. 15-02, and which are described below.

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The Improper Payments Information Act of 2002 as amended by the Improper Payments Elimination and Recovery Act of 2010 and the Improper Payments Elimination and Recovery Improvement Act of 2013 (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. Although CMS has reported error rates for each of its high-risk programs, or components of such programs, it is not in full compliance with the Acts. For example, the Medicare fee-for-service error rate is greater than the statutorily required maximum of 10 percent and CMS did not meet its improper rate reduction target rates for its other programs. In addition, CMS is not in full compliance with Section 6411 of the Patient Protection and Affordable Care Act, as CMS has not yet implemented recovery activities of the identified improper payments for the Medicare Advantage (Part C) program. To date, CMS posted a Request for Quote in June 2014; however, no responses were received but CMS anticipates executing a contract in fiscal year 2016.

CMS' Response to Findings

CMS' response to the findings identified in our audit are described in their letter dated November 9, 2015. CMS' response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of compliance and the results of that testing, and not to provide an opinion on the entity's compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's compliance. Accordingly, this communication is not suitable for any other purpose.

Ernst & Young LLP

November 9, 2015

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

The Administrator and Chief Financial Officer 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, in accordance with auditing standards generally accepted in the United States and 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. 15-02, *Audit Requirements for Federal Financial Statements*, the financial statements of the Centers for Medicare and Medicaid Services (CMS), which comprise the consolidated balance sheet as of September 30, 2015 and the related consolidated statements of net cost and changes in net position, and the combined statement of budgetary resources for the fiscal year then ended, and the related notes to the financial statements, and we were engaged to audit the statement of social insurance as of January 1, 2015, and the related statement of changes in social insurance amounts for the period ended January 1, 2015, and have issued our report thereon dated November 9, 2015. That report states that because of the matters described in the Basis for Disclaimer of Opinion paragraphs, 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, 2015 and the related statement of changes in social insurance amounts for the period ended January 1, 2015.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered CMS' internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances 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. Accordingly, we do not express an opinion on the effectiveness of the CMS' internal control. We limited our internal control testing to those controls necessary to achieve the objectives described in OMB Bulletin No. 15-02. We did not test all internal controls relevant to operating objectives as broadly defined by the Federal Managers' Financial Integrity Act of 1982, 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

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possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected, on a timely basis. 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.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified. We did identify certain deficiencies in internal control related to Financial Reporting Processes and Information Systems Controls, as described below that we consider to be significant deficiencies.

Significant Deficiencies

Financial Reporting 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 and internal controls 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. CMS is a very large organization that is responsible for the management of complex programs that are continuing to increase in scope and size. CMS is entrusted with the lead role in overseeing health services in the United States. Financial reporting of the cost of health programs and the oversight role is important as the country continues to make decisions about this critical mission.

CMS relies on a decentralized organization and complex financial management systems to operate and accumulate data for financial reporting. The business owners and users of the systems are located at contracted organizations, providers, regional offices, Centers and Offices outside of the Office of Financial Management (OFM). Providing oversight requires a common set of accounting and reporting standards, proper execution of those standards/policies, an integrated financial system, properly trained personnel, and meaningful collaboration within CMS and with the Department of Health and Human Services (HHS). We identified deficiencies in implementing new program processes, designing financial controls, and the precision used in executing financial controls. We also have recommendations to improve controls by validating the CMS liability estimation methodologies by using a claims-based approach and monitoring adherence to established policies and procedures. We observed that at times there appears to be a lack of coordination and collaboration within the organization to resolve either the symptoms of or the broader organizational findings. CMS should continue to focus its efforts on identifying the underlying cause of the deficiencies, establishing the proper set of controls and implementing

an effective monitoring function to mitigate the risks over its financial management programs and related systems.

As CMS continues its efforts to enhance internal controls, the following items identified in the current year audit merit continued focus on the areas highlighted as part of the financial reporting systems and processes significant deficiency. Additional focus is required to minimize the risk of current and unresolved prior year deficiencies.

Analyses Required for an Effective Financial Management System

Critical or new financial matters identified within CMS require a robust analysis and review process, including meaningful coordination and collaboration with Centers and Offices, timely summarization of considerations and conclusions, and documentation of the significant accounting and budget matters. Several significant provisions of the Affordable Care Act were effective on January 1, 2014 (for example, the Marketplaces, premium subsidies, risk corridors, re-insurance provisions and risk adjustment). These programs rely on significant amounts of data from third parties and complex analyses to determine the final results. The finalization of the documentation for the internal control structure of the risk corridor, re-insurance and risk adjustment programs was not completed until the end of August 2015 and the analysis of the accounting impact to CMS, including the budgetary accounting for the risk corridor program, was not completed until October 2015. This compressed the timeframe for senior financial management and financial statement auditors to evaluate the internal control structure, the estimates and the related conclusions that impact the annual financial report released in November 2015. The documentation supporting the conclusions on unique, non-routine and critical processes and accounting matters should be prepared timely to assure that all aspects of the important financial matters are thoroughly considered.

CMS has a fiduciary responsibility over the financial relationships between the qualified health plans and the Federal government to authorize and reconcile such collections and/or payments. For the significant provisions of the Affordable Care Act, the effort to build processes to handle these new activities to date has been formidable. Significant work remains to automate and solidify the internal controls over the collections and/or payments in a manner that is reliable and sustainable over the long term.

During the internal control tests, errors were identified that were not detected by the organization's monitoring and review function, and accordingly, the control was not functioning as designed or intended. The errors identified by our audit procedures at the Central Office and regional offices may be summarized, including an example for each category, as follows: (i) policies and procedures are not properly designed and implemented; (ii) review or monitoring functions are established but failed to adhere to policies and procedures (for example, the accounts receivable reconciliation review procedures were established but the reconciliations were not performed consistently with the policy); and (iii) activity or accounts for which no formal, documented review or monitoring function was established (for example, the Medicaid

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Entitlement Benefits Due and Payable (EBDP) methodology does not include a look-back analysis of the prior year estimate based on detailed claims).

Because of its size and complexity, CMS by design relies upon a vast decentralized set of controls, performed by a very large number of people. Oversight of the effectiveness of that control structure at the Central Office could be enhanced by increasing the use of data analytics. Developing robust analytical review procedures or measures against benchmarks to monitor and mitigate risks associated within the decentralized nature of CMS operations should be enhanced and documented as part of the entity level control structure. It may be beneficial for CMS to identify a cross-functional working group to perform such analyses.

Oversight of Third-Party Contractors

CMS 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 Part C and Part D programs. We identified areas where improvements could be made in the control environment related to the oversight of third-party contractors.

The contracts between CMS and its Medicare fee-for-service contractors include provisions that require the Medicare Administrative Contractors (MACs) to develop and follow objectives established by CMS. Through the established procedures, CMS monitors the MACs' compliance with its policies and procedures, established internal controls and the completeness and accuracy of financial reporting. While this approach to financial integrity supports monitoring of the MACs' financial controls, the oversight/monitoring process historically has not been fully effective in identifying and resolving financial recording and reporting issues or ensuring that the issues are timely remediated by the MACs.

As noted in the prior year, we identified deficiencies where actions are required but have not been taken or resolved in the following circumstances: (1) the Medicare Summary Notices, which are returned to the MACs but are not investigated as to why they are returned; (2) the claims outstanding greater than one year – periodic review, track or monitor those aged claims other than those identified as bankruptcy, fraud or abuse; and (3) the provider records – reconcile, review or monitor provider records and provider eligibility status on a periodic basis to verify that all changes were timely, accurately and completely processed.

The nature and volume of its expenditures present a substantial challenge to CMS in the quantification, evaluation and remediation of improper payments. Health insurance claims represent the vast majority of the CMS payments. These payments are complex and involve the evaluation of the program eligibility of both the recipient of the services and of the health provider, oversight of the medical necessity of each covered treatment and concurrence with the cost to be paid, some of which is based on complex financial formulas and/or coding decisions. CMS has developed sophisticated sampling processes for estimating error rates in the high-risk

CMS programs of Medicare Fee-for-Service, Medicare Advantage, Medicare Prescription Drugs, Medicaid and Children's Health Insurance Program (CHIP).

As part of our audit procedures, we reviewed the error rate estimates and activities performed by management to identify and measure errors and reduce improper payments. Over the past few years, refinements have been made to the error rate estimation processes, which can impact the comparability of information on an annual basis. CMS reports that the main purpose of their error rate programs is to report an accurate measure of improper payments for each program. To accomplish this goal they build in time to their study to allow all payments sampled for review sufficient time to allow for appeals of the errors and submission of additional documentation by the claimant. CMS believes that expediting the error rate calculations would result in less time for sampled payments to complete the measurement process allowing errors to be cited solely due to the fact that not enough time was given for things such as appeals or documentation submission. Calling payments in error that were not truly improper payments would lead to a less accurate error rate. Allowing the maximum amount of time for this development causes the study to be completed very near the required annual reporting deadline. Although corrective action activities occurred throughout the year, upon completion of the study an additional analysis linking the results and specific policies and procedures that contribute to the error rate is provided to the administrators of each program. The administrators further develop corrective actions that specifically address the drivers of the error rate. We have identified that despite the extensive processes to increase the accuracy of the error rates and the significant programs and process changes instituted each year the error rate remains high in comparison to the Federal Government's stated goals.

Continued Implementation of the Integrated Financial Management System

CMS continues their efforts to implement a web-based accounting system, Healthcare Integrated General Ledger Accounting System (HIGLAS), which will integrate the reporting of financial data related to the CMS contractors' standard claims processing systems. HIGLAS is the system of record and CMS is preparing financial statements using HIGLAS. In the current year, CMS implemented an upgrade of HIGLAS. The full functionality of HIGLAS has not yet been implemented. The MACs' accounts receivable balances are recorded at Central Office through the manual journal voucher process. Although the creation of the periodic financial statements is largely system dependent, there is a need for manual interventions to properly categorize the information within the financial statements, as required by OMB A-136. In addition, some manual intervention was required to establish the appropriate general ledger beginning balances.

All MACs have implemented HIGLAS, except for the Durable Medical Equipment MACs. For these contractors, the accuracy of the financial 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.

Medicaid Oversight

The Medicaid program is the primary source of medical assistance for low-income Americans. Medicaid operates as a partnership between the states and the Federal government. The Federal government establishes the minimum requirements and provides oversight for the program and the states design, implement, administer and oversee their own Medicaid programs within the Federal parameters. Beginning January 1, 2014, the Affordable Care Act expanded eligibility for Medicaid to certain low-income adults and increased the Federal medical assistance percentage to 100 percent for those qualifying claims for the first three years, and 90 percent thereafter, for states that elected to participate in the program (Medicaid Expansion). The Center for Medicaid and CHIP Services (CMCS) is responsible for providing the Federal government oversight of the program and executing the internal controls at the Federal level, which includes: approval of the state plans and amendments, which serve as the contract describing how that state administers the program; approval of each state's budget (the authorized amount) on a quarterly or annual basis; reconciling the Federal share of the expenditures to amounts reported by the state; requiring the states to have program audits and performing analytical procedures over program expenditures. The Federal government controls were designed with the intention that the states would have their own set of procedures and controls over program costs.

The changes brought about by the Affordable Care Act have identified additional challenges and risks within the Medicaid process that warrant consideration and remediation:

- CMCS relies on each of CMS' ten regional offices to perform the review of each state's budget and expenditure reports and carry out the procedures and process discussed above. During our internal control tests performed for these regional offices, two instances were identified where the regional office did not properly review or document the review procedures of Medicaid expenditure reports against state supporting documentation. The risk is that Medicaid expenditures approved for reimbursement and reported in the financial statements are unallowable.

- Due to the implementation of Medicaid Expansion in January 2014, three states have not yet certified their quarterly expenditure reports for the quarters ended March 31, 2014 through September 30, 2014, and seven states have not certified for the quarters ended December 31, 2014 and March 31, 2015. One additional state has not certified its quarterly expenditure report as of December 31, 2014. This will result in a backlog of uncertified claims as well as delays in grant finalizations for FY 2014 and FY 2015 as the regional offices and CMCS reviews are not completed.

CMCS has been working on a multiyear project to develop data and analytics to improve their program and financial management. That project is not operational at a level where it currently provides controls supporting program integrity. CMCS should continue to enhance its financial management systems and its related data analyses capability to develop robust analytical procedures and measures against benchmarks to monitor and identify risks associated with the

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Medicaid program, including outliers and unusual or unexpected results that may identify abnormalities in state-related Medicaid expenditures. In addition, CMS does not perform a claims-level detailed look-back analysis for the Medicaid EBDP to determine the reasonableness of the various state calculations of incurred (unpaid claims) but not reported liability. The Medicaid EBDP is a significant liability on the FY 2015 financial statements. CMS currently does not have timely access to the states' claim data nor the ability to accumulate the detailed claim data by state to perform the analysis described above. CMS is not able to validate its methodology by using a claims-based approach due to the lack of individual claims-level detail and continues to rely on its estimation process to record the Medicaid EBDP without the ability to confirm the reasonableness of its methodology.

Recommendations

We recommend that CMS continue to develop, refine and adhere to its financial management systems and processes to improve its accounting, analysis and oversight of financial management activity. Specifically, we recommend that CMS implement the following:

- Establish a policy individual or group to analyze the accounting and reporting of unique, newly implemented, non-routine or significant transactions, enhance the financial reporting process and address or identify transactions that required cross-functional input. Enhancement of this process may assist to develop, document and validate the new critical accounting matters that are identified or implemented during the year and improve the timeliness and completeness of the formal documentation. In addition, prepare the required presentations and disclosures to ensure adequate time for analysis and feedback from key stakeholders.

- Continue the significant work required to automate and solidify the controls over the Affordable Care Act expenditures related to the health insurance subsidies in a manner that is reliable and sustainable over the long term.

- Develop robust analytical procedures or measures against benchmarks to monitor and mitigate risks associated with the decentralized nature of CMS operations should be enhanced and documented as part of the entity level control structure.

- Revise and enhance the design of the financial review guidance provided to the various Centers, regional offices and MACs to incorporate more analyses and scrutiny in the review of the financial information. Ensure that the appropriate policies are established, implemented and adhered to by the various Centers, regional offices and MACs or if the specific policy is not implemented determine that the required documentation and approval exists to demonstrate how the risk is appropriately mitigated or responded to through other procedures.

- Consider expediting the error rate development study time to increase the time allocated to analyze the findings and development of the plans for remediation prior to the required reporting deadline. Additional analysis of the error rate study results may increase observations of specific causes, contributing factors and anomalies to drive investigations of the root causes of the errors and improve prevention, mitigation and recovery plans.

- Continue to implement its integrated financial management system for use by CMS and the Medicare fee-for-service contractors to promote consistency and reliability in accounting and financial reporting and assess the capability of and implement the full functionality of HIGLAS.

- Until the states become accustomed to the Medicaid Expansion policies and procedures, CMCS should strengthen oversight and support that will serve to prevent an inordinate backlog of uncertified claims.

- 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 approximately $36.8 billion accrual.

Information Systems Controls

Information systems controls are a critical component of the Federal government's operations to manage the integrity, confidentiality and reliability of its programs and activities and assist with reducing the risk of errors, fraud or other illegal acts. The nature, size and complexity of CMS' operations require the organization to administer its programs under a decentralized business model by using numerous geographically dispersed contractors operating complex and extensive information systems. CMS has initiated several strategic enhancements to its information security controls, including the development of enhanced policies and procedures, implementation of new protections for beneficiary data, and more restrictive system authentication access methods.

CMS' Central Office supports a number of Medicare fee-for-service computerized systems used by numerous external organizations such as MACs, Shared Systems Maintainers (SSMs) and Virtual Data Centers (VDCs), collectively referred to as Medicare fee-for-service contractors, to administer Medicare fee-for-service claims and related beneficiary, provider, payment and financial management data processes.

To manage the operational and financial risk presented by these information systems, CMS established information security and configuration management policies and procedures based on control techniques mandated by Federal standards-setting organizations and adopted government-wide. These policies and procedures are used for CMS Central Office systems and also are incorporated by reference in CMS' agreements with its contractors. Formal monitoring procedures have been developed and implemented by CMS Central Office.

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For the Medicare fee-for-service shared systems, CMS has contracted with several SSMs to provide application software development, documentation, testing and training support for the majority of the systems used to process Medicare fee-for-service claims. The MACs use the shared systems and are responsible for the configuration of locally programmed edits (for example, a valid provider type was entered for the medical service rendered) and automated adjudication software (scripts) and local information security user administration procedures. The complexity of managing changes as a result of new or revised Medicare fee-for-service policies and other directives issued by CMS impacts the overall integrity of the claims process.

Change requests for the shared systems are developed as a result of numerous events, including medical policy revisions issued by CMS' medical staff based on legislative mandates, national trends, historical analysis, implementation of new or revised business processes to efficiently manage the significant volume of claims processed by CMS every day, and the implementation of new processing technologies.

The SSMs perform the initial program design and coding of changes to the shared systems. CMS coordinates the change control activities for the updates to the shared systems. Integration testing is performed to determine whether modified software components are operating in accordance with CMS' requirements and to verify that unexpected or unintended changes to the shared systems do not occur. Through the VDCs, these changes are applied to the shared systems for the individual MACs at least quarterly. MACs may also implement certain local changes provided they are compliant with CMS' directives.

CMS has implemented configuration and change control processes for its Central Office systems that affect the Medicare fee-for-service, Medicare Advantage, Medicare Prescription Drug, Medicaid and CHIP programs. These processes include the use of structured system development methodologies, change control boards, and configuration management software to help ensure the integrity of program code.

As CMS continues its efforts to enhance its internal controls, the following items identified in the current year audit merit continued focus on the information systems controls and processes. Additional focus is required to minimize the risk of current and unresolved prior year deficiencies.

Governance Over Implementation of Information Systems Control Standards and Processes

CMS is challenged in maintaining information systems controls by a number of key factors, including:

- The use and reliance upon contractors to accomplish most business functions, including operation of the computer systems. In many cases, the degree of computer security is dependent upon a contractor's interpretation of and adherence to CMS security policies.

- The responsibilities of the information systems controls oversight includes multiple business units within CMS Central Office, such as the Office of Technology Services (OTS), Office of Enterprise Information (OEI), and the Center for Medicare (CM), resulting in potentially varying interpretations of CMS' security standards and guidance, the degree of monitoring and enforcement and the translation of Federal security mandates into actual CMS practices.

- The large number of users required to have access to CMS systems to process claims and to support beneficiaries in a timely and effective manner.

CMS continues to experience deficiencies in the implementation and monitoring of compliance with its defined computer security polices at both the Medicare fee-for-service contractors and the Central Office. Periodically, change management policies are waived to accommodate a compressed schedule to implement numerous required change requests across the broad range of claims systems. CMS allows in certain circumstances the Medicare fee-for-service contractors to self-approve these waivers. Those waivers are reported after the fact as part of the quarterly oversight process. Monitoring controls would be strengthened if CMS required those waivers for all Medicare fee-for-service contractors to be formally documented, accessible to and reviewed by CMS. The documentation should assess the risk and include mitigating factors to reduce the risk to acceptable levels. Further, CMS' quarterly oversight process should be formalized and include acknowledgement of approval from responsible CMS officials concurring with the need for and use of any waivers.

Certain data edit checks for two significant Medicare claims processing systems were not set in accordance with the prescribed CMS standards. In addition, the results of the quarterly edit compliance review process performed by CMS were not communicated timely to the Medicare fee-for-service contractors.

The Medicare fee-for-service contractors are subject to regular audits as part of the overall oversight by CMS. CMS annually engages, or requires the Medicare fee-for-service contractors to engage, external independent public accounting firms to test various information systems controls at the Medicare fee-for-service contractors. We identified that information security and configuration management-related findings identified by these audits remain unresolved from prior years.

To mitigate the risk of insufficient integration of the information systems, CMS has developed a process requiring interface control documents (ICDs) for its major applications, but the process has not been followed consistently to include all of the standard content.

As a result of the governance deficiencies identified, CMS may not be able to ensure the accuracy, completeness or overall integrity of its Medicare systems and other enterprise-wide systems.

Controls over System Access and Monitoring of System Access

Information management security and configuration controls are fundamental to the integrity of all information systems. Such controls, including properly authorized, designed and implemented controls, and active monitoring of security events for proper assessment and timely remediation, can help manage risks such as unauthorized access and changes to critical data. These controls include physical and logical access restrictions to protect against unauthorized usage of CMS information resources, including programs and data files. In addition, without maintaining an appropriate level of segregation of duties through robust information management security and configuration controls, the integrity of CMS' information resources could be compromised.

Our findings related to system access include:

- Procedures for adding or removing users were not consistently followed.
- Certain authentication mechanisms were insufficiently implemented to require more stringent security requirements for system access.
- Oversight of periodic access reviews for key applications was not performed as required or not adequately performed.
- Several vulnerabilities related to system configurations were identified with the Central Office and Medicare fee-for-service information systems.
- Secure access configuration settings were not consistently implemented or reviewed.
- Evidence supporting testing of claims processing software changes was not always retained.
- Waivers for changes to the information systems configurations were not always obtained by Medicare fee-for-service contractors.

Appropriate consideration of the design of controls over access and monitoring of access is essential to provide a suitable framework for subsequent implementation and operation of the controls.

Prevention of and Monitoring for Inconsistencies in Access Rights Allowing a Potential Lack of Segregation of Duties

CMS continues to experience difficulties in implementing its policy of least privilege access, preventing and monitoring for inconsistencies in access rights to various systems, and mitigating the potential impact on adequate segregation of duties. We found several deficiencies that may

result in a potential lack of segregation of duties at both the Medicare fee-for-service contractors and across the enterprise.

CMS system user access rights were not adequately maintained or monitored. Examples of deficiencies that we found include:

- One Central Office application did not have adequate segregation of duties as it relates to implementing new program code.
- Business users for one significant application had the ability to increase their access capabilities, such as maintaining application program code and the system configuration files.

Without adequate controls over managing access to critical systems and segregation of duties, the risk of errors, fraud or other illegal acts is increased.

Recommendations

CMS should continually assess the governance and oversight across its organizational units charged with responsibility for the configuration management and information security of its Medicare fee-for-service systems and data at both the Central Office and the CMS Medicare fee-for-service contractors. Such an approach will require continued and active communication and integration of efforts by the OTS, OEI and CM.

An improved governance-based approach should result in strengthened control, monitoring, and oversight processes that will enhance the overall integrity of CMS' information systems. Examples of such oversight processes that should be improved include:

- Reviewing and evaluating identified deficiencies and instances of noncompliance with stated CMS policies and guidance, including the documentation of conclusions and evaluating their impact on the financial statements.
- Consistent, current and complete system security and periodic review of data edit checks compliance with prescribed CMS standards and timely communication of the results and actions to be taken by the Medicare fee-for-service contractors.
- Following relevant CMS guidance, documentation should be prepared and retained for all phases of the change management process.
- Consistently completed ICDs for all of CMS' significant systems.

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Specific to the implementation of access controls and related control activities pertaining to configuration management and information security, we recommend that CMS ensure:

- Continued implementation of system security management activities at the Central Office and the Medicare fee-for-service contractors in accordance with CMS' policies and guidance, related monitoring procedures and timely remediation of identified deficiencies.

- All application changes and interfaces to CMS systems, including the Medicare fee-for-service shared systems, and related support systems managed by the Central Office are documented and tested timely, adequately and completely.

- Appropriate segregation of duties is established for all systems that support CMS' programs, including Medicare fee-for-service claims and related financial processing at the MACs and VDCs to prevent excessive or inappropriate access. In addition, access to all systems should be periodically assessed to ensure that access remains appropriate and no incompatible duties exist.

CMS' Response to Findings

CMS' response to the findings identified in our audit are described in their letter dated November 9, 2015. CMS' response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

Purpose of This Report

The purpose of this report is solely to describe the scope of our testing of internal control and the results of that testing, and not to provide an opinion on the entity's internal control. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control. Accordingly, this communication is not suitable for any other purpose.

Ernst & Young LLP

November 9, 2015

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF FINANCIAL MANAGEMENT

November 9, 2015

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

Dear Sir:

The Centers for Medicare & Medicaid Services (CMS) has reviewed your audit report, and we are pleased to receive an unqualified opinion on our Consolidated Balance Sheets, Consolidated Statements of Net Cost, Consolidated Statement of Changes in Net Position, and the Combined Statements of Budgetary Resources. Ernst & Young continues to disclaim an opinion on the Statement of Social Insurance (SOSI) and the related Statement of Changes in Social Insurance Amounts due to the uncertainty of the long-range assumptions used in the SOSI model. CMS continues to believe that the SOSI projections appropriately show the effects of the Affordable Care Act and that we have provided sufficient disclosures regarding the nature and uncertainty of these projections.

The audit identified no material weaknesses in our internal controls; however, significant deficiencies in financial reporting and information systems continue to be cited. Many of the issues surrounding information systems are multi-year efforts which require a significant amount of resources; however, the Agency is committed to strengthening our controls and improving financial transparency. CMS has already taken great strives to remediate the causes of the deficiencies noted in the report and will continue our efforts on resolving these deficiencies.

The annual audit of our financial statements serves as an on-going catalyst to improving our processes and always helps us improve our internal controls. I would like to thank your office for its work in completing the audit and look forward to your continued support as we work to remediate the issues noted.

Sincerely,

Megan Worstell

Megan Worstell
Acting Chief Financial Officer

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OTHER INFORMATION

Summary of Federal Managers' Financial Integrity Act and OMB Circular A-123 Statement of Assurance // Improper Payments

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

CMS assesses its internal controls through: (1) management self-assessments, including annual tests of security controls; (2) Office of Management and Budget (OMB) Circular A-123, Appendix A self-assessments; (3) assessments of internal control over the acquisition function; (4) Office of Inspector General (OIG) audits, and Government Accountability Office (GAO) audits and High-Risk reports; (5) Statement on Standards for Attestation Engagements (SSAE) 16 internal control audits; (6) evaluations and tests of Medicare contractor controls conducted pursuant to Section 912 of the Medicare Modernization Act; (7) the annual Chief Financial Officer (CFO) audit; (8) certification and accreditation of systems; and (9) HHS's Program Integrity Initiative. As of September 30, 2015, the internal controls and financial management systems of CMS provided reasonable assurance that the objectives of the Federal Managers' Financial Integrity Act (FMFIA) were achieved with the exception of two instances of noncompliance.

OMB Circular No. A-123 Statement of Assurance

CMS management is responsible for establishing and maintaining effective internal control and financial management systems that meet the objectives of FMFIA and 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, as of September 30, 2015, CMS provided a qualified statement of reasonable assurance that its internal controls and financial management systems met the objectives of FMFIA due to noncompliance with Improper Payments Information Act of 2002 (IPIA), as amended by the Improper Payments Elimination and Recovery Act (IPERA), signed into law on July 22, 2010, and the Improper Payments Elimination and Recovery Improvement Act (IPERIA), signed into law on January 10, 2013; and Section 6411 of the Affordable Care Act.

Assurance for Internal Control over Financial Reporting

CMS conducted its assessment of the effectiveness of internal control over financial reporting, which includes the safeguarding of assets and compliance with applicable laws and regulations, in accordance with the requirements of Appendix A of OMB Circular No. A-123. Based on the results of this assessment, CMS provided reasonable assurance that internal controls over financial reporting as of June 30, 2015, were operating effectively and no material weaknesses were found in the design or operation of the internal control over financial reporting.

Assurance for Internal Control over Operations and Compliance

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, 2015, 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, 2015, CMS also complied with applicable laws and regulations, except for the two instances of noncompliance noted above.

Assurance for the Federal Financial Management Improvement Act of 1996

The Federal Financial Management Improvement Act of 1996 (FFMIA) requires agencies to implement and maintain financial management systems that are substantially in compliance with Federal financial management systems requirements, Federal accounting standards, and the United States Standard General Ledger at the transaction level. CMS conducted its assessment of financial management systems for compliance with FFMIA. Based on the results of this evaluation, CMS provided reasonable assurance that all CMS financial management and related systems substantially comply with FFMIA as of September 30, 2015.

Noncompliance—Actions and Accomplishments

CMS did not fully comply with IPIA, as amended by IPERA and IPERIA, hereafter referenced as IPERIA, and Section 6411 of the Affordable Care Act.

For Medicare fee-for-service (FFS), CMS and HHS work together to set aggressive reduction targets in an effort to drive improvement in payment accuracy levels. The downside of setting aggressive targets is that they may not always be met. CMS has several corrective actions in place or under development to reduce improper payments. CMS believes these major undertakings will have a larger impact through time.

CMS's FY 2015 IPERIA noncompliance stems from the following:

1. The Medicare FFS improper payment rate was 12.09 percent, meeting the IPERIA reduction target but not meeting the compliance threshold of reporting an improper payment rate below 10 percent.

2. The Medicare Part C improper payment rate was 9.50 percent, meeting the IPERIA compliance threshold of reporting an improper payment rate below 10 percent. However, the Part C improper payment rate did not meet its previously established target of 8.5 percent.

3. The Medicare Part D improper payment rate was 3.60 percent, meeting the IPERA compliance threshold of reporting an improper payment rate below 10 percent. However, the Part D improper payment rate did not meet its previously established target of 3.5 percent.

4. The Medicaid improper payment rate was 9.78 percent. Although the improper payment rate was lower than 10 percent, CMS did not meet its previously established target of 6.7 percent.

5. The FY 2015 CHIP improper payment rate was 6.80 percent. Although the improper payment rate was lower than 10 percent, CMS did not meet its previously established target of 6.5 percent.

CMS has taken, and continues to take a number of actions outlined in the FY 2015 Agency Financial Report (AFR) [please see 2014 HHS AFR released November 17, 2014] to reduce error rates in all of its programs, including the Medicare FFS and Part D programs. CMS continues its efforts to comply with IPERIA and OMB's implementing guidance.

Regarding compliance with Section 6411 of the Affordable Care Act, CMS began implementation efforts in December 2010, by publishing a solicitation of comments regarding the development of the Medicare Part C Recovery Audit Contractor (RAC) program. More recently, a Request for Quote was posted in June 2014; however, no responses were received as a result of that solicitation. CMS continues its implementation efforts and anticipates awarding a contract in FY 2016.

IMPROPER PAYMENTS

In July 2010, Congress amended the IPIA, with the IPERA to better standardize the way Federal agencies report improper payments in programs they oversee or administer. In January 2013, Congress amended IPERA with the IPERIA, which emphasizes the importance of not only measuring improper payments, but also recovering and reducing improper payments. The IPERIA 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. Since FY 2011, CMS complied with the OMB's IPERIA reporting guidance and implemented comprehensive processes that measure the payment error rates for the Medicare FFS, Medicaid, CHIP, Medicare Advantage (Part C), and Medicare Prescription Drug (Part D) programs.

Medicare Fee-for-Service (FFS)

CMS measures the national Medicare FFS improper payment rate annually, through the Comprehensive Error Rate Testing (CERT) program. The Medicare FFS measurement methodology is the same as the 2014 methodology. The Medicare FFS payment accuracy rate was 87.91 percent during the FY 2015 report period. That is, Medicare FFS claim payments were made correctly 87.91 percent of the time, which is an estimated $315.02 billion in proper payments.

The CERT program calculates the Medicare FFS payment accuracy rate by reviewing claims and the supporting medical records. These reviews uncover more complex issues including lack of sufficient information and lack of medical necessity. These issues are not detectable through automated

methods. CMS believes that more can be done to achieve an even greater payment accuracy rate. To do this, CMS must focus its corrective actions on specific areas that are most vulnerable to improper payments.

HHS and CMS developed a Corrective Action Plan that outlines actions the agency will implement to prevent and reduce improper payments. Of particular importance are the following corrective actions:

1. CMS continues to implement corrective actions to address Home Health Agency (HHA) vulnerabilities. CMS issued a final rule, CMS-1611-F (79 FR 66031, November 6, 2014) to update Medicare's Home Health Prospective Payment System payment rates and wage index for calendar year 2015. In this rule, CMS finalized changes to the face-to-face requirements for episodes beginning on or after January 1, 2015 which clarified the HHA regulation to remove the requirement for the physician narrative as part of the certification of patient eligibility for the benefit, to substantiate that the home health patient eligibility criteria have been met. Now reviewers can consider all entries in the medical record when determining medical necessity.

2. CMS proposed an update to the "Two Midnight" rule CMS-1633-P, (70 FR Volume 80, Number 130, July 8, 2015) regarding when inpatient admissions are appropriate for payment under Medicare Part A. At the same time, CMS notified the public of two upcoming changes in education and enforcement strategies.

3. CMS issued a proposed rule that would build on a successful demonstration program to establish a Master List of Durable Medical Equipment, Prosthetic, Orthotics and Supplies (DMEPOS) items that are frequently subject to unnecessary utilization and potentially subject to prior authorization, as well as a Required Prior Authorization List of certain DMEPOS items that are subject to a prior authorization process.

4. CMS expanded the use of prior authorization in the Medicare FFS program. CMS leveraged the success of the prior authorization demonstration program for power mobility devices (PMDs) by expanding the demonstration to an additional 12 states (Arizona, Georgia, Indiana, Kentucky, Louisiana, Maryland, Missouri, New Jersey, Ohio, Pennsylvania, Tennessee, and Washington) effective October 1, 2014, bringing the total number of states participating in the demonstration to 19. CMS also extended the demonstration to August 31, 2018 in FY 2015.

5. In FY 2015, CMS implemented two demonstration projects. In December 2014, CMS implemented a prior authorization demonstration program for repetitive, scheduled non-emergent ambulance transport in New Jersey, Pennsylvania, and South Carolina. Section 515 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) expands the prior authorization model for repetitive scheduled non-emergent ambulance transports effective no later than January 1, 2016 to five additional states (North Carolina, Virginia, West Virginia, Maryland, and Delaware) and the District of Columbia. In 2015, CMS implemented a prior authorization demonstration program for non-emergent hyperbaric oxygen therapy in Michigan, Illinois, and New Jersey.

FY 2015 GROSS IMPROPER PAYMENTS AND ERROR RATES IN THE MEDICARE FFS PROGRAM

		GROSS[1]	
Overpayments	**Underpayments**	**Improper Payment Amount (Overpayments + Underpayments)**	**Improper Payment Rate**
$42.07 B	**$1.26 B**	**$43.33 B**	**12.09%**

[1] Beginning in FY 2012, in consultation with OMB, CMS refined the improper payment methodology to account for the impact of rebilling denied Part A inpatient hospital claims for allowable Part B services when a Part A inpatient hospital claim is denied because the services (i.e. improper payments due to inpatient status reviews) should have been provided as outpatient services. CMS continued using this methodology in FY 2015. This approach is consistent with: (1) Administrative Law Judge (ALJ) and Departmental Appeals Board (DAB) decisions that directed HHS to pay hospitals under Part B for all of the services provided if the Part A inpatient claim was denied, and (2) recent Medicare policy changes that allow rebilling of denied Part A claims under Part B.

CMS calculated an adjustment factor based on a statistical subset of inpatient claims that were in error because the services should have been provided as outpatient. This adjustment factor reflects the difference between what was paid for the inpatient hospital claims under Medicare Part A and what would have been paid had the hospital claim been properly submitted as an outpatient claim under Medicare Part B. Application of the adjustment factor decreased the overall improper payment rate by 0.38 percentage points to 12.09 percent or $43.33 billion in projected improper payments.

Medicare Advantage (Part C) and Prescription Drugs (Part D)

CMS has reported a Part C payment error rate since FY 2008. The Part C error rate measures improper payments made to Medicare Advantage (MA) plans based on diagnoses submitted by MA plans for payment (or risk adjustment error). The Part C payment error rate was 9.50 percent for the FY 2015 reporting period.

Since FY 2011, CMS has reported a composite payment error rate for the Medicare Prescription Drug Benefit, a Medicare benefit effective calendar year 2006. The Part D composite payment error rate combines four component error rates into a single composite measure for total Part D payments: (1) Payment Error Related to Low Income Status (PELS); (2) Payment Error Related to Incorrect Medicaid Status (PEMS); (3) Payment Error Related to Prescription Drug Event (PDE) Data Validation (PEPV); and (4) Payment Error Related to Direct and Indirect Remuneration (PEDIR). The Part D composite payment error rate was 3.60 percent for the FY 2015 reporting period.

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.

CMS measures the national improper payment rate for Medicaid and CHIP annually, through the Payment Error Rate Measurement (PERM) program. Through PERM, CMS measures three areas of Medicaid and CHIP: FFS claims, managed care payments, and eligibility cases. A sample of 17 states is measured each year to produce and report national program improper payment rates.

The FY 2015 Medicaid and CHIP improper payment rate report period covers payments made through September 30, 2014. It is important to note that, for FY 2015 – FY 2018 reporting, Medicaid and CHIP eligibility review pilots are being conducted in place of the PERM eligibility component reviews due to changes in Medicaid and CHIP eligibility required by the Affordable Care Act. During this time, Medicaid and CHIP program error rates are based on the FFS and managed care PERM reviews and an eligibility component error rate that is held constant at the FY 2014 level (which does not reflect eligibility determinations made under new Affordable Care Act requirements), while CMS updates the PERM eligibility component review methodology to reflect the new Affordable Care Act rules. CMS will issue new regulations and guidance, and resume the PERM eligibility component for reporting in FY 2019.

The national Medicaid improper payment rate reported for FY 2015 is 9.78 percent or $29.12 billion in gross improper payments based on measurements conducted in FYs 2013, 2014, and 2015. The national component improper payment rates are as follows, Medicaid FFS: 10.59 percent; Medicaid managed care: 0.12 percent. Medicaid eligibility remains at the FY 2014 level of 3.11 percent.

The Medicaid improper payment rate increased from 6.69 percent in FY 2014 to 9.78 percent in FY 2015. The increase was due to state difficulties getting systems into compliance with new requirements. As in FY 2014 the 17 states reviewed in FY 2015 are still in the process of implementing the requirements. The Affordable Care Act requires all referring/ordering providers to be enrolled in Medicaid and requires states to screen providers under a risk-based screening process prior to enrollment. Additionally, a new Health Insurance Portability and Accountability Act (HIPAA) standard requires the attending provider National Provider Identifier (NPI) on all electronically filed institutional claims. While these requirements will ultimately strengthen the integrity of the program, they require systems changes and, therefore, many states had not fully implemented these new requirements. CMS works closely with states to develop state-specific corrective action plans which address improper payments and describe systems updates to bring states into compliance.

The national CHIP improper payment rate reported for FY 2015 is 6.80 percent, or $0.63 billion in gross improper payments based on measurements conducted in FY 2013, 2014, and 2015. The national component improper payment rates are as follows: CHIP FFS: 7.33 percent; CHIP managed care: 0.37 percent. CHIP eligibility remains at the FY 2014 level of 4.22 percent.

The CHIP improper payment rate increased from 6.46 percent in FY 2014 to 6.80 percent in FY 2015. The increase was due to state difficulties getting systems into compliance with new requirements. As in FY 2014, the 17 states reviewed in FY 2015 are still in the process of implementing the requirements. The Affordable Care Act requires all referring/ordering providers to be enrolled in Medicaid and requires states to screen providers under a risk-based screening process prior to

enrollment. Additionally, a new Health Insurance Portability and Accountability Act (HIPAA) standard requires the attending provider National Provider Identifier (NPI) on all electronically filed institutional claims. While these requirements will ultimately strengthen the integrity of the program, they require systems changes and, therefore, many states had not fully implemented these new requirements. CMS works closely with states to develop state-specific corrective action plans which address improper payments identified and describe system updates to bring states into compliance.

The Medicaid and CHIP eligibility review pilots provide rapid feedback to states and CMS on the accuracy of Medicaid and CHIP eligibility determinations made during the initial years of the Affordable Care Act implementation. The pilots identify strengths and weaknesses in operations and systems to allow states to quickly implement corrective actions. The eligibility review pilots identified vulnerabilities in processes and systems that states took action to address, which is essential to preventing future improper payments. The most common issues identified through the eligibility review pilots were instances where caseworkers or systems did not properly establish household composition or income level, although these issues did not necessarily lead to eligibility determination errors. The pilots also provided states with essential feedback on their processes as states identified issues with improper requests for additional information from applicants, failure to send appropriate notices for denied cases, and failure to appropriately transfer denied cases to marketplaces. States are implementing corrective action strategies such as caseworker training and systems fixes as the pilots continue. More information on the pilots can be found at: **https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/FY2014_FY2016EligibilityReviewPilots-.html**.

GLOSSARY

A

Accountable Care Organizations (ACO): A group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for the patients they serve.

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.

Advance Premium Tax Credit: An advance payment of the premium tax credit in an amount based on the costs of health plans in the applicable Marketplace, household composition, and the amount of household income as compared to the poverty line.

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 the energy sector.

B

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

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

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

C

Carrier: A private business, typically an insurance company, that contracts with CMS to receive, review, and pay physician and supplier claims. Carriers have been largely replaced by Medicare Administrative Contractors.

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.

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 and reporting. The aim of the CFO Act is to improve financial management systems and information, and require the development and maintenance of agency financial management systems that comply with: applicable accounting principles, standards, and requirements; internal control standards; and requirements of the Office of Management and Budget (OMB), the Department of the Treasury, and others.

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 extended and expanded CHIP which was enacted as part of the Balanced Budget Act of 1997 (BBA).

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.

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.

Consumer Operated and Oriented Plan Program (CO-OP): The Affordable Care Act established the CO-OP Program to foster the creation of qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets.

Corrective Action Plan (CAP): The detailed actions that are taken to resolve an audit finding or internal control deficiency.

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.

Cost Sharing Reduction: Payments to health care insurers on behalf of eligible insured low-income individuals and families enrolled in silver-level QHPs based on the amount of household income for the insured as compared to the poverty line. Payments are applied to reduce out-of-pocket costs for the eligible insured individuals.

D

The Debt Collection Improvement Act of 1996 (DCIA of 1996): The DCIA requires Federal agencies to refer delinquent non-tax debts to the Department of the Treasury's Financial Management Service (FMS) for purposes of collection by offset of non-tax payments. Non-tax payments include vendor, Federal retirement, Federal salary, and Social Security benefits.

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 includes 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 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): Durable or long-lasting purchased or rented items such as hospital beds, wheelchairs, or oxygen equipment used for medical reasons in a patient's home.

Durable Medical Equipment Medicare Administrative Contractors (DME MACs): In an effort to provide greater efficiency in the Medicare program as it applies to Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), CMS awarded contracts to four health care contractors which cover a specific geographic region of the country and only process Medicare claims for DMEPOS items.

E

Early Retiree Reinsurance Program (ERRP): The ERRP provides reimbursement to employer and union sponsors of participating employment-based plans for a portion of the cost of health benefits for early retirees and their spouses, surviving spouses and dependents.

Electronic Health Record (EHR): An EHR is a digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users.

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

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.

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 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.

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

G

Government and Performance and Results Act Modernization Act (GPRA Modernization Act): Amends the Government Performance and Results Act of 1993 to require each executive agency to make its strategic plan available on its public website and to the Office of Management and Budget (OMB) on the first Monday in February of any year following that in which the term of the President commences and to notify the President and Congress.

Government Management Reform Act of 1994: Requires the annual financial statements of executive agencies to be audited prior to submission to OMB.

H

Health Care Exchanges (Marketplace): A mechanism for facilitating the purchase of Qualified Health Plans and evaluating eligibility for Advance Premium Tax Credits and Cost Sharing Reductions.

Health Care Fraud Prevention and Enforcement Team (HEAT): The joint initiative between HHS and DOJ to target tools and resources to fight fraud.

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.

Healthcare Fraud Prevention Partnership (HFPP): A public-private partnership among the Federal Government, states and private health insurance companies and associations to prevent and detect fraud across the healthcare industry.

Health Information Exchange (HIE): The electronic sharing of health-related information among organizations.

Health Information Technology (HIT): Health information technology (health IT) involves the exchange of health information in an electronic environment.

Health Information Technology for Economic and Clinical Health Act (HITECH): The American Recovery and Reinvestment Act of 2009 (ARRA) includes the "HITECH Act," which established programs under Medicare and Medicaid to provide incentive payments to eligible professionals (EPs), hospitals, and critical access hospitals for the "meaningful use" of certified EHR technology.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): Major provisions include portability provisions for group and individual health insurance, established 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 Improvement Act (IPERIA): In FY 2010, Congress amended the Improper Payments Information Act (IPIA), which is now known as the Improper Payments Elimination and Recovery Improvement Act (IPERIA) (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.

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

Internal Controls: Management's tools, such as the organization's policies and procedures, that help program and financial managers achieve results and safeguard the integrity of their programs. Such controls include program, operational, and administrative areas, as well as accounting and financial management.

M

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

Marketplace: See definition for Health Care Exchanges.

Material Weakness: A deficiency, or 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.

Medicaid: A joint Federal and state program that helps with medical costs for persons with limited income and resources. Medicaid programs vary from state to state, but most health care costs are covered if one qualifies for both Medicare and Medicaid.

Medical Loss Ratio: Requires health insurance companies to spend 80 to 85 percent of premium dollars on medical care and health care quality improvement, rather than on administrative costs. When they do not, health insurance companies are required to provide a rebate to their customers.

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

Medicare: Medicare is the Federal health insurance program for people who are 65 or older, certain younger people with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD).

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA): Legislation passed to strengthen Medicare, extends the Children's Health Insurance Program (CHIP), and makes numerous other improvements to the health care system.

Medicare Administrative Contractor (MAC): A private entity that CMS contracts with under section 1874A of the Social Security Act, as added by the Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003. The Part A and Part B MACs handle Medicare Part A and Medicare Part B claims processing and related services under the MMA, and DME MACs handle Medicare claims for Durable Medical Equipment.

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.

Medicare Drug Integrity Contractor (MEDIC): A contractor that assists in the oversight and anti-fraud and abuse efforts for the Part C and Part D programs.

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, Medicaid, and State Children's Health Insurance Program Extension Act 2007: Legislation that extended the original CHIP budget authority.

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/or Part B. Beneficiaries who qualify for both Medicare and Medicaid (full benefit dual-eligibles) automatically receive the Medicare drug benefit.

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.

Medicare Shared Savings Program (SSP): Section 3022 of the Affordable Care Act added a new section 1899 to the Social Security Act that establishes the Shared Savings Program. This program encourages providers of services and suppliers (e.g., physicians, hospitals and others involved in patient care) to create a new type of health care entity, an Accountable Care Organization (ACO). ACOs agree to be held accountable for improving the health and experience of care for individuals and improving the health of populations while reducing the rate of growth in health care spending.

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.

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

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.

Patient Protection and Affordable Care Act (Affordable Care Act) (P .l. 111-148): In FY 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. The Affordable Care Act provides 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.

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

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. PI activities target the range of causes of improper payments, including errors, fraud, waste, and abuse.

Program Management: The CMS operational account which supplies CMS with the resources to administer Medicare, the Federal portion of Medicaid, the Children's Health Insurance Program (CHIP), and the Marketplaces under the Affordable Care Act. The components of Program Management are: program operations, survey and certification, and federal administrative costs.

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

Q

Qualified Health Plans: Health insurance plans which meet minimum standards for health benefit coverage.

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).

Reinsurance: The transitional reinsurance program stabilizes premiums in the individual market inside and outside of the Marketplaces. The transitional reinsurance program will collect contributions from contributing entities to fund reinsurance payments to issuers of non-grandfathered, Affordable Care Act-compliant reinsurance-eligible individual market plans, the administrative costs of operating the reinsurance program, and the General Fund of the U.S. Treasury for the 2014, 2015 and 2016 benefit years.

Retiree Drug Subsidy Program: The retiree drug subsidy (RDS) is one of several options available under Medicare that enables employers and unions to continue assisting their Medicare eligible retirees in obtaining more generous drug coverage.

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

Risk Adjustment: The risk adjustment program is designed to protect issuers that attract a high risk population, such as those with chronic conditions. Under this program, money is transferred from issuers with lower risk enrollees to issuers with higher risk enrollees. This is a State-based program that applies to non-grandfathered plans in the individual and small group markets, inside and outside of Exchanges.

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.

Risk Corridors: The risk corridor program provides issuers of qualified health plans (QHPs) in the individual and small group markets additional protection against uncertainty in claims costs during the first three years of the Marketplace. This program, which was modeled after a similar program used in the Medicare prescription drug benefit, encourages issuers to keep their rates stable as they adjust to the new health insurance reforms in the early years of the Marketplaces.

S

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

Significant Deficiency: Is a deficiency, or a combination of deficiencies, in internal control that is less serve than a material weakness, yet important enough to merit attention by those charged with governance.

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

Statement on Standards for Attestation Engagements (SSAE) Number 16 (SSAE 16): A report issued by an independent public accountant in accordance with standards promulgated by the American Institute of Certified Public Accountants (AICPA) on the internal controls of a servicing organization. The AICPA SSAE 16 defines the professional standard used by a service organization's auditor to assess the internal controls at a service organization.

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

T

Tax Relief and Health Care Act: Legislation that required HHS to implement the Medicare FFS Recovery Audit Program in all 50 states no later than January 1, 2010.

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

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Copies of this report are also available on the Internet at http://www.cms.hhs.gov/CFOReport/.

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